Abstract

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The COVID-19 health emergency has thrown the health systems of most European countries into a deep crisis, forcing them to call off and postpone all interventions deemed not essential or life-saving in order to focus most resources on the treatment of COVID-19 patients. To facilitate women who are experiencing difficulties in terminating their pregnancies in Italy, the Ministry of Health has adapted to the regulations in force in most European countries and issued new guidelines that allow medical abortion up to 63 days, i.e., 9 weeks of gestational age, without mandatory hospitalization. This decision was met with some controversy, based on the assumption that the abortion pill could “incentivize” women to resort to abortion more easily.

Keywords: COVID-19 ; abortion ; telemedicine ; Italian legislation ; European backdrop

1. Introduction: The COVID-19 Emergency and Termination of Pregnancy

In order to cope with the emergency, most European governments, including Italy’s, have had to reorganize health services and postpone all non-essential surgeries and procedures so as to prioritize care to COVID-19 patients [1]. To make matters worse, factors such as fear, stigma, misinformation, and limitations on movement have bogged down the delivery of health care for a wide array of life-threatening conditions, such as cancer and cardiovascular diseases [1][2][3]. In fact, when health care systems are overwhelmed, patients may not be able to access necessary care, hence direct mortality from COVID-19 outbreaks and indirect mortality from preventable and treatable conditions both increase dramatically. What can really make a difference is trust from the general public in the capabilities of health care systems to meet essential needs in a safe and effective fashion, while keeping in check the infection risk in health facilities [4].

In Europe, abortion is one of the most common procedures for women of reproductive age, with an annual incidence rate ranging from 6.4 per 1000 women aged 15 to 44 (Switzerland) to 19.2 per 1000 (Sweden). In an effort to “bend the curve” of the pandemic, European governments, including the Italian one, have suspended health services for abortion or have reassigned gynecological ward staff to COVID-19 units. This situation is particularly worrisome for women who live in the few European states where abortion is illegal or severely restricted, such as in Malta [5], and who cannot travel abroad to seek assistance and treatment. MSI Reproductive Choices has estimated that an additional 2.7 million abortions will occur outside the formal health setting (i.e., self-managed abortions [6]), while the World Health Organization warns that reducing the availability of essential services of Sexual and Reproductive Health and Maternal and Neonatal Health will result in thousands of maternal and neonatal deaths, due to “millions of unintentional pregnancies and unsafe abortions [4]”.

With the struggle against the pandemic still far from over, the Council of Europe [7] called on all member states to ensure full access to reproductive health, to urgently remove all obstacles preventing access to safe abortions and uphold the right of all to rely on the highest standard of health, including sexual and reproductive health [8]. Therefore, since access to abortion is necessary to preserve the health and safety of many women, all related services should have continued to be guaranteed with all the essential safety measures in place to limit the spread of the infection without infringing upon the freedom of choice and the right to health [9]. Regrettably, that was not the case.

2. Voluntary Termination of Pregnancy in Italy

For such reasons, access to voluntary termination of pregnancy, already usually problematic due to the high number of conscientious objectors among health professionals, has become even harder to obtain. Data for 2018 show that 69% of gynecologists, 46.3% of anesthesiologists, and 42.2% of non-medical personnel are conscientious objectors, with regional variations [10]. It is for this very reason that the European Committee of Social Rights (CEDS) has twice [11] condemned Italy over the violation of the right to health of women, including its 2016 decision decrying the discrimination suffered by

non-objecting health care personnel [12]. The Committee has therefore urged the Italian government to ensure a more homogeneous distribution of non-objecting personnel, and the effectiveness of the service throughout the national territory within October 2019 [13].

As is known, the woman can legally have an abortion within the ninetieth gestational day if she believes that the continuation of her pregnancy could entail “a serious danger to her physical or mental health, in relation to her state of health, or to her economic, social or family conditions, or the circumstances in which conception took place, or expects fetal anomalies or malformations” (Art. After this term, the conditions for requesting an abortion are stricter, and are related to cases in which pregnancy or childbirth involves a serious danger to the life of the woman, or there are significant fetal anomalies that endanger physical or mental health (Article 6, co. l). Furthermore, in order to undergo termination of pregnancy within the first trimester, the woman needs to turn to a family clinic (or a trusted doctor) where, at the end of an interview focused on the reasons that lead her to make this choice, the doctor issues a document, countersigned by the woman, which certifies the state of the pregnancy along with the request [14] for termination. At that point, the woman needs to wait seven days and only afterwards can she undergo surgery at a health facility authorized to carry out terminations of pregnancy (Art.

The COVID-19 emergency has brought to the fore the issue of the increased demand for medical procedures to terminate pregnancy instead of surgical ones The voluntary termination of pregnancy through pharmacological methods is based on the administration of two different agents, mifepristone (better known as RU486) and a prostaglandin, within 48 h of each other [15]. When these drugs were first marketed, the Italian Medicines Agency (AIFA) authorized their administration by the forty-ninth day of amenorrhea, with mandatory hospitalization in one of the facilities authorized to carry out abortions, until the expulsion of the product of conception. Following the AIFA determination and the related opinion of the Italian High Council of Health [16], the Ministry of Health issued a set of guidelines for medical abortion which prescribed the intake of the two drugs within the seventh week of pregnancy in ordinary hospitalization [17].

The reorganization of health care facilities caused by the pandemic has led some freedom of choice advocacy groups [18] to request greater use of pharmacological abortion to protect women’s health and their rights, jeopardized by the ongoing health care emergency. Firstly, since the greater difficulties that women encounter in accessing voluntary abortion services risk exceeding the time limits set by Law 194/78, an even greater risk is posed for women who live in conditions of marginalization and vulnerability, in precarious health conditions or positivity to COVID-19 [19]. Instead, pharmacological abortion with the two-week extension can provide an effective solution both for women and for easing the pressure on overwhelmed hospitals, reducing the inflow and average hospitalization time of patients, a meaningful contribution in times of unprecedented emergency. The two-week extension also has a significant impact on time allocation, because it enables healthcare staff to follow multiple patients at the same time, reduces the use of surgical procedures, and allows healthcare facilities to carry out, if clinical circumstances permit and the woman agrees, less demanding services in terms of economic and human resources, with a substantially positive impact on health care provision and management overall. A new set of guidelineslaid out by the legislature is meant to serve a connecting function, i.e. incentivizing the regional governments to implement homogeneous and common procedures, while preserving the degree of organizational autonomy to which they are entitled. In reality, however, that did not come to fruition. The update issued by the Italian Health Care Ministry was favorably viewed by those who for years had advocated for the modification of the 2010 guidelines—even more so in view of the new pandemic recrudescence that loomed in early 2021, although it was criticized by those who believed that ordinary hospitalization should always be required in all circumstances [60]. Several regions have not yet enforced the updated guidelines, some regions such as Umbria have even refused to abide by them [61], and in many clinics the RU486 is not yet administered due to several “bureaucratic–administrative” issues

3. Pharmacological Abortion and the Potential of Telemedicine

The World Health Organization has acknowledged the potential benefits of telemedicine in terms of guaranteeing an acceptable level of health care services [4][20]. Throughout the daunting health emergency brought about by COVID-19, with mandatory social distancing, reduced mobility, and hospital closures, telemedicine through video calls proved to be valuable, because it enabled patients to not go to the hospital, drastically reducing the risk of infection both for patients and healthcare professionals, in addition to ensuring truly patient-centered care.

In countries such as Sweden and Denmark, telemedicine has already been well-established and widespread for years [21], while other countries such as England, Wales, Scotland, and France used it during the first wave of the COVID-19 pandemic, in order to cope with the difficulties caused by the growing health emergency. Furthermore, the degree of efficacy and safety of telemedicine is similar to that reported with “in-person” care, with a post-procedure surgical revision rate ranging from 0.9 to 19.3% [22]. Among the services provided, there are virtual consultation, counseling, assistance, and reporting, but not yet voluntary interruption of pregnancy, despite the fact that the Italian Society of Gynecology and

Obstetrics (SIGO) has recommended laying out a set of standards for medical abortion through a “totally remote procedure monitored by telemedicine services” [23]. Hence, authorizing and implementing medical abortion provided through telemedicine services, in addition to being a safe and effective option [24], is even more necessary in the third phase of the health emergency.

4. Coronavirus and Voluntary Termination of Pregnancy: The Policies Implemented by European States

During the COVID-19 pandemic, European governments have unevenly regulated access to abortion services. Overall, most European countries have made few major changes to increase access to medical abortion. In countries such as England, women will be able to take both pills for early medical abortion within 10 weeks in their own homes, without having to go to a hospital or clinic first [25][26]. The national responses ranged from the choice to further restrict access to abortion (Poland, Hungary) to progressive actions that expanded up to 10 weeks the time frame in which medical abortion can be legally provided and supported the use of telemedicine to that end.

5. Conclusions

Abortion “is an essential service of global health care”, the lack of which “profoundly affects a person’s life, health and well-being” [27][28].

In the midst of the pandemic, along with the general reorganization of health care facilities, many hospitals have reduced or suspended access to voluntary termination of pregnancy in order to reassign premises and personnel for the care of COVID-19 patients. Consequently, many women have struggled to find clinics and hospital services to terminate their pregnancies, and have not even been able to travel abroad, as the pandemic has made traveling much harder, as a result of grounded airports and border closures to stem the viral spread. By the approval of the new guidelines on pharmacological abortion, the Italian legislator has sought to ensure that the right to abortion can be upheld throughout the country, as requested by the European Committee of Social Rights. The issuance of the new guidelines, however, has raised concerns and controversy. Those who are opposed to medical abortion have expressed the fear that the woman could end up without the necessary level of assistance. In reality, pharmacological abortion is a health treatment. Women must therefore be informed by their doctors about effectiveness, methods of execution, indications and contraindications in order to make an informed decision possible. Essentially, the Italian law has structured the doctor–patient relationship on the basis of the so-called therapeutic alliance model. According to such a model, doctors are required to inform their patients in an understandable and thorough fashion “about the diagnosis, prognosis, benefits and risks of the diagnostic tests and health treatments indicated, as well as the possible alternatives and the consequences of any refusal” (as codified in Article 1, paragraph 3), while it is up to the patient’s decision-making autonomy to choose whether to start or continue a given treatment or assessment, as well as to choose which treatment or assessment to follow between those alternatively presented whenever possible. The principle of informed consent constitutes an expression of autonomy or, better still, a means for the fulfillment of the self-determination principle in healthcare. Even the Constitutional Court in its ruling no. 438 of 2008 [29] clarified that the right to abortion no longer refers exclusively to the right to health—as it was when law no. 194 of 1978 was enacted—but also an expression of the woman’s self-determination on her own body through her procreative choices. The path of medical abortion in Italy unequivocally shows that it was precisely the self-determination of women that guided the legislature’s choices towards the pharmacological option, since the monitoring of the implementation of law no. 194 found that more than three quarters of women who undergo the medical procedure choose voluntary discharge, thus exercising their right to treatment and informed consent. Statistical data bear out the advantages of medical abortion: in countries where a high percentage of women choose the abortion pill—such as in France or Germany—the number of surgical abortions has not increased at all. Furthermore, facilitating medical abortion does not mean trivializing abortion—which will be a sensitive and often extremely painful choice—but rather it enables those who have already decided to terminate their pregnancy to figure out the best ways to do it. In our opinion, especially in times of pandemics, it is necessary to promote the local governance of pharmacological abortion, with well-equipped counseling centers and specifically trained personnel, so as to limit hospitalization to only the rare, more problematic cases, as has been the case for some time in most European countries with very high rates of medical abortion. At the same time, the optimization and harmonization of shared European abortion oversight systems would be advisable, in order to make sure that women who choose to terminate their pregnancies can be supported in a safe and timely fashion, and to even out the existing discrepancies in Europe in terms of abortion accessibility and waiting periods. Ultimately, improving support and information-sharing networks is of utmost importance: counselling and practical support for women

need to be ensured, particularly when the main reason why a woman seeks to have an abortion is rooted in family or economic pressure, as highlighted in a Council of Europe resolution [82].

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