COMMITTEE OF MINISTERS
COMITÉ DES MINISTRES

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

Resolution CM/ResChS(2016)3
***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,[1]

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.

Appendix 1 to Resolution CM/ResChS(2016)3

In its decision on admissibility and the merits in *Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy, Complaint No. 91/2013, the Committee concluded as follows:

- ***unanimously, that there is a violation of Article 11 § 1 of the Charter;***

Taking account of the assessment in International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, Complaint No. 87/2012, decision on the merits of 10 September 2013, it was noted that:

a) the shortcomings which exist in the provision of abortion services in Italy remain unremedied and women seeking access to abortion services continue to face substantial difficulties in obtaining access to such services in practice, notwithstanding the provisions of the relevant legislation;
b) health care establishments have still not adopted the necessary measures in order to compensate for the deficiencies in service provision caused by health personnel who decide to invoke their right of conscientious objection, or the measures adopted are inadequate;
c) in such cases, the competent regional supervisory authorities do not ensure a satisfactory implementation of Section 9 § 4 within the territory under their jurisdiction.

[1] In accordance with Article 9 of the Additional Protocol to the European Social Charter providing for a system of 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, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Republic of Moldova, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, Serbia, Slovak Republic, Slovenia, Spain, Sweden, "the former Yugoslav Republic of Macedonia", Turkey, Ukraine and United Kingdom.

Furthermore, the situation identified in the abovementioned decision – in which it was found that in some cases, given the urgent character of the procedures needed, women wishing to seek an abortion may be forced to move to other health facilities, in Italy or abroad, or to terminate their pregnancies without the support or control of the competent health authorities, or may be deterred from accessing abortion services which they have a legal entitlement to receive in line with the provisions of Act No. 194/1978 – continues to prevail.

This situation may involve considerable risks for the health and well-being of the women concerned, which is contrary to the right to the protection of health as guaranteed by Article 11 of the Charter.

- by 9 votes to 2, that there is a violation of Article E read in conjunction with Article 11 of the Charter;

Similarly as above with regard to Article 11 of the Charter, CGIL's allegations concerning Article E taken together with Article 11 are almost identical to those examined in IPPF EN v. Italy (cited above).

Two forms of discriminatory treatment are alleged to exist in this complaint: (i) discrimination on the grounds of territorial and/or socio-economic status between pregnant women who have access to lawful abortion and those who do not; (ii) discrimination on the grounds of gender and/or health status between women seeking access to lawful abortion and men and women seeking access to other lawful forms of medical procedures, which are not provided on a restricted basis.

The public authorities fail to ensure an efficient organisation of the services providing access to abortion, taking into account the right to conscientious objection. As a result, many women are deprived of effective access to abortion services.

Pregnant women seeking to access abortion services are treated differently depending on the area in which they live; in addition, the differential treatment on this basis may by extension have an adverse impact on women in lower income groups who may be less able to travel to other parts of Italy or abroad in order to access abortion services.

There is no public health or public policy justification for this difference in treatment. It arises solely due to the inadequate implementation of Act No. 194/1978. Therefore the difference in treatment amounts to discrimination and constitutes a violation of Article E in conjunction with Article 11 of the Charter.

The second allegation claims that discrimination exists on the grounds of health status between women seeking access to lawful abortion services and women seeking access to other lawful forms of medical procedures, which are not provided on a restricted basis.

The groups are comparable as they are all seeking access to medical services provided by the public authorities in accordance with legislation. The difference in treatment is established as a result of the findings under Article 11 of the Charter.

The government has not invoked any objective justification for the difference in treatment. Even if the difference in treatment was to be based on an objective justification it could not be proportionate to such a potential objective, since, because of the specific conditions of access to abortion services, the situation amounts to a denial of access to these services. As a consequence, the difference in treatment constitutes discrimination and therefore a violation of Article E in conjunction with Article 11 of the Charter.

- by 6 votes to 5, that there is a violation of Article 1 § 2 of the Charter on the grounds of the difference in treatment between objecting and non-objecting medical practitioners;

As regards the allegations on discrimination at work, discrimination on the grounds of conscientious objection, or of non-objection, fall within the scope of the prohibited grounds of discrimination under Article 1 § 2 of the Charter.

The allegations with regard to protection at work relate to discrimination between two groups of medical practitioners, those who raise conscious objection to abortion within the meaning of Section 9 § 4 of Act No. 194/1978 and those who do not.

The non-objecting and objecting medical practitioners are in a comparable situation, because they have similar professional qualifications and work in the same field of expertise. They accordingly constitute comparable groups of workers for the purposes of Article 1 § 2.

CGIL has provided a wide range of evidence demonstrating that non-objecting medical practitioners face several types of cumulative disadvantages at work, both direct and indirect, in terms of workload, distribution of tasks, career development opportunities, etc. In particular the evidence of the President of LAIGA and the motions approved by the Chamber of Deputies are noted which, *inter alia*, call upon the government "to take steps to establish a technical monitoring board with the regional Assessors so as to verify that Act No. 194/1978 is being fully and correctly implemented, especially Articles 5, 7 and 9, with the aim of preventing any form of discrimination between objecting and non-objecting health care staff, also through modified management and mobility of staff guaranteeing the existence of an adequate services network in each region" (Motion tabled by Miglore and Others, No. 1-00450) as well as the numerous direct testimonies which demonstrate a lack of career opportunities including promotion for non-objecting medical practitioners, excessive workload and aggravated working conditions.

The government has provided virtually no evidence contradicting the evidence supplied by CGIL. It has not demonstrated that discrimination is not widespread.

This difference in treatment (the disadvantages suffered by non-objecting personnel) between non-objecting medical personnel and objecting personnel arises simply on the basis that certain medical practitioners provide abortion services in accordance with the law, therefore there is no reasonable or objective reason for this difference in treatment.

Consequently, the difference in treatment between the objecting and non-objecting medical practitioners amounts to discrimination in violation of Article 1 § 2 of the Charter.

- ***unanimously, that there is no violation of Article 1 § 2 of the Charter in relation to the allegation of forced or compulsory labour;***

The current complaint raises issues relating to the first aspect of Article 1 § 2, prohibition of discrimination and not to forced labour or any other aspect of the right to earn one's living in an occupation freely entered upon.

- ***unanimously, that there is no violation of Article 2 § 1 of the Charter;***

No information on the average working time of non-objecting medical practitioners was provided. Evidence was submitted on excessive workload which has been considered under Article 1 § 2. No substantiated allegations have been made on their average daily working times, the reference periods for calculating working time, the arrangements providing for shifts for health care professionals, etc.

Neither has information been provided on the supervision of working time regulations by the Labour Inspection, including on the number of breaches identified nor penalties imposed with regard to the working conditions of the non-objecting medical practitioners. The allegations of CGIL are not supported by sufficient evidence; therefore, there is no violation of Article 2 § 1 of the Charter.

- ***unanimously, that there is no violation of Article 3 § 3 of the Charter;***

The situation can only be assessed if statistics are provided on the number of establishments receiving inspection visits and the number of persons they employ, as well as up-to-date figures on the staffing of the labour inspectorate and the number of visits carried out, breaches found and penalties imposed (Conclusions XVI-2 (2004), Spain, Article 3 § 3). Information should also be provided on the proportion of workers covered by inspections compared with the total workforce (Conclusions XVIII-2 (2007), Luxembourg, Article 3 § 3).

As concerns the current complaint, CGIL has provided evidence by LAIGA and direct testimonies from non-objecting medical practitioners which indicate that their working environment and conditions may affect their health and safety at work. However, this evidence is largely anecdotal.

Despite the above information, the allegations made under Article 3 of the Charter relate to the enforcement and monitoring of any national regulations on the right to safe and healthy working conditions with regard to the non-objecting medical personnel in particular. No specific information has been provided by either party on the enforcement or failure to do so of the relevant health and safety provisions.

The allegations of CGIL are not supported by sufficient evidence; therefore, there is no violation of Article 3 § 3 of the Charter.

- ***by 7 to 4, that there is a violation of Article 26 § 2 of the Charter;***

CGIL has provided examples of the moral harassment of non-objecting medical practitioners including direct testimonies from medical practitioners and from LAIGA such as the following:

"The non-objectors are therefore placed under intense pressure to suspend the service, which sometimes takes oral rather than written form "…" Disregarding these pressures very often results in genuine 'mobbing'."

The government does not refute the allegations of moral harassment in any way, for example by referring to preventive and reparatory means taken to protect individual non-objecting workers against such harassment. There is furthermore no indication on the practical application of the existing laws by the relevant authorities or courts that would provide the necessary protection in practice, nor of any policy measures.

The statements by non-objecting medical practitioners alleging moral harassment are insufficient in themselves to ground a violation of the Charter, as they are largely anecdotal. However, the Committee considers that Article 26 § 2 of the Charter imposes positive obligations on States Parties to take preventive action to ensure moral harassment does not occur, in particular in situations where harassment is likely. The failure of the government to take any preventive action, training or awareness-raising measures to ensure the protection of non-objecting medical practitioners amounts to a violation of Article 26 § 2 of the Charter.

- ***unanimously, that no separate issue arises under Article E taken together with Articles 2 § 1, 3 § 3 and 26 § 2 of the Charter.***

No separate issue arises under Article E.

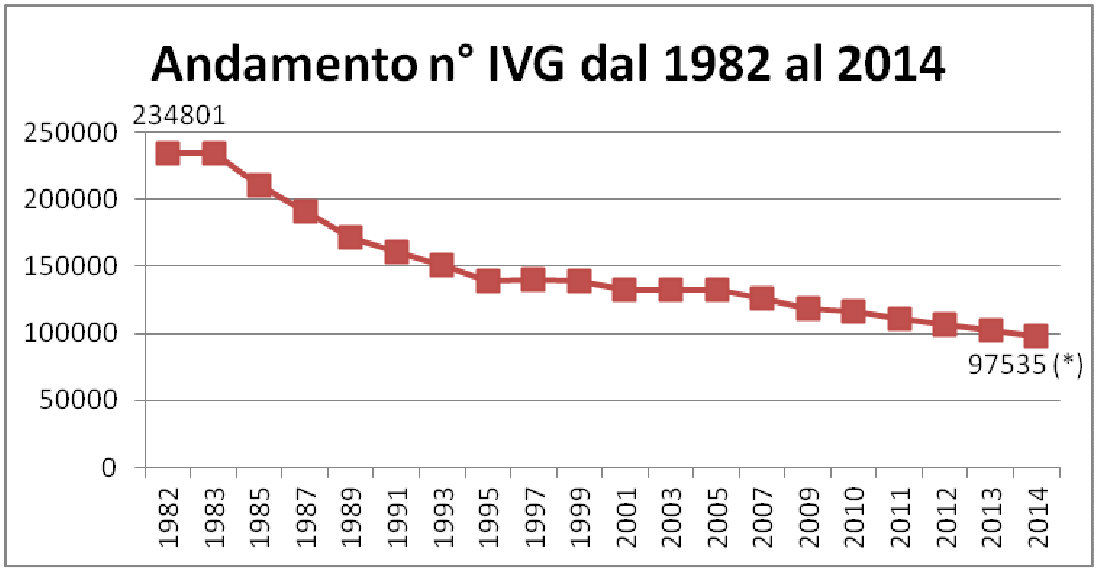
Appendix 2 to Resolution CM/ResChS(2016)3

Information submitted by Italy for the examination of *Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy, Complaint No. 91/2013
(GR-SOC, 24 May 2016)

1. Steady decrease in procured abortions in Italy

With reference to the year 2014, the number of abortions was, for the first time, less than 100,000. The Regions reported 97,535 terminations, a decrease of 5.1% compared with the final figures for 2013 (105,760 cases), and less than half the 234,801 cases in 1982 – the peak year in Italy.

Other indicators also confirm the continuing decline in the use of abortion services: the procured abortion rate (number of abortions per 1,000 women aged 15-49 years) in 2014 was 7.2 per 1000, a decrease of 5.9% compared to 2013, and a decrease of 58.5% compared to 1982. The Italian numbers remain amongst the lowest in industrialised countries. The procured abortion ratio (number of terminations per 1,000 live births) in 2014 was 198.2 per 1,000, a decrease of 2.8% compared to 2013, and a decrease of 47.9% compared to 1982.



[Number of voluntary terminations of pregnancy between 1982 and 2014]

2. Number of non-objector gynaecologists over time compared with voluntary terminations of pregnancy

Evoluzione storica dal 1983 al 2013 degli interventi di IVG, del numero di ginecologi non obiettori e del carico di lavoro per IVG a livello nazionale

anno	N. IVG	N. ginecologi non obiettori	N. IVG l'anno per ogni ginecologo non obiettore	N. IVG a settimana per ogni ginecologo non obiettore
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

[Statistics from 1983 to 2013 of procured abortion operations, number of non-objecting gynaecologists and national abortion workload
Year/No. of Abortions/No. of Non-Objector Gynaecologists/No. of Abortions Per Year Per Non-Objector Gynaecologist/ No. of Abortions Per Week Per Non-Objector Gynaecologist]

3. New data included in the report to Parliament on 26 October 2015, which the European Committee for Social Rights was unable to take into account

a) confirmation of previous data

Analysis of the availability parameters of the service

PARAMETER 1: Service offered in terms of absolute number of facilities available

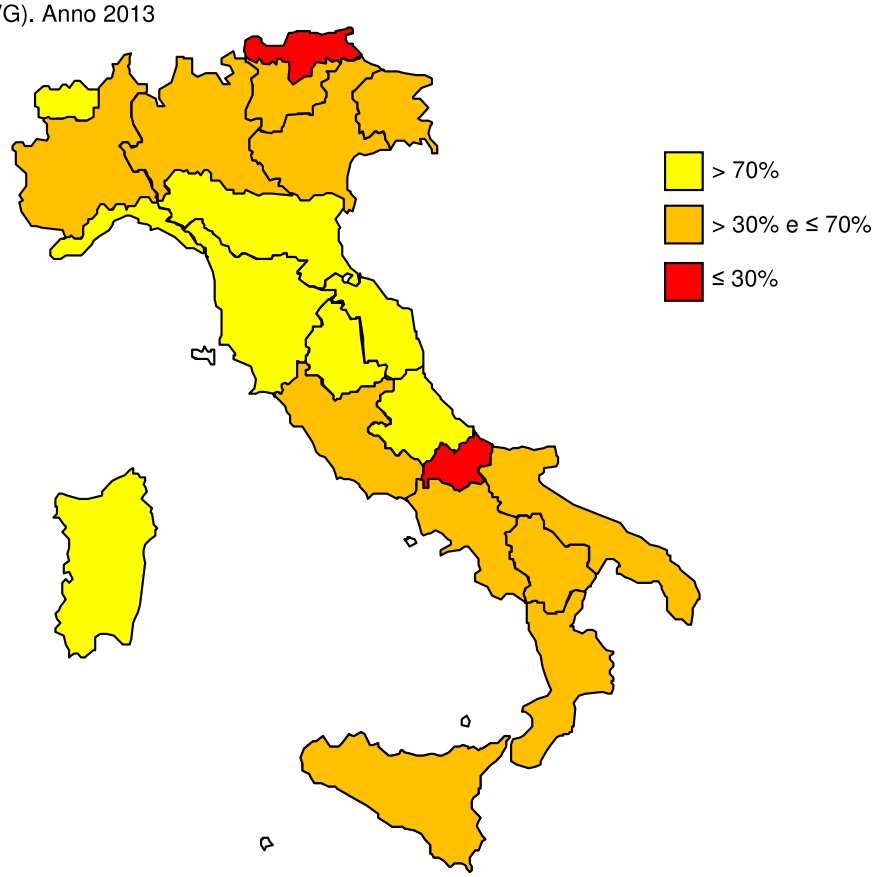
Through analysis of the records received, and based on a comparison with the data collected by ISS and ISTAT, it was determined that in 2013 the total number of facilities nation-wide having a department of obstetrics and/or gynaecology was 632 (it had been 630 the previous year), while the number of those carrying out terminations of pregnancy was 379, i.e. 60% of the total (the figures were 403 and 64% in 2012).

The following table shows a comparison, in absolute terms, of the total number of facilities having a department of gynaecology and the abortion facilities for each region; the data show that only in two cases, with regard to very small Regions (the Autonomous Province of Bolzano and Molise), the abortion points are fewer than 30% of the surveyed facilities, as is also shown in Figure 8. For the rest the coverage is more than satisfactory.

Numero di strutture con reparto di ostetricia e/o ginecologia, di quelle in cui si pratica IVG e il Parametro 1 per Regione, Anno 2013

Regione	Totale strutture	Strutture in cui si pratica IVG	Parametro 1	Regione	Totale strutture	Strutture in cui si pratica IVG	Parametro 1
Piemonte	47	31	66.0%	Marche	15	12	80.0%
Valle d'Aosta	1	1	100.0%	Lazio	45	23	51.1%
Lombardia	96	63	65.6%	Abruzzo	12	9	75.0%
P.A. Bolzano	9	2	22.2%	Molise	4	1	25.0%
P.A. Trento	9	5	55.6%	Campania	79	26	32.9%
Veneto	45	22	48.9%	Puglia	41	21	51.2%
Friuli V. Giulia	15	10	66.7%	Basilicata	7	3	42.9%
Liguria	11	11	100.0%	Calabria	16	11	68.8%
Emilia-Romagna	52	39	75.0%	Sicilia	66	33	50.0%
Toscana	29	28	96.6%	Sardegna	20	16	80.0%
Umbria	13	12	92.3%	**Totale**	**632**	**379**	**60.0%**

Figura 8 Mappa dell'Italia con la percentuale per Regione delle strutture che effettuano Interruzioni Volontarie di Gravidanza (IVG). Anno 2013



Number of facilities having a department of obstetrics and/or gynaecology, those performing abortions and Parameter 1 by Region in the year 2013

Region/Total Facilities/Facilities Offering Abortion/Parameter 1

Figure 8. Map of Italy showing percentage by Region of facilities offering Voluntary Termination of Pregnancy. Year 2013

PARAMETER 2: Availability of service relative to the fertile population and birthing facilities

To have a basis of comparison and better understand the degree of implementation of Law No. 194/78 within the framework of the national health system with respect to pregnancy, it was considered appropriate to contextualise the data on facilities that perform abortions compared with the female population of childbearing age and the number of maternity wards.

Of the 632 facilities surveyed nationally, 510 are public or accredited private birthing centres (2013 Cedap data), i.e. 81% of the total (it was 86% the previous year).

The number of live births in Italy in 2013 was 503,792 (ISTAT data); in the same year there were 102,760 procured abortions, a ratio of 4.9:1 (the same as the previous year), while the ratio between birthing and abortion facilities was 1.3:1 (also the same as the previous year).

The previous year's situation, then, is confirmed: while the number of procured abortions is equal to approximately 20% of the number of births, the number of abortion facilities is equal to 74% of the number of birthing facilities, far greater than the ratio of abortions to births.

The following table shows a comparison between birthing and abortion facilities, not in absolute terms, but normalised with respect to the female population of childbearing age.

Nationally, for every 100,000 women of childbearing age (15-49 years), there are 3.8 birthing facilities as against 2.8 abortion facilities, a ratio of 1.4:1, i.e. for every five facilities where procured abortions take place, there are seven for giving birth.

Considering, therefore, both the absolute number of abortion facilities normalised for the population of women of childbearing age, the large number of abortion facilities is more than adequate for the number of terminations carried out, especially in comparison with birthing facilities.

Tasso dei Punti nascita e Punti IVG per Regione ogni 100˙000 donne in età fertile (15-49 anni), Anno 2013

Regione	n° di punti nascita (*) per 100˙000 donne 15-49 anni	n° di strutture in cui si pratica IVG per 100˙000 donne 15-49 anni	Regione	n° di punti nascita (*) per 100˙000 donne 15-49 anni	n° di strutture in cui si pratica IVG per 100˙000 donne 15-49 anni
Piemonte	3.3	3.3	Marche	4.2	3.6
Valle d'Aosta	3.6	3.6	Lazio	2.9	1.7
Lombardia	3.2	2.9	Abruzzo	4.1	3.0
P.A. Bolzano	5.9	1.7	Molise	4.4	1.5
P.A. Trento	5.1	4.2	Campania	4.7	1.8
Veneto	3.5	2.0	Puglia	3.8	2.2
Friuli Venezia Giulia	4.3	3.9	Basilicata	4.6	2.3
Liguria	3.5	3.5	Calabria	3.3	2.4
Emilia-Romagna	3.1	4.1	Sicilia	4.9	2.8
Toscana	3.1	3.5	Sardegna	5.1	4.3
Umbria	5.7	6.2	**Totale**	**3.8**	**2.8**

(*) punti nascita pubblici o privati accreditati (Fonte Cedap 2013)

Number of birthing and abortion facilities by Region for every 100,000 women of childbearing age (15-49 years) in the year 2013

Region/No. of birthing facilities (*) per 100,000 women 15-49 years of age/No. of abortion facilities per 100,000 women 15-49 years of age

(*) public or accredited private birthing facilities (Cedap data 2013)

PARAMETER 3: Availability of procured abortion services, taking into account the right of conscientious objection of staff, in relation to the average weekly number of abortions performed by each non-objector gynaecologist

Carico di lavoro settimanale medio per IVG per ginecologo non obiettore - anni 2011-2012-2013 (considerando 44 settimane lavorative all'anno)

Regione	Carico di lavoro settimanale IVG per non obiettore		
	(dato 2011 – Sistema di sorveglianza IVG)	(dato 2012 - rilevazione ad hoc per regione)	(dato 2013 - rilevazione ad hoc per asl)
Piemonte	1.5	1.3	1.7
Valle D'Aosta	0.5	0.4	0.6
Lombardia	1.3	1.4	1.4
P.A. Bolzano	2.2	1.5	3.5
P.A. Trento	1.4	1.2	1.0
Veneto	1.8	1.3	1.1
Friuli Venezia Giulia	0.8	0.9	0.8
Liguria	1.7	1.4	2.0
Emilia-Romagna	1.2	-	1.0
Toscana	1.5	1.0	1.0
Umbria	1.2	0.9	1.1
Marche	1.2	0.8	1.0
Lazio	4.0	4.2	3.4
Abruzzo	3.3	2.8	1.9
Molise	2.6	-	4.7
Campania	3.8	3.3	3,5 (*)
Puglia	1.8	2.4	3.1
Basilicata	1.1	2.8	2.0
Calabria	1.7	2.2	1.6
Sicilia	3.0	0.7	4.0
Sardegna	0.6	0.6	0.5
TOTALE	**1.6**	**1.4**	**1.6**

(*) dato calcolato su base aggregata regionale in quanto non pervenuto per ASL

Average weekly abortion workload of each non-objector gynaecologist in the years 2011-2012-2013 (considering 44 working weeks per year)

Region/Weekly Abortion Workload for Non-Objector/
(2011 Data – Pregnancy Termination Monitoring System)/(2012 Data – Special Regional Reporting)/(2013 Data – Special Reporting by Health Authority Area)

b) new data

For the first time it has been possible to calculate at a sub-regional level (at the level of local health authority area) the third parameter relating to the weekly workload for each non-objector gynaecologist.

Region/Av. weekly no. of abortions per non-objector (by local health district)

Regione	N° medio settimanale di IVG per non obiettore (valori per ASL/Distretto)
PIEMONTE	2,25
PIEMONTE	1,68
PIEMONTE	0,80
PIEMONTE	3,39
PIEMONTE	0,90
PIEMONTE	0,83
PIEMONTE	2,08
PIEMONTE	2,17
PIEMONTE	1,39
PIEMONTE	3,95
PIEMONTE	1,56
PIEMONTE	1,93
V. D'AOSTA	0,70
LOMBARDIA	1,53
LOMBARDIA	1,32
LOMBARDIA	3,64
LOMBARDIA	1,57
LOMBARDIA	1,42
LOMBARDIA	0,50
LOMBARDIA	0,97
LOMBARDIA	1,16
LOMBARDIA	0,76
LOMBARDIA	2,53
LOMBARDIA	0,88
LOMBARDIA	1,38
LOMBARDIA	1,18
LOMBARDIA	1,24
LOMBARDIA	0,39
P.A. BOLZANO	3,45
P.A. TRENTO	1,01
VENETO	0,73
VENETO	0,69
VENETO	0,94
VENETO	2,30
VENETO	3,45
VENETO	1,60
VENETO	1,57
VENETO	1,55
VENETO	1,29
VENETO	3,02
VENETO	1,28
VENETO	1,25
VENETO	1,52
VENETO	8,23

VENETO	1,70
VENETO	1,94
VENETO	2,39
VENETO	1,73
VENETO	0,25
F.V. GIULIA	0,53
F.V. GIULIA	4,84
F.V. GIULIA	0,27
F.V. GIULIA	1,56
F.V. GIULIA	0,38
F.V. GIULIA	1,19
LIGURIA	1,17
LIGURIA	1,31
LIGURIA	2,69
LIGURIA	2,38
LIGURIA	1,83
E. ROMAGNA	1,37
E. ROMAGNA	0,82
E. ROMAGNA	0,80
E. ROMAGNA	1,01
E. ROMAGNA	1,28
E. ROMAGNA	0,66
E. ROMAGNA	0,94
E. ROMAGNA	0,67
E. ROMAGNA	0,96
E. ROMAGNA	0,76
E. ROMAGNA	1,52
TOSCANA	2,33
TOSCANA	1,64
TOSCANA	0,79
TOSCANA	2,18
TOSCANA	0,56
TOSCANA	0,82
TOSCANA	0,65
TOSCANA	1,34
TOSCANA	1,58
TOSCANA	1,65
TOSCANA	0,63
TOSCANA	1,68
UMBRIA	1,20
UMBRIA	1,00
MARCHE	1,00
LAZIO	9,39
LAZIO	4,95
LAZIO	2,55
LAZIO	6,17
LAZIO	2,89
LAZIO	1,37
LAZIO	1,65

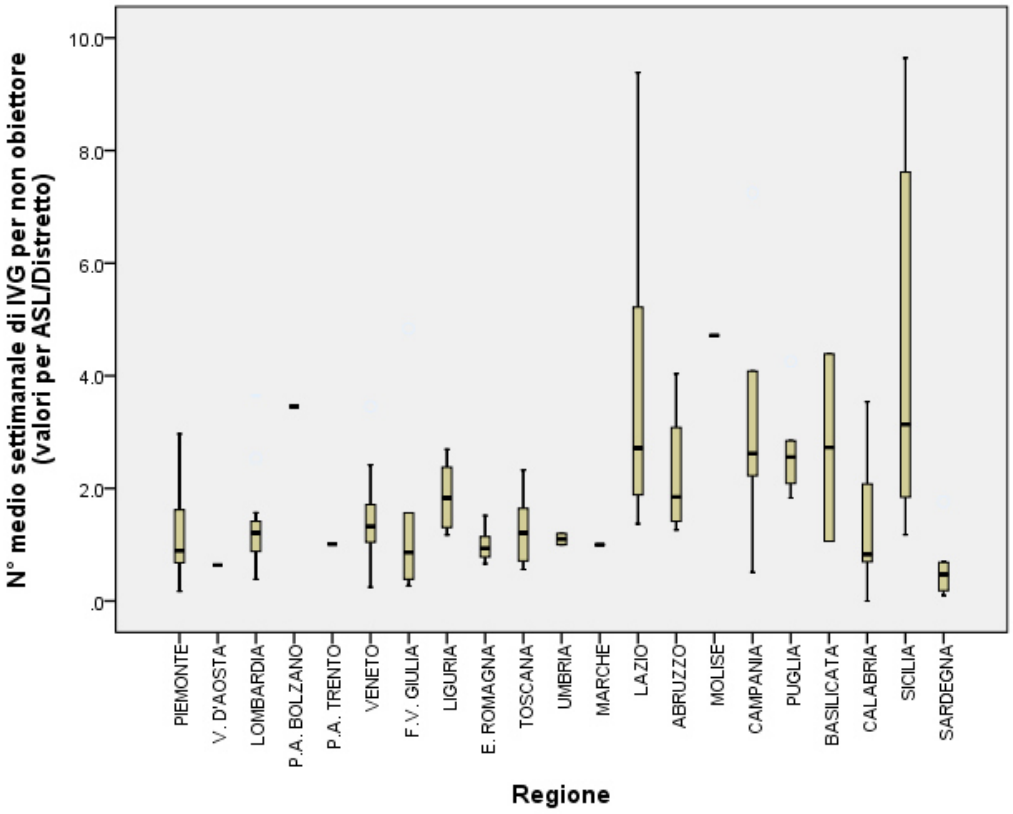
LAZIO	1,93
LAZIO	5,49
LAZIO	3,23
LAZIO	2,27
LAZIO	1,84
ABRUZZO	2,12
ABRUZZO	1,26
ABRUZZO	4,04
ABRUZZO	1,57
MOLISE	9,43
CAMPANIA	2,22
CAMPANIA	7,25
CAMPANIA	4,08
CAMPANIA	0,51
CAMPANIA	2,62
PUGLIA	2,84
PUGLIA	2,63
PUGLIA	2,48
PUGLIA	2,09
PUGLIA	4,25
PUGLIA	1,83
BASILICATA	4,39
BASILICATA	1,06
CALABRIA	2,08
CALABRIA	- 0
CALABRIA	3,54
CALABRIA	0,70
CALABRIA	0,83
SICILIA	8,00
SICILIA	3,57
SICILIA	9,64
SICILIA	1,18
SICILIA	1,33
SICILIA	7,24
SICILIA	2,70
SICILIA	2,36
SARDEGNA	0,70
SARDEGNA	1,77
SARDEGNA	0,68
SARDEGNA	0,10
SARDEGNA	0,22
SARDEGNA	0,43
SARDEGNA	0,15
SARDEGNA	0,51

The situation is summarised in the following box plot graph (Figure 9) and the related data table shows the minimum and maximum values and the median (value that bisects a distribution).

The box plot graph, or box and whiskers diagram, is a graphic representation used to describe the distribution of a variable, whether symmetric or asymmetric, through simple measures of dispersion and

position (minimum, first quartile, median, third quartile, maximum). The longer the lines and rectangles, the greater the variability.

Figura 9 Grafico box plot del carico di lavoro settimanale medio per IVG per regione per ginecologo non obiettore (valori per ASL/distretto). Anno 2013.



Box plot graph of the average weekly abortion workload by Region per non-objector gynaecologist (data from local area health districts). Year 2013.

Carico di lavoro medio settimanale per IVG per ginecologo non obiettore per regione calcolato a livello sub-regionale (valori minimo, mediana, massimo). Anno 2013

Regioni	min	mediana	max
PIEMONTE	0.2	0.9	3.0
V. D'AOSTA	0.6	0.6	0.6
LOMBARDIA	0.4	1.2	3.6
P.A. BOLZANO	3.5	3.5	3.5
P.A. TRENTO	1.0	1.0	1.0
VENETO	0.2	1.3	3.5
F.V. GIULIA	0.3	0.9	4.8
LIGURIA	1.2	1.8	2.7
E. ROMAGNA	0.7	0.9	1.5
TOSCANA	0.6	1.2	2.3
UMBRIA	1.0	1.1	1.2
MARCHE	1.0	1.0	1.0
LAZIO	1.4	2.7	9.4
ABRUZZO	1.3	1.8	4.0
MOLISE	4.7	4.7	4.7
CAMPANIA (*)	0.5	2.6	7.3
PUGLIA	1.8	2.6	4.3
BASILICATA	1.1	2.7	4.4
CALABRIA	0.0	0.8	3.5
SICILIA	1.2	3.1	9.6
SARDEGNA	0.1	0.5	1.8

(*) dato parziale in quanto rilevato solo per alcune ASL

Average weekly abortion workload by Region per non-objector gynaecologist calculated at the sub-Regional level (minimum, median, maximum values). Year 2013.

(*) partial data gathered only for some local area health districts.

As is evident regarding the weekly abortion workload for each non-objector gynaecologist, the situation is different from Region to Region, but in the great majority of cases is fairly homogeneous within the Region. And even in the Regions showing greater variability (Lazio and Sicily), i.e. where there are local areas having workload values that are far from the regional average (outliers), **the number of weekly procured abortions is still always less than ten. Such an abortion workload for each non-objector should not occupy all his working week.**

In particular, the highest values are 9.6 and 9.4 in a local authority in Sicily and one in Lazio respectively; all the other values are lower.

In order to consider the gynaecologists in relation to the time actually worked at the facility, and to exclude the possibility of counting the same person more than once (being present in different facilities), the monitoring also counted the non-objector gynaecologists in terms of FTE (Full-Time Equivalent). One FTE is equivalent to one person working full-time, a part-time worker working half-time corresponds to 0.5 FTE. However, once again the figures for 2013 confirm that the weekly workload reported compared to the number of non-objector gynaecologists on staff is not substantially different from that calculated in terms of FTE, as was also the case in 2012. A single exception was found for the Molise region where the limited number of non-objector gynaecologists available results in a doubling of the workload calculated according to FTEs, working out at 9.4 abortions per week; this is still less than 10.

From an analysis of Parameter 3 to the sub-regional level it is clear, then, that any difficulties in accessing services are probably attributable to more localised circumstances than those of the individual local health units, as measured in this report, and probably should be traced to the individual facilities. In this regard, it is

worth remembering that Article 9 of Law No. 194/78 provides that: “Hospitals and authorised clinics are required in any case to ensure the performance of the procedures provided for in Article 7 and the carrying out of requested pregnancy terminations in the manner prescribed in Articles 5, 7 and 8. The Region shall supervise and ensure this implementation, if necessary by making staff changes.”

It should also be remembered that the concentration in certain facilities of some health services, such as abortions, may not be an unintended discrepancy but the result of a programme of the relevant authorities having the aim of grouping the services together within the territory. Detailed monitoring such as that proposed in this report is nonetheless a fundamental form of support for actually verifying the availability of the service and the workloads of non-objector gynaecologists; it should be taken up at the local level in the interests of a good planning of services.

THE UPDATED DATA BELOW ON REGIONAL MOBILITY AND WAITING TIMES WILL HELP COMPLETE THE PICTURE OF THE CURRENT SITUATION

Regional Mobility

90.8% of abortions are carried out in the Region of residence and, of those, 87.1% in the Province of residence; these percentages are in line with movements observed for other benefits of the national health service as well. It should be recognised that such flows can mask a false migration, as in the case where study or temporary work justify living in a different Region from that of one's official residence; this mainly concerns the younger age groups.

Waiting Time

Waiting times between certification and the operation have been decreasing (possibly an indicator of service efficiency).

The proportion of procured abortions carried out within 14 days after certification has, in fact, increased: it was 62.3% in 2013, 61.5% in 2012 and 59.6% in 2011. The percentage of abortions carried out after more than three weeks of waiting has decreased: 15.7% in 2011, 15.5% in 2012 and 14.6% in 2013. These figures include the one week's wait required by law: therefore, beyond the week stipulated by law, 62.3% of women wait less than a week (a percentage that is increasing), while only 14.6% of women wait more than two weeks (and this is a percentage that is decreasing).

C) INITIATIVE REGARDING THE RESIDENTIAL TRAINING COURSE

"Monitoring System for Voluntary Terminations of Pregnancy and Application of Law No. 194/78" on 24.02.2016

Annex 1 contains a detailed description of the course programme.

Following the course, **the Regions were also invited to develop regional reports on the application of Law No. 194/78, in order to better describe the local situation, at the sub-regional level**, regarding individual health districts and facilities. **For the first time since Law No. 194/78 came into force**, every Region received **a standard format (Annex 2) to be followed for the compilation of the report**, in order to have a uniform presentation of data at the Regional level; this is also consistent with the annual report submitted to Parliament by the Minister of Health.

Region…. *(logo*)

Report on Voluntary Interruptions of Pregnancy
in the Region …..
Year …..

Edited by ..... *(names)*

Socio-demographic characteristics of women

This section analyses the voluntary interruptions of pregnancy in accordance with the main socio-demographic characteristics of women, in order to verify the existence of any subgroups at risk on which, possibly, to focus greater attention.

Characteristics of the intervention

This section analyses the characteristics of the intervention to highlight any critical issues at local level.

Conclusions
In this section, based on the results of the previous analysis, express comments and / or suggestions; identify possible strengths and / or weaknesses in the Region; identify any critical issues to address.

TRAINING COURSE ON THE MONITORING SYSTEM OF THE VOLUNTARY INTERRUPTION OF PREGNANCY AND THE APPLICATION OF THE LAW No. 194/78

Programme

First session: Data flow, quality and timing

Second session: Use of the data for communication

Third session: Focal points and improvement strategies for the full implementation of Law No. 194/78