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Context, Mechanism, and Outcome: Explaining Gendered Administrative Burdens on Abortion Access in Italy

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Correspondence: Debra Lanfranconi (debra.lanfranconi@unil.ch)**Received:** 13 October 2025 | **Revised:** 4 May 2026 | **Accepted:** 15 May 2026**Keywords:** abortion | administrative burden | C-M-O framework | gendered administrative burden | political conflict | qualitative case study

ABSTRACT

Abortion access in Italy provides a case to examine how gendered administrative burdens emerge through the interplay of legal provisions, informal frontline practices, and contextual influences. Drawing on the Context–Mechanism–Outcome framework from realist evaluation, the analysis shows how legal access to abortion is constrained by procedural requirements, widespread conscientious objection among healthcare providers, and the institutional presence of anti-abortion actors. Using qualitative data from *Obiezione Respinta*—a user-generated platform mapping abortion access barriers across Italy—we demonstrate how everyday bureaucratic processes (re)produce gender inequalities. Three contributions follow. First, the analysis extends the gendered administrative burden literature by highlighting how informal policy design and contextual factors contribute to gender inequality. Second, it introduces the C-M-O framework to administrative burden research as a structured yet parsimonious approach to studying how burdens emerge. Third, it centers on women's experiences to offer a qualitative account of how burdens are perceived and navigated.

1 | Introduction

Scholars have recently shown growing interest in gendered administrative burdens, that is, in how the frictions citizens encounter in accessing public services are shaped by gendered power relations (Herd and Moynihan 2025). This research highlights how seemingly neutral procedures can reproduce inequality by imposing disproportionate learning, compliance, or psychological costs on women and other marginalized groups. An important insight stemming from this literature is that burdens can come from different sources, including formal laws, informal frontline practices and contextual conditions. For instance, as Herd and Moynihan (2025, 54) highlight, not all gendered burdens result from formal laws, but “can also emerge in organizational contexts.” This insight is echoed by Ray et al. (2023), who draw on racialized organization theory to show how burdens are produced and structured not only through formal policy design but also through organizational processes and everyday administrative practices. Likewise,

Barnes and Henly (2018) demonstrate how clients' encounters with street-level bureaucrats shape the interpretation and experience of burdens, underscoring the role of frontline discretion in generating unequal administrative experiences.

An analytical challenge lies in capturing these multiple influences within a single, parsimonious framework that clarifies how burdens emerge and interact across levels of governance. To address this, we adapt the Context–Mechanism–Outcome (C–M–O) framework from realist evaluation (Pawson and Tilley 1997) for the study of (gendered) administrative burdens. This framework offers a structured way to explain how policy design, organizational processes, and street-level discretion work together to generate and reproduce administrative burdens. The C-M-O approach is particularly suited to complex policy areas like education, criminal justice, and (reproductive) health, where interventions interact with local conditions to produce variable effects. This approach allows us to gain a more comprehensive and dynamic, yet parsimonious, understanding of how burdens emerge through

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Evidence for Practice

- Public managers should recognize that their actions can actively reproduce gender inequalities. Even when policy frameworks are formally inclusive, burdens embedded in daily administrative routines may function as tools of governance that limit women’s practical access to legal rights.
- Addressing gendered burdens requires attention to how formal regulations interact with informal frontline practices and contextual factors. Monitoring only legal design overlooks how discretion, local culture, and external actors can shape outcomes for service users.
- Platforms like *Obiezione Respinta* demonstrate how citizen-generated data can uncover the cumulative impact of everyday barriers. Practitioners and policymakers can employ similar participatory tools to make administrative burdens visible and guide equitable service reforms.

mechanisms operating within specific contexts. A focus on “mechanisms” helps us to understand how gendered burdens are not just “applied” but emerge, change, or are resisted, and a focus on “context” enables us to better situate burdens in specific local settings, thereby accounting for variation more accurately.

We apply this framework to the case of abortion access in Italy—where legally enshrined rights are often undermined by procedural constraints, medical conscientious objection, and the involvement of anti-abortion groups within public health infrastructure—to show how gendered administrative burdens are created, reinforced, and sometimes resisted in specific local settings. Italy is in many ways a paradigmatic case of a country where abortion access is legally guaranteed but difficult to access in practice. Abortion has long been a polarizing issue in Italy, shaped by conflicts across social, political, and religious lines. During the 1970s, the Catholic Church, closely linked to the dominant political force, the Christian Democracy Party, opposed the legalization of abortion, while feminist and secular movements mobilized to defend reproductive rights. These conflicts culminated in the adoption of Law No. 194 in 1978, which legalized abortion under specific conditions. The law represented a negotiated compromise and left underlying tensions between the opposing camps unresolved (Andall 1994; Reichlin and Lavazza 2023).

Our analysis of the Italian case draws on legal texts, previous literature, and, crucially, data from *Obiezione Respinta*, a self-managed, publicly available platform that maps abortion access barriers across Italy based on first-hand reports from women. *Obiezione Respinta* provides geographically distributed, user-centered data that yields a unique perspective to analyze “accumulated” burdens from the perspective of citizens. We manually coded 85 testimonies to analyze both the nature and origins of burdens, tracing them back to their “sources” (i.e., mechanism and/or context).

Our results suggest that gendered burdens may be already “enshrined” in formal laws, but their exact size is then determined by what happens at the implementation stage, namely the

considerations and practices of frontline workers and the actions of organized interest groups which have a stake in how a policy is administered. Only by analyzing these factors and their interrelations—formal policy design, informal implementation practices, and context—do we get a more complete and accurate understanding of the experienced gendered burdens.

The article’s contribution to the literature is threefold. First, it contributes to a better understanding of how gendered burdens emerge in particular settings. Herd and Moynihan (2025) argue that these burdens are not passive or accidental barriers to access but active tools of governance through which states shape gender relations and sustain inequalities. Our analysis shows this tool “in action” by demonstrating how gendered burdens dynamically emerge from formal laws, frontline practices, and organized interests. This approach better illustrates the instrument’s overall effects on women than an analysis focused on formal laws alone could. Second, by adapting the C-M-O framework to the study of administrative burdens, the article provides a systematic yet parsimonious way to examine “how actors outside the citizen–state interaction may influence experiences of administrative burden” (Halling and Baekgaard 2024, 180; Baekgaard et al. 2025). Third, by centering on women’s testimonies, the article takes up Halling and Baekgaard’s (2024, 180) recommendation to “use qualitative methods to further explore the nature of burdens from the perspective of citizens.”

2 | Literature Review and Research Gap

Administrative burden refers to an individual’s experience of policy implementation as onerous (Burden et al. 2012). Such burdens manifest through three categories of costs. Learning costs refer to the efforts required to understand a policy’s rules, eligibility criteria, and application processes. Compliance costs refer to the efforts needed to meet policy requirements, such as completing and providing documents proving eligibility. Psychological costs capture the emotional toll of navigating administrative processes, including stress, frustration, and stigma (Herd and Moynihan 2018, 2022; Martin et al. 2023; Moynihan et al. 2015).

Growing empirical research on the topic confirms Moynihan et al.’s (2015) initial assertion that administrative burdens are consequential, distributive, and constructed (Halling and Baekgaard 2024). They are consequential in that they significantly impact daily life, involving high time and well-being costs (Martin et al. 2023). They are also distributive, as their impact is not felt equally across society (Herd and Moynihan 2022; Herd et al. 2023). Finally, administrative burdens are constructed in the sense that they often result from deliberate political choices. They may serve specific political interests, such as reducing fraud or limiting access to rights (Herd et al. 2023).

More recently, Herd and Moynihan (2025) introduced the concept of gendered administrative burden to describe situations where administrative constraints are applied in unequal ways based on gender. Gendered administrative burden refers to a specific form of burden that disproportionately affects women, particularly those who are low-income or racialized, but also

other individuals whose gender identity is targeted by state policies. These burdens reinforce precarity and limit autonomy, especially in domains such as caregiving, reproduction, and identity. The authors demonstrate how, in the field of abortion, these burdens function as instruments of control and coercion. Even before the formal bans introduced in some US states following the *Dobbs* decision (2022), authorities had already established an array of administrative barriers that made obtaining abortion care difficult, costly, and stigmatizing. These included mandatory waiting periods, compulsory ultrasounds, parental consent requirements, and unjustified medical protocols.

Despite growing insights, much of the (gendered) administrative burden literature has a rather static, design-focused view of the emergence of burden, suggesting political motivations are the primary cause (Herd and Moynihan 2025). Foundational contributions frame burdens as the result of deliberate political choices, often rooted in ideology or attempts to ration access to welfare. The analysis often emphasizes structural and systemic reproduction—for example, burdens as tools of social exclusion or racialized governance. This approach tends to give burdens a fixed shape: if X rule exists, then Y burden is produced.

Yet, and as the administrative burden literature itself clearly shows, burdens can vary significantly depending on contextual factors as the same compliance requirement may feel minor in one setting and overwhelming in another. For instance, older people lacking digital capabilities and people living in rural areas without broadband access face greater barriers when accessing the US government's Supplemental Nutrition Assistance Program (SNAP) (Negoita et al. 2024). Thus, burdens are not always “set” by design; they depend on a variety of factors that characterize citizen-state interactions in particular settings. It is thus important to explore how various “external” or “contextual” factors such as interest-group pressure on frontline workers or community support can mediate or amplify the experience of burden in certain contexts.

Some recent and adjacent work contributes to a more dynamic understanding of the creation of burdens. For example, research in behavioral public administration explored how stress, scarcity, and cognitive load can impact a person's ability to navigate bureaucratic processes (e.g., Christensen et al. 2020), suggesting that administrative burdens are not uniform but vary based on individual circumstances. Moreover, Halling and Baekgaard (2024) introduced an important conceptual distinction between burdens created through formal policy design and those generated through informal street-level practices. Burdens stemming from formal policy design are typically framed as the result of deliberate political choices, such as (eligibility) requirements in means-tested welfare programs (Holler and Tarshish 2024). By contrast, informal burdens arise during the implementation and communication of formal rules, particularly through the discretionary decisions of frontline workers (e.g., Brodtkin and Majmundar 2010; Lipsky 1980; Soss et al. 2011). Burdens may result from high workload, limited administrative capacities, stress, burnout, red tape, or the specific roles adopted by frontline workers (Ali and Altaf 2021; Mikkelsen et al. 2024). For instance, in abortion care, Jibat et al. (2024) show how Ethiopian healthcare providers, despite relatively permissive laws, use their discretionary power to restrict access to abortion

due to their cultural and religious beliefs, as well as community norms opposed to abortion.

Recent scholarship has therefore moved toward a more dynamic understanding of administrative burden, recognizing that experienced burdens do not arise solely from formal policy design but are also shaped by informal frontline practices, individual resources, and broader contextual conditions. This growing awareness of the multiple influences on burdens is a welcome development, but it also complicates the analysis: as ever more factors are identified, it becomes difficult to examine them systematically and to capture how they interact. What is still missing in the literature is a parsimonious analytical framework that can integrate these diverse elements within a single lens, while also making it possible to explore the interrelations between formal rules, informal practices, and contextual forces.

3 | Theory

This section extends the administrative burden framework through a stronger focus on how (i) formal policy design and informal frontline practices interact and (ii) on how contextual factors shape citizens' experience of burdens. To capture these extensions in a theoretically parsimonious way, we use the C-M-O, or Context-Mechanism-Outcome approach, a well-established framework in realist evaluation, for understanding how and why policies or interventions work (or not) in particular settings (Pawson and Tilley 1997). The C-M-O approach seeks to understand how outcomes are produced through mechanisms operating in specific contexts. Since administrative burdens can be understood as the (un)intended result of policies that are designed in specific ways and implemented in specific contexts, we deem this approach to be a useful theoretical addition to the administrative burden framework.

While the C-M-O approach is typically used to answer the question of “What works, for whom, in what circumstances, and why?”, we adapt it to ask “Which burdens are created, for whom, in what circumstances, and why?” In the original approach, “context” refers to the social, cultural, economic, or political environment in which a policy or intervention is implemented. “Mechanism” describes the underlying processes, such as people's reasoning or behaviors in response to a policy intervention that lead to change in a particular context. Finally, “outcome” captures the result or effect that emerges from the interaction of mechanisms and context. Adapting these concepts to the administrative burden literature, “context” can be understood as the factors or environment in which citizens interact with the state and are subject to burdens; “mechanism” captures all the formal and informal policy elements that contribute to or enable these burdens, and the “outcome” describes the total amount of experienced burden that results from the interaction of mechanisms and context.

The C-M-O approach, we argue, allows us to formulate concrete and testable claims as to why and how groups of citizens face burdens in particular settings. Take the (hypothetical) example of why some citizens experience higher administrative burdens than others when applying for welfare benefits. For instance, one might claim that (and test whether) in under-resourced

welfare offices (context), the requirement for in-person interviews and complex paperwork (mechanism) can lead to many eligible citizens dropping out during the application process (outcome). Likewise, one might hypothesize that in low-trust environments (context), surveillance-like procedures such as invasive questioning or documentation demands (mechanism) often produce feelings of humiliation and distrust among applicants (outcome).

As these hypothetical claims demonstrate, using the C-M-O structure helps clarify how and why administrative burdens emerge by linking them to specific contextual conditions and the mechanisms that trigger them. This structured approach allows researchers to develop nuanced, theory-driven expectations about when and for whom burdens arise, making variation across settings explainable. With its focus on “the mechanisms linking state actions to experiences” (Halling and Baekgaard 2024, 186), the C-M-O approach also allows us to capture interrelations between formal policy design and informal implementation practices, for example, how formal burdens are amplified or reduced at the street-level, or how the preconditions for burdens are created at the level of the law, but actual burdens only emerge if specific conditions at the street-level align. Finally, and with its focus on context, the C-M-O approach helps identify how various contextual or external factors such as the political environment or interest groups influence the central burden creation mechanism. This answers yet another call by Halling and Baekgaard (2024, 180), namely, to also analyze “how actors outside the citizen–state interaction may influence experiences of administrative burden.” In the next sections, we will demonstrate the explanatory potential of the C-M-O approach by using it to account for the uneven existence of burdens to abortion access in Italy.

4 | Case Selection and Research Design

Italy provides a paradigmatic case of a country where abortion is legally authorized but often difficult to access in practice. As in many other countries, legal access is limited by strict gestational limits, specific grounds (such as risk to the woman’s health, in cases of rape or fetal anomalies), and bureaucratic or procedural hurdles (Arroyave and Gutiérrez 2018; Berer 2017; Calkin and Berny 2021; Guillaume and Rossier 2018).

A major obstacle to abortion access is the widespread recourse to conscientious objection. Article 9 of Law 194 allows healthcare professionals to refuse participation in abortion procedures on moral or religious grounds. Originally conceived as a compromise between healthcare professionals’ moral integrity and women’s access to care, this provision has become a central source of restricted access (Chavkin et al. 2017; Crea 2024; Minerva 2015). Empirical studies document that high and uneven rates of objection among healthcare providers produce regional disparities in service provision, extend waiting times, place additional pressure on non-objectors, and force women to travel across regions to access care (Autorino et al. 2020; Bo et al. 2015; Reichlin and Lavazza 2023).

Concerns about these barriers extend beyond the Italian case. International organizations have highlighted how administrative

requirements, provider refusal, and abortion-related stigma can undermine effective access to care. The World Health Organization’s Abortion Care Guideline, for example, identifies waiting periods, unnecessary administrative procedures, and conscientious objection without effective referral mechanisms as major barriers to timely care (WHO 2022). Several studies note that aspects of abortion governance in Italy remain at odds with these recommendations, notably with regard to procedural requirements and the widespread invocation of conscientious objection (Caruso 2023). Similarly, the European Committee of Social Rights found Italy in violation of the European Social Charter in both 2014 and 2016 due to unequal access to abortion services and the working conditions faced by non-objecting providers (European Committee of Social Rights 2014, 2016).

Finally, in Italy as in many other settings, implementation is further shaped by political and contextual pressures. The gap between formal rights and lived reality has drawn international concern. In 2022, the European Parliament warned that access to abortion care was “being eroded in Italy,” situating the country within a broader trend of global threats to sexual and reproductive rights (European Parliament 2022). Taken together, these characteristics make Italy a paradigmatic case for examining how formally recognized rights may coexist with barriers to access, with implications for other settings where abortion rights remain conditional on an array of legal, political, and socio-cultural factors.

Methodologically, this study draws on a combination of legal texts, academic literature, and empirical data collected via the *Obiezione Respinta* platform. Founded in 2017, this feminist citizen initiative gathers anonymous testimonies from women across Italy regarding their experiences seeking abortion care. We collected all testimonies reporting burdens in abortion access published up to February 2025. After excluding unrelated accounts (e.g., emergency contraception consultations), we retained 85 testimonies describing experiences in a wide range of settings, including general practitioners’ offices, hospitals, and *consultori* (family planning centers). These were translated into English with the help of machine translation software. The accounts are already submitted anonymously and publicly available online, and we further anonymized any identifying references to locations or healthcare professionals. To our knowledge, this is the first article to systematically analyze testimonies from *Obiezione Respinta* in detail.

The *Obiezione Respinta* testimonies constitute an exceptionally valuable source of data because they provide rare insight into a highly sensitive policy domain in which women may be reluctant to speak openly in institutional or research settings. Abortion experiences are often silenced by stigma, moralization, and fear of judgment (Astbury-Ward et al. 2012; Chavkin et al. 2017; Hanschmidt et al. 2016); the possibility to report experiences anonymously lowers these barriers and makes visible forms of administrative burden that would otherwise remain undocumented. At the same time, the anonymity that enables participation necessarily limits our ability to verify each individual account. In this research context, however, anonymity is not a weakness to be eliminated but a constitutive condition of access: without the protective infrastructure of the platform, many of these experiences would likely never be reported at all. We therefore accept anonymity as a trade-off

inherent to studying stigmatized phenomena while assessing credibility at the aggregate and contextual level.

Several elements nevertheless increase our confidence in the validity of the material. Existing research and reports document patterns that closely resemble those described in the testimonies. Qualitative studies based on interviews with gynecologists and other healthcare professionals show how abortion stigma, widespread invocation of conscientious objection and organizational constraints within healthcare institutions shape the availability of services and create delays, refusals or additional hurdles in accessing care (e.g., Chavkin et al. 2017; De Zordo 2016). Similar barriers are documented in reports produced by organizations working on reproductive health, which draw on field documentation and interviews with healthcare professionals and service users to highlight uneven service provision, provider refusal, and informal obstacles to care across different regions (e.g., Medici del Mondo 2024). Moreover, and crucially, the testimonies themselves are typically detailed, context-rich, and heterogeneous in style and structure. Many include concrete procedural descriptions, interactions with healthcare staff, and temporal sequences, as for example being redirected from one hospital to another before finding a non-objecting provider, and often contain narrative imperfections and linguistic inaccuracies typical of spontaneous accounts. All these characteristics support the conclusion that the testimonies reflect genuine experiential accounts rather than strategic fabrications. While individually unverifiable, the testimonies therefore constitute a credible and analytically robust body of qualitative evidence which offers insights into the visible part of a broader phenomenon that remains difficult to measure through official data alone.

The analysis combined deductive and inductive elements. The C-M-O framework initially informed the organization of the material, with testimonies being grouped into two main categories: mechanisms (formal and informal policy design) and context. The objective was to examine how women describe the burdens they face, which discretionary practices by healthcare staff are reported, and how these reflect formal constraints, informal amplifications, and contextual pressures. Within each category, sub-themes emerged inductively through close reading of the testimonies. For example, under the “mechanisms” category, informal policy design, sub-themes such as “dissuasive practices” or “judgmental attitudes” were identified. This approach followed the framework method (Ritchie et al. 2003), using thematic matrices that cross-reference cases (or, in our case, testimonies) and sub-themes. Since not all extracts can be quoted in the article, we used Online Appendix Annotations (OAAs). OAAs are inserted after certain analytical claims and refer readers to additional statements reported in the [Data S1](#). This approach allows us to report additional illustrations and demonstrates that specific analytical inferences are based on several testimonies. The testimonies provided in the analysis below are the ones we consider to be the most illustrative; this aligns with our research design, which seeks to demonstrate the creation of gendered burdens in a paradigmatic case.

5 | Empirical Analysis

The analysis is structured according to the C-M-O approach and hence divided into three parts. To better map the original focus

in the administrative burden literature, we will first focus on the formal law, then on the implementation level, and finally on contextual factors before assessing the cumulative burdens for women (i.e., M-C-O).

5.1 | Mechanism

5.1.1 | Formal Policy Design

Italy's Law 194 (1978), which legalized voluntary termination of pregnancy, emerged as a compromise between feminist demands and opposition from the Catholic Church (Busatta 2022). While it permits abortion within the first 90 days of pregnancy, it does not recognize it as a subjective right. Rather, abortion is framed as a tolerated exception within a broader framework centered on the “social protection of motherhood.” This approach of compromise (Reichlin and Lavazza 2023) seeks to balance the interests of the woman and those of the fetus without affirming full reproductive autonomy (Caruso 2020).

The law imposes several procedural requirements to proceed with a voluntary interruption of pregnancy. Abortion is not available on request but is permitted primarily when continuing the pregnancy would endanger the woman's physical or mental health. Women must obtain a medical certification of both the pregnancy and the intent to terminate it. The law then stipulates the observation of a seven-day reflection period (except in emergencies). Furthermore, only gynecologists practicing in public hospitals or accredited private facilities are legally authorized to provide abortion services. After 90 days, abortion is only allowed in cases of serious risk for the woman's life or when fetal anomalies or malformations cause a risk for the physical or psychological health of the woman.

Testimonies collected on *Obiezione Respinta* illustrate how these requirements impose learning and compliance costs, as women must navigate a complex and opaque system and fulfill burdensome procedural steps. One testimony recounts: “(...) *when it is finally my turn, upon declaring my intention, they tell me that I need the document certifying my intention to proceed with the abortion, and that by law, a week must pass between that and the procedure (...). I was around the seventh week, and based on the first available date they offered, I would have been pregnant for over a month more, right at the edge of the legal limit, and still with no certainty that 'my operation' would actually be performed on that date (...)*” [OAA1].

These formal requirements also produce psychological costs, especially in relation to the waiting period and uncertainty around time limits. As one testimony states: “*I found out I was pregnant fairly late. I went to the family planning center with blood test results, and it turned out I was at 7 weeks and 4 days—still within the time frame for medical abortion. Despite the urgency, they made me wait the mandatory 7-day reflection period (...)* so I had to undergo surgical abortion (...) *The wait was psychologically very heavy, as the pregnancy keeps progressing.*”

Among the burdens generated from the legal framework, the law's most consequential (i.e., burden-inducing) element is the conscientious objection provision, which allows healthcare professionals to refuse to participate in abortion procedures based

on moral or religious grounds. While the law requires objectors to submit a written statement to the provincial medical officer (Bo et al. 2015), in practice objection is typically only notified informally to direct supervisors (Chavkin et al. 2017). Moreover, the law neither requires objecting staff to justify the reasons for their refusal nor imposes any financial penalties on their salary (Busatta 2022). As we will examine in the following section, this regulatory configuration facilitates the widespread invocation of conscientious objection by medical staff and hence constitutes an important enabling factor for additional burdens created at the implementation stage.

5.1.2 | Informal Policy Design

While formal legal provisions impose procedural constraints, it is the widespread and normalized use of conscientious objection that most deepens inequalities in abortion access. This shifts the focus beyond the legal framework to the informal practices that shape the law's implementation on the ground (what Halling and Baekgaard (2024) call "informal policy design"). As of 2022, over 60% of Italian gynecologists were registered as conscientious objectors, with rates exceeding 80% in some regions (Busatta 2022; Caruso 2023). This situation leads to extended waiting times, regional disparities, and a shortage of providers, resulting in an increased need to travel to access abortion services (see also Autorino et al. 2020; Bo et al. 2015).

Testimonies from *Obiezione Respinta* illustrate the real-world effects of the widespread use of conscientious objection. Women report entire hospital departments staffed exclusively by objectors [OAA2], services offered only on specific days, or care depending on the availability of a single provider: "There's only one non-objecting doctor in the entire ward, and he is present only on Saturdays (and not always). This makes it difficult to schedule appointments in time" [OAA3].

Even in emergency situations, conscientious objection may delay care. One woman described: "(...) I had to wait for a non-objecting doctor to start labor induction. I spent days in a state of psychological pain and loneliness. (...)" [OAA4]. Objection extends beyond gynecologists to include other members of the medical staff, further compounding access issues. One woman recalled being left alone in a hospital room all day, only to be informed later of the reason for the delay: "(...) The anesthesiologist who had seen me in the morning had refused to perform the surgery because she was an objector—I had to wait for the shift change".

These experiences illustrate the layered burdens imposed on women, emerging from widespread use of conscientious objection: learning costs (understanding how the system works, identifying where and when abortion is available), compliance costs (organizing travel, sometimes to another city), and psychological costs (stress, loneliness, isolation). Importantly, even for those who manage to navigate these burdens, access is not always guaranteed. One woman explains: "It was impossible to access the gynecology department. My gynecologist advised me to go very early—like 4 AM—due to the long waits. Even then, people had arrived before me. The department opens at 8, but they only accept 4 appointments per day. Out of 25 gynecologists on staff, only 4 perform abortions. In the end, I couldn't get in and had to leave."

Even for those who succeed in scheduling care, the experience can prove emotionally draining. A woman describes a race against time in a limited-access system: "(...) After receiving the 'authorization' for the abortion, I went alone, taking the train from my small town and heading toward the hospital. I arrived at the hospital at six in the morning because I knew that only four or five people would be able to go through with the abortion process. So I lined up, handed in my documents, and waited for the crucial hour in front of the ticket kiosk, the one that would finally release the long-awaited tickets for the second phase of the process. That's when you start counting the people around you, realizing they're all there for the same reason. Ten, fifteen... I ended up counting about twenty. But only four would be allowed in. (...) Heartbreaking. But I had to get that ticket—I had to go back to work and couldn't afford to wait another two weeks to try again in that race against time."

Beyond invoking objection, testimonies also reveal the existence of an array of informal practices that add to the burden, such as additional delays, unjustified requirements, or various forms of moral pressure. These are not grounded in law but stem from the individual (or at times, collective) discretionary behaviors of healthcare professionals. For instance, providers sometimes refuse to explain procedures or make referrals, as one woman recalls: "When I went to inquire about the type of abortion performed, the doctor refused to give any information, telling me to return on Tuesday." Another said: "She said she couldn't help because she was a conscientious objector. I asked if she could refer me to another gynecologist who wasn't one. She said she had no idea."

In other instances, obstruction is more overt. Women describe refusals to acknowledge pregnancies or perform required medical exams—thereby impeding their ability to obtain the certification required to begin the process. As one woman recounts: "We only filled out one form. No ultrasound, no testing, even though we had a lab-confirmed pregnancy test. They told us to think about it because it was an early pregnancy (4 weeks). I asked if we could at least do an ultrasound, and they said, 'You still have time - just think it over.'" (OAA5). Elsewhere, extra-legal criteria were added. For example, in one hospital, care was delayed by five weeks (thus preventing access to medical abortion) on the grounds that "they couldn't detect a heartbeat—something they claimed was essential in order to proceed with the termination" [OAA6]. These testimonies offer clear illustrations of burden amplification through frontline practices: the legal requirement of obtaining a certificate confirming the pregnancy is compounded by the refusal to issue it, thereby imposing further obstacles on women and hindering their ability to move forward in the process.

In many cases, delays or procedural obstacles seem aimed at dissuading women from continuing the process. Some testimonies mention appointments scheduled very close to the legal deadline: "(...) They scheduled the appointment for the consultation in the 11th week. When I expressed concern (...), they replied, 'We trust you'll change your mind and keep the baby.'" Others recount consultations focused more on dissuasion than support, often marked by insistent advice or intrusive questions: "I was seen by a doctor. I explained my situation, and she began the consultation. I had read that the purpose was to provide alternatives or other options, but the session turned out to be very one-sided and

persistent in trying to change my mind. The doctor even pointed out that I was 'getting older' and that chances to have children might decrease with time" [OAA7].

Others recount consultation focused less on informed choice than on moral judgment. Several women report being criticized for presumed irresponsibility or lack of contraceptive use, implicitly blaming them for the situation: *"The doctor (...) launched into unsolicited and inappropriate commentary about what he assumed were my sexual behaviors, claiming it wasn't his problem if I 'slept around without precautions.' I kept telling him I was in a committed relationship, but it made no difference."* Other women described being treated *"like a monster"* or facing *"judgmental and disgusted looks."* Such behaviors were not confined to gynecologists but were also reported from midwives, nurses, and administrative staff [OAA8].

Importantly, such pressures are not limited to verbal interactions. Several accounts report distressing experiences of being compelled to listen to the fetus' heartbeat or view ultrasound images without their prior consent. These are described as painful experiences, as one testimony recalls: *"I was 18 years old. During the ultrasound, they positioned the screen clearly in front of me. I started crying out of intense embarrassment and the harsh judgment I felt. The doctor didn't even look me in the eye and said: 'Well, you should've thought about it earlier'"* [OAA9].

The analysis reveals that the challenges surrounding access to abortion in Italy cannot be attributed solely to legal provisions. While the law permits healthcare providers to invoke conscientious objection, it is its widespread and routine use at the street level that produces material constraints for abortion seekers. Moreover, the difficulties extend beyond formal objection, arising also from an array of additional discretionary informal practices that further complicate access. To better understand how such burden-inducing behaviors emerge, the next section turns to the broader context in which abortion care is embedded.

5.2 | Context

As explained in the introduction, abortion remains politically contested in Italy. The historical influence of the Catholic Church—also bolstered by the Vatican's proximity—continues to shape public debate and policy. Although religious practice has declined, a large share of Italians still identify as Catholic (78% in 2017), and the Church consistently condemns abortion and promotes the use of conscientious objection among healthcare professionals (Crea 2024; Pullan and Gannon 2024).

Since the 2010s, opposition to abortion has been reinforced by broader conservative movements, often labeled as "anti-gender." Such coalitions bring together religious actors, international pro-life organizations, and political actors under the shared defense of the "natural family," opposing both abortion and "gender theory" (Crea 2024). Within this evolving political environment, pro-life organizations have increasingly sought a presence within public institutions. Article 2(d) of Law 194 already allows family planning centers to cooperate with volunteer associations in addressing the causes that may lead women to seek abortion. This provision has facilitated the activities of *Centri di*

Aiuto alla Vita (pro-life counseling centers), which offer support to pregnant women and are present in some hospitals through volunteers and informational materials aimed at discouraging abortion (Facincani 2023).

Recent policy developments have strengthened this presence. In April 2024, legislative measures allowed organizations with "qualified experience in supporting motherhood" to operate within abortion-performing facilities, with support from national funding rather than only regional resources (Art. 44 quinquies, Law Decree 19/2024). This provision has enabled the presence of pro-life organizations within clinics where women seek abortion care, for example through initiatives such as the opening of a "listening room" managed by the *Catholic Movimento per la Vita* in a Turin hospital in 2024 (Giuffrida 2024; Lisi 2024).

Crucial for our analysis, these macro-level tensions between pro- and anti-abortion actors translate into concrete pressures for abortion seekers. One of these pressures is related to access itself. Some women report being denied support, particularly in facilities affiliated with religious organizations. One woman recounted visiting a counseling center without knowing it was faith-based: *"I visited this private, religiously affiliated counseling center (I didn't know it was religious until they told me). I was looking for psychological support. They informed me they offer all types of consultations except those related to abortion"* [OAA10].

A second form of pressure stems from the use of religiously charged rhetoric. For example, one woman recalls: *"(...) I had toxoplasmosis during pregnancy, around the tenth week. I asked to speak to a virologist to better understand the situation and make an informed decision with my partner. His reply? 'Let God's will be done'. He said the test results would come in a few weeks and had nothing else to add (...)"* These pressures also occur outside hospital premises, by non-institutional third parties: *"(...) The testimony concerns a patient who, unfortunately, encountered a woman just outside the ward where pregnancy terminations are carried out. This woman insulted her for having just booked the procedure, telling her she was committing a sin and about to kill a person. The patient, already very emotionally shaken by the decision she had made, felt overwhelmed by those words and ended up tearing up the printed appointment (...)"* [OAA11].

A third form of pressure emanating from the politically charged context concerns the physical and symbolic environment of clinical settings. Some women noted the presence of religious symbols, like "crucifixes posted everywhere," or visits from religious actors in post-operative wards. One patient reported: *"(...) After the operation, we were not allowed to see our partners, but a nun was allowed to enter and give us the blessing of Saint Francis. (...),"* and another remarked that *"There are no psychologists supporting women undergoing abortions, but chaplains roam the wards – not to offer comfort to those who have had an abortion, but rather to ignore them, almost with contempt."*

Finally, the testimonies highlight the presence of pro-life actors within hospital settings, where they engage in strategies of influence that range from subtle to more overt. At times, their presence takes the form of uninvited interactions in waiting rooms, as reported by two women: *"In the waiting room, pro-life volunteers hand out offensive flyers, trying to intimidate women*

entering the abortion unit” and “the presence of Catholic associations trying to change patients’ minds didn’t make the process any easier.” In other situations, these groups are embedded more formally within institutional procedures. One woman shared: “(...) One thing shocked me: before seeing the doctor, I was called in for a preliminary interview. I thought it was with a psychologist—which would have been welcome. Instead, it was a man with a PhD in bioethics from a pro-life group. He asked lots of questions to understand my decision, but at one point he said something outrageous—that abortion law is ‘sexist’ because it places all responsibility on us ‘poor women’. I left that meeting furious (...).”

These accounts suggest two main ways in which the broader socio-political context affects abortion access. On the one hand, women directly experience its effects in the form of guilt-inducing interactions, misinformation, and symbolic pressures. On the other hand, this context also influences the practices and decisions of healthcare professionals. Together, these identified pressures amplify the burdens generated by formal law and informal practices.

5.3 | Outcome

As the empirical analysis demonstrates, individuals seeking abortion in Italy face multiple burdens—navigating the system, meeting procedural requirements, and coping with emotional distress. These burdens closely align with the well-established categories of learning, compliance, and psychological costs in the (gendered) administrative burden literature.

Importantly, these burdens do not arise from a single source. Rather, they result from the interaction and interrelations between formal legal rules, informal frontline practices, and the broader cultural and political context in which abortion care is embedded. As summarized in Table 1, these cross-level interactions generate cumulative burdens for women seeking abortion services in Italy.

Some burdens stem directly from the legal framework, particularly the procedural requirements for medical certification, the waiting period, and, above all, the conscientious objection clause without the simultaneous presence of access guarantees for women. These provisions, in turn, create the conditions for additional burdens at the frontline level. The widespread use of conscientious objection leads to provider scarcity, regional limitations in service provision, extended waiting times, and need for interregional travel to access care. However, not all burdens arising at the implementation stage result from loopholes in the law. Many emerge in everyday interactions with healthcare professionals, such as refusals to provide information, delays in appointments or the use of moralizing language and practices to dissuade women from proceeding. Crucially, these informal practices can only be fully understood and accounted for if one considers the politically charged context in which abortion is performed or refused in the Italian context. Specifically, burden-inducing practices by frontline personnel tend to be more widespread and the associated burdens for women greater in settings where the influence of (often religious) anti-abortion groups is pronounced.

Testimonies also highlight how individual circumstances mediate burden. Legal literacy, financial resources, or social support play a role in mitigating barriers. For instance, one woman emphasized how essential her husband’s presence was: “(...) I was scared, in pain, sad, and shaken – even though I had my husband with me. I kept thinking about women who face this alone. What kind of healthcare system is this?” Another described asserting her rights when confronted by a social worker trying to discourage her: “Exhausted, I interrupted her and stated firmly: I am a fully capable woman, and I demanded that my right under Law 194/78 be respected.” [OAA12].

By contrast, some women face heightened vulnerability. The accounts of migrant individuals reveal patterns marked by linguistic barriers, unfamiliarity with the procedures, or extra administrative requirements [OAA13]. One testimony explains: “(...) The staff treats migrant women especially poorly, burdening them with a huge amount of paperwork before agreeing to treat them. These women leave the clinic confused and uninformed. In addition, the clinic’s doctors insist that foreign women present proof from the local health authority that they have been assigned a general practitioner. These requirements exclude recently arrived migrants who are not being assisted by a reception facility (...).”

Taken together, the findings show how a multitude of factors work together to produce burdens for women seeking abortion in Italy. The C-M-O framework allowed us to arrange and analyze these factors in a structured and parsimonious way and explore their interactions, thereby better understanding an empirically complex phenomenon.

6 | Discussion and Conclusion

This article examined how gendered administrative burdens on abortion access in Italy are produced through the interplay of formal law, frontline discretion, and broader sociopolitical context. Using the Context–Mechanism–Outcome (C-M-O) framework and data from *Obiezione Respinta*, we showed how legal rights can be undermined in practice through contingent and context-sensitive implementation.

Our findings suggest that the formal law—particularly the institutionalized right to conscientious objection and procedural requirements imposed on abortion seekers—creates a “baseline burden”. Yet it is through frontline discretion, exercised via gate-keeping, misinformation, and moral suasion, that burdens are amplified and reinforced in particular settings. The analyzed testimonies revealed significant variation, with burdens manifesting as delays, denial of service, and psychological strain. As we tried to show, these patterns are also shaped by contextual factors, including a Catholic cultural milieu and active pro-life mobilization. Women’s characteristics further mediate how these burdens are experienced.

Taken together, our analysis demonstrates how formal, informal, and contextual elements interact to produce learning, compliance, and psychological costs, often leading women to abandon care locally or race against legal time limits. Our findings contribute to the gendered administrative burden literature by illustrating how

TABLE 1 | The C-M-O framework applied to the case of abortion access in Italy.

C-M-O framework	Burden source	Concrete practices/ empirical manifestations	Burden types generated
Mechanism(s)	Formal policy design	<ul style="list-style-type: none"> – Procedural requirements (e.g., medical certification) – Mandatory waiting period – Conscientious objection clause 	<ul style="list-style-type: none"> – <i>Learning</i>: understanding eligibility rules, timelines, and procedural steps; – <i>Compliance</i>: obtaining certification, attending multiple appointments, respecting waiting periods; – <i>Psychological</i>: uncertainty, stress related to legal time limits
	Informal implementation practices	<ul style="list-style-type: none"> – High prevalence of conscientious objection – Discretionary practices such as deliberate delays, attempts to discourage women from proceeding, using guilt-inducing language and practices 	<ul style="list-style-type: none"> – <i>Learning</i>: identifying available providers and navigating uncertain service availability; – <i>Compliance</i>: repeated visits, contacting multiple facilities, interregional travel – <i>Psychological</i>: shame, guilt, isolation, emotional distress
Context	Political, religious, and institutional environment	<ul style="list-style-type: none"> – Religious influence in healthcare settings (actors, symbols, language) – Pressure from anti-abortion groups 	<ul style="list-style-type: none"> – <i>Learning</i>: confusion regarding institutional roles and sources of authority – <i>Compliance</i>: avoidance or switching of facilities – <i>Psychological</i>: stigma, intimidation, moral pressure
Cross-level interaction (Outcome)	Interplay of formal legal provisions, frontline discretion, and politically charged context	<ul style="list-style-type: none"> – Waiting period combined with provider scarcity – Certification requirements combined with refusal or delay – Widespread objection in a stigmatizing environment – Moralizing practices reinforced by religious and political pressures 	<ul style="list-style-type: none"> – Accumulation and reinforcement of learning, compliance, and psychological costs – Time pressure near legal limits – Uneven distribution of burdens across contexts and social groups

burdens on abortion access are not just technical obstacles or unintended side effects, but function as tools through which the state shapes power relations around gender and can maintain formal legality while constraining access in practice (Lanfranconi 2025). By looking beyond policy design to include how discretion is used on the ground and how broader social and political dynamics take place in practice (Herd and Moynihan 2025), we made visible how inequality can actively be produced and reproduced through everyday bureaucratic processes.

The analysis contains several limitations. First, our data focus on testimonies reporting obstacles in abortion access, which, while valuable for tracing the origins of burdens, provide only a partial view of the spectrum of abortion experiences. As a result, our analysis may discount potential cases where front-line discretion or contextual factors facilitated rather than hindered access. Future research could incorporate positive or neutral experiences to identify mitigating factors and actors even in politicized contexts. Second, while *Obiezione Respinta* provides rare, citizen-centered data in a highly stigmatized domain, the testimonies are anonymous, self-reported, and non-representative. Individual accounts cannot be independently verified, and evidence from similar platforms suggests they

may attract more motivated or digitally connected users, limiting the generalizability of the findings (Belfrage et al. 2022). At the same time, anonymity is a necessary condition for accessing such experiences and thus an epistemological necessity rather than a simple weakness. Moreover, the patterns emerging from the testimonies appear across different local contexts and align with findings from existing qualitative research and reports documenting barriers to abortion access in Italy. Together, these features support the credibility of the dataset as evidence of systematic gendered administrative burdens, even if it cannot capture the full distribution of abortion experiences in Italy. Third, our case selection—Italy’s abortion regime—reflects in many ways a typical case of how abortion is legally administered and politically contested. At the same time, Italy’s abortion regime is a particularly politicized domain, shaped by long-standing political and religious conflicts and regional inequalities. While analytically rich, this context may differ from other policy areas or welfare states, which could affect the generalizability of the insights developed here.

Nonetheless, by introducing the C-M-O framework to the administrative burden literature, this paper offers a nuanced yet

parsimonious account of how burdens emerge and evolve in politically contested policy areas; one that can theoretically be applied to a wide variety of settings and situations. It contributes to a context-sensitive perspective on citizen–state interactions and highlights the importance of frontline discretion and social actors in shaping gendered administrative burdens.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** [puar70149-sup-0001-Supinfo.docx](#).