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Reproductive Health of Migrant Women in Italy and Europe

Abortion, Social Conditions and Policy

by Lia Lombardi

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The about 17 million migrant women in the EU countries have significantly higher fertility and abortion rates than their native counterparts, but access to reproductive health services is not always available to them. Notwithstanding the EU provision, which recommends that member states legislate in favour of reproductive health and make it accessible, the legislation on migration and health policies very often discriminates against migrant women. The elective abortion of migrant women has fuelled a heated debate in several European countries: the most controversial issues concern the high abortion rates (for example in Norway, Spain and Italy); the access to abortion for foreign non-residents or undocumented women (as in the Czech Republic and France) and sex-selective abortion (in Sweden and Netherlands). Starting from these issues the paper analyses three aspects of induced abortion: a) abortion rates among migrant women and their related social conditions; b) health and social policies for migrant women; c) access to safe and legal abortion in the EU.

1. Migration and European welfare

The scale of immigration in the EU-27 region is currently estimated at 33.5 million, 52% of whom are women: the majority of foreign citizens living in the EU on 1 January 2013 (Eurostat, 2014), are in Germany (7.7 million), followed by Spain (5.1 million), the United Kingdom (4.9 million), Italy (4.4 million) and France (4.1 million). Foreigners living in these five EU Member States represent 77% of the total number of migrants in the EU-27.

When talking about the recent migration flows, "feminization of migration", is a concept used to explain how globalization directs migration in a new way, in particular with reference to gender distribution. Worldwide, women represent 50% of all migrants, with the highest percentage recorded in Europe (52.4%) and the lowest in South Africa (42.8%).

Women migration highlights different issues to men migration with respect to migration projects, needs, background, expectations and risk factors: e.g. migrant women are more vulnerable to physical, sexual and verbal abuse; they often fall prey of traffickers and are involved in the sex industry. They also face "double" discrimination in the labour market, both as women and as migrants.

According to international observers, migration processes consist of several stages and factors that affect the health status of migrants, such as:

1) pre-departure conditions (individual but also political, and economic conditions, and/or war context);
2) travel conditions;
3) factors relating to the environment and to the society of arrival (immigration policy, access to health and social services, citizenship rights).

These three categories of factors intersect with socio-demographic variables (age, gender, education, skills and resources, etc...) and the interconnections among these factors allow us to capture the relation between migration, gender and health (including reproductive health and induced abortion), thus highlighting the dimension of inequality, which is constructed and reinforced by that relation.

The construction processes of the European system have not yet led to the creation of a unified welfare system, but there is a European Social Model, which «Refers (...) to the presence in the national member states of a system based on common values, such as the respect for fundamental rights, a shared solidarity, the provision of a safety net against some social risks, state intervention in social policies and the presence of social dialogue as a form of participation» (Colombo Svevo 2005: 96).

In general, the welfare system is still in the hands of the individual states, which manage their sovereignty independently on this issue: the increase in migration has led to a progressive exclusion of migrants from welfare benefits as a consequence of tighter rules.

We thus need to reflect on ways of dispensing welfare benefits, on the constraints that limit the use of services, and on the rules concerning access to benefits. Migrants affect the arrival society both in terms of population and cultural plurality, accelerating the changes that are taking place (Blangiardo, 2015).

On the other hand, there is evidence that women's migration follows alternative or parallel routes to that of men: many migrant women are breadwinners and in some national groups they outnumber men, thus «representing a strategic resource in the system of social reproduction of the country of arrival» (Zanfrini, 2005: 253).

2. Abortion and the reproductive health of migrant women

Induced abortion rates among immigrant women should be analyzed in connection with the complexity of migration routes, access to citizenship rights, socio-economic conditions and health-related status. Between 1995 and 2003, the abortion rate (number of abortions per thousand women of childbearing age -15-44 years) fell from 35 to 29 per thousand worldwide, and it reached its lowest, at 28 per thousand, in 2008 (Guttmacher Institute, 2012).

These global data highlight significant differences: nearly half of all abortions worldwide are at risk, and almost all unsafe abortions (98%) take place in developing countries. In these countries, 56% of all abortions are unsafe compared to 6% of those taking place in the ADCs (Advanced Developed Countries). The reduction in the number of abortions which occurred worldwide between 1995 and 2008 is attributable exclusively to the fall in the ADCs (-600 thousand), while an increase of 2.8 million was recorded in the developing countries.

Europe, where abortion is generally legal (albeit with some exceptions) has both the lowest and the highest rate of abortion: in the western countries the average rate is 12 abortions per thousand women of fertile age (15-44 years), while in eastern Europe the rate is 43 per thousand. The discrepancy in rates between the two regions reflects the low use of modern contraceptive methods in Eastern Europe, as well as a frequent use of unsafe contraceptive methods (e.g. *coitus interruptus*, the so-called natural methods, etc.).

Table 1 - Global and regional estimates of induced abortion, 1995, 2003 and 2008

Region	No. of abortions (millions)			Abortion rate (per 1000 women aged 15-44)		
	1995	2003	2008	1995	2003	2008
World	45.6	41.6	43.8	35	29	28
Developed countries (Excluding Eastern Europe)	10.0 3.8	6.6 3.5	6.0 3.2	39 20	25 19	24 17
Developing countries (Excluding China)	35.5 24.9	35.0 26.4	37.8 28.6	34 33	29 30	29 29
Africa	5.0	5.6	6.4	33	29	29
Asia	26.8	25.9	27.3	33	29	28
Europe	7.7	4.3	4.2	48	28	27
Latin America	4.2	4.1	4.4	37	31	32
Northern America	1.5	1.5	1.4	22	21	19
Oceania	0.1	0,1	0.1	21	18	17

Source: Sedgh, 2012

According to the Programme of Action of the UN International Conference on Population and Development (ICPD), signed in 1994 in Cairo by 179 countries (Lazdane, 2005), many countries in Europe have in recent decades developed and adopted national strategies in support of reproductive health and access to services for induced abortion.
All 52 European countries which are WHO members, except Malta, have signed a decisive statement of principle that does not establish the "right to abortion", but interprets it as a practice to avoid and be only used as the last resort:

> In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to

> strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be given to eliminate the need for abortion. (…) In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortion. (Lazdane, 2005).

The regulation of abortion varies across the European Region: almost all countries allow abortion in order to save the life of a woman and 90% in order to preserve physical or mental health; 88% allow it in case of foetal abnormalities or of rape or incest. Almost 80% allow abortion for economic and social reasons, and about 70% agree to it on request.

Table. 2 – Grounds on which abortion is permitted – percentage of European WHO Member States

On request	69.0%
Economic and social reasons	79.0%
Foetal impairment	88.0%
Rape and incest	87.0%
To preserve mental health	90.0%
To preserve physical health	90.0%
To save a woman's life	96.0%

Source: Lazdane, ENTRE NOUS, 2005

We can thus identify 3 different types of access systems for induced abortion:

1) countries with legislation that allows easy access (e.g. Austria, Belgium, Great Britain, Netherlands, Norway, Sweden, Switzerland);
2) countries with limited access (e.g. Denmark, Finland, France, Germany, Italy, Portugal, Spain);
3) countries in which abortion is illegal, such as Malta, Andorra, Ireland (in the latter only permitted in case of danger to the mother's life) and Poland (where it is only allowed in cases of serious risk to the mother's health, of serious foetal conditions and of rape).

With regard to the policies of access to reproductive health and induced abortion for migrant women, there are more or less restrictive approaches that are not always consistent with the welfare system approach. For example, access to abortion in the Netherlands and Sweden is very easy, available up to the 24th week of gestation, and is free for all women living lawfully in the country, but not for foreign women living temporarily in those countries, for illegal migrants and for refugees. Among those countries with limited access to abortion, Denmark does not allow free access to foreign women

who are not resident or are living illegally in the country and France has similar restrictive rules for illegal migrants.

The case of Italy is different because, although this is a country that allows access to induced abortion, albeit with some restrictions *(obligation to perform surgery only in public services, difficult access to medical abortion, a high percentage of conscientious objection*), access to abortion is available to all women: Italian and foreign women, whatever their migration status.

In Portugal, because of restrictive rules and the large number of conscientious objectors, most abortions take place in private clinics or doctors' surgeries, and they are often carried out by midwives and nurses. This applies to Portuguese women and, *a fortiori*, to migrant and undocumented women.

In western and northern Europe the abortion rates for migrant women are significantly higher than those for native women. These data are related to the access to abortion and to reproductive health, to the migratory path, to gender condition and discrimination and to social vulnerability, all factors that often affect migrant women.

We will now consider three studies on the abortion of migrant women in Denmark, the Netherlands and Spain which, albeit using different analytical approaches, show very similar results.

2.1 Three studies on abortion, social conditions of migrant women and welfare state

A Danish study carried out in 2007 (Rasch et al., 2008), shows that, despite the Scandinavian welfare system being among the fairest in the world, the lower socio-economic conditions of the migrant population put a strain on the system, with such conditions being the basis for an increased termination of pregnancy by migrant women.

The Danish act on induced abortion (1973) stipulates that any woman aged 18 and over has the right to pregnancy termination in a public hospital at no cost to her and with no need to provide any justification, providing she is resident in Denmark and the interruption is performed before the end of the 12th week of gestation. The average rate of abortion is 12.2 per thousand women of childbearing age (15-44); the abortion rate for migrant women from non-Western countries, however, is more than double (29 per thousand) that of Danish women.

As far as the socio-demographic characteristics of women requesting termination of pregnancy are concerned, it should be noted that the number of migrant women is slightly higher than that of Danish and Western women: they are more likely to be married (57.2% compared to 42.2% and 37.1% respectively); they have at least two children (51.7% compared to 36% and 37%, for the Danish and other Western women respectively); they are more likely to be unemployed (36.7% vs 20.6% and 27.4% respectively) and to have lower incomes of between 7000 and 9999 DKK (36.1% vs. 22.5% of Danish women).

This social status suggests that abortion risk factors are mainly related to marital status (about half the women who require an abortion are single, but only 5% of women

continuing a pregnancy are single); to having two or more children; to being below 19 or over 40 years of age; to being unemployed, not professionally qualified or a student.

The Danish research concludes that migrant women belong to a particular vulnerable social group, which is at a high risk of incurring unwanted pregnancies and abortion and that, in order to preserve the strength of the Scandinavian welfare model, this vulnerability must be recognized and addressed.

Another study on adolescent abortion carried out in the Netherlands in 2006 (Islam in Europe, 2006) shows that teenagers from Morocco and Turkey are more likely to have an abortion (respectively 67% and 53% in 2005) than their Dutch counterparts or those from other countries. According to Cecile Wijsen (Researcher at Rutger WPF - sexual and reproductive health and right) migrant girls are often confronted with double and ambivalent messages from different cultures and this results in them receiving inappropriate information on how to prevent unwanted pregnancies.

This study also suggests that one of the risk factors in the abortion of migrant women is the difficulty in adequately understanding the information offered by professionals and healthcare services and by campaigns aimed at preventing unwanted pregnancies (ibid.). It should also be noted, that this is not just a linguistic but also a cultural problem, which encompasses the relationship between genders, reproductive models, family structures and the "value of virginity".

The research conducted in three autonomous provinces of Spain (Catalonia, the Balearic Islands, Valencia), all with a high presence of migrants, shows similar results to the previous studies as far as the abortion of migrant women and their socio-demographic characteristics are concerned (Zurriaga et al., 2009).

Age and related factors (having children, marital status, cohabitation, latest pregnancy) appear to be decisive in the choice to have an abortion: wanting to complete their studies and obtaining a job are the main reasons given by young women for interrupting a pregnancy, while family problems and employment status are the prevailing reasons for abortion among adult women.

Moreover, access to family-planning services in Spain is not the same for the native and the migrant population: private clinics are used mainly by Spanish women and Western Europeans (17.3% vs 10.7% for women of other origin), while migrants mainly use public services (50.6% vs 44.3% for Spanish and western European women): this results in a double unequal access to services and information on reproductive health, which is related to economic status and the knowledge of the healthcare system and its environment .

The Spanish research, like other surveys carried out in Europe, shows that a high abortion rate is closely related to the employment status and to low levels of education and income. The difficulty of migrant women in accessing healthcare services also depends on the complexity of the bureaucracy, which differs from region to region: some regions of Spain, for example, require a full or partial payment for surgery in private clinics (ibid.).

Length of migration is an additional risk factor for abortion: in all afore-mentioned countries, including Italy (Lombardi et al., 2015), the longer the migrant has resided in the country, the lower is the request for a termination of pregnancy. In Spain, the recourse to abortion concerns 27.5% of women who arrived before 2001, but 42% of those arriving between 2005 and 2006 (Zurriaga, 2009).

2.2 Induced abortion in Italy and Lombardy

Several studies have explored the reproductive health and abortion of migrant women in Italy, both at a national (Ministero della salute, 2015) and at a regional level (Fondazione Ismu, Osservatorio Regionale per l'integrazione e la multietnicità, *Annual Reports* since 2000 forward; Lombardi, 2001, 2005, 2008, 2011; Farina, Ortensi, 2010).

According to the latest Report from the Ministry of Health (2014), 102,644 induced abortions were performed in Italy in 2013, a decrease of 4.2% compared to 2012 and a decrease of 54.9% compared to 1982. The abortion rate was 7.6 per 1000 women of fertile age (15-49) and it is among the lowest in the industrialized countries (Table 3).

Table 3 - Abortion rate per 1,000 women aged 15-44 in different countries. 2011-2012

Country	Survey year	Abortion rate (1/1000)
Switzerland	2012	6.4
Germany	2012	7.2
Netherlands	2012	8.5
Portugal	2012	9.1
Belgium	2011	9.3
ITALY	2012	9.6[1]
Lithuania	2012	10.0
Finland	2012	10.2
Spain	2012	12.0
Canada	2011	13.3
Denmark	2012	14.7
Norway	2012	15.3
England and Wales	2012	16.5
USA	2011	16.9
France	2011	17.5
Hungary	2012	17.8
Sweden	2012	20.7
Romania	2012	20,8
Bulgaria	2012	21.2
Russian Fed.	2011	31.3

Source: Ministero della salute, Report on IVG, 2014

[1] Recalculated by adjusting the denominator to 15-44 years.

The analysis of the socio-demographic characteristics of those women who resort to abortion shows that one third of them have foreign citizenship (34.0% of all abortions), although this trend shows a decrease in recent years. We believe that this stabilization (of the abortion rate of migrant women) is due both to the reduction of migration flows to Italy and to the improvement in the living conditions of migrant women in previous years.

If we consider the abortion rates by the three main regions of origin (Countries with Strong Migration Pressure, Advanced Developed Countries and Italy), we can observe a significant decrease in the abortion rate among Italian women (6.7 per thousand), women from CSMPs (23.8 *versus* 40.7 per thousand in 2003) and women from ADCs (11.5 per thousand).

The distribution of abortions by nationality shows a significant prevalence of women from Eastern Europe (51% of all the abortions of foreign women in 2012). The prevalence of this number is due to the high presence of women living in Italy and coming from that area of Europe (1,383,915 European migrant women with a M / F ratio of 76.4%). The vast majority are Romanians (529,265) and Albanians (223,275), followed by Ukrainians (160,113), Moldovans (87,951) and Polish (77,603). Overall, European women represent 58% of the whole migrant female population living in Italy (ISTAT, 2011).

Some socio-demographic characteristics that differentiate Italian women from migrant women resorting to abortion show a majority of married women among migrants (48.7%) compared to their Italian counterpart (39.3%); the level of education is on the contrary quite comparable with regard to middle school qualifications (40.5% for Italian women and 47.8% for migrant women) but it is significantly different with regard to primary school (respectively 3.1% and 10.2%) and secondary school qualifications (45.9% vs 35.9%). The employment status of women shows a similar percentage of abortions among Italian and foreign women (45.1% vs 41.2%), while the figure is different for unemployed women (17.2% vs 26.1%) and students (14.2% vs 5.9%).

Finally a few words on Lombardy, the region with the largest number of migrants from countries with a strong migratory pressure (1,295,000 estimated at 1 July 2014), accounting for about 25% of all immigrants in Italy. Here, as throughout the country, the foreign population is represented mainly by people from Eastern Europe (36%) with a huge prevalence of Romanians and Albanians (Blangiardo, 2015): people coming from Romania, the Ukraine, Poland, and Moldova are mainly female (ISTAT, regional data, 2014).

According to the latest ISMU-ORIM Report, migrants living in Lombardy are in good health (Pasini, Merotta, 2016; Lombardi et al., 2015): the analysis of gender hospitalizations in the region in 2013 shows 65,080 female hospital admissions (63.2%) and 14,048 out-patient admissions (78.9%).

The number of female hospital admissions in Lombardy is due mainly to pregnancy, abortion and childbirth: hospital admissions for these reasons account for 27.2% of all admissions of foreign citizens. Hospital admissions of migrant women for childbirth

represent 27% of all births occurring in Lombardy and 33.7% of all abortions. Hospitalizations for abortion and childbirth of foreign women are distributed differently according to their area of origin: among women from Latin America and East Europe abortions prevail over deliveries, while the opposite is true for women from North Africa and among other nationalities (Lombardi et al., 2015).

The abortion rate in Lombardy is around 7.9 per thousand in 2012 (IVG Report, 2014) but the same rate for migrant women, (while showing a significant setback in recent years), is about three times higher than the figure for Italian women.

There are several reasons that contribute to a higher abortion rate among migrant women: among them migration factors (economic and social hardship, communication difficulties, illegality, etc.); communication problems with health care providers; and the type of migratory project (Lombardi, 2005, 2008). In actual fact, women more at risk of an abortion tend to come from South America (Peru and Bolivia), Eastern Europe (Ukraine, Moldova, Romania and Bulgaria) and sub-Saharan Africa. They are women with single, relatively recent and still unstable migratory projects, with no family in the country of arrival, who are employed in the domestic and the care sector and often with an illegal status (Marchetti, Venturini, 2012).

With regard to reproductive behaviour, research shows that women with secondary migration projects, no employment and from families with a male breadwinner, have a greater inclination to motherhood, while a lower propensity is recorded among women with independent migration projects, who have left their children behind (South Americans and Eastern Europeans), and are active in the labour market (Farina, Ortensi, 2010).

Conclusion

The observation of abortion developments at a European, national and regional level, enables us to identify the areas of concern in the abortion of migrant women.

Firstly, repeat abortions are very common in Switzerland, Spain and Italy among Asian and Romanian women (Addor et al., 2003; Ministero della salute, 2015) and selective abortions (to the detriment of female foetuses), are recorded in Albania, Kosovo, and Montenegro, as well as among migrant women from these countries (Hennen, 2013).

Secondly, illegal abortions are still frequent among foreign women, and are estimated at between 3,000 and 5,000 every year in Italy (Ministero della salute, 2015); we cannot forget unsafe abortions, because women often use Misoprostol, a drug for the treatment of ulcers which can cause a miscarriage when taken in excessive quantities.

The third area of concern is that of conscientious objection, which in several European countries, including Italy, has shown a steady increase, hindering, often in a significant way, the opportunity for women (especially migrant ones) to request the termination of a pregnancy within the timescales prescribed by the law.

In 2012 the percentage of objector gynaecologists rises to 69.6% with very high peaks in the southern regions (80.4%) (Ministry of Health Report, 2014).

As a consequence of conscientious objection, on 2 April 2014 the Committee of Social Rights of the Council of Europe (following a request from the International Planned Parenthood Federation European Network and the Italian General Confederation of Labour) has reproached Italy and stated that conscientious objection «violates the right to health for women who want to terminate a pregnancy, according to Article 11 of the European Social Charter».

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ISMU Foundation - Initiatives and Studies on Multiethnicity
Via Copernico 1, 20125 Milano Italy
ismu@ismu.org
Tel. +39 2 67877927
Fax +39 2 67877979