Ministry of Health

REPORT OF THE MINISTER OF HEALTH ON THE IMPLEMENTATION OF THE LAW CONTAINING NORMS FOR MATERNITY PROTECTION AND FOR THE VOLUNTARY TERMINATION OF PREGNANCY (LAW 194/78)

✓ *FINAL DATA 2014 and 2015*

Rome, 7 December 2016

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PRESENTATION

Mister President, Honourable Colleagues,

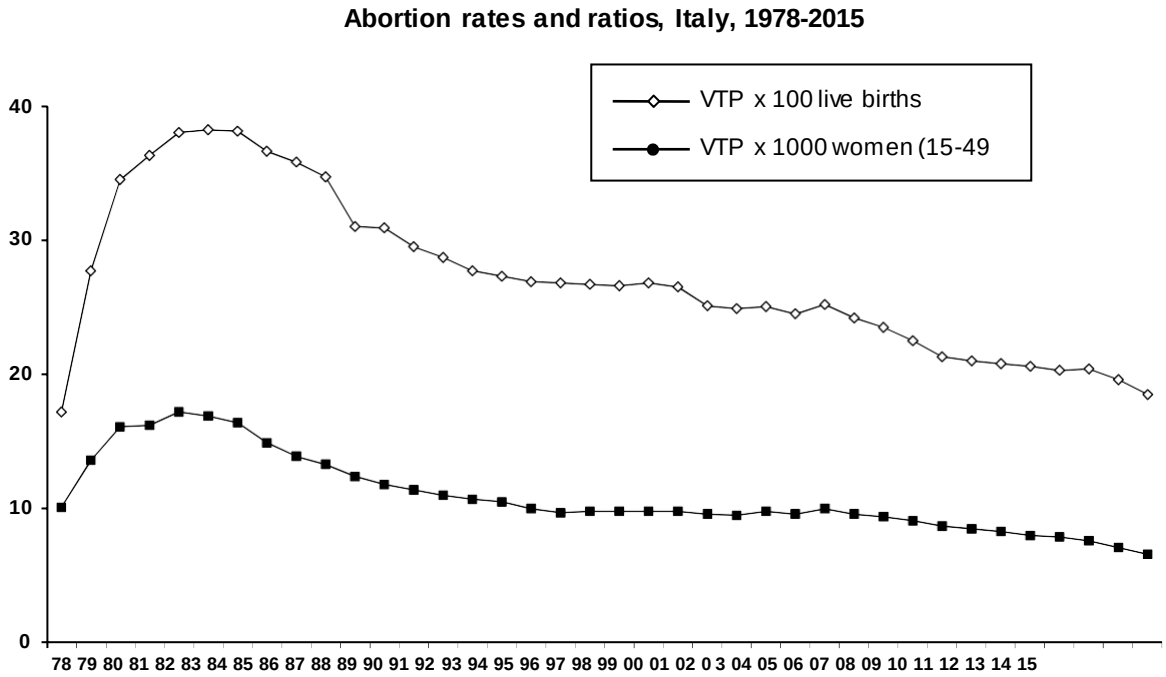
This Report presents and analyzes final data for 2014 and 2015 on the implementation of Law 194 of 1978, which establishes norms for the protection of maternity and for the voluntary termination of pregnancy (VTP).

Since many regions had final data for 2015 available as early as June 2016, and since this data, together with preliminary data from other regions, indicated a significant drop in VTP, we decided to extend the data collection effort by two months, in order to obtain from all regions the final data for both 2014 and 2015 (the year prior to the current one). Thanks to the digitalization of information flows in many regions, the administrative sanctions introduced by ISTAT against facilities that perform VTP and do not transmit their data (Official Journal – gen. series - n. 242 of 15 October 2016), and the excellent job done by our regional liaisons, we were able to obtain complete final data on VTP for 2014 and 2015, with the exception of data on conscientious objectors for 2015. Since the beginning of my mandate, the implementation of Law 194 has been the focus of particular attention and of an extremely detailed and complex monitoring effort at the sub-regional level, which requires an ad hoc questioning of the regions every year. The survey was carried out for 2014, but it was not possible to bring it forward for 2015, as was done instead for the remaining flow of data, which was final.

FINAL DATA 2014 AND 2015

- ✓ The number of VTP continues to diminish;
- ✓ Less than 90,000 VTP were performed in 2015; a total of 87,639 VTP were notified by the regions, a drop of 9.3% compared to 2014, when 96,578 VTP were performed (itself a drop of 6.0% compared to the 102,760 cases in 2013). The number of VTP has thus more than halved compared to the record high of 234,801 cases in 1983. The significant drop observed in 2015, in particular between the second and third trimester, may at least in part be linked to the AIFA ruling of 21 April 2015 (O.J. n.105 of 8 May 2015), which eliminates, for adults, the legal requirement for a medical prescription for the use of ulipristal acetate (ellaOne), an emergency contraceptive better known as the "morning-after" pill. Indeed, data on sales of ulipristal acetate (ellaOne) show a significant increase in 2015 compared to previous years (7,796 packages in 2012, 11,915 in 2013, 16,796 in 2014 and 145,101[1] in 2015).
- ✓ Every indicator confirms this trend: the abortion rate (number of VTP for 1,000 women between the ages of 15 and 49), the most reliable indicator for assessing trends regarding recourse to VTP, was 6.6 per 1,000 in 2015 (-8.0% compared to 2014 and -61.2% compared to 1983); it was 7.1 in 2014. This is one of the lowest values at the international level (see par.1.2).
- ✓ The abortion ratio (number of VTP per 1,000 live births) in 2015 was 185.1 per 1,000, a decrease of 5.7% compared to 2014, when it was equal to 196.2 (it should be kept in mind that the number of live births diminished by 18,666 during this timeframe), and a decrease of 51.5% compared to 1982 (when it was 381,7).

[1] *erroneously indicated as 83,346 in the version sent to Parliament*



FINAL DATA FOR 2014 AND 2015

Characteristics of women who undergo VTP

The highest abortion rates are for women between the ages of 25 and 34. In 2015, 43.1% of women who had abortions had a high school diploma, and 42.9% were employed. More unmarried Italian women had abortions than married ones (56.9% vs. 36.4%), while this was reversed for foreign women (48.3% married, 45.2% unmarried). 44.8% of Italian women who underwent VTP had no children.

Looking only at VTP undergone by Italian citizens, we see a reduction of 74.3% between 1982 and 2015, from 234,801 to 60,384.

VTP for foreign women

Foreign citizens have accounted for an increasing percentage of abortions over time, due both to their growing absolute numbers and to the fact that they resort to abortions more often that Italian women: 31.1% in 2015, 33.0% in 2014 (compared to 7% in 1995), with an abortion rate in 2014 (the last year for which an estimate of the foreign population is available) of 17.2 per 1,000, a drop from 19.0 in 2013, which corresponds to a threefold increase in risk (see par. 2.6). After increasing significantly, the share of abortions undergone by foreign women has stabilized in recent years and has begun to show a diminishing trend, both percentage-wise and in absolute terms (27,168 in 2015 and 31,028 in 2014, compared to 35,388 in 2012 and 40,224 in 2007).

Abortions among minors

In 2015, the abortion rate among minors was 3.1 per 1,000 (3.7 in 2014, 4.4 in 2012), with the highest levels in central Italy; the 2,853 interventions undergone by minors account for 2.9% of all VTP. As in previous years, Italian minors resort to abortions less often than in other Western European countries (see par. 2.1).

Repeat abortions

The percentage of VTP undergone by women who have already had abortions was 26.9% in 2015 (27.3% in 2014), in line with the values for the last ten years. Broken down by citizenship, these percentages were 21.6% for Italian women and 38.3% for foreign women (20.8% and 37.7%, respectively, in 2012). The percentage of repeat abortions in Italy is lower than in other countries (see par. 2.7.3).

VTP procedures

The Karman method remained the most frequently used technique in 2015 (55.6% of cases), followed by vacuum aspiration (17.0%). The use of medication abortions is increasing: in 2015 mifepristone followed by the administration of prostaglandins was used in 15.2% of cases compared to 12.9% in 2014 and 9.7% in 2013. The use of medication abortions varies greatly between regions.

The percentage of VTP performed after the 12^{th} week of pregnancy is slightly rising: 5.0% in 2015 and 4.7% in 2014, compared to 3.8% in 2012 and 3.4% in 2011. This percentage still remains among the lowest worldwide.

Emergency procedures also continue to increase: they took place in 16.7% of cases in 2015 and 14.7% in 2014, compared to 12.8% in 2012 and 11.6% in 2011. As in past years, percentages higher than the national average were recorded in Apulia (32.1%), Piedmont (30.0%), Tuscany (23.1%), Emilia Romagna (22.5%), Latium (24.2%) and Marche (17.4%).

Once again, in both 2015 and 2014 family planning clinics issued more documents and certifications (42.3% and 41.9%, respectively) than other services.

Waiting times

Waiting times between the issuing of the certification and the VTP procedure are falling (a possible indicator of improved efficiency). The percentage of VTP performed within 14 days of the issuing of the certification has increased: 65.3% in 2015 and 64.8% in 2014, versus 62.3% in 2013 and 59.6% in 2011.

The percentage of VTP performed after a wait of 3 weeks or more has dropped: 13.2% in 2015 and 2014, versus 14.6% in 2013 and 15.7% in 2011.

Mobility between regions

In 2015, 92.2% of VTP were performed in the patient's region of residence (91.9% in 2014), of which 87.9% in their province of residence, an increase compared to 2013 (90.8% and 87.1% respectively), indicating low mobility between regions, which has been decreasing over time, in line with mobility between regions for other health services. It should be kept in mind that such flows may mask 'false' migrations, such as students or workers temporarily living outside their region of residence; this mostly affects younger age classes.

Availability of the service and conscientious objectors (2014)

The activities of the "Workshop for the full implementation of L.194", launched by the Ministry of Health of 18 July 2013, continue apace.

It was decided to continue to estimate the three parameters identified during the 2013 monitoring effort, whose results were published in previous reports to the Parliament, including at the sub-regional level (Local Health Units/districts), in order to ensure the adequate application of the law nationwide and identify any problems that may not emerge from aggregated, region-wide data.

In particular, concerning **parameter 1**, availability of VTP services in relation to the total number of available facilities, the total number of health care facilities with obstetrics and gynaecology departments nationwide was 654, while those that perform VTP are 390, or 59.6% (compared to 60% in 2013). A comparison between the total number of health care facilities with obstetrics and gynaecology departments and facilities that perform VTP in each region shows that only in three (Autonomous Province of Bolzano, Molise, and Campania), of which two are very small, the number of facilities performing VTP is less than 30% of total facilities. Elsewhere, coverage is adequate.

Parameter 2, availability of VTP services in relation to the number of women of childbearing age and birthing centres, is useful to better understand the degree of implementation of Law 194/78 by placing this data in its proper context.

Data for 2014 was essentially the same as for the previous years: while the number of VTP is about 20% the number of births, the number of facilities that perform VTP is about 74% of the number of birth centres, much higher than what it would be if it mirrored the ratio of VTP to births.

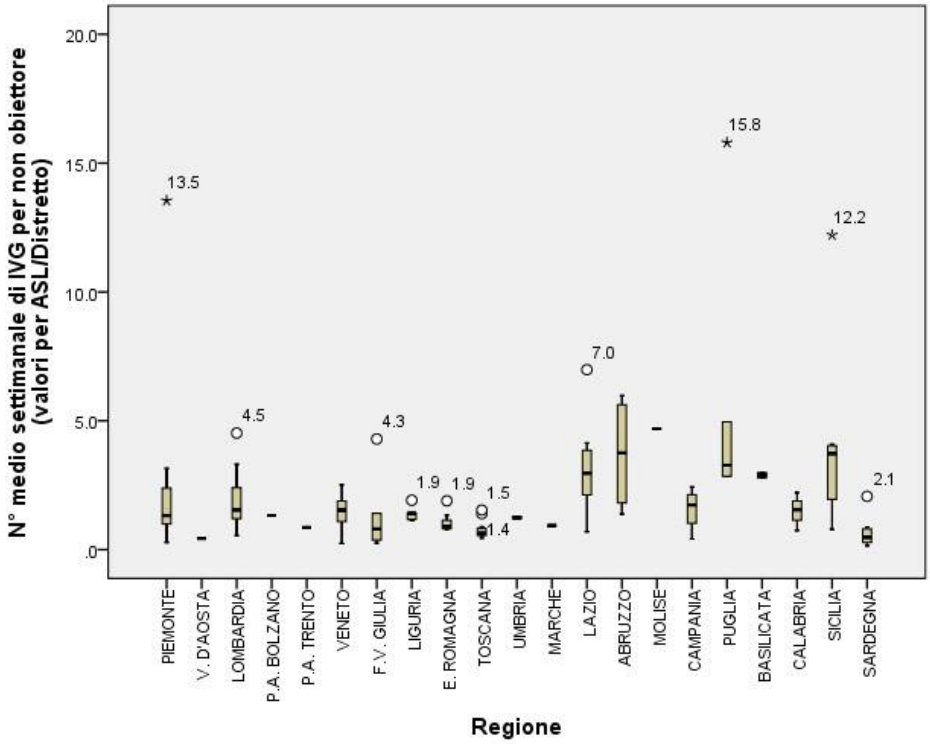
In order to better understand the degree of implementation of Law 194/78, within the framework of the national health service as relates to childbirth, we looked at the number of facilities that perform VTP services in relation to the number of women of childbearing age and birthing centres: at the national level, for every 100,000 women of childbearing age (15-49), there are 3.7 birthing centres versus 2.9 VTP facilities, a ratio of 1.3:1; in other words, for every 5 VTP facilities there are 7 birthing centres.

Considering both the absolute number of VTP facilities and its number in relation to the number of women of childbearing age, the number of VTP facilities appears more than adequate in light of the VTP performed, and if compared with the number of birthing centres.

Data from 2014 related to **parameter 3**, availability of the service in relation to the right of conscientious objection on the part of physicians (average weekly VTP workload for each gynecologist who is not a conscientious objector), indicate a general stability in the weekly workload for each gynecologist who is not a conscientious objector: considering 44 work weeks per year, the number of weekly VTP performed by each gynecologist who is not a conscientious objector ranges from 0.4 in Valle d'Aosta to 4.7 in Molise, with a national average of 1.6 VTP per week (1.6 in 2013, 1.4 in 2012, 1.6 in 2011).

As agreed upon during the workshop, the third parameter was once again assessed at the sub-regional level.

As shown in the graph below, the situation changes from region to region, but on the whole it is rather homogeneous throughout Italy.



Out of 140 ASL (Local Health Units), only three have workloads for gynecologists who are not conscientious objectors that are outliers with respect to the regional average. One is located in Apulia, with 15.8 VTP a week (versus a regional average of 3.5), one is in Piedmont, with 13.5 VTP a week (versus a regional average of 1.7), and the third is in Sicily, with 12.2 VTP a week (compared to the regional average of 3.8). In all other instances these numbers are much lower (for one ASL in Latium it is 7.0 a week, while all the others have lower values that are closer to the regional averages).

The value of parameter 3 at the national level, as revealed by monitoring each and every ASL, is perfectly in line with values calculated from aggregated regional data: in both cases, they show that on average, each gynecologist who is not a conscientious objector performed 1.6 abortions a week during the course of 44 work weeks. Historical data series show that this workload has halved compared to 1983, when it was as high as 3.3 VTP a week: overall, this result is due more to the significant drop in VTP in the last 30 years than to the number of gynecologists who are not conscientious objectors, which has remained essentially the same.

The data transmitted by the regions (except Liguria, Latium, and Sicily, who failed to do so) show that at the national level 11% gynecologists who are not conscientious objectors are assigned to other services and do not perform VTP in spite of not being objectors. This was the case in 46 facilities in 11 regions: Piedmont, Lombardy, Autonomous Province of Bolzano, Emilia Romagna, Tuscany, Umbria, Abruzzo, Molise, Campania, Apulia, and Sardinia.

This data once again underscores the highly uneven availability of non-objectors compared to the demand for VTP from one region to the next. Data collected at the individual hospital level suggest that in most cases, the number of non-objectors is higher than the minimum necessary to meet the demand for VTP, and thus some of the non-objectors are assigned to other services (we should point out that VTP are always scheduled ahead of time, which makes it possible to assign staff to other tasks to meet overall health demands). This further confirms that any problems in providing access to VTP does not seem to be the number of objectors per se, but rather the way health facilities organize themselves in applying Law 194/78. It should be noted that in the three regions where there

are major discrepancies in the weekly workload for non-objectors, two (Piedmont and Apulia) have gynecologists who are not conscientious objectors yet are not assigned to VTP services.

This same data, collected at the individual hospital level, has also made it possible to identify situations in which local health units managed to solve potentially critical situations.

The number of non-objectors – in spite of those not assigned to VTP services – appears to the adequate, including at the sub-regional level, for the number of VTP performed. This workload should not prevent non-objectors to provide other services in addition to VTP and should not create problems in meeting the demand for VTP.

Any difficulties in accessing services are thus likely due to problems related to individual health care facilities.

Additionally, by comparing regional data on wait times and the percentage of conscientious objectors, and how this ratio varied between 2006 and 2014, we see no correlation between the number of objectors and wait times. The application of the law depends largely on regional organizational criteria, which are complex and vary not only from one region to the next, but also within each region (for more detailed data, see chapter 4).

Family planning clinics

Thanks to an intensive effort on the part of regional administrations, 85% of family planning clinics (versus 79% in 2013) provided data on at least some VTP activities, an improvement over last year.

While the available data is not always sufficient, generally speaking the number of conscientious objectors in family planning clinics is much smaller than in hospitals (15% versus 70.7%).

The fact that the number of VTP interviews is higher than the number of certificates issued might indicate the effectiveness of efforts to help women "remove the causes that would bring about the termination of pregnancy" (art. 5 Law 194/78).

Conclusions

- ✓ The prevention of VTP is a primary public health goal; the number of VTP has been dropping in Italy since 1983, and the abortion rate is one of the lowest among Western countries;
- ✓ The number of VTP remains high for foreign women, who account for one-third of VTP performed in Italy: after a period of growth, this percentage stabilized and is now beginning to drop, both in terms of absolute numbers and abortion rates;
- ✓ While wait times are generally getting shorter, there remains significant variability between regions; mobility between regions and provinces is in line with that for other national health care services;
- ✓ Concerning conscientious objection and access to VTP services, the findings of previous reports to Parliament and confirmed: at the regional level - and as concerns workloads for each gynecologist who is not a conscientious objector, at the sub-regional level as well, there are no major problems concerning VTP services. In particular, VTP are performed in 59.6% of available facilities, with adequate coverage except for Campania, Molise, and the Autonomous Province of

Bolzano. The number of VTP facilities compared with the number of birth centres shows that while the number of VTP is only about 20% of the number of births, the number of VTP facilities is 74% the number of birthing centres, higher than what it would be if it merely reflected the VTP-to-births ratio. If we then compare the ratio of VTP facilities and of birth centres to the number of childbearing women nationwide, for every 5 facilities that perform VTP there are 7 birthing centres. Finally, looking at weekly VTP performed by each gynecologist who is not a conscientious objector, and considering 44 work weeks a year, we find that at the national level each non-objector performs 1.6 VTP a week, from a low of 0.4 in Val d'Aosta to a high of 4.7 in Molise. At the sub-regional level, this parameter shows that even in the regions with the highest variability – where the workload in certain facilities is much higher than the regional average – the workload for each non-objector is still low enough to allow them to carry out other activities as well. In eleven Italian regions, a number of non-objectors – 11% of the national total – are not assigned to VTP services, probably because the number of non-objectors is deemed higher than the minimum necessary to fulfil demand for VTP, and thus some of these non-objectors are assigned to other services;

- ✓ The number of non-objectors in hospitals thus seems adequate for the number of VTP performed;
- ✓ Although data in this regard is not always sufficient, the number of conscientious objectors in family planning clinics is much lower than in hospitals;
- ✓ The Ministry invites the regional administrations to continue to collect detailed data and to make available VTP reporting services in their regions. This would make it possible to identify specific regional features faster, and to place them in the proper geographic, demographic, social, and health care context. Whenever possible, it would be preferable to use the same parameters identified in this report, in order to have comparable data across the various territorial units considered, and both between and within the regions themselves, to identify best practices and existing problems in a timely fashion.

Beatrice Lorenzin

DATA COLLECTION SYSTEM

This report presents and analyzes final data for 2014 and 2015 on the implementation of Law n. 194 of 1978, which establishes norms for the protection of maternity and for the voluntary termination of pregnancy (VTP). The data was collected by the Epidemiology Surveillance System for VTP, with the involvement of the National Institute of Health (Istituto Superiore di Sanità - ISS), the Ministry of Health, and ISTAT on one hand; and the regions and autonomous provinces on the other.

Monitoring efforts are based on ISTAT's D12 form, which must be filled out for each VTP in the facility where it was performed. The form contains information on the social and demographic characteristics of the women who underwent VTP, the services involved in the issuing of the document/certification, the services that performed the VTP, and the VTP procedure that was followed. The regions are responsible for collecting this data from the facilities and to analyse it in order to respond to a trimestral and annual questionnaire prepared by ISS and the Ministry, and which reports the distribution by modality of each variable contained in the D12 form. At the central level, ISS, working closely with the regions, is responsible for quality control over the data; subsequently, with ISTAT's collaboration, it prepares the tables that present these distributions for each region and for Italy as a whole.

Ever since its launch in 1980, the Surveillance System has made it possible to monitor the evolution of voluntary abortions, to provide the data and data analysis for the Ministry of Health's annual report to Parliament, to respond to specific questions, and to provide indications for more in-depth research. The knowledge acquired has made it possible to draft strategies and operational models for prevention and the promotion of good health, and for improving the efficacy and efficiency of the services involved in providing abortion services. The Surveillance System has also made it possible to test the hypotheses related to VTP demand and the efficacy of prevention programmes, when applicable.

Since many regions had final data for 2015 available as early as June 2016, and since this data, together with preliminary data from other regions, indicated a significant drop in VTP, we decided in agreement with the Ministry of Health to extend the data collection effort by two months, in order to obtain from all regions the final data for both 2014 and 2015 (the year prior to the current one). Thanks to the digitalization of information flows in many regions, the administrative sanctions introduced by ISTAT against facilities that perform VTP and do not transmit their data (Official Journal – gen. series - n. 242 of 15 October 2016), and the excellent job done by our regional liaisons, we were able to obtain complete final data on VTP for 2014 and 2015. As was the case in previous years, for some regions (Lombardy, Campania, and Sicily in 2014; and Sicily in 2015), it was necessary to augment the data from the Surveillance System with data from hospital discharge papers. Thanks to the efforts of the regions and the coordinating group of the Surveillance System, this was necessary for a smaller number of regions and cases than in 2013. Some of our regional liaisons reported difficulties in receiving data from facilities where VTP are performed, along with the closure of some VTP services. In some cases, there were also problems with incomplete information from D12 forms.

All regions – and through them, all local facilities (ASL and hospitals) – are strongly encouraged to adopt the necessary measures to ensure that the excellent quality of the Italian Epidemiology Surveillance System for VTP, which acquires and publishes relevant data faster and more comprehensively than many other European countries, can remain high in the long term.

In this regard, central institutions (ISS, Ministry of Health, and ISTAT) have always proven willing to help regional offices solve any problems that may arise; suggest procedures for better data collection at the local level; and participate in local meetings on the quality of information flows, the quality of procedures to ensure the application of Law 194, data on VTP trends, and efforts to adopt measures to improve the situation and to monitor their efficacy.

Law 194 is very explicit in this regard. Art. 16 states "Regions must transmit the necessary information [for the Minister of Health's report] by the end of January of each year, on the basis of questionnaires prepared by the Minister". However, as indicated in previous reports, the region point to the impossibility of collecting, verifying, and processing all the information to be sent to the central administration for the drafting of the ministerial report within the deadline established by the law (February of the following year). The ISS agrees that the complexities involved in the accurate and comprehensive management of these information flows makes it impossible to comply with the deadline, but it adds that such data flows are not always met with the proper attention, and that there are margins for improvement regarding both completeness and timeliness of submission.

To ensure the continuity and high quality of data collection and the full implementation of the law, the Ministry of Health promoted a one-year project coordinated by ISS that took place between March 2015 and March 2016. The project included meetings between ISS, the Ministry of Health, and the regional liaisons for the VTP Surveillance System and the technical workshop for the full application of Law 194/78; it also carried out a survey to evaluate problems at the local level.

Every region adhered to this project and sent at least some information to ISS. Many regions have now digitized their data flows, using either local resources or the software provided free of charge by ISS. There are both problems and best practices at the regional levels, with significant differences between and sometimes within regions. For this reason, it is very important that in addition to the data to be sent to the Ministry and ISS for the report to Parliament pursuant to Law 194/78, the regions also produce local reports, so as to identify specific regional features in a timely fashion and place them in the proper geographic, demographic, social, and regional health care contexts. Such contexts often vary widely between (and sometimes within) regions, for example between metropolitan and rural areas, or in areas that have seen immigration flows from specific and often very different ethnic groups.

Finally, a certified training course for regional liaisons was offered, during which ISS and ISTAT presented data monitoring techniques and provided examples on how to overcome the main problems related to data flows (analyses of D12 models and their comparison with hospital discharge papers) and the application of Law 194, including through solutions identified by certain regions. Thirty regional liaisons from 17 regions took part in the course, and the material produced, including a template for a report that regions can use to make their data public, was made available to all regional liaisons.

For the reasons listed above, we hope that more and more regions will produce regional reports on VTP and organize meetings with the professionals involved in order to discuss the data produced and the application of Law 194.

FINAL DATA AND ANALYSES OF VTP PERFORMED IN 2014 AND 2015

General trends

Final analytical data for 2014 and 2015 is available for every region. As in previous years, the data refer to the region where the VTP was performed, regardless of the patient's residence.

In order to have the complete 2014 data for three regions (Lombardy, Campania, and Sicily) and the complete 2015 data for Sicily (68 cases), it was necessary to augment the data obtained from the VTP Surveillance System, based on the ISTAT D12 forms, with data from hospital discharge papers. Last year, in order to obtain complete data for 2013, it was necessary to do this in three regions (Abruzzo, Campania, and Sicily) and for a higher number of cases.

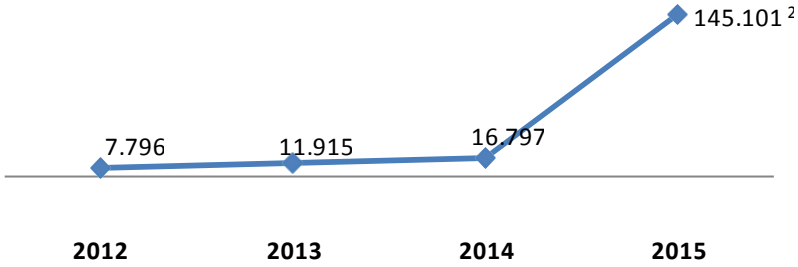
In total, 96,578 VTP were reported in 2014 and 87,639 in 2015 (Tab. 1), confirming the continuing decline in the number of abortions performed, which was particularly evident in 2015 (-9.3% compared to 2014 and -62.7% compared to 1982, when the highest ever number of VTP in Italy was recorded with 234,801 cases). Particularly significant declines were observed in Abruzzo, Molise, Calabria, and Piedmont, and generally during the second half of 2015. The latter aspect, which certainly requires a more in-depth analysis, may be due to the AIFA ruling of 21 April 2015 (O.J. n.105 of 8 May 2015), which eliminates, for adults, the legal requirement for a medical prescription for the use of ulipristal acetate (ellaOne), an emergency contraceptive better known as the "morning-after" pill..

VTP per trimester in 2015 and comparisons with 2014

	N. VTP per trimester				TOTAL	TOTAL	VAR. %
	I	II	III	IV	2015	2014	
NORTHERN ITALY	**11347**	**10383**	**9042**	**8956**	**39728**	**43916**	**-9.5**
Piedmont	1981	1800	1538	1598	6917	7856	-12.0
Valle d'Aosta	48	61	42	33	184	208	-11.5
Lombardy	4137	3776	3301	3090	14304	15991	-10.5
Bolzano	144	125	118	130	517	526	-1.7
Trento	194	179	176	177	726	758	-4.2
Veneto	1415	1333	1129	1167	5044	5472	-7.8
Friuli Venezia Giulia	431	377	340	340	1488	1609	-7.5
Liguria	758	683	608	651	2700	3023	-10.7
Emilia Romagna	2239	2049	1790	1770	7848	8473	-7.4
CENTRAL ITALY	**5336**	**4947**	**4446**	**4041**	**18770**	**20259**	**-7.3**
Tuscany	1659	1636	1403	1402	6100	6526	-6.5
Umbria	384	351	310	320	1365	1479	-7.7
Marche	474	430	428	356	1688	1839	-8.2
Latium	2819	2530	2305	1963	9617	10415	-7.7
SOUTHERN ITALY	**6066**	**5715**	**4899**	**4066**	**20746**	**23564**	**-12.0**
Abruzzo	548	516	430	372	1866	2209	-15.5
Molise	104	94	77	81	356	413	-13.8
Campania	2423	2268	1966	1627	8284	9369	-11.6
Apulia	2186	2115	1834	1439	7574	8514	-11.0
Basilicata	171	131	123	132	557	631	-11.7
Calabria	634	591	469	415	2109	2428	-13.1
ISLANDS	**2342**	**2393**	**1922**	**1738**	**8395**	**8839**	**-5.0**
Sicily	1824	1830	1459	1344	6457	6916	-6.6
Sardinia	518	563	463	394	1938	1923	0.8
ITALY	25091	23438	20309	18801	87639	96578	-9.3

Indeed, data on sales of ullipristal acetate (ellaOne) showed a significant increase in 2015 compared to previous years (7,796 packages in 2012, 11,915 in 2013, 16,796 in 2014 and 145,101[2] in 2015).

Figure 1 –Ulipistral acetate (ellaOne) sales to private individuals - 2012-2015 (AIFA data)



Looking closer at trimestral sales data for Ulipristal acetate (ellaOne) in 2015 compared to 2014, one sees that sales increase significantly starting in the second trimester of 2015, when they increased by more than five-fold compared to 2014 (24,733 vs. 3,729) and continued to rise quite rapidly in 2015 (53,016 vs. 4,001), only to slow down slightly in the fourth semester of 2015 (61,755 vs. 4,991).

Trimestral sales of Ulipristal acetate (ellaOne) to private individuals - 2015 vs. 2014

Trimester	2015	2014	VAR. %
I (January - March)	5597	4076	+37.3
II (April - June)	24733	3729	+563.3
III (July - September)	53016	4001	+1225.1
IV (October - December)	61755	4991	+1137.3
TOTAL	**145101**	**16797**	**+763.9**

(Source: AIFA)

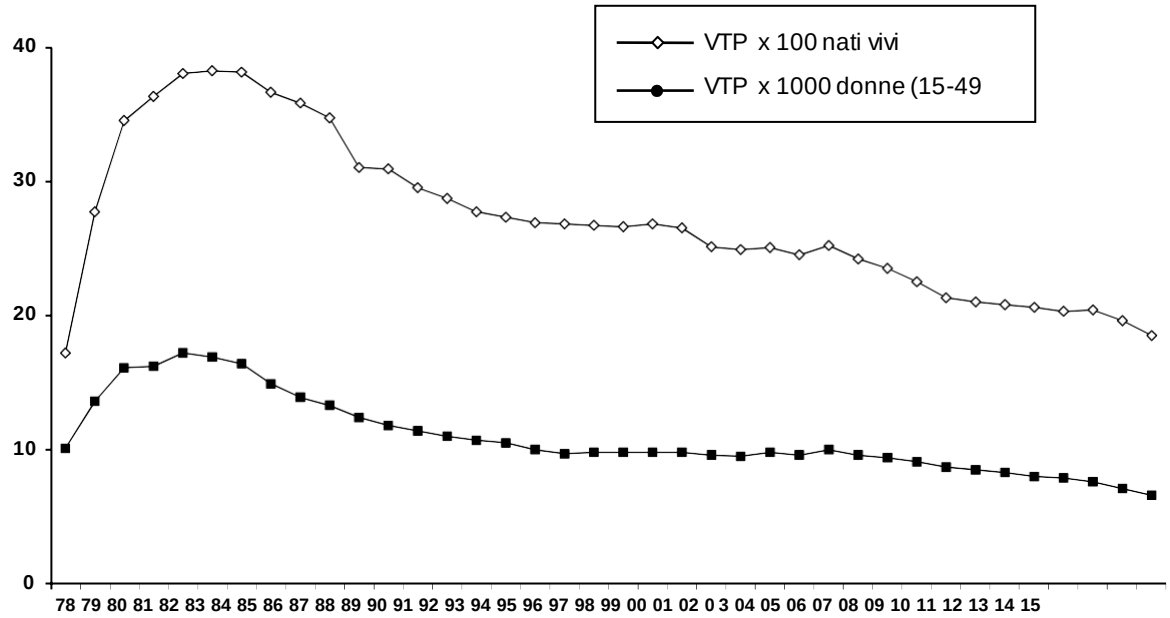
The abortion rate and abortion ratio also confirm this trend. Indeed, the abortion rate (number of VTP per 1,000 women between the ages of 15 and 49 resident in Italy) was 7.1 per 1,000 in 2014 and 6.6 per 1,000 in 2015, a decrease of 8.0% in one year (variation calculated by rounding off the data to the nearest two decimal points) and of 61.5% compared to 1982.

The abortion ration (number of VTP per 1,000 live births) was 196.2 per 1,000 in 2014 and 185.1 per 1,000 in 2015, a decrease of 5.7% in one year and of 51.3% compared to 1982.

Trends concerning abortion rates and ratios (the latter calculated on the basis of 100 instead of 1,000 live births to allow it to fit in the graph) are illustrated in Figure 2.

[2] *erroneously indicated as 83,346 in the version sent to Parliament*

Figure 2 – Abortion rates and ratios – Italy 1978-2015



The abortion rate falls to 6.9 per 1,000 in 2014 and 6.4 in 2015 if one considers only women resident in Italy, by excluding from the total the 2366 VTP (in 2014) and 2564 VTP (in 2015) performed for women who do not reside in Italy (non-residents are excluded from the denominator with which the rate is calculated), also calculated by redistributing the VTP for which the residency of the woman is unknown, with a reduction of 6.8% in 2014 compared to the rate for residents calculated in the same manner in 2013 (7.4 per 1,000), and a reduction of 7.2% in 2015 compared to 2014. Since the number of live births used to calculate the abortion ratio does not differentiate between those born from resident and non-resident women, it is not necessary to make any corrections.

Tables 30, 31 and 32 provide trends for the total number of abortions, abortion rates, and abortion ratio for each region starting in 1982.

1.1. Absolute numbers

The number of VTP performed in 2014 fell by 6.0% compared to 2013, and those performed in 2015 fell by 9.3% compared 2014 (Tab. 4). Foreign citizens accounted for about one-third of all abortions (33.0% in 2014 and 31.1% in 2015), as has been the case for several years now (tab.12). Looking at Italian citizens only, VTP performed in 2015 (60,384, including the estimated share of Italian women for which nationality was not reported in the various regions) fell by 7.1% compared to 2014 (65,021 cases). In absolute terms, the drop was even higher for foreign women: -13.6%.

Trends concerning the number of VTP by geographic area between 1983 and 2015 are as follows:

N° VTP BY geographic area, 1983-2015

					VARIATION %	
	1983	1991	2014	2015	2015/2014	2015/1983
NORTH	105430	67619	43916	39728	-9.5	-62.3
CENTRE	52423	34178	20259	18770	-7.3	-64.2
SOUTH	57441	44353	23564	20746	-12.0	-63.9

ISLANDS	18682	14344	8829	8395	-4.9	-55.1
ITALY	233976	160494	96578	87639	-9.3	-62.5

Data per geographic area in 2015 (Tab. 1, 3 and 4) is as follows: in northern Italy, 39,728 VTP with a decrease of 9.5% compared to 2014, in central Italy 18,770 VTP (-7.3%), in southern Italy 20,746 VTP (-12.0%), and in Sicily and Sardinia 8,395 VTP (- 4.9%).

Concerning clandestine abortions, the ISS performed an estimate for 2012, using the same mathematical model used in the past, while taking account of its shortcomings, which mostly reflect the changes that took place in Italy concerning demographics (decline in the number of women of childbearing age and increase in the foreign-born population) and family planning (desire to have fewer children, conception at older ages, and lack of data on the diffusion of contraception methods). The number of clandestine abortions for Italian women was estimated at 12,000 to 15,000. For the first time, estimates were also made for foreign women, and amounted to between 3,000 and 5,000 clandestine abortions, although in this case potential problems with the methodology used are even more acute. These estimates suggest that the phenomenon has stabilized in recent years, at least as regards Italian women (there were an estimated 15,000 clandestine abortions for Italian women in 2005), with a significant drop compared to the 1980s and '90s (100,000 estimated cases in 1983, 72,000 in 1990, and 43,500 in 1995).

1.2. Abortion rate

In 2015, the abortion rate identified by the World Health Organization (WHO) as the most accurate indicator for the proper evaluation of the tendency to resort to VTP was 6.6 WVT for 1,000 women between the ages of 15 and 49 (Tab. 1), a decrease of 8.0% compared to 2014, when the rate was 7.1 per 1,000 (Tab. 2). In the introduction to the chapter we mentioned the actual abortion rate, which excludes from the tally the number of VTP for women who do not reside in Italy; in 2014 this rate was 6.9 per 1,000 and in 2015 it was 6.4 per 1,000.

Trends on abortion rate in each of Italy's four main geographic areas between 1983 and 2015 are illustrated below:

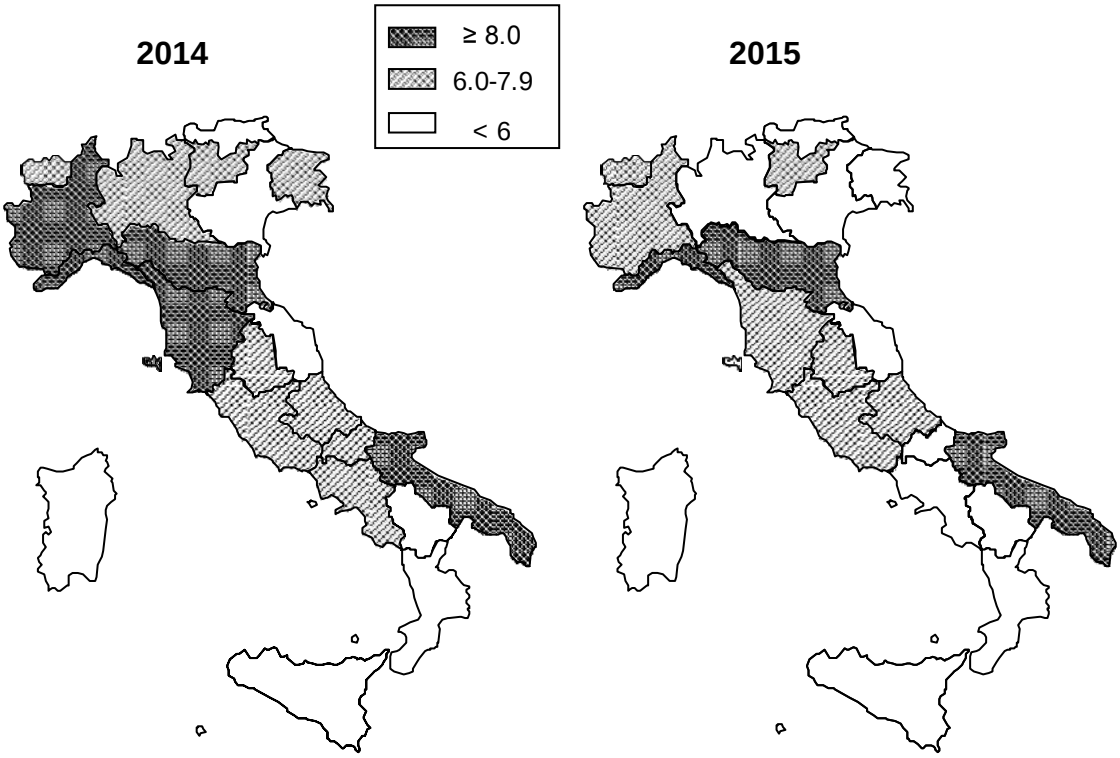
Abortion rates by geographic area, 1983-2015

					VARIATION* %	
	1983	1991	2014	2015	2015/2014	2015/1983
NORTH	16.8	10.6	7.3	6.7	-8.5	-60.1
CENTRE	19.8	12.4	7.6	7.1	-6.1	-64.1
SOUTH	17.3	12.1	7.1	6.4	-10.6	-63.3
ISLANDS	11.7	8.1	5.7	5.5	-3.7	-53.2
ITALY	16.9	11.0	7.1	6.6	-8.0	-61.2

* percentage variation calculated on rates rounded to the nearest two decimal points.

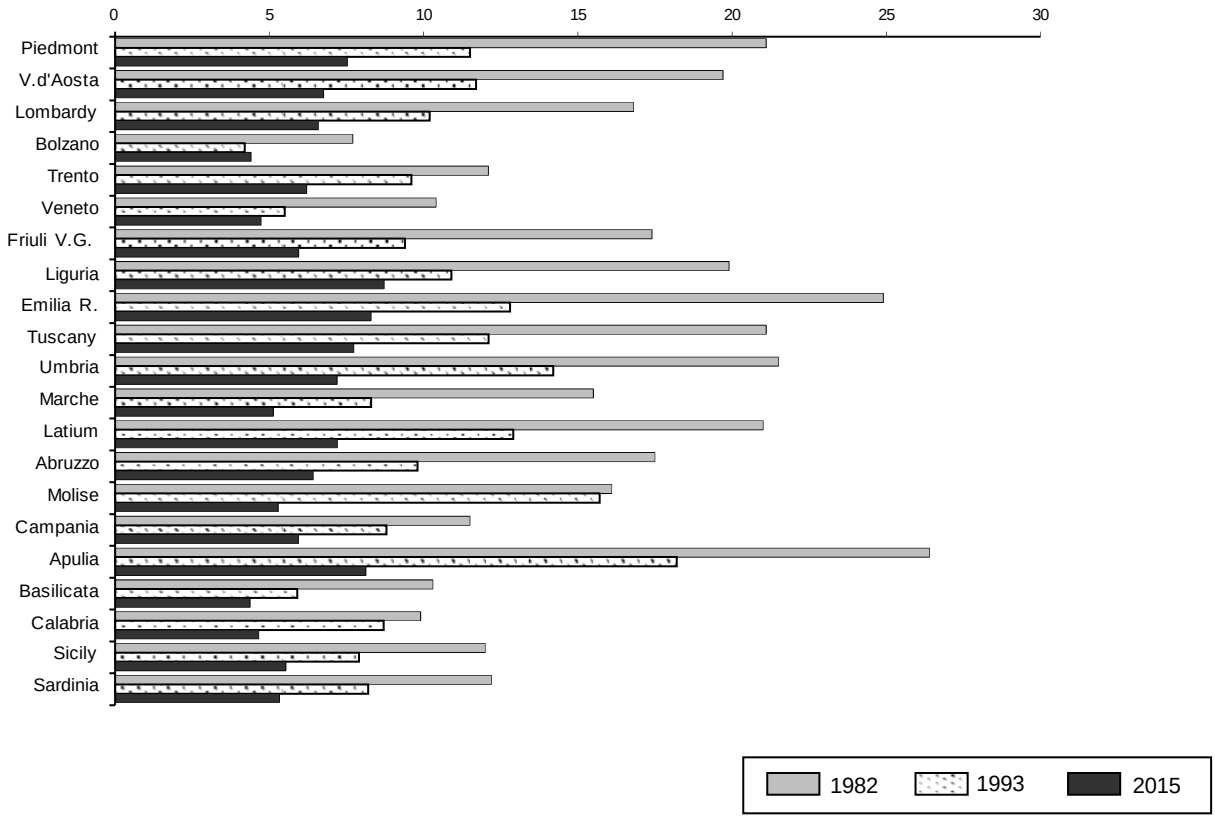
Table 2 reports the percentage variations in abortion rates at the national and regional level in the last two years, while figure 3 shows regional values in 2014 and 2015. When comparing data over time and between regions, one must always take into account the differences in the presence of foreign-born women, given their significant contribution to the VTP phenomenon. For this reason, and given the different abortion rates between Italian and foreign women detailed in this report, as has been the case for several years, the data was in some cases analyzed after being sub-divided by citizenship. Figure 4 shows a comparison between abortion rates in 1982, 1993, and 2015 in each region. There is a general decrease, especially in Apulia (-69.2% compared to 1982), Molise (-67.2%), Marche (-66.9%), Emilia Romagna (-66.7%) and Umbria (-66.5%).

Figure 3 – Abortion rates – Italy 2014 and 2015



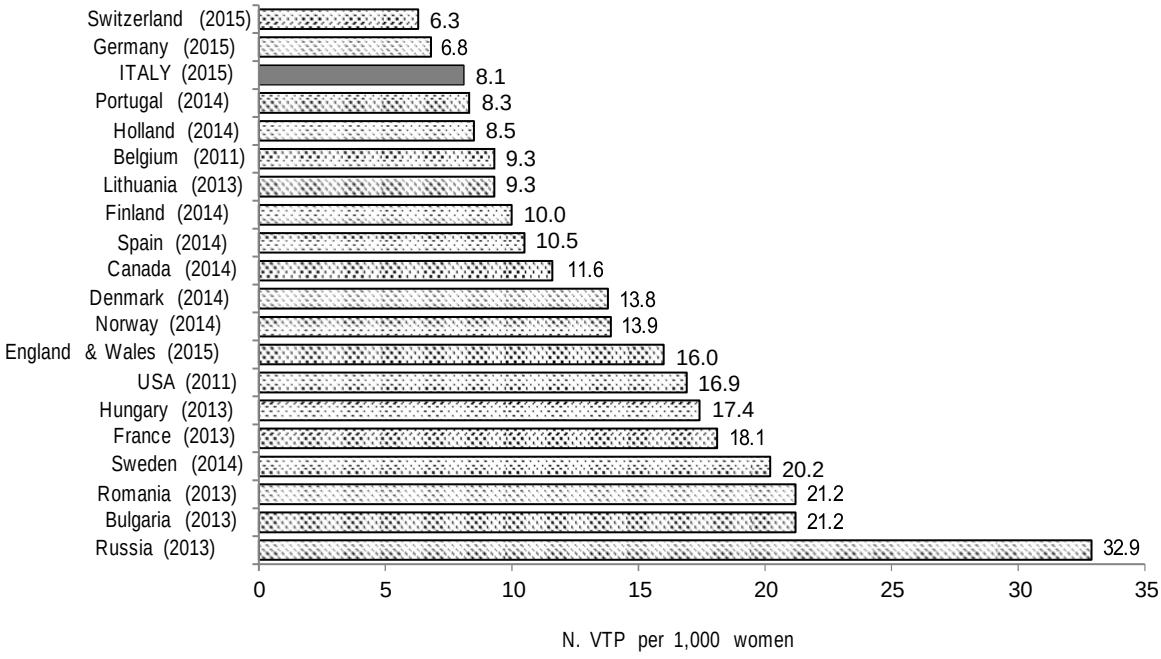
* Note that the intervals used in classifying the rates may change over the years

Figure 4 – Abortion rates per region in 1982, 1993, and 2015



For an international comparison, Figure 5 compares the Italian abortion rate with the latest data from other countries. Since the abortion rate is calculated at the international level for women between the ages of 15 and 44, the Italian rate was re-calculated on this basis, and amounts to 8.1 per 1,000. It remains among the lowest of all.

Figure 5 – Abortion rates per 1,000 women between the ages of 15-44 in various countries, 2011-2015



Source: Statistiques nationales / Eurostat; Alan Guttmacher Inst. 2014

1.3. Abortion ratio

In 2015 there were 185.1 VTP per 1,000 live births (Tab. 1), a decrease of 5.7%, compared to 2014, when this ratio was 196.2 per 1,000 (Tab. 2). It should be kept in mind that the number of live births diminished by 18,666 in this period.

Trends in the abortion ratio (an indicator that is correlated with the birth rate) between 1983 and 2015 were as follows in Italy's four main geographic areas:

Abortion ratio by geographic area, 1983-2015

					VARIATION %	
	1983	1991	2014	2015	2015/2014	2015/1983
NORTH	484.2	327.1	194.6	182.7	-6.1	-62.3
CENTRE	515.2	356.1	214.0	211.4	-1.2	-59.0
SOUTH	283.8	253.0	202.6	182.9	-9.7	-35.6
ISLANDS	205.3	176.1	159.3	156.3	-1.9	-23.9
ITALY	381.7	286.9	196.2	185.1	-5.7	-51.5

Variations in the abortion ratio reflect both variations in abortions and those in live births, both of which are affected by the rising presence of foreign citizens in Italy. This needs to be taken into account when interpreting the data, especially when making comparisons with previous years.

Table 2 also reports percentage variations in the regional abortion ratios in 2014 and 2015.

Characteristics of women who resort to VTP

Trends concerning abortion rates for specific social and demographic conditions, which are generally falling, lead to a modification over the years in the percentage distribution of VTP, with a greater relative weight for the conditions under which reductions have been smaller. Additionally, over the last 15-20 years the share of VTP by foreign women has significantly increased; these women have different social and demographic characteristics than Italian women, and they resort to abortions three times more often. This explains, at least in part, the changes observed for abortion rates by age class and their percentage distribution. This needs to be kept in mind when making comparisons between different years. In particular, one must be careful to avoid the technical mistake of interpreting the increase in the percentage of VTP under a specific condition as an increase in the tendency to abort under that condition, since such an assessment can only be made by considering a specific abortion rate that also takes into account changes at the population level.

The paragraphs below discuss the characteristics of women who resort to abortion in Italy with those who do so in other countries, using the latest available data (Sources: Alan Guttmacher Institute 2014, https://www.guttmacher.org/united-states/abortion; Switzerland: Statistique des Interruptions de grossesse 2015 - Office federal de la statistiques; Spain: Interrupciòn Voluntaria del Embarazo - Datos definitivos correspondientes al ano 2014 – Sanidad – Ministerio De Sanidad – Servicios Sociales e Igualdad; Norway: Rapport om svangerskapsavbrot for 2014 - (Abortregisteret) Folkehelseinstituttet; England and Wales: Abortion Statistics, England and Wales: 2015 – Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales – National

Statistics - Department of Health; The Netherlands: Jaarrapportage 2014 van de Wet afbreking zwangerschap – Utrecht, oktober 2015 - Ministerie van Volkgezondheid, Welzijn en Sport; Germany: Gesundheit – Schwangerschaftsabbruche 2015 - Statistisches Bundesamt, Wiesbaden 2016; Sweden: Statistics on induced abortions 2014 - Sveriges officiella statistic – Socialstyrelsen; Denmark: Historical abortion statistics, Denmark - Abortion Statistics and other data-Johnston's Archive; Czech Republic: Potraty CR 2013 – Zdravotnicka Statistika; Finlandia: Induced abortions in the Nordic countries 2013 – National Institute for Health and Welfare – Helsinki; Romania: Historical abortion statistics, Romania - Abortion Statistics and other data -Johnston's Archive; France: Les interruptions volontaires de grossesse 2015 en France – Direction de la Recherche, des Etudes, de l'Evalutation et des Statistiques; Population 1 January by five years age group and sex – Database Eurostat - http://ec.europa.eu/eurostat/data/statistics-a-z/abc; Abortion Surveillance — United States, 2012 – Surveillance Summaries November 27, 2015– CDC; U.S. Abortion Statistics – Facts and figures relating to the frequency of abortion in the United States – ABORT73.COM.

2.1 Age classes

The percentage distribution of VTP per age class in 2015 and 2014 (Tab. 6) is essentially the same as in previous years, with a drop in women aged 15-19 and 20-24 and an increase in those aged 40-44 compared to 2013. Table 7 details abortion rates per age class and the standardized abortion rate per region. This latter indicator is best suited for making comparisons between regions, because it accounts for any regional differences in the age class composition of the resident population. Indeed, since abortion rates per age class can be quite different (with higher values generally found between the ages of 20 and 35), any differences in age class structures in the resident population would make the gross abortion rate of little use for comparisons between regions. Nevertheless, by comparing data from Table 1 and Table 7, it emerges that the difference between gross and standardized rates are negligible, since age class distributions are roughly similar across all regions.

Distortion thus probably does not come from the use of gross rates, but rather from using as the numerator for this rate the number of VTP performed in a given region (which includes those undergone by women who reside in another Italian region or abroad) and for the denominator the number of women of childbearing age resident in the region. Additionally, migratory flows are not necessarily homogeneous by age class, and in some cases may mask 'false' migrations, such as students or workers temporarily living outside their region of residence; this mostly affects younger age classes.

The rates and rations per region of residence, calculated using ISTAT data, are reported in Table 29. Variations compared to the values for the region where the VTP is performed are not substantial, with the exception of a few cases (Trento, Emilia Romagna, and Umbria, where the abortion rate is lower if one considers only women who reside there; and Molise and Basilicata, whose residents largely travel to other regions for VTP, and where the abortion rate is higher if they are included). It should be kept in mind that the data collected by ISTAT is not complete, since a certain number of VTP is not notified. As such, it is impossible to analyze data on residence patterns within the deadline for drafting the Minister of Health's report.

For this reason, the analysis in this report uses the gross rate per region, as in previous reports.

Below are the trends for abortion rates by age class from 1983 to 2015:

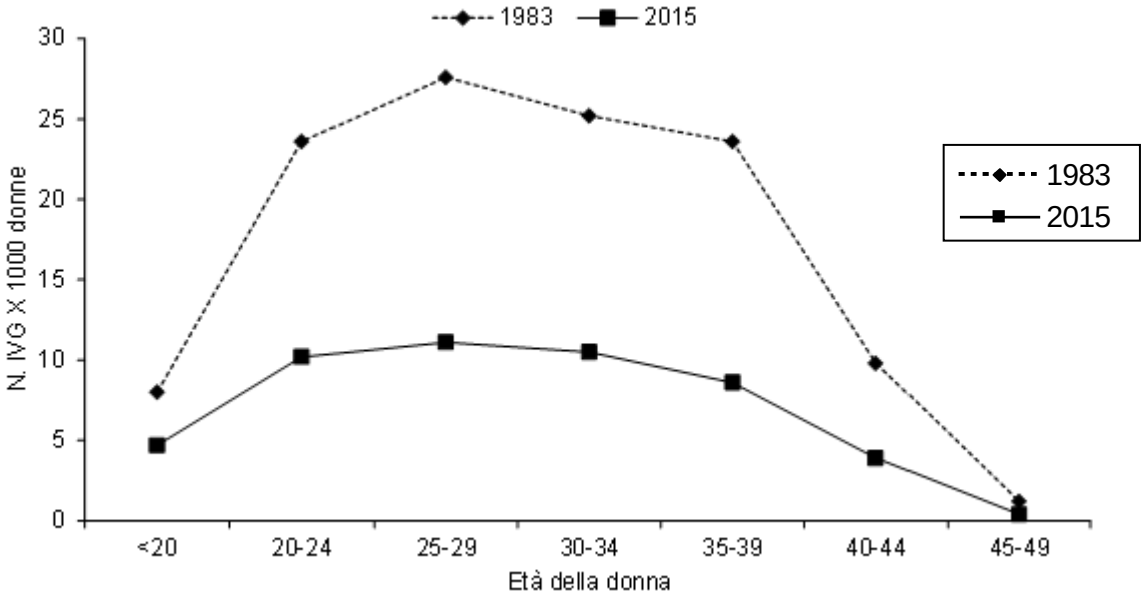
Abortion rates by age class, 1983-2015

	years				VARIATION* %	
Age class	**1983**	**1991**	**2014**	**2015**	**2015/2014**	**2015/1983**
< 20	8.0	5.5	5.2	4.7	-9.4	-41.0
20-24	23.6	13.4	11.0	10.2	-7.6	-57.0
25-29	27.6	15.7	12.0	11.1	-7.4	-59.6
30-34	25.2	17.1	11.3	10.5	-7.2	-58.3
35-39	23.6	15.1	9.3	8.6	-7.4	-63.4
40-44	9.8	7.2	4.2	3.9	-7.8	-60.1
45-49	1.2	0.9	0.4	0.4	-5.3	-70.0

* percentage variation calculated based on rates rounded off to the nearest two decimals

Abortion rates for all age classes have diminished since 1983. These reductions have not been as marked for women under the age of 20 and between 20 and 24; this is partly due to the higher percentage of foreign women in these age classes, both in absolute terms and in terms of abortion rates (Fig. 6). Abortion rates fell in every age class in 2015 compared to 2014, especially for women under 20.

Figure 6 – Abortion rates by age class – Italy, 1983 and 2015



The analysis by geographic area also reflects the different effect of the contribution of foreign women, who are not distributed evenly in Italy.

The distribution of abortion rates by age class in Italy remains different from that of other Western industrialized countries. In the latter, the highest rates are recorded for women aged 20-24, while in Italy abortion rates are relatively high for women aged 30-39 as well. As shown in the table below, these differences have narrowed over the years.

Abortion rates by age class. International comparison

COUNTRY	YEAR	<20	20-24	25-29	30-34	35-39	40-44
ITALY	(2015)	4.7	10.2	11.1	10.5	8.6	3.9
	(2014)	5.2	11.0	12.0	11.3	9.3	4.2
	(2000)	7.2	14.7	14.1	12.9	11.0	5.1
	(1990)	5.6	13.8	16.5	18.0	15.6	7.6
FRANCE	(2015)	7.6	27.2	26.1	20.0	15.0	5.1
GERMANY	(2015)	4.3	9.3	9.7	8.7	6.9	2.6
ENGLAND AND WALES	(2015)	15.0	27.0	23.0	17.0	12.0	4.0
NORWAY	(2014)	9.6	21.8	20.7	15.9	11.4	4.2
HOLLAND	(2014)	6.5	14.1	13.6	12.0	8.6	3.5
CZECH REPUBLIC	(2013)	7.0	12.8	13.5	13.0	11.2	5.1
SPAIN	(2014)	9.9	16.6	15.3	12.3	8.6	3.8
SWEDEN	(2014)	15.1	29.6	27.3	22.3	16.7	7.9
SWITZERLAND	(2015)	3.4	8.7	8.9	7.6	6.5	2.8
USA	(2012)	9.2	23.3	18.9	12.4	7.3	2.8

In 2015, the abortion rate for minors was 3.1 per 1,000 (Tab. 5), less than in previous years, and in keeping with a falling trend since 2005. The table below reports trends in the number of VTP for Italian and foreign women under the age of 18, their percentage as a total of VTP performed between 2000 and 2015,and the abortion rate for minors.

VTP among minors, 2000-2015

Year	N. VTP women under <18*		% of total VTP	Abortion rate
	Italian	Foreign		
2000	3596	181	2.7	4.1
2001	3565	227	2.7	4.1
2002	3446	306	2.9	4.7
2003	3556	428	2.8	4.5
2004	3840	526	3.0	5.0
2005	3441	605	3.0	4.8
2006	3512	608	3.2	4.9
2007	3463	637	3.3	4.8
2008	3451	624	3.4	4.8
2009	3127	592	3.2	4.4
2010	3091	626	3.3	4.5
2011	3008	586	3.4	4.5
2012	2761	588	3.3	4.4
2013	2616	527	3.2	4.1
2014	2383	472	3.2	3.7
2015	2164	357	2.9	3.1

* Istat data

For both Italian and foreign women, the absolute number of VTP continued to drop in 2014-2015. The increase seen in the early years of the sample in the contribution of foreign women to VTP undergone by minors is due mainly to the increase in immigration to Italy. Starting in 2005 this number began to stabilize, and it fell significantly in 2015, as did the contribution of foreign women overall to VTP (Tab. 12).

In general, minors account for a small share of VTP in Italy (3.2% of all VTP in 2014 and 2.9% in 2015), with a rate of 3.7 per 1,000 in 2014 and 3.1 per 1,000 in 2015, values that are much lower than for women over the age of 18 (7.3 and 6.8 per 1,000 respectively).

Compared with available data at the international level, minors in Italy continue to resort to abortion less than their peers elsewhere in other Western European countries, in line with their moderate sexual activity and the extensive use of condoms, as found in several recent studies (De Rose A. Dalla Zuanna G (ed). *Rapporto sulla popolazione – Sessualità e riproduzione nell'Italia contemporanea*. Società editrice il Mulino, 2013 and Istat. *Come cambia la vita delle donne*, 2004-2014. Istat, 2015).

Consent for the intervention was given mainly by the parents (75.4% of cases in 2014 and 75.7% in 2015, Tab. 22), with some differences between regions that may depend on the different percentage of cases with missing information (not recorded), which percentage has been dropping over the years.

2.2 Civil status

Compared to the first decade in which abortion was legal, when married women accounted for the bulk of abortions, in recent years married and unmarried women have accounted for about the same share; indeed, in 2014-15 unmarried women accounted for a slightly higher percentage (51.9% in 2014 and 53.2% in 2015) (Table 8). This change is largely due to a significant drop in VTP on the part of married women, while that for unmarried women has remained similar, thus increasing their relative share of VTP. This is confirmed by the abortion rates for married and unmarried women calculated by ISTAT in 1981, 1994, 2004, and 2011, which show that the rate has dropped among married women (from 20.5 per 1,000 in 1981 a 9.3 in 1994, 8.1 in 2004 and 6.6 in 2011), while for unmarried women it dropped slightly, rose again, and then resumed dropping over the same timeframe (from 11.5 to 8.7, then 10.1 and 8.3). Additionally, it should be kept in mind that an increasing number of Italian families consists of unmarried couples living together, so that the "unmarried women" category is not quite comparable the same as it was in the past.

Percentage distributions by civil status also reflect the significant contribution of foreign women to VTP, for whom distribution by civil status differs from Italian women. Together with the differences at the population level among Italian women, this helps explain the different percentage distributions of VTP by civil status and geographic area in 2015, which confirm a higher percentage of married women in the south and in Sicily and Sardinia compared to central and northern Italy (Tab. 8). Below we report distributions by civil status and citizenship in the four main geographic areas.

VTP (%) by civil status, citizenship, and geographic area, 2015

	Married		Formerly married*		Unma	
	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	30.2	48.8	7.1	6.6	62.6	44.6
CENTRE	28.6	46.7	7.0	5.6	64.4	47.7
SOUTH	49.1	50.0	6.0	7.9	44.9	42.1
ISLANDS	40.5	47.0	6.4	5.4	53.1	47.6
ITALY	36.4	48.3	6.7	6.4	56.9	45.2

Istat data - *separated, divorced, or widowed

The table shows differences between the centre/north and the south/islands for Italian women; for foreign women these differences are less evident, and in general the percentage of married women is higher among foreign women than Italian ones (as in previous years); only in the south are these rates the same.

At the international level, abortion rates for unmarried women are lower in Italy than in Western Europe, although the difference has narrowed over time, as can be seen in the table below.

VTP (%) by civil status: international comparisons

COUNTRY	YEAR	Married	Unmarried or formerly
ITALY	(2015)	40.1	59.9
	(2014)	41.3	58.7
	(2000)	50.0	50.0
	(1990)	62.5	37.5
GERMANY	(2015)	37.9	62.1
ENGLAND AND WALES	(2015)	16.0	84.0
CZECH REPUBLIC	(2013)	34.2	65.8
SWITZERLAND	(2014)	30.0	70.0
USA	(2012)	14.7	85.3

2.3 Educational attainment

In Italy, educational attainment is an excellent indicator of social condition. Tab. 9 reports the percentage distribution of women who underwent VTP in 2014 and 2015 by educational attainment. There is slight prevalence of women with a high school diploma (42.8% in 2014 and 43.1% in 2015), as in 2013.

Variations in percentage distributions for educational attainment over the year reflect both a higher degree of education in the female population as a whole and the different rates at which the number of abortions have diminished by educational attainment, with the highest reduction in abortion risk for well-educated women (as discussed in detail in the 2003 report): these two effects work against each other, since the former tends to lead to a higher percentage of well-educated women, while the latter leads to a higher percentage of less-educated women.

As shown in the table below, there are differences in the percentage distribution by educational achievement and citizenship between geographic areas; these differences are partly explained by the different make-up of the population and differing levels of educational attainment.

In general, foreign women who resorted to VTP in 2014-5 are less educated than Italian women.

VTP (%) by education level, citizenship, and geographic area, 2015

	None/elementary school		Middle school		High school		University	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	1.6	9.0	29.4	40.1	48.6	38.7	20.4	12.2
CENTRE	4.7	9.8	30.7	45.9	48.8	37.1	15.8	7.2
SOUTH	3.2	14.2	46.1	48.4	41.2	32.4	9.4	5.1
ISLANDS	3.9	16.4	48.0	54.5	39.7	25.3	8.4	3.8
ITALY	2.9	10.2	36.6	43.3	45.5	36.9	15.0	9.7

ISTAT data

In order to better understand the evolution of VTP by educational attainment, ISTAT and the Ministry of Health conducted a survey of abortion rates by level of educational attainment between 1981 and 2010. Over the course of these 30 years, the abortion rate dropped among women with high school or university degrees (from 14 per 1,000 in 1981 to 6 per 1,000 in 2010), while since 1991 it has remained essentially the same among women with a middle school diploma, after an initial drop. The rate for the least educated women has not changed over time; in fact, it has increased during the last year for which data is available, as shown in the table below (De Rose A, Dalla Zuanna G (ed). *Rapporto sulla popolazione – Sessualità e riproduzione nell'Italia contemporanea*. Società editrice il Mulino, 2013).

Standardized abortion rate by educational attainment, women ages 20-, Italy 1981-2010

Educational attainment	1981	1991	2001	2010
Elementary	16	14	14	20
Middle school	22	14	13	15
High school and university	14	9	7	6

These variations can be explained by the fact that well-educated women are in a better position to improve their knowledge and behaviour as regards birth control. It should also be kept in mind that a significant share of less educated women are foreign; as shown below, they have higher abortion rates.

2.4 Employment

Tab. 10 reports the percentage distribution of VTP per employment status, which shows that 42.9% of women who aborted in 2015 are employed, 22.8% are homemakers, and 10.8% students. In recent years, the share of employed women has dropped, while that of the unemployed has risen (21.1% in 2015 and 20.8% in 2014 compared to 19.9% in 2013 and 18.8% in 2012), probably influenced by variations in the female population as a while.

As for educational attainment, there are substantial differences in the percentage distribution by employment status between geographic areas, largely explained by differences in this variable in the population as a whole and by the different impact of the contribution of foreign women, for whom employment status percentages are different than for Italian women.

VTP (%) by employment status, citizenship, and geographic area, 2015

	Employed		Unemployed or in search of first employment		Homemaker		Student or other	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	58.4	41.0	19.4	27.8	9.9	25.1	12.4	6.0
CENTRE	48.7	39.1	22.7	29.0	13.5	26.1	15.1	5.8
SOUTH	30.0	30.4	18.6	25.7	39.7	40.1	11.7	3.8
ISLANDS	28.8	28.2	26.0	34.6	33.4	33.9	11.7	3.3
ITALY	45.1	38.7	20.6	28.2	21.17	27.5	12.7	5.6

ISTAT data

In this case as well, ISTAT and the Ministry of Health updated the evaluation of the different trends of diminishing abortion rates by employment status. It shows that abortion rates have fallen faster for employed women than for homemakers: between 1981 and 2009, the rate for the latter fell from 19.0 per 1,000 to 10,3 per 1,000, while for the latter it fell from 15.2 to 7.0 per 1,000 (De Rose A, Dalla Zuanna G (ed). *Rapporto sulla popolazione – Sessualità e riproduzione nell'Italia contemporanea*. Società editrice il Mulino, 2013).

2.5 Place of residence

In the vast majority of cases, VTP performed in any given region concern women who reside in that region: this was true in 91.9% of cases in 2014 and 92.2% in 2015 (Tab. 11), an increase over to 2013 (90.8%). Of the VTP performed by in-region residents in 2015, 87.9% refer to women who resided in the province where the intervention took place. The table shows immigration rates from other women of 10% or more in the Autonomous Province of Trento in the Nord, in Umbria in central Italy, and in Abruzzo, Molise and Basilicata in the south, as in previous years. Nevertheless, it is necessary to know more about women who abort outside their region of residence to have a more complete picture of migratory flows. The example of Basilicata is paradigmatic: in 2015, 16.0% of abortions there involved women who resided elsewhere (89 VTP), but as Table 29 reports, many more women resident in Basilicata travelled outside the region to abort (162 VTP), mainly to Apulia. As a result, the abortion rate for women residing in Basilicata is much higher than the abortion rate in Basilicata itself: 5.63 per 1,000 compared to 4.63. The abortion rate for resident women better describes the abortion risk per region, since the numerator (N. VTP undergone anywhere by resident women) and the denominator (N. resident women of childbearing age) are homogeneous. When the net migratory flow is zero, the correct rate (per region of residence) coincides with the rate used in this report (per region where the VTP was performed). Table 29 clearly shows that in some regions the abortion rates used in the report over-estimate the actual incidence of abortions, while in other regions they under-estimate them. This data is important in order to assess the potential lack of available VTP services in certain parts of the country, which lead to migration flows to other regions. In order to obtain data on resident women who undergo VTP in other regions, the regional administrations must turn to ISTAT.

One must always kept in mind that migratory flows may be due to proximity (women who live near the border between two regions) or may mask false migrations (such as students from southern Italy in northern Italian universities). The other problem with using data on region of residence is the impossibility of obtaining complete information from all regions in time for it to be included in the Ministry's report.

We should also point out that there is a growing percentage of women who officially reside abroad, mostly in countries experiencing significant outbound migration flows, who resort to VTP in Italy because they are currently living here. The number of VTP by women residing abroad increased from 461 cases in 1980 to 2,443 cases in 1997 and 3,651 in 2000; numbers have dropped slightly in recent years: 3,328 in 2013, 2,564 in 2014, and 2,366 in 2015 (having added the share attributed to uncollected data and the contributions of each individual region). The highest rates of VTP by women who reside abroad are seen in northern and central Italy, where the immigrant population is concentrated.

2.6 Citizenship

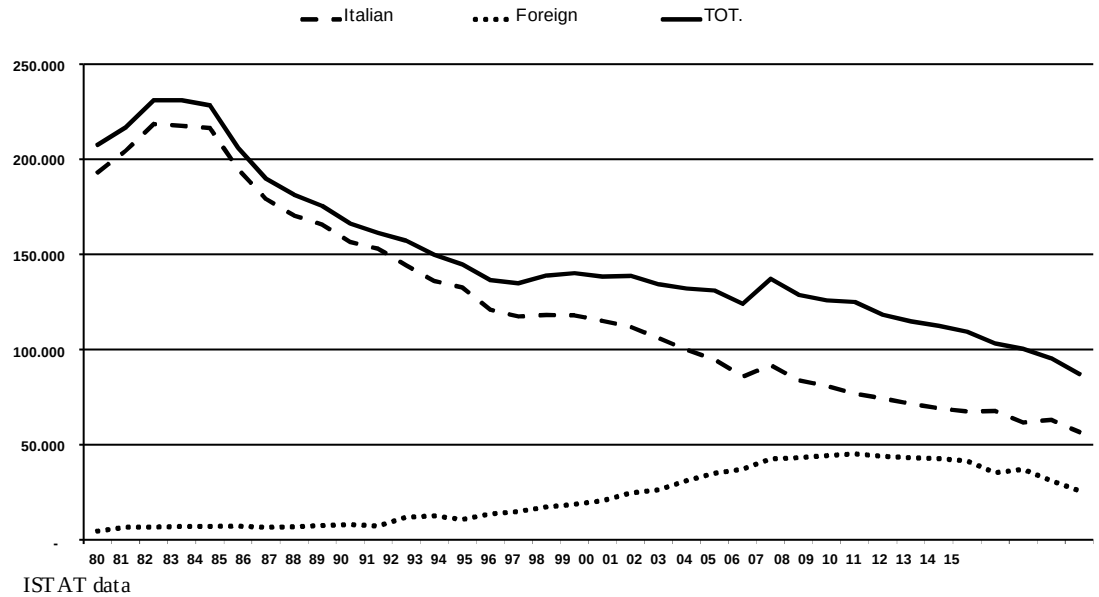
In 1995, the first year in which data on citizenship was recorded systematically, 8,967 foreign women underwent VTP in Italy. This number has increased over the years (together with the number of foreign citizens living in Italy) to a maximum of 40,224 in 2007. Since then, it stabilized, then slowly began to decline. According to data provided by the regions, there were 27,168 abortions by foreign women in 2015 and 31,028 in 2014; taking into account unrecorded data, the projections are 27,255 in 2015 and 31,557 in 2014. Detailed breakdowns by region on the citizenship of women who resorted to VTP in 2014 and 2015 are reported in table 12.

If we consider only VTP by Italian women, we see a constant fall in numbers from 124,448 in 1998, to 113,656 in 2000, 94,095 in 2005, 76,948 in 2010, 68,382 in 2013, 65,021 in 2014 and 60,384 in 2015, including projections for unreported data for the last 8 years. Assuming that the contribution of foreign women to VTP in 1982 (when the number of VTP peaked in Italy) was negligible, then the number of abortions for Italian women fell from 234,801 VTP to 60,384, a reduction of 74.3%.

In 2015 foreign women accounted for 31.1% of VTP in Italy, and for 33.0% in 2014. Immigrant populations are concentrated in northern and central Italy, and they contribute significantly to the number of VTP and the abortion rate. In most cases, these women are either resident or domiciled in Italy.

To compare data starting from 1980, we must use country of birth, as the country of citizenship has been recorded only since 1995 (Figure 7). Trends in VTP per country of birth mirror those per country of citizenship, and show a steady drop in VTP for Italian women, and an increase for foreign women up to 2004, which then plateaued until 2011, and began to drop in recent years.

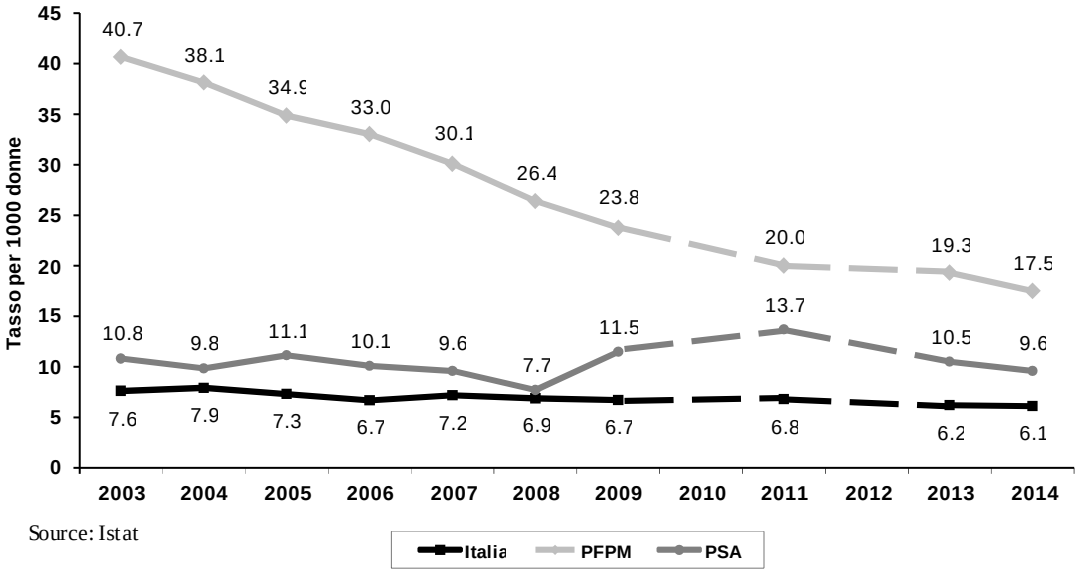
Figure 7 – Number of VTP per country of birth, Italy 1980-2015



ISTAT data

For a more complete picture of abortions per country of citizenship it is necessary to look at abortion rates for foreign and Italian women. These were provided by ISTAT, which keeps track of population data. If we lump countries of citizenship into three major groups – developing countries with high emigration rates (PFPM)[3], advanced developed countries (PSA), and Italy – one sees that abortion rates are decreasing among Italian women, but also – and quite significantly – among foreign women, especially those from PFPM countries, as shown in figure 8. Since data from 2010 and 2012 are not available, we hypothesized a linear drop between 2009 and 2011 and between 2011 and 2013, indicated with a dashed line.

Figure 8 – Abortion rates per country groups of citizenship, 2003-2014



Source: Istat

It is interesting to note that the differences between Italian and foreign women have narrowed over time: in 2003, abortion rates for women from PFPM countries were 5.4 times higher than for Italian women, while by 2014 they were only 2.9 times higher. The number of women from PSA countries who have had abortions in Italy is very small, and so variations in the abortion rates can oscillate widely.

This trend towards a lower abortion rate for women from PFPM countries and the narrowing gap with Italian women could be a sign of integration on the part of foreign women and of changing behaviours in terms of responsible procreation choices, as was the case over the years for Italian women.

The availability of population estimates by country of citizenship and age makes it possible to study the phenomenon in more detail. The table below reports abortion rate data from 2014, and compares Italian and foreign women by age class.

3 PFPM include all countries in Africa, Central and South America, Asia (except for Japan and Israel), Oceania (except for Australia and New Zealand), the countries that joined the EU in May 2004 and January 2007 (except for Malta and Cyprus), namely Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, Bulgaria, and Romania; and all remaining Eastern European countries that have not joined the EU. Stateless persons are not included.

Abortion rates per 1,000 women resident in Italy, by citizenship and age class - year 2014

Age	Citizenship	
	Italian	Foreign
15-19	4.4	13.3
20-24	8.2	28.9
25-29	8.4	27.0
30-34	8.5	23.0
35-39	7.7	18.2
40-44	3.6	7.8
45-49	0.3	0.6
15-49 standardized	*6.1*	*17.2*

Source: ISTAT

Foreign women of all age classes have abortion rates that are 2-3 higher than those of Italian women. The age class for which the rate is highest is 20-24, for both Italian and foreign women. In this age class, abortion rates for foreign women are almost 29 per 1,000, or 3.5 times higher than those for Italian women (while for women aged 15-49 this difference amounts to 2.9).

Studies conducted over the years by ISS and other agencies show that higher abortion rates for foreign women may depend on their living conditions and their limited knowledge of reproductive physiology and of responsible procreation methods, and not on their choosing VTP as a method to regulate fertility (ISTISAN Report 06/17).

Recent ISS studies on women who had just given birth confirms that foreign women prefer to avoid unwanted pregnancies (ISTISAN reports 11/12 and 12/39). These studies also stress the crucial role of counselling on responsible procreation to encourage the use of contraceptive methods upon resumption of sexual relations. Recommendations to provide such counselling to all women – Italian and foreign – were already issued in the late 1980s (ISTISAN report 91/25) and are widely reiterated in the *Progetto Obiettivo Materno Infantile* (POMI). Additionally, in 2010 the Ministry of Health/CCM promoted and funded a project on the prevention of VTP among foreign women. This project, which concluded in December 2012, was coordinated by the Tuscany regional government in collaboration with ISS and La Sapienza University in Rome. It had the following specific goals: training social and health care workers in intercultural approaches to preserving sexual and reproductive health; improving the organization and accessibility of health care services and involving them actively in the prevention of VTP; promoting extensive and wide-reaching information campaigns targeting the immigrant population, including through the participation of the immigrant women's community. The following regions participated: Campania, Emilia-Romagna, Friuli Venezia Giulia, Piedmont, Apulia, Sicily, Tuscany, Umbria, Veneto and the Autonomous Province of Trento. As part of the project a training course was organized with the participation of 32 regional professionals and 5 representatives from scientific societies, who provided training at the local level. Concerning the improvement of the organization of the services involved, over 86% of participating health care facilities signed the programming document on the organizational improvements to be implemented, and almost 92% turned in a final report on actions undertaken and results achieved. In general there were improvements in the areas of intervention, which included VTP, childbirth, screening for cervical cancer, and health education targeting the young. Some of the facilities that implemented these actions for at least six months saw improvements in the knowledge of foreign women concerning contraception and responsible procreation, and a 15-20% increase in the number of women who return to family-planning clinics for post-VTP check-ups. Finally, the project produced communication materials, with the help of foreign women, for the prevention of unwanted pregnancies,

the protection of maternity, and the prevention of the abandonment of newborn children. This material was translated into 8 languages and made available of the Ministry of Health's website.

Recent decreases in abortion rates among immigrant women suggest that the efforts carried out in recent years to prevent unwanted pregnancies and VTP, especially on the part of family planning clinics, are now bearing fruit among the immigrant population as well.

2.7 Obstetric history

As was already hinted at in the paragraphs above, knowing the reproductive history of women who request VTP is important to understand the phenomenon and its evolution over time.

It should be pointed out that some patients who fill out the D12 model form fail to insert any data on their reproductive history if they have not had any children, spontaneous abortions, or VTP, when in fact they should insert a zero. This is a potential problem in terms of the quality of data, as it either means considering this data as not recorded or doing extensive cross-checking of the data during the analysis phase. Since percentage distributions are calculated on recorded data, a consequence of this that the abortion rate for women who have not had any children, spontaneous abortions, or VTP may appear to be lower than it actually is. Therefore, comparisons between regions and over time must account for the percentage of non-recorded data: if it is over 5%, it can affect the accuracy of the information on percentage distributions for the various aspects of obstetric history. Data from Campania and Sicily in 2014 is slightly different, as this information was drawn from hospital discharge papers. Once again, we recommend that operators make sure they fill out all parts of the D12 model forms, and that regional liaisons report the problem to the facilities where it occurs.

2.7.1 Number of live childbirths

When making the difficult decision to terminate a pregnancy, the number of children a woman or a couple already has may be a key factor. Table 13 reports the percentage distribution of VTP per region and per number of live childbirth reported by the woman. In 2015 women with at least one child accounted for 60.6% of VTP (61.5% in 2014) and women with at least two children accounted for 37.2% (in the early 1980s these percentages were 75% and 50%, respectively). This is a clear example of how a percentage distribution can be modified by parity modality, when the evolution over time – in this case, the decrease – of each specific abortion rate per number of live childbirths: the decrease in the abortion rate for women with 0 live childbirths was lower than that for women with ≥1.

The table below reports this information for 2015 for Italy's 4 main geographic areas:

VTP (%) per parity (live childbirths), country of citizenship, and geographic area, 2015

	N° live childbirths							
	0		1		2		3 or more	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	48.3	27.6	22.8	27.7	22.0	30.6	7.0	14.1
CENTRE	52.6	31.4	21.2	26.8	20.5	29.7	5.7	12.1
SOUTH	37.4	20.8	19.6	31.5	30.2	33.0	12.8	14.6
ISLANDS	36.6	23.0	22.1	30.0	26.7	30.9	14.6	16.2
ITALY	44.8	27.5	21.5	28.0	24.5	30.7	9.2	13.8

ISTAT data

Among Italian women who aborted in 2015, those who had one or more previous live childbirths amounted to 51.8% in the North, 47.4% in the Centre, 62.6% in the South, and 63.4% in the islands, thus showing differences by geographical area. The equivalent percentages for foreign women are 72.4%, 68.6%, 79.2%, and 77.0%. Therefore, the percentage of women with children who interrupt their pregnancies is higher among foreign women; this is partly due to higher birth rates among foreign women as a whole.

For the purposes of epidemiological surveillance of VTP, the number of living children is much more important than the information on live childbirths and stillbirths currently present in the D12 model form after it was modified in 2000. Nevertheless, as a first approximation, the new variable "live childbirths" can be used as the equivalent as the older "living children" for comparisons with previous years. Over time, we have seen an increase in the percentage of childless women until the first decade of the 21st century, followed by stabilization.

VTP (%) per number of children, 1983-2015

	N° children				
	0	1	2	3	4 or more
1983	24.6	22.0	31.5	13.6	8.3
1987	29.3	19.6	31.6	13.0	6.6
1991	35.1	19.5	29.3	11.4	4.8
1995	39.0	19.9	27.4	9.9	3.7
1999	41.6	20.5	26.5	8.7	2.8
2004*	42.4	22.8	25.2	7.4	2.2
2007*	42.0	23.1	25.3	7.4	2.2
2009*	41.0	23.5	25.6	7.6	2.3
2010*	40.6	23.8	25.7	7.6	2.3
2011*	40.3	23.9	25.6	7.9	2.3
2012*	39.7	24.0	25.9	8.1	2.3
2013*	39.0	24.3	26.2	8.1	2.4
2014*	38.5	24.2	26.6	8.2	2.5
2015*	39.4	23.4	26.4	8.2	2.5

* Live childbirths

The comparison with other countries in the table below shows similar percentages across the board.

VTP (%) per number of children, international comparisons

COUNTRY	YEAR	N° children or live	
		0	≥ 1
ITALY	(2015) *	39.4	60.6
	(2014) *	38.5	61.5
GERMANY	(2015)	39.1	60.9
ENGLAND AND WALES	(2015)	46.0	54.0
THE NETHERLANDS	(2014)	47.6	52.4
SPAIN	(2014)	44.7	55.3
SWITZERLAND	(2014)	51.0	49.0
CZECH REPUBLIC	(2013)	28.7	71.3
USA	(2012)	40.3	59.7

* Live childbirths

2.7.2 Previous spontaneous abortions

In 2015, 86.5% of women who resorted to VTP stated that they never had any spontaneous abortions (Tab. 14). This percentage was the same in 2013-14 and was quite similar in previous years, suggesting little if any variation over time.

VTP (%) per number of previous spontaneous abortions, 1983-2015

	N° previous spontaneous abortions				
	0	1	2	3	4 or
1983	81.1	13.1	3.8	1.2	0.9
1987	86.1	10.4	2.5	0.6	0.4
1991	87.9	9.4	2.0	0.5	0.3
1995	88.8	8.8	1.8	0.4	0.2
2000	89.4	8.4	1.7	0.3	0.2
2004	88.8	8.6	1.9	0.5	0.3
2007	89.0	8.7	1.7	0.4	0.2
2009	88.1	9.3	1.8	0.4	0.3
2010	88.0	9.5	1.9	0.4	0.2
2011	87.4	9.9	2.0	0.5	0.2
2012	87.0	10.2	2.1	0.5	0.2
2013	86.5	10.6	2.1	0.5	0.3
2014	86.4	10.8	2.1	0.5	0.3
2015	86.5	10.5	2.2	0.5	0.3

2.7.3 Previous voluntary abortions

Data from 2015 (Tab. 15) confirm that the percentage of VTP undergone by women who previously resorted to at least one other VTP has remained steady since 1990.

VTP (%) per previous VTP 1983-2015

	N° previous VTP				
	1	2	3	4 or	Total
1983	18.0	4.5	1.4	1.0	24.9
1987	20.4	6.2	2.1	1.4	30.0
1991	18.9	5.6	1.8	1.2	27.5
1995	17.8	5.1	1.6	1.0	25.5
2000	17.1	5.1	1.6	0.9	24.9
2004	17.6	5.1	1.6	1.1	25.4
2007	18.5	5.5	1.7	1.2	26.9
2009	18.9	5.3	1.6	1.1	27.0
2010	19.0	5.4	1.7	1.1	27.2
2011	18.8	5.3	1.6	1.1	26.8
2012	18.6	5.3	1.6	1.1	26.6
2013	19.0	5.2	1.6	1.0	26.8
2014	19.1	5.4	1.7	1.1	27.3
2015	19.0	5.3	1.6	1.0	26.9

Changes in the trends of repeat abortions in Italy is the clearest evidence of how the risk of unwanted pregnancies has evolved over time: indeed, had this risk remained constant, we would have seen – 30 years after the legalisation of abortion – a percentage almost twice as high as the one we observed, according to mathematical models that can estimate trends in repeat abortions over time, starting with the date of legalisation and assuming a constant risk. The table below reports actual and expected trends.

Percentage of repeat VTP (legal abortions), Italy 1989-2015

	1989	1990	1992	1994	1996	1998	2000	2002	2004	2006	2010	2013	2014	2015
observed	30.0	28.9	27.6	26.3	24.8	24.5	24.9	24.3	25.4	26.9	27.2	26.8	27.3	26.9
expected *	36.9	38.3	40.5	42.0	43.0	43.8	44.2	44.5	44.6	44.6	44.7	44.7	44.8	44.8

(* The expected values were drawn using the mathematical model in the following publication: De Blasio R. Spinelli A. Grandolfo ME: *Applicazione di un modello matematico alla stima degli aborti ripetuti in Italia*. Ann Ist Super Sanità 1988;24: 331- 338).

It should also be kept in mind that immigration in Italy increased starting in the 1990s, and so did the impact of immigrant women on abortion statistics, as reported in the chapter on country of citizenship. The risk of abortion – and the risk of repeat abortions – is higher in foreign women than in Italian ones. Thus, if we considered Italian women only, the reduction in the repeat abortion rate would be even more striking.

The table below, based on data from 2015, confirms that foreign women have rates of repeat VTP that are significantly higher than those of Italian women (38.3% versus 21.6%).

Repeat VTP (%) per previous VTP, country of citizenship, and geographic area 2015

	N° previous VTP							
	1		2		3 or		Total	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	16.6	26.0	3.3	8.3	1.2	4.0	21.2	38.4
CENTRE	14.9	25.2	3.2	9.0	1.1	4.9	19.3	39.2
SOUTH	18.0	22.8	5.0	9.7	2.1	6.4	25.1	38.9
ISLANDS	14.2	19.7	3.3	6.2	1.2	5.6	18.7	31.4
ITALY	16.4	25.2	3.8	8.6	1.4	4.6	21.6	38.3

ISTAT data

In 2015, the highest repeat abortion rates for Italian women were in the South, with 25.1%. Considering both Italian and foreign women (table 15), the highest percentage of repeat abortions in the North were in Emilia Romagna (32.3%); in the Centre in Tuscany (30.5%); and in the South in Apulia (36.0%). Regional differences can depend in part on the number of cases in which this variable was unreported (instead of being reported as zero). Once again, we remind those who fill out D12 model forms to compile all sections, even when the value is "0" or "none".

The comparison with other countries reported in the table below shows that Italy has the lowest rate of repeat abortions worldwide.

VTP (%) per previous VTP, international comparisons

COUNTRY		N° PREVIOUS VTP				
	YEAR	0	1	2	3 or	≥1
ITALY	(2015)	73.1	19.0	5.3	2.6	26.9
	(2014)	72.8	19.1	5.4	2.8	27.3
	(2006)	73.0	18.6	5.5	3.0	27.1
ENGLAND AND WALES	(2015)	62.0	27.0	8.0	3.0	38.0
THE NETHERLANDS	(2014)	64.4	23.9	7.6	4.1	35.6
SPAIN	(2014)	62.5	24.8	8.2	4.6	37.5
SWEDEN	(2014)	57.1	n.r.	n.r.	n.r.	42.9
USA	(2012)	55.7	24.6	11.0	8.6	44.2

In conclusion, the comparison between actual and expected repeat abortion trends shows that the risk of unwanted pregnancies – and thus of abortions – in Italy is falling (especially if the contribution of foreign women is excluded), and the most plausible explanation is the greater and more effective use of alternative methods of responsible procreation, in compliance with the law.

VTP procedures

3.1 Documentation and certification

When a woman visits one of the legally-recognized facilities for pre-VTP procedures, the physician in charge drafts a document - co-signed by the woman herself, and to whom a copy is issued – which certifies the pregnancy and the woman's intention to terminate it, in addition to a request to wait seven days (Art.5 of Law 194/78). After this period the woman can turn to authorized facilities to terminate her pregnancy on the basis of the document that has been issued. The document is issued after all necessary tests and interviews pursuant to Art. 5. This document is often – and inappropriately – referred to as a certificate, due to the wording present in the D12/Istat model form.

In fact, the actual certificate is only issued once the physician from the relevant family-planning clinic or other health facility or the general practitioner verifies the existence of conditions that make the intervention urgent, or in case of VTP after 90 days, in accordance with the modalities established by the law (art. 5).

In 2014 and 2015, as in previous years, family planning clinics issued more documents and certificates (41.6%) than other facilities (Tab. 16): 41.9% in 2014 and 42.3% in 2015. The regions in which these percentages are much higher than the national average, which shows that family-planning clinics play a particularly important role, are the same as in previous years: Emilia Romagna with 68.8% in 2015, Piedmont (62.7%), Autonomous Province of Trento (59.0%), and Umbria (58.9%). Percentages are generally lower in southern Italy and in Sicily and Sardinia, probably due to fewer facilities and staff.

The table below shows significant differences by geographic area and country of citizenship:

VTP (%) per certification, country of citizenship, and geographic area, 2015

	Document/Certification							
	Family-planning		GP		OBGYN		Other facility	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	47.8	60.7	24.5	16.3	25.8	21.7	1.9	1.4
CENTRE	45.5	50.6	17.9	17.8	26.9	23.2	9.7	8.5
SOUTH	25.5	33.6	28.0	19.2	44.3	44.9	2.2	2.3
ISLANDS	20.4	33.4	20.8	14.4	57.2	51.2	1.6	0.9
ITALY	37.9	53.8	23.8	16.9	34.9	26.2	3.4	3.1

ISTAT data

For several years now, the role of family-planning clinics has become more important, mainly due to the greater use of such facilities by foreign women, since they are easier to access and a cultural mediator is often present. It is comforting to note that foreign women – whose use of responsible procreation methods often mirrors that of Italian women 30 years ago – use health care facilities, and especially family planning clinics, given the positive role such facilities have played in reducing abortion rates among Italian women. Perhaps the recent reductions in abortion rates in foreign women – as reported in the chapter on country of citizenship – is partly due to the work of these facilities. This is one more argument in favour of strengthening and renovating family planning clinics in accordance to POMI indications, especially regarding cultural mediation and a department-level model of hospital and local services.

The table below shows trends over time.

VTP (%) per place of issue of the document or certificate, 1983-2015

	GP	OBGYN	Family-planning clinic	Other
1983	52.9	21.4	24.2	1.4
1987	52.4	25.7	20.0	1.9
1991	47.8	29.1	21.4	1.7
1995	45.5	29.1	23.5	1.9
1999	38.6	31.0	28.7	1.7
2000	36.0	32.2	30.1	1.7
2004	32.2	30.8	35.1	1.8
2007	27.7	33.0	37.2	2.2
2009	27.5	31.2	39.4	1.9
2010	26.0	30.9	40.4	2.6
2011	25.3	30.5	40.7	3.4
2012	24.3	30.5	42.0	3.1
2013	22.9	32.3	41.6	3.1
2014	21.7	33.0	41.9	3.4
2015	21.4	33.0	42.3	3.3

In 2015 there were 0.6 public family-planning clinics per 20,000 inhabitants (Tab. 17), slightly less than in 2014 (0.7) and previous years; according to Law 34/96 there should be 1 per 20,000 inhabitants. The POMI sets out recommended staffing levels and opening hours; unfortunately, the 1,970 public family-planning clinics registered in 2015 only partly meet these requirements, and only a small number are organized into an integrated departmental network in accordance with the operational and organizational strategic guidelines issued by the POMI itself. The absence or unavailability of a physician to issue documents and certifications, the lack of integration with facilities where VTP are performed, and the shortage of family clinics in certain areas, reduce the role of this key service. This nullifies a valuable resource, whose experience in the social and health context and whose multi-disciplinary skills in dealing with social determinants can support women and/or couples in making informed choices, including the reconsideration of the motives behind their choices, to help them in the VTP process, and to help prevent future instances.

3.2 Urgency

In 2015 the 3 section of art. 5 of Law 194/78 was invoked in 16.7% of cases, compared to 14.7% in 2014, 13.4% in 2013 and 11.6% in 2011 (Tab. 18). This increase may indicate problems with mailing lists, available VTP facilities, or the need to invoke urgency to carry out abortions with Mifepristone and prostaglandins within the prescribed timeframe (49 days of pregnancy). As in previous years, percentages higher than the national norm were recorded in Apulia (32.1%), Piedmont (30.0%), Latium (24.2%), Tuscany (23.1%), Emilia Romagna (22.5%) and Marche (17.4%).

The geographic distribution of VTP with a certificate of urgency is: 15.8% in the North, 21.8% in the Centre, 17.3% in the South, and 8.2% in Sicily and Sardinia.

3.3 Gestational age

VTP distribution per week of pregnancy in 2015 (Tab. 19) shows that 46.8% were performed no later than the 8th week, 12.9% at 11-12 weeks, and 5.0% after the 12th week (in 2014 these percentages were 45.7%, 13.6% and 4.7% respectively). The percentage of VTP performed within the 8th week of pregnancy increased in recent years (41.8% in 2012 and 43.6% in 2013), probably due at least in part of the increase in the use of Mifepristone and prostaglandins to perform VTP, which takes place early in the pregnancy. Additionally, there is a slight increase in the percentage of VTP after the 12th week of pregnancy: 5.0% in 2015 and 4.7 in 2014 versus 4.2% in 2013 and 3.8% in 2012.

Once again, any analysis of these numbers must account for foreign women, who tend to abort – within the first 90 days – at a later time. As the table below shows, 16.7% of VTP by foreign women are performed at 11-12 weeks, compared to 11.7% for Italian women.

VTP (%) per gestational age, country of citizenship, and geographic area, 2015

	Gestational age							
	≤8		9-10		11-12		> 12	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	46.7	41.9	33.1	38.7	13.1	16.4	7.1	3.1
CENTRE	46.2	38.1	35.2	41.5	13.0	17.9	5.6	2.5
SOUTH	53.9	46.6	32.9	39.2	8.1	12.5	5.1	1.6
ISLANDS	42.9	38.8	37.5	41.6	13.2	17.4	6.4	2.1
ITALY	48.1	41.4	33.9	39.6	11.7	16.4	6.1	2.7

ISTAT data

It should be stressed that the percentage of interventions carried out at 11-12 weeks is an indicator of the availability and quality of facilities, as well as of their level of integration. However, the possibility exists that certain facilities do not perform VTP after a certain gestational age (e.g. the 10th week or the first 90 days), and this might have an impact on the distributions above. It should be kept in mind that possible complications tend to occur at a later gestational age.

Unlike abortions performed within 90 days, those performed after that time are generally the result of unfavourable pre-natal analyses, to which foreign women have less access due to barriers to knowledge and high costs (ISTISAN report 11/12). It is thus not a surprise that for foreign women who resorted to VTP in 2013, the percentage of those who had abortions after the 12th week is lower than for their Italian counterparts for the reasons cited above, and perhaps also due to their lower average age and thus lower risk for fetal malformations. Percentages differ by geographic area as well, perhaps due to the greater availability of facilities that perform VTP after the first 90 days in central and northern Italy.

The percentage of abortions performed after the 12th week of pregnancy in 2015 is reported in the table below:

REGION	%	REGION	%
Piedmont	5.3	Marche	5.0
Valle d'Aosta	2.6	Latium	4.6
Lombardy	5.6	Abruzzo	3.9
Bolzano	8.3	Molise	0.3
Trento	6.4	Campania	3.9
Veneto	6.9	Apulia	4.8
Friuli Venezia Giulia	6.4	Basilicata	5.5
Liguria	4.9	Calabria	5.6
Emilia Romagna	4.6	Sicily	5.0
Tuscany	4.2	Sardinia	7.9
Umbria	3.0		
		ITALY	**5.0**

It should be pointed out that these percentage distributions describe drastically different situations: abortions performed before 12 weeks refer to unwanted pregnancies that can be prevented through the promotion of responsible procreation, while those performed after 12 weeks refer to pregnancies terminated due to issues related to the mother's health or to pre-natal diagnoses. While the former situation is becoming rarer due to the improved ability to avoid unwanted pregnancies, the latter tends to increase as pre-natal diagnoses become more widespread, in part due to the increased frequency of pregnancies at older ages. Both of these aspects need to be kept in mind when making comparisons across regions or time.

Table 20 reports the percentage distribution of VTP per week of gestation and age group. As in previous years, the percentage of VTP at 11-12 weeks is higher in younger women, and may be due to delays in resorting to abortion facilities, as is often the case for foreign women, or to the fact that younger women have fewer abortions after the first trimester since they have fewer unfavourable prenatal diagnoses.

The table below shows international comparisons, which often reflect differences in legislation and in the availability of abortion services.

VTP after the 12th week

PAESE	ANNO	N° total VTP	Abortion rate* (15-44)	% VTP >12 weeks
ITALY	(2015)	87639	8.1	5.0
	(2014)	96578	8.8	4.7
	(2006)	131018	11.1	2.9
DENMARK	(2014)	15097	13.8	4.3
FINLAND	(2013)	10120	10.4	7.0
GERMANY	(2015)	99237	6.8	2.8
ENGLAND AND WALES	(2015)	185824	16.0	9.0
NORWAY	(2014)	14061	13.9	3.9
THE NETHERLANDS	(2014)	30361	8.5	18.4
CZECH REPUBLIC	(2013)	22714	9.2	3.9
SPAIN	(2014)	94796	10.5	10.6

* the abortion rate used for international comparisons is calculated for women between the ages of 15 and 44.

3.4 Waiting times between the issuing of the document/certification and the intervention

Information on the date of issuing of the document or certification, which makes it possible to calculate waiting times for abortions, was included in the D12/ISTAT standard model form in 2000. In recent years, the percentage of VTP performed within 14 days of the issuing of the document has increased slightly: 59.6% in 2011, 61.5% in 2012, 62.3% in 2013, 64.8% in 2014 and 65.3% in 2015 (Tab. 21). At the same time, the percentage of VTP performed after three or more weeks has dropped slightly: 15.7% in 2011, 15.5% in 2012, 14.6% in 2013, and 13.2% in 2014 and in 2015. These trends may be linked to a rise in urgent abortions and the use of Mifepristone + prostaglandins. Data flows regarding this variable have also improved, with a drop in the number of cases in which this information was not recorded (only 0.9% in 2015 and 2.5% in 2014).

The table below reports waiting times for foreign and Italian women in the four major geographic areas.

VTP % per waiting times, country of citizenship, and geographic area, 2015

	Waiting times							
	≤14		15-21		22-28		>28	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	67.0	65.7	21.4	23.0	8.2	8.2	3.4	3.1
CENTRE	64.5	60.8	24.2	25.0	8.4	9.5	2.9	4.6
SOUTH	68.0	67.4	20.2	20.1	8.3	9.1	3.6	3.4
ISLANDS	65.6	61.3	20.1	23.0	9.5	11.2	4.8	4.6
ITALY	66.6	64.5	21.5	23.2	8.4	8.8	3.5	3.6

ISTAT data

High percentages of waiting times beyond two weeks may indicate failure to fully apply the law in certain regions. As in previous years, high percentages of waiting times over 3 weeks were recorded in 2015 in Calabria (24.8% of VTP), Umbria (24.3%), Veneto (23.8%) and Valle d'Aosta (23.5%).

It should also be kept in mind that waiting times are generally shorter for abortions performed at a relatively advanced gestational age, in order to perform the intervention within the legally prescribed timeframe.

3.5 Facility where the abortion was performed

In 2015 the distribution of interventions per type of facility (Tab. 23) did not significantly change compared to previous years, as shown in the table below.

VTP (%) per type of facility, 1983-2015

	Public hospital	Clinic	Day hospital
1983	87.6	9.7	2.7
1987	82.7	12.6	4.6
1991	87.3	11.6	1.0
1995	88.3	10.9	0.7
2000	90.6	9.1	0.3
2004	91.2	8.8	0.0
2007	91.6	8.4	0.0
2009	91.6	8.4	0.0
2010	91.7	8.3	0.0
2011	92.1	7.9	0.0
2012	92.5	7.5	0.0
2013	93.5	7.5	0.0
2014	94.2	5.8	0.0
2015	94.3	5.7	0.0

The vast majority of VTP (94.3% in 2015) is performed in public hospitals, with the percentage performed in clinics dropping in recent years. As in the past, the percentage of VTP carried out in clinics in particularly high in the Autonomous Province of Trento, Apulia, Sardinia, and Campania.

The percentage of VTP per type of facility, country of citizenship, and geographic area is reported below.

VTP % per type of facility, country of citizenship, and geographic area, 2015

	Type of facility			
	Public hospital		Clinic	
	Italian	Foreign	Italian	Foreign
NORTH	98.0	98.0	2.0	2.0
CENTRE	97.8	98.5	2.2	1.5
SOUTH	87.1	91.9	12.9	8.1
ISLANDS	93.0	96.5	7.0	3.5
ITALY	94.4	97.3	5.6	2.7

ISTAT data

For a more detailed framework on the availability of abortion facilities at the local level, for several years now this report has included a table with regional data on the number of hospitals with OBGYN departments and on the number of facilities that perform VTP (Tab. 23bis). Given the need to differentiate between hospitals and other facilities (those where OBGYN interventions are performed, but which do not necessarily have specific departments), regions were asked to provide these data separately in 2014 and 2015, as reported in the table. In 2014 there were 579 hospitals and 654 other facilities, of which 390 performed VTP (59.6%); in 2015 there were 580 hospitals and 648 other facilities, of which 385 performed VTP (59.4%). The percentage of facilities performing VTP thus fell from 60.0% in 2013 and 64.0% in 2012.

There was great variability at the regional level in 2015, from a minimum of 22.2% in the Autonomous Province of Bolzano, 25.0% in Molise and27.1% in Campania to a maximum of 100% in Valle d'Aosta, 92.3% in Umbria, 87.5% in Tuscany, and 86.7% in Liguria.

3.6 Type of anesthesia used

In 2015 the use of general anesthesia remained high (69.0%), although it continues to drop compared to previous years: 80.1% in 2012, 76.6% in 2013, and 73.0% in 2014. Since 2012 the D12/ISTAT model form lists "deep sedation" separately from general anesthesia (Tab. 24). Deep sedation was used in 10.1% of cases (an increase compared to 2.0% in 2012, 4.5% in 2013 and 8.0% in 2014) with significant differences between regions (from 0 cases in the Autonomous Province of Bolzano and in Molise to 39.6% of cases in Veneto). Abortions performed under "no anesthesia" also increased significantly from 5.7% in 2012 to 12.6% in 2015. This is likely due to the increased use of Mifepristone in VTP. Additionally, certain regions and local health units may not have yet used this new classification system, or may not have yet updated their data recording software. In future years it should be possible to have more comprehensive information on this variable. Meanwhile, we recommend that regions and local health units always use the latest ISTAT model forms.

Local anesthesia was used in only 4.5% of cases (6.6% in 2012), in contrast with international guidelines. Indeed, the guidelines on VTP issued by the U.K.'s Royal College of Obstetricians and Gynaecologists (RCOG. *The care of women requesting induced abortion. Evidence-based Clinical Guidelines n.7*. London: RCOG Press; 2011) states that when VTP are performed through vacuum abortions (as in the vast majority of cases in Italy), general anesthesia is not necessary and local anesthesia is preferable. In 2012 published the second edition of the "*Safe Abortion: Technical and Policy Guidance for Health Systems*" guidelines, which also recommend local over general anesthesia to reduce health risks for women having abortions. Additionally, local anesthesia implies a lower demand for pre-VTP analyses and requires fewer staff and equipment, with lower costs. This has significant organizational implications for VTP facilities, especially in light of the high percentage of conscientious objectors. Regional administrations should provide training courses on these procedures and promote their use.

The table below reports the distribution of the type of anesthesia used per country of citizenship and geographic area in 2015.

VTP (%) per type of anesthesia, country of citizenship, and geographic area 2015

	General		Local		Analgesia		Deep sedation		Other/none	
	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign	Italian	Foreign
NORTH	69.2	73.4	3.2	3.4	3.9	3.6	7.7	7.5	23.8	19.7
CENTRE	68.0	69.8	11.4	15.2	0.6	0.6	16.5	23.2	20.1	14.4
SOUTH	83.8	86.0	3.6	6.4	0.7	0.8	6.8	5.7	11.9	6.7
ISLANDS	85.6	90.1	0.5	0.2	2.0	0.8	2.0	0.7	11.9	8.9
ITALY	75.1	75.0	4.5	6.1	2.1	2.5	8.3	10.3	18.3	16.4

ISTAT data

3.7 Type of procedure

Vacuum abortions, and especially the Karman technique, remained the commonest VTP method in 2015 (Tab. 25), although 9.3% of abortions were performed using dilation and curettage, which has a higher risk of complications. A comparison of VTP methods over the years is reported in the table below:

VTP (%) per type of procedure, 1983-2015

	D & C	Vacuum	Karman	Other
1983	24.5	46.7	28.3	0.6
1987	17.8	37.9	43.7	0.5
1991	15.8	33.4	50.2	0.6
1995	14.9	24.8	57.5	2.8
2000*	15.6	19.5	63.6	1.3
2004*	13.3	20.2	64.9	1.6
2007*	11.2	22.9	63.3	2.5
2008*	12.0	22.8	63.0	2.3
2009*	12.6	21.5	63.4	2.4
2010*[a]	11.4	20.3	62.9	5.4
2011* [a]	11.4	19.8	59.6	9.1
2012* [a]	11.7	19.6	58.0	10.7
2013** [a]	9.9	16.6	59.0	14.5
2014** [a]	9.1	17.8	57.0	16.2
2015** [a]	9.3	17.0	55.6	18.2

* excluding data from Latium, which is aggregated differently - ** excluding data from Lombardy, which is aggregated differently
[a] For a comparison with previous years, "Others" includes all pharmacological abortion methods

Much higher percentages in the use of dilation and curettage were recorded in southern Italy and in the islands (especially Sardinia and Abruzzo, where this technique is still used in over 35% of cases, as in previous years), versus much lower percentages in other regions (less than 2% in Molise, Basilicata, Apulia, and Umbria). Since this technique is associated with a higher risk of complications, regional administrations should act to reduce its use. The table below reports abortion methods per geographic area and country of citizenship:

VTP (%) per type of procedure, country of citizenship, and geographic area, 2015

	Type of											
	D & G		Vacuum		Karman		Mifepristone		Mifepristone +Prostag		Pharm. + Other	
	Ita.	For.	Ita.	For.	Ita.	For.	Ita.	For.	Ita.	For.	Ita.	For.
NORTH	11.8	10.7	23.4	24.5	43.4	49.8	3.3	1.8	16.5	12.5	1.7	0.8
CENTRE	7.3	5.8	17.3	25.4	56.3	56.5	0.9	0.7	16.4	10.8	1.7	0.8
SOUTH	8.0	10.9	9.4	9.7	70.7	73.0	1.1	0.5	9.4	5.3	1.4	0.5
ISLANDS	20.0	17.4	11.6	9.4	54.4	63.6	2.1	1.3	8.9	7.3	3.1	0.9
ITALY	10.7	9.8	16.9	22.3	54.9	54.8	2.0	1.3	13.6	11.0	1.8	0.8

ISTAT data

It should be kept in mind that within each region there are differences between hospitals, as shown by an analysis of the D12/ISTAT model forms.

Starting in 2005, a number of facilities in Italy have adopted the pharmacological methods of abortion with Mifepristone (RU486) and prostaglandins (also known as medical abortions, as opposed to surgical abortions), as had already been the case in many other countries, and in line with the recommendations for first-trimester abortions issued by the WHO (*Safe Abortion: Technical and Policy Guidance for Health Systems - Second edition*. WHO, 2012) and other international agencies. Before 2009 this drug was not available in Italy and had to be purchased from abroad.

The procedure to authorize the sale of Mifepristone (MIFEGYNE@) in Italy ended on 30 July 2009 when the Board of Directors of the Italian Medicines Agencies (*Agenzia Italiana del Farmaco* - AIFA) gave its favourable opinion. Since the data collected with the D12/ISTAT model form for 2010-12 did not make it possible to monitor this method, the Ministry of Health decided to embark on a specific data collection project through a trimestral questionnaire submitted in addition to the current one in 2010 and 2011. The Ministry of Health requested the collaboration of the National Institute of Health (ISS) to collect and analyse such data. All region sent their data, which showed that in 2010 this method was used in 3,836 cases (3.3% of the total), and 7,432 cases in 2011 (6.7%). In 2010 this method was used in every region except Abruzzo and Calabria, while in 2011 the only region where it was not used was Marche. The results of this monitoring effort are presented in detail in the Ministry of Health's report *"Interruzione Volontaria di Gravidanza con mifepristone e prostaglandine. Anni 2010 – 2011"* available on the Ministry's website.

In 2015 every region except Lombardy was able to provide detailed information on the type of procedure used, as reported in the D12/ISTAT model form, which has separate listings for pharmacological abortions using "Mifepristone only", "Mifepristone + prostaglandins", and "prostaglandins only". Comparisons over time show a constant increase in the use of Mifepristone and prostaglandins, which are now used in every region.

The table below details the use of this method from 2005 to 2015:

Year	2005	2009	2010	2011	2012	2013	2014	2015
N. of VTP with RU486	132	857	3836	7432	7855	8114	10257	11134
% of total VTP	0.1	0.7	3.3	6.7	7.3	9.7	12.9	15.2
N. Regions	2	5	18	20	20	20	21	21

The frequency of medical abortions changes greatly between regions, regarding both the number of procedures and the number of facilities providing them. The highest percentages are in northern Italy, especially in Liguria (40.3% of all VTP in 2015), Piedmont (32.5%), Emilia Romagna (25.8%) and Tuscany (20.1%), as reported in Table 25.

There are no significant social or demographic differences in the women who resorted to this method, although they are generally younger and better educated and more likely to be Italian and single compared to women who resorted to other methods. Data on 2015 from the D12 model form show that 93.5% of VTP carried out with Mifepristone + prostaglandins took place within the first 49 days of pregnancy, as recommended in Italy (Ordinary Supplement of the Official Journal of 9/12/2009). In 2010-11 this applied to 98.7% of VTP.

The same data collection showed that while most regions and facilities chose to hospitalized women undergoing abortions, most of them (76%) asked to be released after the administration of Mifepristone or before the expulsion of all the products of pregnancy, and to return to the hospital to complete the procedure (in 95% of these cases, the women returned to the same facility). Additionally, in 96.9% of cases there were no immediate complications, and the need to resort to vacuuming or revising the uterine cavity to complete the procedure only arose in 5.3% of cases. Post-dismissal check-ups found no complications in 92.9% of cases.

These data are comparable to those in other countries and in the literature, and appear to confirm the safety of this method.

3.8 Duration of hospitalization

In 2015, the duration of hospitalization was less than 24 hours for 89.8% of VTP; women were hospitalized overnight in 4.6% of cases (Tab. 26). In recent years, the percentage of VTP with hospitalizations lasting less than 24 hours has stabilized:

VTP (%) per duration of hospitalization, 1983-2015

	Days of		
	< 1	1	≥ 2
1983	47.5	30.5	22.0
1991	72.9	19.0	8.0
2000	83.1	12.2	4.7
2004	90.0	6.2	3.7
2007	91.2	6.2	2.6
2008	92.6	4.8	2.7
2009	93.6	3.9	2.5
2010	92.1	4.9	2.9
2011	90.3	5.8	3.9
2012	89.9	5.7	4.3
2013	88.6	6.5	4.8
2014	87.6	5.9	6.6
2015	89.8	4.6	5.6

There are clear differences between the regions, with longer hospitalizations in Apulia, Piedmont, Valle d'Aosta and Veneto.

The table below shows geographic differences in duration of hospitalization in 2014 and 2015 in southern Italy, the percentage of hospitalizations of less than 24 hours increased significantly and that of overnight hospitalization decreased; in other areas there were few differences between 2014 and 2015.

VTP (%) per duration of hospitalization and geographic area, 2014-2015

	Days of hospitalization					
	< 1		1		≥ 2	
	2014	2015	2014	2015	2014	2015
NORD	88.5	88.8	4.1	4.7	7.4	6.7
CENTRO	95.5	96.0	2.0	1.5	2.5	2.6
SUD	79.0	87.5	13.1	6.3	7.9	6.2
ISOLE	86.7	86.3	5.4	7.4	7.8	6.3
ITALIA	87.6	89.8	5.9	4.6	6.6	5.6

3.9 Immediate complications from VTP

In 2015 there were 7.3 complications per 1,000 VTP (Tab. 27), and 7.4 per 1,000 in 2014, with an increase in hemorrhages and infections and a decrease in other complications compared to 2013. There are no differences between countries of citizenship, but there are significant differences between regions.

As of 2015 the D12/ISTAT model form makes it possible to register multiple complications for each VTP and to collect data on failed and incomplete abortions. Nevertheless, many regions have not yet updated their data collection systems, and it is not yet possible to analyze a full set of data. We recommend that regions make all necessary modifications as soon as possible.

In 2014 there were two deaths subsequent to VTP: one in Campania and one in Piedmont. Until these two events in 2014, there were no known deaths linked to VTP since the entry into force of Law 194/78.

In the case that took place in Campania, the regional report states that the woman, in her 8th week of pregnancy, had gone to an authorized facility to undergo a surgical abortion, in accordance with legally-prescribed procedures. As reported by the hospital liaison for clinical risk, she was taken to the operating room after application of prostaglandins, but "due to the insufficient cervical dilatation, the procedure was not completed". The patient was stimulated with additional prostaglandins and subjected to "an ultrasound that showed that VTP has taken place, but without the expulsion of the embryo. The patient was advised to remain hospitalized until further notice, but she voluntarily left the hospital at 19.00". After two days the patient returned to the emergency room with abdominal pain and a 39° fever. She was hospitalized in the OBGYN ward, where she underwent blood tests, a pelvic ultrasound, abdominal x-rays, and an abdominal CT scan." The patient underwent various pharmacological treatments and a subtotal hysterectomy. In spite of pharmacological and surgical treatment, she experienced two cardiac arrests and her condition worsened until she died in the 24 hours following hospitalization.

In Piedmont, the patient who died had undergone a pharmacological VTP with mifepristone (RU486) and misoprostol.

Following the woman's death, the Prosecutor's Office in Turin launched an investigation that included a technical and legal report on the cause of death. The woman was hospitalized and treated with mifepristone according to procedure. After a few hours "she left against the health workers' advice". She returned to the hospital two days later and underwent treatment with prostaglandins according to procedure. While waiting to expel the embryo that evening she "experienced a sudden cardiorespiratory crisis followed by death, in spite of attempts to revive her" .

Both the histological exam and the blood culture test revealed a group A beta-hemolytic streptococcal infection leading to myocarditis and septic shock.

"In order to evaluate the case related to (redacted) and any responsibility on the part of the health workers who treated her, there are no doubts as to the fact that the pharmacological abortion was performed in accordance with the protocol used by the hospital in question, and that toxicological exams ruled out an accidental overdose of pharmaceuticals or the ingestion of foreign substances that may have caused the death. Cardiorespiratory arrest took place suddenly and was not preceded by any premonitory symptoms, as would be typical of heart failure caused by myocarditis. Therefore, I believe that the progression of the

beta-hemolytic streptococcal infection and its impact on the heart and lungs was probably facilitated by the ingestion of mifepristone; nevertheless, this is a very rare adverse effect, and most importantly, it is entirely unpredictable. As such, the health workers who treated (redacted) at the (redacted) hospital cannot be held liable".

CONSCIENTIOUS OBJECTION AND AVAILABILITY OF VTP SERVICES (2014 data)

1. General trends

This report presents data on conscientious objectors for 2014 only, since detailed data from the regions which allow for specific and thorough monitoring are only available for that year.

Data on the absolute numbers of conscientious objectors and non-objectors are not included in the D12 ISTAT model forms (which deal with women who undergo VTP), but the Surveillance System requests them from the regions on an annual basis. This request refers to all staff working in hospitals with OBGYN or gynecology departments, although the regions do not always provide the data in this form.

Table 28 – which refers to 2014 only – shows the percentage of objectors per professional category. In 2014 the share of conscientious objectors stabilized after a significant increase over the years: at the national level, this percentage went from 58.7% in 2005, to 69.2% in 2006, to 70.5% in 2007,to 71.5% in 2008, to 70.7% in 2009, to 69.3% in 2010 and 2011, to 69.6% in 2012, to 70.0% in 2013 and to 70.7% in 2014.

Among anesthetists this share remained more stable, from 45.7% in 2005 to 50.8% in 2010, 47.5% in 2011 e 2012, 49.3% in 2013, and 48.4% in 2014. For non-medical staff, a slight decrease was recorded in 2014 (45.8% in 2014 compared to 46.5% in 2013) after the increase observed since 2005 (38.6%).

There is significant variation between regions, as shown in Table 28.

It should be pointed out that pursuant to art.9 of Law 194/78, "authorized hospitals and clinics must ensure the carrying out of the procedures listed under art. 7 and of the pregnancy termination procedures requested in accordance with the modalities set out under articles 5.7 and 8". The regions are responsible for monitoring and ensuring that this takes place. In any case, all staff must keep in mind that "conscientious objection exempts health care and auxiliary staff from carrying out the procedures and activities strictly and specifically related to terminating pregnancies, and not from assistance prior to and after the procedure" (art. 9 of Law 194).

2. Results of regional and sub-regional monitoring

In continuity with the most recent report to Parliament, submitted on 26 October 2015, in order to monitor the application of Law 194/78 – including with regards to conscientious objection under art. 9 of the law itself – we estimated three parameters related to the availability of VTP service. These parameters included the number of available facilities – both in absolute terms and in proportion to the female population of childbearing age – and the availability of dedicated medical personnel, considering the weekly workload for each gynecologist who is not an objector. These are the same parameters used in the ad hoc national monitoring effort – carried out on a regional basis – on certain aspects of the application of Law 194, which was also discussed in the Reports to Parliament submitted in 2014 and 2015.

In order to identify problems related to the impact of conscientious objection on the availability of access to VTP by those legally entitled to it, the chosen indicator was the weekly VTP workload for each non-objecting gynecologist. This indicator consists of dividing the number of annual VTP per the number of non-objecting gynecologist, considering 44 working weeks a year. This year, we also looked at the number of non-objectors assigned to non-VTP services, in order to ensure that the indicator we chose is a realistic one.

In agreement with the regional representatives who took part in the roundtable on the full application of Law 194 at the Ministry of Health, the same parameters were also once again estimated at the sub-regional level (ASL/health districts), in order to verify if the law was being applied at the local level as well, and to identify any problems that may not have emerged from an aggregate analysis at the regional level.

The three parameters are described below:

- ✓ **parameter 1:** *Availability of VTP services in relation to the absolute number of available facilities*;
- ✓ **parameter 2:** *Availability of VTP services in relation to the female population of childbearing age and to the number of birth centres*;
- ✓ **parameter 3:** *Availability of VTP services in light of the right to conscientious objection in relation to the average weekly number of VTP performed by each non-objecting gynecologist*.

These parameters make it possible to frame the availability of VTP services in terms of demand and the availability of professional and instrumental resources, calculated with reference to 2014.

2.1. Analysis of the parameters on the availability of VTP services

PARAMETER 1: Availability in relation to the number of facilities

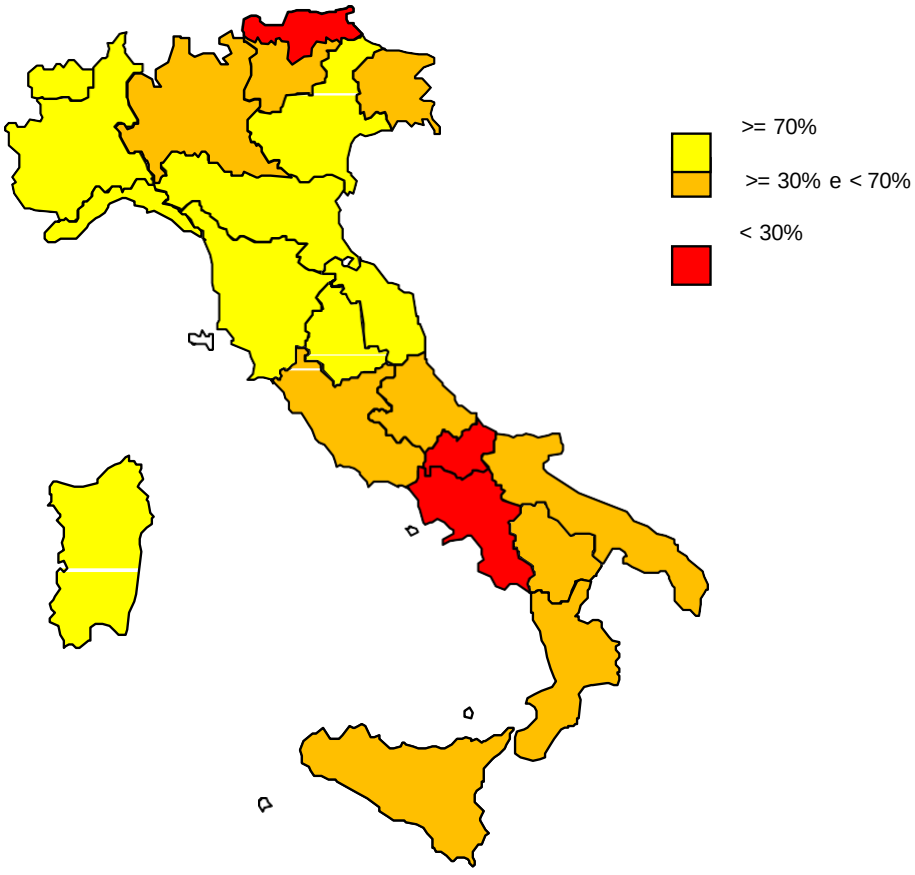
An analysis of the data we received, compared to the data collected by ISS and ISTAT, shows that in 2014 the total number of facilities with OBGYN and/or gynecology departments at the national level was 654, while those who performed VTP was 390, or 59.6% of the total (versus 60% in 2013).

The table below lists the number of facilities with OBGYN departments and the number of facilities that provide VTP in each region. This data shows that there are only three cases (Autonomous Province of Bolzano, Molise, and Campania), of which two concern very small regions, where the number of facilities providing VTP is less than 30% of the total, as also shown in Figure 9. Everywhere else coverage is more than satisfactory. There are also some variations between 2013 and 2014: coverage improved in Piedmont and Veneto, while it decreased in Campania and Abruzzo.

Number of facilities with OBGYN departments and number of facilities that provide VTP, and Parameter 1 for each region, 2014

Region	Total facilities	Facilities that provide	Parameter 1	Region	Total facilities	Facilities that provide VTP	Parameter 1
Piedmont	46	33	71.7%	Marche	14	14	100.0%
Valle d'Aosta	1	1	100.0%	Latium	52	21	40.4%
Lombardy	99	63	63.6%	Abruzzo	16	9	56.3%
A:P. Bolzano	9	2	22.2%	Molise	4	1	25.0%
A.P. Trento	8	5	62.5%	Campania	85	25	29.4%
Veneto	46	34	73.9%	Apulia	42	22	52.4%
Friuli V. Giulia	15	10	66.7%	Basilicata	6	3	50.0%
Liguria	15	15	100.0%	Calabria	18	11	61.1%
Emilia-Romagna	52	38	73.1%	Sicily	61	29	47.5%
Tuscany	32	28	87.5%	Sardinia	20	14	70.0%
Umbria	13	12	92.3%	**Total**	**654**	**390**	**59.6%**

Figure 9 Map of Italy with the percentage of facilities that provide VTP services in each region, 2014



PARAMETER 2: Availability in relation to the female population of childbearing age and birth centres

In order to have terms of comparison and to better understand the level of implementation of Law 194/78 within the national framework of pregnancy facilities, we compared the availability of VTP services in relation to the female population of childbearing age and to the number of birth centres.

Out of 654 such national facilities, 500 are public or accredited private birth centres (CEDAP data, 2014), or 76.4% of the total (versus 81% the previous year).

There were 492,127 live births in Italy in 2014 (ISTAT data); that same year there were 96,578 VTP with a ratio of 5.1:1 (versus 4.9:1 the previous year), while the ratio between birth centres and VTP facilities is 1.3:1 (the same as last year).

The situation is thus essentially the same as last year: while the number of VTP is equal to about 20% of the number of live births, the number of VTP facilities is equal to about 74% of the number of birth centres.

The Table below shows a comparison between birth centres and VTP facilities normalized with respect to the female population of childbearing age.

At the national level, there are 3.7 birth centres for every 100,000 women of childbearing age (15-49) versus 2.9 VTP facilities, with a ratio of 1.3:1; in other words, there are 7 birth centres for every 5 VTP facilities.

If we consider both the absolute number of VTP facilities and the number in relation to the population of women of childbearing age, we find that the availability of VTP facilities is more than adequate in light of the number of VTP performed, especially when compared to the number of birth centres.

Ratio of birth centres to VTP facilities in each region per 100,000 women of childbearing age (15-49), 2014

Region	n° of birth centres (*) per 100,000 women aged 15-49	n° of VTP facilities per 100,000 women aged 15-49	Region	n° of birth centres (*) per 100,000 women aged 15-49	n° of VTP facilities per 100,000 women aged 15-49
Piedmont	3.2	3.6	Marche	4.3	4.3
Valle d'Aosta	3.7	3.7	Latium	2.8	1.6
Lombardy	3.2	2.9	Abruzzo	4.1	3.1
A.P. Bolzano	5.9	1.7	Molise	4.4	1.5
A.P. Trento	5.1	4.2	Campania	4.8	1.8
Veneto	3.7	3.2	Apulia	3.5	2.4
Friuli Venezia Giulia	4.4	4.0	Basilicata	4.7	2.4
Liguria	3.6	4.8	Calabria	3.3	2.4
Emilia-Romagna	3.1	4.0	Sicily	4.8	2.5
Tuscany	3.2	3.6	Sardinia	4.7	3.8
Umbria	5.8	6.3	**Total**	**3.7**	**2.9**

(*) public or accredited private birth centres (Source: CEDAP 2014)

At a closer looks, some regions have as many or more VTP facilities than birth centres (Piedmont, Valle d'Aosta, Liguria, Emilia Romagna, Tuscany, Umbria, and Marche), the opposite of the ratio between live births and VTP.

But even in cases where the ratio is lower (e.g. Campania, which has 1.8 VTP facilities for every 4.8 birth centres; or Sicily, which has 2.5 VTP facilities for every 4.8 birth centres), this ratio is always higher than the ratio between live births and VTP. In addition, both Sicily and Campania plan to reduce their number of birth centres as part of a reorganization effort; once this effort is completed, the ratio between birth centres and VTP facilities will be closer to that of other regions.

It is important to remember than one of the priorities of Italian health policy, in accordance with the State-Regions Agreement of December 2010, is the reorganization of birth centres, with the closure of those where less than 500 children per year are born. The goal to reduce the number of birth centres aims to concentrate births in more adequate facilities, with better technological and structural endowments and with more experience personnel, so as to ensure the safety of childbirth and thus protect the health of both mothers and children.

In accordance with this approach, it would be desirable to monitor the number of VTP facilities where few VTP are actually performed, in parallel with the current approach towards birth centres. This is even more true for late VTP – after the first trimester of pregnancy – which should only be performed in facilities with a neonatal intensive care department, in light of the possibility of having to assist with a live birth as a result of a late VTP.

Having noted that Italy has an adequate number of VTP facilities, below we analyse in more detail the relationship between VTP and non-objector health workers.

PARAMETER 3: Availability in light of the right to conscientious objection in relation to the weekly number of VTP performed by each non-objecting gynecologist.

The data on the number of VTP performed and the number of non-objecting gynecologists – listed in the table below – shows that on the basis of the Ministry's ad hoc survey of regions, the average weekly workload for each non-objecting gynecologist has not changed compared to 2013. This confirms the aggregate regional data from the Surveillance System reported in Table 28 (which refers to 1,408 non-objecting gynecologist, who performed an average of 1.6 VTP a week, based on a total of 96,758 VTP performed over 44 working weeks).

Average weekly VTP workload per non-objecting gynecologist - 2012-2012-2014 (considering 44 working weeks per year)

Region	Average weekly VTP workload per non-objecting gynecologist		
	(2012 data – ad hoc survey per region)	(2013 data – ad hoc survey per ASL)	(2014 data – ad hoc survey per ASL)
Piedmont	1.3	1.7	1.7
Valle D'Aosta	0.4	0.6	0.4
Lombardy	1.4	1.4	1.7
A.P. Bolzano	1.5	3.5	1.3
A.P. Trento	1.2	1.0	0.9
Veneto	1.3	1.1	1.5
Friuli Venezia Giulia	0.9	0.8	0.7
Liguria	1.4	2.0	1.3
Emilia-Romagna	-	1.0	1.0
Tuscany	1.0	1.0	1.0
Umbria	0.9	1.1	1.2
Marche	0.8	1.0	0.9
Latium	4.2	3.4	3.2
Abruzzo	2.8	1.9	3.0
Molise	-	4.7	4.7
Campania	3.3	3,5 (*)	2.3 (**)
Apulia	2.4	3.1	3.5
Basilicata	2.8	2.0	2.9
Calabria	2.2	1.6	2.2
Sicily	0.7	4.0	3.8
Sardinia	0.6	0.5	0.5
TOTAL	**1.4**	**1.6**	**1.6**

(*) data calculated on an aggregate regional data as ASL-level data was not available
(**) partial data

More specifically aggregate regional data from 2014 shows that the average weekly workloads for non-objecting gynecologists have essentially stayed the same: considering 44 working weeks a year (the standard value for European research projects), the number of VTP a week per non-objecting gynecologist ranges from 0.4 in Valle d'Aosta to 4.7 in Molise (in 2013 the minimum was 0.5 and the maximum was 4.7), with a national average of 1.6 VTP a week, the same as in 2013, and slightly higher than 1.4 in 2012.

This confirms the findings of previous Reports to Parliament on the implementation of Law 194/78: the number of non-objectors at the regional level seems sufficient in light of the number of VTP performed, and the number of conscientious objectors should not prevent non-objectors from performing other tasks in addition to VTP. Therefore, any problems with access to VTP are more likely to be due to inadequate organization at the local level.

An estimate of the variation over the years in the number of VTP procedures performed by non-objectors shows that between 1983 and 2011 the average number of yearly VTP performed by each non-objectors has been cut in half, from 145.6 VTP in 1983 (or 3.3 VTP per week) to 68.6 VTP in 2014 (or 1.6 VTP per week), as shown in the table below.

Number of VTP, number of non-objecting gynecologists, and workload per VTP at the national level, 1983 to 2014

Year	N. VTP	N. non-objecting gynecologists	N. VTP per year for each non-objecting gynecologist	N. VTP per week for each non-objecting
1983	233,976	1,607	145.6	3.3
1992	155,266	1,415	109.7	2.5
2001	132,234	1,913	69.1	1.6
2011	111,415	1,507	73.9	1.6
2013	102,760	1,490	69.0	1.6
2014	96,578	1,408	68.6	1.6

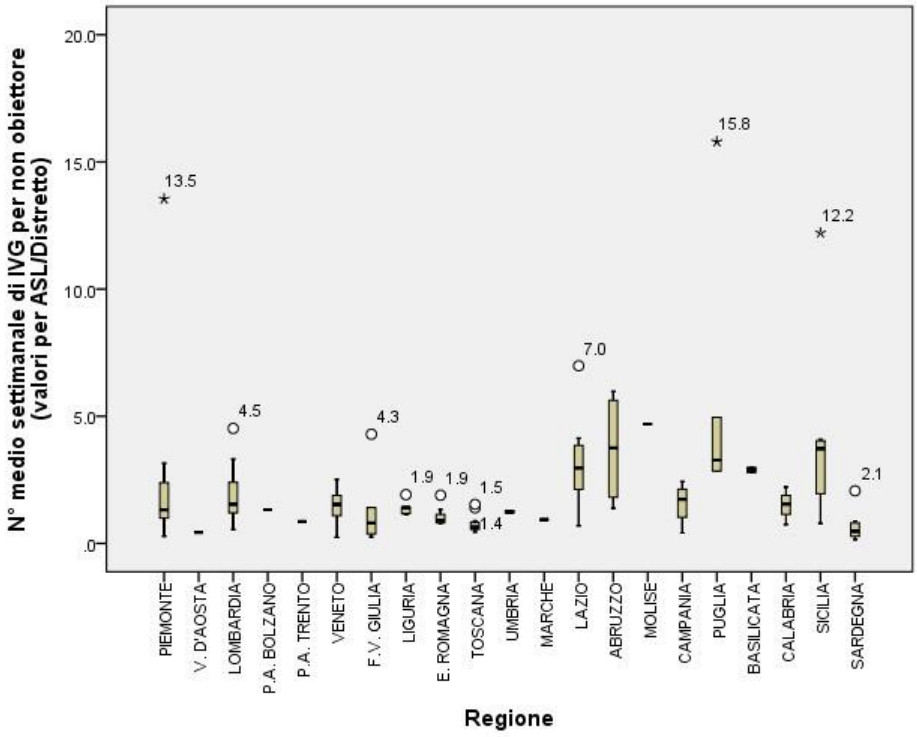
The overall number of non-objecting gynecologists has thus always been adequate compared to the total number of VTP.

In light of the above, during the latest meetings with regional representatives held at the Ministry of Health on 14 January 2015, we agreed to a further in-depth analysis of the monitoring data for each individual region.

Once again, we were able to calculate the third parameter – weekly workload for each non-objecting gynecologist – at the sub-regional level (ASL/health district). The data is summed up in the box plot below (Figure 10) and in the table that shows minimum, maximum, and median values.

The box plot graph is used to describe the distribution of a variable – whether symmetrical or asymmetrical – using simple dispersion and position indexes (minimum, top quartile, median, third quartile, maximum). The longer the lines and rectangles, the greater the variability.

Figure 10 Box plot of the average weekly VTP workload for each non-objecting gynecologist in each region (values per ASL/health district), 2014.



Average weekly VTP for each non-objecting gynecologist in each region calculated at the sub-regional level (minimum, maximum, and median values), 2014

Region	min	Median	max
PIEDMONT	0.3	1.3	13.5
V. D'AOSTA	0.4	0.4	0.4
LOMBARDY	0.5	1.5	4.5
A.P. BOLZANO	1.3	1.3	1.3
A.P TRENTO	0.9	0.9	0.9
VENETO	0.2	1.5	2.5
F.V. GIULIA	0.3	0.8	4.3
LIGURIA	1.1	1.4	1.9
E. ROMAGNA	0.8	0.9	1.9
TUSCANY	0.4	0.6	1.5
UMBRIA	1.2	1.2	1.3
MARCHE	0.9	0.9	0.9
LATIUM	0.7	3.0	7.0
ABRUZZO	1.4	3.8	6.0
MOLISE	4.7	4.7	4.7
CAMPANIA (*)	0.4	1.7	2.4
APULIA	2.8	3.3	15.8
BASILICATA	2.8	2.9	3.0
CALABRIA	0.7	1.5	2.2
SICILY	0.8	3.7	12.2
SARDINIA	0.2	0.5	2.1

(*) partial data available only for some ASL

As the data shows, the weekly VTP workload for each non-objecting gynecologist changes from one region to the next, and this variability has increased compared to last year. Nevertheless, in the vast majority of cases it remains relatively homogeneous at the national level.

Out of 140 ASL, only three had workload values for non-objecting gynecologists that were far removed from the regional average (outliers). One is located in Apulia, with 15.8 VTP a week (versus a regional average of 3.5), one is in Piedmont, with 13.5 VTP a week (versus a regional average of 1.7), and the third is in Sicily, with 12.2 VTP a week (compared to the regional average of 3.8). In all other instances these numbers are much lower (for one ASL in Latium it is 7.0 a week, while all the others have lower values that are closer to the regional averages).

In order to assess workloads in light of the actual schedule of any given gynecologist in any given facility, and to avoid double-counting gynecologists who work in more than one facility, our monitoring effort also evaluated the workload of non-objecting gynecologists in terms of FTE (Full Time Equivalent), where this unit of measurement corresponds to the number of non-objecting gynecologists adjusted as if they were all full-time workers. An FTE value of 1 is equivalent to a full-time worker, whereas an FTE value of 0.5 corresponds to a part-time worker working 50% of full hours. Nevertheless, in 2014 the weekly workload for non-objecting gynecologists in terms of staff units is essentially the same as that measured in FTE units, as was the case in 2012 and 2013. The only exception is in Molise, where the small number of non-objecting gynecologists leads to a doubling in the workload if calculated on an FTE basis to 9.4 VTP per week, a number that remains under 10.

Additionally, in order to ensure that average values really are representative of the actual situation, this year we asked the regions whether there were any non-objecting gynecologists who were not assigned to VTP services. The data we received from the regions (except Liguria, Latium, and Sardinia) shows that at the national level, 11% of non-objecting gynecologists are assigned to services other than VTP – that is, they do no perform VTP in spite of not being conscientious objectors. These gynecologists are present in 46 facilities in 11 regions: Piedmont, Lombardy, A.P. Bolzano, Emilia Romagna, Tuscany, Umbria, Abruzzo, Molise, Campania, Apulia, and Sardinia.

Once again, this confirms the large regional disparities in the impact of the availability of non-objecting gynecologists to meet the demand for VTP. Data collected at the individual hospital level suggest that in most facilities where non-objectors are not assigned to VTP service, the availability of non-objectors seems to be more than enough to meet VTP needs, and so some of them are assigned to other services (it should be remembered that VTP procedures are always scheduled ahead of time, so that it is possible to plan staff assignments to meet needs). This once again suggests that the number of objectors, in and of itself, is not the cause of any problems with access to VTP; instead, the problem probably lies in the way health facilities organize themselves to implement Law 194/78. Note that in two (Apulia and Piedmont) of the three regions where the weekly workloads for non-objectors are much higher than average, there are non-objectors who are nevertheless not assigned to VTP services.

At the same time, data collected at the individual hospital level made it possible to highlight situations in which the hospitals themselves solved potentially critical situations. In Molise, for example, where there are only two non-objecting gynecologists, one of whom is assigned to other services, the latter is assigned to VTP services any time the gynecologist normally assigned to them is away for any length of time.

Our analysis of parameter 3 at the sub-regional level thus shows that any difficulties in providing access to services are probably most easily explained at the individual facility level. In this regard it should be pointed out that art.9 of Law 194/78 establishes that: “authorized hospitals and clinics must ensure the carrying out of the procedures listed under art. 7 and of the pregnancy termination procedures requested in accordance with the modalities set out under articles 5.7 and 8. Regions are responsible for monitoring and ensuring their application, including through staff mobility”.

It should also be remembered that concentrating certain health care services, such as VTP, in a limited number of facilities may simply reflect planning efforts on the part of regional administrations aiming to consolidate local services. Detailed monitoring efforts such as those proposed in this report provide key support in assessing the actual availability of VTP services and the workloads of non-objecting gynecologists; they should be adopted at the local level to optimize the planning of services.

With regards to waiting time, the available data shows that in certain regions waiting times decrease when the number of conscientious objectors increases, while the reverse happens in others, unlike what may be expected. The table below reports data on abortion rates, conscientious objectors and waiting times in each region in 2006 and in 2014.

Abortion rate (A.R.), conscientious objectors, and waiting times (T.AT). Comparisons at the regional level between 2006 and 2014

REGION	2014					2006				
	A.R.	N. VTP	% objectors	% W.T. < 14 day	% W.T. 22-28 days	T.AB	N. VTP	% objectors	% W.T. < 14 day	% W.T. 22-28 days
ITALY	**7.1**	**96578**	**70.7**	**64.8**	**9.2**	**9.4**	**131018**	**69.2**	**56.7**	**12.4**
NORTH	**7.3**	**43916**	**65.1**	**64.6**	**9.0**	**9.8**	**59829**	**65.2**	**53.2**	**13.3**
Piedmont	8.4	7856	63.3	70.5	7.3	11.4	11030	62.9	51.1	13.7
Val d'Aosta	7.5	208	13.3	59.9	6.8	9.6	274	16.7	40.5	7.8
Lombardy	7.3	15991	68.3	60.0	10.4	10.0	22248	68.6	58.6	11.3
Bolzano	4.4	526	85.9	77.2	3.4	4.9	564	74.1	44.7	15.2
Trento	6.4	758	57.4	57.9	10.2	11.6	1358	64.0	62.7	11.1
Veneto	5.0	5472	77.0	50.5	15.3	6.4	7090	79.1	34.0	23.4
Friuli V.G.	6.3	1609	58.4	64.8	8.0	8.0	2107	59.8	54.4	11.0
Liguria	9.5	3023	59.7	71.4	7.5	10.9	3700	56.3	51.1	14.1
Emilia Romagna	8.8	8473	53.0	73.6	5.1	12.2	11458	53.5	56.8	11.1
CENTRE	**7.6**	**20259**	**68.6**	**59.3**	**10.7**	**10.9**	**28888**	**71.0**	**55.2**	**13.4**
Tuscany	8.2	6526	59.5	63.3	9.1	11.0	8879	55.9	63.3	9.3
Umbria	7.6	1479	65.6	43.0	17.5	11.1	2178	70.2	51.0	13.3
Marche	5.5	1839	70.1	70.6	7.7	7.4	2581	78.4	73.9	5.6
Lazio	7.7	10415	78.2	57.1	11.3	11.8	15250	77.7	47.8	17.2
SOUTH	**7.1**	**23564**	**80.4**	**72.0**	**7.3**	**8.8**	**30716**	**71.5**	**63.6**	**9.9**
Abruzzo	7.5	2209	80.7	63.9	11.2	8.8	2709	45.5	71.9	4.9
Molise	6.0	413	89.7	89.8	1.5	8.3	620	82.8	NR	NR
Campania	6.6	9369	81.8	73.4	5.6	8.2	12049	83.0	62.1	10.3
Apulia	9.0	8514	78.5	76.0	6.7	11.2	11333	79.9	60.9	11.5
Basilicata	4.9	631	88.1	78.8	3.8	4.9	701	44.0	78.0	3.5
Calabria	5.3	2428	76.6	55.7	13.4	6.6	3304	73.5	64.9	10.0
ISLANDS	**5.7**	**8839**	**79.0**	**59.2**	**11.3**	**7.0**	**11585**	**76.3**	**66.0**	**8.9**
Sicily	5.9	6916	89.1	55.5	13.0	7.5	9303	84.2	62.0	10.5
Sardinia	5.2	1923	60.2	72.0	5.3	5.5	2282	57.3	77.8	4.1

The top line refers to national data. From 2006, the absolute number of abortions fell along with the abortion rate. The share of gynecologists who are conscientious objectors increased from 69.2% to 70.7%. The percentage of women who wait less than two weeks ("shorter waiting times") between the issuing of the certificate and the procedure increased from 56.7% to 64.8%, which means that VTP services have improved. At the same time, the percentage of women who waited between 22 and 28 days ("longer waiting times") decreased from 12.4% to 9.2%

During this timeframe, on average, the number of objectors rose while waiting times improved (i.e. they became shorter).

The same table shows this data on a regional basis, and here some differences emerge.

For example, in Latium the percentage of objectors increased from 77.7% to 78.2% in eight years, while waiting times dropped (the number of women who waited less than two weeks increased from 47.8% to 51.7%, while the number of women who waited longer than 22 days dropped from 17.2% to 11.3%). A similar trend was found in Piedmont: the number of objectors dropped from 62.9% to 63.3%, and waiting times dropped (short waiting times increased from 51.1% to 70.5% while long waiting times decreased from 13.7% to 7.3%).

In Umbria and Marche, the number of objectors decreased and waiting times increased. In Marche objectors dropped from 78.4% to 70.1%, while shorter waiting times fell from 73.9% to 70.6%, and longer waiting times rose from 5.6% to 7.7%; in other words, the situation

worsened in spite of the lower percentage of objectors; in Umbria objectors dropped from 70.2% to 65.6%, while shorter waiting times dropped from 51.0% to 43.0 %, and longer waiting times rose from 13.3% to 17.5%.

In Veneto the situation is different still: the percentage of objectors diminished (from 79.1% to 77.0 %) and waiting times got shorter (shorter waiting times increased from 34.0% to 50.5% while longer waiting times dropped from 23.4% to 15.3%); the situation thus improved.

These examples show that there is no correlation between the number of objectors and waiting times: the ways in which the law is implemented depend essentially on organizational issues at the regional level, which in turn reflect specific conditions that vary from one region to the next (and probably within regions as well).

It should be remember that it is already possible for regional health administrations to implement staff mobility and differential recruitment policies.

3. Activity of family planning clinics for VTP

Once again, we surveyed the activity of family planning clinics in providing VTP services. This year's data is more complete as it was collected for 85% of family planning clinics (versus 79% for last year). In addition to information on the number (absolute number and in terms of Full Time Equivalent) of gynecologists on staff – both objectors and non-objectors - and their type of contract, we also recorded the number of women who underwent pre-VTP interviews pursuant to Law 194/78, the number of certificates issued, and the number of women who underwent post-VTP check-ups (as part of the effort to prevent repeat VTP).

Data collection is particularly difficult, since there are great differences between regions in the way family clinics are organized, and frequent changes due to mergers and distinctions between main and field offices, which differences are not always clear and reflect criteria that vary between regions. Additionally, many such facilities provide services for adolescents or screening for types of cancer that affect women, and do not carry out activities related to VTP. Once again, there is great variability between regions in the extent to which women resort to family planning clinics for VTP services.

The differences observed are due in part to the fact that while reporting has improved, it still has not achieved full coverage in every region. Additionally, organizational modalities vary at the local level, as does the relationship between hospitals and local health services, and hospitalization modalities for women seeking VTP.

In spite of incomplete data, the percentage of conscientious objectors in family planning clinics is far lower than in hospitals (15.0% vs. 70.7%).

The fact that the number of VTP interviews (a total of 76,855 were counted) is higher than the number of certificates issued (31,277) may suggest that they are effective in helping women "remove the causes that would lead them to resort to termination of pregnancy" (art. 5 L.194/78).

Additionally, there are fewer post-VTP check-ups (34,566) than there are interviews, but more than there are certificates issued. This suggest that some hospitals that perform VTP advise patients to undergo post-VTP check-ups in family planning clinics, which are more suitable than hospitals in providing personalized support and counselling over time. Post-VTP counselling is an excellent opportunity to promote responsible procreation, and it is important to further promote it and implement it.

Monitoring of the activity of family planning clinics for VTP - year 2014

REGION	n° clinics that sent data	% answer	n° gynec. (*=FTE)	% object	intervie VTP	certificates VTP	check-ups post-VTP	TOTAL VTP 2014
Piedmont	163	77%	191	20%	6.490	4.666	2.023	**7856**
Valle d'Aosta	15	100%	10	90%	10	0	20	**208**
Lombardy	246	99%	137	29%	24.283	192	16.133	**15.991**
A.P. Bolzano	14	100%	9	11%	52	11	6	**526**
A.P. Trento	12	100%	23	4%	656	451	325	**758**
Veneto	119	100%	65*	20%	4.366	2.301	784	**5.472**
Friuli Ven. Giulia	26	100%	26	8%	5.090	1.212	1.092	**1.609**
Liguria	24	33%	146	9%	715	1.583	228	**3.023**
Emilia Romagna	234	100%	145*	18%	10.627	2.266	5.104	**8.473**
Tuscany	220	93%	44*	25%	4.036	3.263	1.689	**6.526**
Umbria	33	100%	37*	11%	1.024	938	351	**1.479**
Marche	48	100%	16*	38%	1.795	1.196	587	**1.839**
Latium	99	66%	165	5%	6.508	4.659	1.766	**10.415**
Abruzzo	44	75%	52	21%	1.044	271	134	**2.209**
Molise	7	175%	10	10%	170	43	30	**413**
Campania (*)	39	25%	73	7%	1.599	1.243	671	**9.369**
Apulia	147	100%	63*	11%	2.876	2.573	1.344	**8.514**
Basilicata	32	100%	22	23%	452	374	334	**631**
Calabria	67	100%	96*	16%	1.568	1.213	564	**2.428**
Sicily	166	85%	125	0%	2.969	2.394	1.206	**6.916**
Sardinia	71	100%	47*	19%	525	428	175	**1.923**
TOTAL	**1.826**	**85%**	**1.502**	**15%**	**76.855**	**31.277**	**34.566**	**96.578**

(*) partial data

4. Implementation of Law 194/78 and the Council of Europe

Certain aspects concerning the implementation of Law 194/78, particularly regarding access to VTP services in light of the right to conscientious objection on the part of medical staff, have recently been the focus of collective complaints filed with the European Committee of Social Rights, which partially accepted these claims. The claims were subsequently analysed by the Council of Europe, which through its Committee of Ministers instead expressed appreciation for Italy's actions in this regard.

On 9 August 2012, the ONG International Planned Parenthood Federation – European Network (IPPF EN) filed a collective complaint (87/2012) against Italy with the European Committee of Social Rights, concerning the violation of several articles of the European Social Charter as concerns the application of Law n. 194/78 in relation to the right to conscientious objection on the part of medical staff and access to VTP on the part of Italian women.

On 10 September 2013, the European Committee of Social Rights moved to accept the IPPF-EN's collective complaint.

On 18 March 2014, during a meeting of the GR-SOC (Rapporteur Group on Social and Health Questions), the Italian delegation used the elements provided by the Ministry of Health to illustrate the measures adopted by Italy subsequent to the decision of the European Committee of Social Rights, and requested that during the next GR-SOC meeting of 24 April 24 the Chairperson prepare a draft resolution to acknowledge the results of the data collection effort of the Technical Table established by the Ministry of Health and of the efforts made to verify the full and proper application of Law n. 194/78 at the regional and local levels.

During the GR-SOC meeting of 24 April 2014, a representative from the Ministry of Health illustrated the preliminary report on the results of the monitoring effort. This presentation allowed the Committee of Ministers to adopt a draft resolution, which was approved on 30 April 2014 and marked the closure, in Italy's favour, of collective complaint n. 87/2012, while also requesting that Italy communicate as soon as possible the outcome of the monitoring process carried out by the "Technical table for the full application of Law 194".

The "Technical table" and the full, complete data from the monitoring effort were described in the Report on the Implementation of Law 194/78 presented to Parliament on 15 October 2014.

While waiting for the resolution of the complaint filed by IPPF-EN, the CGIL labour union presented a similar collective complaint (91/2013) against Italy on 17 January 2013.

On 7 September 2015 the European Committee of Social Rights hosted a hearing of the parties – the Italian government and CGIL –; as a result of this hearing, on 12 October 2015, the Committee partially accepted the complaint.

During the GR-SOC meeting of 24 May 2016, a representative from the Ministry of Health illustrated the most recent data on the implementation of Law 194/78, drawn from the most recent report to Parliament on this issue and submitted on 26 October 2016, subsequently to the partial acceptance of the complaint on the part of the Committee, which was thus unable to see the above-mentioned report. This same data was illustrated during Minister Lorenzin's parliamentary hearing of 4 May 2016.

On 6 July 2016 the Committee of Ministers of the Council of Europe had its final say on the complaint; it took note of the information provided by Italy and "welcomed the following developments", and adopted the following resolution:

Draft Resolution CM/ResChS(2016)..
***Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy, Complaint No. 91/2013**

(Adopted by the Committee of Ministers on [6 July 2016] at the 1262nd meeting of the Ministers' Deputies)

The Committee of Ministers,[4]

Having regard to Article 9 of the Additional Protocol to the European Social Charter providing for a system of collective complaints;

Taking into consideration the complaint lodged on 17 January 2013 by *Confederazione Generale Italiana del Lavoro* (CGIL) against Italy;

Having regard to the report transmitted by the European Committee of Social Rights containing its decision on admissibility and the merits (see summary in Appendix 1 to the resolution);

Referring to its resolution ResChS(2014)6 in International Planned Parenthood Federation – European Network (IPPF EN) v. Italy (adopted by the Committee of Ministers on 30 April 2014 at the 1198th meeting of the Ministers' Deputies);

Having regard to the information communicated by the Italian delegation at the meeting on 24 May 2016 (see Appendix 2 to the resolution);

1. takes note of the information provided on the follow-up to the decision of the European Committee of Social Rights and welcomes the positive developments;
2. looks forward to the reporting to the European Committee of Social Rights in 2017.

Therefore the Council of Europe, in light of the additional information provided, never condemned Italy with regards to the failed implementation of Law 194/78, particularly with regards to access to VTP in relation to the right to conscientious objection on the part of medical staff

[4] In accordance with Article 9 of the Additional Protocol to the European Social Charter providing for a systemof collective complaints the following Contracting Parties to the European Social Charter or the revised European Social Charter have participated in the vote: Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Republic of Moldova, Montenegro, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Serbia, the Slovak Republic, Slovenia, Spain, Sweden, "the former Yugoslav Republic of Macedonia", Turkey, Ukraine and the United Kingdom.

TABLES FOR 2014

TABLES FOR 2015