Consiglio regionale della Calabria

DOSSIER

PL n. 139/10
di iniziativa del Consigliere G. GIUDICEANDREA recante:
"Legge 194/1978. Norme per la corretta applicazione sul territorio regionale"
relatore: M. MIRABELLO;

DATI DELL'ITER	
NUMERO DEL REGISTRO DEI PROVVEDIMENTI	
DATA DI PRESENTAZIONE ALLA SEGRETERIA DELL'ASSEMBLEA	18/4/2016
DATA DI ASSEGNAZIONE ALLA COMMISSIONE	19/4/2016
COMUNICAZIONE IN CONSIGLIO	19/04/2016
SEDE	MERITO
PARERE PREVISTO	II Comm.
NUMERO ARTICOLI	

ultimo aggiornamento: 18/07/2016

Testo del Provvedimento

Normativa citata

Documentazione citata

Documentazione correlata

Consiglio Regionale della Calabria

PROPOSTA DI LEGGE
N.ro 139/10^

X Legislatura

3^ COMM. CONSILIARE

2^ COMM. CONSILIARE

"Legge 194/1978. Norme per la corretta applicazione sul territorio regionale."

Proposta di Legge Regionale

presentata dall'On. Giuseppe Giudiceandrea

Consiglio Regionale della Calabria
PROTOCOLLO GENERALE
Prot. n. 16446 del 14.04.16
Classificazione 02 05

Art.1
Principi ispiratori

1. La presente legge, tra origine dagli obblighi rinvenenti da una parte dalla corretta applicazione della L.194/1978 "Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza" e dall'altra, dai continui richiami promossi e pronunciati dalla Commissione Europea riferibili all'inosservanza e disapplicazione (violazione dei diritti della donna e discriminazioni in danno dei medici e infermieri non obiettori) di fatto di una legge come la 194/1978 che ne demanda alle regioni il controllo e la sua corretta applicazione.
2. Preso atto poi, dall'insistere di un Reclamo collettivo (n.91 del 2013) , della condanna del Comitato Europeo ai danni dell'Italia, (decisione dell'8 marzo 2014 sul reclamo collettivo n.87 del 2012) e della sentenza del 12 ottobre 2015 che condanna il Governo italiano per la mancata e corretta applicazione della l.194/1978 che oltre a cagionare danno alle donne insinua principi discriminatori verso quei medici non obiettori che rispettano gli obblighi della legge 194/1978, la Regione Calabria tutto ciò premesso emana le seguenti disposizioni.

Art. 2
Scopi, finalità e funzioni

1. La Regione Calabria, con la presente legge, al fine di potere assicurare la tutela della maternità consapevole, attraverso le modalità codificate e previste dalla legge 194/1978 ne monitora e garantisce il pieno funzionamento sul proprio territorio regionale attraverso gli obblighi derivanti a suo carico e nella fattispecie dall'articolo 9 della legge sopra indicata nella parte che prevede: "la regione ne controlla e garantisce l'attuazione anche attraverso la mobilità del personale".
2. entro 30gg dall'entrata in vigore della presente legge, a questo fine, le ASP e le AO provvedono ad inviare al Dipartimento interessato l'elenco completo di tutte le figure professionali utili agli scopi della presente legge regionale con l'indicazione puntuale per ciascuna figura professionale della avvenuta dichiarazione di obiezione di coscienza ora per allora, così come espressamente previsto all'articolo 9 della l.194/1978.
3. le ASP e le AO che all'interno della propria pianta organica non presentano figure professionali non obiettore, nella misura necessaria a garantire il corretto principio dell'applicazione della legge, che disciplina l'IVG debbono a questo fine reclutare il personale necessario ricorrendo allo strumento obbligatorio della mobilità per come previsto dall'articolo 9 della l. 194/1978.
4. In difetto di una ponderata presenza di medici che garantiscano la corretta applicazione delle norme rinvenienti dalla corretta applicazione della L. 194/1978 la Regione Calabria promuoverà ogni utile azione atta a rimuovere nelle forme e nei modi previsti dalle leggi vigenti il palesarsi d'interruzione di pubblico servizio, di danni cagionati alla salute delle donne e di azioni discriminatorie protratte nei confronti dei medici non obiettori ogni qual volta se ne ravvisino gli estremi.

Art. 3
Clausola di invarianza finanziaria

Per l'attuazione delle disposizioni contenute nella presente legge, la Regione Calabria provvederà con risorse umane e strumentali già disponibili e senza oneri aggiuntivi.

Art.4

Entrata in vigore

La presente legge entra in vigore il giorno successivo a quello della sua pubblicazione nel Bollettino Ufficiale della Regione Calabria. La presente legge è pubblicata nel Bollettino Ufficiale della Regione Calabria.

Relazione

La presente proposta di Legge è frutto della maturata consapevolezza che l'effettività di un principio cardine del nostro ordinamento quale la "Tutela Sociale della Maternità" risulta, oggigiorno, quotidianamente minacciato, soprattutto nel momento in cui le sue più comuni specificazioni vanno a rapportarsi con altri concetti rilevanti quali l'"Esercizio dell'Obiezione di Coscienza".

Ciò, nonostante, in materia, le disposizioni legislative siano ben precise ed espresse. E' infatti la stessa Legge dello Stato, la n. 194 del 1978 (nella puntualità, l'art. 9) ad ammettere da un lato la possibilità di sollevare obiezione di coscienza (possibilità d'altronde ammessa anche in materia di procreazione assistita, art. 16, Legge n. 40 del 2004) e a stabilire dall'altro che anche di fronte ad un notevole numero di obiettori, l'amministrazione deve assicurare che le procedure si svolgano in modo effettivo.

Nei fatti, da quest'impostazione generale, ne deriva che lo specifico diritto della donna di avere accesso ai servizi per l'interruzione volontaria della gravidanza risulta, ormai, inficiato da un elevatissimo numero di Medici obiettori di coscienza presso le strutture sanitarie pubbliche. Fenomeno, questo, che comporta, a sua volta, conseguenze sociali assolutamente negative e che coincidono spesso e volentieri con drammatici ricorsi ad ambulatori fuorilegge e a farmaci di contrabbando, e con le consuete rincorse oltre frontiera. Traducendo, tutto questo, ancora, numericamente, in 20.000 casi di interruzione volontaria illegale di gravidanza (anno 2008; fonte Ministero della Salute) e in 75.000 casi di aborti spontanei (anno 2011; fonte ISTAT).

Relazione finanziaria

Per gli scopi e le funzioni della presente legge, poiché non sono previsti oneri, non occorre impegnare fondi previsti nel bilancio generale della Regione Calabria. Trattasi di legge meramente ordinamentale che ribadisce la corretta applicazione di disposizioni statali che non gravano in alcun modo sul bilancio regionale. Difatti la mobilità del personale per garantire il servizio di IVG come la realizzazione dell'elenco dei medici e infermieri obiettori discendono dall'applicazione e previsione contenute nella l.194/1978

Tab. 1- Oneri finanziari:

Articolo	Descrizionespese	Tipologia I o C	Carattere Temporale A o P	Importo
_____	_____	_____	_____	0,00/____

Tab. 2 Copertura finanziaria:

n. UPB/Capitolo	Anno 2016	Anno 2017	Anno 2018	Totale
_____	_____	_____	_____	_____
Totale	_____	_____	_____	0,00/_____

Reggio Cal., 18/4/2016

Democratici Progressisti

GRUPPO CONSILIARE "DEMOCRATICI PROGRESSISTI" PRESIDENTE On.Giuseppe Giudiceandrea

Legge 19 febbraio 2004, n. 40

"Norme in materia di procreazione medicalmente assistita"

pubblicata nella *Gazzetta Ufficiale* n. 45 del 24 febbraio 2004

CAPO I
PRINCÌPI GENERALI

ART. 1.
(Finalità).

1. Al fine di favorire la soluzione dei problemi riproduttivi derivanti dalla sterilità o dalla infertilità umana è consentito il ricorso alla procreazione medicalmente assistita, alle condizioni e secondo le modalità previste dalla presente legge, che assicura i diritti di tutti i soggetti coinvolti, compreso il concepito.

2. Il ricorso alla procreazione medicalmente assistita è consentito qualora non vi siano altri metodi terapeutici efficaci per rimuovere le cause di sterilità o infertilità.

ART. 2.
(Interventi contro la sterilità e la infertilità).

1. Il Ministro della salute, sentito il Ministro dell'istruzione, dell'università e della ricerca, può promuovere ricerche sulle cause patologiche, psicologiche, ambientali e sociali dei fenomeni della sterilità e della infertilità e favorire gli interventi necessari per rimuoverle nonché per ridurne l'incidenza, può incentivare gli studi e le ricerche sulle tecniche di crioconservazione dei gameti e può altresí promuovere campagne di informazione e di prevenzione dei fenomeni della sterilità e della infertilità.

2. Per le finalità di cui al comma 1 è autorizzata la spesa massima di 2 milioni di euro a decorrere dal 2004.

3. All'onere derivante dall'attuazione del comma 2 si provvede mediante corrispondente riduzione dello stanziamento iscritto, ai fini del bilancio triennale 2004-2006, nell'ambito dell'unità previsionale di base di parte corrente "Fondo speciale" dello stato di previsione del Ministero dell'economia e delle finanze per l'anno 2004, allo scopo parzialmente utilizzando l'accantonamento relativo al Ministero della salute. Il Ministro dell'economia e delle finanze è autorizzato ad apportare, con propri decreti, le occorrenti variazioni di bilancio.

ART. 3.
(Modifica alla legge 29 luglio 1975, n. 405).

1. Al primo comma dell'articolo 1 della legge 29 luglio 1975, n. 405, sono aggiunte, in fine, le seguenti lettere:

"d-bis) l'informazione e l'assistenza riguardo ai problemi della sterilità e della infertilità umana, nonché alle tecniche di procreazione medicalmente assistita;

d-ter) l'informazione sulle procedure per l'adozione e l'affidamento familiare".

2. Dall'attuazione del presente articolo non devono derivare nuovi o maggiori oneri a carico della finanza pubblica.

CAPO II
ACCESSO ALLE TECNICHE

ART. 4.
(Accesso alle tecniche).

1. Il ricorso alle tecniche di procreazione medicalmente assistita è consentito solo quando sia accertata l'impossibilità di rimuovere altrimenti le cause impeditive della procreazione ed è comunque circoscritto ai casi di sterilità o di infertilità inspiegate documentate da atto medico nonché ai casi di sterilità o di infertilità da causa accertata e certificata da atto medico.
2. Le tecniche di procreazione medicalmente assistita sono applicate in base ai seguenti princípi:

a) gradualità, al fine di evitare il ricorso ad interventi aventi un grado di invasività tecnico e psicologico più gravoso per i destinatari, ispirandosi al principio della minore invasività;

b) consenso informato, da realizzare ai sensi dell'articolo 6.

3. È vietato il ricorso a tecniche di procreazione medicalmente assistita di tipo eterologo.

ART. 5.
(Requisiti soggettivi).

1. Fermo restando quanto stabilito dall'articolo 4, comma 1, possono accedere alle tecniche di procreazione medicalmente assistita coppie di maggiorenni di sesso diverso, coniugate o conviventi, in età potenzialmente fertile, entrambi viventi.

ART. 6.
(Consenso informato).

1. Per le finalità indicate dal comma 3, prima del ricorso ed in ogni fase di applicazione delle tecniche di procreazione medicalmente assistita il medico informa in maniera dettagliata i soggetti di cui all'articolo 5 sui metodi, sui problemi bioetici e sui possibili effetti collaterali sanitari e psicologici conseguenti all'applicazione delle tecniche stesse, sulle probabilità di successo e sui rischi dalle stesse derivanti, nonché sulle relative conseguenze giuridiche per la donna, per l'uomo e per il nascituro. Alla coppia deve essere prospettata la possibilità di ricorrere a procedure di adozione o di affidamento ai sensi della legge 4 maggio 1983, n. 184, e successive modificazioni, come alternativa alla procreazione medicalmente assistita. Le informazioni di cui al presente comma e quelle concernenti il grado di invasività delle tecniche nei confronti della donna e dell'uomo devono essere fornite per ciascuna delle tecniche applicate e in modo tale da garantire il formarsi di una volontà consapevole e consapevolmente espressa.

2. Alla coppia devono essere prospettati con chiarezza i costi economici dell'intera procedura qualora si tratti di strutture private autorizzate.

3. La volontà di entrambi i soggetti di accedere alle tecniche di procreazione medicalmente assistita è espressa per iscritto congiuntamente al medico responsabile della struttura, secondo modalità definite con decreto dei Ministri della giustizia e della salute, adottato ai sensi dell'articolo 17, comma 3, della legge 23 agosto 1988, n. 400, entro tre mesi dalla data di entrata in vigore della presente legge. Tra la manifestazione della volontà e l'applicazione della tecnica deve intercorrere un termine non inferiore a sette giorni. La volontà può essere revocata da ciascuno dei soggetti indicati dal presente comma fino al momento della fecondazione dell'ovulo.

4. Fatti salvi i requisiti previsti dalla presente legge, il medico responsabile della struttura può decidere di non procedere alla procreazione medicalmente assistita, esclusivamente per motivi di ordine medico-sanitario. In tale

caso deve fornire alla coppia motivazione scritta di tale decisione.

5. Ai richiedenti, al momento di accedere alle tecniche di procreazione medicalmente assistita, devono essere esplicitate con chiarezza e mediante sottoscrizione le conseguenze giuridiche di cui all'articolo 8 e all'articolo 9 della presente legge.

ART. 7.
(Linee guida).

1. Il Ministro della salute, avvalendosi dell'Istituto superiore di sanità, e previo parere del Consiglio superiore di sanità, definisce, con proprio decreto, da emanare entro tre mesi dalla data di entrata in vigore della presente legge, linee guida contenenti l'indicazione delle procedure e delle tecniche di procreazione medicalmente assistita.

2. Le linee guida di cui al comma 1 sono vincolanti per tutte le strutture autorizzate.

3. Le linee guida sono aggiornate periodicamente, almeno ogni tre anni, in rapporto all'evoluzione tecnico-scientifica, con le medesime procedure di cui al comma 1.

CAPO III
DISPOSIZIONI CONCERNENTI LA TUTELA DEL NASCITURO

ART. 8.
(Stato giuridico del nato).

1. I nati a seguito dell'applicazione delle tecniche di procreazione medicalmente assistita hanno lo stato di figli legittimi o di figli riconosciuti della coppia che ha espresso la volontà di ricorrere alle tecniche medesime ai sensi dell'articolo 6.

ART. 9.
(Divieto del disconoscimento della paternità e dell'anonimato della madre).

1. Qualora si ricorra a tecniche di procreazione medicalmente assistita di tipo eterologo in violazione del divieto di cui all'articolo 4, comma 3, il coniuge o il convivente il cui consenso è ricavabile da atti concludenti non può esercitare l'azione di disconoscimento della paternità nei casi previsti dall'articolo 235, primo comma, numeri 1) e 2), del codice civile, né l'impugnazione di cui all'articolo 263 dello stesso codice.

2. La madre del nato a seguito dell'applicazione di tecniche di procreazione medicalmente assistita non può dichiarare la volontà di non essere nominata, ai sensi dell'articolo 30, comma 1, del regolamento di cui al decreto del Presidente della Repubblica 3 novembre 2000, n. 396.

3. In caso di applicazione di tecniche di tipo eterologo in violazione del divieto di cui all'articolo 4, comma 3, il donatore di gameti non acquisisce alcuna relazione giuridica parentale con il nato e non può far valere nei suoi confronti alcun diritto né essere titolare di obblighi.

CAPO IV
REGOLAMENTAZIONE DELLE STRUTTURE AUTORIZZATE ALL'APPLICAZIONE DELLE TECNICHE DI PROCREAZIONE MEDICALMENTE ASSISTITA

ART. 10.
(Strutture autorizzate).

1. Gli interventi di procreazione medicalmente assistita sono realizzati nelle strutture pubbliche e private autorizzate dalle regioni e iscritte al registro di cui all'articolo 11.

2. Le regioni e le province autonome di Trento e di Bolzano definiscono con proprio atto, entro tre mesi dalla data di entrata in vigore della presente legge:

a) i requisiti tecnico-scientifici e organizzativi delle strutture;

b) le caratteristiche del personale delle strutture;

c) i criteri per la determinazione della durata delle autorizzazioni e dei casi di revoca delle stesse;

d) i criteri per lo svolgimento dei controlli sul rispetto delle disposizioni della presente legge e sul permanere dei requisiti tecnico-scientifici e organizzativi delle strutture.

ART. 11.
(Registro).

1. È istituito, con decreto del Ministro della salute, presso l'Istituto superiore di sanità, il registro nazionale delle strutture autorizzate all'applicazione delle tecniche di procreazione medicalmente assistita, degli embrioni formati e dei nati a seguito dell'applicazione delle tecniche medesime.

2. L'iscrizione al registro di cui al comma 1 è obbligatoria.

3. L'Istituto superiore di sanità raccoglie e diffonde, in collaborazione con gli osservatori epidemiologici regionali, le informazioni necessarie al fine di consentire la trasparenza e la pubblicità delle tecniche di procreazione medicalmente assistita adottate e dei risultati conseguiti.

4. L'Istituto superiore di sanità raccoglie le istanze, le informazioni, i suggerimenti, le proposte delle società scientifiche e degli utenti riguardanti la procreazione medicalmente assistita.

5. Le strutture di cui al presente articolo sono tenute a fornire agli osservatori epidemiologici regionali e all'Istituto superiore di sanità i dati necessari per le finalità indicate dall'articolo 15 nonché ogni altra informazione necessaria allo svolgimento delle funzioni di controllo e di ispezione da parte delle autorità competenti.

6. All'onere derivante dall'attuazione del presente articolo, determinato nella misura massima di 154.937 euro a decorrere dall'anno 2004, si provvede mediante corrispondente riduzione dello stanziamento iscritto, ai fini del bilancio triennale 2004-2006, nell'ambito dell'unità previsionale di base di parte corrente "Fondo speciale" dello stato di previsione del Ministero dell'economia e delle finanze per l'anno 2004, allo scopo parzialmente utilizzando l'accantonamento relativo al Ministero della salute. Il Ministro dell'economia e delle finanze è autorizzato ad apportare, con propri decreti, le occorrenti variazioni di bilancio.

CAPO V
DIVIETI E SANZIONI

ART. 12.
(Divieti generali e sanzioni).

1. Chiunque a qualsiasi titolo utilizza a fini procreativi gameti di soggetti estranei alla coppia richiedente, in violazione di quanto previsto dall'articolo 4, comma 3, è punito con la sanzione amministrativa pecuniaria da 300.000 a 600.000 euro.

2. Chiunque a qualsiasi titolo, in violazione dell'articolo 5, applica tecniche di procreazione medicalmente assistita a coppie i cui componenti non siano entrambi viventi o uno dei cui componenti sia minorenne ovvero che siano composte da soggetti dello stesso sesso o non coniugati o non conviventi è punito con la sanzione amministrativa pecuniaria da 200.000 a 400.000 euro.

3. Per l'accertamento dei requisiti di cui al comma 2 il medico si avvale di una dichiarazione sottoscritta dai soggetti richiedenti. In caso di dichiarazioni mendaci si applica l'articolo 76, commi 1 e 2, del testo unico delle disposizioni legislative e regolamentari in materia di documentazione amministrativa, di cui al decreto del Presidente della Repubblica 28 dicembre 2000, n. 445.

4. Chiunque applica tecniche di procreazione medicalmente assistita senza avere raccolto il consenso secondo le modalità di cui all'articolo 6 è punito con la sanzione amministrativa pecuniaria da 5.000 a 50.000 euro.

5. Chiunque a qualsiasi titolo applica tecniche di procreazione medicalmente assistita in strutture diverse da quelle di cui all'articolo 10 è punito con la sanzione amministrativa pecuniaria da 100.000 a 300.000 euro.

6. Chiunque, in qualsiasi forma, realizza, organizza o pubblicizza la commercializzazione di gameti o di embrioni o la surrogazione di maternità è punito con la reclusione da tre mesi a due anni e con la multa da 600.000 a un milione di euro.

7. Chiunque realizza un processo volto ad ottenere un essere umano discendente da un'unica cellula di partenza, eventualmente identico, quanto al patrimonio genetico nucleare, ad un altro essere umano in vita o morto, è punito con la reclusione da dieci a venti anni e con la multa da 600.000 a un milione di euro. Il medico è punito, altresí, con l'interdizione perpetua dall'esercizio della professione.

8. Non sono punibili l'uomo o la donna ai quali sono applicate le tecniche nei casi di cui ai commi 1, 2, 4 e 5.

9. È disposta la sospensione da uno a tre anni dall'esercizio professionale nei confronti dell'esercente una professione sanitaria condannato per uno degli illeciti di cui al presente articolo, salvo quanto previsto dal comma 7.

10. L'autorizzazione concessa ai sensi dell'articolo 10 alla struttura al cui interno è eseguita una delle pratiche vietate ai sensi del presente articolo è sospesa per un anno. Nell'ipotesi di più violazioni dei divieti di cui al presente articolo o di recidiva l'autorizzazione può essere revocata.

CAPO VI
MISURE DI TUTELA DELL'EMBRIONE

ART. 13.
(Sperimentazione sugli embrioni umani).

1. È vietata qualsiasi sperimentazione su ciascun embrione umano.

2. La ricerca clinica e sperimentale su ciascun embrione umano è consentita a condizione che si perseguano finalità esclusivamente terapeutiche e diagnostiche ad essa collegate volte alla tutela della salute e allo sviluppo dell'embrione stesso, e qualora non siano disponibili metodologie alternative.

3. Sono, comunque, vietati:

a) la produzione di embrioni umani a fini di ricerca o di sperimentazione o comunque a fini diversi da quello previsto dalla presente legge;

b) ogni forma di selezione a scopo eugenetico degli embrioni e dei gameti ovvero interventi che, attraverso tecniche di selezione, di manipolazione o comunque tramite procedimenti artificiali, siano diretti ad alterare il patrimonio genetico dell'embrione o del gamete ovvero a predeterminarne caratteristiche genetiche, ad eccezione degli interventi aventi finalità diagnostiche e terapeutiche, di cui al comma 2 del presente articolo;

c) interventi di clonazione mediante trasferimento di nucleo o di scissione precoce dell'embrione o di ectogenesi sia a fini procreativi sia di ricerca;

d) la fecondazione di un gamete umano con un gamete di specie diversa e la produzione di ibridi o di chimere.

4. La violazione dei divieti di cui al comma 1 è punita con la reclusione da due a sei anni e con la multa da 50.000 a 150.000 euro. In caso di violazione di uno dei divieti di cui al comma 3 la pena è aumentata. Le circostanze attenuanti concorrenti con le circostanze aggravanti previste dal comma 3 non possono essere ritenute equivalenti o prevalenti rispetto a queste.

5. È disposta la sospensione da uno a tre anni dall'esercizio professionale nei confronti dell'esercente una professione sanitaria condannato per uno degli illeciti di cui al presente articolo.

ART. 14.
(Limiti all'applicazione delle tecniche sugli embrioni).

1. È vietata la crioconservazione e la soppressione di embrioni, fermo restando quanto previsto dalla legge 22 maggio 1978, n. 194.

2. Le tecniche di produzione degli embrioni, tenuto conto dell'evoluzione tecnico-scientifica e di quanto previsto dall'articolo 7, comma 3, non devono creare un numero di embrioni superiore a quello strettamente necessario ad un unico e contemporaneo impianto, comunque non superiore a tre.

3. Qualora il trasferimento nell'utero degli embrioni non risulti possibile per grave e documentata causa di forza maggiore relativa allo stato di salute della donna non prevedibile al momento della fecondazione è consentita la crioconservazione degli embrioni stessi fino alla data del trasferimento, da realizzare non appena possibile.

4. Ai fini della presente legge sulla procreazione medicalmente assistita è vietata la riduzione embrionaria di gravidanze plurime, salvo nei casi previsti dalla legge 22 maggio 1978, n. 194.

5. I soggetti di cui all'articolo 5 sono informati sul numero e, su loro richiesta, sullo stato di salute degli embrioni prodotti e da trasferire nell'utero.

6. La violazione di uno dei divieti e degli obblighi di cui ai commi precedenti è punita con la reclusione fino a tre anni e con la multa da 50.000 a 150.000 euro.

7. È disposta la sospensione fino ad un anno dall'esercizio professionale nei confronti dell'esercente una professione sanitaria condannato per uno dei reati di cui al presente articolo.

8. È consentita la crioconservazione dei gameti maschile e femminile, previo consenso informato e scritto.

9. La violazione delle disposizioni di cui al comma 8 è punita con la sanzione amministrativa pecuniaria da 5.000 a 50.000 euro.

CAPO VII
DISPOSIZIONI FINALI E TRANSITORIE

ART. 15.
(Relazione al Parlamento).

1. L'Istituto superiore di sanità predispone, entro il 28 febbraio di ciascun anno, una relazione annuale per il Ministro della salute in base ai dati raccolti ai sensi dell'articolo 11, comma 5, sull'attività delle strutture autorizzate, con particolare riferimento alla valutazione epidemiologica delle tecniche e degli interventi effettuati.

2. Il Ministro della salute, sulla base dei dati indicati al comma 1, presenta entro il 30 giugno di ogni anno una relazione al Parlamento sull'attuazione della presente legge.

ART. 16.
(Obiezione di coscienza).

1. Il personale sanitario ed esercente le attività sanitarie ausiliarie non è tenuto a prendere parte alle procedure per l'applicazione delle tecniche di procreazione medicalmente assistita disciplinate dalla presente legge quando sollevi obiezione di coscienza con preventiva dichiarazione. La dichiarazione dell'obiettore deve essere comunicata entro tre mesi dalla data di entrata in vigore della presente legge al direttore dell'azienda unità sanitaria locale o dell'azienda ospedaliera, nel caso di personale dipendente, al direttore sanitario, nel caso di personale dipendente da strutture private autorizzate o accreditate.

2. L'obiezione può essere sempre revocata o venire proposta anche al di fuori dei termini di cui al comma 1, ma in tale caso la dichiarazione produce effetto dopo un mese dalla sua presentazione agli organismi di cui al comma 1.

3. L'obiezione di coscienza esonera il personale sanitario ed esercente le attività sanitarie ausiliarie dal compimento delle procedure e delle attività specificatamente e necessariamente dirette a determinare l'intervento di procreazione medicalmente assistita e non dall'assistenza antecedente e conseguente l'intervento.

ART. 17.
(Disposizioni transitorie).

1. Le strutture e i centri iscritti nell'elenco predisposto presso l'Istituto superiore di sanità ai sensi dell'ordinanza del Ministro della sanità del 5 marzo 1997, pubblicata nella *Gazzetta Ufficiale* n. 55 del 7 marzo 1997, sono autorizzati ad applicare le tecniche di procreazione medicalmente assistita, nel rispetto delle disposizioni della presente legge, fino al nono mese successivo alla data di entrata in vigore della presente legge.

2. Entro trenta giorni dalla data di entrata in vigore della presente legge, le strutture e i centri di cui al comma 1 trasmettono al Ministero della salute un elenco contenente l'indicazione numerica degli embrioni prodotti a seguito dell'applicazione di tecniche di procreazione medicalmente assistita nel periodo precedente la data di entrata in vigore della presente legge, nonché, nel rispetto delle vigenti disposizioni sulla tutela della riservatezza dei dati personali, l'indicazione nominativa di coloro che hanno fatto ricorso alle tecniche medesime a seguito delle quali sono stati formati gli embrioni. La violazione della disposizione del presente comma è punita con la sanzione amministrativa pecuniaria da 25.000 a 50.000 euro.

3. Entro tre mesi dalla data di entrata in vigore della presente legge il Ministro della salute, avvalendosi dell'Istituto superiore di sanità, definisce, con proprio decreto, le modalità e i termini di conservazione degli embrioni di cui al comma 2.

ART. 18.
(Fondo per le tecniche di procreazione medicalmente assistita).

1. Al fine di favorire l'accesso alle tecniche di procreazione medicalmente assistita da parte dei soggetti di cui all'articolo 5, presso il Ministero della salute è istituito il Fondo per le tecniche di procreazione medicalmente assistita. Il Fondo è ripartito tra le regioni e le province autonome di Trento e di Bolzano sulla base di criteri determinati con decreto del Ministro della salute, da emanare entro sessanta giorni dalla data di entrata in vigore della presente legge, sentita la Conferenza permanente per i rapporti tra lo Stato, le regioni e le province autonome di Trento e di Bolzano.

2. Per la dotazione del Fondo di cui al comma 1 è autorizzata la spesa di 6,8 milioni di euro a decorrere dall'anno 2004.

3. All'onere derivante dall'attuazione del presente articolo si provvede mediante corrispondente riduzione dello stanziamento iscritto, ai fini del bilancio triennale 2004-2006, nell'ambito dell'unità previsionale di base di parte corrente "Fondo speciale" dello stato di previsione del Ministero dell'economia e delle finanze per l'anno 2004, allo

scopo parzialmente utilizzando l'accantonamento relativo al Ministero medesimo. Il Ministro dell'economia e delle finanze è autorizzato ad apportare, con propri decreti, le occorrenti variazioni di bilancio.

Legge 22 maggio 1978, n. 194

Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza

(Pubblicata sulla Gazzetta Ufficiale Gazzetta Ufficiale del 22 maggio 1978, n. 140)

Articolo 1

Lo Stato garantisce il diritto alla procreazione cosciente e responsabile, riconosce il valore sociale della maternità e tutela la vita umana dal suo inizio.
L'interruzione volontaria della gravidanza, di cui alla presente legge, non è mezzo per il controllo delle nascite.
Lo Stato, le regioni e gli enti locali, nell'ambito delle proprie funzioni e competenze, promuovono e sviluppano i servizi socio-sanitari, nonché altre iniziative necessarie per evitare che lo aborto sia usato ai fini della limitazione delle nascite.

Articolo 2

I consultori familiari istituiti dalla legge 29 luglio 1975, n. 405, fermo restando quanto stabilito dalla stessa legge, assistono la donna in stato di gravidanza:
a) informandola sui diritti a lei spettanti in base alla legislazione statale e regionale, e sui servizi sociali, sanitari e assistenziali concretamente offerti dalle strutture operanti nel territorio;
b) informandola sulle modalità idonee a ottenere il rispetto delle norme della legislazione sul lavoro a tutela della gestante;
c) attuando direttamente o proponendo allo ente locale competente o alle strutture sociali operanti nel territorio speciali interventi, quando la gravidanza o la maternità creino problemi per risolvere i quali risultino inadeguati i normali interventi di cui alla lettera a);
d) contribuendo a far superare le cause che potrebbero indurre la donna all'interruzione della gravidanza. I consultori sulla base di appositi regolamenti o convenzioni possono avvalersi, per i fini previsti dalla legge, della collaborazione volontaria di idonee formazioni sociali di base e di associazioni del volontariato, che possono anche aiutare la maternità difficile dopo la nascita.
La somministrazione su prescrizione medica, nelle strutture sanitarie e nei consultori, dei mezzi necessari per conseguire le finalità liberamente scelte in ordine alla procreazione responsabile è consentita anche ai minori.

Articolo 3

Anche per l'adempimento dei compiti ulteriori assegnati dalla presente legge ai consultori familiari, il fondo di cui all'articolo 5 della legge 29 luglio 1975, n. 405, è aumentato con uno stanziamento di L. 50.000.000.000 annui, da ripartirsi fra le regioni in base agli stessi criteri stabiliti dal suddetto articolo.
Alla copertura dell'onere di lire 50 miliardi relativo all'esercizio finanziario 1978 si provvede mediante corrispondente riduzione dello stanziamento iscritto nel capitolo 9001 dello stato di previsione della spesa del Ministero del tesoro per il medesimo esercizio. Il Ministro del tesoro è autorizzato ad apportare, con propri decreti, le necessarie variazioni di bilancio.

Articolo 4

Per l'interruzione volontaria della gravidanza entro i primi novanta giorni, la donna che accusi circostanze per le quali la prosecuzione della gravidanza, il parto o la maternità comporterebbero un serio pericolo per la sua salute fisica o psichica, in relazione o al suo stato di salute, o alle sue condizioni economiche, o sociali o familiari, o alle circostanze in cui è avvenuto il concepimento, o a previsioni di anomalie o malformazioni del concepito, si rivolge ad un consultorio pubblico istituito

ai sensi dell'articolo 2, lettera a), della legge 29 luglio 1975 numero 405, o a una struttura socio-sanitaria a ciò abilitata dalla regione, o a un medico di sua fiducia.

Articolo 5

Il consultorio e la struttura socio-sanitaria, oltre a dover garantire i necessari accertamenti medici, hanno il compito in ogni caso, e specialmente quando la richiesta di interruzione della gravidanza sia motivata dall'incidenza delle condizioni economiche, o sociali, o familiari sulla salute della gestante, di esaminare con la donna e con il padre del concepito, ove la donna lo consenta, nel rispetto della dignità e della riservatezza della donna e della persona indicata come padre del concepito, le possibili soluzioni dei problemi proposti, di aiutarla a rimuovere le cause che la porterebbero alla interruzione della gravidanza, di metterla in grado di far valere i suoi diritti di lavoratrice e di madre, di promuovere ogni opportuno intervento atto a sostenere la donna, offrendole tutti gli aiuti necessari sia durante la gravidanza sia dopo il parto.
Quando la donna si rivolge al medico di sua fiducia questi compie gli accertamenti sanitari necessari, nel rispetto della dignità e della libertà della donna; valuta con la donna stessa e con il padre del concepito, ove la donna lo consenta, nel rispetto della dignità e della riservatezza della donna e della persona indicata come padre del concepito, anche sulla base dell'esito degli accertamenti di cui sopra, le circostanze che la determinano a chiedere l'interruzione della gravidanza; la informa sui diritti a lei spettanti e sugli interventi di carattere sociale cui può fare ricorso, nonché sui consultori e le strutture socio-sanitarie.
Quando il medico del consultorio o della struttura socio-sanitaria, o il medico di fiducia, riscontra l'esistenza di condizioni tali da rendere urgente l'intervento, rilascia immediatamente alla donna un certificato attestante l'urgenza. Con tale certificato la donna stessa può presentarsi ad una delle sedi autorizzate a praticare la interruzione della gravidanza. Se non viene riscontrato il caso di urgenza, al termine dell'incontro il medico del consultorio o della struttura socio-sanitaria, o il medico di fiducia, di fronte alla richiesta della donna di interrompere la gravidanza sulla base delle circostanze di cui all'articolo 4, le rilascia copia di un documento, firmato anche dalla donna, attestante lo stato di gravidanza e l'avvenuta richiesta, e la invita a soprassedere per sette giorni. Trascorsi i sette giorni, la donna può presentarsi, per ottenere la interruzione della gravidanza, sulla base del documento rilasciatole ai sensi del presente comma, presso una delle sedi autorizzate.

Articolo 6

L'interruzione volontaria della gravidanza, dopo i primi novanta giorni, può essere praticata:
a) quando la gravidanza o il parto comportino un grave pericolo per la vita della donna;
b) quando siano accertati processi patologici, tra cui quelli relativi a rilevanti anomalie o malformazioni del nascituro, che determinino un grave pericolo per la salute fisica o psichica della donna.

Articolo 7

I processi patologici che configurino i casi previsti dall'articolo precedente vengono accertati da un medico del servizio ostetrico-ginecologico dell'ente ospedaliero in cui deve praticarsi l'intervento, che ne certifica l'esistenza. Il medico può avvalersi della collaborazione di specialisti. Il medico è tenuto a fornire la documentazione sul caso e a comunicare la sua certificazione al direttore sanitario dell'ospedale per l'intervento da praticarsi immediatamente. Qualora l'interruzione della gravidanza si renda necessaria per imminente pericolo per la vita della donna, l'intervento può essere praticato anche senza lo svolgimento delle procedure previste dal comma precedente e al di fuori delle sedi di cui all'articolo 8. In questi casi, il medico è tenuto a darne comunicazione al medico provinciale. Quando sussiste la possibilità di vita autonoma del feto, l'interruzione della gravidanza può essere praticata solo nel caso di cui alla lettera a) dell'articolo 6 e il medico che esegue l'intervento deve adottare ogni misura idonea a salvaguardare la vita del feto.

Articolo 8

L'interruzione della gravidanza è praticata da un medico del servizio ostetrico-ginecologico presso un ospedale generale tra quelli indicati nell'articolo 20 della legge 12 febbraio 1968, numero 132, il quale verifica anche l'inesistenza di controindicazioni sanitarie.
Gli interventi possono essere altresì praticati presso gli ospedali pubblici specializzati, gli istituti ed enti di cui all'articolo 1, penultimo comma, della legge 12 febbraio 1968, n. 132, e le istituzioni di cui alla legge 26 novembre 1973, numero 817, ed al decreto del Presidente della Repubblica 18 giugno 1958, n. 754, sempre che i rispettivi organi di gestione ne facciano richiesta.
Nei primi novanta giorni l'interruzione della gravidanza può essere praticata anche presso case di cura autorizzate dalla regione, fornite di requisiti igienico-sanitari e di adeguati servizi ostetrico-ginecologici.
Il Ministro della sanità con suo decreto limiterà la facoltà delle case di cura autorizzate, a praticare gli interventi di interruzione della gravidanza, stabilendo:
1) la percentuale degli interventi di interruzione della gravidanza che potranno avere luogo, in rapporto al totale degli interventi operatori eseguiti nell'anno precedente presso la stessa casa di cura;
2) la percentuale dei giorni di degenza consentiti per gli interventi di interruzione della gravidanza, rispetto al totale dei giorni di degenza che nell'anno precedente si sono avuti in relazione alle convenzioni con la regione.
Le percentuali di cui ai punti 1) e 2) dovranno essere non inferiori al 20 per cento e uguali per tutte le case di cura.
Le case di cura potranno scegliere il criterio al quale attenersi, fra i due sopra fissati.
Nei primi novanta giorni gli interventi di interruzione della gravidanza dovranno altresì poter essere effettuati, dopo la costituzione delle unità socio-sanitarie locali, presso poliambulatori pubblici adeguatamente attrezzati, funzionalmente collegati agli ospedali ed autorizzati dalla regione.
Il certificato rilasciato ai sensi del terzo comma dell'articolo 5 e, alla scadenza dei sette giorni, il documento consegnato alla donna ai sensi del quarto comma dello stesso articolo costituiscono titolo per ottenere in via d'urgenza l'intervento e, se necessario, il ricovero.

Articolo 9

Il personale sanitario ed esercente le attività ausiliarie non è tenuto a prendere parte alle procedure di cui agli articoli 5 e 7 ed agli interventi per l'interruzione della gravidanza quando sollevi obiezione di coscienza, con preventiva dichiarazione. La dichiarazione dell'obiettore deve essere comunicata al medico provinciale e, nel caso di personale dipendente dello ospedale o dalla casa di cura, anche al direttore sanitario, entro un mese dall'entrata in vigore della presente legge o dal conseguimento della abilitazione o dall'assunzione presso un ente tenuto a fornire prestazioni dirette alla interruzione della gravidanza o dalla stipulazione di una convenzione con enti previdenziali che comporti l'esecuzione di tali prestazioni.
L'obiezione può sempre essere revocata o venire proposta anche al di fuori dei termini di cui al precedente comma, ma in tale caso la dichiarazione produce effetto dopo un mese dalla sua presentazione al medico provinciale.
L'obiezione di coscienza esonera il personale sanitario ed esercente le attività ausiliarie dal compimento delle procedure e delle attività specificamente e necessariamente dirette a determinare l'interruzione della gravidanza, e non dall'assistenza antecedente e conseguente all'intervento.
Gli enti ospedalieri e le case di cura autorizzate sono tenuti in ogni caso ad assicurare lo espletamento delle procedure previste dall'articolo 7 e l'effettuazione degli interventi di interruzione della gravidanza richiesti secondo le modalità previste dagli articoli 5, 7 e 8. La regione ne controlla e garantisce l'attuazione anche attraverso la mobilità del personale.
L'obiezione di coscienza non può essere invocata dal personale sanitario, ed esercente le attività ausiliarie quando, data la particolarità delle circostanze, il loro personale intervento è indispensabile per salvare la vita della donna in imminente pericolo.

L'obiezione di coscienza si intende revocata, con effetto, immediato, se chi l'ha sollevata prende parte a procedure o a interventi per l'interruzione della gravidanza previsti dalla presente legge, al di fuori dei casi di cui al comma precedente.

Articolo 10

L'accertamento, l'intervento, la cura e la eventuale degenza relativi alla interruzione della gravidanza nelle circostanze previste dagli articoli 4 e 6, ed attuati nelle istituzioni sanitarie di cui all'articolo 8, rientrano fra le prestazioni ospedaliere trasferite alle regioni dalla legge 17 agosto 1974, n. 386.
Sono a carico della regione tutte le spese per eventuali accertamenti, cure o degenze necessarie per il compimento della gravidanza nonché per il parto, riguardanti le donne che non hanno diritto all'assistenza mutualistica.
Le prestazioni sanitarie e farmaceutiche non previste dai precedenti commi e gli accertamenti effettuati secondo quanto previsto dal secondo comma dell'articolo 5 e dal primo comma dell'articolo 7 da medici dipendenti pubblici, o che esercitino la loro attività nell'ambito di strutture pubbliche o convenzionate con la regione, sono a carico degli enti mutualistici, sino a che non sarà istituito il servizio sanitario nazionale.

Articolo 11

L'ente ospedaliero, la casa di cura o il poliambulatorio nei quali l'intervento è stato effettuato sono tenuti ad inviare al medico provinciale competente per territorio una dichiarazione con la quale il medico che lo ha eseguito dà notizia dell'intervento stesso e della documentazione sulla base della quale è avvenuto, senza fare menzione dell'identità della donna.
Le lettere b) e f) dell'articolo 103 del testo unico delle leggi sanitarie, approvato con il regio decreto 27 luglio 1934, n. 1265, sono abrogate.

Articolo 12

La richiesta di interruzione della gravidanza secondo le procedure della presente legge è fatta personalmente dalla donna.
Se la donna è di età inferiore ai diciotto anni, per l'interruzione della gravidanza è richiesto lo assenso di chi esercita sulla donna stessa la potestà o la tutela. Tuttavia, nei primi novanta giorni, quando vi siano seri motivi che impediscano o sconsiglino la consultazione delle persone esercenti la potestà o la tutela, oppure queste, interpellate, rifiutino il loro assenso o esprimano pareri tra loro difformi, il consultorio o la struttura socio-sanitaria, o il medico di fiducia, espleta i compiti e le procedure di cui all'articolo 5 e rimette entro sette giorni dalla richiesta una relazione, corredata del proprio parere, al giudice tutelare del luogo in cui esso opera. Il giudice tutelare, entro cinque giorni, sentita la donna e tenuto conto della sua volontà, delle ragioni che adduce e della relazione trasmessagli, può autorizzare la donna, con atto non soggetto a reclamo, a decidere la interruzione della gravidanza.
Qualora il medico accerti l'urgenza dell'intervento a causa di un grave pericolo per la salute della minore di diciotto anni, indipendentemente dall'assenso di chi esercita la potestà o la tutela e senza adire il giudice tutelare, certifica l'esistenza delle condizioni che giustificano l'interruzione della gravidanza. Tale certificazione costituisce titolo per ottenere in via d'urgenza l'intervento e, se necessario, il ricovero.
Ai fini dell'interruzione della gravidanza dopo i primi novanta giorni, si applicano anche alla minore di diciotto anni le procedure di cui all'articolo 7, indipendentemente dall'assenso di chi esercita la potestà o la tutela.

Articolo 13

Se la donna è interdetta per infermità di mente, la richiesta di cui agli articoli 4 e 6 può essere presentata, oltre che da lei personalmente, anche dal tutore o dal marito non tutore, che non sia legalmente separato.

Nel caso di richiesta presentata dall'interdetta o dal marito, deve essere sentito il parere del tutore.
La richiesta presentata dal tutore o dal marito deve essere confermata dalla donna.
Il medico del consultorio o della struttura socio-sanitaria, o il medico di fiducia, trasmette al giudice tutelare, entro il termine di sette giorni dalla presentazione della richiesta, una relazione contenente ragguagli sulla domanda e sulla sua provenienza, sull'atteggiamento comunque assunto dalla donna e sulla gravidanza e specie dell'infermità mentale di essa nonché il parere del tutore, se espresso.
Il giudice tutelare, sentiti se lo ritiene opportuno gli interessati, decide entro cinque giorni dal ricevimento della relazione, con atto non soggetto a reclamo.
Il provvedimento del giudice tutelare ha gli effetti di cui all'ultimo comma dell'articolo 8.

Articolo 14

Il medico che esegue l'interruzione della gravidanza è tenuto a fornire alla donna le informazioni e le indicazioni sulla regolazione delle nascite, nonché a renderla partecipe dei procedimenti abortivi, che devono comunque essere attuati in modo da rispettare la dignità personale della donna.
In presenza di processi patologici, fra cui quelli relativi ad anomalie o malformazioni del nascituro, il medico che esegue l'interruzione della gravidanza deve fornire alla donna i ragguagli necessari per la prevenzione di tali processi.

Articolo 15

Le regioni, d'intesa con le università e con gli enti ospedalieri, promuovono l'aggiornamento del personale sanitario ed esercente le arti ausiliarie sui problemi della procreazione cosciente e responsabile, sui metodi anticoncezionali, sul decorso della gravidanza, sul parto e sull'uso delle tecniche più moderne, più rispettose dell'integrità fisica e psichica della donna e meno rischiose per l'interruzione della gravidanza. Le regioni promuovono inoltre corsi ed incontri ai quali possono partecipare sia il personale sanitario ed esercente le arti ausiliarie sia le persone interessate ad approfondire le questioni relative all'educazione sessuale, al decorso della gravidanza, al parto, ai metodi anticoncezionali e alle tecniche per l'interruzione della gravidanza.
Al fine di garantire quanto disposto dagli articoli 2 e 5, le regioni redigono un programma annuale d'aggiornamento e di informazione sulla legislazione statale e regionale, e sui servizi sociali, sanitari e assistenziali esistenti nel territorio regionale.

Articolo 16

Entro il mese di febbraio, a partire dall'anno successivo a quello dell'entrata in vigore della Presente legge, il Ministro della sanità presenta al Parlamento una relazione sull'attuazione della legge stessa e sui suoi effetti, anche in riferimento al problema della prevenzione.
Le regioni sono tenute a fornire le informazioni necessarie entro il mese di gennaio di ciascun anno, sulla base di questionari predisposti dal Ministro.
Analoga relazione presenta il Ministro di grazia e giustizia per quanto riguarda le questioni di specifica competenza del suo Dicastero.

Articolo 17

Chiunque cagiona ad una donna per colpa l'interruzione della gravidanza è punito con la reclusione da tre mesi a due anni.
Chiunque cagiona ad una donna per colpa un parto prematuro è punito con la pena prevista dal comma precedente, diminuita fino alla metà.
Nei casi previsti dai commi precedenti, se il fatto è commesso con la violazione delle norme poste a tutela del lavoro la pena è aumentata.

Articolo 18

Chiunque cagiona l'interruzione della gravidanza senza il consenso della donna è punito con la reclusione da quattro a otto anni. Si considera come non prestato il consenso estorto con violenza o minaccia ovvero carpito con l'inganno.
La stessa pena si applica a chiunque provochi l'interruzione della gravidanza con azioni dirette a provocare lesioni alla donna.
Detta pena è diminuita fino alla metà se da tali lesioni deriva l'acceleramento del parto.
Se dai fatti previsti dal primo e dal secondo comma deriva la morte della donna si applica la reclusione da otto a sedici anni; se ne deriva una lesione personale gravissima si applica la reclusione da sei a dodici anni; se la lesione personale è grave questa ultima pena è diminuita.
Le pene stabilite dai commi precedenti sono aumentate se la donna è minore degli anni diciotto.

Articolo 19

Chiunque cagiona l'interruzione volontaria della gravidanza senza l'osservanza delle modalità indicate negli articoli 5 o 8, è punito con la reclusione sino a tre anni.
La donna è punita con la multa fino a lire centomila.
Se l'interruzione volontaria della gravidanza avviene senza l'accertamento medico dei casi previsti dalle lettere a) e b) dell'articolo 6 o comunque senza l'osservanza delle modalità previste dall'articolo 7, chi la cagiona è punito con la reclusione da uno a quattro anni.
La donna è punita con la reclusione sino a sei mesi.
Quando l'interruzione volontaria della gravidanza avviene su donna minore degli anni diciotto, o interdetta, fuori dei casi o senza l'osservanza delle modalità previste dagli articoli 12 e 13, chi la cagiona è punito con le pene rispettivamente previste dai commi precedenti aumentate fino alla metà. La donna non è punibile.
Se dai fatti previsti dai commi precedenti deriva la morte della donna, si applica la reclusione da tre a sette anni; se ne deriva una lesione personale gravissima si applica la reclusione da due a cinque anni; se la lesione personale è grave questa ultima pena è diminuita.
Le pene stabilite dal comma precedente sono aumentate se la morte o la lesione della donna derivano dai fatti previsti dal quinto comma.

Articolo 20

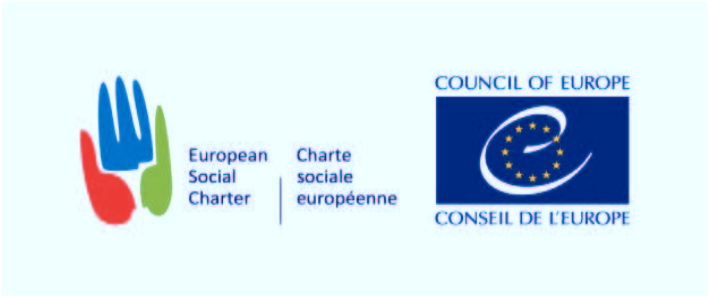
Le pene previste dagli articoli 18 e 19 per chi procura l'interruzione della gravidanza sono aumentate quando il reato è commesso da chi ha sollevato obiezione di coscienza ai sensi dell'articolo 9.

Articolo 21

Chiunque, fuori dei casi previsti dall'articolo 326 del codice penale, essendone venuto a conoscenza per ragioni di professione o di ufficio, rivela l'identità - o comunque divulga notizie idonee a rivelarla - di chi ha fatto ricorso alle procedure o agli interventi previsti dalla presente legge, è punito a norma dell'articolo 622 del codice penale.

Articolo 22

Il titolo X del libro II del codice penale è abrogato.
Sono altresì abrogati il n. 3) del primo comma e il n. 5) del secondo comma dell'articolo 583 del codice penale.



EUROPEAN COMMITTEE OF SOCIAL RIGHTS
COMITE EUROPEEN DES DROITS SOCIAUX

21 January 2013

Case Document No. 1

***Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy**
Complaint No.91/2013

COMPLAINT
(Translation)

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Confederazione Generale Italiana del Lavoro

Corso d'Italia 25

Rome

Italy

Secretariat of the European Social Charter

Directorate General of Human Rights and Legal Affairs

Directorate of Monitoring

F-67075 Strasbourg Cedex

France

COLLECTIVE COMPLAINT

Lodged in accordance with the Additional Protocol of 1995 providing for a system of collective complaints and with Rules Nos. 23 and 24 of the Rules of the European Committee of Social Rights

Confederazione Generale Italiana del Lavoro

v.

Italy

Contents

1. Preliminary observations on the subject matter of the collective complaint

The purpose of this complaint against Italy is to request the European Committee of Social Rights to rule that the implementation of Article 9 of Law No. 194 of 1978 (Appendix 1)[1] governing voluntary terminations of pregnancy is in violation of:

- Article 11 (*The right to protection of health*) of the European Social Charter, read alone or in conjunction with Article E (*Non-discrimination*), in respect of women's legal situation;

- Article 1 (*The right to work*) of the European Social Charter in respect of the legal situation of medical staff and auxiliary staff who are not conscientious objectors;

- Articles 2 (*The right to just conditions of work*), 3 (*The right to safe and healthy working conditions*) and 26 (*The right to dignity at work*) of the European Social Charter, read alone or in conjunction with Article 3, in respect of the legal situation of medical staff and auxiliary staff who are not conscientious objectors.

In addition, the European Committee of Social Rights is asked to determine whether Articles 21 (*The right to information and consultation*) and 22 (*The right to take part in the determination and improvement of working conditions and the working environment*) of the European Social Charter are relevant to the subject matter of this complaint on account of the principles which can be inferred from them, despite the fact that their scope is confined to for-profit undertakings (Appendix to the European Social Charter, Articles 21 and 22).

Indeed, Article 9, governing conscientious objection by medical staff in respect of voluntary terminations of pregnancy, says nothing about the specific implementation measures whereby the hospitals and the regions[2] must guarantee the presence of a sufficient number of non-objecting medical staff in all public hospital establishments, so as to ensure that the right of access to a voluntary termination of pregnancy is always secured.

[1] Law No. 194 of 22 May 1978 governing the social protection of motherhood and voluntary terminations of pregnancy

[2] The regions have their basis in Article 5 of the Constitution, which provides: "The Republic shall be one and indivisible. It shall recognise and promote local self-government, shall ensure the greatest possible administrative decentralisation of services which are the responsibility of the State and shall adapt the principles and methods of its legislation to the requirements of autonomy and decentralisation" and in Article 114, which provides "The Republic shall be composed of the municipalities, the provinces, the metropolitan cities, the regions and the State. The municipalities, provinces, metropolitan cities and regions shall be self-governing entities with their own statutes, powers and functions in accordance with the principles laid down in the Constitution. …".

These legislative deficiencies lead to inadequate implementation of Law No. 194 of 1978, as can be seen from the data on its application in practice, and accordingly to violations of the rights to health and to self-determination of women wishing to terminate a pregnancy.

This legislation also results in a breach of the rights of medical staff who do not wish to raise a conscientious objection in respect of voluntary terminations of pregnancy, since it engenders working conditions which prevent them from exercising their recognised employment rights. They in fact have to bear the full workload relating to such terminations in view of the ever-growing number of doctors in this sector who are conscientious objectors.

Hence, in addition to the doubts concerning the compatibility of these provisions with the Italian Constitution (Articles 1, 2, 3, 4, 13, 32, 35 and 36), while it remains valid in principle the implementation of Article 9 of Law No. 194 of 1078, which gives no specific indications as to the manner in which it is to be applied, can be seen to be contrary to the European Social Charter (Article 11, read alone or in conjunction with Article E; Article 1 and Articles 2, 3 and 26, the latter articles being read alone or in conjunction with Article E).

Furthermore, as already indicated, the question arises of the relevance to the subject matter of this complaint of the provisions of Articles 21 and 22 of the European Social Charter.

2. Admissibility and parties to the complaint

2.1. The respondent State

This complaint is lodged against Italy.

Italy ratified and brought into effect the European Social Charter through Law No. 30 of 9 February 1999, entitled "Ratification and implementation of the revised European Social Charter and the appendix thereto, signed in Strasbourg on 3 May 1996" (Appendix 2).

It ratified the additional protocol to the Charter relating to the system of collective complaints through Law No. 298 of 28 August 1997, entitled "Ratification and implementation of the Additional Protocol to the European Social Charter providing for a system of collective complaints, signed in Strasbourg on 9 November 1995" (Appendix 3).

2.2. The complainant organisation

2.2.1. The Confederazione Generale italiana del Lavoro (CGIL).

The Confederazione Generale Italiana del Lavoro is an association for the defence of workers' and employment rights, founded in 1906, which has its national headquarters in Rome. It is the oldest Italian trade union and the most representative one (the CGIL has about 6 million members, including workers, pensioners and young people entering the labour market).

The CGIL is an organisation which pursues a programme founded on the principles of unity, secularity, democracy and multi-ethnicity and promotes freedom of association and the collective, solidarity-based self-protection of employees and other non-independent workers, workers employed in co-operative and self-managed entities, para-subordinated workers, unemployed workers, non-workers and those seeking their first job, pensioners and elderly people (Article 1 of the Statutes of the CGIL, Appendix 4).

The activities of the CGIL have their basis in the principles of the Italian Constitution, as its aim is to further their full implementation (Article 2 of the Statutes of the CGIL).

In particular "the CGIL asserts the value of solidarity in a society devoid of privileges or discrimination, within which the rights to work, to health and to social protection are recognised and wealth is equally distributed, ... seeking to erase the political, social and economic barriers which prevent women and men, whether of indigenous or immigrant

origin, from taking their own decisions concerning their lives and work based on equality of rights and opportunities and in a manner which acknowledges diversity. …

The CGIL safeguards in the most appropriate ways the right of all workers to just and impartial employment relations …".

Through its own category-based organisations, the CGIL determines the substance of employment contracts and at the same time pursues activities aimed at safeguarding, defending, asserting and conquering individual and collective rights, ranging from social welfare systems to workplace rights.

It plays a fundamental role in the protection of employment against the free and unrestricted operation of market forces. Its action principally consists in establishing solidarity in the workplace and between workers through its day-to-day concrete activities of representation and negotiation.

The association has a vertical structure, formed of category-based federations, and a horizontal one, comprising "chambers of labour". There are presently 13 categories at national level, and 134 chambers of labour.

The CGIL is affiliated to the European Trade Union Confederation (ETUC) and the International Trade Union Confederation (ITUC).

Further information concerning the CGIL can be found on its website *www.cgil.it*.

2.2.2. The CGIL's standing to lodge collective complaints before the European Committee of Social Rights

The CGIL is legitimately entitled to lodge collective complaints before the European Committee of Social Rights.

This entitlement is governed by Article 1 of the Additional Protocol to the European Social Charter providing for a system of collective complaints, which provides that the right to submit complaints shall belong inter alia to "representative national organisations of employers and trade unions within the jurisdiction of the Contracting Party against which they have lodged a complaint" (Appendix 5).

Vested with this authority, the CGIL hereby submits this collective complaint against Italy to the European Committee of Social rights through its Secretary General.

Article 17 of the Statutes of the CGIL provides "… the legal representatives of the CGIL with regard to third parties and in legal matters shall be:

a) the Secretary General for all matters apart from those mentioned below, which may be delegated;

b) other persons appointed by a formal decision of the confederal secretariat to deal with all legal matters of an administrative, fiscal, budgetary or financial nature and work safety matters. The secretariat may by a similar decision withdraw such an appointment without prior notice at any time and proceed in parallel with the appointment of another person. The Governing Board shall be formally informed of such decisions. …"

The current Secretary General of the CGIL is Susanna Camusso, who was elected on 3 November 2010.

3. Subject matter of the collective complaint

3.1. Subject matter of the collective complaint

By lodging this complaint, the CGIL, assisted by lawyers Marilisa d'Amico and Benededetta Liberali del Foro of the Milan Bar, requests the European Committee of Social Rights to declare that Italy is failing to apply in a satisfactory manner Article 11 of the European Social Charter, read alone or in conjunction with Article E, since Article 9 of Law No. 194 of 1978 governing conscientious objection in respect of voluntary terminations of pregnancy does not suffice to guarantee the effective exercise of women's right of access to voluntary terminations of pregnancy.

The CGIL also asks the European Committee of Social Rights to declare that Italy is failing to apply in a satisfactory manner Article 1 and Articles 2, 3 and 26 of the European Social Charter, the latter articles being read alone or in conjunction with Article E, since Article 9 of Law No. 194 of 1978 does not suffice to guarantee the effective exercise of the rights belonging to medical and auxiliary staff in respect of such termination procedures.

The data gathered both at national level and at the level of the individual regions show that the public hospitals have insufficient non-objecting medical staff to carry out terminations of pregnancy, access to which is guaranteed by Law No. 194 itself.

Law No. 194 indeed guarantees women access to a pregnancy termination procedure when certain conditions are met.[3]

This legislation, which was put in place by Parliament following the Italian Constitutional Court's ruling on the unconstitutionality of the provisions criminalising voluntary terminations of pregnancy (judgment No. 27 of 1975),[4] permits medical and auxiliary staff

[3] In particular it states that "In order to undergo a termination of pregnancy during the first 90 days, women whose situation is such that continuation of the pregnancy, childbirth or motherhood would seriously endanger their physical or mental health, in view of their state of health, their economic, social or family circumstances, the circumstances in which conception occurred or the probability that the child would be born with abnormalities or malformations, shall apply to a public counselling centre [...] or to a fully authorised medico-social agency in the region or to a physician of their choice." (Art. 4, Law No. 194 of 1978), and that "a voluntary termination of pregnancy may be performed after the first 90 days: a) where the pregnancy or childbirth entails a serious threat to the woman's life; b) where pathological processes constituting a serious threat to the woman's physical or mental health, such as those associated with serious abnormalities or malformations of the foetus, have been diagnosed." (Art. 6, Law No. 194 of 1978).

[4] With this decision the Italian Constitutional Court further declared: "Now there is no equivalence between the rights not only to life but also to health itself of someone who is already a person, such as the mother, and the protection of the embryo which has yet to become a person."

to raise a conscientious objection in relation to pregnancy termination procedures (Article 9 of Law No. 194 of 1978).

In this respect, Article 9 of Law No. 194 provides that medical and auxiliary staff may opt out of taking part in procedures resulting in a termination of pregnancy if they decide to raise a conscientious objection.

Notwithstanding this provision, it is recognised that women's right of access to such procedures cannot be sacrificed in any way.

First and foremost, the legislation denies all relevance to a conscientious objection if there is an imminent danger to the woman's health. It also provides that the hospitals and the authorised nursing homes must "in any event" guarantee the performance of such procedures in accordance with the provisions of Law No. 194. Each region must take steps to supervise and guarantee the activities carried out by the hospitals and the authorised nursing homes, including – and therefore not solely – through recourse to staff mobility measures.

Given this normative framework, it can be seen from the data relating to the number of non-objecting medical staff that, as expected, the implementation of Article 9 of Law No. 194 is inadequate to guarantee that, firstly, the hospitals and the authorised nursing homes and, secondly, the regions in all cases secure women's right of access to a pregnancy termination procedure.

This impairment of women's right of access renders Article 9 of Law 194, while still valid in principle, incompatible with the Italian Constitution (in particular Articles 2, 3, 13 and 32)[5]

[5] Art. 2: “The Republic shall recognise and guarantee the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic shall require that the fundamental duties of political, economic and social solidarity be fulfilled.” Art. 3: “All citizens enjoy equal social dignity and are equal before the law, without distinction as to sex, race, language, religion, political opinion, and personal or social conditions. It shall be the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country.” Art. 13: “Personal freedom shall be inviolable. No one may be detained, inspected or searched or otherwise subjected to any restriction on personal liberty except by a reasoned judicial order and only in such cases and in such a manner as provided by law. In exceptional circumstances and for reasons of necessity and urgency, as peremptorily defined by law, the police may take provisional measures, which shall be referred for judicial validation within 48 hours and which, in the absence of such validation within 48 hours, shall be revoked and considered null and void. Any act of physical or moral violence against a person whose freedom is restricted shall be punished. The law shall establish the maximum duration of preventive custody.” Art. 32: “The Republic shall safeguard health as a fundamental right of the individual and as a collective interest, and shall guarantee free medical care to persons who are indigent. No one may be obliged to undergo any health treatment, except as provided by law. The law may not under any circumstances violate limits imposed out of respect for the human person”.

and with Article 11 (*the right to protection of health*) of the European Social Charter, read alone or in conjunction with Article E (*non-discrimination*).

As a result of this situation the workload in respect of such termination procedures necessarily falls on those who have conversely decided not to raise a conscientious objection. The data on the law's application in practice show that the number of non-objecting practitioners is insufficient, regard being had to women's guaranteed right of access to a voluntary termination of pregnancy, resulting in an impairment of the employment rights of those who decide not to become conscientious objectors.

In view of the growing number of objecting practitioners and the above-mentioned insufficiency of the number of non-objecting practitioners in relation to the guaranteed right of access, the rights of the latter practitioners are in fact violated, since they have to bear the entire workload in this field.

The impairment of these rights renders Article 9 of Law No. 194 incompatible with both the Italian Constitution (in particular Articles 1, 2, 3, 4, 35 and 36)[6] and Article 1 and Articles 2, 3 and 26 of the European Social Charter, the latter articles being read alone or in conjunction with Article E (*non-discrimination*), showing the need to specify in greater detail the tangible measures whereby the hospitals and the regions are to guarantee the exercise of such rights through the presence of a sufficient, suitable number of non-objecting medical staff in each hospital.

The CGIL would also bring to the attention of the European Committee of Social Rights the possibility that it might assess the relevance to the subject matter of this complaint of Articles 21 and 22 of the Charter, in as much as they lay down certain principles regarding

[6] Art. 1 of the Constitution: "Italy is a democratic republic founded on labour. Sovereignty is vested in the people, who shall exercise it under the forms and within the limits laid down in the Constitution." Art. 2: “The Republic shall recognise and guarantee the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic shall require that the fundamental duties of political, economic and social solidarity be fulfilled.” Art. 3: “All citizens enjoy equal social dignity and are equal before the law, without distinction as to sex, race, language, religion, political opinion, and personal or social conditions. It shall be the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country.” Art. 4: "The Republic shall recognise all citizens' right to work and shall promote the conditions making this right effective. All citizens shall have the duty, according to their own possibilities and personal choice, to carry on an activity or an occupation which contributes to the material and spiritual progress of society." Art. 35: "The Republic shall safeguard work in all its forms and applications. It shall take care of the training and professional advancement of workers. It shall promote and foster international agreements and organisations aimed at asserting and regulating workers' rights. It shall recognise freedom to emigrate, subject to requirements laid down by law in the public interest, and protect Italian employment abroad." Art. 36: "Workers shall be entitled to a remuneration proportionate to the quantity and quality of their work and, in any case, sufficient to ensure them and their families a free and dignified existence. The maximum duration of the workday shall be laid down by law. Workers shall be entitled to weekly rest and to paid annual leave, and may not renounce this entitlement."

information and consultation as well as participation in the determination and improvement of working conditions and the working environment.

3.2. Relevant provisions of the European Social Charter and provisions of Law No. 194 of 1978.

The following articles are alleged to have been violated with regard to the legal situation of women.

Article 11 (*The right to protection of health*):

“With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:
1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in health matters;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.”

Article E (*Non-discrimination*):

“The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health association with a national minority, birth or other status.”

The following articles of the European Social Charter are alleged to have been violated with regard to the legal situation of medical and auxiliary staff who are not conscientious objectors, in addition to Article E.

Article 1 (*The right to work*):

"With a view to ensuring the effective exercise of the right to work, the Parties undertake:

…

2. to protect effectively the right of the worker to earn his living in an occupation freely entered upon;
… ."

Article 2 (*The right to just conditions of work*):

"With a view to ensuring the effective exercise of the right to just conditions of work, the Parties undertake:

1) to provide for reasonable daily and weekly working hours, the working week to be progressively reduced to the extent that the increase of productivity and other relevant factors permit;
2) to provide for public holidays with pay;
3) to provide for a minimum of four weeks' annual holiday with pay;
4) to eliminate risks in inherently dangerous or unhealthy occupations, and where it has not yet been possible to eliminate or reduce sufficiently these risks, to provide for either a reduction of working hours or additional paid holidays for workers engaged in such occupations;
5) to ensure a weekly rest period which shall, as far as possible, coincide with the day recognised by tradition or custom in the country or region concerned as a day of rest;
6) to ensure that workers are informed in written form, as soon as possible, and in any event not later than two months after the date of commencing their employment, of the essential aspects of the contract or employment relationship;
7) to ensure that workers performing night work benefit from measures which take account of the special nature of the work."

Article 3 (*The right to safe and healthy working conditions*):

"With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

1) to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;
2) to issue safety and health regulations;
3) to provide for the enforcement of such regulations by measures of supervision;

4) to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions."

Article 26 (*The right to dignity at work*):

"With a view to ensuring the effective exercise of the right of all workers to protection of their
dignity at work, the Parties undertake, in consultation with employers' and workers' organisations:

> … 2) to promote awareness, information and prevention of recurrent reprehensible or distinctly negative and offensive actions directed against individual workers in the workplace or in relation to work and to take all appropriate measures to protect workers from such conduct."

The following articles of the European Social Charter are considered relevant to the subject matter of this complaint, even if it cannot be argued that they have been violated.

Article 21 (*The right to information and consultation*):

"With a view to ensuring the effective exercise of the right of workers to be informed and consulted within the undertaking, the Parties undertake to adopt or encourage measures enabling workers or their representatives, in accordance with national legislation and practice:

> … b) to be consulted in good time on proposed decisions which could substantially affect the interests of workers, particularly on those decisions which could have an important
> impact on the employment situation in the undertaking."

Article 22 (*The right to take part in the determination and improvement of working conditions and the working environment*):

"With a view to ensuring the effective exercise of the right of workers to take part in the determination and improvement of the working conditions and working environment in the
undertaking, the Parties undertake to adopt or encourage measures enabling workers or their representatives, in accordance with national legislation and practice, to contribute:
a) to the determination and the improvement of the working conditions, work organisation

and working environment;

b) to the protection of health and safety within the undertaking;

c) to the organisation of social and socio-cultural services and facilities within the undertaking;

d) to the supervision of the observance of regulations on these matters."

The provision considered to be in breach of the European Social Charter, while remaining valid in principle, is Article 9 of Law No. 194 of 1978, by reason of the difficulties encountered with its implementation:

"Medical and auxiliary staff shall not be required to participate in the procedures referred to in Articles 5 and 7 [7]or in operations aimed at terminating a pregnancy if they raise a

[7] Art. 5: "In all cases, in addition to guaranteeing the necessary medical examinations, counselling centres and socio-medical agencies shall be required, especially when the request for termination of pregnancy is motivated by the impact of economic, social or family circumstances upon the pregnant woman's health, to examine possible solutions to the problems in consultation with the woman and, where the woman consents, with the father of the conceptus, with due respect for the dignity and personal feelings of the woman and the person named as the father of the conceptus, to help her to overcome the factors which would lead her to have her pregnancy terminated, to enable her to take advantage of her rights as a working woman and a mother, and to encourage any suitable measures designed to support the woman by providing her with all necessary assistance both during her pregnancy and after the delivery. Where the woman has applied to a physician of her choice, he/she shall: carry out the necessary medical examinations, with due respect for the woman's dignity and freedom; assess, in conjunction with the woman and, where the woman consents, with the father of the conceptus, with due respect for the dignity and personal feelings of the woman and of the person named as the father of the conceptus, if so desired taking account of the result of the examinations referred to above, the circumstances leading her to request that her pregnancy be terminated; and inform her of her rights and of the social welfare services available to her, as well as regarding the counselling centres and the socio-medical agencies. Where the physician at the counselling centre or socio-medical agency, or the physician of the woman's choice, finds that in view of the circumstances termination is urgently required, he/she shall immediately issue the woman a certificate attesting to the urgency of the case. Once she has been issued this certificate, the woman may report to one of the establishments authorised to perform pregnancy terminations. If a termination is not found to be urgently required, the physician at the counselling centre or the socio-medical agency, or the physician of the woman's choice, shall at the end of the consultation, if the woman requests that her pregnancy be terminated on account of circumstances referred to in Article 4, issue her a copy of a document signed by him/herself and the woman attesting that the woman is pregnant and that the request has been made, and shall request her to reflect for seven days. After seven days have elapsed, the woman may take the document issued to her under the terms of this paragraph and report to one of the authorised establishments in order for her pregnancy to be terminated."
Art. 7: "The pathological processes referred to in the preceding article shall be diagnosed and certified by a physician on the staff of the department of obstetrics and gynaecology of the hospital establishment in which the termination is to be performed. The physician may call upon the assistance of specialists. The physician shall be required to forward the documentation on the case as well as his/her certificate to the medical director of the hospital in order for the termination to be performed immediately. Where the termination of pregnancy is necessary in view of an imminent threat to the woman's life, it may be performed without observing the procedures referred to in the preceding paragraph and in a place other than those referred to in Article 8. In such cases, the physician shall be required to notify the provincial medical officer. When there is a possibility that the foetus may be viable, a termination of pregnancy may be carried out only in the case provided for in Article 6a) and the doctor performing the operation must take all appropriate measures to safeguard the life of the foetus ."

conscientious objection, which is declared in advance. Such a declaration shall be transmitted to the provincial medical officer and, in the case of staff employed by a hospital or nursing home, to the medical director, within one month of the entry into force of this law or the date of their qualification or commencement of employment within an establishment required to provide services aimed at the termination of pregnancies, or the date of conclusion of an agreement with insurance agencies entailing the provision of such services.

The objection may be withdrawn at any time, or may be notified outside the time-limits specified in the preceding paragraph, in which case the declaration shall take effect one month after it has been submitted to the provincial medical officer.

The hospitals and authorised nursing homes shall be required to guarantee in any event the completion of the procedures provided for in Article 7 and the implementation of terminations of pregnancy requested in accordance with Articles 5, 7 and 8.[8] The regions shall supervise and guarantee the implementation of this requirement, including through staff mobility measures.

Conscientious objection may not be invoked by medical and auxiliary staff when, given the specific circumstances, their personal intervention is indispensable to save the life of a woman in imminent danger.

A conscientious objection shall be deemed withdrawn, with immediate effect, if the person having raised it participates in the procedures or pregnancy termination operations provided for under this law apart from in the cases referred to in the previous paragraph."

[8] Art. 8: ""Pregnancy terminations shall be performed by a physician on the staff of the obstetrics and gynaecology department of a general hospital as referred to in Article 20 of Law No. 132 of 12 February 1968; this physician shall also verify that there are no medical contra-indications. Pregnancy terminations may likewise be carried out in the specialised public hospitals, institutes and establishments referred to in the penultimate paragraph of Article 1 of Law No. 132 of 12 February 1968, and the institutions referred to in Law No. 817 of 26 November 1973 and Presidential Decree No. 754 of 18 June 1958, whenever the competent administrative agencies so request. During the first 90 days, pregnancy terminations may also be performed in nursing homes authorised by the regions which have the requisite medical equipment and adequate obstetric and gynaecological services. The Minister of Health shall issue a decree restricting the capacity of authorised nursing homes to carry out terminations of pregnancy, by establishing: 1) the percentage of pregnancy terminations that may be performed relative to the total number of surgical operations carried out the preceding year at the particular nursing home; 2) the percentage of patient-days allowed for pregnancy-termination cases in relation to the total number of patient-days in the previous year under the conventions concluded with the regions. The percentages referred to in items 1 and 2 shall not be less than 20% and shall be the same for all nursing homes. Nursing homes may select the criterion which they will observe from the two set out above. During the first 90 days, pregnancy terminations may likewise be performed, following the establishment of local socio-medical units, at suitably equipped public outpatient clinics operating under the hospitals and licensed by the regions. The certificate issued in accordance with the third paragraph of Article 5 and, after seven days have elapsed, the document delivered to the woman under the fourth paragraph of the same article shall permit the woman to obtain a termination, on an emergency basis, and, where necessary, her admission to hospital."

3.3. The legal situation in Italy regarding conscientious objection in respect of voluntary terminations of pregnancy

Conscientious objection constitutes a way of exercising one's freedom of conscience, which can be defined as the freedom to act according to one's most inner convictions.

In particular, conscientious objection can be defined as the solution adopted by parliament for certain fields of law on account of the inner conflicts which may be experienced by certain persons in given situations. Indeed, on one hand there are the individual's own inner convictions and, on the other hand, there is the obligation to comply with the law, which may require that person to behave in a manner that departs from those personal convictions.

In this connection, before examining in detail the problems encountered with the application of Article 9 of Law No. 194, arising from the exercise of the right of conscientious objection by staff wishing to opt out of participating in pregnancy terminations, it is necessary to focus specifically on the concept of conscientious objection itself so as to understand how it is construed in Italian law.

It can be noted that the concept of conscientious objection is recognised, albeit indirectly, in Articles 2, 3, 19 and 21 of the Italian Constitution, which safeguard inalienable human rights, human dignity, freedom of religion and freedom of thought.[9]

This recognition is based on the interpretations given by the Italian Constitutional Court, which has considered that the above constitutional provisions provide a justification for certain types of conduct, such as conscientious objection, whereby an individual seeks to evade obligations imposed by law.[10] Concerning this last point, with particular reference to the risk that the possibility of raising a conscientious objection may extend to all fields of law, it can be noted that the legislation in Italy comprises a number of specific provisions

[9] Art. 19: "Everyone is entitled to freely profess their religious beliefs in any form, individually or with others, and to promote them and celebrate rites in public or in private, provided they are not offensive to public morality", Art. 21: "Everyone has the right to freely express their thoughts in speech, writing or any other means of communication. The press may not be subjected to any form of authorisation or censorship. Seizure may be permitted only by a judicial order stating reasons and only for offences expressly determined by legislation on the press or in case of a breach of the obligation to identify a person responsible for such offences. In such cases, where there is an absolute urgency and timely intervention by the judiciary is not possible, a periodical may be confiscated by the criminal police, which shall immediately and within not more than 24 hours refer the matter to the judiciary for validation. Failing such validation within the next 24 hours, the measure shall be revoked and considered null and void. The law may introduce general provisions for the disclosure of periodicals' sources of funds. Publications, performances, and all other exhibits which offend against public morality shall be prohibited. Measures to prevent and punish such violations shall be established by law".

[10] See the Constitutional Court's decisions Nos. 196 of 1987, 467 of 1991 and 43 of 1997, as published on the website *www.cortecostituzionale.it*.

establishing such an entitlement, which seek to strike a fine balance between the various rights which may be at stake.

Conscientious objection therefore takes the form of a subjective right in the specific legal fields where it is expressly provided for, such as military service, medically assisted reproduction and, as already mentioned, voluntary terminations of pregnancy.

In this connection, and with specific reference to the need to standardise such provisions, reference can be made to the Italian Constitutional Court's observations that the protection accorded to freedom of conscience "cannot be considered unlimited and unconditional. It is above all for parliament to strike a balance between the individual's conscience and the possibility to be accorded to that individual, on one hand, and the fundamental duties of political, economic and social solidarity, as imposed by the Constitution (Article 2), on the other hand, so as to safeguard public order and ensure that the resulting burdens are shared equally by all, without privileges" (judgment No. 43 of 1997).

As already mentioned, freedom of conscience can be guaranteed in so far as parliament succeeds in finding the right balance regarding the other rights and duties that may be at issue in this sensitive matter of terminations of pregnancy.

Article 9 of Law No. 194 of 1978 is of particular importance (even though, as we shall see below, its precept is being flouted), since it establishes a balance between the protection of medical practitioners' freedom of conscience and the protection of other constitutional rights conferred on women.

These rights are known to include the personal, inalienable rights to life, to health and to self-determination in the case of a pregnant woman who decides to undergo a termination.

Article 9 of Law No. 194 provides "Medical and auxiliary staff shall not be required to participate in the procedures referred to in Articles 5 and 7 or in operations aimed at terminating a pregnancy if they raise a conscientious objection, which is declared in advance."

This provision is intended to guarantee that doctors and health care staff can enjoy freedom of conscience. To this end, they are afforded the possibility, if they raise a conscientious objection, of abstaining from participating in the procedures and related activities aimed at terminating a pregnancy under the measures provided for by Law 194 of 1978.

However, despite this apparently unlimited recognition, the same provision stipulates "Conscientious objection may not be invoked by medical and auxiliary staff when, given the specific circumstances, their personal intervention is indispensable to save the life of a woman in imminent danger."

Accordingly, the legislation ensures that the possibility of raising a conscientious objection can never jeopardise a woman's right to life.

Article 9 also provides that, even where there is no imminent danger to life, "The hospitals and the authorised nursing homes shall be required to guarantee in any event the completion of the procedures provided for in Article 7 and the implementation of terminations of pregnancy requested in accordance with Articles 5, 7 and 8. The regions shall supervise and guarantee the implementation of this requirement, including through staff mobility measures."

It is clear from Article 9 that the legislators wished to strike a balance between the rights to life and to health of women wishing to obtain a termination of pregnancy and medical staff's freedom of conscience.

They sought to ensure that women were always guaranteed a possibility of access to a termination without having to suffer the negative consequences inherent in medical staff's freedom to raise a conscientious objection.

In this respect, Article 9 provides that a doctor whose personal intervention proves necessary to save a woman's life, in the event of imminent danger thereto, cannot raise a conscientious objection. In all other cases the presence of non-objecting medical staff is to be guaranteed, above all by the hospitals and the authorised nursing homes, and the regions are to superintend the activities carried out in this field, including through staff mobility measures.

This spectrum of means employed (namely, the organisational measures taken by the hospitals, the supervision of their activities exercised by the regions, and the regions' recourse to staff mobility) does not, however, in practice appear sufficient and therefore appropriate to achieve the objective which Law No. 194 seeks to fulfil, as will be shown below.

Lastly, mention must be made here of a point which will be expanded upon below. Women's right of access to pregnancy termination procedures can be exercised solely in hospitals where non-objecting doctors are present in sufficient number to deal with the demand for such terminations.

From this standpoint, it can be seen that there is a close link between the guarantees and the protection of women's legal situation and the guarantees and protection to be accorded to the legal situation of non-objecting medical staff.

Notwithstanding this legal framework, the complainant organisation therefore intends to raise a number of criticisms concerning the manner in which Article 9 of Law No. 194 is applied, making it necessary to specify in greater detail the tangible measures whereby it is possible to secure women's right of access to terminations of pregnancy (in respect of which a violation of Article 11 of the European Social Charter, read alone or in conjunction with Article E, is alleged) and the rights of those who, in the exercise of their medical and health-related activities, do not raise a conscientious objection (in respect of which a violation of Article 1 and Articles 2, 3 and 26 of the European Social Charter, the latter articles being read alone or in conjunction with Article E, is alleged).

3.4. Women's right to health

As already mentioned, Law No. 194 of 1978 establishes a balance between the requirements relating to women (primarily respect for their right to life and to health and the right to self-determination as regards their reproductive choices in matters of termination of pregnancy) and those relating to medical staff (their right to raise a conscientious objection in the manner and according to the time-limits laid down in Article 9 of Law No. 194), ensuring that neither set of rights is ever sacrificed, except in cases where there is an imminent danger to a woman's life (since in such cases, as indicated above, Article 9 precludes the possibility of exercising the right of conscientious objection).

Nonetheless, in practice, the high number of doctors who are objectors prevents the full implementation of the legislation, on account of the same legislation's deficiencies when it comes to determining tangible means of ensuring that there is a sufficient number of non-objecting doctors within each hospital.

As a result of the unsatisfactory implementation of the legislation, women's rights to life and to health and their right to self-determination, as expressly recognised in the Italian Constitution (Articles 2, 13 and 32), are irremediably sacrificed.

The conditions laid down in Law No. 194, governing access to a termination of pregnancy, also clarify the relationship that exists between the exercise of these constitutionally guaranteed rights and the voluntary termination of pregnancy.

As mentioned above, Law No. 194 permits women to have access to termination procedures during the first ninety days when the situation is such that "continuation of the pregnancy, childbirth or motherhood would seriously endanger their physical or mental health, in view of their state of health, their economic, social or family circumstances, the circumstances in which conception occurred or the probability that the child would be born with abnormalities or malformations" (Art. 4), whereas after three months a voluntary termination of pregnancy may be carried out "where the pregnancy or childbirth entails a serious threat to the woman's life" or "where pathological processes constituting a serious threat to a woman's physical or mental health, such as those associated with serious abnormalities or malformations of the foetus, have been diagnosed" (Art. 6).

It can be seen from these provisions that access to a termination of pregnancy may be necessary for a number of reasons closely related to the protection of a woman's health - physical and mental - and life.

Therefore, a situation where it is impossible to obtain a termination requested in accordance with these legal conditions constitutes a direct, absolute breach of women's fundamental rights.

Reference can be made here to the rulings already handed down by the Italian Constitutional Court with regard to voluntary terminations of pregnancy and assisted reproductive technology, so as to clarify the specific scope of women's right to life and health in these matters closely linked to questions of reproduction.

With its judgment No. 27 of 1975,[11] the Court dealt in particular with the question of the constitutionality of the provision of the Criminal Code which criminalised procurement of an abortion, including in cases where it had been established that the pregnancy would endanger the woman's physical and mental health.

In this judgment, while recognising the constitutional basis for protection of the unborn child (Article 31, second paragraph, and Article 2 of the Italian Constitution), the Court held that there can be no equivalence between the rights to life and to health of someone who is already a person, namely the mother, and the rights of someone yet to become a person, namely the embryo.

In matters of assisted reproductive technology, with judgment No. 151 of 2009[12] the Constitutional Court extended the protection of women's health beyond the limit of harm not foreseeable at the time of fertilisation, as established by Article 14 of Law No. 40 of

[11] See the website *www.cortecostituzionale.it*.

[12] See the website *www.cortecostituzionale.it*.

2004.[13] In weighing the legal situations of the woman and the embryo, where there is a risk of harm to the woman's health, it is the protection of the latter that is given precedence. The Court indeed makes it clear that the protection afforded to the embryo is not absolute.

In the light of these considerations, sacrificing a woman's right to health would seem even more unreasonable, regard being had to the acknowledged exceptional nature, as we have already seen, of one of the elements in balance, namely conscientious objection.

As underlined, however, Article 9 of Law No. 194 provides that conscientious objection must never endanger the life or health of the woman, thereby establishing a precise equilibrium between the legal situations of the parties concerned.

3.5. The rights of medical staff and of staff performing auxiliary activities

As already mentioned, with regard to voluntary terminations of pregnancy freedom of conscience can be guaranteed for the protection of individuals in so far as the legislators succeed in striking a fair balance in respect of other rights and obligations that may be at issue.

Article 9 of Law No. 194 of 1978 is of particular importance, since its aim is to grant medical staff and staff performing auxiliary activities the possibility of raising a conscientious objection concerning terminations of pregnancy. An instrument for the protection of practitioners' freedom of conscience has thus been established (Articles 2, 3, 19 and 21 of the Italian Constitution).

However, in the light of this article, consideration must be given to the position of those who, while belonging to the same professional category, decide not to raise a conscientious objection and accordingly agree to carry out termination procedures, thereby putting into effect Law No. 194 of 1978 and guaranteeing women access to terminations in accordance with the conditions laid down therein.

[13] The third paragraph of Article 14 of Law No. 40 provides "When the transfer of embryos to the uterus proves impossible on serious, documented grounds of force majeure, linked to the woman's state of health, which were not foreseeable at the time of fertilisation, the cryopreservation of the embryos shall be permitted up to the date of the transfer, which is to be implemented as soon as possible."

With judgment No. 151 of 2009 the Constitutional Court deemed the third paragraph of Article 14 to be unconstitutional "in so far as it does not provide that the transfer of embryos, which, as this provision states, must take place as soon as possible, shall be carried out without jeopardising the woman's health."

In particular, in view of the data gathered on the law's practical application, it is possible to identify the conditions under which these practitioners – referred to as "non-objectors" - are required to work and, hence, to raise the question of the protection of their rights, namely the right to work and the right to conditions permitting them to avail themselves of this right in practice, in addition to respect for the dignity of the workers themselves (Articles 1, 2, 3, 4, 35 and 36 of the Italian Constitution).

Article 9 of Law No. 194 provides "Medical and auxiliary staff shall not be required to participate in the procedures referred to in Articles 5 and 7 or in operations aimed at terminating a pregnancy if they raise a conscientious objection, which is declared in advance."

The aim of this provision is to afford medical and other health care staff a guarantee of freedom of conscience. To this end, they are indeed granted the possibility of raising a conscientious objection and thereby abstaining from participating in the procedures and related activities aimed at terminating a pregnancy under the conditions laid down in Law 194 of 1978.

The data on the legislation's application in practice, to which we shall return below, show that the number of those who choose to raise a conscientious objection is constantly growing.

This situation accordingly results in a heavier workload for those who decide not to do so.

The rights of the non-objectors are therefore impaired for the very reason that the number of objecting doctors is high compared with the unchanging workload involved in carrying out terminations.

From this standpoint, therefore, it is necessary to determine specific, tangible implementation measures intended to ensure that each hospital has a sufficient number of non-objecting doctors to prevent the impairment and the sacrifice of their legal rights.

Only in cases where there is an imminent danger to a woman's life does the law provide that a conscientious objection, even if notified in a timely manner, cannot be invoked against a woman seeking a termination, when the personal intervention of the objecting doctor proves necessary to save her very life.

Conversely, in all other cases, as already mentioned, the law stipulates in general terms that "The hospitals and the authorised nursing homes shall be required to guarantee in any event the completion of the procedures provided for in Article 7 and the implementation of terminations of pregnancy requested in accordance with Articles 5, 7 and 8. The regions

shall supervise and guarantee the implementation of this requirement, including through staff mobility measures."

As can be inferred from the wording of the law, three levels of control are established in order to secure women's access to terminations and, hence, the presence of non-objecting personnel: the activity of the hospitals, the supervision of their activity exercised by the regions, and the possibility for the regions also to resort to staff mobility measures.

As can be seen from the data on the law's application in practice, this spectrum of controls does not suffice to guarantee that there is a sufficient number of non-objecting doctors in each hospital.

It must also be noted that the objective of guaranteeing a sufficient presence of non-objecting medical and auxiliary staff, so as to avoid any risk of undermining their rights, is clearly and unavoidably linked to the objective – laid down in Law No. 194 itself – of guaranteeing women access to a termination of pregnancy.

In view of the high number of objecting doctors, the tangible implementation measures taken to guarantee the presence of a sufficient number of non-objecting doctors in each hospital, and the achievement of this objective, constitute not only an effective guarantee of access to the required treatment for women, but also a safeguard of the non-objectors' subjective legal rights.

Notwithstanding this legal framework, the complainant organisation therefore intends to raise a number of criticisms concerning the application of Article 9 of Law No. 194, which show the non-conformity of this article with the requirements of the European Social Charter (Article 1 and Articles 2, 3 and 26, the latter articles being read alone or in conjunction with Article E) and the need for greater precision regarding the tangible measures to be taken to guarantee the rights of staff belonging to the category of those who decide not to raise a conscientious objection regarding health care activities linked to terminations of pregnancy.

3.6. The failure to implement Article 9 of Law No. 194 of 1978.

Notwithstanding the provisions of Article 9 of Law No. 194, there is a problem linked to the ever-growing number of objecting doctors and the resulting violation of women's rights when a hospital is not in a position to guarantee them access to a termination of pregnancy on account of a shortage of non-objecting medical personnel.

The exponential growth in the number of doctors exercising the right to raise a conscientious objection impairs the exercise of women's right of access to a termination.

In parallel, the same normative situation negatively affects the rights of the medical and other health care staff who do not raise a conscientious objection.

This is because the law provides, as we have seen, for a spectrum of measures aimed at guaranteeing access to pregnancy termination procedures, but does not specify the tangible means whereby such measures are to be put in place.

Article 9 of Law No. 194 indeed confines itself to providing that the hospitals must in any event guarantee the requested service and that the regions shall superintend the organisational activity of the hospitals, including through staff mobility measures.

As a result of the exponential growth in the number of objecting doctors and of the deficiencies regarding the determination of tangible measures for the implementation of Article 9 of Law No. 194, this normative provision and its application in practice (as reflected in the data set out below) are incompatible with the European Social Charter, and doubts can also be raised as to their conformity with the principles of the Italian Constitution.

Mention must also be made of the fact that the unsatisfactory application of Article 9 (as a result of the same failure to determine tangible measures to guarantee the presence of non-objecting staff and of the growing number of doctors who are objectors) concerns a piece of legislation, Law No. 194 of 1978, to which the Italian Constitutional Court has attributed a specific status.

The Constitutional Court has in fact deemed this law to be of "constitutionally required substance" (judgments Nos. 26 of 1981 and 35 of 1997) and has therefore recognised that it is a law "whose core provisions cannot be amended or rendered ineffective without breaching the corresponding specific provisions of the Constitution itself (or other constitutional laws)" (judgment No. 16 of 1978).

Given these implementation difficulties, the solutions identified in practice have also proved insufficient and unsuitable to guarantee the implementation of Law No. 194 and hence to ensure the effective protection of the rights of women wishing to seek a termination of pregnancy.

In many cases the hospitals have called on external non-objecting staff. This solution, which indeed appears to guarantee the required service, namely a termination of

pregnancy, can be seen to have obvious limits linked to the failure to guarantee the continuity of care provision.

In other cases the hospitals have had recourse to agreements with authorised nursing homes. However, in such cases the conclusion of agreements with private establishments undermines the public sector foundations of Law No. 194. Here, rather than solving the problem of the shortage of staff, it is being circumvented

Another solution consists in including a clause in the notices of competitions to fill vacant posts of doctor in public hospitals which excludes objecting doctors from taking part. In this connection, attention must be drawn to the Italian administrative courts' case-law regarding such clauses, which are not unequivocally recognised as lawful.[14]

It can be seen from this legislative framework and from its application in practice that there is a need for greater precision regarding the practical measures whereby hospitals are to guarantee the presence of non-objecting personnel and the practical measures to be taken by the regions to supervise these activities and have recourse to staff mobility. For these reasons the complainant organisation alleges:

- with regard to the legal rights of women, that the situation is not in conformity with both the principles laid down in the Italian Constitution (in particular Articles 2 and 13, since there is a violation of women's right to life and to self-determination; 3, since there is a violation of the principle of equality and of the reasonableness of the legislation itself; and 32, safeguarding women's right to health) and the principles of Article 11 of the European Social Charter, read alone or in conjunction with Article E;

- with regard to the legal rights of non-objecting medical and auxiliary staff, that the situation is not in conformity with both the principles laid down in the Italian Constitution (in particular Articles 1, 2, 3, 4, 35 and 36), and with the principles of Article 1 and Articles 2, 3 and 26 of the European Social Charter, the latter articles being read alone or in conjunction with Article E.

[14] See for example, concerning the illegality of such clauses, the decision handed down by the Regional Administrative Court (TAR) of Liguria on 3 July 1980, No. 396, whereby every special requirement for admission to public employment which has the effect of limiting access must have its basis in a law, which may lay down restrictions or exclusions in respect of certain categories of persons, on condition that they are linked to the competencies required or to other objective requirements and, in any case, do not institute entirely arbitrary, unjustified differences in treatment.

Conversely, the Regional Administrative Court of Emilia Romagna ruled on 13 December 1982, in judgment No. 289, that a person recruited on a provisional basis by a hospital through a vacancy notice containing a clause whereby the post could be awarded solely to persons who had not raised a conscientious objection could be lawfully dismissed in the event that he or she subsequently decided to become a conscientious objector.

Furthermore, the principles laid down in Articles 21 and 22 of the European Social Charter, which recognise and guarantee the right to information and consultation and to take part in the determination and improvement of working conditions and the working environment, are deemed relevant to the subject matter of this complaint.

3.7. Data on the number of objecting doctors in Italy

In view of the above considerations, it is necessary to supply statistical data to substantiate the alleged inadequacy of the number of non-objecting medical staff in public hospitals, and hence the problems with the application of Article 9 of Law No. 194 of 1978.

Each year the ministry of health submits a report on the state of implementation of Law No. 194 to Parliament.[15]

The latest report, submitted in August 2011, contains the following data on the different professional categories (Appendix 6).

In 2009 the number of conscientious objectors among the gynaecologists and the anaesthetists stabilised, after having increased significantly in recent years.

At national level, for gynaecologists the percentage of objectors increased from 58.7% in 2005, to 69.2% in 2006, 70.5% in 2007, 71.5% in 2008 and 70.7% in 2009;

For anaesthetists the percentage rose from 45.7% to 51.7% over the same period;

For non-medical staff there was also an increase, from 38.6% in 2005 to 44.4% in 2009.

In southern Italy the percentages exceed 80% among the gynaecologists: 85.2% in Basilicata, 83.9% in Campania, 82.8% in Molise, 81.7% in Sicily and 81.3% in Bolzano;

For anaesthetists the highest percentages can be noted in Molise and Campania, with more than 77%, and in Sicily with 75.6%, and the lowest in Tuscany with 27.7% and Trento with 31.8%;

For non-medical staff the percentages are lower, but with a peak of 87% in Sicily and 82% in Molise.

[15] The health minister's reports can be found on the website *www.salute.gov.it*.

If these statistics are compared with the data supplied in the Ministry of Health's reports for previous years (Appendix 7), it can be noted that there has been a significant increase in the percentage of objectors in all three professional categories:

	GYNAECOLOGISTS	ANAESTHETISTS	NON-MEDICAL STAFF
Ministerial report of 2011 (2009 data)	**70.7%**	**51.7%**	**44.4%**
Ministerial report of 2010 (2008 data)	71.5%	52.6%	43.3%
Ministerial report of 2009 (2007 data)	70.5%	52.3%	40.9%
Ministerial report of 2008 (2006 data)	69.2%	50.4%	42.6%
Ministerial report of 2007 (2005 data)	58.7%	45.7%	38.6%
Ministerial report of 2006 (2004 data)	59.5%	46.3%	39.1%
Ministerial report of 2005 (2003 data)	**57.8%**	**45.7%**	**38.1%**

The reports also indicate the percentages for the three categories (gynaecologists, anaesthetists and non-medical staff) in northern, central and southern Italy and the islands (see: *http://espresso.repubblica.it/dettaglio/Camici-obiettori/2131653* for the data of the 2010 ministerial report) (Appendix 8):

	Northern Italy	Central Italy	Southern Italy	Islands
GYNAECOLOGISTS	67%	71.1%	80.5%	74.3%
ANAESTHETISTS	44.3%	54.2%	68.3%	68.3%
NON-MEDICAL STAFF	32.2%	40%	55%	67%

The tables showing the data for these three categories – gynaecologists, anaesthetists and non-medical staff – by region are also appended hereto (Appendices 9 and 10).

We also enclose a question raised by certain members of the Lombardy regional council on this issue of conscientious objections and the state of implementation of Law No. 194 of 1978. This document shows in particular that there are growing obstacles to the full implementation of the legislation in this region on account of a significant increase in the number of objecting medical and non-medical staff, which in some areas exceeds 85% (Appendix 11, with the data relating to conscientious objectors in Appendix 12).

We also provide other data, supplied by the CGIL itself.

Mention can be made above all of the situation in the hospitals at Jesi and Fano in the Marche region, where all the gynaecologists are conscientious objectors. Apart from leading to inadequate implementation of Law No. 194, as regards the guarantee of the service requested, this situation "penalises the non-objecting doctors, anaesthetists and nurses who have to bear the full workload of terminations of pregnancy" (Appendix 13).

In the province of Palermo, the data are as follows by hospital (Appendix 14):

HOSPITAL	OBJECTING GYNAECOLOGISTS
Villa Sofia Cervello	**All are objectors**, apart from two
Ingrassia	**All are objectors**, apart from one coming from Partinico
Buccheri La Ferla	**All are objectors**
Civico	**All are objectors,** apart from two
Policlinico	**All are objectors**, apart from one
Termini Imerese	**All are objectors**, apart from one coming from Petralia
Petralia	**All are objectors**, apart from one
Partinico	**All are objectors**, apart from one

These data show the insufficient number of non-objecting doctors even where staff mobility has been utilised, as in the case of the Ingrassia and Termini Imerese hospitals.

The CGIL has supplied further significant data relating to the Abruzzo region (Appendix 15):

ASL[16] Pescara	Out of three hospitals, terminations of pregnancy are carried out only in the Pescara hospital and by a single gynaecologist
ASL Chieti	Out of five hospitals, terminations of pregnancy are carried out solely in the Ortona, Vasto and Lanciano hospitals. In Vasto the gynaecologist comes from another establishment
ASL Teramo	Out of four hospitals, terminations of pregnancy are carried out solely in the S. Omero and Teramo hospitals
ASL L'AQUILA	All three hospitals carry out terminations of pregnancy, but with just one gynaecologist per establishment

[16] ASL = Azienda Sanitaria Locale – local health authority

With reference to the city of Messina, the data show that there are no non-objecting staff at all in many hospitals (Appendix 16):

	Number of doctors carrying out voluntary terminations of pregnancy
Messina	4
Papardo Piemonte	2
Milazzo	2
Barcellona	None
Patti	None
S. Agata	2
Taormina	2
Lipari	None
Mistretta	None

The CGIL has gathered statistics for the Puglia region (Appendix 17, showing all the data relating to doctors, anaesthetists, nurses and obstetricians for each hospital), from which the overall data below have been drawn:

Anaesthetists **Total**	Anaesthetists **Objectors**	Doctors **Total**	Doctors **Objectors**	Nurses **Total**	Nurses **Objectors**	Obstetricians **Total**	Obstetricians **Objectors**
460	**303**	444	**371**	848	**664**	498	**421**

Here too, the data show the disproportion existing between the total number of doctors and auxiliary staff and the number of those who have raised a conscientious objection.

3.8. Articles of the European Social Charter alleged to have been violated with regard to the legal situation of women

In view of the above, we can proceed to highlight the principal guarantees of the European Social Charter that are alleged to have been violated in the light of the considerations already set out in respect of Article 9 of Law No. 194 and of the practical application of the provisions of that article.

We shall therefore analyse Articles 11 and E of the European Social Charter, and above all their interpretation by the European Committee of Social Rights, with a view to bringing to the fore the inconsistencies between the Charter provisions and the provisions of Italian law with regard to voluntary terminations of pregnancy, in particular Article 9.

It is in fact this article, which is not sufficiently precise with regard to the means whereby the hospitals and the regions are to guarantee the presence of a sufficient number of non-objecting medical staff in each establishment, while respecting the right to freedom of conscience, that can be seen to violate the European Social Charter.

3.8.1. Article 11 of the European Social Charter (the right to protection of health)

With reference to this article, it must be noted that the European Social Charter aims to guarantee the effective exercise of the right to health, requiring the member States to adopt all the necessary and appropriate measures.

This requirement is justified on the ground that the right to health is perceived as a prerequisite for upholding respect for human dignity.

The recognition given to the fundamental right to health is further reinforced by the reference made to the European Convention on Human Rights (Articles 2 and 3, on the right to life and the prohibition of torture) (page 81, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008). In particular, it can be noted that the two international treaties are inextricably linked, since both impose a positive obligation on the member States to guarantee the exercise of the right to health.[17]

[17] With reference to the European Convention on Human Rights, reference can be made to the decision handed down by the European Court of Human Rights in the case of *R. R. v. Poland* (application number 27617/04). The Court held that "States are obliged to organise the health services system in such a way as to ensure that an

In the light of the above, the States undertake to eliminate obstacles to the full enjoyment of the right to health. In this respect, the European Social Charter requires that, as far as possible, the highest possible standard of health care services must be secured, thereby guaranteeing the right to health, construed in the physical and the mental sense.

The extent of the undertaking required of States to this end is determined based on scientific knowledge and therefore also on the basis of the health risks which can effectively be contained through such knowledge.

With reference to the Italian legislation in matters of voluntary termination of pregnancy, particular importance should be attached to the requirement that access to medical care must be universally guaranteed. In this connection, as has been mentioned, even with a specific law on the subject (law No. 194 of 1978) guaranteeing women access to pregnancy termination procedures, because of the high number of objecting doctors there is no effective guarantee of actual access to such health care procedures, which are necessary for the protection of life and health, and of women's right to self-determination.

Another important consideration is that the right of access to medical care entails that the corresponding waiting times must not be such as to jeopardise the person's health itself and that there must be sufficient numbers of medical and other health care staff (page 83, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

This consideration is of particular importance in the sphere of voluntary terminations of pregnancy, since Law No. 194 of 1978 establishes specific time-limits during which such procedures can be carried out and beyond which they are consequently no longer authorised. From this standpoint, it is all the more necessary that there should be a sufficient number of non-objecting doctors to perform the requested termination procedures.

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effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation".

In the same decision the Court also ruled "While a broad margin of appreciation is accorded to the State as regards the circumstances in which an abortion will be permitted in a State, once that decision is taken the legal framework devised for this purpose should be 'shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention' (*A, B and C v. Ireland* …)."

This decision can be consulted on the website *www.echr.coe.int*.

With reference to pregnancy termination procedures, it can be recalled that, in the States which authorise access thereto, women's right to respect for their decision to end a pregnancy is to be recognised under the conditions laid down by the law itself, without any unreasonable restriction being imposed (in this matter see S. BARTOLE – P. DE SENA – V. ZAGREBELSKY, *Commentario breve alla Convenzione Europea dei Diritti dell'Uomo*, Cedam, Padua, 2012, page 325).

Article 11 of the European Social Charter also requires the States to provide for counselling and services aimed at raising awareness of health issues and of the related individual responsibilities. In this connection, special importance must be attached to the attention to be paid to the state of health of pregnant women, for whom free and regular check-ups must be made available.

3.8.2. Article E of the European Social Charter (non-discrimination)

Article E of the European Social Charter is of importance here, since it accompanies the implementation of all the other provisions of the Charter, with a particular focus on the enjoyment of the rights it recognises and guarantees.

It can first be observed that the principle of non-discrimination is universally recognised, including under Article 3 of the Italian Constitution,[18] and requires that legal provisions should be examined according to the principles of equal treatment and reasonableness.

With reference to Article E, mention must also be made of the corresponding provision of the European Convention on Human Rights (Article 14, *Prohibition of discrimination*). Precisely because it is the expression of an internationally recognised principle, the related assessment taking place before the European Court of Human Rights does not differ "significantly from the procedures followed by national courts, in particular the Italian Constitutional Court" (S. BARTOLE – B. CONFORTI – G. RAIMONDI, *Commentario alla Convenzione Europea per la tutela dei diritti dell'uomo e delle libertà fondamentali*, Cedam, Padua, 2001, page 416).

Article E of the European Social Charter requires that people in the same situation must be treated in the same way and those in different situations must be treated differently (see page 176 of the *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

In this respect, the European Committee of Social Rights has ruled that States violate Article E in cases where, "without an objective and reasonable justification" (*ibidem*), they fail to treat differently people whose situations are not the same.

[18] Article 3 of the Italian Constitution reads "All citizens enjoy equal social dignity and are equal before the law, without distinction as to sex, race, language, religion, political opinion, and personal or social conditions. It shall be the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country."

In particular, it has underlined that human differences should not only be viewed positively in a democratic society, but should also be responded to in such a way as to ensure genuine and effective equality.

It therefore follows that Article E is violated not only in cases of direct discrimination, but also by any form of indirect discrimination.

From this viewpoint, indirect discrimination can arise when no account is taken of all relevant differences or when there is a failure to take adequate steps to ensure everyone's effective enjoyment of their rights.

With reference to Article 9 of Law No. 194 and to the implementation difficulties described above, the following observations can be made regarding the violation of the principle of non-discrimination, as guaranteed by Article E of the European Social Charter.

First, attention must be drawn to the geographical and economic discrimination, devoid of any objective or reasonable justification, that exists between women wishing to seek a termination of pregnancy.

This discrimination has its origin in the fact that, since the presence of non-objecting medical staff is not guaranteed in all public hospitals, women are obliged to travel from one hospital to another so as to find an establishment that can guarantee access to the termination procedure.

This need to travel accordingly results in differentiated treatment (a form of geographical discrimination) of individuals in the same situation, namely those seeking to exercise the right of access to a termination of pregnancy in accordance with the conditions and arrangements laid down by law No. 194 of 1978. As already mentioned, this situation also undermines the very possibility of exercising this right in cases where the time spent searching for a hospital capable of providing the required service extends beyond the time-limits established by Law No. 194, within which the procedure itself is authorised.

The shortage of non-objecting medical staff, which obliges women to seek alternative solutions, and hence to look around for a hospital which carries out the required procedure, also results in a form of economic discrimination between women.

Wealthier women are led to resort to private clinics in Italy or to public hospitals or private clinics abroad, since they are able to bear the costs associated with such a decision. Conversely, it can easily be imagined that women who are not in a position to incur such an expense – above all the "categories" of women who are less well off – are forced to

turn to establishments and individuals, or even to other countries, that do not guarantee the full protection required by the termination procedure in terms of health and hygiene.

Secondly, it can be noted that Article E specifically provides that health cannot be assumed to constitute a ground of discrimination, alongside race, skin colour, gender, language, religion, political or other opinion, national extraction or social origin, membership of a national minority, birth or other status.

A person's state of health accordingly cannot qualify as a ground justifying discriminatory treatment, or for differentiating the requirements which apply to some people but not to others.

In matters of voluntary termination of pregnancy, given the problems encountered in applying Article 9 of Law No. 194, there is a kind of discrimination between women wishing to obtain a termination and women who do not intend to do so, whether they are pregnant or not.

The state of health, both physical and mental, of women seeking an abortion becomes a ground (to be included on the list of grounds which cannot constitute a ground of discrimination, as established by Article E) for discriminating against them and thus exposing them to a risk of being treated less favourably regarding the protection and the guarantee of their right of access to a termination procedure, and hence the protection and the guarantee of their rights to life, health and self-determination. The principle of non-discrimination safeguarded by Article E must indeed always be linked to one or more provisions of the European Social Charter: in the instant case Article 11, protecting the right to health.

Accordingly, in the case of the legislation on terminations of pregnancy, it is chiefly a direct violation of the right to health that is recognised, as guaranteed by Article 11 of the European Social Charter.

This legislation is also considered to violate the principle of equal treatment and non-discrimination (Article 11 being read here in conjunction with Article E), since women are unreasonably discriminated against with regard to their decision to terminate a pregnancy, both from the standpoint of their choice of hospital establishment and from an economic standpoint.

The Italian legislation would also seem to infringe these Charter provisions in so far as its own provisions can be seen to be lacking in consistency. On one hand, Law No. 194 provides for and guarantees women's access to hospitals with a view to obtaining a

termination of pregnancy (and thereby guarantees their right to life, to health and to self-determination), while on the other hand it fails to establish the instruments and means necessary to attain this objective, as can clearly be seen from its application in practice.

3.9. Articles of the European Social Charter alleged to have been violated with regard to the legal situation of non-objecting medical and auxiliary staff

With specific reference to the legal situation of non-objecting medical and auxiliary staff, we will continue by highlighting the principles guaranteed by the European Social Charter which are alleged to have been violated by the provisions of Article 9 of Law No. 194, as already mentioned, and by the manner in which this legislation is applied in practice.

We therefore intend to analyse Articles 1, 2, 3 and 26 of the Charter, and above all their interpretation by the European Committee of Social Rights, so as to bring to the fore the inconsistencies between the requirements of the European Social Charter and the provisions of Italian law relating to voluntary terminations of pregnancy, in particular Article 9, which can be seen to breach the European Social Charter in that it fails to lay down with sufficient precision the means whereby the hospitals and the regions are to guarantee, while respecting the right to freedom of conscience, the presence of a sufficient number of non-objecting medical staff in each establishment.

3.9.1. Article 1 of the European Social Charter (the right to work)

With regard to the situation of non-objecting medical and auxiliary staff, particular relevance must be attached to Article 1 of the European Social Charter, which, with a view to guaranteeing the effective exercise of the right to work, requires States to guarantee workers a real possibility of choosing their own employment and hence of pursuing freely undertaken work activities.

Italy's violation of this article is evident not only from its very wording, but also from the manner in which it has been interpreted by the European Committee of Social Rights.

In particular, it has been clarified (page 20 of the *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008) that the substance of Article 1 covers:

- the prohibition of any kind of discrimination in the workplace;

- the prohibition of forced or compulsory labour;

- the prohibition of any practice that might interfere with or undermine workers' rights freely to choose their occupation.

With regard to the first prohibition established by the European Committee of Social Rights, attention must be drawn to the discrimination that exists between the two categories of doctors – the conscientious objectors and the non-objectors – in terms of their workload and the protection of their physical and mental health.

Although the Committee itself has ruled that any discrimination based on grounds of gender, race, ethnic origin, religion, disability, age, sexual orientation or political opinion is prohibited (hence creating a link with Articles 15 and 20 of the Charter, concerning the right to work of persons with disabilities and equality of opportunity and non-discrimination in the workplace on grounds of gender), it can be noted that this list is not rigidly established and can therefore extend to discrimination ensuing from and having its very basis in workers' choice to avail themselves of the possibility of raising a conscientious objection.

In this connection, reference can also be made to the European Committee of Social Rights' rulings on Article E (*non-discrimination*). While in a way being openly worded ("*other status*"), so that the list of grounds on which discrimination is not permitted can be considered as non-exhaustive, the provision always goes hand in hand with the application of other articles of the European Social Charter, thereby supplementing the protection afforded to the rights recognised and safeguarded therein (page 175 of the *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

With specific reference to the type of discrimination, and in keeping with its rulings concerning the scope of Article E, the European Committee of Social Rights has clarified that the prohibition extends to both direct and indirect discrimination.

As can be seen from the data on the practical application of law No. 194 of 1978, the difficulties in implementing Article 9 thereof result in a difference in treatment between two categories of persons in comparable situations, for which there is no objective, reasonable justification and which is moreover not proportionate to the aim which the law in question seeks to achieve.

The Committee has also given a precise definition of discrimination, which it regards as a difference in treatment between persons in comparable situations where it does not pursue a legitimate aim, is not based on objective and reasonable grounds and where there is no proportion between the predetermined objectives and the means put in place

to achieve them (page 21, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

With specific reference to the subject matter of this complaint, and constantly bearing in mind the Committee's interpretation of Article 1, it can be noted that the discrimination against non-objecting medical staff is of an indirect nature, since the provision states explicitly that all doctors have a right to raise a conscientious objection. The discrimination in fact occurs once the decision whether to exercise this right has been made.

Furthermore, discrimination may also exist in the event of a failure to take measures such as to guarantee the effective exercise of rights guaranteed to all ("Discrimination may also result […] by failing to take adequate steps to ensure that the rights and collective advantages that are open to all are genuinely accessible by and to all", page 21, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

With regard to the second prohibition, that of forced or compulsory labour, attention should be drawn to the fact that the hospitals are required to distribute the overall workload relating to voluntary terminations of pregnancy among an insufficient number of non-objecting doctors. In view of the very high number of doctors who are objectors, those who choose not to raise a conscientious objection are obliged endlessly to carry out a single type of operation, that of terminating pregnancies.

It should be noted that the European Committee of Social Rights has interpreted the scope of the anti-discrimination provision with specific reference to the production of goods or services, prison work and conditions for the payment of unemployment benefits (page 23, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

However, although that is the scope to be given to the provision, another interpretation can also be proposed which, in keeping with the interpretative line taken by the Committee, also encompasses the issues at stake with regard to the subject matter of this complaint.

It can thus be noted that the overall workload which the non-objecting medical staff are required to assume, on account of the high and growing number of doctors who are conscientious objectors, leads to conditions which force them to carry out a specific type of procedure – terminations of pregnancy – without discontinuing, as can be seen from the data on the law's practical implementation.

From this standpoint, disregarding the fact that those who do not raise a conscientious objection have made this choice, it can be seen that the non-objecting medical staff are

nonetheless forced to carry out a single procedure for the bulk of their working time and even their entire working time.

What is more, a termination of pregnancy can in no way be compared to other health care procedures, on account of its particularly delicate nature, and not just from a technical standpoint.

Non-objecting medical staff who find themselves obliged exclusively or principally to carry out such procedures moreover cannot perform other kinds of procedure, which prevents them from utilising the skills they have acquired – either during their studies or during their practical work experience – with a view to carrying on the occupation they have chosen.

Further considerations can be advanced on this aspect with regard to the third prohibition contained in the above-mentioned provision, namely the ban on interfering with or undermining workers' rights freely to choose their occupation.

Here too, the European Committee of Social Rights has interpreted the article in question, making reference, as concerns its scope, to the alternative form of service proposed to those who raise a conscientious objection with regard to military service, to part-time work and to private life at work.

With particular regard to the latter aspect, the European Committee of Social Rights has indicated that individuals must be protected from interference in their private or personal lives associated with or arising from their employment situation (page 24, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

As regards the subject matter of this complaint, it can be noted that the article affords workers protection concerning their choice of occupation and, hence, also their subsequent exercise thereof.

As can be seen from the data, the difficulties in implementing Article 9 of Law No. 194 make it impossible for medical and auxiliary staff who are not objectors to carry out procedures other than terminations of pregnancy, on account of the workload they have to bear due to the high number of doctors who are conscientious objectors.

It must be said that, as regards the performance of other medical and health care procedures, the non-objecting doctors have undergone exactly the same preparation during their studies and their work experience, and this makes the discrimination between the two categories – objectors and non-objectors – even more unreasonable.

3.9.2. Article 2 of the European Social Charter (the right to just conditions of work)

With this article the European Social Charter aims to guarantee just conditions of work through the setting of a number of objectives, corresponding to obligations incumbent on States.

The provision requiring the determination of reasonable daily and weekly working hours, so as to ensure just conditions of work is of particular relevance to the subject matter of this complaint.

Although the European Social Charter gives no precise indication of what is meant by "reasonable hours", the European Committee of Social Rights has interpreted this expression, adapting its interpretation to the different tangible situations submitted to its assessment (page 27, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

In the instant case, account must be taken of the observations made with regard to the workload in respect of terminations of pregnancy, which has to be borne entirely by those who decide not to raise a conscientious objection, and the fact that the number of non-objectors is proving completely insufficient to cope with it. Apart from having an impact on women's right of access to termination procedures, this situation also affects the hospitals' organisational arrangements and hence the work organisation and the distribution of the workload among the medical and auxiliary staff.

Given the insufficient number of doctors who do not raise a conscientious objection, the distribution of the workload is likely to lead to the determination of daily and weekly working hours which are entirely unreasonable, regard being had to the requirement that access to the required health care service must be guaranteed "in any event", as laid down by Article 9 of Law No. 194.[19]

[19] In this connection it can be noted that, on 26 April 2012, the European Commission served formal notice on Italy concerning its exclusion of doctors working in public health services from the scope of Directive 2003/88/EC – the Working Time Directive (Appendix 18). In particular, legislative decree No. 112 of 2008 (Appendix 19) provides that managerial staff working within undertakings and organisations belonging to the national health service shall be excluded from the scope of Articles 4 and 6 of legislative decree No. 66 of 2003 on working time and daily rest periods (Appendix 20) (the CGIL's observations are also enclosed in Appendix 21).

3.9.3. Article 3 of the Social Charter (the right to safe and healthy working conditions)

This article aims to guarantee workers effective safe and healthy conditions in the workplace and, to that end, sets a number of objectives to be achieved by States.

In particular, States are required to undertake to adopt a coherent national policy on health and safety of workers and the working environment. The aim of this policy shall be to reduce the risks to workers' health that may arise in connection with their own work activities. Provision is also made for the adoption of health and safety regulations, measures to supervise compliance therewith and prevention and consultation mechanisms.

On account of the clear wording of this article and the manner in which it has been interpreted by the European Committee of Social Rights it cannot be inferred that the Charter intends to safeguard workers from work accidents - and the resulting harm to their health – purely and solely as regards the physical dimension of health.

The right to safe and healthy working conditions (Article 3 of the Charter), and accordingly the right of workers not to have their health jeopardised, also encompasses the psychological dimension of health, which, if impaired, can also undermine the worker's physical integrity.

It is also useful to refer to the observations made by the European Committee of Social Rights, which, with regard to paragraph 3 of Article 3, has indicated that the frequency of the injuries sustained by workers can be determined by calculating the ratio between the number of accidents and the number of workers. The situation is deemed incompatible with the Charter where "for several years, this frequency is clearly too high for it to be maintained that the right to health and safety at work is being effectively secured" (page 39, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

With reference to the subject matter of this complaint, it is therefore necessary to consider whether the "injuries" and "accidents" can be attributed to the difficulties and the poor working conditions with which those who decide not to raise a conscientious objection have to contend, since they alone have to bear the entire workload relating to terminations of pregnancy.

These poor working conditions, due to the insufficient number of non-objectors and the related need endlessly to carry out the same procedure, namely terminations of pregnancy, are likely to have a negative impact on the health, both physical and mental, of the medical and auxiliary staff concerned.

The data on the number of objecting doctors make it possible to establish the frequency with which such situations arise and, consequently, to gauge the extent of the impairment of the right to health, both physical and mental, of the workers who decide not to raise a conscientious objection.

Again, as regards the need to ensure the application of the European Social Charter, reference can be made to the observations of the European Committee of Social Rights, which has deemed that the mere operation of legislation, seeking to resolve certain situations, is not enough. It is in fact necessary to provide for effective mechanisms to apply the regulations and for means of monitoring compliance therewith (page 39, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

With specific reference to Article 9 of Law No. 194 of 1978, it can be noted that there is a need for greater precision regarding the tangible measures to be taken to guarantee non-objecting doctors' right to health and safety at work, a right which is in fact impaired due to the high number of doctors who are objectors.

In this context, the small group of non-objecting doctors is required to cope with the entire workload (relating to terminations of pregnancy), thereby jeopardising their own health, whether mental – above all because they are aware that they belong to a group of medical staff who deal on their own and exclusively with certain procedures which, given their nature, unquestionably cannot be assimilated to other health care procedures – and physical – on account of the fact that the workload can have negative consequences for the physical integrity of these workers, who are called upon to take charge of the overall number of termination requests.

3.9.4. Article 26 of the European Social Charter (the right to dignity at work)

Article 26 of the European Social Charter enshrines the right to respect for one's dignity in the workplace. To this end States are required to adopt information, protection and prevention measures in respect of forms of conduct which impair workers' dignity in the workplace or for work related reasons.

This provision is of particular importance with regard to the issue raised by this complaint.

The growing number of doctors who decide to raise a conscientious objection and the resulting workload, which falls entirely on the insufficient number of doctors who, conversely, choose not to raise a conscientious objection, engender poor working conditions, as we have seen, which impair the rights of the latter category of doctors.

In particular the high and constantly increasing number of objecting doctors and the workload with which doctors who do not raise an objection have to contend result in a situation where the latter doctors are called upon to carry out interruptions of pregnancy on a continuous basis.

Indeed, the hospitals' organisational arrangements have to take account of the choice made by medical and auxiliary staff whether or not to raise a conscientious objection in respect of pregnancy termination procedures.

Since the number of objecting doctors is high and constantly growing, as shown by the data on the law's application in practice, the entire workload ensuing from the demand for pregnancy terminations falls on those who have not raised a conscientious objection (except in cases where, as already mentioned, there is an imminent danger for the woman's life, making the personal intervention of an objecting doctor indispensable).

Non-objecting doctors will therefore be called upon to deal with all the requests for voluntary terminations of pregnancy and, hence, to carry out on a continuous basis this specific type of procedure, which, setting aside the decision whether or not to object, remains a particularly delicate procedure, and not just from a technical standpoint.

This results in the isolation of what has become a genuine "category" of doctors, the non-objectors, whose dignity as health care professionals is undermined or completely sacrificed, since they are required mainly or exclusively to perform certain health care procedures, and not even those for which they have the skills and training.

3.9.5. Article E of the European Social Charter (non-discrimination)

Article E of the European Social Charter is of importance since it accompanies the implementation of all the other provisions of the Charter, with a particular focus on the enjoyment of the rights it recognises and guarantees.

With regard to the subject matter of this collective complaint, and in particular the legal situation of the medical and auxiliary staff, Article E applies in conjunction with Articles 2, 3 and 26 of the European Social Charter. As already mentioned in paragraph 3.9.1. of this complaint, Article 1 of the Charter, as interpreted by the European Committee of Social Rights, already establishes a prohibition on all forms of discrimination, with specific reference to discrimination in employment (page 20, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

It can first be observed that the principle of non-discrimination is universally recognised, including under Article 3 of the Italian Constitution, and requires that legal provisions should be examined in the light of the principles of equal treatment and reasonableness.

With reference to Article E, mention must also be made of the corresponding provision of the European Convention on Human Rights (Article 14, *Prohibition of discrimination*). Precisely because it is the expression of an internationally recognised principle, the related assessment taking place before the European Court of Human Rights does not differ "significantly from the procedures followed by national courts, in particular the Italian Constitutional Court" (S. BARTOLE – B. CONFORTI – G. RAIMONDI, *Commentario alla Convenzione Europea per la tutela dei diritti dell'uomo e delle libertà fondamentali*, Cedam, Padua, 2001, page 416).

Article E of the European Social Charter requires that people in the same situation must be treated in the same way and those in different situations must be treated differently (see page 176 of the *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008).

In this respect, the European Committee of Social Rights has ruled that States violate Article E in cases where, "without an objective and reasonable justification" (*ibidem*), they fail to treat differently people whose situations are not the same.

In particular, it has underlined that human differences should not only be viewed positively in a democratic society, but should also be responded to in such a way as to ensure genuine and effective equality.

It therefore follows that Article E is violated not only in cases of direct discrimination, but also by any form of indirect discrimination. From this viewpoint, indirect discrimination can arise when no account is taken of all relevant differences or when there is a failure to take adequate steps to ensure everyone's effective enjoyment of their rights.

With reference to Article 9 of Law No. 194 and to the implementation difficulties described in respect of the legal situation of doctors who choose not to raise a conscientious objection, the following observations can be made regarding the violation of the principle of non-discrimination, as guaranteed by Article E of the European Social Charter.

Attention must be drawn, in particular, to the discrimination between categories of medical and auxiliary staff, since two categories of staff who have decided to engage in the same career are without reason treated differently according to whether they have decided to raise a conscientious objection or not.

The decision not to raise a conscientious objection in fact leads to poor and unfavourable working conditions for those who make it, without it being possible to identify any objective and reasonable basis for such discrimination.

The unreasonableness of this discrimination is even more evident if one takes into account the fact that those who decide not to raise a conscientious objection are merely putting into effect (in an insufficient, incomplete way on account of their numerical insufficiency) an Italian legal instrument (law No. 194 of 1978).

The failure to identify an "*objective and reasonable justification*" makes this differentiated treatment of persons who, on account of their occupational activity, belong to the same category, discriminatory in nature. As a consequence, the deficiencies in the precisions given by Article 9 of law No. 194, as described above, which result in this difference in treatment, can be seen to be incompatible with the European Social Charter.

3.10. Articles of the European Social Charter assumed to be relevant to the subject matter of this collective complaint

As already mentioned, in relation to the subject matter of this complaint, the European Committee of Social Rights is requested to assess, in the light of the observations set out below, the relevance of Articles 21 and 22 of the European Social Charter and of the

principles that can be derived therefrom, although the scope of these provisions does not include the public hospital establishments required to apply Law No. 194 of 1978.

3.10.1. Article 21 of the European Social Charter (the right to information and consultation)

Article 21 of the European Social Charter enshrines workers' right to information and consultation within the workplace.

To give effect to this right, the States undertake to implement measures permitting workers (or their representatives) to be kept up to date about the economic and financial situation of the undertaking (sub-paragraph a)

For the purpose of this complaint, attention can be drawn to the provisions of sub-paragraph b), requiring States to ensure that workers are consulted in good time on the undertaking's decisions which could affect their interests.

The article refers to the "undertaking" and specifies that, for the purpose of applying both Article 21 and Article 22, this term shall be construed as referring to the set of "tangible and intangible components, with or without legal personality, formed to produce goods or provide services for financial gain and with power to determine its own market policy" (*Appendix to the Revised European Social Charter*, Articles 21 and 22).

Although the European Social Charter uses the term "undertaking" to refer to an entity which produces goods or provides services for a profit, and although the European Committee of Social Rights has clarified that this provision is "however, … not applicable to public servants" (page 144, *Digest of the Case Law of the European Committee of Social Rights*, 1 September 2008), it can nonetheless be noted that principles can be inferred from Article 21 which may also be applied to the subject matter of this complaint.

As we have seen, Article 9 of Law No. 194 brings to the fore the need to specify the tangible measures whereby the rights of the non-objecting doctors can be guaranteed, in accordance with the principle, laid down in the same article, that each hospital must guarantee access to pregnancy termination procedures.

The non-objecting doctors' rights which are being impaired include the right to information on decisions which could be substantially prejudicial to the working conditions of those carrying out pregnancy termination procedures.

In particular, there is a violation of the principle that workers must be "consulted in good time on proposed decisions" which could affect their interests, in so far as such

information and consultation processes are in any case not capable of preventing the damage which Article 21 aims to avert.

The non-objecting doctors, while being aware of the organisational decisions of their own hospitals, cannot in any way avoid the workload relating to terminations of pregnancy (which is due to the high number of doctors who raise a conscientious objection), with the consequence that their own working conditions are undermined, particularly as regards their rights to information and effective consultation.

3.10.2. Article 22 of the European Social Charter (the right to take part in the determination and improvement of working conditions and the working environment)

For the purpose of this complaint, it can be see that there is a close link between Article 21 of the Social Charter and Article 22, whereby, so as to guarantee the effective exercise of the right of workers to take part in the determination and improvement of working conditions and the working environment, the States undertake to adopt or encourage measures enabling workers to contribute to the attainment of this objective (including, apart from the determination and improvement of working conditions, work organisation and working environment, mentioned in sub-paragraph a), the protection of health and safety within the undertaking, mentioned in sub-paragraph b).

4. Conclusions

As has been demonstrated, the lack of specific legal provisions concerning the effective means of guaranteeing a fair balance between objecting and non-objecting medical staff unreasonably sacrifices women's rights to self-determination regarding reproductive choices, to physical and mental health and to life, as well as unreasonably sacrificing the rights of medical and auxiliary staff.

Notwithstanding the recognition given to medical staff's right to raise a conscientious objection, women's right of access to termination procedures must not be impaired, or even denied, since this right too is provided for and safeguarded by the same law, No. 194 of 1978.

The same applies to the rights of those who, in exercising the medical profession, decide not to raise a conscientious objection, and hence to seek to put into effect Law No. 194.

As can be seen from the data on the law's implementation in practice, there is a need for greater precision regarding the tangible arrangements for applying Article 9, guaranteeing a proper balance between the rights at stake in matters of voluntary termination of pregnancy (on one hand the rights of women and of non-objectors, and on the other hand the right to raise a conscientious objection).

This article provides for such a balance only in an abstract and general manner, since it recognises both the women's right of access to a termination of pregnancy and the doctors' right to raise a conscientious objection, without laying down tangible means whereby both these rights can be guaranteed while preventing the high number of objecting doctors from impinging on the women's rights.

Furthermore, as a result of the legal requirement to guarantee the requested service in any event, the entire workload falls on those who do not raise a conscientious objection, thereby jeopardising their position on account of the completely inadequate number of non-objecting doctors. The legislation indeed fails to indicate the tangible implementation arrangements whereby the presence of doctors ensuring access to the service (pregnancy termination procedures) can be guaranteed, and thus impairs the rights of those who decide not to raise a conscientious objection. At the same time, the latter play an even more essential role in the efforts to guarantee the required service and hence the application of Law No. 194 (which the Constitutional Court has defined as being of

constitutionally required substance) given the growing number of doctors who are conscientious objectors.

The reason for the impairment of the rights of women and of non-objecting medical staff must be perceived to lie in the lack, within the law itself, of specific provisions on the implementation measures whereby the hospitals and the regions can give full application to the law by guaranteeing the availability of pregnancy termination procedures.

The general wording of Article 9 regarding the requirement that hospitals and authorised nursing homes should in any event guarantee the performance of the requested pregnancy termination procedures and the regions should supervise and guarantee their implementation through staff mobility can be seen to be particularly inadequate.

On the contrary it is necessary to determine with greater precision the tangible arrangements whereby a sufficient presence of non-objecting doctors can be secured, for example by providing that, as the Constitutional Court has already ruled in matters of assisted reproduction (judgment No. 151 of 2009), each hospital shall be endowed with the "number strictly necessary" to cope with the demand for voluntary terminations of pregnancy, requiring the regions to exercise specific scrutiny over the manner in which this number is determined.

For these reasons the CGIL requests the European Committee of Social Rights to hold that Italy is violating:

- with regard to women's rights, Article 11 of the European Social Charter read alone or in conjunction with Article E, on account of the difficulties in applying Law No.194 of 1978, which impair the right of access to pregnancy termination procedures;

- with regard to the rights of medical and auxiliary staff who are not conscientious objectors, Article 1 of the European Social Charter, on account of the difficulties in applying Law No. 194 of 1978, which impair the legal position of non-objecting medical practitioners, who have to bear the entire workload relating to terminations of pregnancy;

- with regard to the rights of medical and auxiliary staff who are not conscientious objectors, Articles 2, 3 and 26 of the European Social Charter, read alone or in conjunction with Article E, on account of the difficulties in applying Law No. 194 of 1978, which impair the legal position of non-objecting medical practitioners, who have to bear the entire workload relating to terminations of pregnancy.

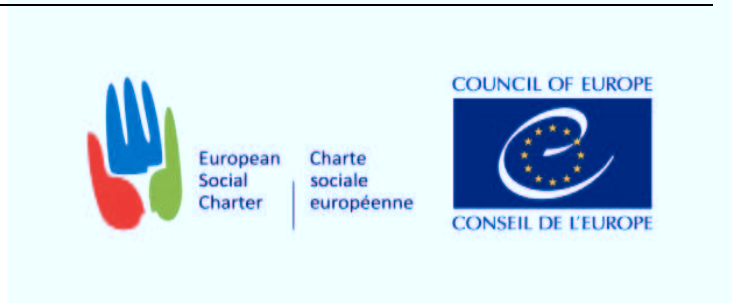
The CGIL further requests the European Committee of Social Rights to recognise the relevance to this complaint of the principles set out in Articles 21 and 22 of the European Social Charter, although their scope is confined to for-profit undertakings.

Susanna Camusso

Secretary General of the CGIL

Appendices

- Appendix 1. Law of 22 May 1978, No. 194, governing social protection of motherhood and voluntary terminations of pregnancy
- Appendix 2. Law No. 30 of 9 February 1999, entitled "Ratification and implementation of the revised European Social Charter and the appendix thereto, signed in Strasbourg on 3 May 1996"
- Appendix 3. Law No. 298 of 28 August 1997, entitled "Ratification and implementation of the Additional Protocol to the European Social Charter providing for a system of collective complaints, signed in Strasbourg on 9 November 1995"
- Appendix 4. Statutes of the CGIL
- Appendix 5. International Non-Governmental Organisations (INGOs) entitled to submit collective complaints
- Appendix 6. Extract relating to conscientious objection – Report by the Ministry of Health, August 2011
- Appendix 7. Extracts relating to conscientious objection – Reports by the Ministry of Health, 2005 – 2010
- Appendix 8. Data on conscientious objection – Report by the Ministry of Health, 2010 – tables relating to the areas of Italy
- Appendix. 9. Data on conscientious objection – Report by the Ministry of Health, 2010 – tables relating to individual regions
- Appendix 10. Data on conscientious objection published on the website *www.laiga.it*
- Appendix 11. Question for a written reply – Conscientious objection and full application of Law 194/1978, from members of the Lombardy regional council – 26 April 2012
- Appendix 12. Conscientious objection – data relating to the question for a written reply – Lombardy region
- Appendix 13. Statement “Conscientious objection in the hospitals of Jesi and Fano and voluntary terminations of pregnancy", CGIL regional secretariat for the Marche region
- Appendix 14. Statement by the provincial secretariat of the CGIL in Palermo
- Appendix 15. Statement by the CGIL concerning the Abruzzo region
- Appendix 16. Statement by the CGIL concerning the towns of Messina and Trapani
- Appendix 17. Statement by the CGIL concerning the Puglia region
- Appendix 18. The EU and doctors' working time in the national health system
- Appendix 19. Legislative Decree No. 112 of 2008, "Emergency measures for economic development, simplification, competitiveness, stabilisation of public finances and tax equalisation"
- Appendix 20. Legislative Decree No. 66 of 8 April 2003, "Implementation of directives 93/104/EC and 2000/34/EC concerning certain aspects of the organisation of working time”
- Appendix 21. The CGIL's observations on Legislative Decree No. 112 of 2008



EUROPEAN COMMITTEE OF SOCIAL RIGHTS
COMITÉ EUROPÉEN DES DROITS SOCIAUX

DECISION ON THE MERITS

Date of adoption: 10 September 2013

Date of delivery : 10 March 2014

International Planned Parenthood Federation – European Network (IPPF EN)
v. Italy

Complaint No. 87/2012

The European Committee of Social Rights, committee of independent experts established under Article 25 of the European Social Charter ("The Committee"), during its 266th session attended by:

Luis JIMENA QUESADA, President
Monika SCHLACHTER, Vice-President
Petros STANGOS, Vice-President
Lauri LEPPIK
Birgitta NYSTRÖM
Rüçhan IŞIK
Alexandru ATHANASIU
Jarna PETMAN
Elena MACHULSKAYA
Giuseppe PALMISANO
Karin LUKAS
Jozsef HAJDU
Marcin WUJCZYK

Assisted by Régis BRILLAT, Executive Secretary

Having deliberated on 19 March, 14 May, 2 July and 10 September 2013,

On the basis of the report presented by Karin LUKAS,

Delivers the following decision adopted on this last date:

PROCEDURE

1. The complaint lodged by IPPF EN was registered on 9 August 2012.

2. IPPF EN alleges that the formulation of paragraph 4 of Section 9 of Act No. 194 of 1978, which governs the conscientious objection of medical practitioners and other health personnelin relation to the termination of pregnancy, is in violation of Article 11 (the right to protection of health) of the Revised European Social Charter ("the Charter"), read alone or in conjunction with the non-discrimination clause in Article E, in that it does not protect the rights of women with respect to access to termination of pregnancy procedures.

3. The complaint was declared admissible by the Committee on 22 October 2012. In accordance with Rule 26 *in fine* of the Committee and in view of the seriousness of the allegations, the Committee decided to give precedence to this complaint and thus set non-extendable time limits for the proceedings.

4. In accordance with Article 7§§1 and 2 of the Protocol providing for a system of collective complaints ("the Protocol") and with the Committee's decision on the admissibility of the complaint, on 31 October 2012 the Executive Secretary communicated the text of the decision on the admissibility to the Italian Government ("the Government") and to IPPF EN. On the same date, he communicated it to the States Party to the Protocol and the States that have made a declaration under Article D§2 and to the organisations referred to in Article 27§2 of the Charter.

5. The Committee set 6 December 2012 as a deadline for presentation of the Government's submissions on the merits and 17 January 2013 for IPPF EN's response on the merits. The Government's submissions on the merits were registered on 4 December 2012 and IPPF EN's response to them was registered on 17 January 2013 and forwarded to the Government on 13 February 2013.

6. On 1st December 2012, the European Centre for Law and Justice ("ECLJ") asked to submit observations in relation to the complaint. In accordance with Rule 32A, on 21 December 2012 the President of the Committee invited ECLJ to submit the afore-mentioned observations before 17 January 2013. ECLJ's observations were registered on 17 January 2013and forwarded to the Government and IPPF EN on 13 February 2013.

7. During its 263th Session, the Committee decided to invite both parties to provide further information. On this basis, on 28 March 2013 the Executive Secretary sent a letter, including a list of questions, to the Government and IPPF EN asking for a reply by 22 April 2013.

8. The reply of the Government to the Committee's request was registered on 23 April 2013. At IPPF EN's request, the President of the Committee granted an extension of the deadline up to 6 May 2013. The reply of IPPF EN was registered on 6 May 2013.

9. On 24 May 2013, Mr Carlo Casini, President of the NGO *Movimento per la Vita italiano* ("MVI") asked to submit observations. In accordance with Rule 32A, on 29 May 2013 the President of the Committee invited Mr Casini to submit the afore-mentioned observations before 28 June 2013. The observations were registered on 26 June 2013 and forwarded to the Government and IPPF EN on 28 June 2013.

10. On 11 June 2013, the NGO *Associazione Luca Coscioni per la libertà di ricerca scientifica* ("ALCLRS") asked to submit observations. In accordance with Rule 32A, on 12 June 2013 the President of the Committee invited ALCLRS to submit the afore-mentioned observations before 28 June 2013. At the request of ALCLRS, the President of the Committee granted an extension of the deadline up to 20 August 2013. The observations were registered on 2 August 2013 and forwarded to the Government and IPPF EN on 5 August 2013.

11. On 20 June 2013, the NGO AIED – *Associazione italiana per l'educazione demografica* ("AIED") asked to submit observations. In accordance with Rule 32A, on 12 June 2013 the President of the Committee invited AIED to submit the afore-mentioned observations before 20 August 2013.The observations were registered on 18 August 2013 and forwarded to the Government and IPPF EN on 29 August 2013.

SUBMISSIONS OF THE PARTIES

1 – The complainant organisation

12. IPPF EN alleges that the high number of objecting medical practitioners and other health personnel electing to be conscientious objectors renders paragraph 4 of Section 9 of Act N° 194 of 22 May 1978 on "Norms on the social protection of motherhood and the voluntary termination of pregnancy" ("Act No. 194/1978") ineffective in guaranteeing the legal right of women to have access to procedures for the termination of pregnancy and that this amounts to a breach of the right to health guaranteed by Article 11 of the Charter. The complainant organisation also alleges that the right to health of women wishing to terminate their pregnancy is not secured without discrimination and that this constitutes a violation of Article E of the Charter read in conjunction with Article 11.

2 – The respondent Government

13. The Government invites the Committee to declare the complaint of IPPF EN unfounded:

"a) due to the interpretation formulated by [IPPF EN] which distorts Articles 11 and E of the Charter to the detriment of women's health and lives who [IPPF EN] wants to be assisted only by non-objecting medical personnel who promotes voluntary termination of pregnancy of the women, without checking their physical and psychological state but only their economic situation;

b) because the State cannot limit the number of medical personnel raising conscientious objection while respecting the freedom of conscience, as recognised in the case law of the European Court of Human Rights relating to Article 9 of the 1950 Convention".

OBSERVATIONS BY THE EUROPEAN CENTRE FOR LAW AND JUSTICE, *MOVIMENTO PER LA VITA ITALIANO*, *ASSOCIAZIONE LUCA COSCIONI PER LA LIBERTÀ DI RICERCA SCIENTIFICA* AND *AIED – ASSOCIAZIONE ITALIANA PER L'EDUCAZIONE DEMOGRAFICA*

1. The European Centre for Law and Justice

14. ECLJ is a non-governmental organisation accredited by the United Nations and specializing in defense of liberty of conscience and religion. With this title, ECLJ has intervened in a number of cases before the European Court of Human Rights and alongside other international bodies protecting human rights.

(Information published on the website of ECLJ: http://www.eclj.org)

15. In its observations regarding the complaint, ECLJ argues that the complainant organisation "(…) does not put forward the slightest concrete case where a patient has not been able to undergo an abortion necessitated by their state of health or even an abortion on request". It considers that "[n]o concrete evidence is put forward to demonstrate that Italy's medical structures are not capable of caring for pregnant patients throughout the country where those patients' lives or health are in danger". With this in mind, ECLJ acknowledges that "[t]his is the sole obligation (of means) binding upon the States parties to the Charter" and points out that IPPF EN "(…) fails to prove that women wishing to abort in order to protect their health cannot do so within the legal time-limit".

16. ECLJ also observes that "[t]he allegation of discrimination in Italy where access to abortion is concerned, (…) is not borne out by the facts and even rather bizarrely formulated in the claim in the IPPF memorial that there is discrimination depending on whether or not women are pregnant". In this context, ECLJ wonders whether "[i]s it to be understood that this 'discrimination" undermines equality between women in their 'right not to be pregnant'". In this regard, it considers that "[t]his takes theorising on notions of the right to abortion, non-discrimination and equality far into the realms of the absurd".

17. More generally, ECLJ observes that conscientious objection to voluntary abortion is a “personal”, “fundamental” and “inalienable” right “which the individual naturally and directly possesses”. It considers that on the contrary abortion is not a “fundamental right” and that one can see it as a “medical treatment only when it is carried out to save the mother’s life”. In this respect, ECLJ takes the view that “the right to conscientious objection exists as a matter of principle outside of any legislative permission; conversely, the abortion (…) is carried out by the physician and the medical institution, which need the authorisation of the law and the approval of the health authorities”. Moreover, ECLJ considers that if the mother’s life is in danger, implementation of Act No. 194 /1978, which allows physicians to carry out an abortion “is seldom directly related to any specific medical cause”. ECLJ stresses that in these cases “the physician is fully entitled to exercise his freedom of conscientious objection as secured under Article 9 of the 1978 Law”.

18. As regard the presentation of the complaint to the Committee, ECLJ refers to the opinion that “[i]nternational human rights protection bodies, particularly the quasi-court bodies producing soft law, are used to assert and build a court-constructed fundamental right to abortion” and, on this basis, states:

“That is the purpose of this application to [the] Committee, which seeks to secure social right status for access to abortion and to whittle down the scope of the right of conscientious objection”.

2. *Movimento per la Vita italiano*

19. MVI is a national Italian federation of more than six hundred local groups, services centres for help in life (*Centri di servizi di aiuto alla vita*) and care homes (*Case di accoglienza*), active throughout the country. MVI’s aim is to promote and defend the right to life and dignity for all, from conception to natural death – based on an ethic of hospitality for those who are weaker and more vulnerable - and, first of all, for the child that is conceived and not yet born.

(Information published on the association’s website: http://www.mpv.org).

20. The observations have been presented by Mr Carlo Casini in his capacity as President of MVI, as well as in his personal capacity. The observations refer first of all to the reasons and legal basis of conscientious objection. In this framework, MVI states that “[t]he physician refuses to carry out an abortion because he does not want to kill a human being”. Reference is made to the recognition of “the value of human life”, which is “the reason for conscientious objection”. It is observed that “[t]he abortion is an exception [to the general principle of recognising the value of human life]”. With this in mind, MVI declares that “in order to defend conscientious objection, it is enough to prove that the decision of conscientious objectors is not unreasonable and unfounded” and that the above-mentioned decision is based on the principle that a child that is conceived, is already a “human being”.

21. In relation to these considerations, a number of legal international documents are mentioned, i.e: the Recommendations 874 (1979), 1046 (1986), and 1100 (1989) of the Parliamentary Assembly of the Council of Europe; the Convention for the

Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine; the European Convention on Human Rights, including some references to the relevant judgments of the European Court of Human Rights; the judgment of the Court of Justice of the European Union in the case Brüstle v. Greenpeace of 18 October 2011; the American Convention on Human Rights; the Convention on the Rights of the Child; and some judgments of the German Constitutional Court. As regards Italy, the following documents are mentioned: the Act No. 40/2004 (Article 1); the Act No. 194/1978 (Articles 1 and 2); the judgment of the Constitutional Court No. 27 of 18 February 1975. Moreover, reference is made to the Opinions adopted by the Bioethics National Committee (*Comitato Nazionale per la Bioetica*), respectively, on 28.06.1986, 11.04.2003, 15.07.2005, 18.11.2005 and 16.12.2005.

22. MVI considers that "[i]f it is reasonable and well founded to recognise that the child carried by a pregnant woman is a human being, the conscientious objection represents a genuine, basic human right: nobody can be obliged to kill. The only possible exception to this right arises when it is necessary to save another life". MVI is also of the view that the idea that conscientious objection is "a human right" is confirmed by a number of international and domestic documents, i.e.: the Resolutions 1763 (2010) and 1518 (2001) of the Parliamentary Assembly of the Council of Europe; the Charter of Fundamental Rights of the European Union (Article 10§2); the judgment No. 27617/04 *Tyasiac* and RR v. Poland of the European Court of Human Rights of 26 May 2011; the Opinion of the Bioethics National Committee of 30.07.2012.

23. MVI argues that "[a]bortion is admitted only as an exception to the principle of respect of human life" and that "[i]n the Italian jurisprudence, its legitimacy is admitted on the basis of the concept of 'state of necessity' (…)". It points out that it is in this context that, in its judgment No. 27 of 18.02.1975, the Constitutional Court considered *inter alia* that not only the life of the women concerned must be taken into consideration, but also their state of health.

24. With respect to the allegations of the complainant organisation, in the last part of his text MVI argues that: a) it is not true and it is not proved that women are obliged to go abroad to terminate their pregnancy because of conscientious objection; b) if "some women" go abroad to terminate their pregnancy, this is not due to conscientious objection, but to the fact that in some foreign countries "the law is less restrictive"; c) all annual ministerial reports indicate that the diminution of abortions in Italy is due to the functioning of Act No. 194/1978 and not to conscientious objection; and d) "nobody" has never affirmed that the conscientious objection is the "cause" of the reduction of registered legal abortions.

3. *Associazione Luca Coscioni per la libertà per la ricerca scientifica*

25. ALCLRS is an Italian non-governmental organisation which promotes freedom of care and scientific research, self-managed personal assistance, civil and political human rights for sick and disabled people. In this context, ALCLRS pursues, also through appeals to courts, several aims including the protection of the rights and interests of persons in relation to public bodies, as well as the protection of people's health and, in this framework, the implementation of the rights of patients and those of their families.

(Information published on the association's website: http://www.associazionelucacoscioni.it)

26. In its observations regarding the complaint, after recalling the evolution of the national case-law and legislation concerning abortion in Italy, ALCLRC specifically refers to Article 9 of Act No. 194/1978, relating to the right of medical practitioners and other health personnel to raise conscientious objection in the framework of abortion procedures. In this respect, ALCLRS considers that in Italy, objection is becoming a "massive phenomenon" and that the high percentage of objecting doctors does not allow for the provision of adequate service to the women wishing to terminate their pregnancy as provided by law. ALCLRS expresses the view that the increasing rates of conscientious objection in Italy reveal the existence of an internal contradiction in the relevant legal framework, undermining the implementation of the above-mentioned service.

27. ALCLRS mentions the report of the Ministry of Health presented to the Parliament on 4 August 2011, showing that in 2009, at national level, 70,7% of gynaecologists raised conscientious objection and that the trend is not decreasing. ALCLRS considers that the risks for women's health linked to these high rates would require a regulatory approach in order to protect the interests at stake: those of the women wishing to terminate their pregnancy, but also those of medical practitioners who are not objectors and cannot cover all requests.

28. ALCLRS is of the view that in 1978, the right to objection "was justified by the context in which it was conceived", but that today, after 35 years, objection "has no longer logical and legal foundation, and "it represents the greatest obstacle to the full implementation of Law 194/1978". ALCLRS argues that the "massive use" of objection – even if according to Italian criminal law does not represent a crime in itself – it may cause the interruption of public service, which constitutes a crime under Italian law. In this respect, ALCLRS recalls that the law obliges hospitals to guarantee abortion health services, regardless of the choice made by the medical personnel concerned.

29. ALCLRS indicates that it is collecting information on experiences of women who suffer because of the inaccessibility of abortion services or bear serious difficulties in acceding these services. In this context, ALCLRS argues that very often women who decide to terminate their pregnancy are not assisted in a moment when time represents a determining factor: after 90 days of pregnancy abortion is only allowed where the pregnancy or childbirth entails serious risks for women's life or where pathological processes constituting a serious threat to a women's physical or mental health, such as those associated with malformations of the fetus. ALCLRS argues that in order to terminate the pregnancy before the third month women are often forced to "wander", looking for a health facility where non-objecting doctors are operating, thus aggravating the physical and mental sufferings inevitably connected to their decision to terminate the pregnancy.

30. As regards the issue of discrimination, ALCLRC considers that in terms of equality and access to care, the search of an available abortion service determines a "territorial and economic discrimination". ALCLRS is of the opinion that the requests of women to access abortion procedures are treated in different ways, "depending on the luck of the patient": if the woman concerned is lucky enough to live in an area close to a health facility providing abortion services, she will have no difficulty in terminating her pregnancy; on the contrary, should she live in an area with a high rate of objecting health personnel, she will be forced to move in search of an operational structure and this at her own expenses.

4. AIED –*Associazione italiana per l'educazione demografica*

31. AIED is an Italian non-governmental organisation whose objectives are, inter alia, as follows: "spread the concept of free and responsible procreation; stimulate cultural and social growth in matters of sexuality; promote and support initiatives aimed at improving the quality of life and safeguard the health of humanity, both at individual and collective levels; be committed to develop a new culture regarding maternity and birth, with particular attention paid to the various problems posed by assisted human procreation and bioethics; stimulate but also watch over governmental institutions, to ensure that laws are duly enforced in terms of contraception, abortion, sexual and andrological information, social-health prevention, and respect of minorities and diversity (in particular homosexuality). AIED is committed to avoiding racial, religious, social and political discrimination".

(Information published on the association's website: http://www.aied.it/english/)

32. In its observations regarding the complaint, AIED recalls a number of constitutional and statutory national provisions related to health, abortion and conscientious objection. In this context, reference is made to the Constitution (Articles 2, 31 and 32– see paragraph 35 below), Act No. 194/1978 on the social protection of motherhood and the voluntary termination of pregnancy(Articles 4, 6 and 9 – see paragraph 36 below), as well as Act No. 405/1975 relating to family advice centres. AIED also mentions the national benchmark case-law relating to abortion, i.e. judgment No. 27 of 1975 of the Italian Constitutional Court (see paragraph 46 below). As regards the international level, AIED notably refers to Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (see paragraph 40 below).

33. With respect to the implementation of Act No. 194/1978, AIED mentions the official figures provided by the Italian Ministry of Health regarding conscientious objection raised by medical practitioners and other health personnel in the period 2006 – 2010. Based on the available data, it indicates that, as for 2012, at national level there were seven objectors out of ten doctors. AIED also considers that the territorial distribution of conscientious objection is not homogenous in Italy; in this respect, it indicates that in some Southern regions the level of objection exceeds 80% of the gynaecologists concerned. Based on the information provided by “LAIGA - *Libera Associazione Italiana Ginecologi per l’Attuazione della legge 194”* (Free Italian Association of Gynaecologists for the Implementation of Act No. 194/1978), AIED argues that in the regions of Lazio and Lombardy the percentage of objectors is larger than that registered by the Italian Ministry of Health (see also paragraphs 84, 109, 120, 123 and 149 below).

34. AIED puts forward that illegal abortionsare increasing in Italy and that the latest figures released by the Ministry of Health in 2008–given the figure of 20.000 the number of clandestine abortions (…) - may be underestimated as they do not include foreign women. In addition, it notes the increase of “spontaneous abortions” which–still according to the above-mentioned figures -amount to some 73.000 cases per year, compared to some 50.000 in the ‘80s.AIED takes the view that these figures may also include the practice of women who, after having tried to terminate the pregnancy by themselves, go to the closest hospital where the responsible doctors complete the initiated abortion process and then record the termination of pregnancy as “spontaneous”. A number of press articles regarding the implementation of Act No. 194/1978 are also provided by AIED.

RELEVANT LAW

DOMESTIC LAW

General rules

35. The Italian Constitution sets forth that:

Section 2

"The Republic recognises and guarantees the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled".

Section 3

"All citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinion, personal and social conditions.

It is the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country".

Section 19

"All persons have the right to profess freely their own religious faith in any form, individually or in association, to disseminate it and to worship in private or public, provided that the religious rites are not contrary to public morality".

Section 21

All persons have the right to express freely their ideas by word, in writing and by all other means of communication. (…)".

Section 32
"The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent.
No one may be obliged to undergo any health treatment except under the provisions of the law. The law may not under any circumstances violate the limits imposed by respect for the human person".

(English translation from the web site of the Italian senate :www.senato.it).

Specific rules

36. Act No. 194/1978 "Norms on the social protection of motherhood and the voluntary termination of pregnancy" (*Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza – Gazzetta ufficiale 22/05/1978, n. 140*) provides that:

Section 4

"In order to undergo termination of pregnancy during the first 90 days, women whose situation is such that continuation of pregnancy, childbirth or motherhood would seriously endanger their physical or mental health, in view of their state of health, their economic, social or family circumstances, the circumstances in which conception occurred or the probability that the child would be borne with abnormalities or malformations, shall apply to a public counselling centre [...] or to a fully authorised medical social agency in the region or to a physician of her choice."

Section 5

"In all cases, in addition to guaranteeing the necessary medical examinations, counselling centres and socio-medical agencies shall be required, especially when the request for termination of pregnancy is motivated by the impact of economic, social or family circumstances upon the pregnant woman's health, to examine possible solutions to the problems in consultation with the woman and, where the woman consents, with the father of the *conceptus*, with due respect for the dignity and personal feelings of the woman and the person named as the father of the *conceptus*, to help her to overcome the factors which would lead her to have her pregnancy terminated, to enable her to take advantage of her rights as a working woman and a mother, and to encourage any suitable measures designed to support the woman by providing her with all necessary assistance both during her pregnancy and after the delivery.

Where the woman applied to a physician of her choice, he shall: carry out the necessary medical examinations, with due respect for the woman's dignity and freedom; assess, in conjunction with the woman and, where the woman consents, with the father of the *conceptus*, with due respect for the dignity and personal feelings of the woman and of the person named as the father of the *conceptus*, if so desired taking account of the result of the examinations referred to above, the circumstances leading her to request that her pregnancy be terminated; and inform her of her rights and of the social welfare services available to her, as well as regarding the counselling centres and the socio-medical agencies. Where the physician at the counselling centre or socio-medical agency, or the physician of the woman's choice, finds that in view of the circumstances termination is urgently required, he shall immediately issue the woman a certificate attesting to the urgency of the case. Once she has been issued this certificate, the woman may report to one of the establishments authorised to perform pregnancy terminations.

If termination is not found to be urgently required, the physician at the counselling centre or the socio-medical agency, or the physician of the woman's choice, shall at the end of the consultation, if the woman requests that her pregnancy be terminated on account of circumstances referred to in Section 4, issue her a copy of a document signed by himself and the woman attesting that the woman is pregnant and that the request has been made, and shall request her to reflect for seven days. After seven days have elapsed, the woman may take the document issued to her under the terms of this paragraph and report to one of the authorised establishments in order for her pregnancy to be terminated."

Section 6

"The voluntary termination of pregnancy may be performed after the first 90 days:
a) where the pregnancy or childbirth entails a serious threat to the women's life;
b) where the pathological processes constituting a serious threat to a women's physical or mental health, such as those associated with serious abnormalities or malformations of the foetus, have been diagnosed."

Section 7

"The pathological process referred to in the preceding Section shall be diagnosed and certified by a physician on the staff of the department of obstetrics and gynaecology of the hospital establishment in which the termination is to be performed. The physician may call upon the assistance of specialists. The physician shall be required to forward the documentation on the case as well as his certificate to the medical director of the hospital in order for the termination to be performed immediately.

Where the termination of pregnancy is necessary in view of an imminent threat to the woman's life, it may be performed without observing the procedures referred to in the preceding paragraph and in a place other than those referred to in Section 8. In such cases, the physician shall be required to notify the provincial medical officer." (…).

Section 8

"Pregnancy terminations shall be performed by a physician on the staff of the obstetrics and gynaecology department of a general hospital as referred to in Section 20 of Law No. 132 of 12 February 1968; this physician must also confirm that there are no medical contraindications.

Pregnancy terminations may likewise be carried out in specialized public hospitals, the institutes and establishments referred to in the penultimate paragraph of Section 1 of Law No. 132 of 12 February 1968, and the institutions referred to in Law No. 817 of 26 November 1973 and Decree No. 754 of 18 June 1958 of the President of the Republic, wherever the competent administrative agencies so request.

During the first 90 days, pregnancy terminations may also be performed in nursing homes that are authorized by the regions and have the requisite medical equipment and adequate obstetric and gynaecological services.

The Minister of Health shall issue a decree restricting the capacity of authorized nursing homes to carry out terminations of pregnancy, by establishing:

1. the percentage of pregnancy terminations that may be performed relative to the total number of surgical operations performed during the preceding year at the particular nursing home;

2. the percentage of patient-days allowed for pregnancy-termination cases in relation to the total number of patient-days in the preceding year under conventions with the regions.

The percentages referred to in items 1 and 2 shall not be less than 20% and shall be the same for all nursing homes (cf. ministerial decree of 20/10/1978).

Nursing homes may select the criterion which they will observe from the two set out above.

During the first 90 days, pregnancy terminations may likewise be performed, following the establishment of local socio-medical units, at adequately equipped public outpatient clinics, operating under the hospitals and licensed by the regions.

The certificate issued under the third paragraph of Section 5 and, after seven days have elapsed, the document delivered to the woman under the fourth paragraph of the same Section shall entitle her to obtain, on an emergency basis, the termination and, where necessary, hospitalization".

Section 9

"Medical practitioners and other health personnel shall not be required to assist in the procedures referred to in Sections 5 and 7 or in pregnancy terminations if they raise a conscientious objection, declared in advance. Such declaration must be forwarded to the provincial medical officer and, in the case of personnel on the staff of the hospital or nursing home, to the medical director, not later than one month following the entry into force of this Law, or the date of qualification, or the date of commencement of employment at an establishment required to provide services for the termination of pregnancy, or the date of the drawing up of an agreement with insurance agencies entailing the provision of such services.

The objection may be withdrawn at any time, or may be submitted after the periods prescribed in the preceding paragraph, in which case the declaration shall take effect one month after it has been submitted to the provincial medical officer.

Conscientious objection shall exempt health personnel and other health personnel from carrying out procedures and activities specifically and necessarily designed to bring about the termination of pregnancy, and shall not exempt them from providing care prior to and following terminations.

In all cases, hospital establishments and authorised nursing homes shall be required to ensure that the procedures referred to in Section 7 are carried out and pregnancy terminations requested in accordance with the procedures referred to in Sections 5, 7 and 8 are performed. The region shall supervise and ensure implementation of this requirement, if necessary, also by the movement of personnel.

Conscientious objection may not be invoked by medical practitioners or other health personnel if, under the particular circumstances, their personal intervention is essential in order to save the life of a woman in imminent danger.

Conscientious objection shall be deemed to have been withdrawn with immediate effect if the objector assists in procedures or pregnancy terminations provided for under this Law, in cases other than those referred to in the preceding paragraph."

(English translation provided by the complainant organisation).

INTERNATIONAL LAW

International Covenant on Economic, Social and Cultural Rights of 16 December 1966

37. Article 12 of ICESCR provides that:

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

38. The General Comment No. 14 (2000) on "The right to the highest attainable standard of health (article 12)", adopted by the Committee on economic, social and cultural rights at its twenty-second session, Geneva, 25 April-12 May 2000 – provides that:

"12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes), have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

(iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

(iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

"11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."

"14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a))may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."

“21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health (…)”.

“33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect protect and fulfil. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote (…)”. (…) [t]he obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health”.

“52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates”.

International Covenant on Civil and Political Rights of 16 December 1966

39. Article 18 of ICCPR provides that:

“1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

2. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.

Convention on the Elimination of All Forms of Discrimination Against Women of 18 December 1979

40. Article 12 of CEDAW provides that:

“1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

41. The General Recommendation on Women and Health, No. 24, adopted in 1999by the Committee on the Elimination of Discrimination against Women, at its 20th Session, provides that:

"11. Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers".

Convention for the protection of Human Rights and Fundamental Freedoms of 4 November 1950

42. Article 8 - Right to respect for private and family life, provides that:

"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others".

43. Article 9 - Freedom of thought, conscience and religion, provides that:

"1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others".

Charter of Fundamental Rights of the European Union of 7 December 2000, which became legally binding with the entry into force of the Lisbon Treaty on 1 December 2009

44. Article 10 - Freedom of thought, conscience and religion, provides that:

"1. Everyone has the right to freedom of thought, conscience and religion. This right includes freedom to change religion or belief and freedom, either alone or in community with others and in public or in private, to manifest religion or belief, in worship, teaching, practice and observance.

2. The right to conscientious objection is recognised, in accordance with the national laws governing the exercise of this right".

45. Article 35 - *Health care*, provides that:

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".

RELEVANT CASE-LAW

NATIONAL CASE-LAW

46. In its judgment No. 27 of 1975, the Italian Constitutional Court (*Corte costituzionale)* stated that:

"(…) No equivalence exists at this time between the right, not only to life but also to health, of the one who is already a person, as the mother, and safeguarding of the embryo who has yet to become a person".

47. In its judgment No. 35 of 1997, the Constitutional Court has defined Act No. 194/1978 as a law with "constitutionally guaranteed content". On this basis, the *Corte costituzionale* declared inadmissible a *referendum* aimed at removing the existing legislation concerning access to abortion procedures during the first 90 days of pregnancy. The court pointed out that the normative nucleus of laws with constitutionally guaranteed content cannot be altered or rendered ineffective on the ground that this would compromise the corresponding specific provisions of the Constitution or of other constitutional acts (cf. also judgment No. 16 of 1978).

48. In its judgment No. 467 of 1991, the Constitutional Court held that:

"(…) even if this occured following a delicate operation carried out by the Parliament, aimed at balancing [the sphere of legal potentialities of individual conscience] with conflicting duties or constitutionally protected assets and to guarantee its exercise in a gradual manner to ensure the good functionning of organisational structures et services of national interest, the [above-mentioned] sphere (…) represents, with respect to the specific expressive contents of its essential nucleous, a particularly high constitutional value which justifies a number of (privileged) exemptions as regards the fullfillment of public duties, [and this,] also when the latter are considered as inderogable by the Constitution".

49. In its judgment No. 43 of 1997, the Constitutional Court stated that the protection accorded to the freedom of conscience:

"[c]annot be considered unlimited and unconditional. It rests primarily with the legislature to establish a balance between individual conscience and ensuing rights, on the one hand, and the overall, mandatory duties of political, economic and social solidarity that the Constitution (Art. 2) requires, on the other, so that the public order is safeguarded and consequent burdens are shared by all, without privileges".

50. In its judgment No. 151 of 2009,the Constitutional Court declared unconstitutional the third paragraph of Article 14 of Law No. 40 of 2004 which provides that: "Where the transfer of embryos to the uterus is not possible due to serious and documented circumstances of the woman's state of health, which were not foreseeable at the time of fertilization, embryo cryopreservation is permitted up to the date of transfer, to be implemented as soon as possible." This decision is based on the principle that the above-mentioned provision does not provide that the transfer of embryos must be carried out without prejudice to the health of women.

51. In its judgment No. 3477 of 2010, the Regional Administrative Tribunal of Apulia *(Tribunale amministrativo regionale della Puglia)* stated that according to Article 9 of Act No. 194/1978, objecting doctors must in any case assist women wishing to terminate their pregnancy, and this, prior and after the abortion. In this respect, the above-mentioned tribunal pointed out that the responsible medical personnel must provide all the necessary information and advice services, as well as assist the women concerned both from the physical and psychological point of view. These indications were provided by the tribunal with regard to the allegations put forward by the Government of Apulia, that not all gynaecologists working in the advice centres pour families (*consultori*) provide the aforementioned services and assistance. The Regional Administrative Tribunal of Apulia said that the exclusion of objecting medical practitioners from the competitions aimed at fulfilling vacant posts within the *consultori* constitute a violation Article 3 of the Constitution. It observed that an alternative solution to compensate the limited number of non-objecting medical personnel working in the *consultori* could be the organisation of recruitment competitions aimed at drawing up reserve lists including 50% of objecting doctors and 50% of non-objecting doctors.

52. In its judgment No. 14979 of 2013, the Supreme Court (*Corte di Cassazione*) with regard to the actual care provided prior to and following an abortion, sentenced a doctor who was a conscientious objector to a year in jail after he refused to aid a woman who had already undergone an abortion and had developed a serious haemorrhage.

INTERNATIONAL CASE-LAW

Judgments of the European Court of Human Rights

53. In P. and S. v. Poland, Application No. 57375/08, judgment of 30 October 2012, the Court said that:

"99. (…) once the State, acting within its limits of appreciation, adopts statutory regulations allowing abortion in some situations, it must not structure its legal framework in a way which would limit real possibilities to obtain an abortion. In particular, the State is under a positive obligation to create a procedural framework enabling a pregnant woman to effectively exercise her right of access to lawful abortion (Tysiąc v. Poland, cited above, § 116-124, R.R. v. Poland, cited above, § 200). The legal framework devised for the purposes of the determination of the conditions for lawful abortion should be "shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention" (… A, B and C v. Ireland [GC], (…) § 249 [16 December 2010])".

“106. (…) For the Court, States are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation (…)” (see below R.R. v. Poland, No. 27617/04, § 206).

54. In R.R. v Poland, Application No. 27617/04, judgment of 28 November 2011, the Court said that:

“187. While a broad margin of appreciation is accorded to the State as regards the circumstances in which an abortion will be permitted in a State, once that decision is taken the legal framework devised for this purpose should be ‘shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention’ (A, B and C v. Ireland [GC], (…) § 249 [16 December 2010])”.

“200. (…) once the State, acting within the limits of the margin of appreciation (…) adopts statutory regulations allowing abortion in some situations, it must not structure its legal framework in a way which would limit real possibilities to obtain it. In particular, the State is under a positive obligation to create a procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion (Tysiąc v. Poland, no. 5410/03, §§ 116 - 124, ECHR 2007‑IV) (…)”.

“206. (…) States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation”.

55. In A, B, and C v. Ireland , Application no. 25579/05, judgment of 16 December 2010, the Court said that:

“212. (…) the notion of “private life” within the meaning of Article 8 of the Convention is a broad concept which encompasses, inter alia, the right to personal autonomy and personal development (…). It concerns subjects such as gender identification, sexual orientation and sexual life (…), a person’s physical and psychological integrity (Tysiąc v. Poland judgment, cited [below]) as well as decisions both to have and not to have a child or to become genetic parents (…)”.

“249 (…) the State enjoys a certain margin of appreciation (see, among other authorities, Keegan v. Ireland, judgment of 26 May 1994, Series A no. 290, § 49). While a broad margin of appreciation is accorded to the State as to the decision about the circumstances in which an abortion will be permitted in a State (…), once that decision is taken the legal framework devised for this purpose should be “shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention” (S.H. and Others v. Austria, no. 57813/00, § 74, 1 April 2010)”.

56. In Tysiac v. Poland, Application no. 5410/03, judgment 20 March 2007, the Court said that:

“118. (…) the very nature of the issues involved in decisions to terminate a pregnancy is such that the time factor is of critical importance. The procedures in place should therefore ensure that such decisions are timely so as to limit or prevent damage to a woman's health which might be occasioned by a late abortion (…)”.

OTHER SOURCES

NATIONAL LEVEL

57. In June 2013, both the Senate and the Chamber of Deputies of the Italian Parliament adopted policy directives in the form of parliamentary motions (*mozioni*) addressed to the Government concerning *inter alia* the implementation of Act No. 194/1978. In particular, on 6 June 2013, at 37th its Session, the Senate approved the Motion No. 1-00059; on 11 June 2013, at its 31th Session, the Chamber of Deputies approved the following motions: Nos. 1-00045, 1-00074, 1-00078, 1-00079, 1-00080, 1-00081, 1-00082, 1-00087 and 1-00089. These motions specifically refer to the the implementation of Section 9§4 of the above-mentioned Act and some of the allegations put forward by the complainant organisation, i.e.:

- "At national level the main consequence of such a high number of conscientious objectors is that the very application of Law No. 194 is becoming increasingly difficult, with serious negative implications for the functioning of the various hospitals (and accordingly for the national health system), which have an impact on women obliged to seek an abortion (often resulting in tragically late abortions on account of the long waiting times)";

- "Given this state of "emergency" women are often obliged to travel to another region or even abroad, while there is a re-emergence of clandestine abortions (above all among immigrant women) and of the related criminal activities, a plague that had been wiped out only by the due application of Law No. 194";

(cf. Senate, Motion No. 1-00059 of 6 June 2013)

- "(…) The high proportion of medical practitioners who are objectors would also seem to be affecting the operability and effectiveness of prevention and support services for women at the pre-termination stage. The (…) report by the Minister of Health shows that, in many cases, the effectiveness and the role of those providing such advisory services is undermined by a shortage of suitably qualified persons available to sign the documents and the approvals necessary for the performance of an abortion, above all in southern Italy. This is a factor that distances women from these structures and from the essential information, prevention and support services they provide (…)";

- "(…) At present there are no effective monitoring, reward or sanction systems, with a view to verifying, encouraging and supporting the effective functioning of the structures required to implement Law No. 194, and also no means of conducting a proper analysis of the manner in which conscientious objection affects their functioning (…)".

(cf. Chamber of Deputies, Motion No. 1-00082 of 11 June 2013)

- (…) There are also cases in which conscientious objection by individuals becomes conscientious objection by an entire hospital, where the staff is solely composed of objectors; this creates yet further difficulties for women wishing to assert their right to a termination, who already find themselves in a hard situation; such hospital-wide objection is unacceptable, in particular in entities affiliated with the national health system; in such cases it would be appropriate to intervene at the level of the "objecting" hospitals themselves, requiring them to ensure the presence also of non-objecting staff, and, if the situation continues, such hospitals must be excluded from the award of any kind of public licence (…)";

- "(…) The growth in the number of medical practitioners objectors in recent years has led to the closure of services, leaving some hospitals devoid of any department performing abortions because virtually all the gynaecologists, anaesthetists and paramedical staff have chosen conscientious objection, (…)".

(cf. Chamber of Deputies, Motion No. 1-00078 of 11 June 2013)

- “At national level the main consequence of such a high number of conscientious objectors is to make it increasingly difficult to apply Law No. 194 of 1978, with a negative impact both on the functioning of the various hospitals, and therefore of the national health system, and on women seeking abortions;

- The dramatic situation regarding application of the law involves an extension of waiting times with greater risks for women's health and more professional risk for the few non-objectors who are forced against their will to adopt poor clinical practice.

- Given this state of "emergency" women are frequently obliged to travel to other regions or even abroad and clandestine abortions are becoming a necessity, above all among immigrant women (…)”.

(cf. Chamber of Deputies, Motion No. 1-00045 of 11 June 2013)

58. The Committee notes that with respect to the difficulties encountered in the implementation of Act No. 194/1978, some motions ask the Government to:

- “Implement in full Law No. 194 of 1978, while respecting the individual right of conscientious objection”;

- “Take all the necessary measures, within the limits of its competence, to guarantee the implementation, as regards the organisation of the regional health systems, of the fourth paragraph of Article 9 of Law No. 194 of 1978, in so far as it institutes an obligation to supervise and guarantee the application of women's right to informed freedom of choice, also through a change of management methods and staff mobility, guaranteeing the presence of a sufficient network of services in every region across the country” (…).

(cf. Chamber of Deputies, Motion No. 1-00074 of 11 June 2013)

- “Take action, within its sphere of competence, soas to ensure, while respecting the right of conscientious objection, the full and effective implementation by hospitals of the procedures necessary to respond to any request for an abortion”;

- “(…) Ensure the timelyadoption of regulatory measures, as also called for by the European Union, so as to allow proper planning of health care activities, embracing not only the legitimacy of conscientious objection but also access to treatment and health protection, in such a way as to avoid a potential conflict detrimental to the right to health” (…).

(cf. Chamber of Deputies, Motion No. 1-00087 of 11 June 2013)

“Verify that, while respecting the freedom of conscientious objectors, public health structures continue to guarantee the application of Law No. 194 of 1978, thereby safeguarding women who choose to terminate a pregnancy against illegal practices that endanger their health and their lives (...) ".

(cf. Chamber of Deputies, Motion No. 1-00089 of 11 June 2013)

- “Conduct an in-depth analysis of the impact of conscientious objection on the implementation of Law No. 194 through a study carried out at the level of each hospital and based on sufficiently detailed data and indicators to deal with the problem of the link between the presence of staff who are non-objectors and the length of waiting lists”;

- “Take all the necessary measures, within its sphere of competence, so as to guarantee compliance with and the full application of Law No. 194 of 1978 in all hospitals throughout Italy, by implementing, where necessary, a revised organisation of tasks and recruitment drawing on the tools of staff mobility provided for in the law, which institutes forms of differentiated recruitment with a view to balancing, according to the available data, the number of objectors and the number of non-objectors, as recommended by the National Bioethics Committee”;

(cf. Chamber of Deputies, Motion No. 1-00082 of 11 June 2013)

- "Guarantee respect for and the full application of Law No. 194 of 1978 throughout national territory in recognition of freedom of choice and of women's right to health";

- "Guarantee a rebalancing of medical and nursing staff, as moreover provided for in Article 9 of Law No. 194, through staff mobility, aimed at ensuring minimum numbers and regional programming, with the aim of having at least 50% of staff who are non-objectors" (…).

(cf. Senate, Motion No. 1-00059 of 6 June 2013)

59. The Committee also notes that on 11 June 2013, during the debate at the Chamber of Deputies relating to the above-mentioned motions, the Minister of Health declared that:

"We have seen that, fortunately, during these years the number of voluntary terminations of pregnancy decreased due to the prevention activities and the greater conscience of the persons [involved]. This was one of the objectives of the legislation which – we should remind it – provides a free of charge service for all users. We have also seen that often, where there has been an increase or a decrease of the objectors, this has not always led to a problems-free situation in the access to local services. Here we come, unfortunately, to what is the theme of governance of territories and therefore more connected to the theme of regions, but surely cannot avoid dealing with [this theme] as Minister of Health, because we find ourselves in the wider complex of issues that affect the protection of the right to health in the national territory".

60. More particularly, in the framework of the same debate, in reply to the requests addressed to the Government within the aforesaid motions, the Minister of Health has made the following statements:

- "(…) I believe that the intention of all is to verify, in the territories and the individual health facilities, whether the principles of the law are effectively applied (…)";

- "(…) this issue of conscientious objection, which has been raised by some of the groups that submitted the motions, is an issue that we feel we must take in, especially in so far as it calls upon the Government and myself to monitor carefully – as required in different motions - the enforcement of the law in this area as well (…)".

(NB: The full text of the intervention of the Minister of Health, Mrs Beatrice Lorenzin, in the occasion of the debate is available at the following website of the Chamber of Deputies: http://documenti.camera.it/leg17/resoconti/assemblea/html/sed0031/pdfel.htm)

INTERNATIONAL LEVEL

World Health Organization (“WHO”) - Department of Reproductive Health and Research Safe abortion

61. The technical and policy guidance for health systems second edition, 2012 indicates that:

“Health-care professionals sometimes exempt themselves from abortion care on the basis of conscientious objection to the procedure, while not referring the woman to an abortion provider. Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman’s life and to prevent serious injury to her health. Women who present with complications from an unsafe or illegal abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviours (see also Chapter 4)”.

(cf. Chapter 3.3.6 - Conscientious objection by health-care providers)

Mandatory waiting periods are often required by laws or regulations and/or administrative procedures imposed by facilities or individual providers. Mandatory waiting periods can have the effect of delaying care, which can jeopardize women’s ability to access safe, legal abortion services and demeans women as competent decision-makers. States and other providers of health services should ensure that abortion care is delivered in a manner that respects women as decision-makers. Waiting periods should not jeopardize women’s access to safe, legal abortion services. States should consider eliminating waiting periods that are not medically required, and expanding services to serve all eligible women promptly.

(cf. Chapter 4.2.2.6 - Waiting periods)

The respect, protection and fulfilment of human rights require that governments ensure abortion services that are allowable by law are accessible in practice. Institutional and administrative mechanisms should be in place and should protect against unduly restrictive interpretations of legal grounds. These mechanisms should allow service provider and facility administrator decisions to be reviewed by an independent body, should take into consideration the views of the pregnant woman, and should provide timely resolution of review processes.

(cf. Chapter 4.2.2.9 - Restrictive interpretation of laws on abortion)

International Federation of Gynaecology and Obstetrics (“FIGO”)

62. In the document Ethical Framework for Gynecologic and Obstetric Care (2007), it is stated that:

“7. If a physician is either unable or unwilling to provide a desired medical service for non-medical reasons, he or she should make every effort to achieve appropriate referral.”

Parliamentary Assembly of the Council of Europe (“PACE”)

63. PACE Resolution 1763 (2010) “The right to conscientious objection in lawful medical care”, PACE contains the following statements:

“2. The Parliamentary Assembly emphasises the need to affirm the right of conscientious objection together with the responsibility of the state to ensure that patients are able to access lawful medical care in a timely manner. The Assembly is concerned that the unregulated use of conscientious objection may disproportionately affect women, notably those with low incomes or living in rural areas. (…).

4. In view of member states' obligation to ensure access to lawful medical care and to protect the right to
health, as well as the obligation to ensure respect for the right of freedom of thought, conscience and religion of health-care providers, the Assembly invites Council of Europe member states to develop comprehensive and clear regulations that define and regulate conscientious objection with regard to health and medical services, and which:

4.1. guarantee the right to conscientious objection in relation to participation in the medical procedure in question;

4.2. ensure that patients are informed of any conscientious objection in a timely manner and referred to another health-care provider;

4.3. ensure that patients receive appropriate treatment, in particular in cases of emergency”.

64. The resolution mentioned in paragraph above was adopted by PACE having regard to the report of its Committee on Social, Health and Family Affairs on “Women’s access to lawful medical care: the problem of unregulated use of conscientious objection” (Document 12347 of 20 July 2010). The report contains the following statements:

“16 (…) Some countries inadequately implement the regulatory framework in respect of conscientious objection. Relevant evidence is known for (…) Italy, for example”.

“17. Health-care providers who invoke conscientious objection have certain legal and ethical duties that aim to protect the patient. States should ensure that regulations on conscientious objection clearly specify these duties. The absence of effective legal and policy frameworks in some member states means that individuals are unable to access the health-care services that they are entitled to receive, undermining, inter alia, their rights to health-care services and to privacy, and potentially constituting a breach of the duty of care and abandonment of patients”.

“32. Conscientious objectors also have a duty to inform the patient in a timely manner of their conscientious objections to a specific procedure, and similarly, to refer such patient, in a timely manner, to a health-care provider who is willing and able to perform the health-care procedure or treatment and who is conveniently accessible. This requirement for timely notice and referral should apply from the moment the patient first requests medical intervention from a health-care provider”.

“44. In practice, various factors can lead to situations where women’s access to lawful medical care is affected. The most widely observed reasons are the lack of oversight mechanisms ensuring the implementation of existing legal provisions and policies, the non-respect of legal duties with regard to the information of patients, the absence of regulations requiring or facilitating timely action (notification of conscientious objection, appeals processes, etc.) as well as the lack of regulation regarding the scope of conscientious objection provisions”.

“55. Member states should enact comprehensive and clear regulations that balance the right of the healthcare provider to conscientiously object to the performance of a procedure, and ensure that

patients can exercise their right to access lawful health services. In situations in which such regulations exist, many member states lack oversight and monitoring mechanisms to ensure that health-care providers act in accordance with them. Such regulations should establish mechanisms to ensure the accessibility and availability of health-care providers when other health-care providers may conscientiously object, and mandate the creation of a registry of conscientious objectors".

"57. National policies should define the scope of the right to conscientious objection in respect of the type of services and health-care professionals to whom it applies, and carve out appropriate exceptions for emergency situations".

"58 Lastly, all national regulations should establish effective complaint mechanisms that can address abuses of the right to conscientious objection and provide women with an effective and timely remedy".

65. PACE Resolution 1607 (2008) "Access to safe and legal abortion in Europe", contains the following statements:

"2. In most of the Council of Europe member states the law permits abortion in order to save the expectant mother's life. Abortion is permitted in the majority of European countries for a number of reasons, mainly to preserve the mother's physical and mental health, but also in cases of rape or incest, of foetal impairment or for economic and social reasons and, in some countries, on request. The Assembly is nonetheless concerned that, in many of these states, numerous conditions are imposed and restrict the effective access to safe, affordable, acceptable and appropriate abortion services. These restrictions have discriminatory effects, since women who are well informed and possess adequate financial means can often obtain legal and safe abortions more easily".

"3. The Assembly also notes that, in member states where abortion is permitted for a number of reasons, conditions are not always such as to guarantee women effective access to this right: the lack of local health care facilities, the lack of doctors willing to carry out abortions, the repeated medical consultations required, the time allowed for changing one's mind and the waiting time for the abortion all have the potential to make access to safe, affordable, acceptable and appropriate abortion services more difficult, or even impossible in practice".

"4. The Assembly takes the view that abortion should not be banned within reasonable gestational limits. A ban on abortions does not result in fewer abortions but mainly leads to clandestine abortions, which are more traumatic and increase maternal mortality and/or lead to abortion "tourism" which is costly, and delays the timing of an abortion and results in social inequities. The lawfulness of abortion does not have an effect on a woman's need for an abortion, but only on her access to a safe abortion".

"6. The Assembly affirms the right of all human beings, in particular women, to respect for their physical integrity and to freedom to control their own bodies. In this context, the ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way".

“7. The Assembly invites the member states of the Council of Europe to: (…)

7.4. lift restrictions which hinder, de jure or de facto, access to safe abortion, and, in particular, take the necessary steps to create the appropriate conditions for health, medical and psychological care and offer suitable financial cover ...”.

THE LAW

PRELIMINARY OBSERVATIONS

The right to protection of health

66. The Committee recalls that in its decision of 8 September 2004 on the merits of FIDH v. France, Complaint No. 14/2003, §31, it stated that "human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights and [that] health care is a prerequisite for the preservation of human dignity (…)”. The right to protection of health guaranteed in Article 11 of the Charter thus complements the protection afforded to the principle of human dignity by Articles 2 and 3 of the European Convention on Human Rights as interpreted by the European Court of Human Rights. As part of the positive obligations that arise by virtue of this fundamental right, States must provide appropriate and timely health care on a non-discriminatory basis, including services relating to sexual and reproductive health. As a result, a health care system which does not provide for the specific health needs of women will not be in conformity with Article 11, or with Article E of the Charter taken together with Article 11.

Responsibility for implementing the Charter

67. The Committee considers that the allegations concerning the violation of the Charter due to actions / omissions by local and regional authorities come within the scope of responsibility of the State: as a State Party to the Charter, the Italian State bears the responsibility in international law of ensuring that obligations arising from the Charter are implemented in full throughout its territory (see European Roma Rights Centre (ERRC) v. Greece, Complaint No. 15/2003, decision on the merits of 8 December 2004, § 29).

Scope of the complaint

68. The Committee is called to rule on how the manner in which sexual and reproductive health care services are organised in Italy impacts upon the enjoyment of the right to protection of health provided for under Article 11 of the Charter. It is not called to determine whether individuals enjoy a right to obtain an abortion or whether individuals should benefit from a right to conscientious objection.

69. The Committee considers that once States introduce statutory provisions allowing abortion in some situations, they are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are legally entitled under the applicable legislation(see, *mutatis mutandis* reference to the European Court of Human Rights in P. and S. v. Poland and R.R. v. Poland, paragraphs 53 and 54 above).

70. Having regard to the specific argument put forward by the complainant organisation to the effect that the conclusion of agreements between public hospitals and private health providers to deliver abortion services is contrary to the public nature of Act No. 194/1978, the Committee considers that issues relating to the public/private character of such agreements and their relationship to the above-mentioned Act fall outside the scope of its competency, except insofar as such issues relate to and have an impact upon the protection of the right to health.

ALLEGED VIOLATION OF ARTICLE 11 OF THE CHARTER

71. Article 11 of the Charter reads as follows:

> **Article 11 – The right to protection of health**
>
> Part I: “Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable."
>
> Part II: “With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed *inter alia:*
>
> 1. to remove as far as possible the causes of ill-health;
>
> 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
>
> 3. to prevent as far as possible epidemic, endemic and other diseases."

A – Arguments of the parties

1. The complainant organization

72. The complainant organisation considers in general that the aim of Act No. 194/1978 is to establish “standards for the social protection of maternity and for the voluntary termination of pregnancy”. IPPF EN points out that Section 9 of the above-mentioned act recognises the right to conscientious objection of medical practitioners and other health personnel as an aspect of its wider objective of making provision for women to enjoy a right of access to procedures for the termination of pregnancy and, more particularly in paragraph 4 of Section 9, imposing an obligation on public and private hospitals to ensure the effective exercise of this right.

73. In reply to the statements contained the Government's submissions (see paragraph 13 above) - IPPF EN makes clear that the complaint "does not contain any request for limiting the number of objecting health personnel or impeding the exercise of the right to raise conscientious objection".

74. The reasoning of the complainant organisation is based on the assumption that the right of access to procedures for termination of pregnancy established by Sections 4 and 6 of Act No. 194/1978 is closely connected to, inter alia, securing the effective enjoyment of the right to the protection of health. In this respect, the complainant organisation notes that Article 11 of the Charter requires that States not only take appropriate measures to remove the causes of ill-health and prevent diseases but also provide advisory and educational facilities to promote health and well-being. The complainant organisation considers that such services should be made available to particularly vulnerable categories of persons, such as pregnant women.

75. IPPF EN recalls that paragraph 4 of Section 9 of Act No. 194/1978 ("Section 9§4") was designed to ensure that women would enjoy access to abortion procedures irrespective of whether individual medical practitioners and other health personnel invoked their right of conscientious objection. The complainant organisation stresses that, in accordance with the said paragraph, hospitals and authorised nursing homes must in all cases guarantee access to abortion procedures and that regional authorities must take action to ensure effective enjoyment of this right, if necessary by making arrangements to transfer personnel between different medical facilities.

76. The complainant organisation goes on to argue that the high number of medical practitioners and other health personnel exercising the right to conscientious objection in Italy renders the right to access abortion procedures in all cases guaranteed by Section 9§4 ineffective in many parts of the country, by limiting the circumstances in which such procedures can be carried out.

77. In this respect, IPPF EN also argues that the provisions of Section 9§4are inadequate to guarantee the exercise of a woman's statutory right to access abortion procedures, on the basis that they do not specify the concrete measures to be taken by hospitals and nursing homes, as well as by the competent supervisory regional authorities, to ensure that women can effectively obtain access to such procedures.

78. IPPF EN considers that the law should :

"[d]etermine more precisely the concrete and specific ways in which to ensure the adequate presence of non-objecting doctors, providing for example as already established by the Constitutional Court in relation to assisted procreation (judgment No. 151 of 2009) that all hospital establishments must be equipped with the 'strictly essential number' to meet the demands for the voluntary termination of pregnancy, requiring that the Regions specifically monitor the means of defining this number".

79. Given the inadequacy of the statutory framework, the complainant organisation also considers that the measures currently adopted by hospitals and nursing homes to provide access to abortion procedures, as well as the initiatives taken by regional authorities, are not sufficient or suitable for fulfilling the objectives of Act No. 194/1978 in relation to the termination of pregnancy.

80. IPPF EN furthermore contends that, given the difficulties encountered in the access to relevant services, the physical and/or psychological stress faced women who decide to terminate their pregnancy may put their health or life at serious risk. In this respect, IPPF EN alleges that in some cases women:"[a]re forced to avail of the establishments and persons, or even to travel abroad, which do not guarantee the full protection of health and hygiene that is required by the termination procedure".

81. In the complaint, IPPF EN indicates that the inadequacy of Act No. 194/1978

"[e]merges from the data collected at both national and regional levels, which show an insufficient number of non-objecting medical personnel in the public hospital system able to properly provide for the termination of pregnancy, the access to which is guaranteed by the same [act]".

82. The complainant organisation points out that these data can be found in the official reports on the implementation of Act No. 194/1978, submitted every year by the Ministry of Health to the Parliament. In this framework, the complainant organisation quotes the information relating to conscientious objection contained in the report submitted by the said ministry in 2011 (cf. Chapter 3.10 of the report):

"(…) in 2009, there was a stabilisation of conscientious objection among gynaecologists and anaesthetists, after a considerable increase in previous years. At the national level, the percentage of objecting gynaecologists increased from 58.7% in 2005 to 69.2% in 2006, to 70.5% in 2007, to 71.5% in 2008 and to 70.7% in 2009; the percentage of anaesthetists in these years increased from 45.7% to 51.7%; the percentage of non-medical staff saw a further increase, from 38.6% in 2005 to 44.4% in 2009. In Southern Italy, there is a rate of more than 80% registered gynaecologists: 85.2% in Basilicata, 83.9% in Campania, 82.8% in Molise, 81.7% in Sicily and 81.3% in Bolzano; the highest percentages of [anaesthetists] are registered in Molise and Campania at more than 77% and in Sicily at 75.6%, and the lowest percentage is in Tuscany at 27.7% and Trento at 31.8%; for non-medical personnel the numbers are lower, with a maximum of 87% in Sicily and 82% in Molise. (…)".

83. More particularly, based on the above-mentioned report, IPPF EN provides the official data relating to the total number / percentages of gynaecologists, anaesthetists and non-medical personnel who exercised the right to conscientious objection in 2009, per region and per macro-area: Northern, Central, Southern, Insular Italy (see table 1 below).

Table 1

REGION / MACRO-AREA	**Gynaecologists**	**Aanaesthetists**	**Non-medical personnel**
NORTHERN ITALY	**1652 / 65,2 %**	**1684 / 43,1%**	**3498 / 31,5%**
Piedont	284 / 63,8%	227 / 40,9 %	367 / 20,8 %
Valle d'Aosta	2 / 18,2%	5 / 26,3 %	0 / 0,0 %
Lombardy	560 / 66,9%	607 / 47,1 %	1000 / 40,3 %
Bolzano	26 / 81,3%	26 / 38,8 %	166 / 68,9 %
Trento	19 / 55,9%	21 / 31,8 %	367 / 22,4 %
Veneto	391 / 78,0%	430 / 49,0 %	1011 / 59,8 %
Friuli Venetia Giulia	67 / 60,4%	39 / 36,1 %	174 / 30,5 %
Liguria (2008)	98 / 57,3 %	128 / 38,1 %	98 / 6,8 %
Emilia Romagna	205 / 52,4 %	201 / 33,9 %	315 / 25,3 %
CENTRAL ITALY	**681 / 69,5 %**	**700 / 52,3 %**	**2813 / 48,6 %**
Tuscany	219 / 62,2%	122 / 27,7 %	347 / 30,8 %
Umbria	62 / 63,3%	95 / 63,3 %	1038 / 62,5 %
Marche	85 / 62,0%	97 / 50,3 %	774 / 43,3 %
Lazio	315 / 80,2%	386 / 69,5 %	654 / 53,6 %
SOUTHERN ITALY	**972 / 80,4 %**	**808 / 66,2 %**	**2415 / 56,5 %**
Abruzzo (data 2008)	84 / 78,5 %	94 / 57,3 %	189 / 66,3 %
Molise (data 2007)	24 / 82,8 %	28 / 77,8 %	73 / 82,0 %
Campania (data 2007)	329 / 83,9 %	262 / 77,1 %	515 / 72,4 %
Apulia	340 / 79,4 %	274 / 61,3 %	953 / 73,5 %
Basilicata	69 / 85,2%	59 / 63,4 %	421 / 27,1%
Calabria	126 / 73,3%	91 / 64,5 %	264 / 78,1%
INSULAR ITALY	**680 / 74,1 %**	**607 / 68,7 %**	**1747 / 72,5 %**
Sicily	541 / 81,7%	526 / 75,7 %	1426 / 87,0%
Sardinia	139 / 54,3%	81 / 42,9 %	321 / 41,8%

84. With respect to Lombardy Region, in the complaint IPPF EN points out that "[t]here has been an increase in the obstacles preventing the proper implementation of the legislation (…) due to the significant increase of objecting medical and non-medical personnel, which in some areas is above 85%" (cf. table provided by the complainant organisation in appendix 13).

85. A comparative table on the percentages relating to medical practitioners and other health personnel who exercised the right to conscientious objection in the period 2003 – 2009 is also provided in the complaint. Also in this case, the information is based on the data provided by the Ministry of Health (see table 2 below).

Table 2

	GYNAECOLOGISTS	**ANAESTHETISTS**	**NON-MEDICAL PERSONNEL**
Ministerial Report 2011(data 2009)	**70,7%**	**51,7%**	**44,4%**
Ministerial Report 2010(data 2008)	71,5%	52,6%	43,3%
Ministerial Report 2009 (data 2007)	70,5%	52,3%	40,9%
Ministerial Report 2008 (data 2006)	69,2%	50,4%	42,6%
Ministerial Report 2007 (data 2005)	58,7%	45,7%	38,6%
Ministerial Report 2006 (data 2004)	59,5%	46,3%	39,1%
Ministerial Report 2005 (data 2003)	**57,8%**	**45,7%**	**38,1%**

86. In light of this data, IPPF EN takes the view that the measures which have been adopted by the competent authorities in response to the high number of objecting medical practitioners and other health personnel are clearly insufficient to guarantee adequate implementation of Act No. 194/1978 and in particular the right of women seeking access to procedures for the termination of pregnancy.

87. In particular, the complainant organisation considers that, on the one hand, recourse to external non-objecting health personnel cannot ensure the necessary continuity in the provision of the care service; on the other hand, that the establishment of agreements between hospitals and private establishments compromises the public nature of the act. In this regard, IPPF EN concludes that, “in response to the shortage of staff, a solution to the problem is not identified, but a mechanism which bypasses it is introduced”.

88. As regards the possibility for women to lodge administrative or judicial appeals when the access to procedures for termination of pregnancy is not guaranteed, the complainant organisation considers that the time necessary for the delivery of a decision by an administrative or judicial authority may have a seriously negative effect on the position of complainant organisation who - within the strict time limits established by Act No. 194/1978 - intend to terminate their pregnancy. Moreover,

IPPF EN notes that the outcome of any such administrative or judicial appeal process would relate only to the specific case at issue, and would not represent a solution for other cases.

89. As regards the Charter's implementation, IPPF EN considers that State parties should not merely take legal action but also practical measures to secure the enjoyment of the rights protected by the Charter, including the provision of resources and the adoption of operational procedures. The complainant organisation also considers that the violation of the Charter due to actions or omissions by regional authorities must necessarily come within the scope of responsibility of the State. In this respect, IPPF EN quotes a number of provisions of the Protocol and its explanatory report, as well as some past decisions of the Committee.

90. As far as the obligation of the State to provide a regulatory framework enabling a pregnant woman to effectively exercise her right of access to lawful abortion is concerned, the complainant organisation also refers to a number of judgments of the European Court of Human Rights (see paragraphs 53 to 56 above).

91. The complainant organisation concludes that the inadequate wording of Section 9§4 of Act No. 194/1978 and the subsequent problems concerning its implementation compromise the rights to life, health and self-determination of women seeking to terminate a pregnancy and therefore places the above-mentioned article in contravention of Article 11 of the Charter.

1. The respondent Government

92. The Government invites the Committee to declare the complaint of IPPF EN unfounded:

"a) due to the interpretation formulated by [IPPF EN] which distorts Articles 11 and E of the Charter to the detriment of women's health and lives who [IPPF EN] wants to be assisted only by non-objecting medical personnel who promotes voluntary termination of pregnancy of the women, without checking their physical and psychological state but only their economic situation ;

b) because the State cannot limit the number of medical personnel raising conscientious objection while respecting the freedom of conscience, as recognised in the case law of the European Court of Human Rights relating to Article 9 of the 1950 Convention".

93. From a general point of view, in both its submissions on the admissibility and the merits, the Government expresses the view that Act No. 194/1978 "achieves a fair and necessary balance between the rights to life and health of the woman and the freedom of conscience of medical practitioners and other health personnel with respect to voluntary termination of pregnancy". As a result, the Government is of the view that the apparent impediment to access to abortion procedures caused by the high number of objecting health personnel should not be interpreted as a violation of Article 11 of the Charter.

94. The Government also contends that Act No. 194/1978 – "which provides modalities and measures aimed at guaranteeing the right to life and the right to health of women in case of voluntary termination of pregnancy" –should be viewed as coming within the framework of "the margin of appreciation" related to Article G of the Charter.

95. Article G of the Charter reads as follows:

> **Article G – Restrictions**
>
> "1. The rights and principles set forth in Part I when effectively realised, and their effective exercise as provided for in Part II, shall not be subject to any restrictions or limitations not specified in those parts, except such as are prescribed by law and are necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public interest, national security, public health, or morals.
>
> 2. The restrictions permitted under this Charter to the rights and obligations set forth herein shall not be applied for any purpose other than that for which they have been prescribed".

96. With respect to paragraph 1 of this provision, the Government places particular emphasis on the expressions "protection of the rights and freedoms of others" and "protection of public health".

97. In the document appended to the submissions on the admissibility of the complaint (cf. document established by Mr Giuseppe RUOCCO, Director General of Prevention, Ministry of Health, dated 28 September 2012), the Government states that "(…) under Act No.194/78, authorised hospitals and private health-care facilities are always obliged to conduct the procedures as envisaged under art. 7 and to perform abortions as provided for under Articles 5, 7 and 8 of this law and the Regions must control and guarantee these procedures also through staff mobility".

98. In this framework, the following general considerations are made:

- "The aim of the law is to establish a principle, clearly specified under Article 9 of Act 194: the possibility for health-care professionals and staff to become conscientious objectors and the obligation for the Regions and the health care organizations to organize accordingly".

- "In this connection, there is no need to change the law but only to ensure that the Regions implement the procedures envisaged under Act 194/78, respecting their full organizational autonomy as provided for in the last changes to Title V of the Constitution in 2001.

- "If this service is not guaranteed, stakeholders, representative organizations and health authorities etc. can appeal to the central or regional governments and even to the court to enforce the legislation".

- "There has always been a high number of conscientious objectors among health care professionals and staff since the inception of the abortion legislation. However, this has not undermined the right of women to benefit from this law and from this procedure".

- "(…) the Regions and the Health Authorities ensure the services as provided for under Act 194 not only through staff mobility, but also through ad hoc agreements with specialists".

99. In order to support these considerations, some data is provided, i.e.:

- "in 2009 (the last report of Parliament), 118.579 abortions were conducted with a 50.9% reduction vs. 1982, when there was a peak number of procedures: 234.801".

- "The abortion rate – the most accurate indicator of abortions in women between 15-49 years – dropped by 52.3%, from 17.2‰ to 8.2‰". (…) "Considering only the number of Italian women who aborted in 2009 (79.535 cases), the abortion rate has gone down by 66.1% with respect to 1982, when the presence of foreign women in Italy was negligible".

- "The emergency procedures (without waiting for 7 days after the certification date) in 2009 amounted to 9.2%, the same value reported in the 1997 Report (…)".

- "85% of the procedures is conducted through Karman hysterosuction".

- "In 93.6% of cases, the hospital stay is less than 1 day and all abortions are performed as outpatients procedures".

- "In the last few years, the time between the certification and the procedure has become shorter and more than 80% of women has undergone this procedure at a gestational age of ≤ 10 week".

- "The complication rate has always ranged between 3 and 4 %.

- "Since 2010, the national health service has organized a pharmacological abortion services. This method is increasingly used by women and is provided by an increasing number of facilities. All this, together with the organizational actions prepared by the Regions and by the health authorities contribute to reducing the impact of the high value given to conscientious objection".

100. On this basis, in the above-mentioned document the Government states that:

- "The reduction in the number of abortions, in the abortion rate and in the number of repeated abortions shows that abortion prevention services have worked very well, that women have a good attitude vis-a'-vis fertility control measures and that the tools for responsible and conscious parenthood are successful. Ad hoc projects have been developed to prevent abortion regarding foreign women with specific initiatives such as cultural mediation, the facilitation of the access to services and the training of professionals".

- "The stable number of emergency procedures and the shorter time between the certification and the procedure show that services are efficient; the percentage increase in the number of day-hospital and 1 day hospital procedures indicate that women can more easily and smoothly access these procedures and that human resources are better organized; the high percentage of women who have an abortion at a gestational age of ≤ 10 weeks, combined to a very low rate of complications, especially to the fact that no death or serious complication has ever occurred following an abortion in line with Act 194 is the best evidence that today abortion is not hazardous for women's health".

101. For these reasons, the Government concludes that: "conscientious objection level present in Italy – partly balanced by staff mobility and agreements with specialized obstetrics and gynaecology services - and the recent introduction of pharmacological abortion in Italy do not seem to have a direct impact on the recourse to abortion and so on the violation of women' s rights; moreover, the reduction in the number of women who undergo an abortion is far greater than the increase in the number of conscientious objectors among health care professionals and staff; in the last few years, services have become more efficient, both in terms of prevention and in terms of access and the abortion procedures are not dangerous for women considering the Karman-hysterosuction technique used, the gestational age when the procedure is performed (≤10 weeks) and the very low complication rate (3 - 4‰).

B – Further information submitted by the parties at the Committee's request

102. During consideration of the complaint, the Committee asked both parties to provide further information relating, *inter alia,* to the following issues: a) any difficulties encountered by pregnant women as well as - at an organisational level - by hospitals and nursing homes in relation to the provision of abortion procedures caused by the exercise of the right of conscientious objection by health personnel; and b) any measures implemented by the competent authorities in order to address any such difficulties that have arisen.

1. The complainant organisation

103. The complainant organisation points out that much of the information presented in its response "was unavailable when the complaint was initially presented and emerged due to the publicity from the complaint itself". However, it also indicates that difficulties exist in obtaining the information requested by the Committee for various reasons which are set out in detail in its response.

104. IPPF EN stresses the particular situation of both "women who decide to interrupt their pregnancy on the one hand and the healthcare professionals on the other, who by playing a supportive role decide not to raise any conscientious objections". It notes "how difficult if not outright impossible it is to be able to ask women first and foremost - but also non-objecting doctors - to reveal themselves publicly in a complaint against individual conscientious objector doctors or facilities where services for voluntary termination of pregnancy are not guaranteed". In order to prove this assertion, a number of direct testimonies are provided. In this context, IPPF EN furthermore provides evidence that the Italian National Institute of Statistics (ISTAT) "even though requested by the LAIGA to submit a list of the facilities where abortions are performed in order to understand the actual state of implementation of Law No. 194 of 1978, refused to provide this". Some evidence is also provided demonstrating that as "a matter of course that cases of women who are forced to go to other facilities slip through this type of investigation, as no traces remain of their requests in those facilities where they do not find adequate assistance".

105. IPPF EN provides further information on the social context in which the issue of voluntary termination of pregnancy and conscientious objection is publicly discussed in Italy at the moment. In this respect, reference is made to some online publications and to the demonstrations held in several Italian cities during 2012 and 2013 "against the application of Act No. 194/1978".

106. In this respect, IPPF EN states that:

"[T]hese types of stands and initiatives completely deny the legitimacy of Law No. 194 of 1978 (which instead, we reiterate, was defined by the Italian Constitutional Court and is constitutionally protected; its essential legal core cannot be broken apart without violating constitutional principles of which it is their direct expression), fostering a climate that makes it very difficult, if not outright impossible, for women and doctors to report failures in implementing the law (…)".

107. As regards the state of enforcement of Section 9§4 of Act No. 194/1978, the complainant organisation refers *inter alia* to the data provided by the President of the LAIGA –*Libera Associazione Italiana Ginecologi per l'Attuazione della legge 194* (Free Italian Association of Gynaecologists for the Implementation of Act No. 194/1978):

"(…) [T]he law [194/1978] is widely disregarded and (…) in many hospitals it is impossible to have an abortion. (…) There are no reliable, easily available, official sources providing up-to-date list of hospitals where legally authorised abortions can be performed nor a list of gynecology units where they are provided. In short, it is impossible to check where abortions are available. (…)[LAIGA] consequently began to enquire (…), hospital by hospital, using information found on certain non-official websites (…), in order to find an answer to our question: is Article 9 of Law 194 being applied in practice? (…) The results of our investigation are summarised in the table below. Given the enormous difficulty in obtaining official data, it should be noted that this information is not exhaustive but gives some idea of the problem".

REGION	Number of hospitals with gynaecology unit	Number of hospitals providing abortions within 90 days of pregnancy	Number of hospitals providing abortions after 90 days of pregnancy
PIEDMONT	36	29	3
LOMBARDY	64	27	6
TRENTINO ALTO ADIGE	15	7	1
VENETIA	42	13	3
FRIULI VENETIA GIULIA	11	8	?
LIGURIA	12	7	2
EMILIA ROMAGNA	29	15	2
TUSCANY	26	24	3
UMBRIA	16	12	2
LAZIO	31	21	7
ABRUZZO	20	9	2
MOLISE	6	3	1
BASILICATA	6	5	?
APULIA	33	22	5
CALABRIA	33	23	5
SICILY	37	26	2
SARDINIA	24	12	10

108. With this in mind, the President of LAIGA concludes: "(…) not all hospitals provide terminations of pregnancy, thereby breaching Article 9 of Law 194 (…)". A list of 45 hospitals where, even if a gynecology unit exists, terminations of pregnancy cannot be performed, is provided by the President of LAIGA (regions concerned: Lazio, Piedmont, Venetia, Friuli Venetia Giulia, Marche, Lombardy, Emilia Romagna, Tuscany, Sicily, Sardinia, Apulia), i.e.:

Azienda Ospedaliera Universitaria S.Andrea, *Policlinico Universitario Tor Vergata* (Rome)*,Ospedale Acquapendente* (*Viterbo*),*Ospedale Andosilla* (*Civitacastellana*), *Ospedale Belcolle* (*Viterbo*),*Ospedale S.Camillo De Lellis* (*Rieti*), *Ospedale Umberto 1°* (*Frosinone*), *Ospedale S.Benedetto* (*Alatri*), *Ospedale di Velletri, Ospedale Maggiore della Carità* (*Novara*),*Ospedali Riuniti S.LorenzoVarmagnola*,*Ospedale di Camposampiero* (Turin),*Ospedale Castelli* (*Verbania*),*Ospedale Portogruaro* (*Verona*),*Ospedale di Belluno, Ospedale di Bassano, Ospedale di Gorizia, Ospedale di Jesi, Ospedale di Fano, Ospedale di Fermo, OspedaliCivili di Brescia, Ospedale S.Maria delle Stelle Melzo, Ospedale di Cernusco, Ospedale di Carate, Ospedale di Gallarate, Ospedale di Gorgonzola, Ospedale di Angera, Ospedale di Treviglio e Caravaggio, Ospedale di Como, Ospedale di Cantu', Ospedale di Monza, Ospedale di Melzo S. Maria delle Stella, Ospedale di Sassuolo,*

OspedaleFranchini-Montecchio Reggio Emilia, Ospedale di Ponte Annicari, Ospedale di Lipari, Ospedale Muscatello (*Augusta*), *Ospedale di Bosa, Ospedale di Ozieri, Regione, Ospedale San Paolo (Bari), Ospedale Perrino* (*Brindisi*),*Ospedale di Venere, Ospedale di Bitonto, Ospedale di Bisceglie, Ospedale di Fasano*.

109. As regards the situation of medical personnel carrying out abortions procedures, the President of LAIGA provides “complete data” only with respect to the Region of Lazio. In this respect, she states that: “In this region, out of a total of 391 gynaecologists attached to hospital units, only 33 are non-objectors and perform abortions; thus 91.3% of gynaecologists in Lazio are conscientious objectors”. As regards other regions (Piedmont, Lombardy, Trentino Alto Adige, Abruzzo, Campania, Basilicata, Apulia, Calabria, Sicily, Sardinia), the President of LAIGA provides data indicating that in “at least” 38 hospitals there are no non-objecting gynaecologists, or there is just one. According to the information provided, the hospitals in this situation are as follows:

Ospedali Riuniti (*Borgomanero*), *Ospedale Broni* (*Stradella*), *Ospedale Civile* (*Sondrio*), *Ospedale Civile* (*Cavalese*),*Ospedale Civile*(*Bassano*),*Ospedale S. Spirito, Policlinico Umberto I, A.O.S. Andrea* (Rome), *Ospedale San Paolo* (*Civitavecchia), Ospedale Paro di Delfino* (*Colleferro*),*Ospdale Gonfalone* (*Monterotondo*),*Ospedale Coniugi Bernardini* (*Palestrina*), *Ospedale Paolo Colombo* (*Velletri*),*Ospedale S. Maria Goretti* (*Latina*), *Ospedale Civile* (*Formia*),*Ospedale Civile* (*Frosinone*), *Ospedale SS Trinità* (*Sora*),*Ospedale S.Benedetto* (*Alatri*), *Ospedale S. Scolastica* (*Cassino*), *Ospedale Belcolle*(*Viterbo*),*Ospedale Civile* (*Tarquinia*), *Ospedale Civile S.Anna* (*Ronciglione*),*Ospedale Civile* (*Rieti*), *ASL 2 Chieti* (*Ortona*), *ASL 3 Chieti* (*Chieti*), *ASL SA* (*Eboli*),*Ospedale Potenza* (*Chiaromonte*), *Ospedale CivileLocri, ASP Catanzaro, Ospedale Civile Cosenza, ASPS* (*Locri*), *Ospedale Civile* (*Cetraro*), *ASP 9* (*Trapani*),*Ospedale Microcitemico* (*Cagliari*),*Ospedale Civile*(*Bosa*), *Ospedale Civile* (*Ozieri*),*Ospedale Civile* (*Businco*).

110. On this basis, the President of LAIGA draws the following conclusion:

“In the majority of hospitals there is an imbalance between the total number of gynaecologists and the total number of non-objectors doctors, since there is a very high percentage of objectors. Many facilities do not provide the service because they have no staff. But even when there is just one non-objector there are huge problems, entailing:

- longer waiting times, with greater risks attaching to the procedure. There are numerous cases of terminations performed at the legal time-limit, that is at around 12 weeks;
- greater occupational risks for non-objecting gynaecologists: extended waiting times (in many cases over 3-4 weeks from issue of the certificate to actual performance of the abortion) force doctors to adopt poor clinical practice;
- reduction of the time available for each patient during the abortion procedure, at the expense of patient protection, information and social care;

- travel by patients to other provinces or regions, or even other countries (many terminations of pregnancy beyond the ninetieth day on account of foetal disease are absorbed by hospitals in neighbouring countries, in France, Spain and the UK);
- if non-objecting staff are on holiday, the abortion service is suspended (for example, in Bari when the only non-objecting gynecologist goes on holiday, prescription of the RU-486 abortion drug is interrupted, and the free telephone number for information and appointments ceases to operate);
- if non-objecting doctors are sick, the service is suspended. For example, in Monterotondo, the only non-objecting gynecologist had a car accident: he is still on sick leave, and ever since his accident (in November 2012) the service has been suspended. In Frosinone, when the gynecologist is on sick leave, the service is similarly interrupted;
- if the only non-objector takes retirement, the unit closes – as happened, for example, in Jesi;
- if non-objectors doctors die, the service is suspended: in Naples the only non-objecting gynecologist died, but the subsequent suspension of the service led to popular protest which made it necessary to recruit a gynecologist for that purpose."

111. Concerning the specific questions put forward by the Committee, the complainant organisation also provides further information based on different sources, i.e. first hand testimonies, press articles, books, blogs, *fora*, etc. This information refers to the state of enforcement of Section 9§4 of Act No. 194/1978 with respect to different Italian hospitals, nursing homes and advice centres.

112. In this context, IPPF EN mentions that:

- "Conscientious objection has denied [the city of] Bari and its Province of the last hospital where voluntary termination of pregnancy was performed. In fact, at St. Paul hospital, the only public facility, all the doctors declared themselves to be conscientious objectors (…).In particular, it turns out that women, due to the impossibility of accessing services for voluntary termination of pregnancy at public hospitals, need to come to the Polyclinic, which is not part of the ASL (local healthcare [public] network) and where there are significant organizational difficulties due to the scarcity of non-objecting doctors, or at the facilities *Monopoli*, *Putignano* and *Corato*, if not another Region outright. Also in the Department of Gynaecology and Obstetrics of the Perrino Hospital of Brindisi all doctors are conscientious objectors (…)".

- "(…) [T]he Polyclinic of Naples (…) shut down its public service for voluntary termination of pregnancy after the death of the only non-objecting doctor (…)".

- "Given the lack of non-objecting personnel service for voluntary termination of pregnancy is no longer available in *Fano* and *Jesi*".

113. As regards the Region of *Lazio*, it is reported that:

"[I]n 31 public facilities 9 do not offer termination of pregnancy services and in three provinces no therapeutic abortions are performed" (reference is made to the provinces of *Frosinone*, *Rieti* and *Viterbo*)". "St. Andrea Hospital, in Rome, a public university hospital, is not performing abortions and is not training new gynaecologists (…)". "[M]any of the non-objecting doctors are on the verge of retirement and will not be replaced due to a lack in professional training (...)".

114. IPPF EN indicates that according to the local branch of the trade union CGIL, as regard the Region of Sicily, province of *Palermo*:

"[I]n some hospitals there isnot a single non-objecting doctor (or there is only one, who is external); in [the province of] Messina there are hospitals without a single non-objecting doctor ([towns of] Barcellona, Patti, Lipari, Mistretta) (…)".

115. Documentation is provided to show that in Sicily the responsible operational unit relating to the advice centers of the Ionian area ASL 5 (*Unità Operativa Consultori Area Ionica Asl 5*) "(…) was obliged to direct women seeking access to abortion to other cities because in Messina (…) it was impossible to guarantee the treatment".

116. Other documents make reference to the fact that in the Region of *Abruzzo*:
"[T]here are hospitals where there are no non-objecting doctors (in [city of] Pescara, out of three hospitals only in one is the service guaranteed and with only one doctor; in [the city of] Teramo, out of four hospitals the service is guaranteed only in two; in [the city of] Chieti, out of five hospitals only three guarantee it, and in one facility with only one external non-objecting doctor; in the three facilities of [the city of] L'Aquila there is only one non-objecting doctor".

117. Concerning the Region of *Liguria*, it is stated that:

"The wide recourse to conscientious objection compromises the access to the voluntary termination of pregnancy".

118. According to IPPF EN, in the Region of Tuscany, with particular reference to [the hospital] *Azienda Ospedaliera Universitaria Senese U. O. C. Ostetricia e Ginecologia – Policlinico 'Le scotte' Iale Bracci* (Siena):

"[T]he suspension of service is expressly motivated by the presence of objecting doctors".

119. Documentation concerning the numerous cases in which the service for termination of pregnancy was suspended in the hospital of *Gavardo*, Province of *Brescia* (Region of Lombardy), is also provided.

120. Regarding the problems of access to the termination of pregnancy procedures of some hospitals in the Milan province, based on the information provided in the report of the President of LAIGA and other relevant documents, it is pointed out that:

"Each hospital takes a set number of women; for example, 'the first 15 women to arrive', 'not more than 20 individuals', 'the first twelve', 'not more than 10-12', etc. This means that more women are coming to the hospitals than can actually be accepted: the Buzzi Hospital in Milan takes the first 15 women to arrive on Wednesdays and Fridays; the San Carlo Hospital takes no more than 20 women on Fridays; the San Paolo Hospital accepts the first 12 patients on Fridays; at the Mangiagalli Clinic in Milan not more than 10-12 women are accepted from Monday to Friday; Luigi Sacco Hospital accepts the first ten women on Wednesdays, while Rho Hospital takes six women a week; Garbagnate Hospital in Milan accepts up to six women a week; Cernusco Hospital takes up to nine women a week".

121. As regards possible cases of non-replacement of non-objecting personnel who are not available (due to holiday, illness, retirement, etc.), the complainant organisation recalls the case of the hospital in [the town of] *Gavardo*" where after the retirement of [a] doctor (…) there were no efforts undertaken to take on an additional physician who would work alongside the only remaining non-objecting doctor."; as well as the case of Polyclinic of Naples "where after the death of the only non-objecting doctor, the service was discontinued".

122. In addition, documents are provided regarding the fact that at the Hospital *San Camillo* in Rome:

"[A] therapeutic abortion was delayed for four days due to a lack of non-objecting anesthetists as they were all on vacation. The delay risked overstepping the time limits stipulated by Law No. 194 of 1978".

123. With respect to the Region of Lombardy, the complainant organisation provides information on an inquiry which,

"[o]ther than underscoring the fact that the real data on conscientious objection is higher than the official data (…), also highlights the problem of needing to tackle non-objecting personnel shortages by depending on external doctors who have already retired, or 'on-call personnel' or freelance doctors paid on a fee-for-service basis".

(reference is made in this case to the cities / provinces of Treviglio, Como, Cremona, Lecco, Lodi, Milano, Monza and Brianza, Mantova, Sondrio and Gallarate).

124. In this respect, it is pointed out that "things are going to get worse, as many non-objecting physicians are elderly and near retirement […] while the younger ones are almost all objectors" and that these problems "might be applicable to the whole of Italy".

125. With respect to the Region of *Marche*, reference is made to the case of the city of Ascoli Piceno:

"[w]here it would not be possible to perform voluntary terminations of pregnancy if it weren't for a doctor who comes from Milan every week to guarantee these procedures".

126. As regards cases of refusal of objecting medical practitioners and other health personnel to provide the necessary care prior to and following abortion, reference is made to the decision of the Supreme Court (*Corte di Cassazione*) of 2 April 2013 "which sentenced a doctor who was a conscientious objector to a year in jail after he refused to aid a woman who had already undergone an abortion and had developed a serious hemorrhage as a result".

127. In this context, IPPF EN recalls the decision of 9 October 1979 of the *Pretura of Ancona*, which established that "the exemption as per Art. 9 of Law No. 194/1978 for objectors applies exclusively to procedures and activities specifically and necessarily intended to terminate a pregnancy, and not care provided prior to and following the procedure" and that "only activities immediately preceding anesthetization of the patient, anesthesia itself, and the abortion are subject to conscientious objection".

128. As regards cases in which pregnant women, due to the limited number of available non-objecting health personnel, tried in vain to access the procedures for termination of pregnancy, IPPF EN reports that in Padova:

"[A] woman was denied a therapeutic abortion and she was forced to go to Napoli. The case led to a parliamentary hearing by the Radical group in the Chamber of Deputies".

129. Having regard to the data provided by CGIL with respect to the Region of Marche, it is stated that:

"[A]lready in 2010, of the 2,409 voluntary terminations of pregnancy that women residing in the Marche had undergone, 5.5% of the procedures were performed outside of their respective Provinces and 24.5% outside of Regione Marche".

130. Having regard to the data gathered in the document provided by LAIGA (see paragraphs107 to 110 above), IPPF EN refers to cases of foreign medical centres in France, Switzerland, United-Kingdom and Slovenia, which, in the period 2010 – 2012, agreed to provide abortion-related services to women who could not access abortion procedures in Italy, and also notes the phenomenon of women 'migrating' from one hospital to another as well as between regions in Italy in order to obtain an abortion.

131. Concerning the situation in the province of Milan, information by a doctor working at the hospitals *Clinica Mangiagalli, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico* in Milan is provided. This information refers to "cases of women which try in vain to access the procedures for the termination of pregnancy in the hospitals of Gallarate, Busto Arsizio, Melegnano and Foggia" and who "are forced to go to the hospital where [the above-mentioned doctor] works (…)".

132. As regards cases in which pregnant women, due to the limited number of available non-objecting health personnel, had abortions in unhealthy conditions and/or at their own expense, the complainant organisation refers to "the problem of clandestine or do-it-yourself abortions". In this respect, it alleges that "there are 15,000 of the former every year, even with Law No. 194 of 1978 in effect".

133. IPPF EN maintains that:

"This phenomenon, which inevitably leads women to expose themselves to significant health and life-threatening risks, in addition to forcing them to pay for a service normally guaranteed in Law No. 194 of 1978, is directly related to the problem that links the decrease in abortions to the alleged lack of problems associated with the number of doctors who are conscientious objectors".

134. Based on different sources, it is reported that:

"(…) [A]mong other variables that have a bearing on the effects of the high number of doctors who are conscientious objectors, there is also the economic factor, i.e. the economic resources women may have, determining whether they will seek treatment abroad or access methods that could place their health or even lives at risk (…)".

135. In respect to potential health risks, a reference is made by the complainant organisation to the use, by certain women of *Cytotec*:

" (…) [a] drug intended to treat ulcers but the collateral effects of which include miscarriage (misoprostol, the active ingredient of Cytotec, is used to terminate pregnancies, but using it as a do-it-yourself medication bears certain risks, depending on where you take it and if you have taken the wrong dosage)".

136. More specifically, the complainant organisation reports "the case of a woman, who tried to access to abortion in the hospital Bassini of Cinisello Balsamo (*RegioneLombardia*), where there are only two externally recruited doctors":

"This woman reports her experience of unhealthy conditions, in which she was forced to interrupt her pregnancy. The [self-managed advice center] *Consultoria autogestita di Milano* argues, from the latest official data on the application of Law No. 194 of 1978, that in the Regions where there is a low percentage of conscientious objectors the post-operative complications are approximately null and in the Regions where there is an increase of conscientious objectors there is a relevant growth of these complications".

137. As regards cases in which pregnant women, due to the limited number of available non-objecting health personnel were forced by the circumstances to continue the pregnancy, IPPF EN refers to "all the cases (…) in which difficulty accessing the service has forced women to continue their pregnancy while hoping to find other available facilities or alternative solutions".

138. More specifically, the complainant organisation provides documentation about a therapeutic abortion in hospital *San Camillo*, Rome:

"[An abortion] was delayed for four days due to the absence of non-objecting anesthetists, who were all on vacation, and the woman had stated previously that 'I'm at the mercy of this case and the vacation of the clinicians (…). They did not give me specific times and the cutoff date to proceed with the abortion is Thursday, after which I'll be forced to keep the baby until the ninth month, who in any case will be stillborn'".

139. Based on examples and figures, the document provided by the President of LAIGA (see paragraphs 107 to 110 above) refers to the difficulties experienced by pregnant women in the access to termination of pregnancy procedures, due to conscientious objection of medical personnel, in the following regions: *Marche*, *Lazio*, *Campania*, Lombardy, Apulia and Venetia.

140. In particular, the President of LAIGA points out that in application of Article 6 and 7 of Act No. 194/1978 in case of therapeutic abortions, abortions are to be performed immediately and where the termination of pregnancy is necessary in view of an imminent threat to the woman's life, it may be performed without observing the applicable procedures. It is also specified that "external or fee-based doctors are not authorized to perform so-called therapeutic abortions".

141. In relation to the above-mentioned statements, the complainant organisation indicates that: "The externally recruited non-objecting doctors cannot carry out therapeutic abortions, taking into account the time required for this kind of intervention. Women are forced to move to other hospitals". In this same context, the President of LAIGA argues that when fetal malformations are identified "(…) the woman is left to her own devices, since there is no continuity of care, and she must take it upon herself to find a hospital where she can have an abortion (…)". A number of direct testimonies concerning concrete situations experienced by pregnant women are provided.

142. In the same document, the President of LAIGA mentions the difficulties connected with the voluntary termination of pregnancy after the first three months (therapeutic abortions). In this framework, reference is made to the testimony of a woman about "the painful events that led to a so-called therapeutic abortion and which were due to the presence of only one non-objecting doctor (…) at the hospital". Concerning the presence of only one non-objecting doctor within a hospital, IPPF EN refers to the opinion expressed by doctor A. Uglietti, in relation to the fact that "where there is only one non objecting doctor it is possible to carry out only one voluntary termination of pregnancy per week".

143. Further to the arguments put forward in its response to the Government's submission, IPPF EN confirms that "there are no data or news on the use of legal appeals against the offending hospital". In this context, after referring to a decision recently taken by the Supreme Court (*Corte di Cassazione* - see paragraph 52 above), IPPF EN recalls the experience of the woman described in the paragraph above, which generated a judicial procedure, and was concluded by a letter of "excuses" of the responsible (objecting) doctor, referring to the "series of unlucky events" caused by the presence in the hospital, at the moment of the above-mentioned events, of just one (non-objecting) doctor.

144. The complainant organisation refers to the lack of measures taken by hospitals, nursing homes and regional authorities to implement Section 9§4 of Act 194/1978. In particular, it references the case of Polyclinic of Bari, for which a non-objecting doctor reported the inadequate organization of the hospital, in particular the lack of a serious outpatient clinic and staff training. Even with regard to Bari and "while specifically citing the hospitals' lack of organization", IPPF EN shares the following comment published on the blog of the national newspaper *La Repubblica*:

"No one in fact needs to deny the existence of sabotage of all non-objecting medical practitioners enacted by department and hospital directors, general administration, and not in the least by the Regional Government, which has shown itself in recent years to be incapable of reminding the local healthcare facility directors of their responsibilities".

145. IPPF EN also refers to the information indicating that:

"(…) women requesting access to voluntary termination of pregnancy services have been 'rerouted' to other hospitals after the death of the only non-objecting doctor at Polyclinic of Napoli and after they were barred from the waiting lists".

146. Still regarding Naples, the complainant organisation refers to the declarations of a former Director of a hospital department responsible for terminations of pregnancy procedures about:

"[t]he difficulties met in the application of Law No. 194 of 1978 and the lack of any improvement measures, like the mobility of doctors or different ways of recruitment".

147. As regards Rome, IPPF EN reports that, according to the Director of the Day Hospital of *San Camillo* hospital, the latter "turns out to be the only hospital in Lazio where the RU 486 pill is administered, while in Umbria there is not a single structure that offers drug-based abortions. There is great economic discrimination inherent in this, as rich women go to Marseille".

148. It is also reported that during her hearing at the Chamber of Deputies, the above-mentioned Director explained that:

"[w]e are 30 gynaecologists at St. Camillus, including the Chief Physician, of whom only three are non-objectors. Over the last four years we have been under continuous attack. We are the clinicians who have decided to defend a law of the state. Thus, in my opinion, conscientious objection constitutes the most serious aspect of the problem. We should talk about it, since those who terminate pregnancies are steadily decreasing and constantly have to justify their work".

149. In relation with the situation in Region of Lombardy, IPPF EN reports that regional councilors posed written questions to the regional government in 2012 and 2013 on the subject of conscientious objection and on the implementation of law No. 194 of 1978. The complainant organisation indicates that according to the above-mentioned questions "(…) there had been an increase in the obstacles preventing the proper implementation of the legislation in the region due to the significant increase of objecting doctors, which in some areas is above 85%".

150. Bearing in mind the Government's submission, the complainant organisation considers that:

"[t]he decrease in the abortion rate is not indicative of the idea that there are no problems in implementing Art. 9 of Law No. 194 of 1978". Instead, this piece of information might indicate that the decrease in abortions is due to the very fact that women have not been able to access this service, having to find other solutions, such as going abroad or undergoing clandestine abortions".

151. With respect to clandestine abortions, IPPF EN refers to:

"[t]he number of clandestine abortions carried out by Italian women (for foreign women there are no reliable estimates), which reaches 15,000 despite Law No. 194 of 1978 being in effect, while prior thereto there were more than 250,000 clandestine abortions every year. We highlight an additional phenomenon, that of the so-called 'do-it-yourself' abortions, done via online purchases of pills or turning to illegal markets".

2. The respondent Government

152. In its response, the Government states: "[t]he Ministry of Health [MoH] collect[s] data on objecting personnel among gynaecologists, anaesthesiologists and other health personnel through Regions: the MoH has no data on specific problems due to objecting health personnel encountered at local level".

153. It indicates that the information on possible cases in which pregnant women, due to the limited number of available non-objecting personnel, tried in vain to access the procedures for termination of pregnancy, carried out abortions in unhealthy conditions and/or at their own expense or were forced by the circumstances to continue the pregnancy is "not available".

154. It states that externally recruited doctors are entitled to carry out terminations of pregnancy. No specific information is provided with respect to therapeutic abortions.

155. The expression "N/A" appears in the Government's reply with respect to the question asked by the Committee in respect of the number of appeals lodged with administrative and/or judicial authorities over the last five years with respect to ineffective procedures for termination of pregnancy.

156. The Government's reply to the specific request to provide detailed information on the measures adopted by hospitals, nursing homes and regional authorities as an implementation of Section 9§4 of Act 194/1978, is as follows:

"In Italy, the practical implementation of Act 194/1978 has registered a stabilisation over time (at least after 2010) of conscientious objection among medical practitioners and other health personnel, compared to the constant increase occurred before. As a consequence, there has been a re-balancing between objecting and non-objecting doctors, in the light of the recent orientations indicated by the National Bioethics Committee".

157. In this framework, the Government provides information on the position of the National Bioethics Committee (*Comitato Nazionale per la Bioetica*) with respect to the right to conscientious objection, safeguarded by Article 2 of the Constitution. More specifically, it is indicated that the above-mentioned Committee:

"[i]s in favour of a sustainability of the possibility to exert conscientious objection, in a way that would not discriminate neither objecting, nor non-objecting personnel, by promoting a revision of the organisation of duties and recruiting through adequate forms of personnel mobility and differentiated selection of human resources".

158. As regards the detailed information measures adopted by hospitals, nursing homes and regional authorities as an implementation of Section 9§4 of Act N° 194/1978, the Government states that:

"Italian Regions, Local Health Units and Hospitals, in order to compensate conscientious objection, have often recourse to external personnel by means of specific, temporary contracts, or stipulate agreements with private healthcare structures. In other cases, hospitals establishment have had recourse to agreements with nursing homes".

159. In response to the Committee' s question as to whether – and if yes, then why – it considers that the reduction in the number of abortions indicate that pregnant women do not encounter problems in accessing procedures for termination of pregnancy, the reply of the Government is as follows:

"Data show a constant reduction in Italy of voluntary termination of pregnancy according to the procedures foreseen by Act 194/78. This is particularly true among better educated women. Furthermore, the percentage of repeated abortions amounted to 27% in 2010 with respect to an expected value of 45% (calculated with mathematical models) without changes in the women's recourse to termination of pregnancy. Moreover in the last few years, the time between the certification and the procedure has become shorter and more than 80% of women has undergone this procedure at a gestional age of ≤ 10 week. Also the emergency procedures (without waiting for 7 days after the certification date) in 2009 amounted to 9,2% the same value reported in the 1997 Ministry of Health Report. Experts' hypothesis is that the promotion of a higher and more efficacious recourse to conscious procreation, especially thanks to the activity of territorial services like family consultations centers, has favored prevention of unwanted pregnancies and, as a consequence, of voluntary terminations of pregnancy".

C – Assessment of the Committee

160. The Committee notes that the essence of IPPF EN's allegations in this complaint is that the inadequacy of Section 9§4 of Act No. 194/1978 is demonstrated by the high number of medical practitioners and other health personnel exercising the right to conscientious objection in Italy. IPPF EN maintains that, in practice, this high number impedes the right of women to access procedures for termination of pregnancy. In particular, the complainant organisation maintains that the high number of medical practitioners and other health personnel exercising the right to conscientious objection prevents the full implementation of Act 194/1978 due to the lack, in Section 9, of specific provisions to ensure that women enjoy effective access to abortion procedures throughout the country.

161. As regards the rights which have allegedly been violated, the Committee considers that, as indicated in paragraph 68 above, the key legal issue at stake in this complaint concerns the protection of the right to health. The Committee therefore has focused its analysis on the adequacy of the steps taken by competent authorities to guarantee effective access to abortion services, which national legislation has classified as a form of medical treatment that relates to the protection of health and individual well-being, and which therefore can be considered to come within the scope of Article 11 of the Charter.

162. The Committee recalls that"[i]n connection with means of ensuring steady progress towards achieving the goals laid down by the Charter, (…) the implementation of the Charter requires state parties not merely to take legal action but also to make available the resources and introduce the operational procedures necessary to give full effect to the rights specified therein" (International Movement ATD Fourth world v. France, Complaint No. 33/2006, decision on the merits of 5 December 2007, § 61). Furthermore, the Committee recalls that "arrangements for access to care must not lead to unnecessary delays in its provision. The management of waiting lists and waiting times in health care are considered in the light of the Committee of Ministers Recommendation (99)21 on criteria for such management. Access to treatment must be based on transparent criteria, agreed at national level, taking into account the risk of deterioration in either clinical condition or quality of life" (cf. Conclusions XV-2, 2011, United Kingdom).

163. In light of the above, the Committee considers that the provision of abortion services must be organised so as to ensure that the needs of patients wishing to access these services are met. This means that adequate measures must be taken to ensure the availability of non-objecting medical practitioners and other health personnel when and where they are required to provide abortion services, taking into account the fact that the number and timing of requests for abortion cannot be predicted in advance.

164. The Committee also considers that it would not be in conformity with the Charter if the resolution of any possible problems encountered by women with respect to gaining access to abortion procedures is left in the hands of administrative or judicial authorities to be determined after the fact. As with other health services provided under Italian law, adequate measures must be put into place to ensure that women are able to access abortion services as and when they are required: the provision of retrospective remedies after the point of demand only supplements the primary obligation under Article 11 to make health care available as it is needed, which applies with particular force to time-sensitive procedures such as abortion. In this particular context, the Committee furthermore notes that appeals represent a stressful and time-consuming measure which can be detrimental to the health of the women concerned.

165. In relation to the relationship between the right to protection of health set out in Article 11 and the exercise of conscientious objection rights guaranteed under national law, the Committee considers that, as stated by the National Committee of bioethics (*Comitato Nazionale per la Bioetica*, "(…) [t]he statutory protection of conscientious objection should neither limit or hamper the exercise of the rights guaranteed by law (…)" (cf. Conscientious objection and bioethics - *Obiezione di coscienza e bioetica*) - p. 18). The Committee also refers to the motions presented in June 2013 within the Chamber of Deputies (see paragraphs 57 and 58 above), the wording of which can be regarded as reflecting the requirements of Article 11 of the Charter in this respect:

- "(…) [Act No. 194/1978]distinguishes between the individual right to object and women's right to freedom of choice in matters of procreation and between the individual's right to object to a law of the State and the States' obligation to provide the required service (…)" (Motion No. 1-00074);

- "(…) Health personnel are guaranteed that they will be able to raise an objection of conscience. But this is an individual right, not a right of the health care structure as a whole, which is obliged to guarantee the provision of health care services" (Motion No. 1-00045).

166. In this context, the Committee notes the Government's declaration that "[t]he aim of the law is to establish a principle, clearly specified under Article 9 of Act 194: the possibility for health-care professionals and staff to become conscientious objectors and the obligation for the Regions and the health care organizations to organize accordingly" and acknowledges that "there is no need to change the law but only to ensure that the Regions implement the procedures envisaged under Act 194/78". In this context, the Committee also notes the opinion expressed within the Parliament pointing out that "(…) it is not the number of objectors in itself to determine the state of access to abortion procedures, but the way in which health facilities organise the implementation of Act No.194/1978" (cf. Motion 1/00079, Chamber of Deputies – see paragraph 57 above).

167. The Committee furthermore does not find that the arguments put forward by the Government with respect to a) the objectives of the complainant organisation and b) the implementation of Article G of the Charter (see paragraph 94 above) relate to the issues at stake. The complaint does not contain any reference or request aimed at impeding the exercise of the right to raise conscientious objection or at limiting the number of objecting medical practitioners and other health personnel.

168. Turning to the substance of the complaint, the Committee considers that the provisions of Section 9§4 establish a balanced statutory framework for the fulfillment of the goals of Act No. 194/1978. As far as the Charter is concerned, the Committee considers that: a) the obligation for hospitals and nursing homes to take steps to ensure that abortion procedures are carried out "in all cases" as laid down in Sections 5, 7 and

8 of the said act, and b) the regions' responsibility to ensure that this requirement is met, represent a suitable legal basis to ensure a satisfactory application of Article 11. Furthermore, the Committee also considers that the high number of objecting health personnel in Italy does not *per se* constitute evidence that the domestic legal provisions at stake are being implemented in an ineffective manner.

169. However, the information provided by the complainant organisation, as well as other relevant elements regarding the issues at stake which is contained in the documents recently published by the Italian Senate and Chamber of Deputies - including the declaration of the Minister of Health made on 11 June 2013 (see paragraphs 57 to 60 above) – establish the existence of serious problems in relation to the following situations:

a) decrease in the number of hospitals or nursing homes where terminations of pregnancy are carried out nation-wide (see paragraphs 57 and 108 above);
b) significant number of hospitals where, even if a gynecology unit exists, there are no non-objecting gynaecologists, or there is just one (see paragraphs 57, 108, 110, 112, 114 and 116 above);
c) disproportionate relationship between the requests to terminate pregnancy and the number of available non-objecting competent health personnel within single health facilities (see paragraphs 115, 117, 120, 125, 128, 129, 131, 136, 137, 139 and 145 above) - which risk the creation of extensive geographical zones where abortion services are not available notwithstanding the legal right to access such services established under Italian law;
d) excessive waiting times to access abortion services (see paragraphs 57, 110 and 120 above);
e) cases of non-replacement of medical practitioners who are not available due to holiday, illness, retirement, etc. (see paragraphs 57, 110, 118, 119, 121, 122 and 124 above) - which pose the risk of substantial disruption to the provision of abortion services;
f) cases of deferral of abortion procedures due to an absence of non-objecting medical practitioners willing to perform such procedures (see paragraphs 57, 122 and 138 above);
g) cases of objecting health personnel refusing to provide the necessary care prior to or following abortion (see paragraphs 52, 126 and 127 above).

170. As outlined in paragraph 171 below, the Government did not provide any detailed information in respect of the above-mentioned situations which served to refute the allegations presented by the complainant organisation.

171. Regarding the arguments put forward by the Government as set out in paragraphs 98 to 101 above, the Committee considers that the evidence presented relating to the good functioning of the "abortion prevention services", namely the "the reduction in the number of abortions, in the abortion rate and in the number of repeated abortions", and in relation to the "stable number of emergency procedures" and "the

shorter time between the certification and the procedure" does not rebut the arguments made by the complainant organisation that pregnant women encounter problems in accessing abortion procedures in many regions of Italy. Moreover, the Committee considers that it has not been demonstrated by the Government that the measures that have been taken in response to these problems, namely the encouragement of "staff mobility" and "the conclusion of agreements with specialized obstetrics and gynaecology service providers" on the one hand; and the "increase in the number of one-day hospital procedures" and the "recent introduction of pharmacological abortion" on the other hand, guarantee in practice effective access to abortion procedures throughout the country.

172. The Committee acknowledges the validity of the Government's contention that "the high percentage of women who have an abortion at a gestational age of ≤ 10 weeks, combined to a very low rate of complications, especially to the fact that no death or serious complication has ever occurred following an abortion" proves that abortion procedures are generally safe. However, it considers that it has not been demonstrated that mechanisms have been put into place to ensure that the access to and the safety of abortion procedures, as well as the provision of ante- and post-operative care is ensured in all cases, including when the number of objecting personnel in a hospital or nursing home is particularly high. Some difficulties are illustrated by the increasing number of clandestine abortions, which have the potential to lead to serious negative health consequences for the women concerned.

173. The Committee further notes that in its reply to the supplementary questions asked by the Committee that related to the evidential basis of this complaint, the Government indicates that: "the Ministry of Health has no data on specific problems due to objecting health personnel encountered at local level". Furthermore, the information on concrete cases in which pregnant women experienced difficulties in the termination of pregnancy procedure (because of the limited number of available non-objecting personnel) was stated to be "not available", while information on possible appeals lodged by women with respect to the difficulties encountered in the termination of pregnancy procedures is stated to be "N/A". Moreover, the Committee notes that the Government: did not answer the question on whether therapeutic abortions can be and are actually carried out by externally recruited doctors; did not provide detailed information on the measures adopted by hospitals, nursing homes and regional authorities in application of Section 9§4; and did not provide a reply to the specific question on whether – and if yes why – the reduction in the number of abortions over the years indicates that women do not encounter problems in the access to abortion procedures.

174. The Committee therefore finds on the balance of the evidence before it that shortcomings exist in the provision of abortion services in Italy as a result of the problems described in paragraph 169 above, and that women seeking access to abortion services can face substantial difficulties in obtaining access to such services in practice, notwithstanding the provisions of the relevant legislation. These shortcomings appear to be the result of an ineffective implementation of Section 9§4 of Act No. 194/1978, given that a number of health facilities providing maternity services in Italy do not ensure that, “in all cases”: a) “the procedures referred to in Section 7 [of the above-mentioned act] are satisfactorily carried out” and, b) “pregnancy terminations, requested in accordance with the procedures referred to in Sections 5, 7 and 8 [of the same act], are adequately performed”. As a consequence, the Committee considers that the aforesaid health facilities do not adopt 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. It also considers that, in such cases, the competent regional supervisory authorities do not ensure a satisfactory implementation of Section 9§4 within the territory under their jurisdiction.

175. Furthermore, it appears that in some cases, given the urgent character of the procedures needed, women wishing to terminate their pregnancy may be forced to move to other health facilities, in Italy or abroad (see paragraphs 57, 110, 130,141 and 147 above), or to terminate their pregnancy without the support or control of the competent health authorities (see paragraphs 57, 132, 133, 135, 136, 142 and 151 above), 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. The Committee considers that these situations may involve considerable risks for the health and well-being of the women concerned.

176. The Committee therefore considers that with respect to the women who decide to terminate their pregnancy, the competent authorities did not take the necessary measures in order to remove the causes of ill-health, in particular by ensuring that, as provided by Section 9§4 of Act No. 194/1978, abortions requested in accordance with the applicable rules are performed in all cases, even when the number of objecting medical practitioners and other health personnel is high.

177. The Committee holds that this situation constitutes a violation of Article 11§1 of the Charter.

ALLEGED VIOLATION OF ARTICLE E READ IN CONJUNCTION WITH ARTICLE 11 OF THE CHARTER

178. Article E of the Charter reads as follows:

> **Article E – Non-discrimination**
>
> "The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status."
> Appendix to the European Social Charter (Revised):
> "A differential treatment based on an objective and reasonable justification shall not be deemed discriminatory".

A – Arguments of the parties

1. The complainant organization

179. IPPF EN considers that the shortcomings indicated with respect to the alleged violation of Article 11 of the Charter also constitute a breach of the principle of non-discrimination guaranteed by Article E.

180. In this respect, the complainant organisation considers that the discrimination is twofold. The first type of discrimination, which allegedly is not based on any objective and reasonable justification, has a territorial and economic nature. IPPF EN is of the view that this type of discrimination is based on the fact that:

"[d]ue to the lack of a guaranteed presence of non-objecting medical personnel in all public hospitals, women are forced to move from one institution to the next in order to find one that can guarantee access to termination procedures".

181. In this regard, IPPF EN considers that:

"The need for moving around qualifies as differentiated treatment in the case of an equal situation, that is, the request to exercise the right of access to termination procedures according to the conditions and measures stipulated by Law no. 194 of 1978".

182. Moreover, the complainant organisation maintains that:

"The lack of non-objecting medical personnel, which forces women to find alternative solutions and thus travel to find a hospital that provides the required procedure, also leads to an economic discrimination among women".

183. In particular, it is pointed out that:

"[w]ealthier women are inclined to avail of private clinics in Italy or in public hospitals or private clinics abroad, as they are able to afford the ensuing costs of their choice. On the other hand, it is easy to imagine that women who are not in a position to afford such costs – bearing in mind the "categories" of women who are less well off – are forced to avail of the establishments and persons, or even to travel abroad, which do not guarantee the full protection of health and hygiene that is required by the termination procedure".

184. According to the complaint, the second type of discrimination is that:

"[b]etween women seeking access to termination procedures and women not seeking such access, whether they are pregnant or not".

185. In this respect, IPPF EN is of the view that:

"[t]he state of health, both physical and mental, of women seeking an abortion becomes a criterion (…) for discrimination and, therefore, renders them a target for unfavourable treatment in relation to the protection and guaranteeing of their right to access termination procedures and consequently, in relation to the protection and guaranteeing of their right to life, health and self-determination".

186. The complainant organisation concludes that the inadequate wording of Section 9 of Act No. 194/1978 and the problems concerning its implementation compromise the rights to life, health and self-determination of women seeking to terminate a pregnancy and therefore places the above-mentioned article in contravention of Article E read in conjunction with Article 11 of the Charter.

2. The respondent Government

187. Concerning the issue of discrimination, the Government states that:

a) "[t]he Italian law [194 of 1978] is notably based on Part V of the Appendix to the Charter (…)";

b) "[c]onscientious objection is an objective and reasonable justification which, as set forth by Article 9 [of the above-mentioned law] does not lead to a discriminatory treatment insofar it can be revoked by objecting medical personnel, in order to respect the right to health of women, in application of the provisions of (…) the above-mentioned article",

188. More specifically, the document of the Ministry of Health (see paragraph 97 above) indicates that “in Italy, abortion is fully paid by the National Health Service (SSN) and that the few authorised private facilities have an agreement with the SSN. So economic discrimination has been erroneously invoked. The same holds true for the discrimination against foreign women. In fact 1 woman out of 3 who undergoes an abortion is of foreign origin and the services provided to them, in particular community services such family planning centers have adopted adequate organizational measures to consider their cultural differences, through cultural mediation, adequate working hours trained staff etc.”

B – Assessment of the Committee

189. The Committee recalls that Article E prohibits both direct and indirect discrimination. In this respect, it recalls that direct discrimination may arise when individuals and/or groups are hampered or prevented from enjoying the rights set forth in the Charter on the grounds of their status. As set forth in the Charter’s appendix, a differential treatment based on an objective and reasonable justification shall not be deemed discriminatory (cf. Autism-Europe v. France, Complaint No. 13/2002, decision on the merits of 4 November 2003, §52). The Committee also recalls that in respect of complaints alleging discrimination, the burden of proof should not rest entirely on the complainant organisation, but should be shifted appropriately (Mental Disability Advocacy Center (MDAC) v. Bulgaria, Complaint No. 41/2007, decision on the merits of 3 June 2008, §52).

190. Two primary forms of discriminatory treatment are alleged to exist in this complaint: (i) discrimination on the grounds of territorial and/or socio-economic status between women who have relatively unimpeded access to lawful abortion facilities and those who do not; (ii) discrimination on the grounds of gender and/or health status between women seeking access to lawful termination procedures and men and women seeking access to other lawful forms of medical procedures which are not provided on a similar restricted basis. The Committee considers that these different alleged grounds of discrimination are closely linked together and constitute a claim of ‘overlapping’, ‘intersectional’ or ‘multiple’ discrimination, whereby certain categories of women in Italy are allegedly subject to less favorable treatment in the form of impeded access to lawful abortion facilities as a result of the combined effect of their gender, health status, territorial location and socio-economic status: the complainant organisation in essence alleges that since women who fall into these vulnerable categories are denied effective access to abortion services as a consequence of the failure of the competent authorities to adopt the necessary measures which are required to compensate for the deficiencies in service provision caused by health personnel choosing to exercise their right of conscientious objection, this constitutes a discrimination.

191. Based on the information provided by the complainant organisation and not contradicted by the government, the Committee notes that, as a result of the lack of non-objecting medical practitioners and other health personnel in a number of health facilities in Italy, women are forced in some cases to move from one hospital to another within the country or to travel abroad (see paragraphs 110, 130, 141 and 147 above); in some cases, this is detrimental to the health of the women concerned. Therefore, the Committee holds that the women concerned are treated differently than other persons in the same situation with respect to access to health care, without justification.

192. In this regard, the Committee also notes that the motions approved by the Italian Senate and Chamber of Deputies in June 2013 confirm that some pregnant women are obliged to travel to other regions of Italy and even abroad to seek abortion treatment as a result of the high level of objecting health personnel in the hospitals situated close to their usual place of residence, while there seems to be a re-emergence of clandestine abortions, in particular among immigrant women (see paragraph 57 above).

193. The Government does not provide specific information that contradicts the claims set out in the two previous paragraphs, or which in the alternative demonstrates that its alleged failure to make measures to ameliorate the less favorable treatment suffered by the women falling into the vulnerable categories described above can be objectively justified. The Committee considers that the Government's argument that abortion is a service whose cost is fully covered by the "National Health Service" does not refute the complainant organisation's reasoning that women have to move to other regions or abroad to have access to abortion services. If a service is not available in practice, it is irrelevant whether it is for free or has to be paid for. Furthermore, women denied access to abortion facilities may have to incur substantial economic costs if they are forced to travel to another region or abroad to seek treatment. In this regard, the time factor is also crucial: women who are denied access to abortion facilities in their local region may in effect be deprived of any effective opportunity to avail of their legal entitlement to such services, as the tight time-scale at issue may prevent them from making alternative arrangements.

194. The Committee thus holds that this situation constitutes a violation of Article E of the Charter read in conjunction with Article 11.

CONCLUSION

For these reasons, the Committee concludes:

- by 13 votes to 1 that there is a violation of Article 11§1 of the Charter;

- by 13 votes to 1 that there is a violation of Article E read in conjunction with Article 11 of the Charter.

Karin LUKAS	Luis JIMENA QUESADA	Régis BRILLAT
Rapporteur	President	ExecutiveSecretary

In accordance with Rule 35§1 of the Rules of the Committee:

- a separate dissenting opinion of Luis JIMENA QUESADA is appended to this decision;

- a separate concurring opinion of Petros STANGOS is appended to this decision.

DISSENTING OPINION OF LUIS JIMENA QUESADA

1. I am unable to subscribe to the majority conclusion of the Committee that there is a violation of Article 11§1 of the Charter, and of Article E of the Charter read in conjunction with this provision in the decision on the merits of 10 September 2013 concerning Complaint No. 87/2012 (*IPPF EN v. Italy*). The reasons for my dissent, which basically focus on paragraph 169 and related paragraphs of the decision on the merits, concern the following aspects: A. *The object of the complaint as explicitly delimitated by the complainant organisation*. B. *The lack of solid evidence supporting the conclusion of a violation of Article 11§1 of the Charter*. C. *The lack of consistency in reaching the conclusion of a violation of Article 11 in conjunction with Article E*.

A. *The object of the complaint as explicitly delimitated by the complainant organization*

2. The *petitum* of the complaint says: “For these reasons, IPPF EN asks the European Committee of Social Rights to declare that Italy is in violation of Art. 11 of the European Social Charter, read alone or in conjunction with Art. E, due to the *inadequate formulation* of Art. 9 of Law no. 194 of 1978 and thus, the protection of the right to access procedures for the termination of pregnancy”. Indeed, with such a petition, the object of the complaint appears ambiguous under the tasks of the European Committee of Social Rights, insofar as while apparently contesting the implementation of the Law, the complainant organisation explicitly asks for the “re-formulation” of the contested legislation. In the same line, the Committee notes that “IPPF EN alleges that the *formulation* of paragraph 4 of Section 9 of Act No. 194 of 1978” is in violation of the Charter (par. 2); that “IPPF EN also argues that the *provisions* of Section 9§4 *are inadequate*” (par. 77); that “IPPF EN considers that the *law* should...” (par. 78); that “given the *inadequacy of the statutory framework*” (par. 79); that “IPPF EN indicates that the *inadequacy of Act* No. 194/1978…” (par. 81); or that “the complainant organization concludes that the *inadequate wording* of Section 9§4...therefore places the above-mentioned article in contravention of Article 11 of the Charter” (par. 91).

3. In parallel, the Committee “notes that the essence of IPPF EN’s allegations in this complaint is that the *inadequacy of Section 9§4 of Act No. 194/1978* is demonstrated by the high number of medical practitioners and other health personnel exercising the right to conscientious objection in Italy. IPPF EN maintains that, in practice, this high number impedes the right of women to access procedures for termination of pregnancy. In particular, the complainant organisation maintains that the high number of medical practitioners and other health personnel exercising the right to conscientious objection prevents the full implementation of Act 194/1978 *due to the lack, in Section 9, of specific provisions* to ensure that women enjoy effective access to abortion procedures throughout the country” (par. 160). The Committee also considers “that the high number of objecting health personnel in Italy does not *per se* constitute evidence that these legal provisions are being implemented in an ineffective manner” (par. 168).

4. However, in my view, while stating that "*per se*" the high number of objecting health personnel and allied health personnel does not represent evidence of an ineffective implementation of Section 9§4 of Act No. 194/1978, the fact is that this is precisely the equation established by IPPF EN in its complaint and, finally, the solution supported by the majority conclusion of violation of Article 11§1 of the Charter, without solid evidences to reach such a conclusion (section B, *infra*).

5. Of course, the task of the Committee consists of the supervision of both law and practice under the Social Charter and, from this point of view, its conclusions of non-conformity and decisions of violation may lead to the adoption of new legislation, rules, practices or jurisprudences at the domestic level. Nevertheless, while not indicating any concrete contradiction of the national law itself with the Charter, I consider that the complainant organisation has failed to demonstrate that the legal provisions aiming at reconciliating the access by women to abortion and the exercise of conscience objection by doctors and other health personnel (in particular, the recourse to external non-objecting health personnel through mobility and the establishment of agreements between hospitals and private establishments) constitute a violation of Article 11§1.

6. From this perspective, in the absence of a clear consensus at European level, Italy (like the other States Parties to the Charter) may exercise its margin of appreciation in order to adopt further legislative measures aiming at improving the positive obligations imposed by Article 11 in the field of the controversial issue of abortion: the judgments of the European Court of Human Rights which are mentioned in paragraphs 53-56 of the decision on the merits confirm this approach. Nonetheless, apart from this possible new legislation concerning abortion (in relation to which not only academicians, scientific and ethic committees, mass media or politicians, but also civil society - through NOGs or through mechanisms of direct democratic participation of the whole citizenship - have an important role to play), what the Committee had in front of it was the assessment of the compatibility and implementation of the current legislation with the Charter. And, under this angle, there is no solid evidence demonstrating that women in Italy are impeded in having access to procedures of termination of pregnancy in healthy conditions implying risks for their life and physical or moral integrity because of the high number of personnel refusing to carry out these procedures on conscientious grounds.

B. *The lack of solid evidence supporting the conclusion of a violation of Article 11§1 of the Charter*.

7. In paragraph 169 of the decision on the merits, the Committee grants decisive weight to the list of elements it mentions [a) to g)] in relation to some governmental statements and parliamentary motions. By contrast, I consider that even the conjunction of these elements provides a weak basis on which to reach the conclusion of a violation of Article 11§1.

8. Under these conditions, when reading the content of the motions adopted in June 2013 within the Senate and the Chamber of Deputies (par. 57-58), if the apparent conclusion for the Committee is that there is a political consensus within the Italian Parliament “with respect to the difficulties encountered in the implementation of Act No. 194/1978”, it seems more logical to ask the “re-formulation” of this Act to those who are entitled to exercise this legislative power, that is to say, to the same national parliamentarians. The importance of these governmental statements and parliamentarian motions for the political and social debate in Italy do not provide a solid support for the legal and judicial reasoning of the Committee.

9. In my opinion, the existing differences between Italian regions in the provision of health care services allowing for the practice of abortions as a result of the diverse number of conscience objectors in this field cannot lead the Committee to conclude that the measures foreseen by the law (mobility of external non-objecting health personnel and agreements between hospitals and private establishments) are not appropriated under Article 11§1 of the Charter. In this regard, the statements of the Minister of Health selected in the decision of the merits referring to the number of objectors (par. 59) do not neither allow to reach a conclusion of violation of Article 11§1 of the Charter. In putting the accent on “the theme of governance of territories and therefore more connected to the theme of regions”, the Minister is locating the issue at stake in the broader problematic of asymmetries between regions within a politically decentralized state. Indeed, when matters like health care and others are under the jurisdiction of regions, the diversity on the level and quality of the protection provided by regional authorities is inherent in the exercise of such self-government.

10. In particular, terms of violation of one fundamental right if they prevent from the enjoyment of the basic level of protection of such fundamental right as required by the Social Charter. Consequently, if the difference in one or several parts of the territory implied a lack of respect of the basic standards set forth in the Charter, the Contracting Party would of course be responsible for one violation of the right at stake. However, when reading the situations a) to f) which are mentioned in paragraph 169 of the decision of the merits, it is obvious that the possible regional differences and deficiencies could be verified, not only in relation to abortion services, but also to other health care services. In this sense, the weight granted to these alleged situations a) to f) seems paradoxical when reading at the same time paragraph 172, in which the Committee “acknowledges the validity of the Government’s contention” and “proves that abortion procedures are generally safe”.

11. With this in mind, a new paradox arises in this paragraph 172 when:

11.1. Firstly, the Committee considers that “it has not been demonstrated that mechanisms have been put into place to ensure that the access to and the safety of abortion procedures, as well as the provision of ante- and post-operative care is ensured in all cases, including when the number of objecting personnel in a hospital or nursing home is particularly high”. Certainly, as recalled by the Committee in paragraph 168, Sections 5, 7 and 8 of Act No. 194/1978 logically establish *in law* the obligation for hospitals and nursing homes to ensure that abortion procedures are carried out in “all cases”, but the majority of the Committee seems to require the “perfection” in the issue at stake: would the existence *in practice* of one case of failure or infringement lead to a conclusion of violation of Article 11 in the framework of the present collective complaint procedure?; should *mutatis mutandis* be applied this zero-tolerance to the assessment of other issues such as infant and maternal mortality rate under Article 11? It is obvious that, which such an approach, no conclusion of conformity could be obtained.

11.2. Secondly, the Committee seems to seek to reinforce its line of reasoning by adding that “some difficulties are illustrated by the increasing number of clandestine abortions, which have the potential to lead to serious negative health consequences for the women concerned”. This element paradoxically and clearly weakens the legal reasoning of the Committee, insofar as no relationship between “the increasing number of clandestine abortions” and the number of objectors is explained or demonstrated at all. As well known, the causes of clandestine abortions (cultural, sociological, etc.) are complex and, in any case, no illustration supports this new equation between clandestine abortions and medical conscience objection. Otherwise said, this automatic equation leads to a kind of stigmatisation of objectors in spite of the apparent approach of the Committee when considering “that the provisions of Section 9§4 establish a balanced statutory framework for the fulfillment of the goals of Act No. 194/1978” and “that the high number of objecting health personnel in Italy does not *per se* constitute evidence that the domestic legal provisions at stake are being implemented in an ineffective manner” (par. 168).

I feel that the Committee has lost a good occasion to reconciliate and find a balanced approach as suggested in different Council of Europe instruments [e.g. the PACE Resolution 1763 (2010) “The right to conscientious objection in lawful medical care”, cited in paragraph 63 of the decision on the merits] and, at the same time, it has also lost a new opportunity to correctly develop the gender perspective in the field of sexual and reproductive health (e.g. in the light of the interpretation principles announced in the framework of the decision on the merits of 30 March 2009 concerning Complaint No. 45/2007,

INTERIGHTS v. Croatia, which is not cited by the Committee in the decision on the merits of the present complaint, even in the context of the "alleged violation of Article E read in conjunction with Article 11 of the Charter", *infra*). In this context, the position of the National Bioethics Committee (*Comitato Nazionale per la Bioetica*) concerning "the possibility to exert conscientious objection, in a way that would not discriminate neither objecting, nor non-objecting personnel, by promoting a revision of the organization of duties and recruiting through adequate forms of personnel mobility and differentiated selection of human resources" (paragraph 157) does not exactly constitute the object of the present Complaint No. 87/2012, but it is rather connected with the pending Complaint No. 91/2013.

12. Furthermore, the final situation or element g) which is mentioned in paragraph 169 ("cases of objecting health personnel refusing to provide the necessary care prior to or following abortion") has no real support. And this illustrates one of the strongest elements of my dissent when I criticise "the lack of solid evidence in reaching the conclusion of a violation of Article 11§1 of the Charter". In particular, the Committee refers to "paragraphs 52, 126 and 127, above", but paragraphs 52 and 126 mention judgment No. 14979 of the Italian Supreme Court (*Corte di Cassazione*) that sentenced a conscientious objector doctor who refused to aid a woman "following an abortion" (*ex post facto*), and not "prior to" (*ex ante*) which is the object of the present Complaint No. 87/2012 (moreover, the decision of 1979 of the *Pretura of Ancona* mentioned in paragraph 127 did not deal with a specific case of termination of pregnancy). With regard to these domestic judicial illustrations (which, I insist, do not strictly relate to the object of the complaint, "access to procedures for the termination of pregnancy", that is, prior to an abortion), I would like to add:

12.1. Firstly, on the balance of the evidence (e.g. paragraphs 169-175), with due respect to the weight granted by the Committee to some elements (presented or not by the complaint organisation, including the data provided by the President of LAIGA or the governmental statements and parliamentarian motions) as well as to the approach of the Committee concerning the burden of proof, it appears strange to me from a judicial assessment perspective that in more than three decades since the entry into force of Act No. 194/1978, not even one example of domestic judicial case of damage liability (before administrative or criminal courts) dealing with objecting health personnel prior to an abortion has been provided. From this point of view, it is evident that I am not suggesting in the framework of the present Complaint "to ask women first and foremost - but also non-objecting doctors - to reveal themselves publicly in a complaint against individual conscientious objector doctors or facilities where services for voluntary termination of pregnancy are not guaranteed" (paragraph 104 of the decision on the merits), but just to provide one example of national judicial case without logically citing the names of the parties and, therefore, with due respect to the right to private life recognised in Article 8 of the European Convention on Human Rights.

12.2. Secondly, this lack of judicial evidence cannot be justified by the consideration that “it would not be in conformity with the Charter if the resolution of any possible problems encountered by women with respect to gaining access to abortion procedures is left in the hands of administrative or judicial authorities to be determined after the fact” (paragraph 164). Of course, one cannot disagree with this preventive approach, which plays an essential role for the effectiveness of the right to health, as explicitly recognized by Article 11(§§2 and 3) of the Social Charter. But this is not the issue at stake. In this regard, the Committee has not found any violation of these two paragraphs (2 and 3) of Article 11 and in Conclusions 2009 Italy (last assessment of the Committee in the framework of the reporting system) was found in conformity with both paragraphs (2 and 3).

C. *The lack of consistency in reaching the conclusion of violation of Article 11 in conjunction with Article E*.

13. Lastly, it is obvious that, by not sharing the conclusion of a violation of Article 11§1 of the Charter, I do not share the parallel conclusion of a violation of Article E in conjunction with Article 11§1 of the Charter.

14. From this perspective, apart from the inherent asymmetries in the reality of a regional state (see above), I do not perceive the consistency of the legal assessment of the Committee in terms of non-discrimination (in particular, paragraphs 190-191). On the one hand, in relation to the territorial and/or socio-economic status, the assessment of the majority of the Committee is not convincing, because the same legal reasoning could be applied to other issues directly related to health care and abortion, that is to say, an important number of abortions are related to the social-economic situation of “potential” mothers (including the difficult situation of migrant women) due to the differences (and deficiencies) in the field of the social protection of maternity among regions. It is interesting to mention, in this last direction: a) the decision on admissibility of 10 September 2013 (the same date as the decision on the merits on Complaint No. 87/2012) concerning Complaint No. 99/2013 (*FAFCE v. Sweden*), in which the Committee has considered that “family policies and rights of the family cover motherhood, procreation and the development of human life” (paragraph 8); b) the Resolution 1946 (2013) on “Equal access to health care” adopted by the Parliamentary Assembly of the Council of Europe on 26 June 2013, which calls on the Council of Europe member States “to ensure that pregnant women and children, as a particularly vulnerable group, have full access to health care and social protection, irrespective of their status”.

15. On the other hand, in relation to discrimination on the grounds of gender and/or health status, the Committee establishes the comparison “between women seeking access to lawful termination procedures and men and women seeking access to other lawful forms of medical procedures which are not provided on a similar restricted basis” (paragraph 190). I think that the terms of comparison used by the Committee are not at all relevant and, therefore, the first element of the standard of non-discrimination (apart from a reasonable and objective grounds or justification to make the distinction as well as the proportionality) is not fulfilled. For this reason, I feel that the last sentence of paragraph 191, in which the Committee concludes “that the women concerned are treated differently than other persons in the same situation with respect to access to health care, without justification” is somehow laconic. Finally, once again, I confirm my idea that: a) the gender perspective and the scope of sexual and reproductive health have not been correctly focused on; b) the equation between medical conscience objection and “a re-emergence of clandestine abortions, in particular among immigrant women” (paragraph 192) is incorrectly articulated.

These are the reasons for my dissent.

CONCURRING OPINION OF PETROS STANGOS

I voted in favour of the decision, both as regards violation of Article 11 of the Charter and as regards violation of Article E in conjunction with Article 11. However, from the first time I studied IPPF EN's complaint, I came to the view that if the two provisions of the Charter had been violated, this was the result not only of Act No. 194/78 being implemented ineffectively in the case brought by the complainant but also in principle because of the fundamental structure of the 1978 act and, more particularly, Sections 4 and 5, which regulate women's right to abortion in a manner incompatible with the requirements of Article 11 of the Charter.

The Committee's assessment that the ineffective implementation of the law is the sole source of the violation of the Charter is summed up in paragraph 176 of the decision, according to which Article 11 of the Charter has been violated because the competent authorities did not take the necessary measures in order that, "as provided by (…) Act No. 194/1978, abortions requested in accordance with the applicable rules are performed (…)", even when the number of objecting medical practitioners and other health personnel is high. I also believe that the decision gives too much weight to the same approach adopted by the Italian parliament in an opinion, whereby it is not the (high) number of objecting medical practitioners which in itself determines access to abortion but the arrangements made by health care institutions for implementing the 1978 legislation (see paragraph 175 of the decision). In addition, the exclusive approach taken by the decision ignores the fact that the complainant had alleged that the real source of the violation of Article 11 of the Charter in the present case is the fact that the 1978 act does not in itself enable women effectively to exercise their right to terminate their pregnancy (see paragraph 12 of the decision).

In my opinion, the exclusive approach adopted by the Committee is not fully in tune with the real issues raised by this complaint. Through the 1978 act, Italy took a clear stance in the several decades-old worldwide legal debate about abortion, which ranges those who oppose women's right to abortion with arguments of an ethical, moral or religious nature, supported by legal reasoning (the foetus is a human being that is simply in the initial stages of its biological growth, which involves assimilating abortion with an act of manslaughter) against the supporters of women's right to abortion as a right stemming from, and forming part of, every human being's right to self-determination, including physical and bodily self-determination. R Dworkin (in *Life's Dominion: an Argument about Abortion, Euthanasia, and Individual Freedom*, 1994) describes the former as "pro-life" and the latter as "pro-choice". Medical practitioners who are conscientious objectors to abortion naturally fall into the former category.

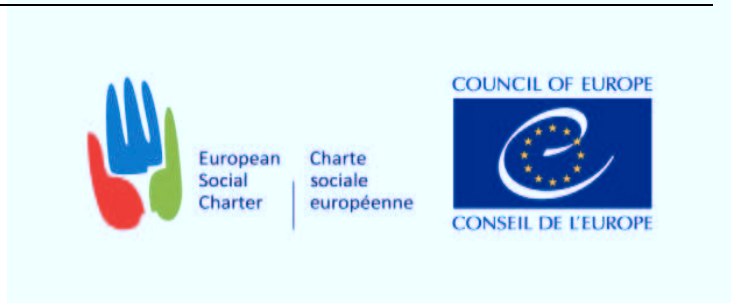
Carrying on from the facts complained of in the present case, I believe that Italy clearly comes out in favour of the opponents of women's right to abortion through Sections 4 and 5 of Act No 194/1978, given the manner in which they regulate the right to abortion. Under these two provisions, in particular Section 5, paragraph 1, a whole set of institutional and operational machinery is put in place (counselling centres and socio-medical agencies) for the purpose of neutralising the supposed, but plausible, reasons of an economic nature for the decision by a pregnant woman who visits these institutions during the first three months of pregnancy to have an abortion. The Italian legislator was so keen to encourage pregnant women who visit the relevant centres during the first three months of pregnancy to remain pregnant and not have abortions that the last sentence of Section 5, paragraph 1, of the 1978 act foreshadows the women ultimately "choosing" to give birth rather than have abortions!

It may be said that this approach by the Italian legislator was in line with the prevailing values in society at the time when it was adopted. However, that is not sufficient to justify its continued application 35 years later, when a consensus now seems to be emerging among European states that women should have an unconditional right to abortion during the first three to five months of pregnancy (see here the judgment of the European Court of Human Rights in the case of *R.R. v. Poland*, paragraph 186, which provides "that there is indeed a consensus amongst a substantial majority of the Contracting States of the Council of Europe towards allowing abortion and that most Contracting Parties have in their legislation resolved the conflicting rights of the foetus and the mother in favour of greater access to abortion"). Through the above-mentioned provisions of the 1978 legislation, Italy operates a sophisticated and official system of pressure on women so that they choose not to terminate their pregnancies.

Moreover, the arrangements established by the 1978 act, which are based on public counselling centres and socio-medical agencies, had a direct impact on the way in which the Italian government defended the case before the Committee. On several occasions, the Italian government highlighted the effective operation of these institutions and the contribution they have made to reducing the number of abortions in recent years, which is not entirely without a hidden agenda on its part; this could have been worded as follows: "as the system with the centres works well, the number of abortions is low and it therefore does not matter that most hospitals only have gynaecologists who raise conscientious objections and that the central and regional authorities are unable to make up for this by employing 'ordinary' physicians". I would even say that this hidden agenda seems to emerge in the arguments put forward by the government in its defence, when its representative tells the Committee that: "(…) the reduction in the number of women who undergo an abortion is far greater than the increase in the number of conscientious objectors among health care professionals and staff; in the last few years, services have become more efficient (…) in terms of prevention (…)" (see paragraph 101 of the decision).

In my view, while solemnly claiming to help pregnant women who visit the public counselling centres during their first months of pregnancy to cope with the economic and social problems alleged to make them seek abortions, the defendant state is caving in to the ethical, moral or religious calls to oblige women not to terminate. The pressure exerted on pregnant women under the conditions set out in the above-mentioned provisions of the 1978 act is likely to cause serious harm both to the dignity and personal integrity of the women concerned and to their psychological health. Women's freedom and independence and their control over their bodies and personalities are at risk of being seriously undermined. Moreover, the system employed by the Italian state leads me to refer both to the circumstances, and to the judgment of the United States Supreme Court, in the highly publicised case of *Planned Parenthood of Southeastern Pennsylvania v. Casey* (No. 112 S. Ct. 2791, 1992) concerning restrictions on the right to abortion in one of the states of the union (like many others); a passage in the *Casey* judgment, whose astuteness is confirmed in a concurring opinion by three judges (Kennedy, O'Connor and Souter), seems very relevant to the complaint examined by the Committee: regulations on abortion may be declared unconstitutional (or, in the instant case, in violation of a treaty protecting fundamental rights) when, even though they do not prohibit abortion, their purpose and consequences entail excessive interference in the personal choice of a woman who has decided to undergo a treatment such as abortion by posing substantial obstacles to the exercise of her decision.

For all these reasons, the above-mentioned legislative provisions, which open the way for pressure to be exerted on women seeking abortions, should in my opinion have been examined by the Committee with a view to determining their conformity with Article 11 of the Charter or, at least, with a view to their being taken into consideration as an aggravating factor in the violation of Article 11 of the Charter caused by ineffective implementation of the domestic legislation in circumstances resulting from the high number of hospital medical practitioners and other health care staff who are conscientious objectors to abortion.



EUROPEAN COMMITTEE OF SOCIAL RIGHTS
COMITÉ EUROPÉEN DES DROITS SOCIAUX

DECISION ON ADMISSIBILITY AND THE MERITS

Adoption: 12 October 2015

Notification: 10 December 2015

Publication: 11 April 2016

***Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy**

Complaint No. 91/2013

The European Committee of Social Rights, committee of independent experts established under Article 25 of the European Social Charter ("the Committee"), during its 281st session attended by:

Giuseppe PALMISANO, President
Petros STANGOS, Vice-President
Lauri LEPPIK, General Rapporteur
Elena MACHULSKAYA
Karin LUKAS
Eliane CHEMLA
Jozsef HAJDU
Marcin WUJCZYK
Krassimira SREDKOVA
Raul CANOSA USERA
Marit FROGNER

Assisted by Régis BRILLAT, Executive Secretary

Having deliberated on 17 March, 30 June, 7 September and 12 October 2015,

On the basis of the report presented by Karin LUKAS,

Delivers the following decision adopted on 12 October 2015:

PROCEDURE

1. The complaint lodged by *Confederazione Generale Italiana del Lavoro* ("CGIL") was registered on 17 January 2013.

2. CGIL alleges that Section 9 of Act No. 194/1978 (“Act No. 194”), which governs the conscientious objection of medical practitioners and other medical personnel in relation to abortion services, is not properly applied in practice and this:

- violates Article 11 (the right to health) of the Revised European Social Charter ("the Charter"), read alone or in conjunction with Article E (non-discrimination),

- violates Article 1 (the right to work), as well as Article 2 (the right to just conditions of work), 3 (the right to safe and healthy working conditions) and 26 (the right to dignity at work) of the Charter, the latter Articles read either alone or in conjunction with Article E (non-discrimination).

3. In accordance with Rule 29§2 of the Rules of the Committee (“the Rules”), the Committee asked the Government of Italy ("the Government") to make written submissions on the merits in the event that that the complaint is declared admissible, by 31 May 2013, at the same time as its observations on the admissibility of the complaint. The Government's submissions were registered on 30 May 2013.

4. CGIL was invited to submit a response to the Government's submissions by 3 September 2013. The response was registered on 29 July 2013.

5. On 30 September 2013 the Committee transmitted CGIL's response to the Government and invited it to submit a further response by 25 November 2013. The Government's further response was registered on 25 November 2013.

6. In a letter of 18 July 2013, the Committee invited the Parties to the Protocol providing for a system of collective complaints (“the Protocol”) and the States having submitted a declaration pursuant to Article D§2 of the Charter to transmit to it, before 3 September 2013, any observations they wished to make on the merits of the complaint in the event that it is declared admissible.

7. In a letter of 18 July 2013, pursuant to Article 7§2 of the Protocol, the Committee invited the international employers' and workers' organisations mentioned in Article 27§2 of the Charter of 1961 to submit observations before 3 September 2013.

8. Observations from the European Trade Union Confederation (“ETUC”) were registered on 2 September 2013.

9. On 22 May 2013, *Movimento italiano per la Vita* asked to be invited to submit observations. In accordance with Rule 32A, on 18 June 2013, the President of the Committee invited the organisation to do so by 3 September 2013. The observations were registered on 2 September 2013.

10. On 3 June 2013, *Associazione italiana per l'educazione demografica* asked to submit observations. In accordance with Rule 32A, on 18 June 2013 the President invited the association to do so by 3 September 2013. The observations were registered on 3 September 2013.

11. On 3 June 2013, *Giuristi per la vita* asked to be invited to submit observations on behalf of *Associazione Medici Cattolici Italiani* (A.M.C.I.), *Associazione Italiana Ginecologi Ostetrici Cattolici* (A.I.G.O.C.), *Confederazione Italiana dei Consultori familiari di Ispirazione Cristiana* (C.F.C), *Centro Studi per la tutela della salute della madre e del concepito dell’Università Cattolica del Sacro Cuore di Roma* and *Forum delle associazioni familiari*. In accordance with Rule 32A, on 19 June 2013 the President invited the organisation to do so by 3 September 2013. The observations were registered on 26 August 2013.

12. On 11 June 2013, *Associazione Luca Coscioni per la libertà di ricerca scientifica* asked to be invited to submit observations. In accordance with Rule 32A, on 18 June 2013, the President invited the association to do so by 3 September 2013. The observations were registered on 26 August 2013.

13. On 19 March 2015 the Committee invited the parties, should they wish, to submit any further information on recent developments in law and practice, by 11 May 2015. Information from CGIL was registered on 8 May 2015 and from the Government on 11 May 2015.

14. On 11 May 2015 the Government requested that the Committee organise a hearing in the case. The Committee, by letter dated 29 May 2015, asked the Government to indicate what further information that had not been submitted to the Committee during the written procedure, it wished to present to the Committee.

15. The Government responded on 30 June 2015 confirming its request. Pursuant to Article 7(4) of the Protocol and Rule 33 the Committee decided to hold a public hearing on 7 September 2015.

16. On 27 July 2015 a list of questions was sent to the parties prior to the hearing setting out the issues the Committee wished them to address.

17. On 16 June 2015, pursuant to Rule 33§4, the ETUC was invited to participate in the hearing pursuant to Rule 33(4) but declined.

18. A hearing took place in public in the Human Rights Building, Strasbourg, on 7 September 2015. There appeared before the Committee:

a) *for the complainant organisation*

Ms Benedetta Liberali, Solicitor,

Dr Andrea Allamprese, Advisor Legal Office of CGIL

b) *for the Government*

Professor Assuntina Morresi, Adviser to the Minister of Health

Ms Paola Accardo, Co-Agent of the Government before the European Court of Human Rights.

19. The Committee was addressed by Ms Liberali and Professor Morresi and Ms Accardo.

20. Additional information was submitted to the Committee and has been taken into account in so far as it was referred to in the oral submissions or was in the public domain.

SUBMISSIONS OF THE PARTIES

A – The complainant organisation

21. CGIL asks the Committee to find that the inadequate implementation of Section 9§4 of Act No. 194, which regulates the conscientious objection of medical practitioners and personnel in relation to abortion services, is in violation of Article 11 of the Charter, read alone or in conjunction with the non-discrimination clause in Article E, in that it does not protect the right guaranteed to women with respect to access to abortion services.

22. CGIL also alleges a violation of Article 1, as well as Articles 2, 3 and 26 of the Charter, the latter Articles read either alone or in conjunction with the non-discrimination clause in Article E, on the grounds that the Government has failed to protect the rights of medical practitioners involved in the provision of abortion services.

23. Moreover, CGIL invites the Committee to recognise the relevance of Articles 21 (the right to information and consultation) and 22 (the right to take part in the determination and improvement of the working conditions and working environment) for the application of the relevant domestic law.

B – The respondent Government

24. The Government considers the complaint to be inadmissible as CGIL failed to exhaust domestic remedies and further asks the Committee to declare the complaint unfounded in all respects.

OBSERVATIONS BY THE EUROPEAN TRADE UNION CONFEDERATION ("the ETUC")

25. The ETUC considers that the situation in practice amounts to a violation of:

- Article 11§§1 and 2 of the Charter due to the non-application of Section 9 of Act No.194. The ETUC notes that despite the data provided by the complainant organisation in support of its allegations, the Government does not refer to any measures taken to improve the implementation of Section 9 of Act No. 194/1978;

- Article E of the Charter, which does not set out an exhaustive list of prohibited grounds of discrimination, but covers also any territorial differences in the application of a law. The ETUC maintains that considerable differences exist with regard to the access to abortion between various provinces and other entities.

26. As to the employment-related rights of non-objecting medical practitioners, the ETUC observes that the national situation amounts to a violation of the following provisions:

- Article 1§2, due to the failure of the authorities to ensure the effective exercise of the right to work without discrimination in employment in the application of Section 9 of Act No. 194/1978. The ETUC maintains that the career development of non-objecting medical practitioners differs from that of objectors due to the excessive workload, and limitation of work mainly to the provision of abortion services.

- Article 2§1, due to the excessive working time of non-objecting medical practitioners. It refers in this regard to infringement proceedings initiated by the Commission of the European Union against Italy due to an alleged failure to implement Directive 2003/88/EC on part of doctors in general in the public sector (Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time; OJ L 299, 18.11.2003, p. 9–19). The ETUC maintains that the situation is more problematic for non-objecting doctors and notes that in the context of the collective complaint, the Government fails to challenge the allegations made in this regard;

- Article 3§3, due to the absence of an effective labour inspection system. The ETUC refers to the previous Conclusions of non-conformity in respect of Article 3§3 (Conclusions 2009, Italy); and

- Article 26§2, due to the isolation at work of non-objecting medical practitioners, who often need to carry out abortions alone as the only medical practitioners undertaking this type of work. In the ETUC's view this amounts to moral harassment.

OTHER OBSERVATIONS

A. *Associazione "Luca Coscioni per la libertà" di ricerca scientifica*

27. The association is a non-governmental organisation that promotes, inter alia, the freedom of scientific research, as well as human rights for sick persons and persons with disabilities. It also provides assistance to women who are unable to access abortion services.

28. According to the association, a very high number of medical practitioners have objected to abortion on conscientious grounds pursuant to Act No. 194, which leads to situations, witnessed by its members in its field work, where many women are unable to access abortion services as provided by law.

29. The association maintains that there is a significant regional disparity in the provision of abortion services due to the lack of non-objecting medical practitioners, which means that women need to rely on private service providers or obtain an abortion in other geographical areas.

30. It also maintains that the work-related rights of the non-objecting medical practitioners are violated and refers to situations where, according to its observations from the field, their work has been limited to performing abortions or the personnel has been required to work overtime, to work in isolation, as well as without replacement or assistant personnel.

B. *Movimento Italiano per la Vita*

31. *Movimento Italiano* per la Vita is a national federation of more than six hundred local groups, service centres promoting the right to life (centri di servizi di aiuto alla vita) and care homes (case di accoglienza). Its aim is to promote and defend the right to life and dignity for all. In the organisation's view human dignity is intrinsically linked to the right to life, which is why abortion is only permitted in exceptional circumstances in Italy.

32. *Movimento Italiano* per la Vita argues that human life begins at conception and refers in this respect to several texts, such as Recommendations 874 (1979), 1046 (1986), and 1100 (1989) of the Parliamentary Assembly of the Council of Europe, as well as to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine. It highlights that the European Court of Human Rights has in several decisions been called upon to rule whether an unborn child is covered by Article 2 of the European Convention on

Human Rights, and has consistently held that States have a margin of appreciation in this respect.

33. *Movimento Italiano* per la Vita argues that the right of a doctor to refuse to carry out abortions on the grounds of conscience is widely recognised as a fundamental right. On the contrary, abortions can only be carried out in cases of necessity, as defined in the domestic legislation and by the decisions of the domestic courts.

34. *Movimento Italiano* per la Vita maintains that it has not been proven that women are obliged to travel abroad for abortion as a result of the high numbers of conscientious objectors. This is rather due to the fact that in some countries the law is less restrictive.

35. It lastly argues that all annual ministerial reports indicate that the diminution of abortions in Italy is due to the effective functioning of Act No. 194/1978, and not to conscientious objection.

C. *Associazione italiana per l'educazione demografica*

36. *Associazione italiana per l'educazione demografica* is a non-governmental organisation which seeks to, inter alia, promote free and responsible procreation; support initiatives for the improvement of the quality of life and safeguarding human health; as well as ensuring due enforcement of abortion legislation.

37. *Associazione italiana per l'educazione demografica* observes that in 2012, on average seven out of ten gynaecologists refused to carry out abortions on conscientious grounds. Significant regional disparities exist, with certain regions having a higher number of doctors objecting to abortions, for example in the south. In this respect, it refers to recent information indicating that the percentage of conscientious objectors may in some regions be considerably larger than that registered by the Italian Ministry of Health.

38. It further maintains that the number of illegal abortions is on the increase in Italy and the figures published by the Ministry of Health in 2008 –20.000 clandestine abortions – may underestimate the problem as they do not include foreign women. In addition, the Associazione italiana per l'educazione demografica observes an increase in "spontaneous abortions", which – according to the above figures – amount to some 73.000 per year, compared to some 50.000 in the 1980s. It suggests that these figures may also include women who, having tried to terminate their pregnancy by themselves, go to the hospital to complete the abortion process and have the abortion recorded as "spontaneous".

D. *Giuristi Per La Vita*

39. *Giuristi Per La Vita* is a non-governmental organisation which aims to promote and protect the right to life. It submits its observations on behalf of *Associazione Medici Cattolici Italiani* (A.M.C.I.), *Associazione Italiana Ginecologi Ostetrici Cattolici* (A.I.G.O.C.), *Confederazione Italiana dei Consultori familiari di Ispirazione Cristiana* (C.F.C), *Centro Studi per la tutela della salute della madre e del concepito dell'Università Cattolica del Sacro Cuore di Roma* and *Forum delle associazioni familiari*.

40. *Associazione Italiana Ginecologi Ostetrici Cattolici (*The Italian Association of Catholic Obstetricians and Gynecologists (AIGOC)) has over 100 members all over the country. Its purpose is to work nationwide for the improvement of life and health of mothers and children. The association offers various services, training, research and advocacy designed to propose to the mothers other solutions than abortion, to prevent maternal and perinatal mortality.

41. *Associazione Medici Cattolici Italiani (*The Association of Catholic Doctors (AMCI)) has over 4000 members and 4000 followers and is present in 17 Regions and has 130 Sections. The main activities of the association consist in permanent training of physicians, protection of doctors and patient's rights, actions to address a dignified practice of medicine, health promotion, conscientious objection, environmental protection and the ecumenical dialogue with the representatives of the other religious denominations.

42. *Centro Studi per la tutela della salute della madre e del concepito dell'Universitàb Cattolica del Sacro Cuore di Roma (*The Study Centre for Health Protection of the Mother and Conceived) is a non-profit body of the Catholic University of the Sacred Heart in Rome. The Centre promotes research and activities on reproduction and motherhood.

43. *Confederazione Italiana dei Consultori familiari di Ispirazione Cristiana (*Christian Italian Confederation of family counseling (CFC)) brings together 200 advisory centers in Italy. It aims to promote the development and the coordination of counseling centers in the light of the Christian principles.

44. *Forum delle associazioni familiari (t*he Italian Forum of family associations) is a network of 50 national and 400 local associations grouped into 20 regional Forums and various local Forums. Representing three millions of families, its purpose is to support the family in all its aspects, recognizing its irreplaceable values as the cornerstone of any civilized society.

45. *Giuristi Per La Vita* maintains that the right to conscientious objection cannot be limited in any circumstances and refers to various international sources in support of this position.

46. *Giuristi Per La Vita* observes that Act No. 194/1978 does not oblige objecting medical practitioners to guarantee the provision of abortion. They must nevertheless provide care both before and after abortions and cannot be exempted from assisting with the procedure when the life of the woman is in imminent danger.

47. It does not consider the domestic situation to violate the right to health. It refers to data from the 2012 report on the implementation of Act No.194/1978 and notes that approximately 95 % of abortions are carried out within four weeks from the statutory certification date. There is moreover no record of any kind on requested abortions not having been carried out. Also the complications rate is low and the hospitalisation time short.

48. *Giuristi Per La Vita* does not consider that the national situation amounts to prohibited discrimination under Article E, as women are able to move about easily and because no fully isolated rural areas exist in Italy. Pursuant to the statistics, more than 20 % of elective abortions are performed outside the woman's province or region of residence.

49. *Giuristi Per La Vita* lastly considers that the alleged violations of the work-related rights of the Charter have not been substantiated. There is no evidence that those who carry out or assist in abortions have additional work, work longer or suffer from an increased number of work-related injuries than their objecting colleagues. It further maintains that the objecting and non-objecting medical practitioners have different work tasks and are thus not in a comparable position for the purposes of the complaint.

RELEVANT DOMESTIC LAW AND PRACTICE

50. Constitution

Section 1

"Italy is a Democratic Republic, founded on work.
Sovereignty belongs to the people and is exercised by the people in the forms and within the limits of the Constitution. "

Section 2

"The Republic recognises and guarantees the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled".

Section 3

"All citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinion, personal and social conditions.

It is the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country".

Section 4

"The Republic recognises the right of all citizens to work and shall promote such conditions as will make this right effective.
Every citizen has the duty, according to capability and choice, to perform an activity or function that contributes to the material or spiritual progress of society."

Section 19

"All persons have the right to profess freely their own religious faith in any form, individually or in association, to disseminate it and to worship in private or public, provided that the religious rites are not contrary to public morality".

Section 21

"All persons have the right to express freely their ideas by word, in writing and by all other means of communication. (…)".

Section 32

"The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent.

No one may be obliged to undergo any health treatment except under the provisions of the law. The law may not under any circumstances violate the limits imposed by respect for the human person".

Section 35

"The Republic shall protect work in all its forms and practices.

It shall provide for the professional or vocational training and advancement of workers.

It shall promote and encourage international agreements and organisations which have the aim of establishing and regulating labour rights.

It shall recognise the freedom to emigrate, subject to the obligations set out by law in the general interest, and shall protect Italian workers abroad. "

Section 36

"Workers have the right to a remuneration commensurate to the quantity and quality of their work and in all cases to an adequate remuneration ensuring them and their families a free and dignified existence.

Maximum daily working hours are established by law.

Workers have the right to a weekly rest day and paid annual holidays. They cannot waive this right."

51. Act No. 194/1978 "Norms on the social protection of motherhood and the voluntary termination of pregnancy" (Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza – Gazzetta ufficiale 22/05/1978, n. 140)

Section 4

“In order to undergo termination of pregnancy during the first 90 days, women whose situation is such that continuation of pregnancy, childbirth or motherhood would seriously endanger their physical or mental health, in view of their state of health, their economic, social or family circumstances, the circumstances in which conception occurred or the probability that the child would be borne with abnormalities or malformations, shall apply to a public counselling centre [...] or to a fully authorised medical social agency in the region or to a physician of her choice.”

Section 5

“In all cases, in addition to guaranteeing the necessary medical examinations, counselling centres and socio-medical agencies shall be required, especially when the request for termination of pregnancy is motivated by the impact of economic, social or family circumstances upon the pregnant woman’s health, to examine possible solutions to the problems in consultation with the woman and, where the woman consents, with the father of the *conceptus*, with due respect for the dignity and personal feelings of the woman and the person named as the father of the *conceptus*, to help her to overcome the factors which would lead her to have her pregnancy terminated, to enable her to take advantage of her rights as a working woman and a mother, and to encourage any suitable measures designed to support the woman by providing her with all necessary assistance both during her pregnancy and after the delivery. Where the woman applied to a physician of her choice, he shall: carry out the necessary medical examinations, with due respect for the woman’s dignity and freedom; assess, in conjunction with the woman and, where the woman consents, with the father of the *conceptus*, with due respect for the dignity and personal feelings of the woman and of the person named as the father of the *conceptus*, if so desired taking account of the result of the examinations referred to above, the circumstances leading her to request that her pregnancy be terminated; and inform her of her rights and of the social welfare services available to her, as well as regarding the counselling centres and the socio-medical agencies. Where the physician at the counselling centre or socio-medical agency, or the physician of the woman’s choice, finds that in view of the circumstances termination is urgently required, he shall immediately issue the woman a certificate attesting to the urgency of the case. Once she has been issued this certificate, the woman may report to one of the establishments authorised to perform pregnancy terminations.

If termination is not found to be urgently required, the physician at the counselling centre or the socio-medical agency, or the physician of the woman’s choice, shall at the end of the consultation, if the woman requests that her pregnancy be terminated on account of circumstances referred to in Section 4, issue her a copy of a document signed by himself and the woman attesting that the woman is pregnant and that the request has been made, and shall request her to reflect for seven days. After seven days have elapsed, the woman may take the document issued to her under the terms of this paragraph and report to one of the authorised establishments in order for her pregnancy to be terminated.”

Section 6

“The voluntary termination of pregnancy may be performed after the first 90 days:
a) where the pregnancy or childbirth entails a serious threat to the women’s life;
b) where the pathological processes constituting a serious threat to a women’s physical or mental health, such as those associated with serious abnormalities or malformations of the foetus, have been diagnosed.”

Section 7

“The pathological process referred to in the preceding Section shall be diagnosed and certified by a physician on the staff of the department of obstetrics and gynaecology of the hospital establishment in which the termination is to be performed. The physician may call upon the assistance of specialists. The physician shall be required to forward the documentation on the case as well as his certificate to the medical director of the hospital in order for the termination

to be performed immediately. Where the termination of pregnancy is necessary in view of an imminent threat to the woman's life, it may be performed without observing the procedures referred to in the preceding paragraph and in a place other than those referred to in Section 8. In such cases, the physician shall be required to notify the provincial medical officer." (…).

Section 8

"Pregnancy terminations shall be performed by a physician on the staff of the obstetrics and gynaecology department of a general hospital as referred to in Section 20 of Law No. 132 of 12 February 1968; this physician must also confirm that there are no medical contraindications.
Pregnancy terminations may likewise be carried out in specialized public hospitals, the institutes and establishments referred to in the penultimate paragraph of Section 1 of Law No. 132 of 12 February 1968, and the institutions referred to in Law No. 817 of 26 November 1973 and Decree No. 754 of 18 June 1958 of the President of the Republic, wherever the competent administrative agencies so request.

During the first 90 days, pregnancy terminations may also be performed in nursing homes that are authorized by the regions and have the requisite medical equipment and adequate obstetric and gynaecological services.

The Minister of Health shall issue a decree restricting the capacity of authorized nursing homes to carry out terminations of pregnancy, by establishing:

1. the percentage of pregnancy terminations that may be performed relative to the total number of surgical operations performed during the preceding year at the particular nursing home;
2. the percentage of patient-days allowed for pregnancy-termination cases in relation to the total number of patient-days in the preceding year under conventions with the regions.
The percentages referred to in items 1 and 2 shall not be less than 20% and shall be the same for all nursing homes (cf. ministerial decree of 20/10/1978).

Nursing homes may select the criterion which they will observe from the two set out above.

During the first 90 days, pregnancy terminations may likewise be performed, following the establishment of local socio-medical units, at adequately equipped public outpatient clinics, operating under the hospitals and licensed by the regions.

The certificate issued under the third paragraph of Section 5 and, after seven days have elapsed, the document delivered to the woman under the fourth paragraph of the same Section shall entitle her to obtain, on an emergency basis, the termination and, where necessary, hospitalization".

Section 9

"Medical practitioners and other health personnel shall not be required to assist in the procedures referred to in Sections 5 and 7 or in pregnancy terminations if they raise a conscientious objection, declared in advance. Such declaration must be forwarded to the provincial medical officer and, in the case of personnel on the staff of the hospital or nursing home, to the medical director, not later than one month following the entry into force of this Law, or the date of qualification, or the date of commencement of employment at an establishment required to provide services for the termination of pregnancy, or the date of the drawing up of an agreement with insurance agencies entailing the provision of such services.

The objection may be withdrawn at any time, or may be submitted after the periods prescribed in the preceding paragraph, in which case the declaration shall take effect one month after it has been submitted to the provincial medical officer.

Conscientious objection shall exempt health personnel and other health personnel from carrying out procedures and activities specifically and necessarily designed to bring about the termination of pregnancy, and shall not exempt them from providing care prior to and following terminations.

In all cases, hospital establishments and authorised nursing homes shall be required to ensure that the procedures referred to in Section 7 are carried out and pregnancy terminations requested in accordance with the procedures referred to in Sections 5, 7 and 8 are performed. The region shall supervise and ensure implementation of this requirement, if necessary, also by the movement of personnel.

Conscientious objection may not be invoked by medical practitioners or other health personnel if, under the particular circumstances, their personal intervention is essential in order to save the life of a woman in imminent danger.

Conscientious objection shall be deemed to have been withdrawn with immediate effect if the objector assists in procedures or pregnancy terminations provided for under this Law, in cases other than those referred to in the preceding paragraph."

National case law

52. In its judgment No. 27 of 1975, the Italian Constitutional Court (*Corte costituzionale)* stated that:

> "(…) No equivalence exists at this time between the right, not only to life but also to health, of the one who is already a person, as the mother, and safeguarding of the embryo who has yet to become a person".

53. In its judgment No. 35 of 1997, the Constitutional Court has defined Act No. 194/1978 as a law with "constitutionally guaranteed content". On this basis, the *Corte costituzionale* declared inadmissible a *referendum* aimed at removing the existing legislation concerning access to abortion procedures during the first 90 days of pregnancy. The court pointed out that the normative nucleus of laws with constitutionally guaranteed content cannot be altered or rendered ineffective on the ground that this would compromise the corresponding specific provisions of the Constitution or of other constitutional acts (cf. also judgment No. 16 of 1978).

54. In its judgment No. 467 of 1991, the Constitutional Court held that:

> "(…) even if this occured following a delicate operation carried out by the Parliament, aimed at balancing [the sphere of legal potentialities of individual conscience] with conflicting duties or constitutionally protected assets and to guarantee its exercise in a gradual manner to ensure the good functioning of organisational structures and services of national interest, the [above-mentioned] sphere (…) represents, with respect to the specific expressive contents of its essential nucleous, a particularly high constitutional value which justifies a number of (privileged) exemptions as regards the fullfillment of public duties, [and this,] also when the latter are considered as inderogable by the Constitution".

55. In its judgment No. 43 of 1997, the Constitutional Court stated that the protection accorded to the freedom of conscience:

> "[c]annot be considered unlimited and unconditional. It rests primarily with the legislature to establish a balance between individual conscience and ensuing rights, on the one hand, and the overall, mandatory duties of political, economic and social solidarity that the Constitution (Art. 2) requires, on the other, so that the public order is safeguarded and consequent burdens are shared by all, without privileges".

56. In its judgment No. 151 of 2009, the Constitutional Court declared unconstitutional the third paragraph of Article 14 of Law No. 40 of 2004 which provides that:

> "Where the transfer of embryos to the uterus is not possible due to serious and documented circumstances of the woman's state of health, which were not foreseeable at the time of fertilization, embryo cryopreservation is permitted up to the date of transfer, to be implemented as soon as possible."

This decision is based on the principle that the above-mentioned provision does not provide that the transfer of embryos must be carried out without prejudice to the health of women.

57. In its judgment No. 3477 of 2010, the Regional Administrative Tribunal of Apulia *(Tribunale amministrativo regionale della Puglia)* stated that according to Article 9 of Act No. 194/1978, objecting doctors must in any case assist women wishing to terminate their pregnancy, and this, prior and after the abortion. In this respect, the above-mentioned tribunal pointed out that the responsible medical personnel must provide all the necessary information and advice services, as well as assist the women concerned both from the physical and psychological point of view. These indications were provided by the tribunal with regard to the allegations put forward by the Government of Apulia, that not all gynaecologists working in the advice centres for families (*consultori*) provide the aforementioned services and assistance. The Regional Administrative Tribunal of Apulia said that the exclusion of objecting medical practitioners from the competitions aimed at fulfilling vacant posts within the *consultori* constitute a violation Article 3 of the Constitution. It observed that an alternative solution to compensate the limited number of non-objecting medical personnel working in the *consultori* could be the organisation of recruitment competitions aimed at drawing up reserve lists including 50% of objecting doctors and 50% of non-objecting doctors.

58. In its judgment No. 14979 of 2013, the Supreme Court (*Corte di Cassazione*) with regard to the actual care provided prior to and following an abortion, sentenced a doctor who was a conscientious objector to a year in jail after he refused to aid a woman who had already undergone an abortion and had started hemorrhaging seriously.

Other sources

59. In June 2013, both the Senate and the Chamber of Deputies of the Italian Parliament adopted policy directives in the form of parliamentary motions (*mozioni*) addressed to the Government concerning *inter alia* the implementation of Act No. 194/1978. In particular, on 6 June 2013, at 37th its Session, the Senate approved the

Motion No. 1-00059; on 11 June 2013, at its 31th Session, the Chamber of Deputies approved the following motions: Nos. 1-00045, 1-00074, 1-00078, 1-00079, 1-00080, 1-00081, 1-00082, 1-00087 and 1-00089. These motions specifically refer to the the implementation of Section 9§4 of the above-mentioned Act and some of the allegations put forward by the complainant organisation, i.e.:

> - “At national level the main consequence of such a high number of conscientious objectors is that the very application of Law No. 194 is becoming increasingly difficult, with serious negative implications for the functioning of the various hospitals (and accordingly for the national health system), which have an impact on women obliged to seek an abortion (often resulting in tragically late abortions on account of the long waiting times)”;
>
> - “Given this state of "emergency" women are often obliged to travel to another region or even abroad, while there is a re-emergence of clandestine abortions (above all among immigrant women) and of the related criminal activities, a plague that had been wiped out only by the due application of Law No. 194”;
>
> (cf. Senate, Motion No. 1-00059 of 6 June 2013)
>
> - “(…) The high proportion of medical practitioners who are objectors would also seem to be affecting the operability and effectiveness of prevention and support services for women at the pre-termination stage. The (…) report by the Minister of Health shows that, in many cases, the effectiveness and the role of those providing such advisory services is undermined by a shortage of suitably qualified persons available to sign the documents and the approvals necessary for the performance of an abortion, above all in southern Italy. This is a factor that distances women from these structures and from the essential information, prevention and support services they provide (…)”;
>
> - “(…) At present there are no effective monitoring, reward or sanction systems, with a view to verifying, encouraging and supporting the effective functioning of the structures required to implement Law No. 194, and also no means of conducting a proper analysis of the manner in which conscientious objection affects their functioning (…)”.
>
> (cf. Chamber of Deputies, Motion No. 1-00082 of 11 June 2013)
>
> - “(…) The growth in the number of medical practitioners objectors in recent years has led to the closure of services, leaving some hospitals devoid of any department performing abortions because virtually all the gynaecologists, anaesthetists and paramedical staff have chosen conscientious objection, (…)”.
>
> (cf. Chamber of Deputies, Motion No. 1-00078 of 11 June 2013)

60. The Committee notes that with respect to the difficulties encountered in the implementation of Act No. 194/1978, some motions ask the Government to:

> - “Implement in full Law No. 194 of 1978, while respecting the individual right of conscientious objection”;
>
> - “Take all the necessary measures, within the limits of its competence, to guarantee the implementation, as regards the organisation of the regional health systems, of the fourth paragraph of Article 9 of Law No. 194 of 1978, in so far as it institutes an obligation to

supervise and guarantee the application of women's right to informed freedom of choice, also through a change of management methods and staff mobility, guaranteeing the presence of a sufficient network of services in every region across the country" (…).

(cf. Chamber of Deputies, Motion No. 1-00074 of 11 June 2013)

- "(…) Ensure the timely adoption of regulatory measures, as also called for by the European Union, so as to allow proper planning of health care activities, embracing not only the legitimacy of conscientious objection but also access to treatment and health protection, in such a way as to avoid a potential conflict detrimental to the right to health" (…).

(cf. Chamber of Deputies, Motion No. 1-00087 of 11 June 2013)

- "Conduct an in-depth analysis of the impact of conscientious objection on the implementation of Law No. 194 through a study carried out at the level of each hospital and based on sufficiently detailed data and indicators to deal with the problem of the link between the presence of staff who are non-objectors and the length of waiting lists";

- "Take all the necessary measures, within its sphere of competence, so as to guarantee compliance with and the full application of Law No. 194 of 1978 in all hospitals throughout Italy, by implementing, where necessary, a revised organisation of tasks and recruitment drawing on the tools of staff mobility provided for in the law, which institutes forms of differentiated recruitment with a view to balancing, according to the available data, the number of objectors and the number of non-objectors, as recommended by the National Bioethics Committee";

(cf. Chamber of Deputies, Motion No. 1-00082 of 11 June 2013)

- "Guarantee a rebalancing of medical and nursing staff, as moreover provided for in Article 9 of Law No. 194, through staff mobility, aimed at ensuring minimum numbers and regional programming, with the aim of having at least 50% of staff who are non-objectors" (…).

(cf. Senate, Motion No. 1-00059 of 6 June 2013)

61. The Committee also notes that on 11 June 2013, during the debate at the Chamber of Deputies relating to the above-mentioned motions, the Minister of Health declared that:

"We have seen that, fortunately, during these years the number of voluntary terminations of pregnancy decreased due to the prevention activities and the greater conscience of the persons [involved]. This was one of the objectives of the legislation which – we should remind it – provides a free of charge service for all users. We have also seen that often, where there has been an increase or a decrease of the objectors, this has not always led to a problems-free situation in the access to local services. Here we come, unfortunately, to what is the theme of governance of territories and therefore more connected to the theme of regions, but surely cannot avoid dealing with [this theme] as Minister of Health, because we find ourselves in the wider complex of issues that affect the protection of the right to health in the national territory".

62. In this connection, the Minister expressed the hope that she will be able to come before parliament with "all the data required for a general debate, so as to be able to verify the state of implementation of the legislation throughout national territory, since we realise that some of the data presented here today can give rise to multiple interpretations."

63. In particular she has stated that she intends "to take action to enable the establishment of a technical board of the regional ministers, so as to obtain, and present to parliament, information on the state of implementation of the law as regards non-discrimination between objectors and non-objectors at regional level."

64. In the framework of the same debate, in reply to the requests addressed to the Government within the aforesaid motions, the Minister of Health has made the following statements:

> - "(…) I believe that the intention of all is to verify, in the territories and the individual health facilities, whether the principles of the law are effectively applied (…)";
>
> - "(…) this issue of conscientious objection, which has been raised by some of the groups that submitted the motions, is an issue that we feel we must take into account, especially in so far as it calls upon the Government and myself to monitor carefully – as required in different motions - the enforcement of the law in this area as well (…)".
>
> (NB: The full text of the intervention of the Minister of Health, Mrs Beatrice Lorenzin, in the occasion of the debate is available at the following website of the Chamber of Deputies: http://documenti.camera.it/leg17/resoconti/assemblea/html/sed0031/pdfel.htm)

65. Resolution of the Commission of Social Affairs of the Chamber of Deputies adopted 6 march 2014 on the "Report on the state of implementation of Law No. 194 of 1978 governing the social protection of motherhood and voluntary terminations of pregnancy, containing preliminary data for 2012 and final data for 2011":

> "The monitoring activity initiated by the Government was rightly decided in order to verify the possible problems of implementation of Law No. 194, with particular reference to the issue of conscientious objection; in this perspective, in 2013, a 'technical table "was created within the Ministry of Health, with the participation of all relevant regional ministers."

calls on the Government:

> "... to report to the competent parliamentary committees on the initiatives taken by the ministry itself in application of the commitments it entered into on 11 June 2013 before the Chamber of Deputies, as set out in the motions adopted on this subject, and to take all the necessary measures to ensure the implementation of Article 9§4 of Law no 194, in all regional health systems, especially as regards the obligation to monitor and ensure the right of a woman to a free and conscious choice, and this even using a different staff mobility and ensuring the presence of a suitable network services in the territory of each region."

RELEVANT INTERNATIONAL MATERIALS

I. Council of Europe

66. The European Convention for the protection of Human Rights and Fundamental Freedoms includes the following provisions:

Article 8 - Right to respect for private and family life

"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

Article 9 - Freedom of thought, conscience and religion

"1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others."

a. Relevant judgments of the European Court of Human Rights

- In Tysiac v. Poland, Application no. 5410/03, judgment 20 March 2007; the Court stated that:

"118. (…) the very nature of the issues involved in decisions to terminate a pregnancy is such that the time factor is of critical importance. The procedures in place should therefore ensure that such decisions are timely so as to limit or prevent damage to a woman's health which might be occasioned by a late abortion (…)".

- In A., B., C. v. Ireland, Application No. 25579/05, judgment of 16 December 2010; the Court stated that:

"212. (…) the notion of "private life" within the meaning of Article 8 of the Convention is a broad concept which encompasses, inter alia, the right to personal autonomy and personal development (…). It concerns subjects such as gender identification, sexual orientation and sexual life (…), a person's physical and psychological integrity (Tysiąc v. Poland judgment, cited [below]) as well as decisions both to have and not to have a child or to become genetic parents (…)".
"249 (…) the State enjoys a certain margin of appreciation (see, among other authorities, Keegan v. Ireland, judgment of 26 May 1994, Series A no. 290, § 49). While a broad margin of appreciation is accorded to the State as to the decision about the circumstances in which an abortion will be permitted in a State (…), once that decision is taken the legal framework devised for this purpose should be "shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention" (S.H. and Others v. Austria, no. 57813/00, § 74, 1 April 2010)".

- In R.R. v. Poland, Application No. 27617/04, judgment of 20 November 2011; the Court stated that:

"187. While a broad margin of appreciation is accorded to the State as regards the circumstances in which an abortion will be permitted in a State, once that decision is taken the legal framework devised for this purpose should be 'shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention' (A, B and C v. Ireland [GC], (…) § 249 [16 December 2010])".

"200. (…) once the State, acting within the limits of the margin of appreciation (…) adopts statutory regulations allowing abortion in some situations, it must not structure its legal framework in a way which would limit real possibilities to obtain it. In particular, the State is under a positive obligation to create a procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion (Tysiąc v. Poland, no. 5410/03, §§ 116 - 124, ECHR 2007-IV) (…)".

"206. (…) States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation".

- In P. and S. v. Poland, Application No. 57375/08, judgment of 20 October 2012, the Court stated that:

"99. (…) once the State, acting within its limits of appreciation, adopts statutory regulations allowing abortion in some situations, it must not structure its legal framework in a way which would limit real possibilities to obtain an abortion. In particular, the State is under a positive obligation to create a procedural framework enabling a pregnant woman to effectively exercise her right of access to lawful abortion (Tysiąc v. Poland, cited above, § 116-124, R.R. v. Poland, cited above, § 200). The legal framework devised for the purposes of the determination of the conditions for lawful abortion should be "shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention" (… A, B and C v. Ireland [GC], (…) § 249 [16 December 2010])".

"106. (…) For the Court, States are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation (…)."

b. Other materials

67. The Parliamentary Assembly of the Council of Europe has adopted the following text:

Resolution 1763 (2010), "The right to conscientious objection in lawful medical care

"1. No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus or embryo, for any reason.

2. The Parliamentary Assembly emphasises the need to affirm the right of conscientious objection together with the responsibility of the state to ensure that patients are able to access lawful medical care in a timely manner. The Assembly is concerned that the unregulated use of conscientious objection may disproportionately affect women, notably those with low incomes or living in rural areas.

3. In the vast majority of Council of Europe member states, the practice of conscientious objection is adequately regulated. There is a comprehensive and clear legal and policy framework governing the practice of conscientious objection by health-care providers ensuring that the interests and rights of individuals seeking legal medical services are respected, protected and fulfilled.

4. In view of member states' obligation to ensure access to lawful medical care and to protect the right to health, as well as the obligation to ensure respect for the right of freedom of thought, conscience and religion of health-care providers, the Assembly invites Council of Europe member states to develop comprehensive and clear regulations that define and regulate conscientious objection with regard to health and medical services, and which:

4.1. guarantee the right to conscientious objection in relation to participation in the medical procedure in question;
4.2. ensure that patients are informed of any conscientious objection in a timely manner and referred to another health-care provider;
4.3. ensure that patients receive appropriate treatment, in particular in cases of emergency."

II. United Nations

68. The United Nations International Covenant on Economic, Social and Cultural Rights of 16 December 1966 includes the following provisions:

Article 12

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of
this right shall include those necessary for:

(a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

69. The General Comment No. 14 (2000) on "The right to the highest attainable standard of health (article 12)", adopted by the Committee on economic, social and cultural rights at its twenty-second session, Geneva, 25 April-12 May 2000 – provides that:

"11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health…"

"12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes), have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
(iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
(iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

"11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."

70. The United Nations International Covenant on Civil and Political Rights of 16 December 1966 includes the following provisions:

Article 18

"1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

…

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others."

71. The Convention on the Elimination of All Forms of Discrimination Against Women of 18 December 1979 includes the following provisions:

Article 12:

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

72. The General Recommendation on Women and Health, No. 24, adopted in 1999 by the Committee on the Elimination of Discrimination against Women, at its 20th Session, provides that:

"11. Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."

III. European Union

73. The Charter of Fundamental Rights of the European Union of 7 December 2000 provides that :

Article 10 - Freedom of thought, conscience and religion

"1. Everyone has the right to freedom of thought, conscience and religion. This right includes freedom to change religion or belief and freedom, either alone or in community with others and in public or in private, to manifest religion or belief, in worship, teaching, practice and observance.

2. The right to conscientious objection is recognised, in accordance with the national laws governing the exercise of this right".

Article 35 - Health care

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".

IV. Other materials

74. World Health Organization (“WHO”) - Department of Reproductive Health and Research “Safe Abortion: technical and policy guidance for health systems” (second edition, 2012) indicates that:

> “Health-care professionals sometimes exempt themselves from abortion care on the basis of conscientious objection to the procedure, while not referring the woman to an abortion provider. Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman’s life and to prevent serious injury to her health. Women who present with complications from an unsafe or illegal abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviours (see also Chapter 4).”
>
> (cf. Chapter 3.3.6 - Conscientious objection by health-care providers).

THE LAW

ADMISSIBILITY

As to the admissibility conditions laid down by the Protocol and the Committee’s Rules

75. The Committee observes that, in accordance with Article 4 of the Protocol, which was ratified by Italy on 3 November 1997 and entered into force with respect to this State on 1 July 1998, the complaint has been submitted in writing and concerns Articles 1, 2, 3, 11, 26 and Article E of the Charter, provisions accepted by Italy when it ratified this treaty on 5 July 1999 and to which it is bound since the entry into force of the Charter in its respect on 1 September 1999.

76. Moreover, the grounds for the complaint are indicated.

77. The Committee notes that CGIL invites the Committee to determine, whether Articles 21 and 22 of the Charter are of relevance to the circumstances of the complaint. It argues that the principles embodied by them should be implemented also in the public sector, insofar as they provide for the timely consultation of workers.

78. The Committee recalls that Article 21 guarantees the right of workers to be informed and consulted within the undertaking, and Article 22 their right to take part in the determination and improvement of their working conditions and working environment.

79. The Committee further recalls that pursuant to Part II of the Appendix to the Charter, the term “undertaking” is, in connection with the application of Articles 21 and 22, understood as referring to a mechanism “with or without legal personality, formed to produce goods or provide services for financial gain and with power to determine its own market policy”.

80. The Committee consequently stresses that even though Articles 21 and 22 may apply to workers in state-owned enterprises, public employees are as a whole not covered by these provisions (Conclusions XIII-5, 1997, Norway, p. 288, Additional Protocol, Article 2; European Council of Police Trade Unions v. Portugal, Complaint No. 40/2007, decision on the merits of 23 September 2008, §42; European Council of Police Trade Unions v. Portugal, Complaint No. 60/2010, decision on the merits of 17 October 2011, §36).

81. The above reasons lead the Committee to conclude that the participation of doctors working in the public sector in the determination and improvement of their working conditions and working environment does not fall within the scope of Articles 21 or 22 of the Charter. In any event CGIL has not alleged that Articles 21 and 22 have been violated. Therefore the Committee considers that, the complaint does not extend to Articles 21 and 22.

82. The Committee observes that CGIL is a national trade union organisation representing, inter alia, workers in the public sector. It has approximately 6 million members. On the basis of the information at its disposal, the Committee finds that in accordance with Article 1 c) of the Protocol, CGIL is a representative national trade union for the purposes of the collective complaints procedure.

83. The complaint is signed by Susanna CAMUSSO, Secretary General of CGIL, who, in accordance with its Statutes, is entitled to represent the complainant organisation. The Committee, therefore, considers that the condition set out in Rule 23 is fulfilled.

As to the objection of inadmissibility raised by the Government

84. As to the Government’s argument that the domestic remedies have not been exhausted with regard to the complaint relating to employment rights, the Committee recalls that neither the Protocol nor the Rules require the exhaustion of domestic remedies as a prerequisite to lodging a collective complaint. It accordingly dismisses this objection to admissibility (*Syndicat des Agrégés de l'Enseignement Supérieur* (SAGES) v. France, Complaint No. 26/2004, decision on admissibility of 12 July 2004, § 12; European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 31/2005, decision on admissibility of 10 October 2005, § 10).

85. On these grounds, the Committee declares the complaint admissible.

MERITS

PART I: ALLEGED VIOLATION OF ARTICLE 11§1 OF THE CHARTER

86. Article 11 of the Charter reads as follows:

> **Article 11 - The right to protection of health**
>
> Part I: "Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable."
>
> Part II: "With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:
>
> 1. to remove as far as possible the causes of ill-health;
>
> [...]."

87. Article G of the Charter reads as follows:

> **Article G – Restrictions**
>
> "1. The rights and principles set forth in Part I when effectively realised, and their effective exercise as provided for in Part II, shall not be subject to any restrictions or limitations not specified in those parts, except such as are prescribed by law and are necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public interest, national security, public health, or morals.
>
> 2. The restrictions permitted under this Charter to the rights and obligations set forth herein shall not be applied for any purpose other than that for which they have been prescribed."

A – Arguments of the parties

88. The parties' arguments are presented here in the order in which the relevant case-file documents were registered.

1. Arguments put forward by the complainant organisation in the complaint

89. CGIL considers in general that Law No. 194/1978 establishes "a balance between women's rights (primarily the right to life, the right to health and the right to self-determination as regards their reproductive choices in matters of termination of pregnancy) and those of medical staff (the right to raise a conscientious objection in the manner and according to the time-limits laid down in Article 9 of the [above-mentioned] law) ensuring that neither set of rights is ever sacrificed, except in cases where there is an imminent danger to a woman's life …".

90. Concerning conscientious objection, CGIL indicates that "Article 9 … is of particular importance, since its aim is to grant medical practitioners and staff performing auxiliary activities the possibility of raising a conscientious objection …

An instrument for the protection of practitioners' freedom of conscience has thus been established." Concerning the protection of health, it underlines that "Women's right of access to pregnancy termination procedures can be exercised solely in hospitals where non-objecting doctors are present in sufficient number to deal with the demand for such terminations."

91. In this connection, CGIL points out that, pursuant to Article 9§4, hospitals and authorised nursing homes are required to guarantee that all requests for abortions requested in accordance with the procedures (set out in Articles 5, 7 and 8 of the law) will be carried out. It also points out that the regions must supervise and guarantee the implementation of this requirement, including through staff mobility measures.

92. CGIL highlights the fact that the Italian Constitutional Court has deemed that Act No. 194/1978 is of "constitutionally required substance" (see judgments Nos. 26 and 35 of 1997) and its "core provisions cannot be amended or rendered ineffective without breaching the corresponding specific provisions of the Constitution (or other constitutional laws)" (cf. judgment No. 16 of 1978).

93. CGIL considers that, while providing for a spectrum of measures aimed at guaranteeing access to abortion services, Article 9§4 is not appropriately worded since it does not specify the tangible means whereby such measures are to be put in place. The organisation states that "in practice, the high number of doctors who are objectors prevents the full implementation of the legislation, [for lack of] tangible means of ensuring that there is a sufficient number of non-objecting doctors within each hospital."

94. In view of the above, CGIL maintains that, on account of the legislation's deficiencies, the measures put in place by the hospitals concerned and the initiatives taken by the regional authorities "are insufficient and unsuitable to guarantee the achievement of the objectives of Act No. 194 regarding terminations of pregnancy". CGIL is of the opinion that "the solutions [implemented by the competent authorities] have proved insufficient and unsuitable to guarantee the implementation of Act No. 194 and hence to ensure the effective protection of the rights of women wishing to seek a termination of pregnancy."

95. On this subject, it is specified that in many cases hospitals have called on external non-objecting staff. For CGIL, this solution, which appears to guarantee the required service, namely a termination of pregnancy, "can be seen to have obvious limits linked to the failure to guarantee the continuity of care provision." Mention is made of the fact that, in other cases, hospitals have reached agreements with nursing homes. CGIL considers that "the conclusion of agreements with private establishments undermines the public sector foundations of Law No. 194" and that "rather than solving the problem of the shortage of staff, it is being circumvented."

96. On this basis, CGIL concludes that Article 11 of the Charter is not being implemented in a satisfactory manner, since the deficiencies in applying Article 9§4 do not make it possible to guarantee the effective exercise of women's right of access to abortion services.

97. According to CGIL, this conclusion is primarily based on the statistical data which show that the public hospitals have insufficient non-objecting medical staff. It indicates that these data can be found in the official reports on the implementation of the law, which the ministry of health submits to Parliament each year. In this connection, it refers to the information given in the reports published by the ministry between 2005 and 2011, relating to the years 2003 to 2009.

98. Upon comparing the data contained in these reports, CGIL notes an increase in the number of conscientious objectors in three professional categories (see the following table):

	GYNAECOLOGIST	**ANAESTHETISTS**	**NON-MEDICAL PERSONNEL**
Ministerial Report 2011(data 2009)	70,7%	51,7%	44,4%
Ministerial Report 2010(data 2008)	71,5%	52,6%	43,3%
Ministerial Report 2009 (data 2007)	70,5%	52,3%	40,9%
Ministerial Report 2008 (data 2006)	69,2%	50,4%	42,6%
Ministerial Report 2007 (data 2005)	58,7%	45,7%	38,6%
Ministerial Report 2006 (data 2004)	59,5%	46,3%	39,1%
Ministerial Report 2005 (data 2003)	57,8%	45,7%	38,1%

99. As concerns the 2011 report, CGIL cites the following information:

> “In 2009, there was a stabilisation of conscientious objection among gynaecologists and anaesthetists, after a considerable increase in previous years. At the national level, the percentage of objecting gynaecologists increased from 58.7% in 2005 to 69.2% in 2006, to 70.5% in 2007, to 71.5% in 2008 and to 70.7% in 2009; the percentage of anaesthetists in these years increased from 45.7% to 51.7%; the percentage of non-medical staff saw a further increase, from 38.6% in 2005 to 44.4% in 2009. In Southern Italy, there is a rate of more than 80% registered gynaecologists: 85.2% in Basilicata, 83.9% in Campania, 82.8% in Molise, 81.7% in Sicily and 81.3% in Bolzano; the highest percentages of [anaesthetists] are registered in Molise and Campania at more than 77% and in Sicily at 75.6%, and the lowest percentage is in Tuscany at 27.7% and Trento at 31.8%; for non-medical personnel the numbers are lower, with a maximum of 87% in Sicily and 82% in Molise. (…)”.

100. CGIL also provides tables containing data for the three professional categories concerned (gynaecologists, anaesthetists and non-medical staff) analysed by region and by geographical zone.

101. So as to provide evidence of the difficulties with which many hospitals have to contend in satisfying requests for abortion, given the high number of conscientious objectors, CGIL refers to the situations of a number of hospitals in the following regions: Lombardy, Marche, Sicily, Abruzzo and Puglia. Most of this information is reiterated and expanded upon in CGIL's reply to the Government's submissions on the merits of the complaint, as set out below.

2. Arguments put forward by the respondent Government in the section of its submissions relating to the merits of the complaint

102. According to the Government CGIL's interpretation of the situation in respect of Articles 11 and E of the Charter "… distorts their meaning, threatens women's health and lives because it wants them to be assisted solely by non-objecting medical staff, who facilitate voluntary terminations of pregnancy without verifying women's physical and psychological state".

103. The Government contends that the situation is not incompatible with the Charter for the following reasons:

a) the State has introduced every practical and legislative measure to apply Act No. 194/1978 for the benefit of women and in support of their rights to abortion;

b) the State cannot restrict the number of medical staff who declare that they are conscientious objectors while respecting freedom of conscience and opinion, as is also recognised by the European Court of Human Rights in accordance with Article 9 of the 1950 Convention and other international instruments (in this connection the Government refers to the following documents: PACE Resolution 1763(2010) and Recommendation 1518/2002; Article 10§2 of the Charter of Fundamental Rights of the European Union; and Article 18 of the International Covenant on Civil and Political Rights);

c) Italian law reconciles the rights of women and doctors by giving them the possibility of making choices that are compatible with their conscience according to the principle of non-discrimination set out in the Charter.

104. In general, the Government considers that Act No. 194/1978 "strikes a proper and necessary balance between women's right to life and health and the freedom of conscience of medical or paramedical personnel vis-à-vis voluntary termination of pregnancy."

105. The Government further notes that Act No. 194/1978 "which sets out the arrangements and measures to secure women’s right to health in the event of voluntary termination of pregnancy" was adopted in accordance with the "margin of appreciation" provided for by Article G of the Charter.

106. Concerning the arguments advanced by CGIL, the Government considers that the decline in the number and the rate of abortions shows the quality of the work being done by the health services to prevent abortions; according to the Government it also shows a positive attitude among women towards birth control and the results of measures aimed at making women more aware and responsible. In this connection, the Government indicates that ad hoc abortion prevention projects aimed at women of foreign origin have been set up, involving specific initiatives focusing on cultural mediation, facilitation of access to services and staff training.

107. The Government states that the stabilisation of the number of urgent procedures (procedures carried out without waiting for seven days after certification) and the reduced waiting period between certification and surgery testify to the services' efficiency; it considers that the increase in the number of procedures performed on an outpatient basis and in hospitalisations lasting less than one day shows that women are encountering fewer difficulties in accessing these services and that human resources are better managed; it maintains that the high percentage of women who undergo an abortion at a gestation of 10 weeks or less and the low rate of complications – no deaths or serious complications following abortions carried out in accordance with Act No. 194/1978 have been recorded – constitute proof that abortion now poses no threat to women's health.

108. Regarding conscientious objection and abortion services, the Government states that the number of conscientious objectors observed in Italy – which is partly offset by staff mobility and agreements with specialist obstetrics and gynaecology departments – has no practical direct impact on recourse to abortion services and therefore does not affect women's rights.

109. The Government indicates that the reduction in the number of women resorting to abortion has been considerably more significant than the increase in the number of conscientious objectors among health care professionals and medical staff. From this standpoint, it considers that, in recent years, the services have become more efficient in terms of both prevention and access to abortion services, and that operations are carried out with no danger for women's health.

110. The Government also indicates that Act No. 194/1978 has resulted in a reduction in clandestine abortions.

3. Arguments contained in the response of the complainant organisation to the submission of the Government regarding the merits of the complaint

111. As regards the arguments of the Government concerning the unsatisfactory implementation of Section 9§4 of Act No. 194/1978, CGIL put forward the following considerations:

a) the decrease in the number of abortions cannot be considered a sign that there are no problems in implementing the abovementioned provision. CGIL is of the view that “this could instead signify that the number of abortions is falling due to the very fact that women cannot access the service and have to fall back on other solutions, such as travelling abroad or undergoing a clandestine abortion”;

b) even though the Ministry of Health estimates the number of illegal abortions at about 20.000, the real figure for the number of clandestine abortions could be as high as 50.000. In this regard, it is pointed out that official figures have not been updated since 2008 and the ministry itself recognises that they are understated. It is underlined how difficult it is to quantify a phenomenon which, by its very nature, escapes any kind of monitoring. With this in mind, CGIL considers that “the clandestine abortion phenomenon, where women are inevitably risking their own lives and health, apart from being obliged to pay for a service which should usually be free of charge, as provided for by Act No. 194/1978, is closely related to the question of the link between the decrease in the number of abortions and the alleged lack of problems due to the number of practitioners who are conscientious objectors”;

c) the positions expressed in the Italian Government's submission are in contradiction with the declarations made by the Government itself, in the person of the Minister for Health, Beatrice Lorenzin, following the tabling in the Chamber of Deputies of nine motions on the right of conscientious objection in medical and health matters; in this framework, the Minister stated that “where there has been an increase or a decrease of the objectors, this has not always led to a problems-free situation in the access to local services” (see paragraph 61). Moreover, CGIL considers that the Minister’s declarations are pointless, “since they are based on the simple idea that it is enough to monitor the application of Act No. 194/1978 and therefore that they cannot be regarded as effective stances likely to bring about a change in the situation regarding application of the relevant law”.

112. Following these considerations, with respect to other assertions contained in the Government’s submission, CGIL provides detailed information on the difficulties of implementation of Act No. 194/1978 and the negative consequences for the protection of health of the women concerned. This information is based on a number of documents appended to its response. CGIL specifies that the information provided does not represent a full review of covering each and every hospital, care home or counselling centre throughout Italy.

113. In this respect, it points out that:

a) the annual reports by the Ministry of Health on the implementation of the abovementioned act contain no specific information on the number of requests for abortions per hospital;

b) the request of LAIGA – *Libera Associazione Italiana Ginecologi per l'Attuazione della legge 194* (Free Italian Association of Gynaecologists for the Implementation of Act No. 194/1978) that ISTAT provide a list of all the establishments was refused and it was therefore not possible to carry out any survey on the link between requests for abortion and the number of non-objecting practitioners called upon to perform this type of intervention;

c) in any case, the number of requests cannot be taken into account since they are not registered in cases where the woman is obliged to find another hospital or seek a different solution in view of the difficulty of accessing such treatment.

114. CGIL also considers that the cases of women who are obliged to turn to other establishments necessarily escape this type of survey, since there is no trace of their requests when they are not given adequate assistance. It also mentions that as referred to one of the motions adopted by the Italian Parliament in June 2013 in the current situation it is virtually impossible to verify, that women who withdraw from a waiting list do so because they have indeed changed their minds or because, as the wait grows longer, they decide to have recourse to a clandestine abortion.

115. CGIL refers to the information provided in the report on cases of unsatisfactory implementation of Act No. 194/1978 drafted in 2013 by Mrs Silvana Agatone, President of LAIGA. This document, which is also appended to CGIL's response to the Government submission, contains the following statement:

> "(…) [T]he law [194/1978] is widely disregarded and (…) in many hospitals it is impossible to have an abortion. (…) There are no reliable, easily available, official sources providing up-to-date lists of hospitals where legally authorised abortions can be performed nor a list of gynecology units where they are provided. In short, it is impossible to check where abortions are available. (…)[LAIGA] consequently began to enquire (…), hospital by hospital, using information found on certain non-official websites (…), in order to find an answer to our question: is Article 9 of Law 194 being applied in practice? (…) The results of our investigation are summarised in the table below. Given the enormous difficulty in obtaining official data, it should be noted that this information is not exhaustive but gives some idea of the problem."

116. The abovementioned report indicates that "(…) not all hospitals provide terminations of pregnancy, thereby breaching Article 9 of Law 194 (…)". A list of 45 hospitals where, even if a gynecology unit exists, terminations of pregnancy cannot be performed, is provided by the President of LAIGA (regions concerned: Lazio, Piedmont, Venetia, Friuli Venetia Giulia, Marche, Lombardy, Emilia Romagna, Tuscany, Sicily, Sardinia, Apulia), i.e.:

Azienda Ospedaliera Universitaria S.Andrea, *Policlinico Universitario Tor Vergata* (Rome)*, Ospedale Acquapendente* (*Viterbo*),*Ospedale Andosilla* (*Civitacastellana*), *Ospedale Belcolle* (*Viterbo*), *Ospedale S.Camillo De Lellis* (*Rieti*), *Ospedale Umberto 1°* (*Frosinone*), *Ospedale S.Benedetto* (*Alatri*), *Ospedale di Velletri, Ospedale Maggiore della Carità* (*Novara*),*Ospedali Riuniti S. Lorenzo Varmagnola*, *Ospedale di Camposampiero* (Turin), *Ospedale Castelli* (*Verbania*), *Ospedale Portogruaro* (*Verona*), *Ospedale di Belluno, Ospedale di Bassano, Ospedale di Gorizia, Ospedale di Jesi, Ospedale di Fano, Ospedale di Fermo, OspedaliCivili di Brescia, Ospedale S.Maria delle Stelle Melzo, Ospedale di Cernusco, Ospedale di Carate, Ospedale di Gallarate, Ospedale di Gorgonzola, Ospedale di Angera, Ospedale - di Treviglio e Caravaggio, Ospedale di Como, Ospedale di Cantu', Ospedale di Monza, Ospedale di Melzo S. Maria delle Stella, Ospedale di Sassuolo, OspedaleFranchini-Montecchio Reggio Emilia, Ospedale di Ponte Annicari, Ospedale di Lipari, Ospedale Muscatello* (*Augusta*), *Ospedale di Bosa, Ospedale di Ozieri, Regione, Ospedale San Paolo (Bari), Ospedale Perrino* (*Brindisi*),*Ospedale di Venere, Ospedale di Bitonto, Ospedale di Bisceglie, Ospedale di Fasano*.

117. As concerns the situation of medical personnel carrying out abortions procedures, CGIL considers that the report by President of LAIGA provides "complete data" with respect to the Region of Lazio. In this respect, the President of LAIGA states that: "In this region, out of a total of 391 gynecologists attached to hospital units, only 33 are non-objectors and perform abortions; thus 91.3% of gynecologists in Lazio are conscientious objectors". As regards other regions (Piedmont, Lombardy, Trentino Alto Adige, Abruzzo, Campania, Basilicata, Apulia, Calabria, Sicily, Sardinia), the report provides data indicating that in at least 38 hospitals there are no non-objecting gynecologists, or there is just one. According to the information provided, the hospitals in this situation are as follows:

Ospedali Riuniti (Borgomanero), Broni hospital (Stradella), Ospedale Civile (Sondrio), Ospedale Civile (Cavalese),Ospedale Civile (Bassano),Ospedale S. Spirito, Policlinico Umberto I, A.O.S. Andrea (Rome), San Paolo hospital (Civitavecchia), Paro di Delfino hospital (Colleferro), Gonfalone hospital (Monterotondo), Coniugi Bernardini hospital (Palestrina), Paolo Colombo hospital (Velletri), S. Maria Goretti hospital (Latina), Ospedale Civile (Formia), Ospedale Civile (Frosinone), SS Trinità hospital (Sora), S.Benedetto hospital (Alatri), S. Scolastica hospital (Cassino), Belcolle hospital (Viterbo), Ospedale Civile (Tarquinia), spedale Civile S.Anna (Ronciglione), Ospedale Civile (Rieti), ASL 2 Chieti (Ortona), ASL 3 Chieti (Chieti), ASL SA (Eboli), Potenza hospital (Chiaromonte), Ospedale Civile Locri, ASP Catanzaro, Ospedale Civile Cosenza, ASPS (Locri), Ospedale Civile (Cetraro), ASP 9 (Trapani), Microcitemico hospital (Cagliari), Ospedale Civile (Bosa), Ospedale Civile (Ozieri), Ospedale Civile (Businco).

118. In this connection, in her report the President of LAIGA declares:

"In the majority of hospitals there is an imbalance between the total number of gynecologists and the total number of non-objectors doctors, since there is a very high percentage of objectors. Many facilities do not provide the service because they have no staff. But even when there is just one non-objector there are huge problems, entailing:

- longer waiting times, with greater risks attaching to the procedure. There are numerous cases of terminations performed at the legal time-limit, that is at around 12 weeks;

- greater occupational risks for non-objecting gynecologists: extended waiting times (in many cases over 3-4 weeks from issue of the certificate to actual performance of the abortion) force doctors to adopt poor clinical practice;

- reduction of the time available for each patient during the abortion procedure, at the expense of patient protection, information and social care;
- travel by patients to other provinces or regions, or even other countries (many terminations of pregnancy beyond the ninetieth day on account of foetal disease are absorbed by hospitals in neighbouring countries, in France, Spain and the UK);
- if non-objecting staff are on holiday, the abortion service is suspended (for example, in Bari when the only non-objecting gynecologist goes on holiday, prescription of the RU-486 abortion drug is interrupted, and the free telephone number for information and appointments ceases to operate);
- if non-objecting doctors are sick, the service is suspended. For example, in Monterotondo, the only non-objecting gynecologist had a car accident: he is still on sick leave, and ever since his accident (in November 2012) the service has been suspended. In Frosinone, when the gynecologist is on sick leave, the service is similarly interrupted;
- if the only non-objector takes retirement, the unit closes – as happened, for example, in Jesi;
- if non-objectors doctors die, the service is suspended: in Naples the only non-objecting gynecologist died, but the subsequent suspension of the service led to popular protest which made it necessary to recruit a gynecologist for that purpose."

119. Further to the data and considerations mentioned in the abovementioned report, CGIL provides specific information on the difficulties of implementation of Act No. 194/1978 at regional level. The latter are based on different sources, i.e. first hand testimonies, data provided by CGIL's regional agencies, press articles, books, blogs, fora, etc. This information refers to the state of enforcement of Section 9§4 of Act No. 194/1978 with respect to different Italian hospitals, nursing homes and advice centres. The relevant documents are appended to the response to the Government's submission.

120. CGIL also provides further information from different sources. This information refers to the state of implementation of Section 9§4 of Act No. 194/1978 in different Italian hospitals, nursing homes and advice centres. This material corresponds to the information provided by the complainant organisation concerned in IPPF EN v. Italy (IPPF EN v. Italy, Complaint N° 87/2012, decision on the merits of 10 September 2013, paragraphs 112 – 151).

121. Having regard to the data gathered in the document provided by LAIGA, CGIL refers to cases of foreign medical centres in France, Switzerland, United-Kingdom and Slovenia, which, in the period 2010 – 2012, agreed to provide abortion-related services to women who could not access abortion procedures in Italy, and also notes the phenomenon of women 'migrating' from one hospital to another as well as between regions in Italy in order to obtain an abortion.

4. Arguments put forward by the respondent Government in its further response

122. The Government rejects all the arguments made by CGIL concerning the points raised in its submissions on the merits of the complaint. It considers that the complainant organisation's arguments are nothing new, are ill-founded and devoid of justification and, with regard to the data on the application of Act No. 194/1978, fail to take account of the analyses supplied.

123. The Government underlines that the complaint merely sets out to show the limited number, or even the complete lack, of non-objecting doctors in healthcare facilities, which allegedly prevents women from having access to abortion services.

124. The Government appends to its further observations the report published by the Ministry of Health in October 2013 concerning the implementation of the above law.

B – Additional information provided by the parties at the Committee's request

1. The Respondent Government

125. Concerning the merits of the complaint, after reiterating a number of points already raised in its submissions, the Government refers to "the measures currently being adopted in Italy on the subject at issue".

126. In this connection, it indicates that in June 2013 the ministry of health convened a "Technical Panel for the full application of Law No. 194/1978", with the participation of the regions and the National Health Institute (*Istituto Superiore di Sanità*).

127. The Government explains that this "panel" is charged with performing monitoring at national level of abortion activities and the extent to which the right to conscientious objection is exercised by gynaecologists working in private and public facilities and family counseling centres.

128. It states that the monitoring activities have revealed "no conflicts between voluntary termination services and the services dealing with childbirth (*punti nascita*)". In this connection, it refers to the relevant chapter of the ministry of health's report on the implementation of Law No. 194/1978, as submitted to Parliament in October 2014 (pages 43-48). This document is appended to the document setting out the additional information.

129. The Government specifies that the above-mentioned "panel" met on 14 January 2015 "to continue its monitoring work, whose aim is to provide a degree of co-ordination and comparison at national level for the full application of Law No. 194/1978". It also states that, for this purpose, the Ministry of Health has financed a project aimed inter alia at organising a training course, in October 2015, for regional officials in charge of monitoring any critical situations arising in relation to abortion and conscientious objection.

130. Lastly, the Government declares that it is "keeping track of every situation relating to the question put by CGIL in the interest of the persons concerned, namely the women and doctors, but above all the unborn children, with a view to the … protection of their rights."

2. The complainant organisation

131. In its response to the Committee's request, CGIL firstly refers to the decision on the merits of 10 September 2013, International Planned Parenthood Federation European Network (IPPF EN) v. Italy, complaint No. 87/2012.

132. CGIL notes that, in this decision, the Committee considered that the information submitted by IPPF EN and the documents approved by the Italian Senate and Chamber of Deputies established the existence of serious problems.

133. Concerning the violation of the above mentioned article, CGIL asks the Committee to confirm the analysis and the conclusion contained in the above-mentioned decision.

134. CGIL also notes that, with regard to that decision, on 30 April 2014 the Committee of Ministers of the Council of Europe adopted a specific resolution [Resolution CM/ResChS(2014)6] in which the Committee of Ministers:

> - takes note of the statement made by the respondent government and the information it has communicated on the follow-up to the decision of the European Committee of Social Rights and welcomes its commitment to bring the situation into conformity with the Charter (see appendix to the resolution);
> - looks forward to Italy reporting, at the time of the submission of the next report concerning the relevant provisions of the Revised European Social Charter, that the situation has been brought into full conformity.

135. CGIL notes that in the abovementioned declaration, published in annex to the resolution of the Committee of Ministers, the Government after having indicated that it had taken note of the Decision of the Committee, stated that it considered it:

> “(A)s a stimulus to better the application of Act No. 194/1978.”

136. Concerning the initiatives taken in order to assess the impact of conscientious objection, CGIL notes that the Government informed the Committee of Ministers that:

> “ (…) In June 2013, the Ministry of Health opened a “Technical table” calling Regional Assessors, appointed to supervise Health Management in the Regional Governing Bodies, to gather data in order to assess the impact of conscientious objectors at local level.”

137. With reference to these initiatives, CGIL indicates that no positive steps have been taken by the Government to address the problems with the application of Article 9§4 of Act No. 194/1978.

138. In this context, CGIL notes that the report on the implementation of the above law published in October 2014 makes no reference to the Committee's decision in IPPF EN v. Italy; nor to the Committee of Ministers' related resolution; nor to any measures taken by the ministry to remedy the deficient application of Article 9§4, as noted by the Committee in its above-mentioned decision.

139. Concerning the part of the report of the Ministry of Health devoted to conscientious objection, while supplementing the information provided in its complaint (covering the period 2003- 2009), the CGIL refers to the data on the levels of objection among medical and non-medical staff for the period 2010 – 2012.

140. In this connection, it notes that for gynaecologists the percentage of objectors rose from 69.3% in 2010 to 69.6% in 2012, whereas for anaesthetists the figure fell from 50.8% in 2010 to 47% in 2012; for non-medical staff it rose from 38.6% in 2005 to 45% in 2012. The CGIL also notes significant differences between the regions: among gynaecologists percentages in excess of 80% are to be found in the following regions: Molise (90.3%), Basilicata (89.4%), the Autonomous Province of Bolzano (87.3%), Sicily (84.5%) Lazio (81.9%), Campania (81.8%) and Abruzzo (81.5%). Among the anaesthetists the highest figures are recorded in Molise (78.3%), Sicily (77.4%), Lazio (71.5%) and Calabria (71.3%). Among non-medical staff peaks can be observed in Molise (90.1%) and Sicily (80.9%).

141. After having noted these data, CGIL refers to the chapter of the report concerning the results of the ad hoc monitoring of abortions and conscientious objection.

142. CGIL observes that this chapter refers to the results of the monitoring activities regarding the impact of conscientious objection on abortion services performed by gynaecologists, carried out by the Ministry of Health in the regions between December 2013 and June 2014. The CGIL points out that these activities were implemented further to the commitments entered into by the Government, in response to the motions adopted by the Chamber of Deputies and the Senate in June 2013, with a view to identifying potential deficiencies.

143. Concerning the reasons for the ministerial monitoring activities CGIL also refers to the considerations on this issue set out in a resolution adopted by the Committee on Social Affairs of the Chamber of Deputies on 6 March 2014 (this document is appended to the CGIL's reply to the Committee).

144. Concerning the data resulting from the monitoring activities, CGIL points out that, as acknowledged by the Government, the figures provided are sometimes

incomplete. In this connection, CGIL notes that the number of non-objecting staff may be under-estimated (according to CGIL the number of objectors is far higher); to corroborate this statement, CGIL refers to the considerations set out in the above-mentioned resolution of the Chamber of Deputies' committee:

> “According to the ministerial Report, the total number of non- objecting personnel is considered sufficient in relation to the total number of abortion procedures, the eventual difficulties in accessing such procedures appear to result from an inadequate distribution of personnel between the health facilities in the regions.
>
> A verification is necessary since the statistics on the number of non- objectors may be overestimated, as, given that there is no obligation to inform the competent health authority of a decision to raise a conscientious objection, all the gynaecologists that have never raised an objection simply because their institutional role does not entail the performance of voluntary terminations of pregnancy could be considered as non-objectors.”

145. As to the observations made by the Ministry in this chapter, CGIL advances the following arguments:

a) It is necessary to reject the conclusion that coverage of national territory by establishments providing abortion services (hereafter "termination centres") is more than sufficient on the ground that the number of such establishments represents less than 30% of the total number of hospitals with an obstetrics and gynaecology department in only two small regions. CGIL considers that in reaching this conclusion the ministry has failed to verify whether the number of termination centres is in practice sufficient in relation to the demand for abortion. In this connection, CGIL points out that the hospitals concerned do not register requests for abortion which cannot be satisfied on account of a shortage of non-objecting staff;

b) It also calls for rejection of the Ministry's conclusion that the number of termination centres is more than sufficient as compared with the number of abortions carried out, given that, in 2012 and at national level, firstly, the ratio of births to terminations stood at 4.9 /1 and that of birth centres to termination centres at 1.3 /1 and, secondly, for every 100 000 women of fertile age (15-49) the number of birth centres as compared with the number of termination centres resulted in a ratio of 1.3 /1. CGIL considers it evident that the number of termination centres is more than sufficient as compared with the number of abortions carried out as, if that were not the case, the abortions in question would simply not have been performed. It contends that the conclusion reached in this chapter fails to take account of the fact that the alleged violation of Article 11 of the Charter concerns abortions which cannot be carried out under the conditions provided for in Law No.194/1978 due to the difficulties in applying Article 9§4 thereof. In this context, CGIL refers to the observations made in its complaint concerning illegal abortions and the fact that the lack of non-objecting staff obliges certain women who have decided to seek an abortion under the conditions provided for by the law to travel to other regions where they can, if they can afford it, pay to have the procedure in a private establishment.

C - Information provided by the parties at the hearing held on 7 September 2015

1. The respondent Government

146. The Government recalls some of the information already provided. In this context, it recalls that since 1982 abortions have virtually halved, having dropped by 45%, both in absolute terms and with respect to the indicators calculated in relation to the female population of reproductive age (abortion rates and ratios), while illegal abortions and the ensuing very high maternal death-rate have been eradicated. According to the Government the number of gynaecologists performing abortions is constant and the number of abortions per week has been halved.

147. However, the Government indicates that despite these positive developments, by way of follow-up to the commitments taken on by the Minister of Health during the debate of Parliament concerning the application of Act 194/1978, the Minister of Health, set up a Technical Panel for the monitoring the implementation of Act 194/1978 (cf. paragraph 63 above). It recalls that the goal of this body is the monitoring of the abovementioned act across the national territory, through an ad hoc survey including the exercise of the right to conscientious objection by gynaecologists both in individual facilities and in the family planning clinics.

148. The Government indicates that “the final results” of these monitoring activities were published in the Report of the Ministry of Health presented to the Parliament on 15 October 2014. In this connection, it is stated that “as emerges from the report, the aggregate data on a regional basis do not show up any critical problems in the application of the Act 194 especially with reference to conscientious objection and access to services”. It is indicated that “in order to continue to ensure coordination and discussion at national level of the full application of Act 194/1978, and in order to monitor any problems that might emerge at the local level, the Ministry of Health has decided to maintain the Technical Task Panel”.

149. To summarise the monitoring data surveyed in individual hospitals, the Government refers to the relevant chapter of the abovementioned report. In this framework, it recalls the identified parameters; parameter 1 is related to the provision of abortion services versus the absolute number of available facilities: in this respect, the Government concludes that according to the data, abortions are performed in 64% of available facilities with satisfactory coverage, with the exception of two very small regions; parameter 2 is related to the provision of abortion services versus the female population of reproductive age and versus birth facilities: in this respect, the Government indicates that while the number of abortions is equal to 20% of births, the number of abortion facilities is 74% of the number of birth facilities, that is to say it is greater than what it would otherwise be if the proportions between number of abortions and number of births were considered; parameter 3 is related to the average weekly number of abortions by gynaecologists: in this respect, the Government considers that the figures show that at the national level each gynecologist performs 1.4 abortions per week, an average between a minimum of 0.4

in Valle d'Aosta and a maximum of 4.2 Lazio; that also means in the worst situation in Lazio a non-objecting doctor performs less than 5 abortions per week; the conclusion of the Government is that the number of non-objecting doctors in hospitals is therefore satisfactory.

150. The Government recalls that in order to improve the quality of the data gathered by the monitoring action that could help ensure the proper implementation of Act 194/1978, the Ministry of Health has provided funds of 10,000 € to run a twelve-month project coordinated by the Higher Institute for Health (see paragraph 129 above). The Government considers that this project will be an opportunity to assess the potential problems present at the local level regarding inter alia the application of Act 194/1978.

151. The Government recalls that on the basis of Section 9§4, the Regions are responsible for ensuring that Act 194/1978 is implemented properly and adds that the Italian Constitution attributes the task of organising healthcare services at the local level exclusively to the Regions, and therefore it is up to the Regions to mobilise health personnel where it was inadequately distributed at local and sub-regional levels. It is pointed out that the Health Minister may intervene in specific cases where problems have been invoked through ad hoc reporting. In this connection, the Government informs the Committee that in March 2015 the Health Minister signed a decree establishing a permanent crisis unit for the coordination of emergency measures in case of major problems occurring in the delivery of services by the National Health Service.

152. As regards the waiting time between the request for an abortion and the performance of the procedure, the Government indicates that the last Ministerial report confirms that the waiting time between the issuing of a certificate and the procedure is decreasing. 61.5% of women have an abortion within one week from requesting the procedure and there is a decrease in the number of those who wait for more than two weeks from the request for the procedure. The Government considers that this figure confirms the time trend according to which the waiting time for the procedure is constantly declining, and this is a further indication of the improvement in access to abortion services.

153. The Government indicates that the number of conscientious objectors has increased a little from 69.2% to 69.6%, but waiting time has decreased at national level. According to the Government, specific regional situations demonstrate different trends: for example in Lazio, the number of conscientious objectors in the last six years has increased but the waiting time for abortion has decreased, similar trend is shown in Piedmont. On the other hand in Lombardy, the number of objectors has decreased but waiting time has increased, similar trends can be seen in Umbria, Tuscany and Marche. In Emilia Romagna the picture is different still: the number of objectors has decreased but also has the waiting time. The Government concludes that "there is no correlation between the number of conscientious objectors and the application of the law: The way in which the law is applied depends substantially on regional organisation which is the result of a number of contributing factors that of course vary from one Region to another, and probably even within the same Region".

154. The Government states that in December 2014 “certain representatives of the Ministry of Health met with the representatives of LAIGA”. According to the Government “the representatives of LAIGA were asked to file reports on failures to apply the law and on any specific problems identified at the sub-regional level”. In this respect, it is pointed out that “no specific report has been filed with the Ministry by LAIGA”.

2. The complainant organisation

155. CGIL states that the state of violation as depicted by the Committee in IPPF-EN v. Italy, Complaint 87/2012, decision on the merits of 10 September 2013 has remained completely unchanged, “If not actually deteriorated”. In particular, the complainant organisation argues that no discernible measures were taken by the Government for resolving all the cases which it has duly brought to the attention of the Committee in the framework of the written procedure.

156. CGIL argues that the Government, in all official acts following the above mentioned decision, “has never made reference to the above mentioned decision” and “has consistently denied any kind of problem”. In this context, the following documents are mentioned:

a) documents lodged by the Government during the current complaint;
b) first declaration by the Government published as an appendix to the Committee of Ministers Resolution of 30 April 2014 concerning the Committee’s decision on IPPF EN v. Italy;
c) report presented on 15 October 2014 by the Ministry of Health to the Italian Parliament on the state of application of Act 194/1978.

157. As regards the Technical Task Panel for monitoring and the organisation of a training course for the operators mentioned by the Government (see paragraphs 126 and 129 above), CGIL observes that these measures are not fit to overcome the material problems already established by the Committee, but represent at best a procedure for ordinary implementation of Act No. 194/1979. Furthermore, CGIL brings to the Committee’s attention thirty new questions tabled in the Italian Parliament in the period 2013-2015 which have not been answered by the Government.

158. With reference to one of the grounds adduced by the Government to justify the request for the hearing, the complainant organisation indicates that the President of LAIGA has released written declarations stating that during the meeting held in Rome with representatives of the Ministry of Health “the problems concerning non-objecting doctors was not raised”. The object of the meeting, in the opinion of the President of the LAIGA, “was solely the violation of women’s rights, hence the problems of access to the service”. According to CGIL, during the meeting in question the Ministry asked LAIGA to carry out monitoring of the entire demand for abortions. LAIGA responded that, “not being an official public entity, it was obviously unable to inquire into the actual demand for voluntary termination of pregnancy”. CGIL considers that this aspect is of particular importance because, “in the Ministry report it is stated that the number of non-objecting doctors is quite consistent with the voluntary terminations of pregnancy performed”.

159. While referring to the extensive documentation already lodged, CGIL invokes in this connection the substance of the resolution passed by the Social Affairs Committee of the Chamber of Deputies of March 2014, which explicitly mentions “the overestimation of non-objecting doctors with corresponding underestimation of objecting doctors”.

160. Concerning the phenomenon of migration of women abroad, CGIL emphasises that the migration phenomenon not only concerns foreign countries, but also involves movement within Italian borders, whereby women are compelled to move from one town to another, from one hospital to another within the same town, or even to a different region, with obvious discrimination of an economic, social and territorial nature, already clearly determined by the Committee in the decision IPPF EN v. Italy. CGIL stresses that this phenomenon was already recognised when the Chamber of Deputies passed Motion No. 45 in June 2013. CGIL draws the attention of the Committee to the difficulty in finding data on the entire demand for abortions, because “there is not an institutional system registering unfulfilled requests for termination of pregnancy”. In this connection, CGIL refers to the information contained in the relevant report drafted by the President of LAIGA (see § 115).

D. – Assessment of the Committee

1. Object of the complaint and of the decision of the Committee

161. In the text of the complaint, the allegations of CGIL are essentially based on a demonstration of the inadequacy of Article 9§4 of Act No. 194/10978 due to the fact that the vast majority of medical practitioners and other health personnel exercise their right to conscientious objection. CGIL underlines that this situation prevents effective access to abortion procedures in Italy and, in so doing, undermines the right of women to the protection of their health.

162. The Committee notes that, in its response to the submissions of the Government, CGIL without referring to an alleged inadequacy of the aforementioned Article, considers that the difficulties of access to abortion procedures are due to the particularly high number of personal health exercising their right to conscientious objection and the fact that the measures taken by the competent authorities under Article 9§4 of Act No. 194/1978, in order to cope with this phenomenon, are not sufficient.

163. In this regard, in the document providing additional information to the Committee CGIL requests the Committee to find that the failures in the implementation of Article 9§4 do not allow the effective exercise of the right of women to access abortion services and, consequently, a satisfactory implementation of Article 11 of the Charter. In other words, the CGIL asks the Committee to confirm the assessment that it adopted in the decision on the merits of 10 September 2013, IPPF EN v. Italy, complaint No. 87/2012.

164. As regards the rights that CGIL alleges are violated, the Committee recalls that, as stated in the aforementioned decision, the central legal question at stake in the complaint concerns the protection of the right to health.

165. As in its decision in IPPF EN c. Italy, the Committee is called to rule on the adequacy of measures taken by the relevant authorities to ensure effective access to the services responsible for carrying out abortion procedures defined by national legislation as a form of medical treatment related the protection of health and well-being, which therefore can be considered as falling within the scope of Article 11 of the Charter.

166. The Committee notes that, in referring to the legislative provisions governing the right to health of women in case of abortion, the Government states that Act No. 194/1978 was adopted within the framework of a "margin of appreciation" under Article G of the Charter. The Committee notes that the complaint does not refer to the exercise of the right to conscientious objection guaranteed by the above mentioned Act as a restriction or limitation on the right of women to protect their health. Given the above, the Committee considers that Article G of the Charter is not applicable to the allegations in the complaint.

167. Regarding the applicable caselaw and other relevant sources the Committee recalls that :

> “[i]n connection with means of ensuring steady progress towards achieving the goals laid down by the Charter, (…) the implementation of the Charter requires state parties not merely to take legal action but also to make available the resources and introduce the operational procedures necessary to give full effect to the rights specified therein” (IPPF EN v. Italy, complaint no.87/2012, decision on the merits of 10 September 2013, §162).

168. In light of the above, the Committee considers that

> “the provision of abortion services must be organised so as to ensure that the needs of patients wishing to access these services are met. This means that adequate measures must be taken to ensure the availability of non-objecting medical practitioners and other health personnel when and where they are required to provide abortion services, taking into account the fact that the number and timing of requests for abortion cannot be predicted in advance.” (IPPF EN v. Italy, ibid., §163).

169. The Committee recalls that as stated by the National Committee of Bioethics (Comitato Nazionale per la Bioetica, “(…)

> [t]he statutory protection of conscientious objection should neither limit or hamper the exercise of the rights guaranteed by law (…)” (cf. Conscientious objection and bioethics - *Obiezione di coscienza e bioetica*) - p. 18). (IPPF EN v. Italy, ibid., §165)

170. As regards, on the one hand the relationship between access to abortion services and on the other hand the right to conscientious objection of medical practitioners the Committee refers to the different motions adopted recently by the

Chamber of Deputies of the Italian Parliament the content can be taken to reflect what is provided by Article 11 of the Charter. In this context, the Committee considers that the following statements appear relevant:

> - "(…) [Act No. 194/1978]distinguishes between the individual right to object and women's right to freedom of choice in matters of procreation and between the individual's right to object to a law of the State and the States' obligation to provide the required service (…)" (cf. Motion No. 1-00074) (see paragraph 59 above);
>
> - "(…) Health personnel are guaranteed that they will be able to raise an objection of conscience. But this is an individual right, not a right of the health care structure as a whole, which is obliged to guarantee the provision of health care services" cf. (Motion No. 1-00045) see paragraph 59 above).

171. In this context the Committee refers also the position expressed in Parliament according to which

> "(…) it is not the number of objectors in itself to determine the state of access to abortion procedures, but the way in which health facilities organise the implementation of Act No.194/1978" (cf. Motion 1/00079, Chamber of Deputies – see paragraph 59 above).

2. Assessment of the arguments of the parties submitted between January and November 2013

172. Regarding the allegations contained in the complaint and other documents presented by CGIL during the proceedings, referring to the assessment made in the decision on the merits of 10 September 2013, IPPF EN v. Italy, Complaint No. 87/2012, §168, the Committee considers that:

a): "the provisions of Section 9§4 establish a balanced statutory framework for the fulfilment of the goals of Act No. 194/1978. "

b) "the high number of objecting health personnel in Italy does not *per se* constitute evidence that the domestic legal provisions at stake are being implemented in an ineffective manner ";

c) "the obligation for hospitals and nursing homes to take steps to ensure that abortion procedures are carried out "in all cases" as laid down in Sections 5, 7 and 8 of the said act, and b) the regions' responsibility to ensure that this requirement is met, represent a suitable legal basis to ensure a satisfactory application of Article 11" (decision on the merits IPPF EN v. Italy (see above), §168).

173. Furthermore the Committee considers that certain information provided by CGIL as well as other relevant elements referring to the allegations made by CGIL, featured in documents published in June 2013 by the Senate and Chamber of Deputies of the Italian Parliament, including declarations made by the Minister of Health on 11 June 2013 (see paragraph 61 above) which indicate that the competent authorities have not yet remedied the problems found by the Committee in its decision IPPF EN v. Italy as regards the implementation of Article 9§4 of Act No.194/1978.

174. In this context, as found in the above mentioned decision, the Committee finds the th persistence of the following situations:

a) decrease in the number of hospitals or nursing homes where abortions are carried out nation-wide (see paragraph 101 above);
b) significant number of hospitals where, even if a gynecology unit exists, there are no non-objecting gynaecologists, or there is just one (see paragraphs 97-99, 116-117 above);
c) disproportionate relationship between the requests to terminate pregnancy and the number of available non-objecting competent health personnel within single health facilities (see paragraphs 116-118 above) - which risk the creation of extensive geographical zones where abortion services are not available notwithstanding the legal right to access such services established under Italian law;
d) excessive waiting times to access abortion services (see paragraph 118 above);
e) cases of non-replacement of medical practitioners who are not available due to holiday, illness, retirement, etc. (see paragraph 118 above) - which pose the risk of substantial disruption to the provision of abortion services;
f) cases of deferral of abortion procedures due to an absence of non-objecting medical practitioners willing to perform such procedures (see paragraphs 118 above);
g) cases of objecting health personnel refusing to provide the necessary care prior to or following abortion (see paragraph 120 above).

175. In this respect, the Committee notes that the Government has provided insufficient information on the above mentioned situations in order to refute the allegations made by CGIL.

176. As regards the arguments put forward by the Government, similar to those put forward in the complaint IPPF EN, the Committee considers that the evidence presented relating to the good functioning of the “abortion prevention services”, namely the “the reduction in the number of abortions, in the abortion rate and in the number of repeated abortions”, and in relation to the “stable number of urgent procedures” and “the shorter time between the certification and the procedure” does not rebut the arguments made by CGIL that pregnant women encounter problems in accessing abortion procedures in many regions of Italy.

177. Moreover, the Committee considers that it has not been demonstrated by the Government that the measures that have been taken in response to these problems, namely the encouragement of “staff mobility” and “the conclusion of agreements with specialized obstetrics and gynaecology service providers” on the one hand; and the “increase in the number of one-day hospital procedures” and the “recent introduction of pharmacological abortion” on the other hand, guarantee in practice effective access to abortion procedures throughout the country.

178. As in its assessment in the abovementioned decision, the Committee recognises the merits of the argument by the Government that the large percentage of women having abortions before the tenth week of gestation and the very low rate of complications - no death or serious complications were identified as a result of an abortion to – demonstrate that abortions are less dangerous for women who have recourse to them.

179. However, it considers that it is still not established that mechanisms have been put in place to ensure that access to safe abortion services, or to ensure care before and after abortion, is guaranteed, notably when the hospital or the health center has a particularly high number of conscientious objecting staff.

3. Consideration of the arguments/ information submitted in May 2015 and at the public hearing held on 7 September 2015

180. In its reply to the question of the Committee regarding the submission of further additional information, the Government refers to “measures currently being adopted in Italy” concerning abortion and conscientious objection, and states that the Government “is following every situation relating to the issues put by CGIL in the interest of the persons concerned (...) with a view to the protection of their rights”.

181. In this context, the Government indicates that in June 2013 the Minister of Health initiated monitoring activities, in collaboration with the Italian Regions, concerning abortion procedures and the conscientious objection of gynaecologists concerned, in view of the full implementation of Act No. 194/1978. The Committee notes the specification by the Government that these monitoring activities are undertaken in view of the full application of the law in question.

182. The Committee recognises that the monitoring activities represent a first critical step towards the eventual adoption of measures to resolve the identified problems. In this regard, the Committee notes that in the Resolution adopted on 6 March 2014, the Committee on Social Affairs of the Chamber of Deputies declared that:

> “The monitoring activity initiated by the Government was rightly decided in order to verify the possible problems of implementation of Law No. 194, with particular reference to the issue of conscientious objection."

183. The Committee also notes that in anticipation of the results of the monitoring activities, in the abovementioned Resolution the Committee on Social Affairs invited the Government:

> “... to report to the competent parliamentary committees on the initiatives taken by the ministry itself in application of the commitments it entered into on 11 June 2013 before the Chamber of Deputies, as set out in the motions adopted on this subject, and to take all the necessary measures to ensure the implementation of Article 9§4 of Law no 194, in all regional health systems, especially as regards the obligation to monitor and ensure the right of a woman to a free and conscious choice, and this even using a different staff mobility and ensuring the presence of a suitable network services in the territory of each region.”

184. Despite the on-going nature of the monitoring activities, the Committee notes the declaration of the Government in the abovementioned reply that they have “revealed no conflicts between voluntary termination services and the services dealing with childbirth”. In this regard, the Government refers to the chapter relating to the (first) results of these monitoring activities, contained in the report of the Minister of Health on the implementation of Act No. 194/1978, submitted to Parliament in October 2014.

185. The Committee, first of all, notes that the abovementioned chapter contains wording which reveal uncertainties with regard to the full implementation of Section 9§4 of Act No. 194/1978. In this respect, reference is made to the following statements:

> "… the number of non-objectors at regional level seems to be compatible with the number of terminations carried out …";

and

> "… any problems of access to a voluntary termination of pregnancy may be due to local organisational difficulties, which, following this monitoring exercise, will now be easier to pinpoint."

186. Furthermore, the Committee notes that, as is recognised by the Government, the information contained in the abovementioned chapter refer to data which are sometimes incomplete. The Committee also notes that, as was raised by CGIL, the number of non-objecting medical staff could be overestimated.

187. The Committee underlines firstly having regard to the fact that in a number of regions the number of institutions providing abortion services constitute fewer than 30% of the total number of institutions offering obstetric and gynaecological services, this does not justify the conclusion contained in the report according to which the national coverage of such institutions is “more than satisfactory”. It notes that it is not certain that a record is kept of the number of women refused abortion services due to the lack of non-objecting personnel,

188. Secondly, the Committee considers that the data relative to the ratio of births to abortions, on the one hand, and the facilities for childbirth and abortion facilities, on the other, do not substantiate the conclusion contained in the abovementioned report according to which the number of such facilities “is more than sufficient, having regard to the number of abortions carried out”. As also pointed out by CGIL this conclusion does not take into account the fact that the alleged violation of Article 11 of the Charter refers to abortion procedures which could not be carried out despite the relevant provisions of Act No. 194/1978 being fulfilled.

4. Conclusion

189. The Committee considers that the additional arguments advanced by the parties do not modify its assessment of the situation.

190. Taking account of the foregoing, and having regard to the assessment in its decision on the merits of the complaint IPPF EN v. Italy, the Committee notes that:

a) the shortcomings which exist in the provision of abortion services in Italy as a result of the problems described in paragraph 174 above 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) the aforementioned health facilities still do not adopt 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.

191. Furthermore, the Committee notes that the situation raised in the abovementioned decision – in which it appears 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 pregnancy 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.

192. The Committee emphasises that these situations 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.

193. For all these reasons, the Committee holds that there is a violation of Article 11§1 of the Charter.

PART II: ALLEGED VIOLATION OF ARTICLE E READ IN CONJUNCTION WITH ARTICLE 11§1 OF THE CHARTER

194. Article E of the Charter reads as follows:

> **Article E – Non-discrimination**
>
> "The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status."

A – Arguments of the parties

1. The complainant organisation

195. CGIL considers that the situation described with respect to Article 11; inadequate implementation of the legislation, also amounts to a breach of the principle of non-discrimination guaranteed in Article E.

196. CGIL maintains the discrimination to be twofold with regard to access to abortion services. The first type of discrimination is of a territorial and economic nature between women seeking to access abortion services in different parts of the territory because the difference in treatment is not based on any objective and reasonable justification. Women living in areas where there is no provision are obliged to travel to other areas or if they have the means to do so, pay for private services.

197. According to CGIL, the second type of discrimination takes place between women seeking access abortion services as a health service, and those seeking access to other health services, regardless of whether they are pregnant or not.

198. It points out that that Article E does not contain an exhaustive list of grounds of discrimination. Differences in territorial application are thus prohibited similarly as the prohibited grounds of discrimination expressly enlisted in Article E. The equal territorial implementation of a law is an important element of the principle of equality before the law. All over Italy, women must be guaranteed effective access to abortion facilities.

199. CGIL considers that the situation is in violation of Article E read in conjunction with Article 11§1 of the Charter.

2. The respondent Government

200. The Government points out that Italian law prohibits discrimination. It considers the documentation presented by CGIL to support its argument as insufficient in this regard.

201. However it further argues that the law strikes a fair balance between the various rights at stake, the right to life and health of a woman and the right to conscientious objection. It refers in this respect to Part V of the Appendix to the

Charter on Article E which provides a differential treatment based on an objective and reasonable justification shall not be deemed discriminatory. The Government furthermore invokes the applicability of Article G – margin of appreciation.

202. It also argues that the objecting medical personnel avails itself of a fundamental right, whereas access to abortion is not a human right.

203. The Government also observes that only the National Health Service ("NHS") and a small number of private service providers in consultation with NHS are authorised to perform abortions in Italy. Recourse to private, non-authorised abortion providers in furthermore expressly prohibited in Section 8 of Act No. 194/1978. Sections 8 and 19 of the said Act similarly prohibit all forms of payment for abortion and provide for appropriate penal sanctions. On the basis of these considerations, the Government contests that those unable to access the public abortion would be forced to turn to private actors.

B – Assessment of the Committee

204. Similarly as above with regard to Article 11 of the Charter, the Committee notes that CGIL's allegations concerning Article E taken together with Article 11 are almost identical to those examined in IPPF EN v. Italy (cited above, §179).

205. 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.

206. The Committee considers that the allegation that discrimination exists on the grounds of health status between women seeking access to lawful abortion services and others seeking access to other lawful forms of medical procedures, which are not provided on a restricted basis, are closely linked and constitute a claim of 'overlapping' or 'multiple' discrimination, whereby certain categories of women are allegedly subject to less favourable treatment in the form of impeded access to lawful abortion as a result of the combined effect of their, health status, territorial location and socio-economic status.

207. As regards the allegation of 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; the Committee recalls having established in the decision in IPPF EN v. Italy (cited above), that as a result of the lack of non-objecting medical personnel, pregnant women are in some cases forced to travel to another region or to travel abroad. With reference to its findings under Article 11, the Committee confirms this assessment since nothing in the submissions of the Government indicates any significant change in the practical implementation of Section 9§4.

208. In other words 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 an effective access to abortion services.

209. Pregnant women seeking to access abortion services are therefore 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.

210. The Committee considers that 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.

211. 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.

212. The Committee firstly considers that the groups are comparable as they are all seeking access to medical services provided by the public authorities in accordance with legislation. The Committee considers the difference in treatment to be established as a result of its findings under Article11 of the Charter.

213. The Committee further observes that the Government has not invoked any objective justification for the difference in treatment. The Committee considers that even if the difference in treatment were 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.

PART III: ALLEGED VIOLATION OF ARTICLE 1§2 OF THE CHARTER

214. Article 1§2 provides as follows:

> **Article 1 - The right to work**
>
> "Part I: Everyone shall have the opportunity to earn his living in an occupation freely entered upon."
>
> "Part II: With a view to ensuring the effective exercise of the right to work, the Parties undertake:
>
> […]
>
> 2. to protect effectively the right of the worker to earn his living in an occupation freely entered upon;
>
> […]."

A – Arguments of the Parties

1. The complainant organisation

215. CGIL alleges a violation of Article 1§2 of the Charter which prohibits discrimination in employment on the grounds that non-objecting medical practitioners are discriminated against in terms of workload, career opportunities and protection of health and safety. The insufficient number of medical practitioners to carry out abortion means that non-objecting medical practitioners have an excessive workload.

216. It refers to statistics on the numbers of non-objecting medical practitioners which allegedly demonstrate that in some parts of Italy abortions are performed by a very small number of medical personnel (e.g. one operational doctor per hospital at a minimum).

217. CGIL maintains that the grounds on which discrimination is prohibited is not exhaustive in Article 1§2 of the Charter and can be extended to include discrimination on grounds of belief.

218. Non-objecting medical practitioners suffer from direct and indirect discrimination in this respect. Discrimination results from the absence of appropriate measures to ensure that all medical personnel can effectively exercise their rights. CGIL argues that the relevant authorities have failed to take adequate steps to ensure that all the rights at work that are in principle open to all are genuinely accessible also to the non-objecting medical personnel.

219. CGIL also maintains that the situation amounts to a violation of Article 1§2 of the Charter on the grounds that given the limited number of non-objecting medical practitioners, they are forced to undertake without adequate assistance and support,

a sole type of intervention, namely abortion procedures, in breach of the prohibition on forced labour. CGIL emphasises that non-objecting practitioners are required to exclusively carry out abortion procedures, and are unable therefore to carry out other procedures, for which they have been trained and thereby negatively affecting the non-objecting medical practitioners possibility to develop their professional competencies.

220. CGIL lastly alleges a breach of Article 1§2 of the Charter on the grounds that non-objecting medical practitioners are prohibited from exercising their right to earn their living in an occupation freely entered upon. CGIL relies on the Committee's case law on the right to privacy of employees.

221. CGIL in support of its arguments refers to a publication: "Notes on the application of the Act No. 194/1978 in Italy" by Ms Silvana Agatone, President of *Libera Associazione Italiana Ginecologi per Applicazione legge 194* ("LAIGA"), a third-party intervener to IPPF EN v. Italy, which includes testimony from non-objecting medical practitioners; for example:

> "For the application of Law 194, the non-objecting gynaecologists are often the only ones needing to undertake multiple tasks, including sometimes those of anaesthetists, assistants, and of other personnel who have also raised conscientious objection"
>
> "It is not rare that during an operational session, if the assistant is not present, it is the doctor themselves who undertakes to place the patient on the operating table, or when the anaesthetist is absent, the non-objecting gynaecologist equally proceeds without their help, thus taking on a large supplementary stress and responsibility ."
>
> "Almost immediately everyone came out as an objector. Only two of us were left, without even one anaesthetist, and at the same time the workload grew out of all proportion. I couldn't attend conventions I couldn't take time off or do anything else: I was alone, the only one performing abortions. I held on for ages - without me the service would close- but I now felt it was an unsustainable burden."
>
> A non-objector is often forced to make long and tiring journeys in order to perform terminations of pregnancy in an establishment other than the hospital to which he or she belongs.
>
> Article 9 of Law 194 refers to "ensuring the interventions also through staff mobility", but here too it is always the non-objector who bears the fatigue and the increased workload and responsibility, becoming a commuter within the region.

222. It also cites Motions approved by the Chamber of Deputies which call upon the Government to take measures to prevent discrimination between objecting and non-objecting health care staff (for example Motion tabled by Miglore and others, no. 1-00045, Motion tabled by Brunetta and, No. 1-00079) and others - statements from regional councillors.

223. Finally it provides numerous examples of direct testimonies from medical practitioners:

> "My assistant, (…), was to sit a competition to become a head doctor and he was advised to raise a conscientious objection. The other two gynaecologists followed his example."
>
> "…doctors who are objectors are given preferential treatment in terms of their career and earnings prospects."
>
> "The truth is that no one wants to perform abortions any longer because they are discriminated against in their career and obliged to work alone and to carry out only those operations."

2. The respondent Government

224. The Government responds very generally to these allegations referring to the National Italian Committee on Bioethics document of 12 July 2012, as well as Act No 194/1978.

225. The Government states that the situation complained of results from attempts to balance the right to conscientious objection with the statutory right to access abortion services provided by Act No. 194/1978. Reducing the number of objecting medical personnel must in the Government's view be balanced against the need to safeguard the continued access to the medical professions of such personnel.

226. It refers to a statement by the National Bioethics Committee of 12 July 2012, according to which:

> "The law must provide appropriate measures to ensure the delivery of services, […]. Conscious objection in bioethics must be regulated in such a way that there is no discrimination of objectors or non-objectors and therefore no burdening of either, on an exclusive basis, with services that are particularly heavy […]. For this purpose, we recommend the setting up of an organisation of tasks and recruitment in the fields of bioethics, in which conscientious objection is applied, which may include forms of personnel mobility and differentiated recruitment so as to balance, on the basis of available data, the number of objectors and non-objectors."

227. The Government further maintains that conscientious objection is "partly balanced by staff mobility and agreements with specialised obstetrics and gynaecology services."

B – Information provided at the hearing held 7 September 2015

1. The complainant organisation

228. The representative of CGIL submits that there is a link between the already established violation of women's rights and the labour rights of non–objecting doctors. CGIL has further testimony from non- objecting doctors attesting to their

poor working conditions, failure to pay overtime or properly compensate doctors for work performed.

229. The representative from CGIL highlights the difficulties doctors face when seeking to report their poor working conditions, and also the difficulties faced by them when seeking to gather testimonies.

230. It also refers to testimony of non-objecting doctors who bear very heavy workloads as a result of being the sole non-objecting doctors where they work.

231. As regards the Government's argument that the number of non-objecting doctors is satisfactory when compared with the number of abortions performed, CGIL states that this was due to an overestimation of the number of non-objecting doctors and an underestimation of objecting doctors.

232. CGIL refers to motions No. 1-00045 and 1-00079 adopted by the Chamber of Deputies in June 2013 which call on the Government to eliminate discrimination between objecting and non-objecting doctors.

2. The respondent Government

233. The Government recalls that in 1983 the number of abortions performed by a gynaecologist per week was 3.3 while in 2011 the number of abortions performed by a gynaecologist per week was 1.6 assuming that there are 44 working weeks in a year. Recent figures show that at the national level each gynaecologist performs 1.4 abortions per week an average between a minimum of 0.4 in Valle d'Aosta and a maximum of 4.2 in Lazio. That also means in the worst situation in Lazio a non-objecting doctor performs less than 5 abortions per week. The conclusion is that the number of non- objecting doctors in hospitals is therefore satisfactory.

234. The Government states that it was not aware of widespread problems relating to non- objecting doctor's working conditions.

C – Assessment of the Committee

i) Discrimination

235. The Committee recalls that Article 1§2 requires the States having accepted it to effectively protect the right of workers to earn their living in an occupation freely entered upon. This obligation requires, inter alia, the elimination of all forms of discrimination in employment regardless of the legal nature of the professional relationship (*Syndicat national des Professions du Tourisme* v. France, Complaint No. 6/1999, decision on the merits of 10 October 2000, §24; Quaker Council for European Affairs (QCEA) v. Greece, Complaint No. 8/2000, decision on the merits of 25 April 2001, §20; FFFS v. Norway, cited above, §104).

236. It recalls that discrimination is defined as a difference in treatment between persons in comparable situations, where the treatment does not pursue a legitimate aim, is not based on objective and reasonable grounds or is not proportionate to the aim pursued *(Syndicat national des Professions du Tourisme* v. France, Complaint No. 6/1999, decision on the merits of 10 October 2000, §§24-25).

237. Indirect discrimination may arise by failing to take due and positive account of all relevant differences between persons in a comparable situation or by failing to take adequate steps to ensure that the rights and collective advantages that are open to all are genuinely accessible by and to all (Autism-Europe v. France, Complaint No. 12/2002, decision on the merits of 4 November 2003, §52).

238. Discriminatory acts prohibited by Article 1§2 are those that may occur in connection with employment conditions in general (in particular with regard to remuneration, training, promotion, transfer and dismissal or other detrimental action) (Conclusions XVI-1, 2002, Austria).

239. The Committee recalls that in respect of complaints alleging discrimination, the burden of proof should not rest entirely on the complainant organisation, but should be shifted appropriately (Mental Disability Advocacy Center (MDAC) v. Bulgaria, Complaint No. 41/2007, decision on the merits of 3 June 2008, §52; IPPF EN v. Italy, cited above, §189).

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

241. It further observes that the allegations with regard to the 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.

242. The Committee considers that 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.

243. The Committee notes that 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 it notes the evidence of the President of LAIGA and the motions approved by the Chamber of Deputies which, inter alia, call upon the Government to “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.

244. The Committee notes that the Government has provided virtually no evidence contradicting the evidence supplied by CGIL. It has not demonstrated that discrimination is not widespread.

245. The Committee finds that 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.

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

ii) Forced labour

247. Article 1§2 also covers issues related to the prohibition of forced labour (International Federation of Human Rights Leagues v. Greece, Complaint No. 7/2000, decision on the merits of 5 December 2000, §17), as well as certain other aspects of the right to earn one's living in an occupation freely entered upon (FFFS v. Norway, cited above, §104).

248. Forced or compulsory labour in all its forms must be prohibited. The definition of forced or compulsory labour is based on Article 4 of the European Convention on Human Rights and on ILO Convention 29 on forced labour: "all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily" (Article 2§1). Forced labour is understood as "coercion of any worker to carry out work against his wishes and without his freely expressed consent" (see Conclusions III, p. 5).

249. However the Committee considers that 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.

250. Therefore the Committee holds that there is no violation of Article 1§2 of the Charter in this respect.

PART IV: ALLEGED VIOLATION OF ARTICLE 2§1 OF THE CHARTER

251. Article 2§1 provides as follows:

> **Article 2 - The right to just conditions of work**
>
> "Part I: All workers have the right to just conditions of work."
>
> "Part II: With a view to ensuring the effective exercise of the right to just conditions of work, the Parties undertake:
>
> 1. to provide for reasonable daily and weekly working hours, the working week to be progressively reduced to the extent that the increase of productivity and other relevant factors permit;
>
> […]."

A – Arguments of the parties

1. The complainant organisation

252. CGIL alleges a violation of Article 2§1 of the Charter on the grounds that given the heavy work load of non- objecting medical personnel in carrying out abortions and the distribution of the workload there is a risk that this will lead to unreasonable daily and weekly working hours.

253. It refers in this regard to the opinion of the European Commission, issued within pending infringement proceedings before the Court of Justice of the European Union. The proceedings have been initiated pursuant to several complaints concerning the fact that doctors are obliged to work excessive hours due to the insufficient implementation of the relevant Directive (Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time, OJ L 299, 18.11.2003, p. 9–19).

254. CGIL further refers to a publication by the President of LAIGA (Notes on the application of Act No 194/1978 in Italy), cited above, pp. 29, 35), which includes testimony from non-objecting medical practitioners.

> "Often, the non-objector is obliged to work long and tiring shifts in order to perform IVGs in establishments outside their hospital."

255. It also cites Motions approved by the Chamber of Deputies which make reference to the heavy work load of non- objecting doctors.

256. In response to the Governments figures which indicate that non- objecting doctors on average carry out a low number of abortions CGIL argues that the data used is by no means certain, the number of non-objecting doctors could be overestimated as there is no obligation for a doctor to inform the hospital in which he/she is employed of a decision to become a conscientious objector. It refers in this respect to a Resolution adopted by the Committee on Social Affairs of the Chamber of Deputies on the “Report on the state of implementation of Act No.194/1978 governing the social protection of motherhood and voluntary terminations of pregnancy” (6 March 2014).

2. The respondent Government

257. The Government responds very generally to these allegations referring to the National Italian Committee on Bioethics document of 12 July 2012, as well as Act No 194/1978. (see above §§222-226)

258. It maintains that Italian law adequately protects worker’s rights and is entirely compatible with Article 2§1 of the Charter.

259. It submitted the latest report on the implementation of Act No. 194/1978, submitted by the Ministry of Health to the Parliament, and notes that pursuant to the report, a non-objecting gynaecologist is on average required to perform 1.4 abortions per week, whereas a doctor who objects to abortions is not required to do so (Report of 15 October 2014, p. 7).

B – Assessment of the Committee

260. The Committee observes that the provisions of the Charter on working time are intended to protect workers' safety and health in an effective manner. Every worker must receive rest periods adequate for recovering from the fatigue caused by their work.

261. The Committee recalls that weekly working time of more than sixty hours is too long to be considered as reasonable under Article 2§1. This limit cannot be exceeded even in the context of flexibility schemes, where compensation is granted by rest periods during other weeks (Conclusions 2010, Albania, Article 2§1).

262. The Committee observes that it has not been provided with any information on the average working time of non-objecting medical practitioners. It was provided with evidence on excessive workload which it has 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.

263. Neither has information been provided on the supervision of working time regulations by the Labour Inspection, including on the number of breaches identified and penalties imposed with regard to the working conditions of the non-objecting medical practitioners.

264. In light of all the information available to it, the Committee finds that the allegations of CGIL are not supported by sufficient evidence and therefore holds that there is no violation of Article 2§1 of the Charter.

PART V: ALLEGED VIOLATION OF ARTICLE 3§3 OF THE CHARTER

265. Article 3 of the Charter reads as follows:

> **Article 3 – The right to safe and healthy working conditions**
>
> Part I: "All workers have the right to safe and healthy working conditions."
>
> Part II: "With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:
>
> […]
>
> 3. to provide for the enforcement of such regulations by measures of supervision;
>
> […]."

A – Arguments of the parties

1. The complainant organisation

266. CGIL alleges that, due to inadequate implementation of Section 9 of Act No. 194/1978 and high rates of objecting physicians and medical personnel, the few non-objecting medical practitioners available are left to perform the entire workload of all requested abortion procedures. The increased number of such procedures performed by non-objecting practitioners, their gradually repetitive character as well as working conditions involving overtime, work in isolation or without replacement, affect the physical and mental health of such practitioners, in breach of the right to safe and healthy working conditions enshrined in Article 3 of the Charter, read alone or in conjunction with the non-discrimination clause in Article E.

267. CGIL also contends that the extent of the damage to the health and safety of non-objecting medical practitioners, as well as the breach of Article 3 of the Charter, can be established on the basis of the frequency of performed abortion procedures, as deducted from figures on the number of objecting medical practitioners.

268. CGIL points at general difficulties in obtaining information and criticises the general data put forward by the Government as being unreliable or irrelevant.

2. The respondent Government

269. The Government rejects the allegations of CGIL as being unsubstantiated and unfounded.

270. It does not directly address the issue of the health and safe working conditions of non-objecting medical practitioners. It maintains that the available data demonstrates that the rate of non-objecting medical practitioners to the number of abortion procedures is adequate.

271. The Government maintains that it is for the regions and the relevant medical establishments to ascertain the implementation of Act No. 194/1978.

272. It notes that according to the National Health Plan 2012-2013, the domestic health services are based on, inter alia, the systematic surveillance of situations, where the provision of health services is discontinued.

273. The Government's commitment to the implementation of Act No. 194/1978 is furthermore attested by the annual reports it submits to the Parliament on the implementation of the Act.

B – Assessment of the Committee

274. Under Article 3 of the Charter, CGIL mainly refers to the necessity of effectively supervising the implementation of the relevant legal framework on occupational health and safety. Therefore the Committee decides to review of the situation under Article 3§3 of the Charter.

275. The Committee notes that Article 3 grants everyone the right to safe and healthy working conditions. This right stems directly from the right to personal integrity (Conclusions I, Statement of interpretation of Article 3, p. 22).

276. In accepting Article 3, States have undertaken to guarantee individuals' right to physical and mental integrity at work. The Committee recalls that the conformity with the Charter "cannot be ensured solely by the operation of legislation if this is not effectively applied and rigorously supervised" (International Commission of Jurists v. Portugal, Complaint No. 1/1998, decision on the merits of 9 September 1999, §32; Conclusions 2004, Spain, Article 3§3).

277. However, the Committee is able to assess the development of the situation only if it is provided with statistics 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 2004, Spain, Article 3§3). The Committee also needs to know the proportion of workers covered by inspections compared with the total workforce (Conclusions 2007, Luxembourg, Article 3§3).

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

279. Further the Committee notes that 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.

280. No specific information has been provided by either party, on the enforcement or failure to do so of the relevant health and safety provisions.

281. In light of all the information available to it, the Committee finds that the allegations of CGIL are not supported by sufficient evidence and therefore holds that there is no violation of Article 3§3 of the Charter.

PART VI: ALLEGED VIOLATION OF ARTICLE 26§2 OF THE CHARTER

282. Article 26§2 of the Charter reads as follows:

> **Article 26 – The right to dignity at work**
>
> Part I: “All workers have the right to dignity at work.”
>
> Part II: “With a view to ensuring the effective exercise of the right of all workers to protection of their dignity at work, the Parties undertake, in consultation with employers' and workers' organisations:
>
> […]
>
> 2. to promote awareness, information and prevention of recurrent reprehensible or distinctly negative and offensive actions directed against individual workers in the workplace or in relation to work and to take all appropriate measures to protect workers from such conduct.”

A – Arguments of the parties

1. The complainant organisation

283. CGIL alleges that, due to the inadequate application of Section 9 of Act No. 194/1978 and high rates of objecting medical practitioners, the few non-objecting practitioners available are left to perform the entire workload of all requested abortion procedures. This involves in particular more and repeated abortion procedures that often are outside the field of training and specialisation of non-objecting medical practitioners. The situation, CGIL contends, affects the career and dignity of non-objecting physicians and medical personnel, in breach of the right to dignity at work enshrined in Article 26 of the Charter, read alone or in conjunction with the non-discrimination clause in Article E.

284. CGIL points at general difficulties in obtaining information and criticises the general data put forward by the Government as being unreliable or irrelevant.

285. It provides direct testimony from non-objecting medical practitioners.

2. The respondent Government

286. The Government rejects the allegations of the complainant organisation as being unsubstantiated and unfounded.

B – Information provided at the public hearing held on 7 September 2015

1. The complainant organisation

287. The representative of CGIL highlights again the difficulties of reporting behavior such as mobbing / harassment experienced by non objecting medical practitioners especially in light of the fact that the Italian legal system does not recognise “mobbing” as a specific criminal offence.

2. The Respondent Government

288. The Italian representative underlined that medical practitioners in the public system were afforded the same protection as employees in the private system. Therefore a doctor who alleges he/she has been harassed may address a labour judge alleging mobbing or discrimination. The Italian legal order provides remedies for those who have been harassed.

C – Assessment of the Committee

289. Under Article 26 of the Charter, CGIL refers to moral harassment and not to sexual harassment. The Committee consequently examines this allegation under the second paragraph of the Article.

290. The Committee recalls that, under Article 26§2, irrespective of admitted or perceived grounds, harassment creating a hostile working environment characterized by the adoption towards one or more persons of persistent behaviours which may undermine their dignity or harm their career shall be prohibited and repressed in the same way as acts of discrimination. And this is independently from the fact that not all harassment behaviors are acts of discrimination, except when this is presumed by law (Conclusions 2007, Statement of Interpretation of Article 26§2).

291. Article 26§2 requires the States Parties to take adequate preventive measures against moral harassment. In particular, they should inform workers about the nature of the behaviour in question and the available remedies (Conclusions 2010, Albania, Article 26§2; Conclusions 2007, Statement of Interpretation of Article 26§2). States parties are required to take all necessary preventive and compensatory measures to protect individual workers against recurrent reprehensible or distinctly negative and offensive actions directed against them at the workplace or in relation to their work,

292. The Committee recalls that it has further considered that, from the procedural standpoint, effective protection of employees may require a shift in the burden of proof to a certain extent, making it possible for a court to find in favour of the victim on the basis of sufficient prima facie evidence and the conviction of the judge or judges (Conclusions 2007, Statement of Interpretation of Article 26§2).

293. The Committee notes that it has found that the legal situation protecting persons from moral harassment at the workplace to be in conformity with the Charter (Conclusions 2014).

294. CGIL has provided examples of the moral harassment of non-objecting medical practitioners for example direct testimonies from medical practitioners and from LAIGA:

> “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".”

295. The Committee also notes the following information:

> “In addition, at the above-mentioned hearing by the Chamber of Deputies, Doctor *Scassellati* further clarified “[w]e are 30 gynaecologists at St. Camillus, including the Chief Physician, of whom only three are non-objectors. Over the last four years we have been under continuous attack. We are the clinicians who have decided to defend a law of the state. Thus, in my opinion, conscientious objection constitutes the most serious aspect of the problem. We should talk about it, since those who terminate pregnancies are steadily decreasing and constantly have to justify their work”.

296. The Committee observes that 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.

297. The Committee regards the statements by non-objecting medical practitioners alleging moral harassment to be 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, to take preventative action to ensure moral harassment does not occur in particular in situations where harassment is likely. It therefore finds that the failure of the Government to take any preventative action, training or awareness raising to ensure the protection of non-objecting medical practitioners amounts to a violation of Article 26§2 of the Charter

298. Therefore the Committee holds that there is a violation of Article 26§2 of the Charter.

PART VII: ALLEGED VIOLATION OF ARTICLE E READ IN CONJUNCTION WITH ARTICLE 2§1, 3§3 AND 26§2 OF THE CHARTER

A – Arguments of the parties

1. The complainant organisation

299. CGIL argues that the situation complained of also amounts to a violation of Article E read in conjunction with Articles 2§1 (right to just conditions of work), 3§3 (right to safe and healthy working conditions) and 26§2 (right to dignity at work) of the Charter.

300. CGIL alleges that physicians and medical personnel suffer discrimination on the basis of whether they choose to exercise their right to conscientious objection or not. In particular, non-objecting personnel are placed in bad or unfavourable working conditions in comparison to objecting personnel, with regard to both the right to safe and healthy working conditions and to the right to dignity at work.

CGIL contends that such discrimination has no reasonable and objective grounds required by the case law of the Committee (e.g. *Association internationale Autisme-Europe* (AIAE) v. France, Complaint No. 13/2000, decision on the merits of 4 November 2003, §52). It considers such discrimination all the more unreasonable given that, as much as their limited workforce allows them to, non-objecting personnel are committed to the proper implementation of Section 9 of Act No. 194/1978.

2. The respondent Government

301. The Government rejects the allegations as unsubstantiated and unfounded.

B – Assessment of the Committee

302. The Committee holds in light of its findings above that no separate issue arises under Article E.

CONCLUSION

For these reasons, the Committee:

- unanimously declares the complaint admissible

and concludes:

- unanimously that there is a violation of Article 11§1 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
- by 6 votes to 5, that there is a violation of Article 1§2 of the Charter ; i) first ground
- unanimously that there is no violation of Article 1§2 of the Charter ii) second ground
- unanimously that there is no violation of Article 2§1 of the Charter
- unanimously, that 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 and
- unanimously no separate issue arises under Article E taken together with Article 2§1, 3§3 and 26§2 of the Charter

Karin LUKAS	Giuseppe PALMISANO	Régis BRILLAT
Rapporteur	President	Executive Secretary

In accordance with Rule 35§1 of the Rules of the Committee, a separate dissenting opinion of Giuseppe PALMISANO, joined by Lauri LEPPIK, Elena MACHULSKAYA Eliane CHEMLA and Raul CANOA USERA and a separate concurring opinion of Petros STANGOS are appended to this decision.

SEPARATE DISSENTING OPINION OF GIUSEPPE PALMISANO JOINED BY LAURI LEPPIK, ELENA MACHULSKAYA, ELIANE CHEMLA AND RAUL CANOA USERA

1. Article 1§2 requires the States having accepted it to effectively protect the right of workers to earn their living in an occupation freely entered upon. According to the Committee, this obligation requires *inter alia* the prohibition and elimination by States of such discriminatory acts that may occur in connection with employment conditions, in particular with regard to remuneration, training, promotion, transfer and dismissal (Conclusions XVI-1; 2002, Austria).

2. In this respect, the alleged disadvantages experienced by non-objecting doctors (i.e. lack of career opportunities, heavy workload and working conditions) for which some evidence has been supplied by the complainant organization (CGIL), do not properly fall, in my view, within the scope of the acts prohibited by Article 1§2 of the Charter, which are essentially related to remuneration, training, promotion, transfer and dismissal.

3. Furthermore, to the extent that certain of the alleged acts may be considered to fall within the scope of Article 1§2 of the Charter, the evidence put forward by CGIL is, in my view, largely anecdotal and is not sufficient to ground a finding of discrimination likely to affect the core of Article 1§2 of the Charter, that is the right of workers to earn their living in an occupation freely entered upon.

4. For the above reasons, I cannot share the decision adopted by the Committee, according to which Italy, insofar as the treatment of non-objecting medical doctors is concerned, would have infringed its obligation under Article 1§2 of the Charter to effectively protect the fundamental right of workers to earn their living in an occupation freely entered upon .

SEPARATE CONCURRING OPINION OF PETROS STANGOS

While I agree with the majority of the members of the Committee, who decided that there is a violation of Article E read in conjunction with Article 11 of the Charter, I did not concur with the legal reasoning behind the finding of a violation of the provisions in question. I am therefore obliged to file a separate concurring opinion.

In part II of its decision, the Committee mentions various grounds on which the Italian authorities' policy discriminated against women seeking access to abortion: place of residence (or, to quote the decision, "the area in which they live"), socio-economic status ("lower income groups"), gender, health status, public health and public order. In my view, the place of residence is the only ground of discrimination with which the Committee ought to have concerned itself, so that it could then ascertain whether the Italian authorities have applied it in practice.

In order for discrimination to be established, however, there must be one or more acts by public authorities which affect the material or non-material interests of the persons concerned, and two distinct individuals, such that it is possible to determine whether, through the act or acts in question, the authorities either treated one of these individuals differently from the other even though they were in a comparable situation, or treated them in the same way, even though their situations differed. As the Committee rightly points out in paragraph 209 of its decision, a group of people exists, who are homogenous in terms of their health status and who are also entitled to protection against discrimination, namely "pregnant women seeking to access abortion services". As I see it, however, this group can be further divided into two sub-groups. The first, whose defining feature is the fact that its members live in certain areas of the country, goes to hospitals where the presence on the staff of objecting gynaecologists does not prevent the relevant services from being provided in a timely and effective manner. The second sub-group, which is likewise by defined by the fact that its members live in other parts of the country, is made up of people who go to hospitals where the presence on the staff of objecting gynaecologists does in fact make it difficult for the pregnant women concerned to receive early and effective medical treatment. In my view, the Italian authorities, to the extent that they are not interested in adopting a policy that would address the shortcomings in health care provision for the people in the second of the sub-groups mentioned above, have opted for inaction, which is no different from their treatment of the pregnant women in the first sub-group (although in this instance, no public action was required, for the obvious reason that the pregnant women did not encounter any difficulties in accessing abortion services connected with the fact that there were objecting gynaecologists on the hospital staff). In my opinion, therefore, the Italian government, in according identical treatment to people in different situations, is in breach of Article E of the Charter and, by extension, Article 11 of the Charter, since the pregnant women are prevented from effectively exercising their right to protection of their health, enshrined in Part I of the Charter.

I realise that the approach outlined here, albeit in fairly broad terms, is based on individual cases of discrimination and, as such, may be seen as derogating from the Committee's usual approach when assessing compliance with Article E of the Charter, in which individual cases are disregarded. It will be noted, however, that the approach presented here is in keeping with the unwritten principle of equal treatment (which requires that equal situations be treated equally and unequal situations differently, unless there is an objective justification), which the Committee has repeatedly upheld as being inherent to the normative system of the Charter. Lastly, as a "reading" of Article E, taken in conjunction with a substantive provision (Article 11), this approach follows a similar line to that taken by the Committee in its decision of 15 June 2005 on the merits of complaint No. 26/2004 SAGES v. France, when it observed with respect to Article E: "Its role is comparable to Article 14 of the European Convention on Human Rights. It has no independent existence and has to be combined with a substantial provision of the Charter. Nevertheless, a measure (...) may infringe this [substantial] provision when read in conjunction with Article E for the reason that it is of a discriminatory nature" (§34).

CAMERA DEI DEPUTATI N. **3623**

PROPOSTA DI LEGGE

D'INIZIATIVA DEI DEPUTATI

BRIGNONE, CIVATI, ANDREA MAESTRI, PASTORINO, MATARRELLI

Modifiche alla legge 22 maggio 1978, n. 194, in materia di obiezione di coscienza all'interruzione della gravidanza

Presentata il 23 febbraio 2016

Onorevoli Colleghi ! — La legge n. 194 del 1978, che regola l'interruzione volontaria della gravidanza, è una legge, nel suo complesso efficace, che ha consentito dagli anni ottanta a oggi una riduzione del 55 per cento delle interruzioni volontarie della gravidanza. Oggi circa un terzo (il 34 per cento) delle interruzioni riguarda le cittadine straniere. Rispetto alle altre nazioni europee, che registrano il maggiore tasso di aborti tra le donne di età inferiore a venticinque anni, in Italia si registra un'alta percentuale tra le donne comprese tra trenta e trentanove anni, verosimilmente a causa delle difficoltà economiche e del minore tasso di occupazione femminile.

Ciononostante, la legge n. 194 del 1978 oggi è in grande parte inapplicata a causa delle altissime percentuali di obiezione di coscienza del personale sanitario ed esercente le attività ausiliarie: un'obiezione media del 70 per cento, con punte particolarmente elevate in alcune regioni (dal 73 per cento della Calabria all'82 per cento della Campania fino al 90 per cento della Basilicata e addirittura al 93,3 per cento del Molise, dove solo due medici praticano l'interruzione volontaria della gravidanza) e con ospedali che non garantiscono il servizio (per la presenza di un'« obiezione di struttura » o anche per una mera questione accidentale, per esempio a Jesi per nove mesi il servizio è stato sospeso perché gli unici due medici che applicavano la legge n. 194 del 1978 sono diventati obiettori), mentre in Francia, per esempio, tutti gli ospedali pubblici hanno l'obbligo per legge di rendere disponibili i servizi di interruzione della gravidanza.

La recente relazione annuale della Ministra della salute Beatrice Lorenzin sulla

legge n. 194 del 1978 non riporta dati assoluti sull'obiezione del personale medico e paramedico. Per quanto riguarda invece l'obiezione di struttura, essa riguarda ben il 36 per cento dei reparti di ginecologia e ostetricia. Anche l'attività dei consultori si è fortemente ridotta: diminuisce il numero (per esempio, in Lombardia si è passati dai 335 consultori del 1997 agli attuali 200 circa) ed è depotenziata la loro capacità di azione.

A tutto ciò si accompagna la costante iniziativa del Movimento per la vita, in Italia e in Europa e il proliferare dei cimiteri dei non-nati, con cerimonie di sepoltura dei prodotti abortivi (è bene ricordare che il diritto di seppellire i feti di qualunque età gestazionale è già garantito dal regolamento di polizia mortuaria di cui al decreto del Presidente della Repubblica n. 285 del 1990 e che non vi è quindi alcuna necessità, se non ideologica e propagandistica, di istituire cimiteri dedicati).

Tornando all'obiezione di coscienza, essa è molto ampia anche tra il personale paramedico; infatti, anche alla presenza di un numero sufficiente di medici non obiettori, l'obiezione del personale paramedico rende problematica l'esecuzione degli interventi.

Una così massiccia obiezione sembra spiegabile attraverso una pluralità di ragioni che vanno dalla carriera (per non porsi in contrasto con « maestri » o colleghi più anziani) agli eccessivi carichi di lavoro (tanto maggiori con l'aumentare delle obiezioni, in un perfetto circolo vizioso), economicamente e professionalmente non remunerativi, dalla sindrome del *burnout*, per la quale da non obiettore si diventa obiettore per stanchezza e per le difficoltà connesse a un lavoro che pone costantemente di fronte a questioni etiche e a motivazioni religiose.

Chi sceglie di specializzarsi in ginecologia e ostetricia dovrebbe sapere bene che tra i suoi compiti ci sono anche quelli previsti dalla legge n. 194 del 1978 in ogni sua parte: dalla prescrizione di contraccettivi a quella del *Levonogestrel* e della *RU 486*, all'interruzione chirurgica di una gravidanza non desiderata, all'aborto terapeutico (e infatti si apprende che in Svezia dove, all'eccesso opposto, l'obiezione di coscienza non esiste, agli studenti che chiedono di specializzarsi in ginecologia e ostetricia è chiesto se abbiano problemi di interventi per l'aborto, consigliando, in caso affermativo, di scegliere un'altra specialità).

In tutto il territorio italiano è possibile compiere la villocentosi e l'amniocentesi; tali procedure diagnostiche sono effettuate in strutture pubbliche, private convenzionate, laiche e religiose (anche dove è praticata l'obiezione di struttura). Ma l'amniocentesi e la villocentesi si effettuano per una diagnosi prenatale, cioè permettono di analizzare il numero e la forma dei cromosomi del feto, di accertare se il feto è affetto da una malattia cromosomica come la trisomia 21 (sindrome di Down), se vi è rischio di talassemia o di fibrosi cistica. Questi esami diagnostici sono la *condicio sine qua non* dell'aborto terapeutico, eppure gli operatori sono in gran parte medici obiettori.

Si deve richiamare l'attenzione sul fatto che all'obiezione massiccia conseguono una serie di fenomeni:

1) il ritorno all'aborto clandestino. Il Ministero della salute stima le interruzioni clandestine tra le 12.000 e le 15.000, fra le donne italiane, e intorno alle 5.000 tra le straniere (stima in difetto perché nelle strutture di ostetricia è in costante aumento il numero degli « aborti spontanei », almeno un terzo del quale sarebbe attribuibile al « fai da te »);

2) il « turismo abortivo », che è un fenomeno che colpisce particolarmente il Veneto, con migrazioni in Emilia-Romagna, dove la legge n. 194 del 1978 funziona meglio, il Lazio, con migrazioni in Toscana, e così via. Il tasso di abortività per regione rilevato dal Ministero della salute è quindi spesso falsato dalle migrazioni interne;

3) l'incremento del *business* dell'aborto. Per esempio, delle 3.776 interruzioni volontarie della gravidanza effettuate

nell'azienda sanitaria locale di Bari nel 2011, 2.606, ovvero il 70 per cento, sono state praticate in case di cura convenzionate, mentre 1.170 (il 30 per cento) negli ospedali pubblici. Il raggruppamento omogeneo di diagnosi (DRG) per interruzione volontaria della gravidanza ammonta a una cifra tra 1.100 e 1.600 euro. Questo significa 3.000.0000 di euro nelle casse del privato (privato in cui l'obiezione è poco significativa).

A fronte di una situazione come quella descritta solo per sommi capi, dobbiamo considerare che siamo di fronte a una questione di bilanciamento tra diritti fondamentali (dalla quale, peraltro, nasce – come noto – la stessa obiezione di coscienza, in questo come in altri casi).

Infatti, l'obiezione di coscienza è un diritto previsto dall'articolo 9 della legge n. 194 del 1978, ma lo è anche l'interruzione volontaria della gravidanza, come la stessa legge stabilisce, in conformità alla Carta costituzionale e alle Carte internazionali. Infatti, la Corte europea dei diritti dell'uomo, con sentenza 26 maggio 2011, ha stabilito che « gli Stati membri sono tenuti a organizzare i loro servizi sanitari in modo da assicurare l'esercizio effettivo della libertà di coscienza dei professionisti della salute », ma che ciò « non deve impedire ai pazienti di accedere a servizi cui hanno legalmente diritto ».

L'8 marzo 2014, quindi, il Consiglio d'Europa ha condannato l'Italia a causa dell'elevato numero degli obiettori di coscienza, stabilendo che essa « viola i diritti delle donne che alle condizioni prescritte dalla 194 del 1978 intendono interrompere la gravidanza ».

Il 10 marzo 2015, poi, il Parlamento europeo ha approvato a larga maggioranza la cosiddetta risoluzione Tarabella, che tra l'altro afferma che le donne devono « avere il controllo dei loro diritti sessuali e riproduttivi, segnatamente attraverso un accesso agevole alla contraccezione e all'aborto ».

Su queste basi, la presente proposta di legge, intervenendo in modo del tutto limitato sulla legge vigente, mira – alla luce delle circostanze di fatto evidenziate – a un migliore bilanciamento tra il legittimo esercizio dell'obiezione di coscienza e l'altrettanto legittimo ricorso all'interruzione volontaria della gravidanza, garantendo che almeno il 50 per cento del personale sanitario e ausiliario degli enti ospedalieri e delle case di cura autorizzate sia non obiettore. Ciò, al fine di salvaguardare i diritti dei lavoratori interessati (anch'essi sacrificati, oggi, per il personale non obiettore, che deve sobbarcarsi un lavoro straordinario), avviene attraverso la considerazione dell'equilibrio tra personale obiettore e non obiettore al momento dell'assunzione e anche attraverso le procedure di mobilità relative al personale che esercita il proprio diritto all'obiezione.

La proposta di legge mira così a realizzare, nel rispetto del principio di ragionevolezza, il migliore possibile bilanciamento tra diritti.

PROPOSTA DI LEGGE

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ART. 1.

1. Il quarto comma dell'articolo 9 della legge 22 maggio 1978, n. 194, è sostituito dal seguente:

« Ai fini di cui al terzo comma, gli enti ospedalieri e le case di cura autorizzate assicurano, anche attraverso nuove assunzioni e procedure di mobilità del personale obiettore, che almeno il 50 per cento del personale sanitario e almeno il 50 per cento di quello esercente le attività ausiliarie in servizio non sia obiettore di coscienza. La regione controlla e garantisce l'attuazione di quanto previsto dal presente comma ».

ART. 2.

1. Al primo comma dell'articolo 16 della legge 22 maggio 1978, n. 194, sono aggiunte, in fine, le seguenti parole: « e dell'obiezione di coscienza del personale sanitario ed esercente le attività ausiliarie, fornendo i relativi dati, anche riguardanti le singole regioni e aziende sanitarie locali ».

ART. 3.

1. Ai fini dell'attuazione della legge 22 maggio 1978, n. 194, entro trenta giorni dalla data di entrata in vigore della presente legge, il Servizio sanitario nazionale istituisce un numero telefonico nazionale gratuito, per informare gli utenti sulle modalità di attuazione della stessa legge n. 194 del 1978.

ART. 4.

1. Le disposizioni di cui alla presente legge entrano in vigore il giorno successivo a quello della pubblicazione della medesima legge nella *Gazzetta Ufficiale*.

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