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# Sanctuaries, Islands, and Deserts

## A Typology of Regionalized Abortion Policy

Payton Gannon and Danielle Pullan


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## Abstract

This paper elaborates a typology of regionalized abortion policy based on a comparative case study of Italy and the United States. Italy originally legalized abortion in 1978 and has seen little effort to modify the law since. Contrastingly, the United States' abortion landscape has been in near constant flux since 1974, when, in *Roe v. Wade*, the Supreme Court recognized a constitutional right to abortion. This became even more unstable in 2022 when the Supreme Court overruled *Roe* in *Dobbs v. Jackson Women's Health* and held there is no constitutional right to abortion.

Despite their differences in national abortion policy, both Italy and the US have regionalized the implementation of their abortion policies. Italy's law is national, but implementation is interpreted differently at the regional level. Since *Dobbs*, US states have proposed and passed many laws about abortion, creating even greater regional variation than before.

We propose a typology of regionalized abortion access: "Sanctuaries" where abortion is most protected and available; "Islands" with liberal policies that are surrounded by more restrictive territories; and "Deserts" with minimal abortion access. Through qualitative analysis of policies, political activities, and firsthand accounts by abortion providers and advocates working in places of each type, we then highlight the long-term implications of each of these components of the typology, analyzing the ways that they impact abortion providers and patients.

**Keywords:** abortion, health policy, human rights, policy implementation, regionalization

## Zusammenfassung

Dieser Beitrag beschreibt die Erarbeitung einer Typologie regionalisierter Abtreibungspolitik auf Basis einer vergleichenden Fallstudie zwischen Italien und den Vereinigten Staaten. Italien hat die Abtreibung ursprünglich im Jahr 1978 legalisiert und seitdem kaum Bemühungen unternommen, das Gesetz zu ändern. Im Gegensatz dazu befindet sich die abtreibungspolitische Landschaft in den USA seit 1974, als der Oberste Gerichtshof im Urteil *Roe v. Wade* ein verfassungsmäßiges Recht auf Abtreibung anerkannte, in kontinuierlichem Wandel. Die Situation wurde noch instabiler, als der Oberste Gerichtshof im Jahr 2022 das frühere Urteil in der Entscheidung *Dobbs v. Jackson Women's Health* außer Kraft setzte und feststellte, dass die Verfassung kein Recht auf Abtreibung enthalte.

Trotz ihrer unterschiedlichen nationalen Abtreibungspolitik haben sowohl Italien als auch die USA deren Umsetzung regionalisiert. Das italienische Gesetz gilt auf nationaler Ebene, wird jedoch auf regionaler Ebene unterschiedlich ausgelegt und umgesetzt. Seit dem *Dobbs*-Urteil haben US-Bundesstaaten zahlreiche Abtreibungsgesetze vorgeschlagen und verabschiedet, was zu noch größeren regionalen Unterschieden geführt hat.

Der Beitrag schlägt eine Typologie des regionalisierten Zugangs vor: „Schutzzonen" (Sanctuaries), in denen Abtreibungen am besten geschützt und verfügbar sind; „Inseln" (Islands) mit liberaler Politik, die von restriktiveren Gebieten umgeben sind; und „Wüsten" (Deserts) mit minimalem Zugang zu Schwangerschaftsabbrüchen. Durch eine qualitative Analyse von Politiken, politischen Aktivitäten sowie Erfahrungsberichten von Abtreibungsanbietern und -befürwortern, die in Orten aus den verschiedenen typologischen Kategorien tätig sind, werden die langfristigen Folgen aller Komponenten der Typologie herausgearbeitet und im Hinblick darauf untersucht, wie sie sich auf Abtreibungsanbieter und Patientinnen auswirken.

**Schlagwörter:** Abtreibung, Gesundheitspolitik, Menschenrechte, Regionalisierung, Umsetzung von Richtlinien

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# Sanctuaries, Islands, and Deserts: A Typology of Regionalized Abortion Policy

## 1 Introduction

Governments regulate, criminalize, and legalize abortion in many different ways from complete legalization, to complete criminalization, to decriminalization. Choices such as when, why, and for whom abortion is legal are among the more obviously political questions that feed into abortion policymaking. We would argue that another component of this policymaking is also a political choice: which level of government has authority to make abortion policy. Some countries adopt one nationalized policy, where others allow for more local control. This paper brings two countries with regionalized abortion regulation into conversation: Italy and the United States.

These two countries adopted relatively similar abortion rules within five years of each other, and over the intervening decades retained those similarities with little change. On the face of it, the policy in both of these countries appeared to regulate abortion policy at the national level: the US Supreme Court decision in *Roe v. Wade* in 1973 and the Italian Law 194 of 1978 both applied nationwide. But upon closer examination and with the passing of time, both countries allowed regions/states more and more authority to regulate abortion differently. Abortion governance in the United States changed fundamentally in 2022 when the Supreme Court overturned *Roe v. Wade*. Prior to this decision, states were able to regulate abortion within certain bounds, which led to some variation in the abortion access climates across the country. The 2022 decision in *Dobbs v. Jackson Women's Health Organization* expanded the regulatory options available to states, but it would be disingenuous to pretend that all states had the same level of abortion access before 2022. Similarly, Italian regions are allowed to regulate abortion within certain bounds defined by Law 194. In recent years, the gap between Italian regions with the most and least access to abortions has grown ever wider.

We organize this regional divergence into a typology of Abortion Sanctuaries, Abortion Islands, and Abortion Deserts, comparing an archetypical US state to an Italian region. In doing so, we contemplate the importance of bilateral comparisons, and we highlight the specific role each typology plays in the larger regionalized system.

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## 2 Why Italy and the US?

In the summer of 2022, the US Supreme Court reversed nearly fifty years of precedent and held that the right to abortion was not protected by the Constitution, despite high levels of support for legal abortion in 2020 (Scoglio and Nayak 2023). In the days and weeks immediately following this decision, statehouses across the country took up the issue of abortion regulation and access: in the calendar year of 2023, 2393 bills that would protect or expand reproductive rights and 1098 bills that would restrict them were introduced (Forouzan and Guarnieri 2023), even though there is not widespread agreement on the definition of abortion (VandeVusse et al. 2023). Cases related to both federal (*Alliance for Hippocratic Medicine v. US Food and Drug Administration*; *Matsumoto v. Labrador*) and state laws (*Idaho v. United States; Texas v. Becerra*) are regularly proceeding through the US court system, and will likely continue for many years. While the exact abortion policy in any given US jurisdiction is subject to change, what we know is that abortion policy varies significantly across the nation, with no immediate prospects of restoring a national standard of abortion governance.

Before 2022, *Roe v. Wade* acted as a floor, guaranteeing some national protection for abortion seekers, but as other scholars have described in depth, regional variability had been on the rise for years (Luthra 2024; McFarlane and Hansen 2024). With the 1992 decision in *Planned Parenthood v. Casey*, the US Supreme Court introduced the standard of the "undue burden." States were permitted to regulate abortion so long as these regulations did not pose an "undue burden" to abortion seekers.

Italy, on the other hand, has had one consistent abortion law since 1978, only five years after the US's landmark *Roe v. Wade* case in 1973 and earlier than many of its European neighbors (Pullan and Gannon 2024b). While this may appear different from the US at first glance, we will argue in this paper that Italy's abortion governance is actually quite varied at the regional level. Cicchetti and Gasbarrini (2016) demonstrate that healthcare provision in Italy generally differs across regions, and this is particularly true for abortion due to its special regulatory status. In their forthcoming manuscript, De Giorgi, Cozzi, and Ripamonti explore the efforts of Italian regional political actors to regulate abortion, documenting a relationship between the left-right ideology of the party that controls a region's government and their positions on abortion.

Law 194 of 1978 also allows medical professionals to register as conscientious objectors, which exempts them from providing abortion care. This is in tension with the law's mandate that all public hospitals providing gynecological services ought to provide abortion services. Official statistics estimate the national rate of objection among gynecologists to be 63.4 percent as of 2021, with some regions reaching as high as 85 percent (Ministero della Salute 2023). Critics suggest that the Ministry's data may actually underestimate the rate of objection (Pullan and Gannon 2024a). The variation in conscientious objection rates, as well as other choices in the implementation of Law 194

that are made at the regional or provincial (subregion) level, are the primary source of Italy's regional variation, as we will demonstrate in the following sections.

In the US, *Dobbs* ended the national constitutional protection to abortion that was rooted in the First, Third, Fourth, Fifth, Ninth, and Fourteenth Amendments. Now that states are empowered to enact a wider range of policies without the floor that *Roe* provided, the variation across the US has drastically increased. Some states have enshrined a similar right in their state constitutions, which makes it more difficult for future lawmakers to reverse the policy when the balance of power in the state government changes, as constitutional amendments usually require a higher threshold of approval than a simple majority. Other states have passed laws that legalize abortion under specific conditions, but without constitutional protection at either the state or federal level, these laws are in greater danger of being overturned by future hostile politicians.

The first wave of studies since *Dobbs* already shows that doctors are confused by the legal landscape and hesitant to provide care without legal protections (De Vos et al. 2023); that states are eager to regulate abortion and the majority of proposed legislation expands abortion access (Forouzan and Guarnieri 2023; Kim et al. 2023); that medication abortion is a complex new area of regulation (Biggs et al. 2024; Karlin and Joffe 2023) that fundamentally changes abortion care (Nandagiri and Berro Pizzarossa 2023; Calkin 2023); and that in total there were likely more abortions in 2023 than in 2020 in spite of the *Dobbs* decision (Guttmacher Institute 2024). Additionally, in a post-*Dobbs* landscape there is increasing acknowledgement of the role of local bureaucrats in creating, implementing, and managing policy (Heymann et al. 2023), a reality which has also been acknowledged and studied in Italy (Pullan 2024a; Gannon 2023).

Both the US (Sasani 2023; Simmons-Duffin 2023; Noor 2023a) and Italy (Cavallaro 2019; Caruso 2020) have experienced high-profile cases where abortion patients were denied urgently necessary care and faced dire consequences and even death. These cases come about because of a combination of healthcare personnel who are uncertain about their legal obligations (Pullan 2024a; De Vos et al. 2023; Simmons-Duffin 2023) and those personnel who actively oppose abortion and refuse care even in situations when they are mandated to provide it (Minerva 2015). While such cases have occurred elsewhere (e.g., Savita Halappanavar's death in Ireland and Izabela in Poland), this is not common in most of the world (Ralph 2020, chap. 3).

We do not argue that the Italian and United States cases are identical, nor that they will ever be. No Italian region has the authority to completely ban abortion in principle, or to prosecute residents who seek abortion care elsewhere. We instead focus on the roles each state or region plays in the larger system. We argue that in systems with intense regionalization of abortion policies, states or regions largely separate into three different roles, Abortion Sanctuaries, Islands, and Deserts.

As we lay out our typology below, we argue that regions or states in a certain type category have similar configurational relationships to other states and regions, following a configurational understanding of cases (Ragin 2000, chap. 3). Such an understanding allows for theoretical generalizability from one configuration of cases (Italian regions) to a similar configuration of cases (US states). As scholars, policymakers, and citizens alike try to understand long-term implications of an increasingly regionalized post-*Dobbs* America, the example of Italy provides insights, for better or for worse.

The arguments in this paper flow from the robust fields of literature on comparative politics and abortion policy and governance. The United States has also always had intensely regionalized abortion access, due to local regulations such as Targeted Regulation of Abortion Providers (TRAP laws [Medoff 2012; Greenier and Glenberg 2014; Medoff and Dennis 2011; Mercier, Buchbinder, and Bryant 2016]), the Hyde Amendment (Ely et al. 2017), and statewide politics that regulated abortion without banning it (Chatillon et al. 2023; Ehrenreich and Marston 2019; Gaj, Sanders, and Singer 2021; Janiak et al. 2022; Bentele, Sager, and Aykanian 2018; Vandewalker 2012; Witwer et al. 2020). The effects of this regionalization and disparate ability to access care have been well-researched (Greene Foster 2020; Brown et al. 2020; Cartwright et al. 2018; Thompson et al. 2021; Brown 2019; Gober 1997; McFarlane 2015; Jones, Ingerick, and Jerman 2018; Kimport 2022; Makleff et al. 2023; Smith et al. 2022). McFarlane and Hansen's 2024 book explores the role of US states in regulating abortion in much greater depth than we can in this paper, considering the time period directly before *Dobbs* and the immediate aftermath.

Italy's abortion regime is less well-researched but still substantial. Several scholars focus on the role of conscientious objection in Italian abortion policy (Minerva 2015; Bo, Zotti, and Charrier 2015; 2017; De Zordo 2017) and the relationship between objection and abortion access (Pullan and Gannon 2024a). By exploring the difference between what the law prescribes and what actually happens in implementation (Caruso 2023; Pullan 2024a), scholars find that patients in different regions have quite different experiences with accessing abortion (Gannon and Pullan 2024; Gannon 2023) and sometimes need to leave their region (Autorino, Mattioli, and Mencarini 2020) or the country (De Zordo et al. 2021; 2023; Garnsey et al. 2021) to receive care. While abortion is not illegal in any region of Italy, there may be only a single doctor in a single hospital offering only a few abortion appointments on a single day each week serving the entire region. If that doctor goes on vacation or retires, abortion services are interrupted (see the section on "Abortion Deserts" below). In some ways, this quiet denial of access in Italy that only becomes visible when a patient tries to actually make an appointment for an abortion is more insidious and pervasive than the obvious policy efforts to legally punish abortion doctors or patients in the United States.

We ground our research in political science and public policy implementation, which brings us to the canon on federalism and regionalism. Specialists may rightfully claim that the US is a proper federal system, while Italy is at best semifederal but more accurately described as a regionalized system, based on its constitutional structure (Lippi

2011; Arban, Martinico, and Palermo 2021). The public policy outcomes are not very different however: regions with significant delegated authority operate in ways quite similar to federal states. We build upon scholarship that considers how regionalizing policies can lead to disparate outcomes, particularly in healthcare (Ciccheti and Gasbarrini 2016; Toth 2014; Gannon and Pullan 2024) and put it in conversation with studies on the variability across US states' abortion policies (Cassese, Ondercin, and Randall 2025, chap. 3; Vilda et al. 2021; Kim et al. 2023; Roth and Lee 2023; Medoff 2012).

## 3 A note on geography

It goes without saying that Italy and the United States operate on different scales of geography and population. In both countries, abortion seekers are traveling from region to region or state to state to places where abortion is more accessible. Traveling for care (Pleasants, Cartwright, and Upadhyay 2022; Sethna and Doull 2023; Torenz et al. 2023; Reinholz et al. 2018; Zanini et al. 2021) and the political geography of abortion more generally (Calkin 2019) has been studied in many countries. Studies have already been looking at the geospatial dimensions of abortion access in the US for several years, as even before *Dobbs*, some states had very little access to abortion. As of 2023, Texas patients have the farthest travel distances: an average of 515 miles (829 km) for abortions before fifteen weeks. Brown et al. (2020) and Thompson et al. (2021) demonstrate that there is an association between increased distance to abortion providers and decreased abortion rates, based on data in the US.

In Italy, qualitative scholars also contribute to our understanding of abortion-related travel, sharing stories of people who flew from the southern region of Sicilia to far northern Lombardia or left Italy altogether to seek care in France, Switzerland, Belgium, or even the UK (Gannon 2023; Garnsey et al. 2021; De Zordo et al. 2021). Other studies that evaluate international travel show significant numbers of Italian women traveling internationally for care. In Canton Ticino, the farthest southern region of Switzerland, between 2009 and 2015, 24.2 percent of all abortions were performed on Italian patients (Reinholz et al. 2018). Additionally, so many Italian patients were crossing the border into Nice, France for abortion care that the city hospital stopped accepting Italian patients (Minerva 2015). One study of patients traveling to England for abortion care found that Italian patients were second only to Irish patients in number traveling to England for abortion care (Garnsey et al. 2021).

There is less concrete quantitative data on the distances abortion seekers travel for their procedures in Italy or Europe in general. Pullan (2024b) presents the first multi-country dataset of where abortion providers are located in Europe, but the work to calculate these travel trends on a European scale still needs to be done. In the Italian case, though, Autorino, Mattioli, and Mencarini (2020) track patterns of travel from one Italian re-

gion to another. This data does not necessarily report the nearest possible abortion provider, but it provides important insights: they know where abortions actually took place, compared to where the abortion seekers live, based on the robust data gathered by the Italian national health system. We include these numbers and case studies to illustrate that both US American abortion seekers and their European counterparts are forced to travel long distances to access abortion care.

## 4 A typology of regionalized abortion access

In this paper, we propose a three-part typology of abortion access: Abortion Sanctuaries, Abortion Islands, and Abortion Deserts, each with distinct characteristics (see Table 1). We will develop and more fully explain what each of these types looks like in the following sections. Fundamentally, we contend that within a system where regions have discretion over policymaking and implementation, most states or regions will fall into these three categories. While we illustrate this typology with the cases of the US and Italy, it could also be used to describe international or intra-regional systems as well. One might consider entire regions like Europe or Latin America in such a way: there are entire countries that function as Islands, surrounded by abortion-hostile neighbors (such as Uruguay for many years until Argentina legalized abortion), and there are Sanctuaries that actively protect abortion access (such as Scandinavia).

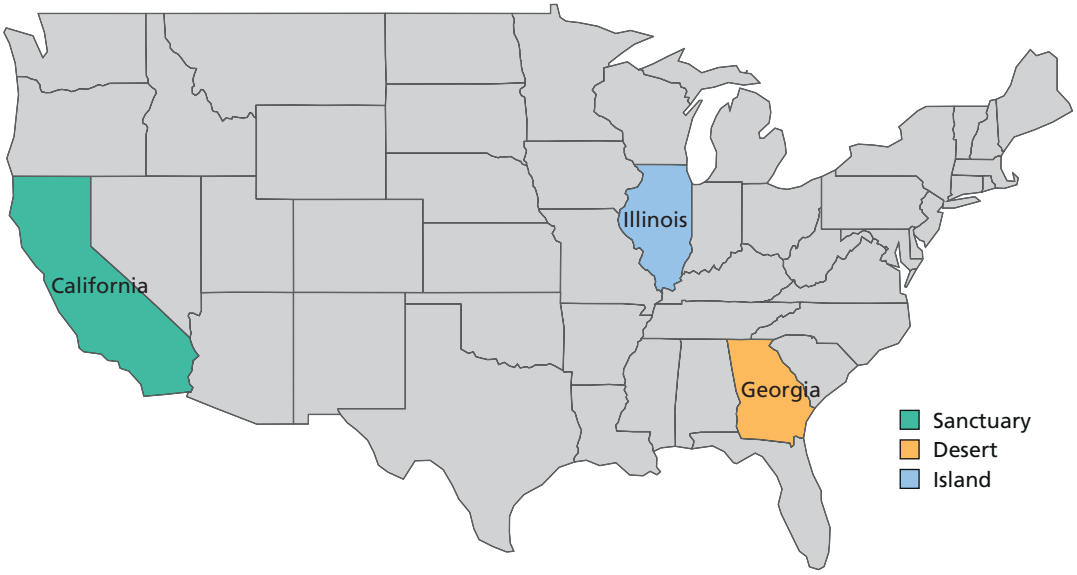
Table 1 Typology of regionalized abortion access

| Type | Italian region | US state | Characteristics |
|---|---|---|---|
| Abortion Sanctuaries | Emilia-Romagna | California | Throughout the region, abortion is accessible and access is relatively uniform. Cities continue to have a greater concentration of services, but provision is still adequate outside of cities. |
| Abortion Islands | Puglia | Illinois | A progressive city dominates this region and is large enough to lead to permissive regional regulations, but outside the city there is less cultural support for the region's progressive policies. |
| Abortion Deserts[1] | Molise | Georgia | Abortion is very difficult or effectively impossible to access due to an unsupportive local culture and lack of providers, despite technically being legal. |

1 We are not the first to use this term: Cohen, Donley, and Rebouché (2022), Cartwright et al. (2018), and C. Smith et al. (2022) use it, among others.

In sorting regions or states into each type, we consider a range of factors including current political leanings, political history, socio-cultural attitudes (GAL-TAN), the number of abortion providers, the level of conscientious objection, the religiosity of the population, and the region's geography. We choose US states (highlighted in Figure 1) and Italian regions (highlighted in Figure 2) that are prototypical examples of each type in this threefold typology, though they are not of course the only regions and states that

Figure 1 Map of US states referenced




Map produced by authors using shapefiles from US Census Bureau (2022) using R package tmap (Tennekes 2018).

fit such characteristics: for example, New York, Massachusetts, and Toscana could be considered Abortion Sanctuaries and Mississippi, Idaho, Sardegna, and Sicilia could be considered Abortion Deserts. Islands shift more rapidly as abortion laws change in different US states in particular, but as of writing, New Mexico, Minnesota, and the District of Columbia play this role in the US, and perhaps Lazio in Italy, though it should be noted that some Italians might find that the most accessible "Island" of care is actually in a different country, such as those who travel from Valle d'Aosta to Southern France, or residents of Sardegna and Sicilia who fly to London.

## Abortion Sanctuaries

Abortion Sanctuaries are regions that have a reputation for providing good abortion care, enhanced in a virtuous cycle by policy choices that strengthen an already good system due to supportive politicians. We pair Emilia-Romagna with the state of California to exemplify this type.

Emilia-Romagna has historically been considered part of Italy's "Red Belt" of regions with communist and Marxist feminist political leanings. Though the ideological strength of the Red Belt as a whole has deteriorated in recent years with the rise of La Lega, a far-

Figure 2 Map of Italian regions referenced


Map produced by authors using Shapefiles from GISCO, © EuroGeographics for the administrative boundaries, using R package *tmap* (Tennekes 2018).

right ethno-regionalist party (Donà 2020), Emilia-Romagna is still a stronghold of the largest Italian center-left party. Leftist ideology is a necessary but insufficient condition for pro-abortion policymaking (Blofield and Ewig 2017).

Emilia-Romagna also has a relatively low conscientious objection rate of 45 percent (Ministero della Salute 2023). While that number may sound high by non-Italian standards, it is low enough that hospitals generally have several nonobjecting gynecologists on staff (on average, 6.3), which means abortion services run much more smoothly than in other parts of the country (Ministero della Salute 2023; Gannon 2023). Until 2016, the Italian National Health Service paid for contraception, but the program was discontinued at the national level. Emilia-Romagna is one of only six regions that now provides free contraceptives to any part of their population (though this is not universal, only applying to those under twenty-six years old and/or in poor economic circumstances). Contraceptive use is higher in Emilia-Romagna than anywhere else in Italy (Internazionale 2020).

The region also has the highest number of family planning centers (*consultori familiari*) per capita (Ministero della Salute 2023). These centers are well-integrated with the hospital system and are actually used by abortion patients at a higher rate than in almost all other regions, capturing 73.4 percent of abortion requests (Ministero della Salute 2023). 93.3 percent of patients in Emilia-Romagna receive their abortion within fourteen days of first registering their request (Ministero della Salute 2023). These factors led Emilia-Romagna to become a destination for abortion seekers who live in less-supportive regions. Roughly 5 percent of abortion patients in Italy travel outside their region of residence to access abortion services, and of these, 15.4 percent come to Emilia-Romagna.

California also has a long history of progressive politics, producing many Democratic politicians who went on to gain national fame, such as Speaker Nancy Pelosi, Senator Dianne Feinstein, and Vice President Kamala Harris. In response to the 2022 *Dobbs* decision, California amended its state constitution to guarantee the right to abortion (Center for Reproductive Rights 2024a) and enacted a law that shields Californian doctors as well as their patients from criminal liability that might result from laws passed in other states, like Texas and Oklahoma (Gutierrez 2022).

In 2020, California had 174 abortion clinics, the most of any US state by a significant margin. Only 0.01 percent of Californians left the state to access abortion care, according to 2017 data (Smith and Glueck 2022). By contrast, roughly 20 percent of US abortion patients traveled out of state for their abortion in the first half of 2023, and California absorbed the second-highest number of patients in the Western half of the country (Guttmacher Institute 2023). Additionally, the state will increase its budget allocation to abortion clinics in order to support the influx of patients who are now traveling to California from other jurisdictions (El-Bawab 2022; Gutierrez 2022). California's reproductive rights advocates seem to enthusiastically embrace their role as an Abortion Sanctuary. As Jodi Hicks, President of Planned Parenthood of California, said: "to people across the country living in a state hostile to abortion: California is here for you" (Colliver 2018).

Thus far, we have painted a fairly rosy picture of abortion access in both of these Abortion Sanctuaries, however, they still face their own complications. One type of regulation that still inhibits abortion access in Sanctuaries is viability limits. Gannon (2023) observes

issues caused by the rigidity of policies that allow abortion until "viability" in Emilia-Romagna. This is a tenet of the national law in Italy that is interpreted somewhat differently in different regions, and it is also included in the California abortion law, as well as laws in many other seemingly progressive US states. Gannon's interviewees in Emilia-Romagna reported extreme frustration and anger with their inability to help patients whose genetic testing revealed severe or fatal abnormalities relatively late in a wanted pregnancy and then faced a difficult choice under additional pressure of time. Authorities in Emilia-Romagna interpret "viability" to occur at twenty-two weeks, and doctors are required to try to save the fetus beyond this point in time, even if it may have fatal developmental abnormalities. These doctors felt that they were not able to provide the best care for their patients and even shared stories of patients feeling forced to abort a wanted pregnancy based on the chance of a negative test result that would only be available after the deadline.

Hartwig et al. (2023) conducted similar interviews with US doctors working under a twenty-two-week gestational limit, and one of their interviewees stated, "a lot of our patients have these fetal anomalies and extenuating circumstances that go beyond 22 weeks … it limits our ability to provide adequate healthcare" (Hartwig et al. 2023, 3). Laws that apply rigid gestational limits are known to cause harm to patients (De Zordo et al. 2023). Such provisions are common in progressive US laws and were actually the national standard under *Roe v. Wade*.

Sanctuaries' role in the system is to guarantee abortion access, both to people within the state and people traveling from other states. They actively work to support and protect abortion access by updating their policies with technological advancements and regularly reaffirming their commitment by keeping abortion access in the political discourse. California stands out by moving to actively support abortion seekers who need assistance covering costs and legally protecting doctors and patients. Emilia-Romagna this year moved to become the first Italian region to allow elements of self-managed abortion (SMA), permitting patients to leave the hospital after taking the first dose of medication and complete their medication abortions at home (Cirant 2024). Emilia-Romagna and California both have rich histories of progressivism and a broad leftist tradition. This attitude also includes wide support and even protection for abortion access, leading them to serve as Sanctuaries for abortion seekers in their respective countries.

## Abortion Islands

Abortion Islands are regions, usually including a relatively large city, that have a supportive climate for abortion access but are surrounded by other regions where abortion is more difficult to access. We compare Puglia in Southeastern Italy to Illinois in the Midwestern United States, as both have become unintentional abortion destinations that struggle to meet demand from outside their territory.

Puglia lies on the Adriatic coast. Its capital city, Bari, is the second-largest population center in the South (after Naples), but most of the region is made up of relatively small towns that thrive on fishing and tourism. The region has relatively moderate politics, with control passing back and forth between center-left and center-right parties over the last twenty-five years.

In terms of abortion access, though, Puglia's infrastructure is relatively strong compared to its geographical neighbors. While abortion services are not offered at every hospital, they are offered in at least one location in each province (Pullan 2024a). The conscientious objection rate among gynecologists in Puglia is typical of the South: 80.6 percent in 2021, compared to 78.5 percent across all southern regions (Ministero della Salute 2023). But what is atypical is their abortion rate: 6.3 per 1000 women aged 15–49, which is second only to Emilia-Romagna among Italian regions. Despite only being home to 28.6 percent of women of reproductive age in Southern Italy, Puglia performs 35.6 percent of the South's abortions (Ministero della Salute 2023). In their 2020 paper, Autorino, Mattioli, and Mencarini demonstrate that patients flow out of some regions and into others for abortion care, with Puglia receiving patients from across other southern regions. This is a key attribute of Islands: they are part of a system where geographically and politically neighboring regions are less supportive of abortion. An Island cannot exist in isolation. Thus, while we do describe what is specific within the regions of Puglia and Illinois in this section, we also must consider their position in a regional or national system and the role that these regions play for residents of those other regions.

Likewise, Illinois is surrounded by more conservative states. Abortion is completely banned in three of the five states that border it, and the other two states have generally conservative governments and hostile climates. Illinois, on the other hand, has long been a Democratic stronghold, in large part due to the city of Chicago's voter base. Before *Dobbs,* Illinois had already established a right to abortion under the state constitution, and since 2022 has adopted some laws similar to California's efforts to protect doctors and patients traveling from out of state and to limit misinformation about abortion (Center for Reproductive Rights 2024b).

What makes Illinois an Island instead of a Sanctuary like California is the geopolitics of its neighbors. There are simply more out-of-state abortion seekers who live in an abortion-hostile state that is closer to Illinois geographically. In both raw numbers and as a percentage of all abortion patients receiving care in the state, Illinois has absorbed more patients than any other state (DoCampo et al. 2024). From 2019 to 2023, Illinois now performs 72 percent more abortions, with 41 percent of all abortions in 2023 performed on non-residents (Escobar et al. 2024, based on DoCampo et al. 2024).

Private care providers are struggling to pick up the slack. Planned Parenthood anticipated the fall of *Roe* and began constructing new clinics near the borders. Bonyen Lee-Gilmore, Spokesperson for Planned Parenthood of the St. Louis Region which serves

Southern Illinois, described the situation in an interview: "Illinois is an island of reproductive health care in the region; Southern Illinois is like a micro island in that region just because there are only two of us" (Leventis Lourgos 2022). As Lee-Gilmore suggests, the typology we present here can be seen operating at different levels, depending on the context. When looking at the entire US, residents travel from many Midwestern states to Illinois for care. But within the state of Illinois itself, a resident of the southeastern portion of the state may travel to the "Islands" of Carbondale or the St. Louis suburbs, whereas a resident living near Chicago would have a much easier time accessing care.

Abortion Islands also face their own concerns with abortion access and the experience of providers. In both Puglia and Illinois, abortion providers experience isolation from their geographic peers and pressure to absorb high levels of patients. This is causing strain on the individuals and clinics involved in abortion care. These healthcare workers in Abortion Islands face stigma and isolation, though American providers face significantly more physical risk than their Italian peers. In Illinois, one man pled guilty to federal criminal charges related to crashing a car full of explosive materials into a building that was preparing to open as an abortion clinic. (Leventis Lourgos 2024). In Puglia, the threat is that one will never advance in one's career and be left to perform abortions over and over again for years (Pullan 2024a). Duffy et al. (2018) have demonstrated the importance of considering the "feel" or "affect" of an abortion governance regime from the perspective of healthcare providers – providers' willingness to provide abortion care goes beyond what is legal and considers the environment in which they work.

The long-term implications of the isolation and stigmatization of abortion providers are serious, as they cause providers to burn out and leave the field. If Illinois or other Abortion Island states in the US truly are committed to providing abortion care for out-of-state patients in the long run, they must preventatively address this burnout among their physicians. Abortion has always been a politically salient issue in the US, but in the immediate aftermath of *Dobbs*, there is some sense of national solidarity with abortion providers as they adjust to a "new normal." The novelty of providing care despite the political odds against it will wane with time, as it has in Puglia, and abortion providers in Illinois may find themselves in the trenches, providing this care day in and day out, without much thanks or social support. McKinney (2024) describes the phenomenon of the "tragedy of the abortion provider" and argues that while there are indeed individuals who are struggling to keep working in abortion care, this occurs because of institutional failures. Medical facilities and the state regulatory agencies have failed to provide for abortion providers as well as for patients. Correcting this failure is particularly important for states like Illinois or Puglia that are the only jurisdiction in a large region where abortion services are available.

Abortion Islands in Italy have adopted administrative structures that are not helpful for preventing burnout among abortion providers, and as a consequence, we see a small number of dedicated, overworked professionals persisting as long as they can,

but sometimes ultimately concluding that abortion care was not something they could continue to provide (Pullan 2024a). Abortion Islands that wish to sustain themselves must monitor the absolute number of doctors who can perform abortions, not only the percentage, and consider how the region can attract doctors to this work by addressing the isolation and threats to their safety that providers face. Abortion Islands embody this phenomenon: abortion is legal, but the stressful climate for abortion providers threatens its continued availability. Both Illinois and Puglia continue to provide abortion care largely thanks to the individual will of healthcare workers who believe in abortion rights despite the personal costs to themselves.

## Abortion Deserts

Abortion Deserts are regions that have little to no access to abortion care. Both in Italy and in the US, these regions are largely associated with the southern parts of both countries, though other regions throughout the countries also struggle to provide adequate care. They are also usually characterized by conservative politics and politicians. Abortion Deserts usually occur because the regional or state government is actively hostile to abortion, though there are certainly other factors that affect it as well, such as the ability to recruit doctors.

Molise is a region in Southern Italy whose government is currently controlled by right-wing parties that are hostile to abortion, with center-left parties only controlling the region's presidency for six of the last twenty-four years. There is only one doctor actively performing abortions in the whole region, even though official data says that the conscientious objection rate in Molise was only 82.8 percent (Ministero della Salute 2022; Pullan and Gannon 2024a). When there is only one abortion provider for the entire region, whenever they have a day off, go on vacation, or get sick, abortion access ceases in the region. This also results in increased costs in terms of both time and money for patients to travel across the region to a single provider, as compared to receiving treatment closer to home. It is estimated that 20 percent of the patients seeking abortion care in Molise leave the region to access care (Grazi 2021).

There used to be two doctors who provided abortions in Molise; Dr. Mariano delayed retirement multiple times in an effort to find another full-time doctor to fill his post, but was unsuccessful. His compatriot, now the sole remaining abortion provider in the entire region, had only been working for eighteen hours a week (Grazi 2021). Being the only abortion doctor in a region also attracts stigma and discrimination. When Dr. Mariano was originally hired, he was supposed to be head of the Department of Obstetrics and Gynecology, but that changed when the hospital made an agreement with a Catholic university. Dr. Mariano credits his status as a nonobjector with preventing the advancement of his career (De Luca 2017).

In the United States, we consider the state of Georgia. Georgia's state government is controlled by the Republican Party and is hostile to abortion. Though Georgia does have fourteen abortion clinics, access to care is still incredibly difficult because of the state's laws (AbortionFinder.org 2023). Georgia has a six-week abortion ban with narrow exceptions (AbortionFinder.org 2023). These laws, common in Southern states and often referred to as "heartbeat bills," forbid abortion once fetal cardiac activity is visible on an ultrasound. Abortion advocates are quick to note that a six-week abortion ban and a complete abortion ban are functionally the same thing. Because of the way gestational age is calculated, very few people know they are pregnant before six weeks or would have time to schedule an appointment. Abortion patients in Georgia reported that a lack of social and economic support were major drivers in their decision to end their pregnancies (Dickey et al. 2022).

Neither Molise nor Georgia's laws completely ban abortion, but the way the laws are each applied has the effect of making abortion almost impossible in these regions. In both regions, patients are forced to travel, which obviously increases the costs and difficulty of obtaining an abortion. In both Molise and Georgia, it is significantly easier to get an abortion in cases that are deemed more justifiable – the Georgia law frames these as permissible exceptions to the six-week ban, and the Italian law considers such cases to be "therapeutic" abortions where even objecting gynecologists are required to assist with abortions.

Both Dr. Mariano of Molise and the American abortion provider and writer Dr. Willie Parker describe similar motivations for continuing their work despite the obstacles. Dr. Parker, who travels across the US Southeast providing abortion care, said in his book, "each one of these backwards moves will not only restrict women's access to safe care, but will diminish women's access to good health care in general, putting their lives ... at risk" (Parker 2017). When asked why he continued to perform abortions, Dr. Mariano responded, "Because I do not want women to return to clandestine abortions and die at the hands of butchers" (De Luca 2017). Both Drs. Parker and Mariano demonstrate what Dickens (2008) describes as "conscientious commitment" – a positive belief that doctors' moral imperative is to provide medically appropriate care, regardless of the cultural or social norms under which they are working.

Working in Abortion Deserts poses unique challenges to providers, so it logically follows that doctors with similar moral commitments do this work in both the US and Italy. Despite different legal and political contexts, the outcome for patients is also the same: traveling long distances, often out of state, to access medical care, in contrast to residents of other regions of the same country where abortion is relatively easily accessed.

We must discuss the complete bans on abortion that are now being enforced in about a dozen US states. We choose Georgia as our case for the Desert typology because its level of access is most similar to the level in Molise, and also to highlight how similar the effects of a six-week ban are to a total ban. Almost all abortion seekers in Georgia

will need to seek assistance from outside their state of residence to have an abortion, just as residents in a total ban state will. To our knowledge, there have not yet been studies published that compare the impact of total bans versus Georgia-style bans in terms of the number of abortion seekers who are affected. States enforcing total bans are certainly causing their residents to travel at greater rates and in more dangerous situations. By highlighting a six-week ban instead of these total bans, we wish to emphasize the point that in both cases, almost all abortion seekers from that jurisdiction will be unable to access care because of the policy. This paper considers the implementation of policy, such as the effects of conscientious objection in Italy, not only the letter of the law, and therefore, we consider total bans and near-total bans to have very similar effects.

Unclear interpretations and misunderstandings of the law by doctors and hospitals have serious long-term implications for patient safety and have already caused dangerous situations for patients in both Italy and the US. In the Italian region of Sicilia, a woman died when a doctor refused to perform her therapeutic abortion, even though there is no right to object to therapeutic abortions (Minerva 2015). In Georgia, Amber Nicole Thurman, a twenty-eight-year-old woman was nine weeks pregnant when she died of sepsis when the hospital waited twenty hours to provide her an abortion. In the US, the lack of clarity about abortion exceptions has caused immense confusion and forced women to travel to access abortion care in life-threatening situations or caused the death of women like Amber Nicole Thurman. (Sasani 2023; Simmons-Duffin 2023; Noor 2023b). This issue has been made especially pertinent in the US Supreme Court decision *Moyle v. United States* in June 2024. The case concerns a conflict of a state abortion ban and the federal law Emergency Medical Treatment and Active Labor Act (EMTALA), which requires stabilizing care for pregnant women in emergency rooms, even if that care is an abortion. The Supreme Court ultimately declined to rule on the merits of the case, allowing emergency room abortion care in Idaho for the time being, but without clarifying the underlying conflict between state governments' interest in restricting abortion and the federal government's interest in ensuring emergency care is provided. Italy has had the same abortion law for almost fifty years and is still having these problems, and the US should not assume that abortion laws and exceptions will become clearer with time.

## 5 Conclusion

In this paper we have explored a typology of regionalized abortion access by comparing the regionalized systems in Italy and in the United States. We posit that in regionalized healthcare systems, states or regions usually fall into one of three categories when it comes to abortion care: Sanctuaries, Islands, and Deserts. We demonstrate that regions or states in a certain type category have similar configurational relationships to other states and regions. Though we have illustrated this typology with three US states and three Italian regions, it could also be zoomed out to describe international or large regional systems,

Table 2 Long term implications of the typology

| Type | Long-term implications |
|---|---|
| Abortion Sanctuaries | Gestational limits later in pregnancy or at "viability" restrict the care providers are allowed to offer their patients. |
| Abortion Islands | As healthcare workers are pressed to absorb more patients from outside the region, they are at heightened risk for burnout due to overwork and isolation. |
| Abortion Deserts | Patients struggle to access urgently needed care due to legal confusion and the paucity of doctors with a conscientious commitment. |

or alternatively zoomed in to describe the dynamics within a single state. When abortion access is not uniformly guaranteed across the area in question, some areas will function as Sanctuaries that protect access, and others will be Deserts where care is extremely difficult or impossible. Among Deserts, we will find Islands that serve the needs not only of their local population, but also those from the Desert area around them.

While this paper has largely focused on describing the characteristics of each type, in our conclusion we briefly turn to the long-term implications that arise in the types, summarized in Table 2. In Abortion Sanctuaries, there can remain problems accessing care when viability limits restrict care for abortions later in pregnancy. In Abortion Islands, doctors are particularly likely to face isolation and burnout, leading to difficulty staffing abortion services that are already overtaxed as the closest option for residents living outside the territory. Private groups may require state support to sustain their operations, similar to the role the state plays in Sanctuaries; otherwise, this region risks becoming part of the Desert. In Abortion Deserts, even when there are supposed to be exceptions to abortion bans for certain types of particularly urgent abortions, there will be patients who fail to receive the care they need, whether due to risk aversion or to a conscious refusal to intervene. By recognizing which type a specific state or region belongs to, policymakers and advocates can more effectively plan for the future and take steps to protect abortion patients and abortion providers.

Future research could focus on the experience of care providers. Mills and Watermeyer (2023) recently reviewed the current state of research on abortion care providers' experiences and motivations. Some studies like those performed by De Zordo (2017), Pullan (2024a), and Gannon (2023) explore this in the Italian case, as do some scholars in the US such as Freedman, Landy, and Steinauer (2008), Hartwig et al. (2023) and Reeves et al. (2023), but these papers all reflect the pre-*Dobbs* landscape. Such new studies could apply the typology presented in this paper for a comparative analysis among states, particularly Islands that are absorbing patients from neighboring states with abortion bans. We would welcome an in-depth application of this typology beyond the US and Italy to other countries with large regional disparities in abortion access (perhaps Mexico or Germany), or even to entire regions like Latin America or Europe where scholars have already documented the ways that abortion seekers travel internationally to access care in friendlier climates (Rahm et al. 2023; Gerdts et al. 2016; Mishtal et al. 2023).

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