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Medicalization of Abortion in Poland: How Medicine Affects the Lives of Women

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The process of medicalization of abortion in Poland began when pregnancy termination procedures were legalized in 1956. The context in which that was possible is important: it happened under the communist rule as part of the Soviet bloc. The main goal of communism was to promote scientific approach to medicine and to eliminate popular folk medicine. The communist rule was also characterized by state feminism, which involved mass employment of women in industry and other occupations. The positive side to the changes was the fact that health care was free of charge. However, the system excluded the care of village healers and abortionists who were replaced by obstetricians-gynecologists, usually men. According to the official propaganda, an abortion that was not performed by a medical professional was dangerous for a woman's health and could cause her death. Indeed, abortion-related mortality decreased, but the rate of abortion itself did not fall; it gradually increased. This is typical for countries with no free market, including communist ones, where access to contraceptive pills is very limited with abortion being the primary method of birth control. After the fall of communism in Poland, access to abortion was severely restricted; nevertheless, contraceptive pills and morning-after pills are available on prescription from pharmacies. The total fertility rate decreased in comparison to the period of communism and its broad access to abortion. Therefore, I maintain that the process of medicalization of abortion has not ended despite the partial disenfranchisement of women.

Keywords: medicalization, abortion, gynecologists, communism, feminism, pro-life movement, church

Introduction

The process of medicalization of abortion in Poland was shaped by three factors. The first one is the introduction of communism, which was based on scientific medicine. Physicians from the educated intelligentsia were supposed to treat members of lower social classes, particularly those living in rural areas and educate them on hygiene and health (Szpak, 2018). Physicians were also expected to be able to persuade women to undergo abortions and to see performing abortion procedures as their mission. The second factor stood in opposition to the first one: the Catholic Church expressed its growing objection against the increasing imposition of birth control among women. This paradoxically contributed to an increase in clandestine abortions. The third factor is in a way the result of the first two factors: there was a notable increase in the knowledge and awareness of birth control methods among women thanks to widespread propaganda in the media such as women's guidebooks and magazines (Kuźma-Markowska, 2020; De Zordo & Mishtal, 2011).

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This state policy was based on the provision of appropriate training sessions and courses to physicians and on making it possible for them to participate in international conferences. It is also worth taking note of the fact that the beginning of the medicalization process in Central and Eastern Europe was different to that in the Western world since medicalization was part of a political project that was imposed and centrally governed by the ruling party, similar to the whole health care system (Freidson, 1988). The abortion ban frequently described in the literature (Mishtal, 2009; Hussein, Cottingham, Nowicka, & Kismodi, 2018), which was introduced shortly after the fall of communism in 1989, is invariably considered to be associated with the influence of the Catholic Church; however, it should also be appreciated that the accessibility of abortion was associated in Poland with the unwanted government, and therefore, the ban was a way of rejecting communist standards. Obviously, these processes are complex and I would like to demonstrate further in the paper that as much as having a significant influence on abortion being legalized in the 1950s, medical professionals also contributed to it being banned in the 1990s.

In sociology, medicalization is associated with the notion of social control whereby physicians have too much authority over patients by setting the standards of health and disease (Zola, 1972). Therefore, it can be said that communists, who held science as the highest value, achieved the most in terms of medicalization, sometimes by forceful introduction of medical practices into the everyday lives of individuals (e.g. birth control in China and one-child policy; Ebenstein, 2010). According to Michel Foucault (2010), scientific medicine and psychology impose ways of thinking on individuals from lower social strata, with those individuals subjecting their bodies without reflection to the heartless control of physicians. In other words, physicians use their knowledge in order to exert power over as many patients as possible. This type of medicalization was brought about by the state, not by a conscious choice of individuals. Biopolitics theory is applicable here (Foucault, 2010), since birth control through abortion is part of state policy.

Conrad, Mackie, and Mehrotra (2010) believed that medicalization is a process in which non-medical problems are defined and treated as medical problems, usually as diseases or dysfunctions. There is a growing concern that medicalization increases the costs of health care. An example of medicalization in the Western world is giving birth in hospital, which has contributed to an increase in the risk of dangerous consequences of access to medical technology. Johanson, Newburn, and Macfarlane (2002) stated that childbirth has become medicalized with excessive numbers of unnecessary cesarean sections. In Poland, there were successful efforts towards demedicalization of childbirth in the 1990s (Domańska, 2005); however, currently, the rate of cesarean sections in Poland is one of the highest in Europe (389 per 1,000 live births[1]). However, many authors (Cameron, 2018; Shepherd & Turner, 2018) maintain that the medicalization of abortion is a positive phenomenon since it promotes women's rights, while a reverse process would be unfavorable and would contribute to discrimination against women. Lack of access to safe abortion in the health care system, particularly for women from poorer socioeconomic backgrounds, is of particular significance (Oberman, 2018). Such an approach can be explained by a different understanding of abortion from that of childbirth in terms of medicalization: abortion is not treated as an ordinary medical service, but as a factor shaping "reproductive health".

The aim of this article is to present the process of medicalization of abortion in Poland from the point of view of social, political and medical change. In Poland, this phenomenon is more complex than in other European countries: apart from the specific situation caused by the COVID-19 pandemic restrictions and the

[1] OECD. Website: https://data.oecd.org/health.htm.

associated limited access to health care, medical services for women are relatively easily accessible and free of charge under the public insurance system. However, abortion is an exception: current regulations on abortion were introduced in 1993, when the Parliament passed a ban on socially motivated abortion after the fall of communism. In October 2020, the Polish Constitutional Tribunal revoked the right of access to abortion due to suspected incurable disease or deformation of the fetus; on January 27, 2021, the Tribunal published this regulation and the ban came into force[2]. The law permits abortion in two other circumstances: when continuing the pregnancy is a threat to the woman's health or life and when there is a reasonable suspicion to believe that the pregnancy is the result of rape or incest. However, currently legal abortion is practically impossible to obtain. For this reason, feminists from the Women's Strike movement (Polish: Strajk Kobiet) organized numerous protests in Polish cities.

Method of Analysis

This article is a review of literature from the fields of sociology, medicine, demography, social history and feminism. I have analyzed social and political change over the last few decades in order to present the exact process of medicalization. To this end, I have used various sources, particularly Polish literature and research; I have also used the results of my own qualitative study on the subject of abortion. My study included medical professionals: gynecologists, nurses and midwives (Maciąg, 2019). I conducted 18 in-depth interviews in a large city (Warsaw) and in a small town in the south of Poland. I also analyzed official data and letters of women who had undergone abortion published in magazines and other publications for women and by the Federation for Women and Family Planning (Polish: Federacjana Rzecz Kobieti Planowania Rodziny). Based on that, I collected comparative material for my interviews, which include answers to the questions about the way abortion is performed, the attitudes of gynecologists towards abortion and those of feminist publications towards male physicians.

Medicalization Process: Abortion Act of 1956

As I have mentioned before, after the Second World War a communist system was introduced in Poland. With it, a central, state-governed health care system was established, which was based on the one existing in the Soviet Union (Kuźma-Markowska, 2020). Soon after the war, the Criminal Code of 1932 was in force in Poland regarding abortion, which allowed it only under exceptional circumstances: in the case of rape, incest and a pregnancy of a minor. During the war in 1943, in the areas of Poland under Nazi occupation (called the General Government at the time) a regulation was issued allowing Polish women, as "racially foreign" individuals, to have abortion on demand (Zielińska, 1990; 1993).

In rural areas, abortion was widely performed by older women from the community who functioned as healers and midwives, which was associated with trust in care provided by women (Ciechomska, 2018). Magical procedures and rituals were used for treatment, which often stood in contradiction to the practiced religion (Piątkowski, 2012). The official propaganda stigmatized the procedures of village abortionists as unhygienic since they contributed to a high female mortality rate and were performed outside of hospitals (Maciąg, 2019). In the official health care system, hospitals and clinics were initially present only in large cities and physicians charged their patients for their consultations.

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[2] Federacja na Rzecz Kobiet i Planowania Rodziny. Website: https://en.federa.org.pl/.

The abortion act was introduced at a point when an increasing number of births were recorded. Neo-Malthusianism (a view opposing overpopulation) was not promoted in the countries of the Soviet bloc. Moreover, Poland at the time was still rebuilding its population after the demographic loss associated with the war. However, at some point the government started to campaign for limiting reproduction since otherwise new housing, schools and kindergartens would have to be built and there were no financial resources available for that; in 1955, approximately 800,000 children were born (Lesiński, 1961). On April 27, 1956, the government introduced an act on the conditions for legal abortion, which allowed abortion for social reasons, when pregnancy was the result of rape and for medical reasons. At the same time, the promotion of Marxist ideology was discontinued in terms of urging "the masses" to seek employment. A somewhat different type of propaganda was launched, which emphasized planned motherhood and having a small family (Kuźma-Markowska, 2013). This stood in contradiction to the policy of the Catholic Church, which opposed abortion and contraception and promoted the doctrine of "a large nation". New regulations were based on a similar act introduced in the Soviet Union (1955). At the same time, women were being employed in industry, education and science, and preschools and nurseries were being opened. These new measures combined with access to abortion were called "state feminism" of the communist government by De Zordo and Mishtal (2011). Feminists had their own organization called Women's League (Polish: Liga Kobiet); however, the feminist movement was present only in propaganda since the regime imposed drastic restrictions on freedom of speech (Heinen & Matuchniak-Krasuska, 1995). According to the government, medicine as a science was supposed to ensure safe procedures which could only be performed by physicians in hospitals. Private and non-scientific forms of care were reduced or closed down by imposing high taxes and persecuting women who functioned as village healers, midwives and abortionists (Kuźma-Markowska, 2017). People used free medical services very reluctantly, particularly in rural areas, and the intention was to change their mentality, since infant mortality rates were high and many abortions were performed without proper hygiene, which resulted in deaths of women.

The state had two opponents in this respect: one of them was the Catholic Church, which organized pro-life masses with high numbers of participants. Some gynecologists who lost their business of paid abortions were another organized opponent. In the 1950s, there were not many physicians in Poland, but they had a strong position: in 1955, there were only 8,169 physicians in total, including 827 obstetricians-gynecologists (Koronkiewicz, 1998; apart from physicians, feldshers similar to physician assistants worked at the time, who did not have the diploma of physician). Gynecologists were opposed to the new regulations, because the Stalin regime introduced many limitations to their practice. First, the government ordered private practices to be closed down, labeling them antisocialist activity. Physicians' self-governing body, an independent institution that doctors could appeal to on professional issues, was also closed down. The right to conscientious objection to abortion was also taken away from physicians. Physicians who refused to perform the procedure were dismissed from work (Maciąg, 2019). Physicians were allowed to have private practices only after a process of negotiation. In return, they were to perform free-of-charge abortions in hospitals (Okólski, 1983).

The introduction of communism involved a significant change: the majority of gynecologists were male and they examined intimate areas of women's bodies (Wejbert-Wąsiewicz, 2011). Medicine entered areas which had not been considered diseases before and which had been dealt with at home, such as pregnancy, giving birth, motherhood and child feeding. New health measures were introduced such as pregnancy follow-up, infant testing, artificial feeding and mass vaccination. The majority of the population did not trust the new

forms of care; moreover, even the fact that the services were free of charge raised significant suspicion (Szpak, 2018). In Poland, it was still mainly men who became physicians, although the proportions between the sexes started to slowly change compared to the interwar period. In the Soviet Union, the situation was different: after the revolution of 1917, women were willingly accepted to medical schools in line with the idea of class equality (Freidson, 1988).

In 1960, the official figure for abortion was 223,795 procedures, in 1970 it was 214,034, and in 1980 the figure was 137,950 (after the calculation methodology was changed, with miscarriages being registered separately since 1980; Maciąg, 2019; Statistics Poland, 1990). At the same time, at the beginning of the 1980s more than 700,000 children were born; however, the demographer Marek Okólski (1983) estimated that 620,000 abortions were performed. Despite the fact that abortions were available in hospitals free of charge, many women preferred to use paid services of private gynecologists to ensure anonymity. The majority of abortions performed in gynecologists' offices were not recorded (Okólski, 1983) and incomplete data were presented by the government (10,000-13,000 procedures at the beginning of the 1980s; Maciąg, 2019). Okólski wrote that the state tampered with the official data, reducing the apparent scale of the problem in order to reassure the public.

Contraception was poorly available and of low quality; therefore, abortion had the same function as contraceptives in countries where they were more widely available (Kulczycki, 1999). In 1957, the Women's League established the Conscious Motherhood Society (Polish: Towarzystwo Świadomego Macierzyństwa) supervised by the state, which became part of the International Planned Parenthood Federation (IPPF). Some of the Society doctors started their activity already before the war: a well-known physician and columnist Tadeusz Boy-Żeleński was one of the founders of a planned parenthood clinic. The new Society's intention was to promote contraception and conduct research on the subject. Polish physicians traveled beyond the Iron Curtain to receive training (Kuźma-Markowska, 2013). Factors such as intensive activity, participation in numerous conferences and the fact that abortion had become a woman's right in Poland were all conducive to a positive attitude towards the Polish scientific community in the West. However, Kulczycki believes that abortion rates were the highest in developing and communist countries due to a lack of easy access to contraception as a result of absence of free market. Currently this is the case in communist and post-communist countries (cf. abortion rates in Cuba, Russia, and China; Johnston, 2020) and in certain African countries; however, the cultural and economic complexities should also be taken into consideration (Kulczycki, 1999). The activity of the Conscious Motherhood Society eventually decreased towards the end of the 1960s, although it continued to publish numerous guides. Interestingly enough, when training physicians, the Society took into account cultural and organizational factors affecting the acceptance of contraception in Poland: on the one hand, natural birth control methods promoted by the Catholic Church were included; on the other hand, initial prejudice among rural communities against any changes in family life and health issues was anticipated (Kuźma-Markowska, 2013).

After 1956, additional regulations related to the abortion act included some strict formal requirements that made access to hospital procedures difficult for women. Before abortion was performed, the woman was required to report to her district physician who was supposed to obtain an opinion on the patient from the workplace and local area boards. It was only in 1959 that these provisions were withdrawn. At the same time, the police (called "milicja" in Poland at the time) prosecuted illegal rural practices. People often had more confidence in the skills of village abortionists than physicians (Szpak, 2018). However, with time, the situation

changed: a decreasing number of people practiced folk medicine since it was unprofitable, heavily taxed and socially stigmatized. A physician's appointment was free of charge and medicine was increasingly popular among people. In this way, confidence in physicians was increasing, although initially people were wary of the novelties promoted by doctors and nurses. The world of magic and myth passed into oblivion, since medical professionals offered chances of being cured by medicines and vaccinations. Universal education was introduced and advertisements appeared in women's magazines. Many of them promoted knowledge on health. There were also publications on sex life and articles debating abortion. However, they were only accessible to individuals from small social groups, mainly those living in cities (Kuźma-Markowska, 2020).

At the same time, the process of medicalization of abortion progressed, although it was different than in Western countries and even the Soviet Union. In the West (United Kingdom, France), there was an open debate on women's rights, although abortion was legalized there only many years later. As mentioned before, free abortion was allowed in the Soviet Union many years earlier (in 1920 for the first time); however, due to political reasons, Polish society definitively rejected communist models after the war. The only official institution in which Polish people put their confidence was the Catholic Church. There were masses held against abortion which were at the same time political demonstrations against the authorities (Heinen & Matuchniak-Krasuska, 1995).

However, everyday life was different from big political events. A well-known gynecologist Michalina Wisłocka wrote that an appointment with a gynecologist was an unusual event for a woman for a long time, which she found difficult to become accustomed to. Sex life was associated with certain customs, rituals and language (Wejbert-Wąsiewicz, 2011). Interaction with a male physician was a more significant mental barrier than today; in such a situation, after the woman took off her clothes, her integrity as a person was completely compromised and she was often unable to entrust her secrets with a stranger. The institutional settings were out of the ordinary, as was the language that imposed new practices, including exposing one's body. Wisłocka wrote that in the 1970s women still had sex with the duvet pulled over and during a medical appointment they were not able to pronounce or understand the word "uterus".

Physician education in medical schools was part of medicalization of abortion. To this end, new obstetrics and gynecology textbooks were developed with separate chapters on the aim, need and technique of the abortion procedure. Another element of physician education was a kind of social Darwinism whereby it was argued that abortion was justified in the case of poor mothers and those having many children; thus, professional performance of abortion was a physician's mission (Lesiński, 1961). Therefore, the use of persuasion with an appropriate language when speaking to the patient during a consultation was important. Language played a major role in persuading women to undergo abortions; in medical school, future physicians were taught that during the prenatal period there was a fetus rather than a child in the mother's womb. This was important in the communication with a woman who had doubts about having a child.

Mishtal wrote that after the fall of communism in 1989, it was the Catholic Church that imposed control over the private sphere of women (Mishtal, 2009). This is certainly true since it did happen in the domain of official language and legal restrictions. However, a comprehensive institutional control was imposed by the state on the private sphere of women already in the 1950s and 1960s by organizing antenatal screening, hospital births and massive vaccination of children. This was a major change for women, who, as mentioned previously, were initially reluctant to undergo medical examination (Szpak, 2018). According to Foucault's theory, the state supervises many areas of the lives of individuals using medicine, demography and population policy, only

seemingly giving people the freedom of choice (Foucault, 2010). As mentioned before, Catholic bishops and priests were against abortion, and they were widely supported by members of the Catholic Church in society. Medical schools also supported the Church regarding the abortion ban. They submitted petitions with state institutions, particularly during the period of legal activity of the Solidarity trade union in 1980-1981 (Zielińska, 1990), although there was no consensus on the matter among medical professionals. Among the communist bloc countries, it was only in Poland that the government did not close down the institution of church due to strong social opposition (Staniszkis, 1984). These circumstances were of significance later, when the Catholic Church authorities demanded abortion to be banned.

Prohibition of Abortion for Social Reasons Since 1993 and for Impairment of Fetus Since 2021

Legal abortion in health care institutions contributed to a change in the awareness of Polish people. A large proportion of women and men became accustomed to the fact that abortion was free of charge and performed in safe conditions. This became strikingly apparent at the beginning of systemic transformation after the fall of communism, when Catholic members of Parliament submitted a draft act on complete prohibition of abortion. Even though the Church had demanded that for a long time, it was only then that such a change was possible. A heated social debate ensued, since feminists, left-wing and post-communist politicians did not want any change. A public opinion poll report shows that since 1992, Polish people have invariably agreed with the right to abortion in the following circumstances: when continuing the pregnancy is a threat to a woman's health or life, when the pregnancy is the result of rape or incest and when it is known that the child will be born impaired. However, the majority of the Polish public oppose abortion for reasons of the woman's difficult personal situation, her simply not wanting a child and when the woman is in a difficult financial situation. In the last case, there has been the highest change in responses, since in 1992 nearly half of the respondents (47%) supported the right to abortion in such circumstances, and now only 20% do so (Feliksiak & Roguska, 2020). The legal ban on abortion refers to the social reasons mentioned above; apart from that, recently the abortion ban was extended to the child being born ill or disabled.

After numerous amendments were made to the draft act, on January 7, 1993, the Act on family planning, protection of human fetus and conditions for legal pregnancy termination was passed. By 2021, abortion was available in three cases: when continuing the pregnancy was a threat to the woman's health or life, when antenatal screening or other medical evidence indicated that there was a high likelihood of severe and irreversible impairment of the fetus or of an incurable potentially unsurvivable disease and when there was a reasonable suspicion to believe that the pregnancy was the result of rape or incest.

Towards the end of the 1990s, the official figures regarding abortion procedures were decreasing: 1989: 82,137 vs. 1992: 11,640 (Statistics Poland, 1990; Maciąg, 2019). In 1990, a regulation of the Minister for Health came into force which limited access to abortion procedures: a woman who wanted to have her pregnancy terminated had to obtain the consent of two consultant physicians and a psychologist. Kulczycki (1999) noted that in the same period (1989-1990) the number of abortions recorded in Polish hospitals decreased; instead, there was a two-fold increase in the figure for spontaneous miscarriages. Interestingly enough, the same phenomenon was independently corroborated by gynecologists in my study more than a decade later: spontaneous miscarriages were recorded when induced abortion was actually performed. Such a procedure was covered from public funds, but the gynecologist also demanded payment for themselves from

the patient (Maciąg, 2019). Currently, the National Health Fund (NFZ) reports an annual figure of 85,000 for miscarriages; however, it is not known how many of them are induced abortions (NFZ, 2021).

Nowadays, many doctors, including gynecologists, cooperate with the Catholic Church, although there are differences in the stance on ethical issues concerning abortion in the medical community (Hussein et al., 2018). In the 1980s, a significantly larger proportion of physicians supported the Church rather than the government. This attitude was based on the universal membership of the medical community with the Solidarity trade union, which had become a social anti-communist movement. Another reason for this attitude among physicians was that the government established low pays for occupations requiring higher education: the communist authorities treated blue-collar workers better than white-collar workers (Ost, 2006). When in 1989 the draft act prohibiting abortion mentioned above was proposed in Parliament, physicians continued to voice their demands for pay rise; as far as working conditions are concerned, the new authorities did not treat medical professionals better than communists for many years (Stepurko, Pavlova, Gryga, Murauskiene, & Groot, 2015).

In 2019, there were 89,119 employed physicians in Poland in total, including 3,537 obstetricians-gynecologists (Centrum e-Zdrowia, 2020). Thus, the number of obstetricians-gynecologists increased 4.2 times compared to 1955. However, the ratio of active physicians relative to population size in Poland is notably one of the lowest in the world (2.4 per 1,000 inhabitants[3]). In the context of long waiting lists and physical queues in the public health care system that is based on state insurance, private medical providers offer easier access to care. However, many gynecologists refuse to perform legal abortions based on conscientious objection, a right that physicians regained at the beginning of the post-communist period. They also do not issue referrals to specialist testing out of fear of being held complicit in abortion. In 2014, approximately 4,000 physicians and medical students signed a declaration of Catholic faith with regard to conscientious objection to abortion (Półtawska, 2015). In this declaration, they obliged to refuse to perform abortion and prescribe contraceptive pills. This event was criticized by the Federation for Women and Family Planning and left-wing politicians, who accused the signatories of breaking the law, stigmatizing women and denying them human and patient right protection. In the meantime, a well-known gynecologist Bogdan Chazan refused to perform a legal abortion and to refer the patient to a different gynecologist who could perform this procedure. He exercised his right to conscientious objection; however, in the case of refusal to perform abortion, a physician was then obliged by law to indicate another place where the procedure could be performed. As a result of pressure of the Federation for Women and Family Planning, Dr. Chazan was dismissed from his role as director of an obstetric hospital. However, the Constitutional Tribunal ruled that a gynecologist does not have to indicate another physician who would perform the procedure (Hussein et al., 2018).

Other gynecologists perform abortions outside of the formal system, usually demanding high fees (approximately PLN 2,000 according to Maciąg, 2019; PLN 1,000-3,000 according to De Zordo & Mishtal, 2011). Abortion tourism became widespread among women, since a trip abroad to have an abortion turned out to be cheaper than a procedure in Poland. As mentioned before, the Catholic Church successfully pressed for legal change on the matter; in addition, the medical community, including some gynecologists, strove to achieve abortion ban to protect their professional interests. In 1991, a Code of Medical Ethics was introduced at the Polish National Congress of Physicians, which established fundamental principles for responsibility regarding “the transmission of human life”. Currently, the physicians’ self-governing body (Polish Chamber of

[3] OECD. Website: https://data.oecd.org/health.htm.

Physicians and Dentists[4]) still declares the protection of the life of the fetus, explaining that abortion is not reimbursed by the National Health Fund (Maciąg, 2019). However, after the Constitutional Tribunal judgment in 2020 on the prohibition of abortion as a result of fetal impairment, the medical chamber raised a formal objection (Stanowisko Prezydium NRL 27.10.2020). Some gynecologists and leaders of the medical community, expressed a separate position and were defending the judgement in the media.

After the anti-abortion law was enacted in 1993, very few procedures were recorded: 874 in 1994, with the lowest figure being 124 for 2001, when hospital authorities were afraid of repercussions from supervising bodies; many hospitals introduced their own internal abortion bans. Towards the end of the 1990s, three state-reimbursed contraceptive pills appeared in pharmacies. However, the government did not agree to the reimbursement of other pills. Currently, the state partially reimburses insured individuals for 15 types of oral contraceptives, charging relatively low prices on them (from PLN 5 to 20) and provides the service of fitting an intrauterine device free of charge to the insured (Sejm Rzeczypospolitej Polskiej, 2018). In 1996, the post-communist government allowed abortion due to poor financial situation; 3,047 procedures performed for this reason were recorded. However, a year later, the Constitutional Tribunal ruled that such a provision is inconsistent with the Polish Constitution; consequently, the legal situation of 1993 was reinstated.

When making its decisions, the government takes into consideration the position of the Catholic Church. In 2016, the Law and Justice government expressed their support for the draft act called “Stop abortion” (Polish: “Zatrzymaj aborcję”) banning abortion altogether. At the time, feminists organized “black protests” in cities, at workplaces and at universities (Hussein et al., 2018); as a result, the government ceased debating abortion for some time, much to the dissatisfaction of the Church.

Over a period of ten years, there was a twofold increase in the official number of abortions: there were 538 recorded procedures in 2009, whereas in 2018, the figure was 1,076 (Sejm Rzeczypospolitej Polskiej, 2018). The majority of abortions were performed due to fetal impairment: the figure increased for the respective years from 510 to 1,050, which accounted for 98% of all procedures. During the interviews conducted by me, gynecologists and a geneticist told me that the majority of procedures performed for that reason were not recorded despite the fact that they were allowed by law. Thus, it is not known how many illegal abortions are performed. The Federation for Women and Family Planning estimates the size of “the abortion underground” to range between 80,000-200,000 procedures (Hussein et al., 2018; a different publication provides an estimated figure of 120,000-150,000 procedures[5]). In contrast, organizations associated with the Catholic Church provided the figure of 7,000-14,000 illegal procedures (Deszcz, Stachura, Trzcińska, & Wronicz, 2006). All of the calculations above are hypothetical and they were devised for political purposes associated with election campaigns; they were based on earlier opinions of demographers that did not take into account the current conditions (cf. Best, 2001). In addition, both groups provided different data before the abortion ban was passed in 1993: at the time, feminists quoted the underestimated official data, while the pro-life movement overestimated the size of the abortion underground to be 1,000,000 (Maciąg, 2019). Meanwhile, the demographer Igor Jaruga (1999) conducted a nationwide survey in which he estimated the number of abortions using objective indices of fertility and contraceptive use among women of childbearing age. He calculated that as of the study, there were not more than 100,000-120,000 abortions and the rate was decreasing, since

[4] Retrieved from https://nil.org.pl/aktualnosci/5122-pnrl-o-wyroku-tk-dot-aborcji.
[5] Federacja na Rzecz Kobiet i Planowania Rodziny. Website: https://en.federa.org.pl/.

contraception started to slowly replace pregnancy termination. This study, which is not taken into account in public debate at all, shows the effects of medicalization, advertising and free market, in which pharmaceutical companies started to operate. To support this view, I would also like to quote other data: in a representative nationwide survey of 2014, half of women aged 15-49 in Poland admitted to using contraception. The majority of women declared using condoms (42%). Oral contraceptives were used by 29% of women, while natural birth control methods were used less frequently (Statistics Poland, 2016). In addition, a morning-after pill is available in pharmacies on prescription: in 2015, 179,300 packs were sold (Karwowska, 2017). Birth data confirm the trend to postpone the decision to have a child until the next age range: in the 1990s, women usually had their first child when aged 20-24, whereas now they have it at the age of 30-34. As a result, a low total fertility rate is observed: in 1989, it was 2.1, while the current rate is 1.3[6].

In Poland, mifepristone (RU-486) is not available; however, unofficially, some gynecologists administer it to their patients. The Federation for Women and Family Planning promotes the use of mifepristone (Maciąg, 2019). Already in 2003, feminists arranged for the Dutch ship Langenort of the organization Women on Waves to arrive at the Polish coast. On the ship, the feminists conducted seminars for women. There is a social problem associated with the introduction of mifepristone to medical practice, because it raises understandable moral indignation. To quote the comment on the introduction of RU-486 in the USA made by Joffe and Weitz (2003), the actions of Polish feminists are similarly intended to “normalize the exceptional”.

The morning-after pill was introduced in a different way in Poland in 1996, when the left-wing Alliance for the Democratic Left (SLD) government allowed it to be marketed in Poland as a contraceptive that works up to 72 hours after sexual contact with the package leaflet indicating that it does not cause pregnancy termination. The majority of the gynecologists with whom I conducted interviews assured me that this tablet does cause miscarriage. Some of the physicians issue prescriptions for it and others do not and are against it. A morning-after pill is an effective “contraceptive” when there is no access to abortion; however, it was actually introduced “on demand” of the pharmaceutical lobby.

It is important to ask the question whether legal restrictions and prohibition of abortion cause abortion to become demedicalized. This would mean that medicine is being withdrawn from abortion. In the official domain, such a change has indeed happened in the language of two areas: legal acts and medicine. Since the 1990s, sociologists who study the concept of social discourse (Heinen & Matuchniak-Krasuska, 1995) have noticed huge changes. Religious language, as opposed to medical language, became a permanent part of the social debate: the term “conceived child” replaced the term “fetus” (“embryo”) and “procreation” replaced “reproduction” etc. (Graff, 2001). New terms started to circulate in legal language as well: in the Criminal Code, the term “conceived child” also replaced the term “fetus”. However, it is worth pointing out that the “old” terms were introduced along with the process of medicalization beginning in the 1950s, when scientific medicine broke ties with the traditional religious language and family aspects such as giving birth at home, baptizing children after birth and treating abortion as a sin.

In my study, midwives and nurses said that some women have abortions at home on their own and others use the services of the abortion underground. Unassisted abortion could be a sign of demedicalization, but in many cases women need medical intervention in hospital. Women seek the advice of other women who are in a

[6] Statistics Poland. (2020). Website: https://stat.gov.pl/en/ [Source: Statistics Poland. (2020). http://swaid.stat.gov.pl/en/Demografia_dashboards/Raporty_predefiniowane/RAP_DBD_DEM_4.aspx].

similar situation, including on Internet forums, and buy tablets on the Internet (based on my survey, cheap medicines used for stomach pain can also be used). The process of abortion is often controlled by a gynecologist when a woman has sought the advice of a physician. Sometimes the procedure is recorded as a spontaneous abortion in order to conceal the actual intention from the police, to receive reimbursement from the National Health Fund and ensure that there is appropriate documentation to make the procedure look legitimate in the eyes of hospital staff. Thus, one can only speak of partial demedicalization; it is partial since there is no legal confirmation for many medical acts performed illegally.

Medicalization of Genetics and Antenatal Screening

Recently, there has been a big social debate regarding moral justification for medical selection of children with disabilities. There is a paradox in that on the one hand, campaigns are run for the integration and assistance of children with disabilities and their caregivers, while on the other hand, it is stressed that they can be "killed" before birth. Governmental data show that after 30 years of age, the older the women are, the more likely they are to decide to have an abortion if the fetus is found to be impaired. This correlates with age since older mothers have a higher risk of fetal impairment. Such decisions are made by better educated women who are aware of their rights, since they know where to go in the case of an unfavorable diagnosis from their gynecologist (Sejm Rzeczypospolitej Polskiej, 2018).

Medical genetics and antenatal screening soon started to address an increasing demand among patients for the diagnosis of conditions such as Down's syndrome, Turner syndrome and Edwards' syndrome. In such cases, married and unmarried couples chose abortion. Members of the pro-life movement called this legal option "eugenic abortion", associating it with Nazi eugenics. The activity of the pro-life movement intensified after the right-wing Law and Justice party won election: the right to have an abortion due to fetal impairment was expected to be revoked. Moreover, members of the pro-life movement are closely associated with the community of families with disabled children, particularly children with intellectual disability, and it was that community that proposed draft acts to ban abortion on several occasions (Korolczuk, 2016). One of the main initiators of legal change was Kaja Godek, a pro-life activist whose initiative became popular in Polish society, with 830,000 citizens signing a letter of support for her draft abortion act. Despite having a majority vote in Parliament, the Law and Justice party did not put the draft act to a vote for three years due to the resistance expressed by feminists during the black protests mentioned earlier.

Complete demedicalization of abortion due to fetal impairment seems to be impossible at this point since the pursuit of a healthy body requires giving birth to children of perfect health. Thus, it is understandable that a decision to have children with physical or intellectual disabilities seems irrational; however, it needs to be noted that some women consciously decide to have children who were diagnosed with developmental or genetic defects before birth. Women had a right of choice on this matter up until the Constitutional Tribunal revoked it in 2020. Another ethical issue was whether waiting until natural birth occurred served any purpose when a child was diagnosed with an incurable disease that would lead to its inevitable death after birth. The revoked reason for abortion had been widely utilized, which caused divisions in the gynecological community (Maciąg, 2019).

As mentioned previously, the formal procedure for abortion due to fetal impairment was highly medicalized: it required antenatal screening, genetic testing and a referral. In my study, gynecologists said that there were concerns regarding the issue of such referrals due to the fear of being accused of complicity in

abortion. Despite poor accessibility, medicalization of abortion due to incurable disease or impairment of the fetus involved an elaborate and highly formalized system of medical procedures. A geneticist said during an interview that the couples who reported for invasive antenatal screening were practically only those who were prepared to choose abortion in the case of an unfavorable diagnosis. Up until recently, the majority of genetic and antenatal clinics did not issue referrals for abortion; for this reason, women who needed abortion visited a clinic in Warsaw that did. Likewise, the majority of clinics do not perform legal abortions fearing stigma and protests from pro-life activists.

In my study, gynecologists from a clinic that performed abortions said that many women do not make an independent decision to have an abortion, but are pressed to do so by the partner or his family. There are also observations that pregnant women visit doctors already in the first trimester in order to learn about the child's condition. Women often come for a follow-up visit with their partner in order to check "if everything is OK", "if the child will be born healthy". When the diagnosis is unfavorable, women are often left by their partners. Gynecologists say that a woman decides to give birth to a disabled child when she has a stable marriage and the child is not her first one, but she already has other children.

Medicalization involves inequalities in access to abortion, since any problem a pregnant woman may have limits her to the public health care system with access to services being limited by the referral system, waiting time for appointment and dependencies in the professional-layperson relationship. In this way, pregnancy is a medical problem, which generates costs and increasing problems with access to professionals. It is clear that a law that prohibits abortion creates access for the privileged, and women from lower social classes usually do give birth or incur debt in order to pay for abortion. During the interviews in my study, physicians, both male and female, put their patients into stereotypical categories. When I reviewed their responses, I noticed that they unwittingly created classifications using knowledge from their professional practice, which was probably based on established interpretations in their professional community (Schutz, 1953). The first category includes women with clearly defined goals who pay for services in private offices. These patients usually buy contraceptives and are ready to undergo paid abortion if necessary. In contrast, the second group of patients are those whom physicians see in public hospitals where health care is "free of charge". The physicians believe that the majority of those women come from poor families and communities, give birth to one child after another and often have big families (with three or more children). As a result, such women cannot afford contraceptives and according to physicians, they do not plan their families using appropriate prevention measures. Thus, according to the gynecologists, medicalization of abortion means awareness of one's rights or simply awareness of being a mother again; the surveyed physicians used the term "conscious" to characterize educated patients from higher social classes with a higher income who have that awareness and know what they want. At the same time, it is clear that these "conscious" women increase physicians' profits (Maciąg, 2019).

A liberal state allows an individual to pursue their plans and to freely choose the path that they want to follow in life. Up until 1989, Poland was a communist country (with state socialism), which involved a lack of civil liberties and freedom of speech, media censorship and a lack of freedom of association, for example in medical self-governing bodies or women's organizations. It can be denied that after the fall of communism, these freedoms are pursued in the domain of reproductive women's rights; however, the general sociocultural context needs to be taken into account. Some sociologists believe that the Catholic Church delayed the processes that were already present in other countries, i.e. women's liberation and the pursuit of gender equality (Mishtal, 2010). Apart from that, Polish society is attached to the traditional values of family and having

children. In the latter domain, there are tendencies similar to those in other countries such as childlessness, having only one child and living in cohabitation (Kwak, 2014; Mynarska, Matysiak, Rybińska, Tocchioni, & Vignoli, 2015).

In Poland, women pay much attention to health, which is associated with educational level and urbanization. The same factors apply to pregnant women reporting for follow-up visits (Statistics Poland, 2016). Family planning and pregnancy prevention using contraceptives is more common among the younger generation of women who do not remember the wide availability of abortion. A nationwide survey shows that women before 35 years of age had an abortion three times less frequently than those from older age groups. This is associated with a more frequent rate of abortion before the tightening of the law in 1993 (Hipsz, 2013). Despite the fact that the Catholic Church does not agree to sex education at schools, contraception is popular and that is the result of medicine advertising. In practice, it is only feminists and left-wing media that promote education regarding knowledge on family planning and taking conscious decisions to have children[7].

The analysis of letters of women who had an abortion shows that members of the feminist movement criticize the abortion ban and the health care system, but at the same time are satisfied with the activity of gynecologists who perform abortions (Maciąg, 2019). Feminists in Poland fight for free abortion, however, despite certain reports, the feminist movement is not as strong as elsewhere and such efforts are thus uncommon. An increasing number of publications have been appearing and women's demonstrations calling for free choice are being organized (Korolczuk, 2016) such as Women's Strike. There is also the pro-abortion activity of the Federation for Women and Family Planning. Feminists assume that gynecologists will support legal abortion. It is indeed the case, although the majority of gynecologists are men and there are very few gynecologists who openly support pro-abortion efforts. According to my study, female gynecologists are very cautious in how they talk about abortion. It is also worth bearing in mind that in their linguistic and symbolic façade, medical institutions support the protection of life. There are Catholic chaplains, baptisms after birth and conversations on religion in hospitals. In Poland, the majority of citizens declare affiliation with the Catholic Church and 40% of them declare being highly religious, which puts Poland high on the list of European countries (Evans & Baronavski, 2018).

Conclusions

The medical community controls the phenomenon of abortion and at the same time participates in the ethical discussion on the acceptability of abortion. Some gynecologists perform illegal abortions; women in a good financial situation undergo such procedures. An image of an educated woman who knows her rights, uses contraception and does not give birth has emerged, which is maintained by physicians. According to various theories, physicians have a very strong influence on society due to the position and respect that they enjoy and due to expansion of their power through skills and qualifications. Medicalization is a complex process, since physicians try to impose medical language and models of behavior, which makes it easier for women to liberate themselves from the norms imposed by the "patriarchal culture". At the same time, physicians impose the practice of giving birth in medicalized obstetrics settings. The first stage of medicalization of abortion began with the political and legal decisions of communism and the associated free services and raising women's awareness by physicians. The second stage of medicalization started in the 1990s, when women started to use

[7] Federacja na Rzecz Kobiet i Planowania Rodziny. Website: https://en.federa.org.pl/.

contraception and consciously plan their family life, career and sex life despite legal restrictions. As a result, the total fertility rate is low. Even though there is no access to abortion in Poland, women can buy a morning-after pill on prescription and they go abroad to have an abortion. The second stage of medicalization is very different from the first one and focuses on an individual and her choices, who is less likely to respect the imposed norms and sometimes expresses her rebellion during women's rights protests. One cannot say that abortion has been demedicalized, since the choices of young women are supported by medicine and pharmaceutical companies. Rather, one can argue for partial demedicalization, which has been hugely supported by the contraceptive market as a very profitable business for gynecologists and pharmaceutical companies. In fact, medicalization is also associated with language, advertising and new concepts such as "reproductive health" or "health market", which do not encourage having children, but encourage one to choose the practices recommended by business people working in the health sector: male physicians and pharmacists.

References

Best, J. (2001). *Damned lies and statistics. Untangling numbers from the media, politicians, and activists*. Berkeley, Los Angeles: University of California Press.

Cameron, S. (2018). Recent advances in improving the effectiveness and reducing the complications of abortion [version 1; peer review: 3 approved]. *F1000 Research,* 2018, 7 (F1000 Faculty Rev.), 1881.

Centrum e-Zdrowia. (2020). *Biuletyn Statystyczny 2020*. Retrieved from https://cez.gov.pl/fileadmin/user_upload/Biuletyny_informacyjny/biuletyn_statystyczny_2020_5fa959206ef00.pdf

Ciechomska, A. (2018). Ziołolecznictwo ludowe w Polsce. In K. Łukomiak (Ed.), *Wieloaspektowość antropologii kulturowej. Polityka—Kościół—Kultura*. Lodz: Wydawnictwo Archaegraph.

Conrad, P., Mackie, T., & Mehrotra, A. (2010). Estimating the costs of medicalization. *Social Science & Medicine, 70*(12), 1943-1947.

Czyżewicz, A. (1950). *Częstość poronień. Z Kliniki Położnictwa i Chorób Kobiecych UW*. Warsaw: PZWL.

De Zordo, S., & Mishtal, J. (2011). Physician and abortion: Provision, political participation and conflicts on the ground—The cases of Brazil and Poland. *Women's Health Issues, 21*(3 Suppl), S32-S36.

Deklaracja wiary lekarzy katolickich I studentów medycyny w przedmiocie płciowości i płodności ludzkiej. Wikipedia, Wolna encyklopedia. Retrieved from https://pl.wikipedia.org/wiki/Deklaracja_wiary_lekarzy_katolickich

Deszcz, J., Stachura, M., Trzcińska, B., & Wronicz, J. (2006). *Podziemie aborcyjne—mity I fakty*. Krakow: Polskie Stowarzyszenie Obrońców Życia Ludzkiego.

Domańska, U. (2005). Medykalizacja i demedykalizacja macierzyństwa. In W. Piątkowski and W. Brodniak (Eds.), *Zdrowie i choroba. Perspektywa socjologiczna* (pp. 311-322). Tyczyn: Wyższa Szkoła Społeczno-Gospodarcza.

Ebenstein, A. (2010). The "missing girls" of China and the unintended consequences of the one child policy. *The Journal of Human Resources, 45*(1), 87-115.

Evans, J., & Baronavski, C. (2018). *How do European countries differ in religious commitment? Use our interactive map to find out*. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2018/12/05/how-do-european-countries-differ-in-religious-commitment/

Feliksiak, M., & Roguska, B. (2020). *O dopuszczalności przerywania ciąży i protestach po wyroku Trybunału Konstytucyjnego*. Centrum Badania Opinii Społecznej Report 153/2020. Retrieved from https://www.cbos.pl/SPISKOM.POL/2020/K_153_20.PDF

Foucault, M. (2010). *The birth of biopolitics: Lectures at the College de France, 1978-1979*. New York: Palgrave Macmillan.

Freidson, E. (1988). *Profession of medicine. A study of the sociology of applied knowledge. With a new afterword*. Chicago and London: The University of Chicago Press.

Graff, A. (2001). *Świat bez kobiet. Płeć w polskim życiu publicznym.* Warsaw: WAB.

Heinen, J., & Matuchniak-Krasuska, A. (1995). Abortion in Poland: A vicious circle or a good use of rhetoric: A sociological study of the political discourse of abortion in Poland. *Women's Studies International Forum, 18*(1), 27-33.

Hipsz, N. (2013). *Doświadczenia aborcyjne Polek*. Centrum Badania Opinii Społecznej Report 60/2013. Retrieved from https://www.cbos.pl/SPISKOM.POL/2013/K_060_13.PDF

Hussein, J., Cottingham, J., Nowicka, W., & Kismodi, E. (2018). Abortion in Poland: Politics, progression and regression. *Reproductive Health Matters, 26*(52), 11-14.

Jaruga, I. (1999). Bezpośrednie determinanty płodności. Aplikacja modelu Bongaartsa dla Polski dla lat 1991 i 1995. *Studia Demograficzne, 2*, 95-120.

Joffe, C., & Weitz, T. A. (2003). Normalizing the exceptional: Incorporating the "abortion pill" into mainstream medicine. *Social Science & Medicine, 56*(12), 2353-2366.

Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalisation of childbirth gone too far? *BMJ, 324*(7342), 892-895.

Johnston, R. (2020). *Abortion statistics and other data, by Wm. Robert Johnston last updated 16 Feb. 2020*. Retrieved from http://www.johnstonsarchive.net/policy/abortion/index.html

Karwowska, A. (2017). *Ella One* tylko na receptę. Rząd utrudnia dostęp do awaryjnej antykoncepcji. Kto z niej korzysta? *Wyborcza.pl*, portal Gazety Wyborczej, 16.02.2017.

Korolczuk, E. (2016). Explaining mass protests against abortion in Poland: The power of connective action. *Zoon Politikon, 23*(7), 91-113.

Koronkiewicz, A. (1998). *50 lat służby zdrowia w Polsce*. Warsaw: Centrum Organizacji i Ekonomiki Ochrony Zdrowia.

Kulczycki, A. (1999). *The abortion debate in the world arena.* London: Macmillan Press.

Kuźma-Markowska, S. (2013). Międzynarodowe aspekty działalności Towarzystwa Świadomego Macierzyństwa w latach 50. i 60. XX w. In B. Płonka-Syroka and A. Szlagowska (Eds.), *Problem kontroli urodzeń i antykoncepcji. Krytyczno-porównawcza analiza dyskursów* (pp. 263-280). Wrocław, Poland: Uniwersytet Medyczny im. Piastów Śląskich.

Kuźma-Markowska, S. (2017). Walka z "babkami" o zdrowie kobiet: medykalizacja przerywania ciąży w Polsce w latach pięćdziesiątych i sześćdziesiątych XX wieku. *Polska 1944/45-1989. Studia i Materiały, XV*, 189-215.

Kuźma-Markowska, S. (2020). Marx or Malthus? Population debates and the reproductive politics of state-socialist Poland in the 1950s and 1960s. *The History of the Family, 25*(4), 576-598.

Kwak, A. (2014). *Współczesne związki heteroseksualne: małżeństwa (dobrowolnie bezdzietne), kohabitacje, LAT*. Warsaw, Poland: Wydawnictwo Akademickie ŻAK.

Lesiński, J. (1961). *Zarys zapobiegania ciąży.* Warsaw, Poland: PZWL.

Maciąg, R. (2019). *Społeczne znaczenia aborcji*. Warsaw, Poland: Medical University of Warsaw.

Mishtal, J. (2010). Neoliberal reforms and privatisation of reproductive services in post-socialist Poland. *Reproductive Health Matters, 18*(36), 56-66.

Mishtal, J. Z. (2009). How the church became the state: The Catholic regime and reproductive rights in state socialist Poland. In S. Penn and J. Massino (Eds.), *Gender politics and everyday life in state socialist Eastern and Central Europe* (pp. 133-149). New York: Palgrave Macmillan.

Mynarska, M., Matysiak, A., Rybińska, A., Tocchioni, V., & Vignoli, D. (2015). Diverse paths into childlessness over the life course. *Advances in Life Course Research, 25*, 35-48.

NFZ. (2021). *National Health Fund—Narodowy Fundusz Zdrowia, Statystyki*. Retrieved from https://statystyki.nfz.gov.pl/

Oberman, M. (2018). Motherhood, abortion, and the medicalization of poverty. *Journal of Law, Medicine & Ethics, 46*(3), 665-671.

Okólski, M. (1983). Abortion and contraception in Poland. *Studies in Family Planning, 14*(11), 263-274.

Ost, D. (2006). *The defeat of solidarity: Anger and politics in postcommunist Europe*. Ithaca & London: Cornell University Press.

Piątkowski, W. (2012). *Beyond medicine: Non-Medical methods of treatment in Poland*. Frankfurt am Main: Peter Lang.

Półtawska, W. (2015). Declaration of faith of Catholic doctors and students of medicine, on the sexuality and fertility of human beings. *The Linacre Quarterly, 82*(2), 99-100.

Schutz, A. (1953). Common-sense and scientific interpretation of human action. *Philosophy and Phenomenological Research, 14*(1), 1-38.

Sejm Rzeczypospolitej Polskiej. (2018). *Sprawozdanie Rady Ministrów z wykonywania oraz o skutkach stosowania w 2018 r. ustawy z dnia 7 stycznia 1993 r. o planowaniu rodziny, ochronie płodu ludzkiego i warunkach dopuszczalności przerywania ciąży (Dz. U. poz. 78, z późn. zm., Druk nr 339)*. Retrieved from https://www.sejm.gov.pl/sejm9.nsf/PrzebiegProc.xsp?id=AABDC381C9A618FDC125854B003673BF

Shepherd, L., & Turner, H. D. (2018). The over-medicalization and corrupted medicalization of abortion and its effect on women living in poverty. *Journal of Law, Medicine & Ethics, 46*(3), 672-679.

Staniszkis, J. (1984). *Poland's self-limiting revolution*. (J. Gross, Ed.). Princeton, NJ: Princeton University Press.

Statistics Poland. (1990). *Rocznik statystyczny ochrony zdrowia* (Statistical yearbook of health care). Warsaw 1990.

Statistics Poland. (2016). *Stan zdrowia ludności Polski w 2014 r.* (Health status of population in Poland in 2014). Central Statistical Office, Warsaw 2016.

Stepurko, T., Pavlova, M., Gryga, I., Murauskiene, L., & Groot, W. (2005). Informal payments for health care services: The case of Lithuania, Poland and Ukraine. *Journal of Eurasian Studies, 6*(1), 46-58.

Szpak, E. (2018). *"Chory człowiek jest wtedy jak coś go boli". Społeczno-kulturowa historia zdrowia i choroby na wsi w Polsce Ludowej*. Warsaw, Poland: Instytut Historii PAN.

Wejbert-Wąsiewicz, E. (2011). *Aborcja: między ideologią a doświadczeniem indywidualnym. Monografia zjawiska*. Lodz: Wydawnictwo Uniwersytetu Łódzkiego.

Zielińska, E. (1990). *Przerywanie ciąży: warunki legalności w Polsce i na świecie*. Warsaw: Wydawnictwo Prawnicze.

Zielińska, E. (1993). Recent trends in abortion legislation in Eastern Europe, with particular reference to Poland. *Criminal Law Forum, 4*, 47-93.

Zielińska, E. (2000). Between ideology, politics, and common sense: The discourse of reproductive rights in Poland. In: S. Gal and G. Kligman (Eds.), *Reproducing gender: Politics, publics, and everyday life after socialism* (pp. 23-58). Princeton, NJ: Princeton University Press.

Zola, I. K. (1972). Medicine as an institution of social control. *The Sociological Review, 20*(4), 487-504.