

Transnational healthcare practices in the enlarged Europe: the case of Polish migrant women in Ireland and their pregnancy and childbirth practices

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Declaration

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Table of Contents

Declaration	3
Abbreviations	8
List of Tables	9
List of Graphs	11
Abstract	12
Acknowledgments	13
Chapter 1: Introduction	15
Chapter 2: Theoretical perspectives: medicalisation, healthcare pluralism and the transnational lens	25
2.1 Women’s bodies as a playground of medicalisation?	26
2.1.1 Women and medical technology: between structure and agency	28
2.2 Biomedicine(s) and healthcare pluralism	36
2.3 Migration and healthcare: toward the transnational perspective	42
Chapter 3: Methodological approaches: multi-sited fieldwork	53
3.1 Qualitative methods of research and ethnographic inspirations	53
3.2 Multi-sited ethnography: Conducting research at various locations	54
3.2.1 Interviews	56
3.2.2 Elements of participant observation	61
3.2.3 Using secondary sources of information	63
Chapter 4: Polish migration into Ireland	67
4.1 Postsocialist Polish migration (1990s – 2004)	67
4.2 Polish migration in the enlarged European Union	69
4.3 Polish migration to Ireland	70
4.3.1 The socio-demographic characteristics of Polish nationals living in Ireland	71
4.4 Migration trends in Ireland	75
4.4.1 The diversification of migration in Ireland	76
4.5 From temporary migration to <i>intentional unpredictability</i> ? Changing strategies and mobility patterns among Polish migrants before and after the 2004 European Union enlargement	79

4.6	Polish migrant women in Ireland	82
4.7	Education, employment situation and migration strategies of Polish migrant women living in Ireland who participated in the study	85
Chapter 5: Irish healthcare services: a two-tier system.....		97
5.1	The structure of the Irish healthcare services and inequalities in access to them	97
5.2	Maternity care in Ireland	102
5.3	Inequalities in access to maternity care in Ireland	107
Chapter 6: Barriers, preferences and beyond: Polish migrant women's healthcare pathways in a transnational perspective.....		113
6.1	Lines of division: exploring the barriers that migrants face when accessing healthcare services in the host country.....	113
6.2	Exploring the barriers to healthcare services and searching for patterns among the "messy" healthcare pathways? Drawing a lesson from the studies on Polish migrants in the UK and Ireland	118
6.3	Polish outpatient clinics: a new point on the Polish migrants' map of access to healthcare services in Ireland	121
6.4	Relying on Polish or Irish maternity care: Polish migrant women's pathways within maternity care in Ireland	125
6.5	The link between migrant women's social position and their pathways within maternity care in Ireland	128
Chapter 7: Polish healthcare and maternity services: "personal" (but unequal) biomedical regime.....		133
7.1	The structure of the Polish healthcare services and inequalities in access to them	133
7.2	Maternity care in Poland	137
7.3	Inequalities in access to maternity care in Poland and women's quest for "personal biomedicine"	145
Chapter 8: Engagements with biomedicine: Polish migrant women in search for "personal biomedicine" in Ireland and in Poland		151
8.1	Polish migrant women's quest for personal biomedicine in Poland.	151
8.2	Polish migrant women's quest for personal medicine in Ireland	160
8.2.1	"All is fine. Thank you and goodbye": Polish migrant women in search of specialist care.....	161
8.2.2	"The magical touching of my belly [...] was not enough": Polish migrant women in search of more medical and screening procedures.....	165

8.2.3	“Everything was like a mass production” Polish migrant women in search of time and continuity of care.....	173
Chapter 9: A rip-off or a blessing? The ambiguous position of Polish clinics in Ireland as providers of “personal biomedicine”.		181
9.1	Ambiguous marketisation: Doctors as profit-makers?	182
9.2	Migrant doctors: “othering” the migrant	186
Chapter 10: Engagements with biomedicine: Polish migrant women’s quest for “personal biomedicine” during labour in Ireland.....		191
10.1	In search of personal relationships: the friendliness of healthcare personnel ...	192
10.2	In search of medical technology: epidural on demand	196
Chapter 11: Engagements with medical technology: the role of structural aspects in shaping the use of ultrasound screenings.....		203
11.1	Safe, easy and affordable? The proliferation of ultrasound scanning in prenatal care	204
11.2	National guidelines on the use of ultrasound technology in prenatal care in Poland and Ireland	208
11.3	Abortion, workforce structure and commercialisation of ultrasound technology: The factors shaping the use of ultrasound technology in Ireland and in Poland	214
11.4	Women’s role in the increased use of ultrasound technology in prenatal care..	223
Chapter 12: Conclusions		227
12.1	Polish migrant women and their transnational healthcare practices	227
12.2	The diversity of Polish and Irish biomedical regimes.....	232
12.3	Limitations of the study and directions of further research.....	238
Bibliography:		241
Appendix 1: Plain Language Statement (in Polish)		267
Appendix 2: Plain Language Statement (in English).....		269
Appendix 3: Interview guide (migrant women)		271
Appendix 4: Interview guide (healthcare professionals)		273
Appendix 5: Migrant women participating in the study		275

Abbreviations

AIMS - Association for Improvements in Maternity Services Ireland

CAM: Complementary and Alternative Medicine

CEE: Central and Eastern Europe

EU: European Union

HIA: Health Insurance Authority

HSE: Health Service Executive

IFPA: Irish Family Planning Association

IMR: Infant Mortality Rate

ISUOG: International Society of Ultrasound in Obstetrics and Gynaecology

NGO: Non-governmental Organisation

NIK: Najwyższa Izba Kontroli [Supreme Chamber of Control]

NMS: New Member States

NT: Nuchal Translucency

PTG: Polskie Towarzystwo Ginekologiczne [Polish Gynaecological Society]

TFR: Total Fertility Rates

WFUMB: World Federation for Ultrasound in Medicine and Biology

List of Tables

Table 1: Participants in the study.....	57
Table 2: Polish GDP growth and unemployment rates 1989-2014	68
Table 3: Inflow of Polish nationals into selected OECD countries (1991-2000)	69
Table 4: PPS numbers issued to Polish nationals 2003-2011	71
Table 5: Polish nationals and the total population in Ireland, by age group (2011)	72
Table 6: Polish nationals and total population in Ireland, by level of education (2011)	72
Table 7: Population aged 15 and more by employment status.....	73
Table 8: Polish nationals and the total population in Ireland, by occupation (2011).....	74
Table 9: Immigration and emigration flows in Ireland 1988-2013 (in thousands)	75
Table 10: The composition of immigrant flows in Ireland, in thousands and in per cent (1996-2011).....	76
Table 11: The share (in %) of Medical Card and GP Visit Card holders in Ireland (2003-2012)	98
Table 12: The share of private health insurance holders in Ireland (2003-2012)	98
Table 13: Infant mortality rates in Poland (1950-2011)	139
Table 14: Number of OB/GYN specialists, births and births per OB/GYN specialist in Poland and Ireland in 2012	220

List of Graphs

Graph 1: The number of births and deaths registered in Ireland (1989-2013)	102
Graph 2: Birth rates in selected countries in Europe (2011)	103
Graph 3: The number of births and deaths registered in Poland (1950-2011) (in thousands)	138
Graph 4: Total fertility rates in selected countries in Europe (1990-2013)	139
Graph 5: Infant mortality rates in selected European countries in 2011	140

Abstract

Transnational healthcare practices in the enlarged Europe: the case of Polish migrant women in Ireland and their pregnancy and childbirth practices

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The 2004 EU enlargement and the subsequent migratory movements of citizens from the new member states (NMS) to old EU countries created a new transnational space in which biomedical regimes, as practiced in various locations, come together. In this study, I explore the new transnational space created by the migratory movements of Polish women living in Ireland and their healthcare practices associated with pregnancy and childbirth. I use these practices as a starting point to reflect on the power configurations characterising healthcare, particularly maternity services, in Ireland and in Poland.

The study aims to answer two complementary research questions. First, how Irish and Polish healthcare services regulate women's (pregnant) bodies? Second, how Polish migrant women engage with these regulatory regimes and how these engagements are influenced by the position they occupy in larger power configurations in the host and home countries? In order to answer these questions, I adopt an encompassing perspective attentive to the larger context of structural configurations concerning healthcare in Ireland and in Poland, as well as the lived experiences of migrant women who engage with these services. In order to grasp the complexity of Polish migrant women's transnational healthcare practices, I build my theoretical tools on three larger concepts: medicalisation, healthcare pluralism and transnational healthcare practices.

I use a variety of methods and sources: qualitative semi-structured interviews but also elements of participant observation, informal conversations with Polish women, healthcare professionals and community activists in Ireland and in Poland, as well as analysis of secondary data such as reports, newspaper articles, and internet forums.

The study shows that Polish and Irish biomedical regimes differently regulate women's bodies. However, these differences go beyond the national realisations of biomedicine, and result in the internal diversification of healthcare services in each country. Women, depending on their social positions, engage with these various realisations of biomedical regimes. As the study suggests, their active engagements should be seen in terms of their quest for a very specific enactment of biomedical regime, namely "personal biomedicine".

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Chapter 1: Introduction

In 2008, while searching through Polish internet discussion forums devoted to health and maternity care, I came across heated debates between Polish women who had recently migrated to the UK or Ireland. They shared their experiences with their host countries' maternity care. One group of women complained about the supposed "backwardness" of their host country's healthcare services, manifested in the "insufficient" use of medical technology or the doctors' "lack of medical knowledge". They expressed concerns about the "small" number of screening procedures offered to them by their host country's healthcare services and searched for recommendations of clinics where they could get "more serious" care. By contrast, another group of women complimented their host country's healthcare services, praising the "friendliness" of the personnel. Both groups compared and contrasted their host countries' healthcare services with the Polish ones.

These discussions highlight the importance of biomedicine as a regulatory regime of pregnancy and childbirth. Indeed, women taking part in these discussions not only embraced the biomedical approach to pregnancy and childbirth, but also engaged in practices aimed at enhancing biomedical control over their bodies. In this study, I use the healthcare practices in which migrant women engage as a lens to reflect on the power configurations that characterise maternity services. Taking the case of Polish migrant women living in Ireland, I undertake to answer a two-fold question. First, I want to explore how Irish and Polish healthcare services regulate women's (pregnant) bodies. I therefore look at the structural configurations of Polish and Irish healthcare services. Second, I enquire into the ways in which Polish migrant women engage with these biomedical regimes and how these engagements are influenced by the position women occupy in larger power configurations in the home and host societies.

Apart from highlighting the importance of biomedicine as a regulatory regime, the discussion of the above mentioned issues also show how, in the context of the enlarged European Union (EU), migrants bring together the biomedical regimes from their host and home countries. As they are no longer limited by resident or work permits, migrants from new member states (NMS) now enjoy new social and economic rights, including better access to the labour market as well as social security and healthcare services. This has an enormous impact on migrants' mobility patterns, giving them greater ease in crossing national borders (Krings et al. 2013) and, hence, allowing them to engage with both their

host and home countries' healthcare services. Indeed, despite common assumptions in host societies, that depict migrants coming from poorer countries as potentially frequent users and abusers of their healthcare services, studies conducted in Ireland (see for example MacFarlane and de Brún 2010, Migge and Gilmartin 2011, Stan 2015) show that migrants, and especially those coming from Central and Eastern Europe (CEE), apart from accessing healthcare services in Ireland also strongly rely on their home countries' healthcare services. This is how they engage in what Stan (2015) called "transnational healthcare practices".

In this study I focus on women's healthcare practices associated with pregnancy and childbirth. These practices constitute very particular examples of women's engagement with healthcare services, because pregnancy and childbirth are among the most thoroughly medicalised areas of "normal life". Conrad (2007, p. 4) defined medicalisation as "a process through which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorder". Indeed, over the last century, control over these areas of human life has shifted almost entirely from women to medical professionals. Previously seen as physiological processes that women themselves controlled, once medicalised, they came to be seen as potentially pathological and risky processes, and thus in need of constant medical control (Davis-Floyd 1993, Ehrenreich and English 1973).

As a result of medicalisation, doctors are now perceived as the main profession with expertise in managing pregnancy and childbirth. Women, by contrast, are expected to just follow medical recommendations. Their knowledge and bodily experiences are no longer considered important for medical diagnosis. This shift in control has had a fundamental impact on the position pregnant women occupy vis-à-vis healthcare professionals and in wider power configurations in healthcare services. According to some feminist scholars, this reinforces the subordinate position of women in society (Davis-Floyd 1993). In the early feminist studies that looked at medicalisation, women were primarily conceptualised as victims of medicalisation (see for example Ehrenreich and English 1973, 1978; Martin 1987, 1991). As various aspects of the female physiology, including pregnancy and childbirth, started to be treated as medical problems in need of doctors' supervision, women could no longer exercise control over their bodies. Instead, they were expected to conform to medical (usually male) advice. Thus, maternity care constitutes an excellent example to analyse power configurations in healthcare (and beyond), as well as the position women occupy vis-à-vis them.

The early feminist approach to medicalisation was subsequently challenged by other feminist scholars who conceptualised women as not being passive victims of medicalisation, but active agents who pragmatically engage with medicine and healthcare personnel to meet their own needs (see for example Lupton 2003, Lock and Kaufert 1998, Rapp 1999). These studies emphasised that the medicalisation of pregnancy and childbirth has brought new possibilities, fulfilling the promise to alleviate problems that had threatened women's lives for generations. These include, for example, reliable methods of birth control, fertility treatments or medical procedures to deal with complications occurring during pregnancy and labour. Thus, women's engagement with medicine, rather than being a manifestation of women's subordinate position, should be seen as an expression of pragmatism and willingness to pursue one's own goals. In this sense, the medicalisation of pregnancy and childbirth, and the resultant maternity services on offer, should not be seen as simply means to control women and their bodies, but as processes that women actively engage.

In this study, I draw on both these perspectives on the position women occupy in power configurations in healthcare. Drawing on early feminist perspectives, I look at maternity care services in Ireland and in Poland as powerful regimes of control over women's bodies. With their strong reliance on technology and medical knowledge, maternity services limit women's control over their own bodies. By treating women's knowledge and experiences of their bodies as unimportant, they put them in a vulnerable position vis-à-vis healthcare professionals. However, despite taking control away from women, the medicalisation of pregnancy and childbirth also puts forward solutions and promises to meet some of the women's needs. Thus, drawing on feminist perspectives that stress women's agency, I do not look at women as passive victims who, despite their reluctance, are "pushed" into maternity care and subjected to medicalisation. On the contrary, I look at women as agents who not only find solutions to some of their health needs in maternity care, but also actively engage in medicalisation and have the power to shape their encounters with maternity care and healthcare professionals. This includes their ability to sometimes refuse medical procedures or, on the contrary, to seek more.

However, women's agency and their engagement in medicalisation are embedded in particular realisations of medicine and the inequalities that characterise biomedical regimes. Not all women have the same power to actively seek medicalisation. Thus, in this study I also draw on research that stresses the relation between women's attempts to

shape their encounters with maternity care in ways that meet their own desire and the various position they occupy in the society (see for example Diniz and Chacham 2004, Lazarus 1994, McCallum 2005). As societies and healthcare services are built on various lines of division, women's access to certain healthcare services as well as their ability to shape their medical encounters are strongly dependent on their level of education, employment, access to financial and social resources and, in our case, migration trajectory. This is particularly true in the context of increasing commercialisation of healthcare that results in a complicated mix of private and public services and allows women who can pay for care to access some services faster or access services of better quality. Thus, in this study, while I conceptualise women as agents, I also acknowledge that their agency is constrained or enabled by larger structural forces that women find themselves in.

Power configurations in healthcare are realised in various ways depending on location. Although popularly perceived as immune to local variation, biomedicine has been shown to be by no means unitary but differently practiced in different locations (Good 1995, Hahn and Kleinman 1983, Lock 1993, Lupton 1999, MacFarlane and de Brún 2010, Martin 1987). Despite its purported objectivity, biomedicine is influenced by local interpretations of health, illness and care that shape the dynamics of doctor-patient relations, the structure of healthcare services or the norms governing good care practices. As argued by Good (1995, p. 462), the end result is a plurality of biomedicines practiced in various locations. Thus, in this study, I look at what I call the migrants' transnational use of Irish and Polish healthcare services as a form of healthcare pluralism (see also MacFarlane and de Brún 2010).

Thus, the perspective I take in this study builds on three larger concepts. First, in order to unpack power configurations in healthcare services and in the society, and particularly the position women occupy in these power configurations, I draw on the concept of medicalisation. Second, in order to grasp the differences across the local realisations of biomedicines, I draw on the concept of transnational healthcare pluralism. Third, in order to examine the relation between migrants' position in the larger national and transnational context and migrants' healthcare practices, I draw on the concept of transnational healthcare practices (see also Stan 2015).

As already mentioned, the perspective I take in this study is attentive to larger structural configurations in healthcare in Ireland and in Poland, as well as the lived experiences of migrant women who engage with these services. In order to get a good understanding of

both these aspects, I draw on methodological tools that allow for collecting data on the micro level, and at the same time make it possible to grasp the broader context. Thus, in order to collect data on lived experiences, I used qualitative research methods inspired by ethnography that included semi-structured interviews and elements of participant observation. In 2011, I conducted forty semi-structured interviews, out of which twenty two were conducted with Polish migrant women, twelve with women living in Poland and six with Polish healthcare providers, including three midwives and three doctors. The interviews included a combination of open-ended and structured questions.

Apart from interviews, I also used elements of participant observation. This included numerous informal conversations with Polish migrant women, maternity healthcare users and providers, activists working in the area of women's health, as well as participation in a number of meetings and workshops where the topic of maternity care and migration was discussed. Finally, I also engaged in the analysis of secondary sources of information. These included newspaper articles, websites and internet discussion forums of both Polish and Irish origin. I also used reports, legislation and statistical data, which constitute a crucial tool in building an understanding of the larger context in which these lived experiences take place.

My fieldwork was divided between sites in Ireland and in Poland. This approach was inspired by multi-sited ethnography (Marcus 1995), a method of research which advocates that certain social phenomena, instead of being studied over an extended period of time in a single location, are better grasped when followed as they move through various locations. In this sense, researchers can use their findings from one location to better contextualise and understand the findings from another location (see for example Gallo 2009). In my study of Polish migrant women's transnational healthcare practices, I adopted this approach and used my "Polish" site to contextualise and better understand the findings from the "Irish" site and vice versa.

The thesis is divided into twelve chapters. In Chapter 2, I detail the theoretical perspective I take when looking at Polish migrant women's transnational healthcare practices. I start by presenting the concept of medicalisation, particularly as it developed within the feminist perspective. As medicalisation provides the tools to look at the position of women vis-à-vis healthcare professionals, and at the larger institutional and social contexts, I use this concept in order to better understand the way in which biomedical regimes regulate women's (pregnant) bodies. However, theories of medicalisation rarely question the

“locality” of biomedical regimes and assume them to take the universal form of “modern medicine”, immune to local variations. Thus, in the second part of Chapter 2 I discuss the concept of healthcare pluralism. I use this concept in order to grasp the complexity of women’s healthcare practices. While the concept of medicalisation provides tools to unpack power relations within biomedical regimes, the concept of healthcare pluralism makes it possible to look at the way these biomedical regimes are influenced by local power configurations. As these local power configurations are brought together by migrants’ cross-border mobility, in Chapter 2 I also discuss the literature exploring the intersection of migration and healthcare. These studies bring valuable insight into how migrants’ position vis-à-vis healthcare services in the host country may be looked at. I pay particular attention to studies that go beyond a national framework of analysis and adopt a more encompassing transnational perspective. These studies provide a good background for looking at migrants’ healthcare practices in terms of their embeddedness in both host and home countries’ healthcare power configurations.

After detailing the perspective I take in this study, in Chapter 3, I discuss the methodological tools I use, namely qualitative methods of research based on semi-structured interviews, elements of participant observation and the analysis of secondary sources of information. As the healthcare practices that I look at in this study are not limited to one location, I detail the concept of multi-sited ethnography (Marcus 1995). This approach allows the researcher to follow the object of their study across different locations.

In order to understand Polish migrant women’s healthcare practices and make a link between these practices and their position in society, it is first necessary to answer the questions of who Polish migrants living in Ireland are and what position they occupy in Irish and Polish societies. Thus, in Chapter 4, I review studies that look at Polish migration, paying particular attention to those that focus on recent migratory movements enabled by the 2004 EU enlargement. Indeed, the 2004 EU enlargement had an enormous impact not only on Polish migrants’ mobility patterns and their migration strategies, but also on the positions they occupy in their host and home societies. All of these aspects together, namely changes in mobility patterns, migration strategies and the positions Polish migrants came to occupy in their host and home societies, had a great influence on their use of social security and healthcare services.

Biomedical control over women's (pregnant) bodies is realised through the local structure of healthcare services. The structure of healthcare services, and most notably inequalities in their provision, play a crucial role in establishing the link between women's social position and the way they use healthcare services. Thus, in Chapter 5 I take a closer look at the structure of Irish healthcare services and maternity care, paying particular attention to the lines of division that run across these services. Despite efforts to overcome some divisions and the introduction in 1953 of free access to healthcare services for pregnant women, , inequalities reverberate in Irish maternity services, resulting in a two-tier healthcare system that offers different biomedical regimes depending on the social class of the users of these services. In other words, due to the structure of Irish maternity care, access to particular types of biomedical care is strongly dependent on women's social position and their access to financial resources.

Taking into consideration the internal diversification of Irish maternity care and the social position of Polish migrant women living in Ireland, in Chapter 6 I discuss the kinds of biomedical regimes that migrant women have access to. Thus, I first review studies that focus on the health status of recent Polish migrants. Then I look at studies that deal with Polish migrants' healthcare practices. The latter provide insight into the possible barriers that Polish migrants may encounter while accessing healthcare in their host country. Subsequently, I look at my own data and discuss Polish migrant women's pathways into healthcare services, which include frequent use of Polish healthcare services. I then discuss the barriers migrants encounter when accessing healthcare services in their host country. These barriers are often intertwined with local inequalities, which even further constrain women's access to healthcare services and makes them more likely to search for care outside mainstream Irish healthcare services. This search renders migrant healthcare strategies particularly complex and "messy" (Osipovič 2013).

However, the abovementioned barriers are only partially an answer to the question of how Polish migrant women's use of biomedicine is influenced by their social position. Their preferences for particular forms of care are also a crucial factor. These are shaped by migrants' experiences with home country's healthcare services and are embedded in inequalities of access to these services. Thus, in Chapter 7, I discuss the structure of the Polish healthcare services and maternity care as a site where Polish migrant women's preferences for particular forms of care had developed. As in the case of Irish healthcare services, I discuss patterns of access to these services and link them to inequalities that

characterise the provision of healthcare services in Poland. Similar to the situation in Ireland, inequalities in access to healthcare services in Poland result in different regimes of biomedicine being offered to different groups of people. Polish women's strategies and patterns of access to healthcare services in Poland show that the type of care they search for is characterised by frequent use of both medical technology and personal relations with healthcare personnel. However, access to what I call "personal biomedicine" is mediated by women's social position, more notably in terms of women's personal network of relations and their ability to pay for private services.

Due to their greater mobility, migrant women's quest for a desired form of care differs from that of women living in Poland. Thus, in Chapters 8, 9 and 10 I look at the particular practices in which Polish migrant women engage in order to access "personal biomedicine". As they constantly move between "Irish" and "Polish" healthcare services, migrant women confront and compare two biomedicines, providing an excellent window into the aspects women seek in healthcare services and into the way their practices are embedded in larger power configurations. Chapter 8 shows that in the case of prenatal care quest for "personal biomedicine" is fulfilled by the use of "Polish" healthcare services, either provided by private clinics in Poland or, more frequently, by private clinics run by Polish doctors in Ireland. However, as I discuss in Chapter 9, in the case of Polish clinics in Ireland, women's quest for "personal biomedicine" is hindered by the fact that some migrant women perceive the migration of healthcare professionals as a sign of lack of professionalism. In addition, although they talk about accessing services provided by Polish clinics in Ireland in consumer-like terms, women still expect these services not to be fully commercialised, but more embedded in social relations. Finally, as I discuss in Chapter 10, in the case of care during labour, women's quest for "personal medicine" is met by "Irish" maternity care. This shows that neither Polish nor Irish healthcare services fulfil all the requirements concerning "personal biomedicine", but migrant women manage to combine elements from each that helps them approximate this ideal.

After discussing the Polish migrants' quest for a specific form of biomedicine, in Chapter 11, I focus on one of the elements of "personal biomedicine", namely medical technology. By using the example of prenatal ultrasound screenings, I take an approach complementary to women's lived experiences (explored in Chapters 8, 9 and 10) and look at the structural level of how medical technology is realised in Poland and in Ireland. Indeed, the comparison between the ways prenatal ultrasound scans are practiced in the two

countries, permits us to go deeper into structural forces that bear on women's use of ultrasound screening. Thus, in Chapter 11, I comparatively look at how the regulation of abortion, trends in maternity care workforce and delivery, the division into private and public care and the commercialisation of prenatal ultrasound technology play into women's use of ultrasound screenings as well as their larger expectations towards biomedicine.

Finally, in Chapter 12 I summarise the main findings of my study and present conclusions. I discuss the ways we can look at the diversifications across and within the Polish and Irish biomedical regimes. I also discuss the limitations of my study and suggest further areas of research.

Chapter 2: Theoretical perspectives: medicalisation, healthcare pluralism and the transnational lens

I look at Polish migrant women's healthcare practices and their use of maternity services as actions embedded in larger power configurations that are realised at various levels. This includes the level of individual doctor-patient relations in which healthcare users (Polish migrant women) are situated vis-à-vis healthcare providers (doctors, midwives or nurses), as well as the level of the healthcare system and the wider society in which healthcare users and providers occupy various social positions that inform their practices. In social sciences, these power configurations have been analysed in terms of medicalisation, providing us with tools to unpack complex power relations that influence healthcare practices, not only at the level of individual doctor-patient relations, but also within the larger context of healthcare and society.

Medicalisation theories usually focus on a single healthcare system embedded in a particular society. However, as shown by numerous studies on migration and healthcare (see for example Glinos et al. 2010 and 2012, Green et al. 2006, Lee et al. 2010, MacFarlane and de Brún 2010, Migge and Gilmartin 2011, Stan 2015), it is the transnational perspective that may be very fruitful when looking at migrants' healthcare practices. Thus, in my study on Polish migrant women, I adopt a perspective attentive not only to the power relations that ensue in particular locations (healthcare services in Ireland and Poland), but also to the differences in the enactment of those power relations depending on the location (country). In order to do that, I take a broader perspective by making use of the concept of healthcare pluralism that provides tools necessary to look at power relations across different healthcare systems.

In the first part of this chapter, I discuss works written in the social sciences that deal with the concept of medicalisation, paying particular attention to feminist studies and their various takes on the subject. Then I move on to discuss various theories on healthcare pluralism, paying particular attention to studies that look at medical pluralism in terms of variety across different biomedical regimes. Finally, in the last part of the chapter, I review selected studies that look at the intersection of migration and healthcare, with a focus on studies that look at migrants' healthcare practices from a transnational perspective.

2.1 Women's bodies as a playground of medicalisation?

For over a century, people have been increasingly relying on medicine to solve problems or to control those areas of their lives which had not been previously seen as medical issues. Social scientists analysed this increasing reliance on medicine in terms of medicalisation. Defined by Conrad (2007, p. 4) as a “process through which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorder”, medicalisation can also be seen a process that leads to a major shift in power relations in the societies it takes place in. Thus, as noticed by Olafsdottir (2011, p. 241), theories of medicalisation are theories of power that search to answer the question of which mechanisms allow some groups to gain power to define and respond to various social behaviours.

The first theories on medicalisation were developed in the 1970s and early 1980s within the political economy perspective. They focused on medical doctors and the way they gained and exercised their power to define certain aspects of human life as illness and in need of medical supervision (Freidson 1970, Illich 1976, Zola 1981). These studies saw medical doctors as representatives of capitalist elites who used medicine as a powerful tool of social control over the working classes (Freidson 1970, Illich 1976, Zola 1981). With the rapid expansion of medical jurisdiction into the areas of human life that had not previously been considered to be medical problems (e.g. mental states such as anger or sadness, or some life-cycle events like ageing), doctors gained extensive control over many aspects of people's everyday lives. Doctors exercised this control by labelling these aspects as “being ill” or “being healthy” and, once labelled, by holding an exclusive right to advise on and act upon them (Zola 1981). In this sense, medical doctors became very powerful agents that certify whether people are able to work and function in society or not. However, as argued by Freidson (1970), doctors used their power not only to improve patients' health, but also to keep them under surveillance and maintain the unequal social order that ensured the doctors' privileged position. Thus, it was in the doctors' best interest to keep people in constant need of medical help because it reproduced their superior position of power (Illich 1976, Waitzkin 1984). Medical doctors were seen as primary agents of medicalisation, which was seen as a tool in the class power struggle and used by the doctors themselves to secure their dominant position in the society.

Also in the 1970s and 1980s, feminist scholarship contributed to the early theories on medicalisation by adding a new approach. While the first theories of medicalisation saw it

primarily as an issue of a class power struggle, early feminist scholarship saw medicalisation primarily as an issue of gender inequalities (see for example Ehrenreich and English 1973, 1978; Martin 1987, 1991). Although feminist scholarship looked at medicalisation as a powerful tool of social control, its focus was not so much on the capitalist elites exercising control over the working classes, but rather on the powerful and predominantly male physicians who used medicine to exercise control over women and keep them under male dominance. Thus, feminist scholars emphasised the fundamental role of gender as a factor that determines the way medicalisation is played out on people. Scholars representing this approach argued that doctors, as representatives of powerful elites, used structural forces to establish themselves in the position of experts. By using seemingly neutral medical discourses and technologies, they labelled aspects of female physiology as pathological or in need of medical (and male) control. In this early feminist view on medicalisation women were primarily seen as passive victims of the process with very little agency to resist medical knowledge and male dominance.

The early feminist scholarship on medicalisation stressed the structural aspects of healthcare systems that left women very little room for manoeuvre and made them victims of the medical establishment, procedures and technology (see for example Ehrenreich and English 1973, 1978, Evans 1985, Martin 1987). In their historical analysis of the professionalization of medicine in the 19th and early 20th centuries in the United States, Ehrenreich and English (1973) showed how women were denied access to newly established medical schools and universities and were soon marginalised from the healthcare sector. As a result, male physicians replaced traditional female midwives and popular healers and gradually gained control over those areas of female physiology that were previously mostly controlled and handled by women (such as menstruation, pregnancy or childbirth) (Ehrenreich and English 1973). As pointed out by these feminist scholars, the medicalisation of female physiology had a negative impact on women's position in the society. It not only reinforced the views that women's bodies are fragile and in need of medical control, but, as medicine was predominantly a male profession, it also reinforced the idea that men should control female bodies (Ehrenreich and English 1973, Evans 1985).

One of the aspects lying at the core of medical power is the apparent neutrality and scientific objectivity of its knowledge basis. In her now classic study, Martin (1991) argued that scientific discourse is neither objective nor neutral, but shaped by cultural stereotypes

that reproduce unequal social relations, most particularly women's subordinate position vis-à-vis men. Martin (1991) analysed the scientific language of medical textbooks, articles and public debates on human biological reproduction in the US and showed that it was strongly influenced by stereotypical beliefs developed in western societies on how women and men should act. For example, in scientific descriptions of the process of conception, the egg and the sperm were respectively described as acting in ways that were popularly believed in American society to be typically female and male behaviours, respectively. Indeed, while female eggs tended to be depicted as passive, distressed and waiting, the sperm was often depicted as fearless, active and strong. In the same manner, while the reproductive processes happening in the female body were often described in medical textbooks as being wasteful, male reproductive processes were praised as productive and powerful. In this way, Martin (1991) showed how scientific discourse, one of the most important tools of medicalisation, is neither objective nor neutral, contrary to assumptions. Instead, it is shaped and produced by cultural stereotypes that often belittle the position of women in society. As a result, medical discourse reinforces the subordinate position of women vis-à-vis men in society.

2.1.1 Women and medical technology: between structure and agency

Apart from the seemingly neutral medical discourse, scholars pointed to another important aspect lying at the core of the increasing power of medicine, namely medical technology. Indeed, by the second half of the 20th century, doctors started to increasingly rely on medical technology in their practice. In the area of women's health, the increase in the use of medical technology in pregnancy and childbirth was particularly spectacular. Ultrasound scanning, foetal monitoring, prenatal genetic tests or in vitro fertilisation are just some of the examples of technological novelties that were gaining popularity in western societies in the second half of the 20th century. Consequently, the increasing use of medical technology became the focus of many feminist scholars studying medicalisation.

Those inspired by the early feminist scholarship on medicalisation continued to focus their research on predominantly male medical establishments that gained yet another powerful tool to exercise control over women's bodies: medical technology (see for example Davis-Floyd 1992, 1993, Oakley 1984, Petchesky 1987). A study by Davis-Floyd (1992, 1993) on childbirth in the United States represents a good example of this approach. Davis-Floyd (1992, 1993) showed how routine use of medical technology in childbirth transformed women from active agents in charge of childbirth to passive recipients of medical

procedures. She argued that once childbirth became the domain of male physicians, it came to be perceived as a highly risky, pathological process that needs to be transferred to a hospital setting and managed by technology. Routine use of medical technology during childbirth (e.g. foetal monitoring or ultrasound scans) is to ensure that labour follows standard patterns and “fits” the hospital environment. If labour deviates in some way from the pre-established norms, it is managed by more medical technology: IVs, caesarean sections or forceps. In this way, as Davis-Floyd (1993) showed, the use of medical technology reinforced the view of childbirth as a risky medical event that needs to be closely controlled. It also reinforced the view that women’s bodies are faulty, unable to cope with their own physiology and in need of medical help. Thus, as argued by Davis-Floyd (1993), the medicalisation of childbirth, and particularly the use of medical technology, bolstered women’s subordinate position and led to a situation in which women’s knowledge and bodily experiences are perceived as less valuable and important than the knowledge of predominantly male medical professionals and their interpretation of information provided by medical technology.

Contrary to the early feminist approach to medicalisation that stressed the structural power of medicine and looked at women primarily as victims, subsequent feminist scholars (see for example Lupton 2003, Lock and Kaufert 1998, Rapp 1999) stressed the ambivalent relationship between medicine and women. They argued that many women willingly engage with medicine and medical technology. This is because medicine and medical technology hold the promise to alleviate some problems that haunted women’s lives for generations, such as unwanted pregnancies, infertility or complications associated with childbirth. Thus, as scholars working in what we could call the “agency perspective” suggested, women should not be seen as passive victims of medicalisation, but rather as active agents that engage with medicine in a variety of ways in order to achieve their aims.

Lock and Kaufert (1998), as proponents of the “agency approach”, suggested that women are deeply pragmatic in their responses to medicalisation and medical technology. They argued that women willingly engage with medicine and medical technology provided that this holds the promise of fulfilling some of their goals. Otherwise they refuse to engage with them. In other words, in order to pursue their own aims, women make conscious decisions to embrace or even encourage some medical procedures and, alternatively, refuse others. Thus, as suggested by Lock and Kaufert (1998), women make pragmatic choices, informed by what they perceive as being in their best interest. Contrary to the

early feminist perspectives on medicalisation that tended to see women as surrendering their autonomy to medical professionals, Lock and Kaufert (1998) argued that women should be seen as active and pragmatic agents who, relying on various sources available to them, engage with medicine or go against it to satisfy their own needs.

In their study on amniocentesis and prenatal testing in the United States (US), Markens et al. (2010) presented an interesting approach to women's pragmatic engagement in medicalisation and medical technology. They highlighted women's agency and the role of various sources of knowledge in women's decisions concerning whether to undergo prenatal testing or not. On the basis of over 140 interviews with women of Mexican background living in the US, Markens et al. (2010) challenged the view of women as passive recipients of medical procedures and suggested that the women they spoke to actively drew on a variety of sources to make decisions they believed were the best for them. For example, although identified by medical personnel as being at risk of having a baby with Down Syndrome, some women declined the medical recommendation to undergo amniocentesis as they believed their pregnancy was healthy. In making this decision, they relied on their bodily experiences such as foetal movements or family history (such as healthy babies born to other members of their family). This knowledge made them believe that their pregnancy was healthy and there was no reason to undergo an invasive prenatal procedure that implied a risk of miscarriage. At the same time, their trust in their embodied knowledge and experiences did not make them entirely distrustful towards biomedicine. On the contrary, they took a variety of other prenatal tests, attended prenatal visits and followed other recommendations of their doctors. Thus, as suggested by Markens et al. (2010), women should not be seen as passive victims of medicalisation but as pragmatic agents that draw on a variety of knowledge sources available to them in making decisions on their engagement with medical technology and prenatal screenings.

However, as stressed by a another growing body of feminist studies, women's access to various sources of knowledge and other resources is very much shaped by the social position they occupy in society (see for example Lazarus 1994, Liamputtong 2005, Rapp 1999, Zadoroznyj 1999). Several studies highlighted that women's agency and their willingness to reject some medical procedures and to encourage others is very much dependent on the social class, nationality, ethnicity, education and financial resources they have access to, as well as on the knowledge and the expectations they develop. For example, studies from Brazil showed how women's financial position and their ability to

pay for private care mediated their access to caesarean sections (Diniz and Chacham 2004, McCallum 2005). . In Brazil, caesarean sections are often perceived as a preferred type of childbirth that carries less risks for mothers and babies. Private hospitals attended mainly by middle-class women have much higher rates of caesarean sections than public facilities attended mostly by working-class women. Many middle-class women paid for private care in order to ensure that they would have the type of treatment they wanted. They avoided public hospitals where the rates of caesarean sections were lower and chose private facilities where they believed doctors would be more willing to perform surgical birth procedures. In this sense, they used their financial position and their ability to pay for private care to ensure access to the treatment they believed was better for them. In other words, their pragmatic engagement with medicine was facilitated by their financial resources.

The need to look at women as pragmatic actors who use medicine and medical technology was also explored by Béhague et al. (2002) who demonstrated that despite their limited resources poor women in Brazil also actively engaged with medicine. As they feared that vaginal birth would expose them to the possibility of being mistreated by healthcare personnel due to social prejudice, the women from the study sought ways to gain access to caesarean sections. However, unlike middle-class women who paid for private care, poor women engaged in strategies to avoid paying. For example, they arrived at the hospital in early labour to encourage the obstetrician on call to advise surgery, sought more prenatal tests that would increase their chances of having a caesarean section, or tried to pay for the surgery under the table (half the official price for care). In this sense, they actively engaged with medicine and used a variety of strategies that were available to them in order to seek what they believed was better care.

The studies on childbirth in Brazil show that middle-class women have access to sources of knowledge or financial resources that allow them to encourage medicalisation. By contrast, poorer women have very little leeway and are left with a very limited set of options in their decision-making process. Thus, although both groups sought ways to access caesarean sections, poor women were far less likely to access it than middle-class women. They were also more likely than middle-class women to fear being mistreated by the hospital personnel. As these studies illustrate, the social position women occupy in society strongly influences their healthcare practices and the reasons why they seek or refuse certain types

of medical procedures. Thus, in order to understand how women respond to and engage with medicine and medical technology it is also necessary to consider their social position.

Lazarus (1994) examined into the issue of women's choices and ways of exercising control in maternity care in the US in correlation with social position. All women in her study, irrespective of their social class and resources, embraced medical birth and believed that some medical interventions and technologies are necessary in order to ensure a healthy pregnancy and safe labour. However, middle-class and poor women diverged in the way in which they engaged with biomedicine. While they were all aware that acceptance of the medical model limited their control over the process of childbirth to some extent, middle-class women employed a variety of strategies and drew on various resources in order to maximise their control over the course of their pregnancy and childbirth. For example, in order to attend the doctors of their choice, they used their knowledge of the healthcare system or paid for private care. Middle-class women believed that in this way they maximised their chances of getting the treatment they wanted.

By contrast, poor women had very few resources that helped exercise control over pregnancy. Overwhelmed by other social problems (such as unemployment), and with limited access to services (only public maternity clinics), they had less knowledge about the medical system and procedures than middle-class women. They were also far less likely to have private health insurance and therefore had a limited chance of attending the doctors of their choice. Seen by junior doctors in busy public maternity clinics, poor women had very meagre chances of acquiring knowledge necessary to control their pregnancies and labours or manipulate the system. As a result, unlike middle-class women, they were less concerned with maximising their control. Instead, they wanted to ensure continuity of care that public maternity clinics often failed to provide. Their response to medicalisation was very much shaped by their weak social position that limited their chances of exercising control over their pregnancies and of influencing the system so as to receive the desired treatment. Thus, as Lazarus (1994) emphasised, in investigating the way women experience and engage with medicalisation, it is necessary to look at the social relations, power inequalities and the position women occupy within society, the latter being responsible for shaping women's responses to medicalisation.

Attending to the social position and the role of social class and financial resources in constraining or enabling women's choices and influencing the way they respond to medicalisation is a crucial step in analysing power relations in healthcare, especially in the

context of the increased privatisation of healthcare services. Indeed, over the last decades a growing number of social scientists have looked at medicalisation through the lens of the increased commodification and commercialisation of healthcare (see for example Conrad 2007, Singer 1987). They focused on the role of new actors (such as private insurance companies, pharmaceutical companies and private healthcare providers) in reconfiguring power relations in healthcare. Contrary to the early studies on medicalisation that focused primarily on medical doctors as the most powerful agents, the new approach saw private companies as new agents of medicalisation that play an increasingly important role in encouraging the use of medical technology. The representatives of this perspective stressed the importance of looking at organisational changes in healthcare systems (such as managerial reforms) (Singer 1987) as well as at the growing power of the pharmaceutical industry and commercialisation of healthcare (Conrad 2007).

As managerial reforms often result in a complicated mix of private and public healthcare services, they often have a fundamental impact on doctors' working patterns. Following such changes, physicians have to juggle shifts at public and private facilities and, as a result, often work in time-constrained environments. In an attempt at presenting the way in which managerial reforms may increase medicalisation in maternity care, Diniz and Chacham (2004), in their study on caesarean section in Brazil, linked the rising rates of surgical births to the time-constrained environment that Brazilian doctors work in. They suggested that rising rates of caesarean sections resulted from the doctors' struggle to manage time efficiently. As the doctors juggled several shifts in public and private hospitals, they often preferred scheduled caesarean sections to vaginal births that, unlike the first, are difficult to predict time-wise. In addition, the doctors did not want to "leave" women in labour in the hands of colleagues coming for the next shift because they considered this to be rude (Diniz and Chacham 2004, p. 103). Thus, they used caesarean sections or other forms of medicalised birth procedures, such as forceps, as ways of managing their work time-wise and, if needed, as ways of speeding up the labour so that the doctors coming for the next shift do not have to take care of patients "left" after the previous shift. In this way, managerial reforms and the resulting time-constrained environments contributed to the medicalisation of childbirth.

Apart from managerial reforms, the growing importance of private providers also plays a crucial role in the way medicalisation is played out. For example, a number of studies on prenatal screenings (see for example Gammeltoft and Nguyễn 2007, Roberts 2012)

suggested that the increasing popularity of some prenatal tests (such as ultrasound scans) among middle-class women should be analysed in the context of additional revenues they bring to private providers. Indeed, as some private maternity clinics get paid for each prenatal test, it is in their economic interest to encourage more screenings. In this way, in their quest for increased revenues, private healthcare providers may encourage the medicalisation of pregnancy.

As demonstrated above, approaches that focused on larger structural forces (such as managerial reforms and the privatisation of healthcare) set a new direction in looking at the way women engage with medicine and medical technology. They do it by shifting the focus of analysis from immediate doctor-patient relations (as it was the case in much of the early studies on medicalisation) to the larger structural context that these relations are embedded in. Thus, they recognize the importance of the market and of the commercialisation of healthcare services in shaping the way women engage with medicine.

My approach to migrant women's healthcare practices and power configurations in healthcare is inspired by feminist perspectives on medicalisation that saw gender as a crucial factor in the ways medicalisation is played out. Drawing on early feminist theories on the issue, I look at women's bodies as a playground for medicalisation, with pregnancy and childbirth representing the most spectacular examples of the process (Davis-Floyd 1992, 1993, Ehrenreich and English 1973, Evans 1985, Martin 1987). Numerous studies showed that women's bodily knowledge and experiences are regarded by healthcare personnel as unimportant, while medical technology is believed to be most reliable and necessary in order to ensure healthy outcomes (Davis-Floyd 1992, 1993). This approach allows me to look at pregnancy and childbirth as processes that are no longer considered to be a domain of women, but are now considered to be the domain of medicine and medical establishment.

However, taking into consideration that many women actively seek ways of increasing medicalisation or influencing the type of care they receive, I also draw on the works of scholars who recognised women as agents that have the power to actively demand or, in much rarer cases, refuse medicalisation and use of medical technology. This approach allows me to look at women not only as victims of medicalisation whose bodily knowledge is disregarded, but also as agents who engage in various strategies to influence the process of medicalisation and shape the care they receive.

In addition, the perspective I adopt in this study also takes into consideration that women's strategies and engagement with medicine are very much influenced by their social position that not only constrains or enables certain healthcare practices, but also produces certain needs and expectations. Thus, I draw on feminist studies that stress the fundamental importance of women's social position in shaping their encounters with healthcare (Lazarus 1994, Rapp 1999). This approach allows me to look at women's education, employment situation, migration trajectory, as well as their more general socio-economic status, all of which mediate their access to certain medical technologies, sources of knowledge and social expectations.

Finally, I draw on scholars that advocated the need to look at the larger structural forces (such as privatisations) that shape the institutional context in which women's healthcare practices take place (Evans 1985, Roberts 2012). Indeed, some studies (see for example Gammeltoft and Nguyễn 2007) showed that increasing demand for some types of medical technology is linked to the commercialisation of healthcare and to the growing importance of private healthcare providers and pharmaceutical companies. This approach to medicalisation allows me to place women's healthcare practices in a broader context of structural processes, and more specifically the increasing number of private healthcare providers and the commercialisation of healthcare that play a very important role in shaping the structure of the healthcare system.

The various perspectives on medicalisation presented in this chapter provide tools that allow us to unpack the power configurations that characterise the provision of healthcare. However, these perspectives on medicalisation usually focus on particular healthcare systems in a given society. In looking at migrants' healthcare practices, which are often transnational and include use of more than one healthcare system, this perspective on medicalisation risks being too narrow. Thus, in order to account for healthcare practices that cross national borders or refer to more than one healthcare system, I broaden my perspective to include the concept of healthcare pluralism. Indeed, as I show in the next section, the concept of healthcare pluralism helps unearth the power configurations that are not necessarily identical across all locations. On the contrary, they are usually subject to local variations and characteristic to particular locations. As a result, combining perspectives on medicalisation with those on healthcare pluralism allows me to grasp the power configurations not only within particular healthcare systems, but also between and across them.

2.2 Biomedicine(s) and healthcare pluralism

In many societies, in order to alleviate ill health, people employ a variety of healthcare sources. They consult various specialists and healers, rely on their family and friends for advice, or engage in self-treatment. Social scientists analyse this phenomenon in terms of healthcare pluralism, or what is sometimes referred to as medical pluralism. Janzen (1978, p. xviii) defined medical pluralism as “the existence in a single society of differently designed and conceived medical systems”. The term “medical” is strongly associated with a reductionist approach to healing specific to western biomedicine. By contrast, the term “healthcare” indexes the more diverse and pluralistic nature of people’s practices associated with seeking treatment and care that go beyond modern medicine. Thus, the term “healthcare pluralism” seems to be better suited to account for the diversity of people’s health-seeking practices. As a result, in my study, I decided to use the term “healthcare pluralism” instead of “medical pluralism”.

Initially, the term healthcare pluralism was used in the context of non-western societies in which the introduction of western biomedicine did not manage to eliminate local healing systems and traditions (Helman 2007, Penkala-Gawęcka 2006, p. 27). In these places, as numerous studies showed, western biomedicine coexists with local healing systems, forming a network of healing options available to people to different degrees (Janzen 1978, Penkala-Gawęcka 2006, Wądołowska 2013). In order to alleviate health problems, people in these societies employ a variety of healthcare resources. Depending on their interpretation of illness as well as their financial resources, they use home remedies, consult local healers or attend medical clinics where they are examined by physicians trained in western medicine (Wądołowska 2013).

However, healthcare pluralism is by no means limited to non-western societies. In most societies, including western ones, more than one healthcare system is usually available. Although in western societies biomedicine occupies a somewhat privileged position - it is backed by national and international laws - other forms of therapy, such as homeopathy or herbalism, are also available (Baer et al. 1997). Thus, healthcare pluralism in western societies is usually seen as a situation in which modern western biomedicine coexists with other healing traditions that either developed locally or appeared in a particular place as a result of global flows of people, knowledge and technology. In the latter case we can enumerate for example practitioners of traditional Chinese medicine, acupuncturists or

shamans that offer treatments to various groups of people in western societies, including migrants, but also “native” members of the host society.

One of the theoretical tools that may be used to discuss healthcare pluralism across societies is the model of healthcare sectors proposed by Kleinman (1980). He suggested that, in any society, the healthcare system consists of three sectors: popular, folk and professional. The popular sector includes all unspecialised healthcare activities initiated and carried out within the family and social networks. The folk sector includes specialised healers that do not belong to the professional sector, such as herbalists or traditional birth attendants. Finally, the professional sector includes formally trained physicians that belong to the nationally recognized official healthcare system. In the case of western societies, the professional sector consist of representatives of biomedicine¹ such as formally trained GPs, specialist doctors, nurses or midwives. Thus, using the model suggested by Kleinman (1980), healthcare pluralism may be seen as the coexistence of these three sectors in a particular society. Such a system provides a set of different healing options and interpretations of health problems for people afflicted by ill health.

Taking the perspective of healthcare pluralism as a coexistence of different sectors as a point of departure, subsequent research showed that in order to alleviate health problems people usually draw on a variety of resources belonging to different healthcare sectors (Helman 2007, Janze 1978, Kleinman 1980, Lock 1993, Moore 2010). In his research on health practices in two Northern Ireland communities, Moore (2010) showed that folk healers constituted an integral part of local healthcare resources available to people in these two communities. Many people went to see these practitioners, most often parallel to accessing professional healthcare services. As Moore (2010) demonstrated, sometimes people went to the professional doctor first. If they found the prescribed treatment did not work, they turned to the local folk healers for help. At other times, they initially went to the folk healer but then turned to professional physicians if they believed the illness was more serious or not suitable for being treated solely in the folk sector. Moreover, physicians from the professional sector were aware of the presence of folk healers in the community and in most cases recognised their work as valuable for cases of minor health problems. As a result, the folk and professional sectors coexisted in the two communities, providing different treatment options to local residents.

¹ I use the term biomedicine, western medicine and modern medicine interchangeably.

Studies that conceived healthcare pluralism in terms of the coexistence of different healthcare sectors rarely questioned the uniformity of the biomedical professional sector. Whereas the folk sector is often seen as internally pluralistic, locally bounded and including of a variety of healers with different ideologies, interpretation and approaches to health and healing, the biomedical system is often assumed to be unitary and immune to local interpretations and specificities. Western medicine is often depicted as being objective and, as a result, winning over the multiple other forms of healing, such as traditional herbalists, midwives or irregular doctors. Indeed, because biomedicine is perceived as the most scientific form of healing and backed by national and international funding, it has managed to gain a privileged position and dominate over other forms of healing in most societies (Ehrenreich and English 1973).

However, several scientists (Good 1995, Hahn and Kleinman 1983, Lock 1993, Lupton 1999, MacFarlane and de Brún 2010, Martin 1987) questioned the seeming objectivity and uniformity of biomedicine and argued that it is by no means immune to local interpretations and social or cultural-specific meanings. For Hahn and Kleinman (1983) biomedicine:

is not simply a natural phenomenon but an artifact of human society, founded in a cultural framework of values, premises, and problematics, explicitly and implicitly taught by the communications of social interaction and then enacted in a social division of labor in institutional settings (Hahn and Kleinman 1983, p. 306).

Thus, from this perspective, biomedicine is a cultural system influenced and shaped by local interpretations and meanings, as well as by global political and economic forces. The result is not a unitary body of knowledge and practice, but a plurality of biomedicines practiced in various locations (Good 1995, p. 462).

The differences among these biomedicines include, for example, the nature and dynamics of the doctor-patient relation, the structure of the healthcare system, and even varied therapeutic options. For instance, based on the data on preferred oncological treatments, Good (1995) noticed that there are considerable differences between some European countries and the United States in the types of surgeries favoured by doctors. While in Europe surgeons often opted for less invasive surgeries in treating breast cancers, this was not the case in the United States. In the latter country, in many hospitals doctors continued to prefer more invasive treatments (Good 1995, 467). There were even considerable

differences in the choice of the type of surgery between the different states in the US. Thus, the types of treatment patients were presented with and were likely to receive very much depended on local traditions and doctors' interpretations of what works best.

Studies comparing national biomedical healthcare systems in various countries provide abundant examples of the differences in the organisation of professional sectors across the globe. As a result of these differences, people are presented with varying care options and treatments that are locally often believed to be the best practice. In their study on the structure of maternity care in the UK, Finland, the Netherlands and Canada, Benoit et al. (2005) show how state's definition and approach to citizens' rights, gender roles, professional competence or market principles in healthcare support certain types of maternity care while discouraging others. While all four countries are characterised by very good maternal health outcomes, their maternity services are structured differently. In the UK and Canada, the governments had only recently started to support midwifery after a period of medical doctors' domination over other healthcare professionals providing care in childbirth. This change in governmental support was expressed in terms of rationalisation of public funds and consumers' rights to choose between different care options. In contrast, both the Netherlands and Finland have a long tradition of midwives as sole attendants of childbirth. However, while in Finland the overwhelming majority of births, although attended by midwives, take place in the hospital and there is little governmental support in offering different options (such as home births), in the Netherlands the government strongly supports home births and midwifery-led care. As a result of these structural differences, pregnant women attending the professional healthcare sector in these four countries are likely to receive different care, be attended by different specialists and, finally, give birth in different places. In this sense, the professional healthcare sector in these countries does not represent a unitary body of knowledge and practice, but rather results from local interpretations and traditions.

One way in which these local traditions are brought together is through migration. In studies on migrants' healthcare practices, the concept of healthcare pluralism was usually employed in terms of availability of, and migrants' use of therapeutic options other than those offered by biomedicine in their host country. These options included, for instance, folk healers consulted by migrants in their host and home countries as well as practitioners of Complementary and Alternative Medicine (CAM), such as doctors trained in traditional Chinese medicine. In the already mentioned study on Chinese migrants in the UK, Green at

al. (2006) showed how Chinese migrant women draw on both biomedical services provided by British doctors and on treatments such as acupuncture, provided by doctors trained in Chinese medicine. In this context, the healthcare pluralism that Chinese migrants draw upon in the UK involved a coexistence of biomedicine, as practiced by British doctors, and therapeutic options that had their roots in other healing traditions. In some rare cases, these other therapeutic options might have been partially incorporated into biomedical practices, as is sometimes the case with acupuncture or aromatherapy, but this partial incorporation does not make them strictly biomedical practices. Thus, in studies of migration, healthcare pluralism was usually analysed in terms of migrants' use of professional and folk sectors.

However, in their study on Eastern European refugees and asylum seekers in Ireland, MacFarlane and de Brún (2010) argued that the traditional approach to healthcare pluralism does not fully reflect migrants' healthcare practices. Thus, they offered a wider definition of the concept that includes not only recourse to treatments that are derived from different healthcare sectors or from different healing traditions (for example western or Chinese), but also a coexistence of various biomedicines. In their already mentioned study conducted in Ireland, they suggest that Eastern European migrants' strong preference for biomedicine from their home country and their dissatisfaction with GP services in Ireland result from "the mismatch between different socio-cultural presentations of biomedicine offered differentially in Galway, Croatia, Serbia, Russia and the Ukraine" (MacFarlane and de Brún 2010, p. 186). Contrary to popular beliefs and expectations that assumed strong reliance on folk and popular sectors on the part of the migrant, Eastern European migrants did not necessarily look for forms of care that were alternative to biomedicine. Rather, they usually strongly relied on biomedicine. However, they were dissatisfied with it and, as a result, tried to avoid biomedicine as it was practiced by Irish GPs. What they did instead was seek more "familiar biomedicine" (MacFarlane and de Brún 2010, p. 195), that is, the form of biomedicine practiced in their home country. In this context, as suggested by MacFarlane and de Brún (2010), migrants' use of their home country's biomedicine may be seen as a form of engagement with healthcare pluralism that I would call "transnational healthcare pluralism". Different healthcare sectors or different healing traditions do not lie at the core of healthcare pluralism in this particular case. Rather, the term encompasses different biomedicines understood as "different socio-cultural mediations of biomedicine" (MacFarlane and de Brún 2010, p. 186). The different biomedicines are brought together by migrants via their cross-border movement. This way

of defining healthcare pluralism in the studies on migration seems innovative and provides a new lens for looking at migrants' healthcare practices.

In my analysis of the Polish migrant women's healthcare practices, I use the concept of healthcare pluralism as proposed by MacFarlane and de Brún (2010). In this perspective, different socio-cultural mediations of biomedicine (in the case of my study Polish and Irish) form healthcare pluralism by being seen as different therapeutic options available to people who engage in health seeking strategies. This approach to healthcare pluralism allows me to look at Polish and Irish healthcare services as different sectors shaped by local traditions, interpretations and culturally specific meanings that may lead to differences not only in doctor-patient relations, but also in the very structure of healthcare services and in the availability of therapeutic options.

The different biomedicines referred to above are brought together by migrants and their use of their host and home country healthcare services. The latter may include services provided both in migrants' host country by doctors trained in the migrants' home country as well as services provided by doctors in migrants' home country. Thus, in order to account for migrants' use of their home country's healthcare services provided in their host country, as well as for the migrants' cross-border movement in seeking medical care, I use the term "transnational healthcare pluralism" instead of the term "healthcare pluralism". It seems that the former term is better suited to describe the situation of two biomedicines "coexisting" as a result of migrants' cross-border movement in seeking medical care on the one hand, and of the "migration" of biomedicine in the form of "migrant" clinics on the other.

This brings us to the next question that needs to be considered, namely the theoretical and methodological tools used to grasp migrants' healthcare practices. So far I have discussed the tools that allow me to unpack the power configurations within healthcare services, as well as tools to problematize the relations between the different healthcare systems. In the following part of the chapter I review various perspectives developed in the social sciences in the field of migration and healthcare. I pay particular attention to studies that looked at migrants' access to and use of healthcare services and draw the lessons that these studies may offer us in looking at migrants' healthcare practices.

2.3 Migration and healthcare: toward the transnational perspective

Research that explored the relationship between migration and healthcare often took as a starting point the differences between the migrants' health status and that of the "native" population of the host country (Jayaweera and Quigley 2010, Lalchandani et al. 2001, Lyons 2004, Razum et al. 1998, Williams and Ecob 1999). Studies investigated the relations between a variety of factors (such as the length of stay in the host country, ethnicity, language proficiency, socio-economic position or country of origin) and the health status of the members of particular migrant groups. Some of these studies reported better health outcomes among migrants than non-migrant population (Razum et al. 1998). Razum et al. (1998) showed that Turkish migrants living in Germany have considerably lower mortality rate than the German population. They explained these findings in terms of "unhealthy re-migration effect" (Razum et al. 1998, p. 302), arguing that sicker and less successful migrants tend to migrate back to Turkey, while the more successful and healthier individuals (whose mortality rates are likely to be low) tend to stay in Germany.

Other studies, however, showed that some migrant groups have poorer health indicators than the non-migrant population (see for example Hyde et al. 2004 and Lalchandani et al. 2001 on Ireland, or Williams and Ecob 1999 on the UK). Researchers usually link these results with the process of migration and factors such as loss of social networks, increased levels of stress, falling living standards or lack of knowledge on healthcare services in the host country (Hyde et al. 2004). From this perspective, migration and processes associated with it are seen as potentially sickening. Migrants, especially those coming from poorer countries, usually not only occupy lower socio-economic positions in their host country, but also experience additional disadvantages that can negatively influence their well-being. For example, in their study on Irish migrants in the UK, Williams and Ecob (1999) suggested that additional disadvantages experienced by Irish migrants can explain their higher mortality rates when compared to the general population in the UK. As Irish migrants tended to cluster in low-paid jobs and live and marry within their own communities, they had very small chances of upward social mobility. This vulnerable position was further aggravated by the hostile attitude of the host society. This, in turn, led to an even greater isolation of Irish migrants and even smaller chances for upward social mobility. Thus, Irish migrants experienced a series of additional disadvantages compared to the non-migrant population in similar economic and social positions. As suggested by Williams and Ecob (1999), this resulted in higher mortality rates among Irish migrants.

Studies looking at the migrants' health status provide various perspectives for looking at the way migration and processes associated with it may influence people's health. They point to the importance of acknowledging that the migrants' health status may differ, for a variety of reasons, from the health status of the general population in the host country. In my study on Polish migrant women's healthcare practices I do not look into the health status of Polish migrant women, but focus on access to healthcare and Polish migrant women's use of healthcare services in Ireland and in Poland. Nonetheless, I bear in mind that migrants' health can be influenced by different processes than the health of the "native" population. As a result, migrants may have different health needs than the non-migrant population and this may influence the way they engage with healthcare services. Thus, in order to understand migrants' healthcare practices, it is necessary to look at their health status and, following it, health needs.

Research that explored the relation between migrants' position in the host country and their use of the host country's healthcare system often focused on a variety of barriers that prevent migrants from accessing healthcare in the host country (see for example Holmes 2012 on Mexican migrants in the US, or MacFarlane and de Brún 2010 on refugees and asylum-seekers in Ireland). Some of these barriers may be "formal", such as lack of health insurance, high prices of healthcare services, or lack of entitlement to the host country's healthcare services. In such a case, the reason behind migrants' noted avoidance of healthcare services in the host country may lie in their fear of the elevated costs of such services. In the case of migrants engaged in undocumented work, they may also fear disclosure and deportation (Osipovič 2013, p. 104). However, apart from the "formal" barriers, migrants may also experience a variety of "informal" barriers, such as problems with communication, accusations of abusing social security services, cultural misunderstandings, ethnic stereotypes, racism or discrimination. In this case, migrants' avoidance of healthcare services in the host country may be attributed to the fear of being stigmatised and mistreated. Thus, despite having formal access to healthcare services in the host country, migrants may be prevented from receiving satisfactory care due to "informal" barriers.

One of the major informal barriers that hinders migrants' access to healthcare and prevents them from receiving satisfactory care is cultural assumptions held by healthcare personnel. For instance, medical staff may think that migrants themselves are to blame for their poor health. Holmes (2012) provided an example of this blaming mechanism in his

study on poor Mexican migrants living in the US. He showed that physicians providing care in American health clinics to poor undocumented Mexican migrants understood very little about their life situation. They also held several, often contradictory assumptions on their patients' culture, practices or biological make-up. For example, some physicians believed that Mexican migrants attended folk healers instead of medical doctors, engaged in domestic violence or had bad diets, which resulted in their poor health. Such assumptions, combined with the doctors' reductionist biomedical approach to health and with structural barriers such as rushed appointments or lack of interpretation services, made physicians blame migrant patients for their health (Holmes 2012). Social and economic factors, such as very low standards of accommodation, physically demanding work or frequent changes in the place of residence due to the migrants' undocumented status, were not taken into account in medical encounters despite the fact that they hugely contributed to migrants' poor health. As argued by Holmes (2012), the blaming of the migrants' culture or practices, and poor understanding of their situation by American medical staff resulted in great dissatisfaction with healthcare services on the part of the migrants and added to their reluctance to access healthcare in the host country.

Studies focusing on the barriers that migrants encounter while engaging in healthcare practices provide a very valuable tool for looking at the power dynamics within the particular healthcare system. However, as Migge and Gilmartin (2011) rightly pointed out, the "barrier" perspective privileges the national state in the context of migrants' engagement with healthcare services. Indeed, studies taking the "barrier" perspective usually explored migrants' encounters with the host country's national healthcare system or their use of the popular or folk sectors within the borders of a nation state. It is only recently that scientists have started to move their investigative frameworks beyond state borders and address the issue of migrants' cross-border mobility as an integral part of their health-seeking practices (see for example Glinos et al. 2012, Green et al. 2006, Lee et al. 2010, MacFarlane and de Brún 2010, Migge and Gilmartin 2011, Stan 2015). These studies found that while migrants usually use the host country's healthcare system, they also travel to their home countries and beyond to access healthcare services. Thus, instead of limiting their analyses to migrants' interactions with healthcare services in host countries, the authors of these studies started from the assumption that migrants' healthcare practices have to be understood in a broader, transnational context.

One of the key elements these studies explore are the reasons why some people engage in patient cross-border mobility (Glinos et al. 2010) or what Stan (2015) calls transnational healthcare practices. By looking at both the micro and the macro levels, Glinos et al. (2010) investigated and mapped various motivations and structural factors that set people in motion to search for healthcare. Although they did not look specifically at migrants but more broadly at patient mobility, Glinos et al. (2010) constructed a practical tool to group people's travels to access healthcare outside their country of residence according to their motivations and the ways they pay for it. The researchers identified four main types of motivations (availability, affordability, familiarity and perceived quality) and analysed them in conjunction with two types of funding (with cover and not covered). In this way they suggested eight possible scenarios of why patients travel and how they pay for it.

For example, patients may decide to travel because certain services (such as abortion, fertility treatment, highly specialised care) are not available in their country of residence due to legal restrictions, long waiting times, lack of technology or specialist care (availability). They may also seek healthcare in another country because it is cheaper (affordability), more familiar (familiarity) or perceived to be of higher quality than in the country of residence (perceived quality). In some cases patients pay out-of-pocket, usually in the case of services that are outlawed in their country of residence (e.g. abortion services) or available but expensive (e.g. fertility treatments or dental care) (not covered). In other cases, they may be reimbursed or entitled to access services for free at the point of delivery – usually when travelling as a part of bilateral agreements between countries. The eight possible scenarios proposed by Glinos et al. (2010) constitute a practical tool that allows us to systematize a very diverse phenomenon of cross-border patient mobility that exists across the world.

The study by Migge and Gilmartin (2011) adopted the tool developed by Glinos et al. (2010) and used it to discuss the phenomenon of patient mobility among migrants in Ireland. The two researchers show that many recent migrants preferred to travel to their countries of origin to access healthcare services instead of accessing planned care in Ireland. As they argued, the motivations behind migrants' travelling for care fell into the four categories proposed by Glinos et al. (2010). First, some migrants travelled because they lacked knowledge of the Irish healthcare system, they felt confused and misinformed or thought certain treatments were unavailable (perceived availability). Second, some declared that care in Ireland was expensive so they preferred to access treatment back home

(affordability). Third, some migrants thought that the quality of care in their countries of origin was better than in Ireland (perceived quality). And finally, they travelled because they were more familiar with the services in their home countries and felt more at ease with them than when accessing healthcare in the host country (familiarity). As Migge and Gilmartin (2011) suggested, the fact that migrants accessed healthcare in their home countries and avoided accessing it in Ireland points to the shortcomings of the Irish healthcare system in providing for a diverse population. In this sense, analysing the individual motivations behind migrants' travels may be a fruitful way toward identifying these shortcomings and improve healthcare provision in migrant populations (Migge and Gilmartin 2011).

One of the aspects that studies taking a transnational perspective brought into the research on migration and healthcare is the shift of focus from looking primarily at migrants' access to services (or lack of it) to looking also at migrants' preferences and individual motivations. Migrants' preferences and motivations governing the search for healthcare outside host countries are rooted in the local characteristics of the different biomedicines (both in host and home countries). In other words, the transnational perspective points out that access is not the only factor that influences migrants' healthcare practices. Migrants' expectations concerning the ways in which biomedicine is practiced are also very important.

There is a growing body of literature that looks at migrants who, despite having access to healthcare services in their host countries or the means to pay for them, still chose to travel to their countries of origin, mainly because they are more familiar with the healthcare services in their countries of origin and perceive them to be of higher quality. Lee et al. (2010) demonstrated that professional Korean migrants working as skilled professionals in New Zealand had very strong preferences for Korean healthcare services and chose to travel back to Korea whenever they had major health problems. Lee et al. (2010) linked these preferences to such problems as language barriers that migrants encountered when accessing healthcare in the host country. They also pointed to the importance of past experiences with the Korean healthcare system. Migrants' past experiences shaped their expectations concerning the form healthcare encounters should take. For example, Korean migrants had very strong preferences for specialist care instead of primary care because they often by-passed the primary care level and went directly to a specialist in Korea. They also wanted their doctors to be more confident in stating the

diagnosis and thought that GPs in New Zealand are less authoritative than doctors in Korea. In addition, some migrants said that they felt more “at home” in Korea than in New Zealand and this feeling provided them with additional comfort during medical treatment. Thus, as showed by Lee et al. (2010), despite having formal access to the healthcare system, Korean migrants preferred to use healthcare services in Korea. As skilled professionals, they were in a relatively good financial situation and therefore could afford air fares and hospital bills in Korea.

Also, in the already mentioned study on refugees and asylum seekers in Ireland, MacFarlane and de Brún (2010) showed that contrary to popular belief in the host society, the participants of their study had a very strong preference for their home countries’ medical services. Those of the refugees who could travel back, obtained treatment in their countries of origin. Others contacted doctors back home over the phone or requested their families back home to send them medications to Ireland. In this way they avoided visiting GP surgeries in Ireland and asserted the superiority of their home countries’ healthcare services over the Irish ones. In this sense, similarly to the study by Migge and Gilmartin (2011), MacFarlane and de Brún (2010) advocated the need to look beyond the nation-state borders and concentrated on migrants’ preferences for their home country’s healthcare services.

While some migrants have strong preferences for one particular healthcare system (usually their home countries’), many use healthcare services in their host countries in parallel to the services in their home countries. Green et al. (2006) showed that Chinese migrant women in the UK attended either British doctors or Chinese medicine practitioners depending on their interpretation of the symptoms they suffer from. Whenever they interpreted certain of their health problems to be “Chinese complaints”, migrant women believed that Chinese doctors were more suitable to effectively deal with them. In such cases they sought help in Chinese medicine either in the UK or in China. By contrast, when they interpreted their health problems as more likely to be effectively dealt with by western biomedicine, the migrants went to British clinics. In addition, Green et al. (2006) argued that some of the migrant women used Chinese medicine as a way of overcoming barriers they encountered within the British system. For example, women turned to Chinese practitioners when they felt that the treatment prescribed to them by British doctors did not work, or when they had communication problems or felt that they were being discriminated against by the British healthcare personnel. In such situations, the use

of Chinese medicine did not result from drawing on a particular explanatory model (Kleinman 1980), but from the barriers migrants encountered in accessing healthcare services in the host country. Thus, as Green et al. (2006) demonstrated, Chinese migrants' reliance on both their host and home countries' healthcare services resulted not only from the simple preference for a particular system, but also from the barriers inhibiting access to services in the host country.

This takes us to the next aspect that needs to be considered in terms of migrants' use of their home country services, namely the link between migrants' transnational healthcare practices and the position migrants occupy within the host and home societies. For example, if undocumented, migrants' status may preclude them from accessing healthcare services in their host country and in some cases even from travelling to their country of origin to access care there. Moreover, documented migrants may no longer be entitled to public healthcare services in their countries of origin so their access to healthcare may depend on their financial resources or social connections. Also, some may not be able to afford the costs of travel to their country of origin to access care there. Thus, migrants' transnational healthcare practices are strongly mediated by the position they occupy in the host and home societies.

Stan's (2015) study on Romanian migrants in Ireland may serve as an example of the perspective that stresses the importance of taking into consideration migrants' social position when analysing their healthcare practices. By taking the example of Romanian migrants in Ireland who prior to 2012 did not have access to the Irish labour market, Stan (2015) shows how their legal and socio-economic position is crucial for understanding their healthcare practices. Indeed, while migrants in highly skilled, low skilled and undocumented employment all frequently used Romanian healthcare services, their concrete practices differed considerably from one group to another and reflected high inequalities in access to care in Romania and Ireland. In the study, highly skilled migrants tended to stress the idea of choice when speaking of accessing healthcare services in Romania. They saw their decision to access Romanian services as being driven not by necessity but rather by the possibility to choose from different options (using either the Romanian or the Irish healthcare system, or both). Their access to healthcare services in Romania was therefore facilitated by their social, economic and cultural capital. They either paid for private clinics or they used their social connections or informal payments in order to access better care in public healthcare facilities.

In contrast, for migrants who occupied lower positions on the socioeconomic ladder or were engaged in undocumented work in Ireland, Irish healthcare services might have been prohibitively expensive. As a result, the Romanian healthcare system remained their main source of care. Despite living in Ireland, they continued to pay their public health insurance premiums in Romania in order to ensure access to public healthcare services. In some cases, they also used the money accumulated in Ireland to pay for private care in their country of origin.

Thus, although on the surface Romanian migrants' use of the healthcare system in their country of origin may seem as following a similar pattern for all migrants, it strongly depended on migrants' social position and reflected social inequalities in the host and home countries. Particularly, migrants' transnational healthcare practices reflected highly unequal access to healthcare caused by the increasing privatisation of healthcare services taking place across Europe (Stan 2015). However, as argued by Stan (2015), these practices not only reflect but also contribute to the reproduction of inequalities by encouraging the provision of private care and the states' withdrawal from its responsibilities. In this sense, migrants' transnational healthcare practices should be analysed in a broader context of socio-economic configurations including, most notably, privatisation of healthcare services.

The growing body of research that looks at migrants' healthcare practices (see for example Glinos et al. 2012, Green et al. 2006, Lee et al. 2010, MacFarlane and de Brún 2010, Migge and Gilmartin 2011, Stan 2015) demonstrated that the transnational perspective may be a very fruitful approach. Indeed, these studies showed that while some migrants use healthcare services in their host countries, they also frequently travel to their home countries (and beyond) in order to access care. They engage in these transnational healthcare practices for various reasons that are fostered by individual motivations (such as preference for certain forms of care) and shaped by their previous experiences with healthcare services in other countries. However, migrant practices are also embedded in larger socio-economic configurations. In this sense, migrants actively engage with various healthcare systems in order to ensure access to what they believe is good or optimal care, but their practices are strongly influenced by the position they occupy within the host and home societies.

In the context of migrants from Eastern European countries to Western Europe, studies that took the transnational perspective in looking at their health practices showed that migrants do not necessarily perceive the host country's healthcare services as superior to

those offered in their countries of origin (MacFarlane and de Brún 2010). On the contrary, they often assert the superiority of their home countries' healthcare systems and actively avoid using health services in their host countries. In this sense, as noticed by Stan (2015), such studies challenge the popular assumptions about migrants from less developed countries as potential abusers of the already overburdened host countries' social systems.

In looking at Polish migrant women's healthcare practices, I take a transnational perspective that stresses the need to look beyond the context of nation-states in order to understand the way people engage in health-seeking practices. This perspective allows me to look at women's engagement with both their home and host countries' healthcare services. As these practices are embedded in larger structural configurations that are differently realised in both locations, the transnational perspective allows me to look at both these configurations, as well as at the social position that women occupy in their host and home societies.

By engaging in transnational healthcare practices, women bring together the different realisations of biomedicine. In my study, I look at the "confrontation" of different biomedicines in terms of what I call transnational healthcare pluralism. This approach allows me to analyse the different realisations of biomedicine, and particularly the biomedical control over female (pregnant) bodies (as it is practiced in Poland and in Ireland), as different healthcare sectors (Kleinman 1980) that can be compared and contrasted in terms of their structures, their treatment options and the nature and dynamics of the doctor-patient relation. However, in order to compare these elements across different biomedicines, we need first to detail their realisations in particular biomedicines. This is where the concept of medicalisation becomes helpful. As mentioned above, it provides the tools necessary to unpack the power configurations within particular biomedicines.

Thus, in my study on Polish migrant women's healthcare practices, I intend to take a perspective attentive to the larger structural context of healthcare services, as well as to the lived experiences of migrant women who engage with these services. On the one hand, this perspective requires a deep understanding of the local realisations of biomedicine, which includes understanding of the mechanisms that shape the structure of and access to healthcare services in a particular location. On the other hand, it requires a good understanding of the way migrant women engage with the local realisations of biomedicine. This includes women's nuanced patterns of access and the ways in which they

are influenced by women's social position. This encompassing anthropological approach requires theoretical tools that help to problematize and understand the studied phenomena, as well as particular methodological tools. In the next chapter, I discuss the methodological tools I use in my study.

Chapter 3: Methodological approaches: multi-sited fieldwork

As discussed in Chapter 2, the perspective I adopt in this study is attentive to larger structural forces shaping healthcare services in Ireland and Poland, as well as the lived experiences of women who engage with these services. As it focuses on both the macro and micro levels, it requires a set of methodological tools that can be used to collect data at these two levels. Thus, in this chapter I discuss the methodological approach I take in this study, showing how the qualitative methods of research based on semi-structured interviews, elements of participant observation and analysis of the secondary sources of information meet the requirements of a methodological tool that, on the one hand, makes it possible to collect data on Polish women's lived experiences of engaging with healthcare services and, on the other, provides the means to explore the structural factors that shape these services.

3.1 Qualitative methods of research and ethnographic inspirations

In my study on Polish migrant women's healthcare practices, I had employed qualitative methods of research. As noticed by Hammersley and Atkinson (1995, p. 7-9), one of the most common reasons for the use of these methods of research is the assumption that social phenomena are different from physical phenomena and thus call for a different set of tools in order to be understood. In the area of women's health, qualitative methods of research have proven to be very successful in producing rich accounts of women's everyday experiences and uncovering what women themselves have to say about their health (Inhorn 2006). In this sense, qualitative methods of research are a very powerful tool that brings to light the perspective of the individuals the researcher seeks to understand.

In my study, I was particularly inspired by the ethnographic approach to fieldwork. Ethnography, as defined by Hammersley and Atkinson (1995, p.1), is a "set of methods (...) [that] in its most characteristic form involves the ethnographer participating, overtly and covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research". Although I did not fully immerse myself in ethnography, I used elements of it, particularly the approach that encourages one to use whatever sources of information are available to deepen the understanding of a particular social phenomenon. As I explain below, the topic of maternity

care was hardly present in the public spaces where I initially planned to conduct participant observation. Thus, although my research is primarily based on qualitative, semi-structured interviews, in order to better grasp the nuanced character of Polish migrant women's healthcare practices and the larger context in which these practices take place, I also had employed some elements of participant observation and analysis of secondary sources of information such as newspaper articles and internet discussion forums.

3.2 Multi-sited ethnography: Conducting research at various locations

Although my research cannot be regarded as full-fledged ethnography, I was strongly inspired by this approach to fieldwork and by the concept of multi-sited ethnography (Marcus 1995) in particular. The assumption that lies at the core of the multi-sided approach to fieldwork is that cultural formations, ideas, social practices and other subjects of anthropological research that move across different locations are better understood if studied in those different locations than in only one of them.

Multi-sited ethnography departs from the traditional idea of ethnographic fieldwork that involves a long-term stay at a single research site. As Falzon (2009, p. 1) put it, the latter "was understood (...) to be a container of a particular set of social relations, which could be studied and possibly compared with the contents of other containers elsewhere". Traditionally, anthropologists conducted their ethnographic fieldwork by focusing on particular aspects of social lives in a given community in a geographically defined location. In order to contextualise their subjects of research in a larger system, such as for example capitalism, they used secondary sources of information and other scholarship on these larger systems (Marcus 1995, p. 96).

However, Marcus (1995) observed that in contemporary world, cultural logics (as subjects of anthropological investigation) are no longer produced in one local context but are in constant motion, produced and re-produced in various locations (Marcus 1995, p. 97). The multi-sited approach to ethnography responds to changes in the contemporary world by requiring the researcher to follow their object of study (such as people, things, metaphors, stories, biographies, or conflicts) as they move between different locations, and to expand the fieldwork over these various locations (Marcus 1995).

Multi-sited ethnography is particularly attractive for studies of migration, which seems to embody the idea of motion and being influenced by various locations. As migrants move between different places (from their home country to the host country, sometimes passing

through yet other places and countries), they link a variety of locations that shape their social positions and practices. In this sense, undertaking fieldwork in the migrants' host countries as well as in their home countries and beyond adds a very valuable dimension to the study and allows the researcher to better understand and contextualise his or her experiences and assumptions. A case in point is Gallo's (2009) article on conducting fieldwork among Malayali migrants in Rome and in India. Gallo (2009) started her fieldwork in Rome among Malayali migrants. After she moved to India to continue her work among the families of migrants, Gallo (2009, p. 91) started to question some of the experiences and assumptions she had formulated during her fieldwork in Rome. The research in India allowed her to better contextualise her research in Rome by putting it into a larger historical perspective of movement and female migration in Kerala, India. Gallo (2009) stressed that she re-defined her research site as she went along with her fieldwork and that the multi-sited approach allowed her to better contextualise the findings and assumptions from each site. Thus, conducting fieldwork in various locations proved to be a powerful tool, which Gallo (2009, p. 89) termed cross-fertilisation between different fields.

My fieldwork on Polish migrant women in Ireland and their healthcare practices is inspired by the multi-sited approach. I carried out fieldwork in Ireland and in Poland. However, in both sites, the fieldwork was not limited to a specific geographical location, since I interviewed women in different cities. After obtaining ethical approval from the DCU Research Ethics Committee in March 2011, I started my fieldwork in Ireland. Between March and June 2011, I conducted my first interviews with Polish migrant women living in Dublin, Cork and towns nearby. In June 2011, I travelled to Poland where, between June and September 2011, I continued my fieldwork. For most of the "Polish" part of my fieldwork I was located in Warsaw. Although the majority of my interviews were carried out in Warsaw, my network of friends and acquaintances allowed me to contact people living in other places. As a result, I also conducted interviews in my home town of Sieradz, in the city of Łęborg and villages nearby and finally in a town in the south of Poland, where I interviewed one of the returned migrants. I also travelled to the city of Poznań for a conference for midwives. In September 2011, I moved back to Ireland to complete the second part of my Irish fieldwork, during which I conducted more interviews with Polish migrant women living in Dublin.

Although I initially planned to follow Polish migrant women as they travelled back to Poland in order to access healthcare services, this idea quickly proved to be impractical.

Women rarely travelled back to Poland solely for the purpose of accessing healthcare. In addition, I realised that what I really needed in order to contextualise the information I had collected during my fieldwork in Ireland was insight about the inner workings of the Polish healthcare systems and maternity care, since I could not fully understand Polish migrant women's healthcare practices without understanding maternity care and patterns of access to it in Poland. Thus, using Gallo's (2009, p. 89) terminology, fieldwork in Ireland and Poland were cross-fertilised by each other and each provided context for the other. As a result, I did not follow people or things in my research. Rather, I followed what Marcus (1995) called metaphors or associations people make, or the references they have in thinking about social reality. In the case of my study, there were associations and references migrants had in thinking about and using maternity care services.

The fact that my fieldwork was strongly inspired by ethnography allowed me to utilize a variety of qualitative methods of data collection. These included semi-structured interviews and informal conversations, as well as elements of participant observation and analysis of secondary sources of information, such as internet discussion forums, newspaper articles and information leaflets. The employment of various methods and sources allowed me to better grasp the complexity and the nuanced character of Polish migrant women's healthcare practices and the contexts in which they occur. In the following part of the chapter, I discuss each method in turn by providing a brief theoretical background and then discussing the way I used this method in my fieldwork. I also discuss some of the limitations and challenges I encountered during my fieldwork and the way they influenced my research.

3.2.1 Interviews

In their article on the use of interviews in qualitative methods of research, Fontana and Frey (1994, p. 361), stated that interviewing "is one of the most common and most powerful ways we use to try to understand our fellow beings". In social sciences, qualitative interviewing seems to be one of the most extensively used tools to learn about the subject of study. Together with participant observation, they constitute the two pillars of ethnographic fieldwork. Qualitative interviewing is of particular value in studies that seek to uncover patterns in people's practices. As argued by Groleau, Young and Kirmayer (2006, p. 673), qualitative interviews that include a combination of structured and open-ended questions allow the participant to talk about the issues that he or she finds particularly important, but also ensure that certain predetermined topics are not left undiscussed. As a

result, the participant has a chance to “tell their story in their own way” (Groleau, Young and Kirmayer 2006, p. 674) and is not limited to a predetermined set of answers, as is the case with structured interviews. At the same time, structured questions allow the researcher to make comparisons across interviews (Groleau, Young and Kirmayer 2006, p. 674).

In the course of my work, semi-structured interviews with a combination of open-ended and more structured questions became my main research tool. I conducted interviews with two main groups of people: 1. Polish women who were pregnant, had a baby or were frequent users of the healthcare system and 2. healthcare providers (Table 1). Altogether, I conducted forty interviews that lasted from about one hour to over two hours. As all of the participants that I interviewed were speakers of Polish, interviews were conducted in Polish. Twenty two of these interviews were carried out with Polish migrant women. Three of those were carried out with returned migrants who were living back in Poland at the time of the interview. Twelve further interviews were conducted with women living in Poland who used maternity services or, in rare cases, who were frequent users of other healthcare services. Finally, six interviews were conducted in Poland with healthcare providers, including three midwives working in Polish maternity hospitals and private clinics, and three specialist doctors, one of whom specialised in obstetrics and gynaecology. Three women were interviewed twice. In each case, the woman was pregnant during the first interview so I asked for a second meeting after the baby was born to discuss the woman’s experiences with the care she received during labour and with postnatal services.

Initially, to reflect the two sides of the healthcare encounter, in addition to interviews with healthcare users, I planned to interview healthcare professionals both in Poland and in Ireland. However, while doing fieldwork I realised that due to the limited scope of this thesis I need to focus either on healthcare users and their experiences and practices, or healthcare professionals. Thus, I have decided to limit the number of interviews with healthcare professionals and use them mainly for context.

Table 1: Participants in the study

	Ireland	Poland
Women	22	12
Healthcare providers	-	6

In order to find women willing to talk to me, I used the snowball sampling technique. I usually found a first person to talk to through my network of friends or acquaintances. I then asked the person interviewed to suggest other suitable individuals. This way of finding participants proved to be very effective. It was often the case that the women I interviewed spontaneously suggested that I should talk to a friend of theirs and put me in contact with the next person. If a woman did not suggest a new participant by herself, I usually said at the end of the interview that I was looking for other participants and that if there was anyone she thought I could talk to, I would be very happy to be put in contact with them. I always made sure that women did not feel obliged to do that. However, women were usually very willing to put me in contact with another person. As argued by Patton (2001, p. 111-112) this approach to sampling, in which participants recommend other participants, makes it possible to identify key informants in particular areas. I also found that being referred from one person to the next helped to build the necessary trust needed in the relation between the researcher and participants.

When I contacted a potential participant, I provided her with the basic information about the study and asked whether she would agree to an interview. Most of the women I approached agreed to take part in the research. In most of the cases, the interviews took place at the women's homes. This was especially true for women who had small children. In the few cases when the interview did not take place at a woman's home, we met in public spaces, such as cafés. In one case, a woman invited me to her workplace and we talked after she finished her workday. I also conducted two interviews via Skype. However, in both cases I met the woman in person prior to the interview. Unlike interviews with healthcare users, most interviews with healthcare professionals took place in the clinic or in the waiting area of the hospital where these healthcare professionals worked, most often after their shifts. I met one of the midwives in a café.

I tape-recorded and transcribed most of the interviews. After the transcription, the recording was deleted. Before using a tape-recorder, I always asked the participants for permission to do so. The women were generally comfortable with the tape-recorder. The fact that I was tape-recording our conversation did not seem to influence the way they spoke to me, either. For example, when some women saw me switch off the tape-recorder after the interview, they joked that they should have been more careful with the language they used. On the whole, then, tape-recording did not seem to pose any problems for the

majority of women or to make them uncomfortable. However, in a few cases, I refrained from recording from the very beginning. This happened mainly when I noticed that a woman did not feel completely comfortable when talking to me. In these few cases I took detailed notes during and right after the interview.

Unlike the healthcare users, the healthcare professionals were far more reluctant to agree to a meeting. When initially approached, most of them informed me that they were busy and had very little spare time. Despite their initial reluctance, they eventually agreed to meet me and usually suggested their workplaces as a meeting point. Since I believed healthcare professionals would not feel very comfortable with the idea of the interview being recorded, I did not do so. Instead, I took detailed notes.

As already mentioned, the interviews I conducted included open-ended as well as more structured questions, following the approach suggested by Groleau, Young and Kiermayer (2006). In this way, I aimed at allowing women to talk about the issues most important to them, while also trying to establish some links across the interviews I carried out. For example, I asked the women to say what they thought about the Irish maternity services or to describe their experiences with the care they received during labour in Ireland or in Poland. However, I also asked questions concerning the number of ultrasound scans they had during pregnancy or, in the case of women living in Ireland, whether at any stage of pregnancy they accessed maternity services in Poland. The interviews also included questions on the women's basic socio-demographic characteristics, such as education or employment situation, migration trajectories and their plans for the future, including the question of whether they were planning to return to Poland (Appendix 3).

The way I conducted interviews with women was very much inspired by the approach suggested by Oakley (1981). Oakley (1981, p. 40) argued that the traditional interviewing format, in which the researcher only asks questions and refrains from expressing his or her opinions or from answering questions asked by participants, puts the participant in a subordinate position vis-à-vis the researcher and prevents the two from building a trustful relation. Historically, this type of one-sided conversation in which the researcher extracts the information volunteered by the participant without sharing their own thoughts, was believed to ensure the objectivity of this method of data collection. However, Oakley (1981), who repeatedly interviewed women about their experiences with pregnancy and motherhood, found this type of interviewing unfruitful and morally indefensible. She noted that repeated interviews and conversations about such intimate topics like pregnancy,

birth-giving or motherhood led to her building a relation between her and the women she talked to. Women not only shared their experiences with her and answered questions, but also asked questions themselves. In this situation, dismissing those questions and following the traditional approach to the interview struck Oakley (1981) as both impractical and exploitative.

My experience with interviewing women about their pregnancy and maternity care very much reflects what Oakley (1981) described in her article. Not only did the women ask me numerous questions during our conversations, but it was also not uncommon for me to help them with some chores, baby-sit their children, help them carry their shopping bags or prams up and down the stairs or interpret for them. Some women walked me back to the bus stops after the interview to continue the conversation. In this situation, refusing to answer the questions they asked seemed unfair and, as argued by Oakley (1981), exploitative. Thus, whenever women asked me about my marital status, family plans, migration trajectory, or utilisation of healthcare services, I answered their questions. This said, I always made sure that women understood that I am a social scientist and have no medical training, thus not being in a position to advise them on any health issues. Women seemed to understand this very well and did not ask or expect me to advise them on their health issues. A few women asked me questions concerning social services, including childcare and maternity leave. In these few cases, I gave them a printout of the information from the Irish *Citizens Information* website or referred them to organisations such as *Cairde*, an Irish community organisation working in the area of migrants' health and well-being. A few women I interviewed became my friends and we have continued to stay in touch.

One of my concerns before starting fieldwork was that women may be unwilling to talk to me about such intimate experiences as pregnancy and childbirth. As I did not have children myself, I worried that women would assume that I am not a person with whom they could share these experiences. However, my concerns were not warranted. On the contrary, I found that women were very eager to talk to me and to share many details of their lives. In retrospect, one of the reasons why the women felt comfortable talking to me could have been the fact that I shared some of my own experiences with them. In addition, I had the impression that some of the women simply needed someone with whom they could share their experiences connected to maternity care, childbirth and pregnancy. They might have treated me as a safe person to talk to because I expressed a keen interest in their

experiences and asked many questions. Moreover, since I was not connected to their network of family and friends, there was a good chance they would not see me again. In some cases, this seemed to have helped women to be more open about their experiences.

3.2.2 Elements of participant observation

Although semi-structured interviews constituted the core of my fieldwork, during my research, I also used some elements of participant observation. In ethnographic research, participant observation is usually understood as a “method in which a researcher takes part in the daily activities, rituals, interactions and events of a group of people as one of the means of learning the explicit and tacit aspects of their life routines and their culture” (DeWalt and DeWalt 2002, p. 1). Together with other methods of data collection, such as qualitative interviews, informal conversations and analysis of secondary sources of information, it constitutes the core of ethnographic fieldwork. In traditional ethnographic research, often focused on small communities geographically and culturally distant from those of the researcher, participant observation meant that the researcher lived and interacted on a daily basis with the members of the community he or she aimed to learn about.

As mentioned above, in my research on Polish migrant women’s healthcare practices, I did not fully immerse myself in this traditionally defined participant observation. Although I initially planned to do so, I quickly realised that the topics I wanted to explore were hardly present in the spaces where I conducted participant observation. For example, in order to learn more about the issues concerning the Polish community in Ireland, I started going to the cultural events organised by the Polish embassy in Dublin and by other Polish organisations, particularly *Forum Polonia*. I also started going to the local Polish church and attended weekly masses. I sat for hours in Polish cafés and cafeterias and visited several Polish shops operating in Dublin. I attended Polish festivals and went to information meetings and workshops organised for Polish migrants in Ireland. However, the topic of healthcare, let alone maternity care, was hardly mentioned in these settings. Consequently, I decided to limit participant observation to the few, selected strategic events during which I knew that maternity care, pregnancy and healthcare would be discussed and to rely more on qualitative interviews instead. As noticed by Warren (2002, p. 85) the practice of choosing qualitative interviewing over ethnography (which strongly relies on participant observation) is common among the researchers that seek to find some patterns or themes among members of a particular group rather than investigate a particular setting.

Although I did not undertake systematic participant observation, I did use elements of it. For example, during my fieldwork in Ireland I attended an open day at the Polish clinic in Dublin that had just started to offer prenatal classes for future parents. Furthermore, I went to several information meetings and health forums for members of ethnic minorities organised by *Cairde*: an Irish organisation working in the area of migrants' health and wellbeing. Of particular interest to me were the meetings organised by *Cairde* for Polish migrants on maternity care and childcare services available in Ireland. In order to learn about the barriers that Polish migrants might face when accessing healthcare services in Ireland, I approached *Cairde* and offered to work for them as a volunteer. As a result, once a week between February and June 2011, I volunteered in a drop-in centre of *Cairde*, where I provided advocacy work.

In addition, during my fieldwork in Poland, in June 2011, I attended a conference for midwives and other healthcare professionals working in the area of women's health, organised by the foundation *Childbirth with Dignity*, a Polish organisation working in the area of women's health. The conference was focused on the newly introduced Decree on the Standards of perinatal care in Poland (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012). In September 2011, I took part in a meeting with the Polish Minister of Health concerning the recent changes in maternity units after the introduction of the aforementioned Decree. While in Poland, I also approached the *Childbirth with Dignity* foundation and offered to work for them as volunteer. As a result, between June and September 2011, I helped them organise workshops and conferences for midwives and other maternity care professionals. This volunteering experience gave me the opportunity to participate in various meetings related to the topic, during which I took very detailed notes.

A final element of participant observation I found to be essential were the numerous informal conversations I had with Polish migrant women, other maternity healthcare users and providers, or activists working in the area of women's health and migration. Although most of my data comes from qualitative interviews, the informal conversations provided me with the context of maternity care and migrants' well-being issues in Ireland and Poland. This not only became a valuable source of inspiration for some of the questions and topics that I developed during interviews, but also provided me with crucial knowledge that helped me to interpret and analyse the data I had gathered during interviews. In sum,

my fieldwork consisted of qualitative interviews which went hand in hand with elements of participant observation, informal conversations included.

3.2.3 Using secondary sources of information

On a very general level, the material gathered in qualitative research falls into two categories: the material generated by the researcher (such as interviews carried out by the researcher) and the material that a researcher did not generate himself or herself (such as previous studies, newspaper articles or television programmes) (Peräkylä 2005). Although in some qualitative research, particularly that inspired by ethnography, the division between the two is not clear cut, the type of data that comes closest to the second type of material are already recorded conversations (for example, recorded radio interviews) and already written texts (for example, newspaper articles) (Peräkylä 2005, p. 870). During my fieldwork, I accessed several types of these sources of data. Like the data I gathered using elements of participant observation, the already existing material provided me with the context of the problems emerging in the area of maternity care and migrants' well-being. Additionally, it proved to be an excellent source of information about the barriers that migrant women may encounter while accessing healthcare services.

By way of example, in order to learn about the problems surrounding maternity care, general healthcare and migrants' well-being in Ireland, I regularly followed newspaper articles on the relevant topics published in the most important Irish dailies (such as *The Irish Times* and *The Irish Independent*) and Polish dailies (such as *Gazeta Wyborcza*). I also followed articles posted on several information portals such as IrishHealth.com, AIMS Ireland, GdzieRodzic.Info, which specialise in the area of health and maternity care. I read information provided on the websites of the Polish and Irish maternity hospitals and clinics, including the websites of the clinics run by Polish doctors in Ireland. I collected and read leaflets with information concerning maternity care and access to healthcare in Ireland and in Poland. All these secondary sources of information provided me with a great deal of practical information, such as the prices of some of the maternity services and packages offered at Polish and Irish hospitals and clinics, or the list of prenatal screenings offered within both healthcare systems. They also allowed me to learn about various problems arising in the area of maternity care or migrants' well-being. This included, for example, controversies linked to the workings of particular maternity units in Ireland and in Poland. Moreover, secondary sources of information allowed me to gain a better understanding of the way migrant women and their healthcare practices may be depicted in the media.

One of the most important secondary sources of information that I used in my fieldwork were internet discussion forums. For several months between January 2011 and March 2012, I followed various discussion threads on Irish and Polish forums dedicated to pregnancy and maternity care. The forums that I followed for discussions among future parents (mainly pregnant women) living in Ireland included Mum2be.ie and RollerCoaster.ie. It seems to me that Polish migrant women living in Ireland very rarely, if at all, took part in these discussions. In fact, I never identified any of the posts as having been written by a Polish woman.

For discussions among Polish migrant women living in Ireland, I followed threads on gazeta.ie, a Polish portal run for the members of the Polish community in Ireland, during the same period of time (January 2011-March 2012). As a matter of fact, discussions concerning maternity care in Ireland were among the most popular on this portal. Women taking part in the discussions there not only shared their experiences concerning pregnancy, but also sought practical information, such as contact details for particular healthcare providers, opinions on particular doctors or information regarding the prices of healthcare services offered in Ireland and in Poland.

Internet discussion forums proved to be a great source of information because they gave me an inside look at the issues that at least some women were concerned with. They helped me to identify some of the themes that could be developed during qualitative interviews, such as women's expectations towards the healthcare services. They provided me with a wealth of knowledge on women's healthcare practices and pathways within the Irish and Polish maternity care. Finally, they were a great source of information about the barriers that women may encounter while seeking maternity care.

While the data I collected through qualitative interviews together with the analysis of discussions on internet forums provided the bulk of material for Chapters 6, 8, 9, and 10, the analysis of the secondary sources of information, particularly newspaper articles and acts of law, are the basis of Chapters 5 and 7 as well as Chapter 11.

In this chapter, I discussed the methodological approach I take in this study in order to collect data on the healthcare practices of Polish migrant women and the structural context that these practices take place in. In the next chapter, I turn to painting a picture of the subjects of my study, namely Polish migrant women. I try to answer the question of who

are Polish migrant women living in Ireland and what position they occupy in their host and home countries.

Chapter 4: Polish migration into Ireland

The perspective I adopt in looking at Polish migrant women's healthcare practices requires attention to the women's social position which is an important factor influencing women's access and use of healthcare services. Thus, in this chapter, I look at Polish migration and situate the recent Polish migrant women living in Ireland in the larger context of migratory movements from Poland as well as migratory movements into Ireland. I seek to answer the question who are the Polish migrant women living in Ireland and what positions do they occupy in the Irish and Polish societies.

4.1 Postsocialist Polish migration (1990s – 2004)

Poland has a long tradition of being a country of emigration. Since the 19th century it has acted as an important reservoir of labour for Germany and North America (Okólski 1994). Throughout the 20th century, migration from Poland continued, increasing especially during and immediately after the two world wars. Even during the socialist regime, despite the restrictive regulations on international travel and migration, people continued to leave Poland.

The political and economic changes brought about by the fall of the socialist regime in 1989 had a strong impact on Polish migration. First, the Polish state lifted restrictions for international travel for its citizens. Second, at the beginning of the 1990s, the series of economic reforms known as the Balcerowicz Programme were launched (Hardy 2009). Their main aim was to introduce a market economy in Poland as fast as possible by, among others, dramatically limiting government spending and increasing interest rates. As a result, during the initial phase of the transformations, the standard of living in Poland decreased and unemployment rates increased significantly (Hardy 2009). Table 2 shows the initially negative GDP growth and the rise in unemployment rates in Poland. While in 1990 the unemployment rate was 6.5 per cent, it almost doubled by 1991 reaching the level of 12.2 per cent. (GUS 2014). Following the return to positive economic growth after 1992 the unemployment rates decreased to a low of 10.3 per cent by 1997 (GUS 2014). However, by the end of the 1990s economic growth slowed down once again and the unemployment rate reached 17.5 per cent in 2001 (Grabowska 2003). Many people, especially semi-skilled and unskilled workers lost their employment and struggled to find a job. For some of them migration to the West was one of the ways to improve their economic position.

Table 2: Polish GDP growth and unemployment rates 1989-2014

Year	% of GDP growth	Unemployment rate	% of real wage growth
1989	0.2	-	6
1990	-11.6	6.5	-14.7
1991	-7	12.2	5.9
1992	2.6	14.3	-0.4
1993	3.8	16.4	-0.6
1994	5.2	16	3.5
1995	7	14.9	6
1996	6.2	13.2	4.3
1997	7.1	10.3	6.6
1998	5	10.4	4.1
1999	4.5	13.1	2.1
2000	4.3	15.1	1.6
2001	1.2	17.5	2.6
2002	1.4	20*	0.2
2003	3.9	20	1.2
2004	5.3	19	0.8
2005	3.6	17.6	5.1
2006	6.2	14.8	4.4
2007	6.8	11.2	4.2
2008	5.1	9.5	3.5
2009	1.6	12.1	2
2010	3.9	12.4	1.3
2011	4.5	12.5	0.1
2012	2	13.4	-
2013	1.6	13.4	-
2014	3.3	11.5	-

Source: GUS 2014

* change in methodology in measuring the unemployment rate in Poland that applies to all years after 2000 .

The rising rates of unemployment and the drop in the growth of real wages (see Table 2) coupled with the liberalisation of restrictions on international travel had a great impact on mobility patterns in Poland. One of the most significant changes in this respect was the increase in the number of people engaged in temporary migration (Okólski 2001). Among these temporary migrants were seasonal workers who spent several months a year in the host country (including Germany, Italy or Belgium) working on constructions sites, in the agricultural sector (Kępińska 2007), or in the case of women, as domestic workers, cleaners and childminders.

This type of temporary migration, dominant in the 1990s, is rarely recorded in official statistical data and thus, it is hard to estimate (Grabowska-Lusińska and Okólski 2009). According to the OECD International Migration Database that measures inflows of people to a particular country, between 1991 and 2000 over 860,000 Polish people migrated to Germany and over 8,820 to Belgium (see Table 3). In addition, only between 1998 and 2000 over 111,000 Polish nationals migrated to Italy (see Table 3).

Table 3: Inflow of Polish nationals into selected OECD countries (1991-2000)

Destination Country	1991 - 1995	1996 - 2000
Germany	501,270	361,790
Italy	* N/A	** 111,540
Belgium	3,410	5,410

Source OECD 2015b

* N/A Data not available

** Data from 1998-2000

Men generally dominated among the temporary migrants, but the gender structure was very much dependent on the country of destination (Grabowska-Lusińska and Okólski 2009). Whereas men were far more likely than women to migrate to Germany, women dominated among those migrating to Italy or Belgium (Grabowska-Lusińska and Okólski 2009, p. 43).

4.2 Polish migration in the enlarged European Union

Polish accession to the European Union in 2004 marked another important point in recent history and had an important influence on the mobility patterns among Polish people.

While most countries of the old EU temporarily restricted access to their labour markets for the citizens of the new member states (NMS), the United Kingdom, Ireland and Sweden were the only three countries that did not enforce these restrictions. As a result, from May 2004 Polish citizens did not require a work permit in order to take up employment in these countries. The opening of those countries' labour markets made migration and finding a job in these countries much easier for the new migrants. As a result, in the first years following the 2004 EU enlargement, the number of Polish migrants rose significantly, especially in the UK and Ireland.

Grabowska-Lusińska and Okólski (2009) estimated that over 1 million Poles migrated from Poland between May 2004 and December 2006. A large share of these migrants went to the UK. Between May 2004 and March 2007 almost 400,000 Polish citizens registered with the British Work Registration Scheme in order to take up employment in the UK (Fihel and Piętko 2007). Whereas by the end of 2004 there were about 95,000 Polish-born residents in the UK, by the end of 2007 their number was more than four times higher and reached 532,000 by the end of 2010. Ireland was second, after the UK, most popular country of destination for post-accession Polish migrants. Thus, I now turn to discuss the characteristics of those migrants who moved to Ireland.

4.3 Polish migration to Ireland

Prior to 2004 Poles rarely migrated to Ireland. Those who did had to seek work permits in order to work legally. Just over 9,000 work permits had been issued to Polish citizens between 1999 and 2003 (Grabowska 2003). However, after 2004, when Ireland opened its labour market to citizens from the NMS, it became one of the most popular destination countries for Poles. This is reflected in the sharp increase in PPS numbers² issued to Polish nationals between 2004 and 2008. Whereas in 2003 just under 4,000 Polish nationals applied for PPS numbers, in 2004 the figure was over 27,000 and in 2006 over 93,000. Following the financial crisis, from 2009 the number of Polish nationals applying for PPS numbers declined (see Table 4). In 2011 just over 8,000 Poles received PPS numbers.

² Personal Public Service (PPS) Number is a unique number allocated to people residing in Ireland. It is required in order to access various social welfare services (see for example Citizen Information 2015b). The PPS number is required in order to take up legal employment in Ireland.

Table 4: PPS numbers issued to Polish nationals 2003-2011³

2003	2004	2005	2006	2007	2008	2009	2010	2011
3,828	27,295	64,731	93,787	79,816	42,553	13,794	8,742	8,087

Source: Department of Social Protection 2015

Still, the 2011 Census counted over 122,000 Polish nationals living in Ireland (CSO 2011a). This makes Polish nationals the most numerous group of migrants in the country. The allocation of PPS numbers to Polish nationals illustrates a certain dynamics of the Polish migration to Ireland and its direct link to the 2004 EU enlargement (Table 8). It shows that mass Polish migration to Ireland started after Poland joined the EU, peaked in 2006 and decreased significantly in 2009 when Ireland was severely hit by the financial crisis. Altogether, between 2004 and 2008, the years during which Polish migration to Ireland was most intense, over 300,000 Polish nationals received PPS numbers. A large share of these people no longer reside in Ireland. Some of them came only for a short period of time. This was the case for example for students who used their summer holidays to earn some extra money. Others returned to Poland after a few years of living in Ireland and yet others moved to another country. Thus, the actual number of Polish nationals residing in Ireland is likely to be closer to the 122,000 recorded by 2011 Census (CSO 2011a).

In order to see who are the Polish migrants living in Ireland and how their age structure, education, employment situation compare to the total population in Ireland, I turn now to discuss the main socio-economic characteristics of Polish nationals living in Ireland.

4.3.1 The socio-demographic characteristics of Polish nationals living in Ireland

Polish nationals are noticeably younger than the total population of Ireland (see Table 5). In 2011 over 64 per cent of them are in the 25-44 age bracket, compared to 31 per cent for the total population of Ireland (CSO 2011c). Whereas Polish nationals over the age of 65 constitute only 0.18 per cent of the total number of Polish residents in Ireland, in the total population of Ireland, people over the age of 65 constitute over 10 per cent (CSO 2011c). Thus, most Poles living in Ireland are of working age with very few being in the post-productive age group.

³ In order to reflect the time I conducted most of fieldwork, here and elsewhere in the thesis I present data sources that run to 2011.

Table 5: Polish nationals and the total population in Ireland, by age group (2011)

Age group	Polish nationals	Share	Ireland	Share
0-14	22,204	18.11%	97,3992	21.52%
15-24	12,357	10.08%	56,5471	12.50%
25-44	78,742	64.23%	142,9975	31.60%
45-64	9,063	7.39%	102,7132	22.70%
65 and more	219	0.18%	52,8711	11.68%
Total	122,585	100.00%	4,525,281	100.00%

Source: CSO 2011g

Polish nationals in Ireland are also relatively well educated. Only 2 per cent of those aged 15 and over have only primary or no formal education compared to over 15 per cent for the total population in Ireland (CSO 2011c, CSO 2011d). The largest group (over 53 per cent) constitute people with secondary, technical or vocational education (CSO 2011c). The share of people with third level degrees is roughly comparable among Polish nationals and among the total population of Ireland. About 23 per cent of Polish nationals have third level degrees, compared to almost 25 per cent among the total population of Ireland (CSO 2011c, CSO 2011d).

Table 6: Polish nationals and total population in Ireland, by level of education (2011)

Level of education	Polish nationals	Total population of Ireland
Primary or no formal education	2.21%	15.21%
Secondary, technical or vocational	53.03%	45.27%
Advance certificate	9.04%	5.72%
Higher certificate	7.73%	4.50%
Third level (degree)	23.31%	24.64%
Not stated	4.68%	4.66%
Total	100.00%	100.00%

Source: CSO 2011c and CSO 2011d

Despite the relatively high educational levels, unemployment rates have been higher for Polish nationals than for the total population in Ireland (see Table 7). In 2006, that is before the outbreak of the 2008 economic crisis, the unemployment rate among citizens from the

NMS was about 5.5 percent, that is about one percentage point higher than for the total population of Ireland (Grabowska-Lusińska 2007). Moreover, as noticed by Krings et al. (2009) migrants from the NMS were more likely to be adversely affected by the 2008 economic crisis. According to the last Irish Census, in 2011 the declared unemployment rate for Irish nationals aged 15 and over was 18.5 per cent, whereas, for Polish nationals aged 15 and over it was over 21 per cent (CSO 2011b). However, Polish nationals also have a much higher rate of labour force participation than the total population of Ireland. In 2011, 88 per cent of Polish nationals aged 15 and over participated in the labour market. This is mainly due to their young age and very low rate of people in the retirement age. Less than 0.3 per cent of the Polish nationals living in Ireland declared they had retired (CSO 2011c).

Table 7: Population aged 15 and more by employment status

	Irish nationals	Polish nationals	Total population of Ireland
At work	49.01%	69.21%	50.08%
Not in labour force	39.87%	12.01%	38.06%
Labour force participation rate	60.10%	88%	61.90%
Unemployment rate	18.5%	21.30%	19.20%

Source: CSO 2011b

Polish migration to Ireland is also characterised by some differences in employment status between genders. According to the 2011 Census almost 60 per cent of Polish men and 53 per cent of Polish women living in Ireland were in employment (CSO 2011c). However, women were less likely than men to declared themselves unemployed. They were far more likely not to participate in the labour market. Over 9 per cent of them declared taking care of the house and family, compared to less than 0.5 per cent of Polish migrant men (CSO 2011c).

In terms of occupational distribution, Polish migrants in Ireland are over-represented among both manual and non-manual workers (excluding professional occupations) but the difference between Polish migrant workers and the total population of Ireland is particularly high in manual occupations (Table 8). Over 44 per cent of Polish nationals declared working as manual workers compared to about 20 per cent of the total population

in Ireland (CSO 2011c). Polish nationals are also underrepresented in all professional occupations. Only 7.6 per cent of them work as professionals and about 6 per cent as employers and managers. In comparison, over 15 per cent of the population of Ireland work as employers and managers and over 18 per cent as professionals (CSO 2011c).

Table 8: Polish nationals and the total population in Ireland, by occupation (2011)

Occupation	Polish nationals		Total population of Ireland	
Employers and managers	8,023	6.54%	705,132	15.37%
Higher professionals	3,226	2.63%	295,586	6.44%
Lower professionals	5,711	4.66%	556,587	12.13%
Non-manual	30,940	25.24%	931,068	20.29%
Manual skilled	22,375	18.25%	386,742	8.43%
Semi-skilled	21,783	17.77%	359,725	7.84%
Unskilled	10,609	8.65%	151,949	3.31%
Own account workers	2,204	1.80%	196,774	4.29%
Farmers	320	0.26%	166,231	3.62%
Agricultural workers	948	0.77%	23,504	0.51%
All others	16,446	13.42%	814,954	17.76%
Total	122,585		4,588,252	

Source: CSO 2011c

It seems then that Polish nationals in Ireland tend to occupy lower positions on the Irish labour market. Despite the fact that almost a quarter of them have some kind of third level degree, only about 14 per cent work in professional or managerial occupations. As 70 per cent of them work as manual or non-manual workers, Polish nationals are over-represented in non-professional occupations in Ireland.

In order to better understand the position Polish migrants occupy in Ireland, it is important to also look at the larger picture of the changing trends in migration flows into Ireland in the last decades. Thus, I now turn to discuss the various migrant groups living in Ireland and the positions they occupy in Irish society.

4.4 Migration trends in Ireland

Historically, Ireland was a country of emigration with high rates of population outflows that continued throughout most of the 20th century. As shown in Table 9, a spectacular change in migration trends came in the 1990s when Ireland experienced a rapid economic growth followed by low unemployment rates (Massina 2009, p. 5). In 1996 immigration overtook emigration and since then has grown steadily to peak in the years following the two EU enlargements in 2004 and 2007 (CSO 2014a). In about a decade, from a relatively homogenous country when compared to other European states (Loyal 2007), Ireland was transformed into a multi-ethnic state.

Table 9: Immigration and emigration flows in Ireland 1988-2013 (in thousands)

Years (April)	Immigrants	Emigrants	Net migration
1988-1995	249.2	359.7	-110.3
1996-2003	417.1	224.3	192.7
2004-2011	684.3	409.2	274.7
2004	58.5	26.5	32
2005	84.6	29.4	55.1
2006	107.8	36	71.8
2007	151.1	46.3	104.8
2008	113.5	49.2	64.3
2009	73.7	72	1.6
2010	41.8	69.2	-27.5
2011	53.3	80.6	-27.4
2012	52.7	87.1	-34.4
2013	55.9	89	-33.1
2014	60.6	81.9	-21.4

Source: CSO 2014a

Initially, around half of the migrants entering Ireland were Irish return migrants (Barrett and Duffy 2008, p. 600). The other half were migrants from the UK, as well as from old European and non-EU countries (CSO 2014a). At the beginning of the 2000s, the number of non-EU migrants entering Ireland grew significantly. In 2003 migrants from non-EU countries constituted around 40 per cent of the total number of migrants entering Ireland. The biggest change in the numbers and composition of migrant flows came after the two

EU enlargements of 2004 and 2007. Between 2006 and 2010 487,900 migrants entered Ireland and almost half of them were citizens from the new EU member states (CSO 2014b). In 2007 out of 151,100 immigrants to Ireland, 85,300 (56.4 per cent) came from the NMS, 30,700 (20 per cent) were return Irish migrants and 19,000 (12.5 per cent) were from non-EU countries (CSO 2014b). After 2007, the number of migrants entering Ireland started to fall. Since 2009, once again the number of people leaving Ireland has been greater than the number of people entering the country (CSO 2014a).

Table 10: The composition of immigrant flows in Ireland, in thousands and in per cent (1996-2011)

	1996 - 2000		2001 - 2005		2006 – 2010		2011	
Irish	114.3	49.50%	106.1	32.25%	114.3	23.43%	19.6	36.77%
New EU 10 (13)	-	-	34.1	10.36%	220.3	45.15%	10.1	18.95%
UK	41.9	18.15%	41.8	12.71%	27.4	5.62%	4.1	7.69%
Old EU (15)	31.7	13.73%	46	13.98%	51.8	10.62%	7.1	13.32%
Rest of the world	43	18.62%	101	30.70%	74.1	15.19%	12.4	23.26%
Total	230.9	100.00%	329	100.00%	487.9	100.00%	53.3	100.00%

Source: CSO 2014b

In 2011 this resulted in over 16 per cent of the population in Ireland being born outside its borders (OECD 2015a). This puts Ireland among the countries with the highest ratios of foreign-born population in Europe. However, what makes the Irish case exceptional in Europe is the short ten-year timeframe during which the country went from a relatively homogenous country to a multi-ethnic state (Loyal 2007).

4.4.1 The diversification of migration in Ireland

Migrants in Ireland are not a homogenous group, but they occupy a variety of social positions to which different social, political and economic rights are attached. According to Loyal (2007) one of the major factors that determines migrants' position in the host country is the mode of entry. Whether migrants entered Ireland as asylum seekers, work permit holders or EU citizens depended on their country of origin and profession and determined their social, political and economic rights. Thus, migrants living in Ireland range from citizens of EU countries who are entitled to reside and work without any additional requirements, to semi-skilled or unskilled workers on work permits whose right to reside in

Ireland is highly dependent on their employment situation, to asylum-seekers in the direct provision system with no right to work.

One of the most vulnerable groups is asylum seekers. In the late 1990s and early 2000s their number in Ireland increased considerably. In 2002 over 11,000 people applied for asylum in Ireland (ORAC 2013). Since then the number fell significantly and in 2013 there were only 946 new applications (ORAC 2013). Asylum seekers do not have the right to work in Ireland (Citizens Information 2015c). Those who arrived in Ireland after April 2000 are put in the system of direct provision (Loyal 2007). They receive a weekly allowance of EUR 19.10 for every adult and additionally EUR 9.60 for each child and are provided with housing, usually in the form of hostel accommodation and meals (Citizen Information 2015c). The study by Kennedy (2003), conducted in the initial years of the direct provision system found that the conditions in the hostels were very poor, to the point that many asylum seekers had to share a room with several other people, often complete strangers. Some of them had no access to kitchen facilities (Kennedy 2003). The recent report (Working Group on the Protection Process 2015) reported that cramped living space and lack of privacy remain issues in the system of direct provision. Poor living conditions coupled with no legal permission to work and the general public hostility shaped by the public discourse that often depicts asylum seekers as abusers of the social security services (Loyal 2007) put this group of migrants in a particularly vulnerable position, prone to racism and discrimination with very limited social, political and economic rights.

The next group of migrants are work permit holders. In general, they are nationals from non-EU countries because in order to work legally in Ireland most non-EU citizens have to have a work permit. Internally very diverse, they range from highly skilled professionals (such as doctors and IT specialists) to lower level professionals (such as nurses), to semi-skilled and unskilled manual workers. Initially most of the work permits were issued to unskilled workers, who were to fill shortages in the Irish labour market. However, after the 2004 EU enlargement citizens from the NMS, who do not need a work permit to take up employment in Ireland, started to fill these unskilled positions (Ruhs and Quinn 2009). As a result, more restrictions have been put on migrants from the non-EU countries who wish to access unskilled jobs and the number of work permits issued to unskilled workers dropped significantly (Ruhs and Quinn 2009). At the same time, professionals from sectors with labour force shortages (for example some highly skilled engineering or healthcare

professionals) may apply for work permits on preferable conditions and enjoy more rights for example, a right to apply for immediate family reunification, than those in semi-skilled and unskilled occupations (Citizens Information 2014b).

The internal diversification in the professions of work permit holders is reflected in the variety of social positions they occupy within the Irish society. While some of these migrants enjoy privileged positions as representatives of highly valued professions such as doctors, others find themselves in precarious situations strongly dependent on the vagaries of Ireland's labour market. However, both groups are primarily seen as temporary workers whose main purpose is to fill labour shortages and whose permission to remain in Ireland is strongly dependent on their employment situation (Loyal 2007).

Another group of migrants, to which Polish nationals belong, are citizens from EU member states. This group of migrants enjoy a variety of social, political and economic rights, including the right to work without any of the additional permits required for the two previous migrant groups. Since the two EU enlargements in 2004 and 2007, this group of migrants became the most numerous among the non-Irish population in Ireland. This is mostly due to migration from the NMS. As already mentioned, Ireland did not restrict access to its labour market for people coming from the countries that joined the EU in 2004. As a result, since May 2004 citizens of these states have the right to work and reside in Ireland without seeking any additional permits. Migrants from Bulgaria and Romania, countries that accessed the EU in 2007, had restricted access to the Irish labour market and had to seek work permits before 2012 (Citizens Information 2016). Since the lifting of this restriction in 2012, they enjoy the same rights as other nationals from the EU member states. This includes the right to work and reside in Ireland and access to some social security services. However, despite these social and economic rights, migrants from NMS occupy a much weaker position on the labour market than their Irish counterparts (Loyal 2011). As already mentioned, the unemployment rate among citizens of the new member state is higher than among Irish citizens. They are much more likely to occupy low-paid manual and non-manual positions. They are also more prone to discrimination in their workplace and generally earn considerably less than Irish citizens (Loyal 2011, p. 203-205).

Migrants in Ireland constitute a very heterogeneous group ranging from vulnerable asylum seekers with very restricted social and economic rights, to work permit holders whose right

to remain in Ireland is strongly dependent on their employment situation, to migrants from the EU member states who enjoy various social and economic rights, including access to the labour market, to which the previous two groups lack or have limited access. However, migrants coming from the NMS to which Polish migrants belong, continue to occupy lower positions on the Irish labour market than Irish nationals. As migrants from CEE countries, generally considered to be less developed than Ireland, they are often perceived as potential abusers of the Irish social security and healthcare services. Thus, although their position improved since the EU enlargement they remain prone to potential discrimination and unfair treatment.

However, as I have already signalled in the previous sections of this chapter, post-accession Polish migrants constitute a heterogeneous group of people with various levels of education, employment situation and access to material resources. This internal differentiation is partly reflected in the official statistics on socio-economic characteristics that I have discussed above. However, in order to understand who are the Polish migrants living in Ireland and what position they occupy in the host as well as the home societies, we need to go beyond the statistical data and look into the strategies that these migrants engage in.

4.5 From temporary migration to *intentional unpredictability*? Changing strategies and mobility patterns among Polish migrants before and after the 2004 European Union enlargement

Poland's accession to the EU brought significant changes to migration strategies and mobility patterns among Polish people. As already mentioned, during the 1990s and early 2000s, when access to labour markets in old European countries was greatly restricted, one of the most popular strategies, especially among people with low levels of education, was temporary or circular migration. Circular migrants had very little job security, usually did not have access to social and healthcare services and often engaged in what Grabowska-Lusińska and Okólski (2009, p. 34) called the "work there, life here" strategy. Many of them transferred a considerable share of their income back to their families in Poland and rarely built relationships in the host society.

In contrast, migrants who left Poland after 2004 were less likely to engage in circular migration. They were much less likely to describe their migration as an economic necessity

and were much more likely to focus on their individual needs. In a 2008 internet survey conducted among post-accession migrants in the UK and Ireland (Milewski and Ruszczak-Żbikowska 2008), only about 24 per cent of participants described their migration as a necessity resulting from their poor economic situation in Poland. The remaining 76 per cent of participants, included, among reasons for leaving Poland, a search for opportunities and new experiences. They either wanted to find better jobs abroad (about 49 per cent of the sample) or to gain new life and work experiences and learn English (27 per cent of the sample) (Milewski and Ruszczak-Żbikowska 2008). Many of them were very disappointed by the political and economic situation in Poland and believed that migration to Ireland or the UK would open new perspectives to them and allow them to build more fulfilling lives. These declarations show that many recent Polish migrants decided to leave Poland not only in search of better wages and higher incomes. Although these aspects played a very important role, they also searched for better possibilities for career advancement and new life and work experiences.

The shift in migration strategies is also illustrated by the relatively high share of recent migrants not transferring any money to their families back in Poland, something that very often has been practiced by circular migrants. In a study conducted among Polish migrants in the UK and Ireland (Garapich and Osipovič 2007), over 35 per cent of the participants declared that they transferred little or no money to Poland and a further 12 per cent that they transferred around one tenth of their monthly income. Only about 11 per cent of participants declared that they transferred more than half of their monthly salary back to Poland (Garapich and Osipovič 2007). This shows that post-accession migrants are more likely to spend their money in their host countries than transfer it back to Poland.

Eade et al. (2007) distinguished four main types of migration strategies among Polish migrants in London. The first group, called *storks*, constituted about 20 per cent of the sample and were seasonal migrants who came to London for short periods of time (between two and six months) to work and save money in order to improve their financial situation in Poland. They ranged from agricultural workers who came to London during winter to work on construction sites, to students who used their summer holidays to earn money for their university tuition. Members of this group usually worked in low-paid jobs and did not engage much with the host society. They relied on other Polish migrants in

regard to accessing accommodation and work. They often circulated between the UK and Poland for several years.

The second group, called *hamsters*, were people who came to London for a longer period of time than the first group, but they treated their stay as a “one-off act to acquire enough capital to invest in Poland” (Eade et al. 2007, p. 34). Similarly to *storks*, they also treated their migration mainly in terms of improving their financial situation back in Poland. As migrants in the first group, they tended to work in low-skilled jobs and rely on other Polish migrants. They constituted about 16 per cent of the sample. *Storks* and *hamsters*, the two groups that were primarily focused on accumulating financial capital to improve their position back in Poland, together constituted 36 per cent of the sample.

The third group, named *stayers*, were migrants who declared that they were planning to stay in the UK for good and did not consider moving back to Poland. They constituted about 22 per cent of the sample. Unlike the first two groups, who mainly focused on improving their socio-economic position in Poland, they were very much focused on improving their position within the host society.

Finally, the biggest group (42 per cent of the sample), called *searchers*, included migrants who were unsure of their future migration plans and kept their options open. They ranged from workers in low-skilled jobs to skilled professionals. *Searchers* considered the possibility of staying in London and pursuing their careers there, returning to Poland or even moving to yet another country. Eade et al. (2007, p. 34) called this last and most popular strategy *intentional unpredictability*. As noticed by Grabowska-Lusińska and Okólski (2009) this strategy is only possible in the post-accession context. This is because migrants are no longer limited by work and residence permits, as was the case in pre-accession Europe. They do not have to worry about the legal status of their residence in the host country and have more social rights when losing their employment. As a result, they can afford more flexibility in their migration trajectories and many of them take this opportunity.

Poland's accession to the EU and, following it, new social and economic rights such as open access to labour markets in some of the EU countries, brought significant changes in mobility patterns among Polish people. As they are no longer bound by residence and work

permits, Polish migrants in the enlarged EU are more mobile across national borders and have better chances of developing their careers in the host country. As Krings et al. (2013) suggested, this is especially true for better educated migrants who tend to consider their migration not so much in terms of economic necessity, but as part of the larger process of self-development. Most of these migrants, even in the context of the recent economic crisis, stayed in Ireland or searched for other job opportunities in yet another country. This said, it seems that some of the migrants who came to Ireland mainly in order to accumulate capital and improve their financial situation in Poland (*hamsters* or *storks*) also decided to stay. As a result, the diversity among Polish migrants living in Ireland persists.

One of the important factors that influences the migration strategies and mobility patterns among the recent Polish migrants is gender. Gender plays a significant role in determining the position migrants occupy in the host and home societies. Thus, in the next section, I discuss studies that looked particularly at post-accession Polish migrant women and their migration strategies and patterns of mobility.

4.6 Polish migrant women in Ireland

According to the last Census, women constituted over 48 per cent of the Polish-born residents in Ireland in 2011 (CSO 2011f). There is a growing body of research that looks particularly at Polish women and their migration strategies in the post-accession context. These studies help us to better understand the various social and economic aspects that differently influence women and men and translate into different migration strategies. For example, Storch (2008) investigated the ways post-accession migrant women adapted to life in Ireland. She stressed that many of the participants in her study felt very much “in-between” and, at least at first, struggled to build their lives in the host country. Polish migrant women maintained very strong connections with their families and friends in Poland, frequently phoned them (sometimes as often as every day) and travelled back to Poland for major holidays such as Christmas or Easter. They also often shopped in Polish stores and socialised mainly with other Polish people in Ireland. However, despite their strong connection with Poland, in some aspects they also successfully adapted to life in Ireland and managed to create, a real, albeit temporary, “home away from home” (Storch 2008).

If during the first post-accession years most Polish migrants to Ireland were men, over the last few years Polish migration became more gender balanced. This may be because, over

time, more women decided to migrate for both economic, as well as lifestyle reasons. As suggested by studies from the UK (Ryan et al. 2010, White 2010) this may also partly result from the process of family reunification and Polish women joining their husbands who migrated earlier. Prior to the 2004 EU enlargement, especially among temporary migrants, family migration was complicated and rather rare. Undocumented or bound by residence and work permits, Polish migrants had very restricted access to educational and healthcare services. Thus, usually one parent migrated, while other members of the family stayed in Poland where children could attend school or have access to healthcare services in case they needed medical help. Poland's accession to the EU and the newly gained access to education and healthcare services in the host countries resulted in the increasing popularity of family migration. This still very much resembles the traditional model of family reunification, whereby a migrating father is subsequently reunited with the mother and children. However, in the post-accession reality the whole process is shorter than it used to be prior to the 2004 EU enlargement (White 2010). Women, encouraged by easier access to education and healthcare services, are more likely to migrate with children to join their husbands than they were prior to Polish accession to the EU (White 2010). As a result, the number of families migrating with children to the UK rose significantly since the EU enlargement.

Migration, and especially family migration, has the potential to change gender roles in the family. It may be greatly empowering for both partners, especially if they struggled to find satisfactory employment in their home country. For them migration may bring new possibilities in terms of employment and career development. However, if one partner follows the other to a country where he or she has little language proficiency, chances of finding employment or possibilities for career development, migration may result in the reinforcement of one partner's dependency on the other. Muszel (2013) analysed how gender roles were rearranged in Polish families who migrated to Ireland after 2004. She noticed that women with low levels of education who followed their husbands were particularly likely to become more economically dependent on their partners after migrating to Ireland. Although some of them worked before leaving Poland, after moving to Ireland they tended to become full time housewives and were less likely to enter the Irish labour market. Better educated women or those with higher language proficiency were more likely to find employment in Ireland. As shown by Muszel (2013), those women tended to be more economically independent from their husbands than they had been in

Poland. Even though some of them worked below their qualifications, wages in Ireland allowed them to contribute proportionally more to their household budgets than wages in Poland. In this sense, migration allowed them to gain more control and economic independence.

However, as Muszel (2013) argued, this economic independence was not necessarily followed by greater equality in gender roles within the family. This is because men rarely participated in household responsibilities even in the families where women engaged in waged labour and contributed to the household budget. In the migrant families that participated in Muszel's study (2013) despite their contributions to the household budgets, women continued to do most of the domestic tasks and those associated with childcare. This was especially problematic, as many of them reported that taking care of children is more time-consuming in Ireland than it was back in Poland. This was because in Poland these women relied on their social networks of female relatives to share childcare arrangements and some household responsibilities. In this sense, migration reinforced more traditional gender roles in families and put greater pressure on women as they had to deal with more of the household tasks by themselves than they had done in Poland.

Open access to the labour market and social and healthcare services fostered family migration among post-accession migrants (White 2011). Although many of the post-accession migrants, both men and women, had no dependents such as a partner or children and migrated as individuals (Drinkwater, Eade and Garapich 2010, Grabowska-Lusińska and Okólski 2009), those who had a partner and children were likely to be followed by them once settled in the host country. Also, it seems that many of the post-accession Polish migrants started their families in the host country. The increasing number of families among Polish migrants is reflected in the growing number of Polish children living in Ireland. Whereas in 2006 children under the age of 14 constituted around 7 per cent of the total number of Polish nationals in Ireland (CSO 2006), in 2011 they constituted over 18 per cent (CSO 2011a). Also, the share of births to mothers from NMS (among which Polish women are the most numerous group), grew from 6 per cent of births registered in Ireland in 2007 (CSO 2007) to over 10 per cent in 2011 (CSO 2011h). These data suggest that in the post accession period, migrants from the NMS, and Polish migrants among them may be settling down in their host country. However, as studies from the UK suggest, although starting a family and having a baby are very important aspects in migrants'

decisions about future migration plans (White 2011), they do not determine whether Polish migrants will return to Poland or stay in the host country for good (Janta 2013). As pointed out by Janta (2013), the increasing number of children born to Polish mothers in the UK is linked to the age structure of the recent Polish migrants, a large share of whom are now in their peak reproductive age. Available statistical data and research show that a rising number of post-accession migrants decided to start a family and have children in their host country. This, similarly to family migration, is also likely to be linked to easier access to education and healthcare services in the host country.

Post-accession Polish migrant women constitute a very diverse population in terms of education, employment situation, migration strategies and plans for the future. Open access to the labour market encouraged many young women to migrate in order to improve their economic situation back in Poland, develop their careers or gain new life experiences. The majority of post-accession migrants, including women, had no dependants at the time when they migrated to the UK and Ireland (Drinkwater, Eade and Garapich 2010, Grabowska-Lusińska and Okólski 2009). Indeed, most women who participated in my study did not have children at the time of their move to Ireland. Moreover, as shown by other studies (Ryan et al. 2010, White 2010) access to social security services became a very important aspect in fostering family migration. In other words, in the post-accession period, those Polish migrants who had families were far more likely to be followed by their partners and children than migrants in the pre-accession period. Finally, as suggested by the available data (CSO 2006, CSO 2011a, CSO 2011h), the number of Polish migrants living in Ireland who started families in the host country is rising. In this context, access to healthcare services as well as the potential barriers, become very important, but little studied aspects of recent Polish migration to Ireland. However, as already mentioned, access and the potential barriers to healthcare services in the host and home countries are strongly dependent on the social position migrants occupy. Thus, in order to understand the way migrants engage with the host and home countries healthcare services, it is necessary to understand the social position they occupy in both societies.

4.7 Education, employment situation and migration strategies of Polish migrant women living in Ireland who participated in the study

As discussed earlier in this chapter, Poland's accession to the EU and the extensions of social and economic rights, had a significant impact on the positions Polish migrants occupy in the host and home countries. No longer bound by work and residential permits, post-

accession Polish migrants to Ireland can afford more flexibility in their migration trajectories, have a better chance to develop their careers, and are more likely than pre-accession migrants to engage in family migration or start their families in the host country. This said, not all post-accession Polish migrants have the same access to these new possibilities. As shown above, post-accession migrants form a heterogeneous group with various levels of education, employment situation and access to resources that differently influence their migration strategies and mobility patterns. Thus, I now turn to the Polish migrant women who participated in my study. I sketch the social position they occupy, by first looking at their education level and employment situation and secondly, by linking these two aspects to women's migration strategies.

During my fieldwork I interviewed twenty two Polish migrant women. At the time of the interviews, nineteen of them lived in Ireland and three lived in Poland. All but one of the women I interviewed arrived in Ireland after Poland joined the EU in 2004. In this sense, the women who took part in my research as well as the majority of Polish migrants living in Ireland, belonged to the group of post-accession Polish migrants. They were also young. The majority of them were between 25-34 years of age. This means that almost all of them belonged to the most numerous age group of Polish migrants living in Ireland (see **Błąd! ie można odnaleźć źródła odwołania.**). Furthermore, as already mentioned, because my study focused on healthcare practices associated with pregnancy and childbirth, the migrant women I interviewed were either pregnant or had recently given birth. Among the three returned migrants who lived in Poland, one had her first baby in Ireland, and, after she had moved back to Poland, she had a second baby. The other two women had their babies in Poland after they had moved back. All the women interviewed in Ireland had or planned to have their babies in Ireland. At the time of the interviews, most women had one child, three had two children and only one woman had three. Finally, most of the women were either married or in a relationship. Two of the migrants I interviewed were single mothers.

In terms of the level of education, the migrant women who participated in my study fell into three main groups: 1. Women who had a university degree. 2. Women who had secondary education and 3. Women who had vocational education. Women in the first group (nine out of twenty two) were more likely than women in the other groups to work in the field of their education. For example, they worked as accountants, physiotherapists,

researchers and social workers. One had her own small business. Those who worked below their qualifications had done so for a relatively short period of time, usually at the beginning of their stay in Ireland. Some of them planned to undertake some kind of training or university courses in Ireland in order to improve their qualifications and increase their chances of accessing employment that would better match their qualifications. This said, among the women with third level education there were also women who worked in Ireland below their education for a significant period of time and struggled to find better employment. Finally, the women with third level education tended to speak fluent English.

Women in the second group (nine out of twenty two) had secondary education, in some cases complemented by post high school diplomas (for example in banking, pedagogy, physiotherapy or human resources). They tended to work below their qualifications, for example in cafeterias or as shop assistants. There were also women who worked in positions closer to their education for example, as a care assistant or as an office assistant. Women in this group were likely to quit their employment once they finished their maternity leave. They often explained that they could neither afford the cost of childcare, nor did they want to send their children to childcare institutions. This said, they also declared that once their children reached a certain age, they would start looking into employment options and would try to find a job. There was considerable variation in the proficiency in English among women in this group. While some spoke fluent English, others declared themselves as average or poor speakers of English.

Women in the last group (four out of twenty two) had vocational education. They worked for example, in fast food restaurants, in the informal economy as cleaners or careers, or were not successful in securing any type of employment. One of the women in this group went back to part-time work after maternity leave. The other three remained unemployed at the time of the interviews. They also tended to declare themselves as poor speakers of English.

Despite the relatively high level of education among the participants in my study, a considerable share of women worked below their qualifications in Ireland. Many of these women declared that they saw little opportunity to change their situation and improve their position on the Irish labour market and develop their careers. This said, many of them also declared that despite working below their qualifications, their earnings were relatively

higher in Ireland than in Poland. In this sense, they felt that migration improved their economic situation and standards of living, but did not necessarily help to develop their careers.

The next aspect that helps us to situate Polish migrant women in the host and home societies is the migration strategies that migrant women engage in. The majority of the participants in my study moved to Ireland directly from Poland. However, other women came to Ireland from other EU countries, including the UK, Belgium and Germany. As already mentioned, at the time of their move to Ireland some women were single, had no children and migrated by themselves. These women met their partners and started their families in Ireland. Others came to Ireland with their partners, often right after graduating from university or not long after graduating from secondary school. Yet other women migrated in order to join their partners who were already living in Ireland. Among the latter, only one woman had children at the time of her move as she came to Ireland to join her husband who migrated there first and was already working in Ireland. The other women from this group were pregnant or had no children at the time that they moved to join their partners in Ireland. This shows that among the participants of my study, only one woman followed what may be seen as the traditional model of family reunification, in which a woman with children follows her husband. Most participants had no dependants at the time of their move to Ireland and migrated either by themselves or with their partners.

The migration strategies of the participants in my study reflect the changes in migration patterns that occurred after Poland joined the EU in 2004. In particular, they reflect the changes in motivations for migration that prevailed among post-accession migrants. Indeed, the greater share of participants tended to explain their migration in terms of lifestyle choices and better opportunities rather than economic necessity. Similar to the result of the already mentioned study on recent Polish migrants in the UK and Ireland (Milewski and Ruszczak-Żbikowska 2008) only a few of the women I interviewed explained their migration to Ireland in terms of economic necessity. The rest declared that they came to Ireland in search of better employment opportunities or higher living standards. Among them there were also women who stressed that they migrated in the search for new life experiences and adventure. Before coming to Ireland, some of these women gave up, what they described as promising, although not necessarily well paid employment. In general, the women's explanations for their decisions to come to Ireland could be divided into three

main categories: 1. Economic necessity because of the poor financial situation women suffered in Poland. 2. Plans to fulfil particular economic goals for example, to work and save enough money to buy a flat in Poland and 3. A search for better life opportunities or adventure.

1. Migrant women who fall into the first group either did not have employment in Poland or worked in temporary employment positions that did not give them any security. Thus, frustrated with their poor economic position and lack of employment opportunities, these women tend to see their migration to Ireland in terms of economic necessity. Some of these women managed to secure some type of employment in Ireland, but others remain in precarious employment positions. Despite that, they do not plan to move back to Poland in the near future. They believe they have very little chance of finding employment and improving their financial situation in Poland. Instead, those in a relationship partly rely on their partner's income, who are often also in a precarious employment position. Others work temporary jobs and continue to seek other types of employment.
2. Two women explained to me that their move to Ireland was initially driven by a particular aim they wanted to realise. In the first case it was to earn and save up enough money to throw a wedding in Poland, and in the second, to buy a flat. Both women moved with their partners to work in Ireland because they hoped the higher wages in Ireland would allow them to save enough money to fulfil their plans. Although, both couples set up a timeline to reach their goal, in both cases the plan did not work out the way they initially planned. In the first case, the couple managed to secure enough money to throw a wedding party in Poland, but they did not move back afterwards and decided to stay in Ireland for longer than initially anticipated. In the second case, the couple never managed to save enough money for a flat. At the time of the interview they had been living in Ireland for over three years (although initially they planned to stay only for a year) and did not have any concrete plans to return to Poland.
3. Finally, the women who fall into the third category constitute the most heterogeneous and numerous group among the participants in my study. Among these migrants are women with secondary education who work in Ireland as shop

assistants, as well as highly qualified women with university degrees who work according to their qualifications. They range from women who came to Ireland to “try their luck at working abroad”, to women, some of them highly skilled, who wanted to develop their careers and “gain some work and life experience”. Although most of these women mentioned higher wages and better employment opportunities as important aspects in the process of moving to Ireland, similarly to Polish migrants in the study by Krings et al. (2013) they see their migration in terms of lifestyle choices and adventure.

Although women migrated to Ireland for various reasons, the majority came with a plan to return to Poland at some point in the future. However, in most cases their stay was longer than initially anticipated and, at the time of the interviews, most did not have any concrete plans to move back to Poland. Thus, most of the women I interviewed fell into the group of *searchers* (Eade et al. 2007). They were rather unsure of their plans for the future. Only two out of the nineteen migrant women who were living in Ireland at the time of the interviews declared that they planned to stay there for good (*stayers*) (Eade et al. 2007). The rest were unsure of their plans. Some declared that they definitively wanted to move back to Poland, but they did not have any concrete plans to do so. As they explained, this was because they were rather sceptical of the employment possibilities in Poland and worried that their standard of living may decrease significantly once they move. Some mentioned that they hoped to save enough money to open their own business in Poland, but again, were rather sceptical as to whether this would work out. In general, the women who declared that they want to go back to Poland at some point in the future stressed that although life in Ireland may be comfortable, as migrants they did not feel completely “at home”. They missed their families or “felt like foreigners”, but, at the same time, they believed that in Ireland they could afford a higher standard of living than in Poland.

Other women who fell into the category of *searchers* (Eade et al. 2007) were those who kept their options opened and considered the possibility of staying in Ireland as well as moving back to Poland or even moving to another country. These women’s migration strategies were closest to what Eade et al. (2007) called *intentional unpredictability*. Migrants from this group stressed that they would have to decide whether they will move back or stay in Ireland, but for now they were not sure what to do. Some of them set up some kind of deadlines to decide on their next steps (for example, “until the children will

have to go to school"). As women in the previous group, they worried about the employment situation in Poland and thought that if they moved back, their living standards would decrease significantly. One of the participants encapsulated her experience of living in the state of *intentional unpredictability* by saying that she and her partner live constantly "in-between". As she explained, although they had been living in Ireland for over 10 years and would like to have a nice and comfortable house, so far they restrained from investing much money in the apartment they currently lived in. As she stressed, this is because they still want to keep their options open. If they invested money in the house in Ireland (for example, by buying new furniture or even by buying a house) it would decrease their chances of moving back to Poland. Thus, they continued to live "in-between" in order to keep their options open.

Even those women who initially belonged more to the group of *hamsters* (Eade et al. (2007) (i.e. migrants who treat their migration mainly in terms of improving their financial situation back in Poland), with time, started to change into *searchers*. This was particularly obvious in the case of women who primarily came to Ireland with the aim to save up enough money to invest in Poland (e.g. to buy an apartment). Irrespective of whether they fulfilled their initial plan, they remain in Ireland, and, at the time of the interviews, did not have any particular plans to go back to Poland. As women in other groups, they worried about the employment prospects in Poland and thought that their standard of living will decrease once they move back. In this sense, they no longer focused primarily on improving their financial situation in Poland but kept their options open.

Finally, all three returned migrants (all university graduates) explained their decision to move back to Poland as partly resulting from their or their partners' employment situation (for example, little chance to work according to their qualifications in Ireland) and partly from the lack of social and family support in Ireland. The latter played a particularly important role in the context of their family plans. However, two of the returned migrants raised doubts whether their return to Poland was a good idea. They both complained that their standard of living had decreased significantly since they moved back. Although in Ireland they worked below their qualification, their standard of living was relatively high. In Poland, despite finding employment close to their education, they struggled financially and experienced a decrease in living standards. Thus, both of these women declared that they did not rule out the possibility of migrating again. Only one of the returned migrants was

happy with their decision to move back to Poland and was relatively sure that they would remain in Poland. Although, as she stressed, she really enjoyed living in Ireland, she and her husband managed to secure a good life in Poland and they have the support of their families and they planned to settle down in their home country.

In order to illustrate the various migration strategies that participants of my study engage in, I present below four stories of migrant women's trajectories. These stories reflect Polish migrant women's different levels of education and employment situation, and the way these two play out on motivations for migration to Ireland and women's plans for the future. They include stories of women from each of the three educational backgrounds: two stories of university graduates, one of a woman with secondary education and one of a woman with vocational education. Although they do not exhaust all the possible variations of mobility patterns among the participants of my study, they nonetheless, show main trends and illuminate the Polish migrant women's varied experiences of new opportunities and patterns of mobility following Polish access to the EU.

Łucja is a 29 year old university graduate with a degree in banking. She and her husband rented a two bedroom apartment in Dublin. When we met in 2011 Łucja was on maternity leave. She had a baby a few months earlier. Before going on maternity leave she worked in a finance office. Her husband worked as an engineer in a large company in Dublin. They both came to Ireland in 2006, right after graduating from university. They both had previous migration experiences as they had both lived and worked for some time in Sweden. Łucja found employment very quickly and started working almost immediately after her arrival. She worked in different positions, but finally found employment that matched her qualification. Although she liked her job, she decided to resign from it after her maternity leave was over and become a stay-at-home-mum. As her husband earned a good salary, she felt that being a stay-at-home mum made more sense for her and her family. As she explained to me, she did not want to hire a nanny and see her child only in the evenings. At the time of the interview, Łucja and her husband were considering the possibility of moving to another country in the near future. They had no concrete plans at the time but were looking into different options.

Unlike Łucja, Patrycja does not have a university degree. She came to Ireland in 2007, right after finishing secondary school. A friend of hers who migrated to Ireland told Patrycja that

she could help to arrange a job for her in a local Spar. Patrycja decided to leave Poland and treated her move to Ireland as an adventure. As she explained to me, she wanted to “try her luck” and “have fun” so she was ready to accept her friend’s proposition. The day after she arrived in Ireland she started working at the Spar. Unlike Łucja who spoke fluent English before moving to Ireland, Patrycja spoke very poor English and she struggled to communicate with her supervisors. Nonetheless, after a short trial period, she was employed and she was working in the same shop when we met for the interview in 2011. As she explained to me, soon after arriving to Ireland she met her current partner. When they had a baby in 2010, Patrycja went on maternity leave, and when it finished, unlike Łucja, she went back to her position in Spar. She explained to me, that the work allowed her to have a rather comfortable life. She learned English and no longer had problems communicating with her supervisor or colleagues at work. Despite that, Patrycja and her partner planned to go back to Poland at some point in the future. At the time of the interview they did not have any concrete plans. As she explained, she was quite worried about how they will adjust back to life in Poland. She believed that life in Ireland was much easier, in the sense that even their relatively low wages allowed them to live a rather comfortable life.

Ewa, a 25 year old vocational school graduate, came to Ireland in 2006. As Patrycja, she was fresh out of the school with no plans on what to do next, when a friend of hers, a migrant living in Ireland, promised to help her find employment. Ewa took the opportunity and left for Ireland mainly because her financial situation in Poland was poor. However, unlike Patrycja, on her arrival, she learned that the promised employment did not exist. She spent some months looking for any kind of work, but did not succeed in finding anything. Similarly to Patrycja, Ewa spoke no English at the time of her arrival in Ireland. In searching for employment she mainly relied on other Polish migrants. She described to me how frustrated she was at that time and wanted to go back to Poland, but could not afford to pay for the ticket. However, she soon learned of a job from a friend who worked as a house cleaner in Cork. The job was undocumented, but it paid well. The friend promised to help Ewa and she too started to work as a house cleaner. She managed to establish a group of clients for herself whose houses she cleaned on a regular basis. She worked in this capacity for over a year and then found a job in a factory. When the financial crisis came, Ewa, together with many other factory workers was made redundant. She once again turned to the informal economy and started to work as a cleaner. Again, she established a group of

clients whose houses she cleaned. Although she earned enough to support herself, this type of work gave her no security. When we met in 2011, Ewa was single and she just had a baby. She was living with her sister and brother-in-law and their children in a house in Cork. She struggled financially as she had not been able to work over the past few weeks due to her pregnancy and childbirth. She did not manage to secure any source of income. She also had no concrete plans for the future. Although she said she would like to move back to Poland at some point in the future, similarly to Patrycja, she did not want to do it at this time. She was rather convinced that moving back to Poland would not improve her life or work situation in any way. As she explained, in Ireland at least she had an established group of clients for whom she cleaned houses. She hoped to go back to work as soon as possible.

Emilia is one of the three returned migrants that I interviewed for the study. I met with her in her house situated about 30 minutes' drive from Warsaw, where she lived with her husband, their two children and her parents-in-law. Emilia, a university graduated therapist, moved to Ireland in 2006 to join her husband who worked in Dublin in the construction industry. The work was below his qualifications, but paid reasonably so he continued working there. Very soon after her arrival in Dublin, Emilia found a job at the local coffee shop. She worked full time until she gave birth to their first child a few months later. After that, Emilia continued to work weekends while she took care of the baby during the week. When the financial crisis came, as many other people in the construction business, Emilia's husband found himself in a precarious employment situation where he was very likely to lose his job. In addition, Emilia believed she had very few chances of developing her career in Ireland, and, as she declared, they both missed their families and wanted to be closer to them. As a result, in 2008 they both started to look into the employment options for them in Poland. A few months later they moved to Poland hoping that they would have better chances of obtaining employment closer to their qualification. Indeed, Emilia quickly found a job as a psychotherapist at a local clinic. However, although the job matched her qualifications, Emilia was very disappointed by the salary. She earned below the Polish average wage and reported that the standard of living of her family decreased significantly since their move back to their home country.

The migration stories presented above show that the Polish migrant women who participated in my study are a heterogeneous group with various levels of education and employment that differently impact their migration trajectories and plans for the future.

Although the stories only illustrate some of the possible migration trajectories, they illuminate important differences in the position migrant women occupy in the host and home societies. Most particularly these stories illuminate the differences between highly-skilled women with third level education and those with vocational education. Whereas the former were more likely to find employment closer to their qualifications and move within the Irish labour market, the latter often struggled to secure any kind of employment and found themselves in a precarious situation. In this sense, the migration trajectories of the women who participated in my study seem to confirm the argument made by Krings et al. (2013) that it is mostly the well-educated migrants who became the new generation of post-accession “free-movers”.

Łucja and her husband, whose story I presented above, are a good example of this new group of “free-movers”. They both not only work according to their qualifications, but they also managed to develop their careers and treated their migration in terms of life-style choices. However, not all well-educated women managed to establish a successful career in Ireland. Some, as was the case for Emilia and her husband, despite being highly skilled, worked below their qualification in unskilled positions with little chance of moving up within the Irish labour market. For them, the move back to Poland became the way to find employment closer to their qualifications and prevent the process of de-skilling. In this sense, Emilia and her husband never really become “free-movers” (Krings et al. 2013).

The women with vocational education found it particularly difficult to secure any type of employment in Ireland. Some of them, as was the case for Ewa, turned to the informal economy and engaged in undocumented work that provided them with no security. In this sense, their migration trajectories resembled those of pre-accession temporary migrants than of post-accession “free-movers”.

However, irrespective of their socio-economic position, the majority of women remain in a state of *intentional unpredictability* (Eade et al. 2007). This migration strategy, as noticed by Grabowska-Lusińska and Okólski (2009), is only possible thanks to the open access to the Irish labour market and some of the social security services, including healthcare. As migrants are no longer bound by work and residential permits, they can afford more flexibility in their migration trajectories. Even those women who did not manage to secure any type of employment, did not have to worry about the possibility of deportation. In

addition, as a great proportion of Polish post-accession migrants are currently in their peak reproductive age and many of them decide to start a family, access to healthcare services in the host country is of particular importance for them. However, this access is strongly shaped by women's social position. Having discussed the complex factors that situate Polish migrant women in various positions within the Irish and Polish societies, I now turn to discuss the Irish healthcare services.

Chapter 5: Irish healthcare services: a two-tier system

In the previous chapter I discussed the various social positions that Polish migrant women occupy in the host and home societies. In order to grasp the link between these social positions and women's concrete healthcare practices, it is necessary to understand the structural context that these practices occur in. This is because the structural realisations of healthcare services, and particularly the inequalities that characterise them, influence the way patients from various social groups engage with healthcare services. Thus, in this chapter I briefly present the overview of the Irish healthcare services, and secondly discuss the inequalities in access to them. I also present the structure of Irish maternity care and discuss the main patterns of access to it, paying particular attention to inequalities that characterise the provision of maternity care in Ireland.

5.1 The structure of the Irish healthcare services and inequalities in access to them

The Irish healthcare services is a two-tier system which structure is based on a complicated mix of private and public services. Residents in Ireland fall into two categories determining their eligibility to care: Medical Card holders and people without Medical Cards. In general, Medical Card holders are entitled to receive most healthcare services free at the point of delivery within the public care and people without Medical Cards have to pay at least part of the costs of their treatment. In 2013 every ordinarily resident⁴ whose weekly income⁵ was below EUR 184 or in the case of families below EUR 266.50, was entitled to a Medical Card (HSE 2013b). People whose income was above this level had to cover out-of-pocket full costs associated with primary care and some of the costs associated with hospital or emergency care. In 2005, a GP Visit Card was introduced which caters to people with incomes just above the threshold that would entitle them for the Medical Card. The GP Visit Card entitles its holder to free GP visits, but unlike the Medical Card, it does not cover the costs of prescribed drugs or hospital charges (Nolan 2008, p. 303). In 2013, an ordinarily resident whose weekly income exceeded the limit for a Medical Card, but was below EUR 276 or, in a case of families, below EUR 400, was entitled for a GP Visits Card (HSE 2013b).

⁴ Ordinarily resident is someone who is living in Ireland and has lived there, or intends to live there, for at least one year (Citizen Information 2015a)

⁵ The income is calculated after tax and the deduction of rent/mortgage, childcare and travel to work costs

Over the last years, the number of Medical Card holders has been constantly increasing. Whereas in 2002 29.1 per cent of the population in Ireland had Medical Cards, the number rose to 37 per cent in 2011 (Table 11) (Department of Health and Children 2013). In 2011, an additional 2.7 per cent of ordinarily residents in Ireland held GP Visits Cards. This means that the rest (about 60 per cent) of the population in Ireland were liable to the full costs of primary care.

Table 11: The share (in %) of Medical Card and GP Visit Card holders in Ireland (2003-2012)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Medical Cards	29.1	28.4	28	28.8	29.2	30.1	32.6	36.5	37	40.4
GP Cards			0.1	1.2	1.7	1.9	2.2	2.6	2.7	2.9

Source: Department of Health and Children (2013)

Apart from those holding Medical Cards and GP Visit Cards, there are also people who have private health insurance. Since the beginning of the 2000s, the share of private insurance holders among the Irish population had been close to 50 per cent (Table 12). However, private health insurance is mostly used to partially cover the costs of inpatient care. Private health insurance plans rarely provide coverage for primary care. Thus, private insurance holders in most cases have to pay out-of-pocket at least some of the charges for their GP visits, private out-patient care and emergency care (Department of Health and Children 2010, p. 44)

Table 12: The share of private health insurance holders in Ireland (2003-2012)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Private health insurance	49.8	50.2	50.4	50.3	50.5	50.9	49.7	48.8	47.2	45.7

Source: HIA 2014

There are also people who are covered by both Medical Cards and private health insurance. According to the Department of Health and Children (2010b, p.44), in 2009 about 4 per cent of Medical Card holders also had private health insurance plans. About 19 per cent of the population in Ireland in 2009 had neither Medical Card, nor private health insurance (Department of Health and Children 2010, p. 44). This means, that they had to pay out-of-pocket for the full costs associated with primary care as well as public hospital charges.

Since 2009, these public hospital charges include fixed day charges as well as A&E charges. Indeed, as for 2013, a person without a Medical Card who came for care to the A&E department with no referral letter from a GP and not in an ambulance, was liable a charge of EUR 100. Irrespective on how the person arrived at the hospital, if he or she was admitted, they were charged a fixed fee of EUR 75 a day, up to EUR 750 in a given year (HSE 2013a). This means that a patient without a Medical Card could not be charged more than EUR 750 in one year for in-patient care delivered in a public hospital. However, if they did not have private health insurance, they had to pay these charges out-of-pocket.

Primary care in Ireland is provided by General Practitioners (GPs), who are self-employed and work in private single-handed or group practices (EOHSP 2009, p. 163). Generally, in Ireland, primary care is provided on a fee-for-service basis. Only Medical Card or GP Visit Card holders are entitled to free primary care. Private insurance plans rarely include reimbursement of GP consultation costs. As the majority of GPs have contracts with the Health Service Executive (HSE), they provide care to both public patients (Medical and GP Visit Card holders) and private patients (EOHSP 2009, p. 163). However, Medical and GP Visit Card holders must register with a particular GP surgery while applying for a card in order to be able to access free primary care (EOHSP 2009). People who pay out-of-pocket (private patients) can seek medical advice from any GP (EOHSP 2009).

GPs set up their charges individually. For a patient without a Medical or GP Visit Card these amount to between EUR 45 and 60 to see a doctor (Department of Health and Children 2010, p. 44). Patients with private health insurance may, although rarely, be reimbursed for some charges. Depending on the insurance plan they have, the reimbursement varies and rarely covers full costs. GPs are reimbursed by the HSE for caring for Medical Card and GP Visit Card holders on a yearly basis (EOHSP 2009). The rates are dependent on a number of factors, including the patient's age or the distance from the GP's practice (Burke 2009, p. 270).

GPs are supposed to act as the first point of reference and be gatekeepers to specialist care. They are responsible for guiding a patient through healthcare services and, if needed, refer him or her to specialist care. Over the last decade consecutive governments embarked on plans to better develop the primary care sector. Setting up multidisciplinary teams of GPs, nurses, midwives and therapists providing care in the communities was to

keep people away from unnecessary visits to already overburden hospitals. However, the government's success in developing primary care services was only partial. While in some areas it managed to set up health centres with multidisciplinary teams providing care to local communities, most areas are still lacking this kind of services (Burke 2009, p. 260-280). This gap started to be filled by some private investors who established private for-profit health centres (Burke 2009, p. 277). Some of these centres contract their services with HSE and also provide free care at the point of delivery for Medical Card holders.

Most specialist care in Ireland is delivered in hospitals, either in specialist clinics attached to the hospitals or in hospital wards. Hospitals in Ireland are of three main types: public (owned and run by the HSE), voluntary (owned and run on a not-for-profit basis by private organisations usually religious orders) or fully private (owned and run for profit by private businesses) (Nolan 2008, p. 299). In 2009 there were thirty four public hospitals, eighteen voluntary hospitals and approximately twenty private hospitals in Ireland (Department of Health and Children 2010, p. 47). Both public and voluntary hospitals receive most of their funding from the state and fully private clinics depend on fee-paying patients (Department of Health and Children 2010, p. 47).

If a GP decides a patient needs a specialist consultation, he or she refers them to one of the specialist outpatient clinics. As most of the consultants in Ireland work both in public and private outpatient clinics, patients may be referred either to a public or to a private clinic. The latter may be situated either on or off the site of a public or voluntary hospital. Whether patients will be referred to a private or public outpatient clinic depends on their access to private insurance or their ability to pay out-of-pocket for consultant fees. In general, patients with Medical Cards are usually referred to public clinics. Patients who are referred by a GP to a public specialist clinic do not have to pay any specialist charges but they also cannot choose the consultant they will attend (HSE 2013a).

Irish healthcare services are built on various lines of division. An important one runs between private and public care. Indeed, as shown by various studies (see for example Harmon and Nolan 2001, Wren 2003), speedy access to specialist healthcare is predominantly dependent on a patient's ability to pay for care out-of-pocket or through private insurance. While it may take several months for a patient to see a specialist in a public clinic, the waiting time for an appointment in a private clinic is considerably shorter.

Public patients are also more likely to be seen in overcrowded outpatient departments, where they may spend several hours waiting before being seen by a doctor. A patient who can afford to spend around EUR 200 (part of which may be reimbursed by private insurance) can usually see a consultant within a matter of days or weeks, in a private consultation room with a comfortable waiting area. As there are very few non-consultant doctors working in private clinics, private patients are very likely to be treated by a consultant. Also, they can usually choose the particular consultant they want to attend. Patients in public clinics are more likely to be attended to by a junior doctor with much less experience (see for example Burke 2009) and they have no choice of the doctor they see.

When it comes to inpatient or day procedures, the situation is similar. Private hospitals can admit patients within a matter of days or weeks, providing the patient has private insurance or can afford to pay from several hundred to several thousand euro for staying in private facilities (see Burke 2009). Public patients may need to wait several months or longer in order to be admitted to a public hospital for treatment.

The fear of long waiting times in accessing treatment in public hospitals is reflected in the reasons reported for taking out private insurance. In a study by Harmon and Nolan (2001), over 86 per cent of respondents declared that “being sure to get to the hospital quickly when they need treatment” was a very important reason in their decision to take out private insurance. For over 77 per cent of the respondents “being sure of getting good treatment in a hospital” was also a major reason (Harmon and Nolan 2001). In comparison, “being able to have a private or semi-private room” or “being able to get into private hospitals” were also very important reasons for just over 27 per cent of the respondents (Harmon and Nolan 2001). These declarations showed that people in Ireland are highly concerned with the lengthy waiting times to receive treatment in public hospitals. Those who buy private insurance do so primarily to ensure that they will receive treatment in a timely manner.

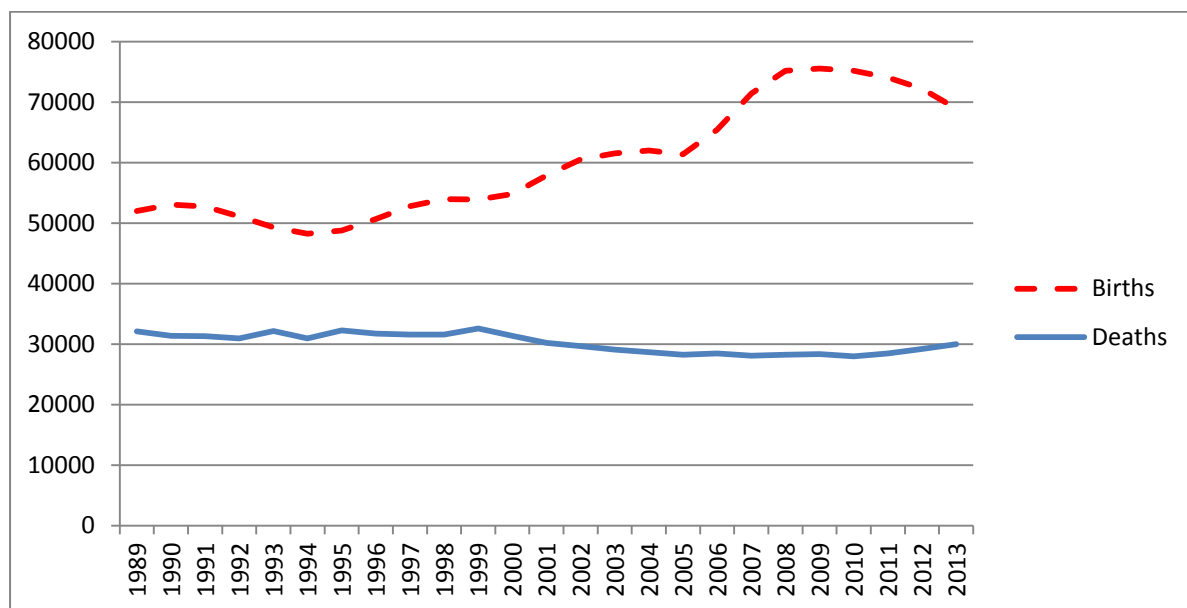
Access to a speedier treatment available for private patients constitute one of the most important inequalities within the Irish healthcare services. In maternity care, due to the nature of care provided, speedier access seems to play a less important role. However, the line of division between private and public patients prevails and, as I show in the remaining part of this chapter, manifests itself, for example, in the different types of care received by

pregnant women. Thus, I now turn to discuss maternity care services in Ireland. I start by providing an overview of the demographic trends in Ireland as they impact the workings of maternity care. Then, I move to discuss the inequalities that characterise the provision of maternity care in Ireland.

5.2 Maternity care in Ireland

Over the last two and a half decades, Ireland has experienced a significant population growth. While the number of deaths remained rather stable, the number of births has been gradually increasing. Also, during this time, Ireland experienced an unprecedented increase in the number of migrants entering the country. These two aspects had a fundamental impact on the dynamics of population growth. While in 1991 the total population of Ireland was just above 3.5 million people, twenty years later, it was over 1 million higher (CSO 2015b). According to the 2011 Census, there were over 4.5 million people living in Ireland (CSO 2015b).

Graph 1: The number of births and deaths registered in Ireland (1989-2013)



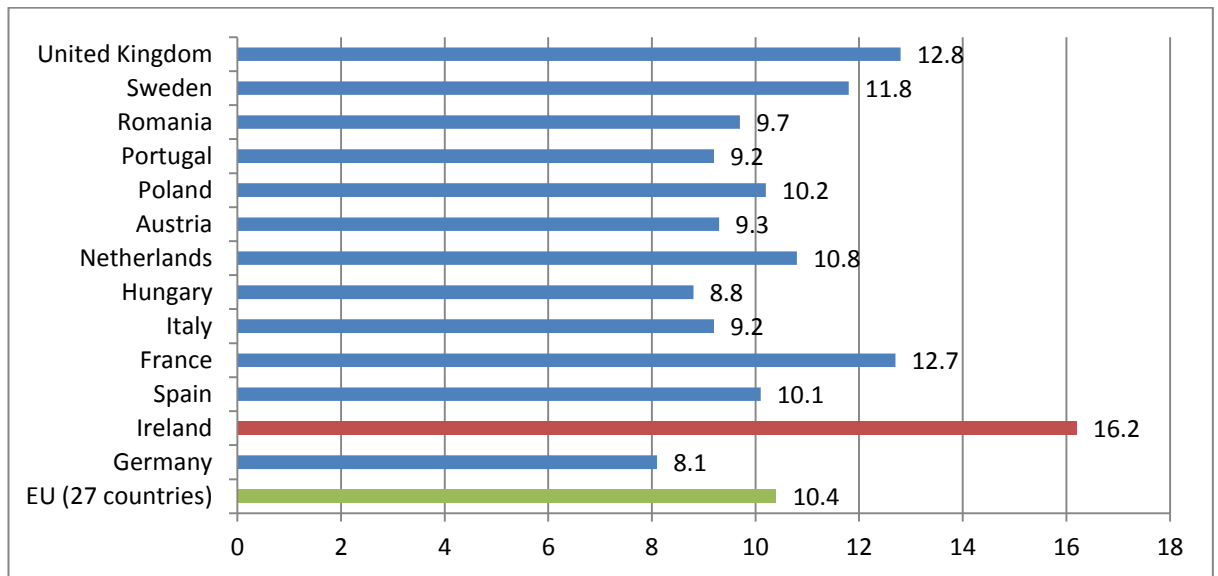
Source: CSO 2015a

Since the mid-1990s the number of children born in Ireland has been increasing (CSO 2015a). Whereas in 1995, 48,787 children were born, resulting in a birth rate⁶ of 13.5, the number increased to 60,503 in 2002 and reached its highest level in 2009 when 75,554 children were born resulting in a birth rate of 16.7 (CSO 2015a). Since then, the number of

⁶ Birth rate is the number of births per 1,000 of the estimated population

births has been decreasing and in 2013, 68,930 children were born resulting in a birth rate of 15 (CSO 2015a). However, despite the decrease in the last years, Ireland remains the country with one of the highest births rates in Europe⁷ (Graph 2). In 2011, the birth rate in Ireland was 16.2, way above the EU average of 10.4 and the highest in Europe (Graph 2).

Graph 2: Birth rates in selected countries in Europe (2011)



Source: Eurostat 2015a

In Ireland, as in other countries in Europe, the infant mortality rate (IMR)⁸ has constantly been decreasing over the last decades. At the moment, Ireland has one of the lowest mortality rates in Europe (Graph 5). In 2011 the infant mortality rate in Ireland was 3.5, below the EU average of 3.9 (Graph 5) (Eurostat 2015b). Ireland also has a very low maternal mortality rate. In 2011 there were two maternal deaths registered in Ireland (CSO 2011h). Maternal mortality rates are very difficult to compare across European countries due to the small number of maternal deaths in general and to differences in data collection methods (see for example EuroPeristat 2010). However, rates of infant and maternal mortality, although very important, tell us very little about the various forces at play within Irish maternity care services. Thus, in order to have a more complete picture of the challenges women face when accessing maternal care services, other aspects such as the structure of these services and patterns of access to them need to be analysed. In the following part of the chapter, I discuss the structure and the provision of maternity services in Ireland as well as inequalities in the access to these services.

⁷ See also Graph 4 for fertility rates in selected countries in Europe

⁸ Infant mortality rate is the number of deaths of children under the age of one calculated per 1000 live births

In Ireland, since 1953 when the state passed the Health Act that granted free access to healthcare to pregnant women (McKee 1986), maternity care, unlike other services, is not formally dependent on patients' means. All pregnant women who are ordinarily residents are entitled to the Maternity and Infant Care Scheme (Citizens Information 2013). This public programme combines care provided by GPs with that provided by healthcare personnel, traditionally obstetricians, at maternity hospitals (Citizens Information 2013, Kennedy 2010). In order to access this programme a pregnant woman needs to attend a GP surgery where she should be provided with an initial check-up and the set of documents to fill in and send to the maternity hospital of her choice in order to schedule subsequent outpatient visits. Typically, healthy women are expected to attend up to six visits at the GP surgery (Citizens Information 2013, Kennedy 2010). These visits are usually alternated with an additional six visits at the maternity hospital. Both are provided free of charge. Women with more complex health needs may be scheduled for more frequent consultations, also provided for free. The Maternity and Infant Care Scheme does not necessarily provide continuity of care, which means that women are seen by whoever is on duty at the maternity hospital and this may be a different midwife or doctor each time. Finally, as maternity outpatient clinics are typically located on the grounds of maternity hospitals, the choice of the outpatient clinic usually determines the choice of the maternity unit where women plan to give birth.

Apart from the public Maternity and Infant Care Scheme pregnant women may opt to access the semi-private or private maternity care schemes. These are usually offered to women in the form of "packages" that, depending on the hospital and the consultant in charge of care, may vary considerably in price. While most private health insurance plans available in Ireland cover some of the costs of semi-private and public care, women usually have to pay out-of-pocket from around EUR 1200 for the semi-private care "package" to between EUR 3500 and 5500 and more for the private care "package"⁹. These "packages" usually include a number of visits at the semi-private or private maternity clinics and some prenatal screenings. However, there are considerable differences among hospitals in the exact services they provided under both schemes (see for example bump2babe 2011). In some hospitals under the semi-private scheme, the schedule of the visits remains similar to public care. Visits to the GP clinic are alternated with visits to the maternity hospital. However, unlike in public care scheme, in the semi-private scheme, women are seen by the same obstetrician at the separate semi-private maternity hospital outpatient clinic during

⁹ My own calculations on the basis of information provided on maternity hospitals' websites.

each visit. In other hospitals, in the semi-private “package”, women are offered visits with the consultant of their choice or one of the senior doctors working in the team led by the consultant. This means that women paying for semi-private care may be seen by different doctors during their antenatal visits. During labour and delivery, women using the semi-private care scheme are usually attended by the staff on duty. This means that, if no medical complications arise, they are attended by the same midwives as are women under the public scheme. After labour, depending on availability, women paying for a semi-private “package” are accommodated in a shared, but smaller than public ward (usually up to four beds) semi-private ward.

The private care “package” includes a number of visits to a consultant at the private maternity clinic. During each visit women are seen by the same obstetrician. Depending on the hospital, the same obstetrician may also be present for the delivery of the baby. However, at least during the initial part of labour, women paying for private “packages” are attended by the same midwives who also provide care to public and semi-private patients. After labour, women paying for the private care scheme are accommodated in single rooms. However, as private rooms cannot be booked in advance in the case when they all are full, women paying for private care scheme may also be accommodated in shared semi-private or public wards.

Some hospitals also charge their semi-private and private patient for some of the prenatal screenings such as ultrasound scans. For example, a private patient in one of the maternity hospitals in Dublin will be charged between EUR 110 to 140 for each prenatal ultrasound scan. Again, private insurance plans rarely cover the costs of these procedures. Maternity hospital also apply accommodation charges to their private and semi-private patients. For example, maternity hospitals in Dublin charge EUR 813 per night in a semi-private shared ward and EUR 1000 per night in a private room. However, these charges are usually at least partly covered by private health insurance so women are not liable for these costs.

Maternity care in Ireland is predominantly doctor driven (see for example Devane, Murphy-Lawless and Begley 2007; Kennedy 2002). Until recently, midwife driven care had been marginalised and remained underdeveloped (Kennedy 2010, KPMG 2008, p. 70). Typically, for their prenatal care women were seen by their GP and the obstetrician at the maternity clinic (see for example KPMG 2008 for the use of maternity care in the Dublin area). However, over the last two decades the model of care started to change (Devane, Murphy-Lawless and Begley 2007). In some locations midwifery-led units were opened, providing an

alternative to consultant-led care for women in low risk pregnancies (Kennedy 2010). Women who opt for this type of care, attend clinics run by qualified midwives for their prenatal visits, instead of attending an obstetrician. If no complications arise, they can deliver their babies in midwifery-led units, where the level of medical intervention is expected to be lower than in consultant led units at maternity hospitals. Also, some hospitals started to offer Community Midwives or “Domino care” schemes that allow healthy women to attend their prenatal visits either at the local health centres or at the community midwives clinics where they are seen by a team of midwives (Bump2babe 2011). In general, these care schemes are primarily offered to public patients and are provided free of charge. However, the great majority of women continue to use the hospital based and consultant led maternity services (KPMG 2008). Thus, maternity services in Ireland continue to be hospital based and predominantly consultant-led¹⁰.

As in other countries in Europe, almost all births in Ireland take place in hospitals. Home births account for less than 1 per cent of all births. In 2011, there were 168 home births that represented 0.2 per cent of all births registered in Ireland (ESRI 2012). All pregnant women availing themselves of the Maternity and Infant Care Scheme are entitled to free emergency services and in-patient care associated with the pregnancy. Irrespective of their financial position, women are not charged the standard EUR 75 daily hospital rate in case they are hospitalized for reasons related to the pregnancy, childbirth and the subsequent hospital stay. In 2011, there were twenty maternity units in Ireland that altogether accommodated 74,209 births (ESRI 2012). Only one of these maternity units was fully private but it closed down in 2014 due to financial difficulties (Kennedy 2015, p. 49). The other nineteen maternity units were public. However, all public units accommodate public as well as private and semi-private patients. This means that in each public maternity unit, there are beds designated to private or semi-private patients. For example, in 2005 three major hospitals in Dublin had from 29 to 34 per cent of all beds designated for private or semi-private patients (KPMG 2008, p. 93).

As in other countries in Europe, one of the major issues emerging in maternity care in Ireland is the increasing rate of medical interventions during labour, including the constantly rising rates of caesarean section. While in 2002 21.9 per cent of births were

¹⁰ After the submission of this thesis, in January 2016 the Irish Department of Health launched the National Maternity Strategy that, among other changes, recommended to increase the number of midwifery-led units and community midwifery services (Department of Health 2016). One of the objectives of the strategy is to ensure healthy women with better access to alternative to predominantly consultant-led and hospital based care (Department of Health 2016).

caesarean sections, the rate increased to 27.3 per cent in 2011 (ESRI 2012). The 2012 HSE report showed differences in the rates of caesarean sections among hospitals (AIMS Ireland 2014). While in some units the rates were well over 30 per cent, in others caesarean sections constituted around 20 per cent of all deliveries (AIMS Ireland 2014).

5.3 Inequalities in access to maternity care in Ireland

Although structured on the principles of free and universal access for all women who meet the ordinarily resident criterion in Ireland, Irish maternity care services are characterised by various inequalities that result in considerable differences in the type and quality of care that women receive. The most obvious line of division runs between public, semi-private and private care schemes. Indeed, as already mentioned above, there are differences between public, semi-private and private patients in relation to who provides them with maternity care. While women attending private care schemes are typically seen by consultant obstetricians for their prenatal visits, women in public care are more likely to be seen by GPs and non-consultant doctors (KPMG 2008, p. 94).

Moreover, recent research on medical interventions during labour on a statistically representative sample of childbirths taking place in Ireland between 2005 and 2010 shows that there are also considerable differences in the type of care that women receive during labour (Lutonski et al. 2014). For example, while 17.8 per cent of women from the sample who booked as private patients had an elective caesarean, the share of women in public care was 9.4 per cent (Lutonski et al. 2014, p. 3). This means that women using private care were almost twice as likely as women using public care to have elective caesarean sections. Also, women using private care were more likely to have operative vaginal deliveries through forceps or vacuum, their labours were more likely to be induced and they were far more likely to have episiotomies than women in the public care (Lutonski et al. 2014, p. 4). In general, women in private care were far more likely than women in public one to have more medical interventions while giving birth to their children. Differences persisted even when controlled for various risk factors that may increase the likelihood of certain interventions. Thus, as the authors of the study suggested (Lutonski et al. 2014), differences in care cannot be fully explained by differences in women's medical situation, but are likely to result from non-medical aspects such as whether deliveries were attended by midwives (as is more likely in the case of public and semi-private patients) or obstetricians (as is more likely in the case of private patients). In this sense, women's financial position and their ability (or inability) to pay for care, have a great impact on the

type of care they receive. As showed by Lutomski et al. (2014), this also includes the type and frequency of medical interventions.

Despite the considerable costs, a significant share of women in Ireland decide to access maternity care as private and semi-private patients. In the already mentioned study by Lutomski et al. (2014) on the statistically representative sample of childbirths, 30.2 per cent of pregnant women attended private or semi-private care for their maternity care. For many women paying for private or semi-private maternity care became a strategy to ensure access to what they believe is better and more attentive care. As over the last decade Irish maternity services experienced rising demand (due to the increasing number of births) as well as shortages of healthcare personnel, (including obstetricians and midwives) (see KPMG 2008 for maternity care in the Dublin area), public care is under considerable pressure and generally believed to be overcrowded and very busy. Anecdotal evidence suggests that women wait several hours for their outpatient appointments at public maternity clinics. Women attending private and semi-private clinics are less likely to wait for several hours for the consultation. Also, the semi-private and private care schemes, unlike public ones, offer a form of continuity of care. Women using these schemes are more likely to be seen by the same doctors and, in the case of women using private schemes, more likely to be attended during labour by their consultants. Thus, some women believe that by paying for private and semi-private “packages” they are more likely to receive more attentive care. Some women decide to pay for private maternity care hoping that this will allow them to develop more personal relation with their maternity care provider and avoid the overcrowded and busy public maternity wards.

Another line of division is impacted by different locations. In Ireland, depending on the maternity unit, pregnant women may receive different prenatal screenings and types of inpatient care. A study by Walsh et al. (2013) found that there are considerable differences between maternity units in Ireland in what ultrasound scans were offered at which stage of pregnancy and to whom. For example, while in some public clinics all women were offered mid-trimester foetal anomaly screenings, in others it was only offered to some women and in yet another it was not offered at all (Walsh et al. 2013). While some clinics offered first trimester scans, other did not (Walsh et al. 2013). In this sense, the type of maternity care women received was determined by the region of Ireland they lived in.

Also, the recent study by Lutomski et al. (2012) compared data from the four major areas of Ireland (Dublin Mid Leinster, Dublin Northeast, South of Ireland and West of Ireland) and

showed that there are considerable regional variations in the type of medical interventions carried out during hospital births. For example, women giving birth in the Dublin Mid Leinster area were far more likely than women giving birth in other areas of Ireland to receive oxytocin during their labours or to have an episiotomy (Lutonski et al. 2012). In contrast, women giving birth in the West area were more likely than others to have an elective caesarean section or to have their labour induced (Lutonski et al. 2012). Regional differences between the medical interventions during hospital labour are also reflected in the already mentioned variations in the rates of caesarean sections. For example, while in the St. Luke's Kilkenny hospital caesarean sections constituted 38 per cent of all births, in the National Maternity Hospital in Dublin they constituted just over 20 per cent (AIMS Ireland 2014). Thus, the differing data showed, that giving birth in a particular maternity unit influenced the probability of undergoing certain medical procedures and determined the type of care women were likely to receive.

Finally, only two hospitals in Ireland (the Cavan General Hospital and the Our Lady of Lourdes Hospital, Drogheda) offer midwifery-led units where healthy women can opt to deliver their babies with the minimal number of medical interventions (Devane, Murphy-Lawless and Begley 2007; Kennedy 2010). In all other regions, women have very limited choice and deliver in highly medicalised consultant-led units (Devane, Murphy-Lawless and Begley 2007; Kennedy 2010). In this sense, access to midwifery-led care is determined by whether pregnant women live in the region where this type of care is available.

The differences in the types of care offered in public, semi-private and private care schemes, as well as the differences across regions, suggest that various groups of patients have access to different enactments of biomedical care. As these different enactments of care include differences in the therapeutic options available to patients (such as higher or lower probability of having a caesarean section or episiotomy depending on the hospital or type of maternity care scheme) as well as differences in the type of relation formed between patients and care providers (availability of continuity of care), they may be seen in terms of plurality of biomedicines. In other words, the biomedical care realised, for example, in public care schemes may be seen as different to those realised in semi-private or private care schemes. In this sense, instead of one realisation of biomedicine, we could look at the differences between public, semi-private, private as well as differences among regions in terms of plurality of biomedicines.

As I have shown in this chapter, access to healthcare services in Ireland is built on various inequalities and strongly dependent on patients' means. Indeed, only patients with the lowest income are entitled to free access to public primary and specialist care. The rest of the population have to pay the full costs of their primary care and some of the costs of specialist care. Furthermore, the complicated mix of private and public services results in sharp inequalities between private and public patients when it comes to waiting times for specialist care. The latter tend to wait much longer than the former to access treatment and diagnostic procedures.

As maternity care is built on the principles of universal access, these inequalities are partly challenged in this area of healthcare. All women with the ordinarily resident status are entitled to free public perinatal care. This said, there are considerable differences between public, semi-private and private maternity schemes in the type of care offered. Studies showed (Devane, Murphy-Lawless and Begley 2007, Kennedy 2010, Lutonski et al. 2014) that private patients experience far more medical intervention during labour and delivery than public ones. However, as public clinics and wards are generally perceived as being very busy, many women pay for private care not so much to access speedier treatment, as in the case of general healthcare services, but to ensure access to what they believe to be more attentive and personal care. In this way, women who can afford to pay for private care have a better chance of building personal relations with their maternity care providers and thus, access more attentive care.

The second line of division runs among different locations across the country. In most regions in Ireland, women do not have access to midwifery-led units and only some maternity hospitals offer healthy women an option to attend midwife instead of doctor driven care. There are also major differences among maternity units in Ireland in what medical procedures they offer to their patients. Thus, the type of maternity care women in Ireland receive is intensely dependent not only on their ability to pay for semi-private or private care but also on what region they reside in. As I have suggested, these differences in the types of care provided may be looked at in terms of different realisations of biomedicine.

After detailing the structural context of healthcare services in Ireland, in the next chapter I turn to migrants and look at their patterns of access to healthcare services. I discuss what barriers they experience when accessing healthcare services in their host country and what types of care they have access to.

Chapter 6: Barriers, preferences and beyond: Polish migrant women's healthcare pathways in a transnational perspective

As discussed in Chapter 5, access to healthcare services in Ireland is highly unequal and strongly dependent on social position. These inequalities seem to be even greater among migrants than in the general population. In this chapter, I look closer at migrants' patterns of access to healthcare services in Ireland. I discuss the main barriers that migrants experience while seeking healthcare in their host country and pay particular attention to maternity care, reviewing studies that particularly looked at migrants' access to maternity care in Ireland. Then, I turn to recent Polish migrants and review studies that looked at their health and healthcare practices in the enlarged Europe. Next, I turn to Polish migrant women living in Ireland and present a portion of the data I have collected. I explore the different health-seeking pathways that Polish migrant women take during pregnancy and childbirth. In the final section of this chapter, I situate Polish migrants women' healthcare practices in the larger social context and discuss the links between these practices and the social position women occupy.

6.1 Lines of division: exploring the barriers that migrants face when accessing healthcare services in the host country

As already discussed in Chapter 5, the Irish healthcare system is built on various lines of division, out of which the line between public and private care seems to be the most prevalent. As a result of this division, access to healthcare services is strongly dependent on people's access to financial resources. As showed by studies that I have discussed in Chapter 5, those who can afford to pay for private care are more likely to access care faster than those who rely on public healthcare services. Taking into consideration that migrants, particularly those from poorer countries such as the NMS, tend to be over-represented in low-skilled and low-paid employment, thus migrants are a group strongly affected by the inequalities in the Irish healthcare services. Indeed, the vulnerable position of migrants is partly illuminated by their relatively low uptake of private health insurance and stronger reliance on Medical Cards. Indeed, in 2010 only 24 per cent of non-Irish nationals compared to 51 per cent of Irish nationals had private health insurance (CSO 2011e). By contrast, migrants were slightly more likely than non-migrants to have Medical Cards. In 2010, 34 per cent of non-Irish nationals and 29 per cent of Irish nationals were Medical

Card Holders (CSO 2011e). Furthermore, the share of those covered neither by Medical Cards, nor by private health insurance is twice as high among non-Irish population. Indeed, whereas 20 per cent of Irish nationals have neither Medical Cards, nor private health insurance, the share is 42 per cent among non-Irish nationals (CSO 2011e). This shows that migrants are a particularly vulnerable group when it comes to access to healthcare services in Ireland.

The various “formal” and “informal” barriers that they encounter while seeking care in the host country further exacerbate migrants’ access to healthcare services. For example, one of the “formal” barriers may be the ordinarily residence requirement that a person needs to meet in order to be entitled to healthcare services in Ireland. Migrants with an undocumented status or those engaged in undocumented work may not be in a position to meet this requirement and may be liable to pay full outpatient and hospital charges. In this situation, some of them may choose to avoid or delay seeking medical help in Ireland. Indeed, as Stan (2015) showed in her study on Romanian migrants in Ireland, migrants engaged in undocumented work lacked access to the healthcare services in Ireland and were forced to rely on their home country’s healthcare services. Although Polish migrants do not require work or residential permits in order to legally work and live in Ireland, some of them may still rely on undocumented work. Thus, they may worry that when having to use hospital care, they may be asked about their employment, for example, to prove their residence status and their eligibility to access Irish healthcare services. Because of fear of disclosure (see for example Osipovič 2013 on Polish migrants in the UK) and high hospital bills if they fail to prove the ordinarily residence status, they may avoid looking for medical help. Thus, access to healthcare services for migrants in Ireland who engage in undocumented work may be particularly problematic.

Apart from the “formal” barriers, there are also various “informal” barriers that influence migrants’ access to healthcare services in Ireland. These “informal” barriers include, for example, language problems, cultural stereotypes or migrants’ limited knowledge on how things work in the host country. As shown by several studies (see for example Lyons et al. 2008, MacFarlane et al. 2008), communication problems continue to be an issue in the provision of healthcare services to patients with little language proficiency in Ireland. Although interpreting services are available in some Irish hospitals, their provision is inconsistent and some of them may be of doubtful quality (Phelan 2009). In addition, when communication problems occur, it sometimes takes a long time for the interpreter to

get to the hospital. Thus, a patient may be required to wait several hours for the interpreter to arrive. As a result, most migrants rely on informal interpreters such as friends or family members, including their younger children to facilitate communication between them and healthcare professionals (MacFarlane et al. 2008).

The use of informal interpreters not only raises concerns about the accuracy of interpretation and its medical consequences, but, especially in the case of young children interpreting for their parents, it raises concerns about confidentiality (Lyons et al. 2008). Several studies (MacFarlane et al. 2008, MacFarlane and de Brún 2010) have shown that the use of informal interpreters is particularly prevalent during GP consultations. In their study on GPs who provided care to CEE refugees and asylum seekers in Ireland, MacFarlane et al. (2008) found that although a large majority of GPs reported that during some consultations they felt that a form of language assistance was required, they very rarely used professional interpreters to overcome these communication problems. Instead, GPs strongly relied on the patient's friends or relatives to interpret during consultations or they just tried to "get by" by using gestures, signs and patients' limited vocabulary in English or other languages in order to communicate with them (MacFarlane et al. 2008). The migrants themselves also employed a variety of techniques to overcome the language barriers. Apart from asking their friends or relatives to accompany them to the GPs surgery and interpret for them, they also tried to memorise whole sentences or used phrasebooks and dictionaries in order to communicate with their GP (MacFarlane and de Brún 2010). Although some of these techniques proved to be partially successful, in general, migrants with limited language proficiency assessed the communication with GPs in Ireland as very poor. They complained that GPs often seemed to be "switched off" or impatient while talking to them and that they equated migrants' lack of language competence with their lack of intelligence (MacFarlane and de Brún 2010).

This takes us to the next barrier that greatly impacts migrants' access to healthcare services, namely cultural stereotypes. While these are held by both healthcare professionals and migrants alike, however, during healthcare encounters healthcare professionals occupy a much stronger power position than patients. In this sense, stereotypes held by healthcare professionals have a greater potential to negatively impact migrants' access to healthcare services. Indeed, as shown by some studies, healthcare professionals in Ireland held a variety of stereotypes about migrants and their practices (see for example Lyons et al. 2008, Radford 2010). These presuppositions ranged from

beliefs that migrants engage in practices that may be dangerous for their health and wellbeing (Radford 2010), to assumptions that migrants are more time-consuming and, as patients, they demand more attention than Irish nationals (Lyons et al. 2008). As noticed by MacFarlane and de Brún (2010), in the case of migrants coming from Eastern Europe, one of the commonly held assumptions was that they frequently used folk medicine and distrusted biomedicine. The cultural prejudice held by healthcare professionals on lifestyle choices and practices of migrants, may lead to migrants being blamed for their health problems (see also Holmes 2012 on Mexican migrants in the US). In this context, building a trustful and meaningful relationship between healthcare providers and migrants may be particularly challenging.

Finally, one of the major barriers that migrants may encounter while accessing healthcare services is limited knowledge of how things work in the host country. In their study on migrants' healthcare practices Migge and Gilmartin (2011) showed that many migrants seemed to be very confused about the structure of the Irish healthcare services. This high level of confusion might have been partly due to HSE's ineffectiveness in providing information on healthcare services to newcomers to Ireland (Migge and Gilmartin 2011). Instead of looking for the information provided by official agencies such as the HSE or Citizens Information Centre, migrants who participated in the study relied heavily on their friends and relatives in order to learn about the healthcare services available to them (Migge and Gilmartin 2011). Although this strategy may be successful, it also raises concerns about the accuracy of information obtained. Indeed, as suggested by Migge and Gilmartin (2011, p. 1146), information obtained from informal sources may obstruct migrants' understanding of the available healthcare services in the host country. Misinformed, migrants may assume that certain healthcare services are not available to them in the host country and, as a result, either seek them somewhere else or delay seeking help.

The Irish healthcare system is built on various lines of division that privilege private patients over public patients. Migrants coming from poorer countries, including CEE states, usually found themselves among the latter. However, migrants experience additional barriers in accessing healthcare services, which include language problems, cultural stereotypes and lack of knowledge of how things work in the host country. Although over the last decades the Irish government has made some progress in eliminating some of these barriers, they nonetheless continue to affect migrants' access to healthcare services. Among the most

affected groups are migrant women. This is not only because women continue to be predominantly responsible for their families' healthcare, but also, in the light of data suggesting that many of the recent migrants decide to start their families in Ireland. Migrant women are also frequent users of maternity services in Ireland. These services, as I have shown in Chapter 5, despite the state's effort to ensure free and universal access to all women who meet the ordinary residence status, services continue to be characterised by various inequalities. These inequalities in access to maternity care strongly affect migrant women, making them a particularly vulnerable group. Thus, I now turn to discuss the studies that look specifically at the barriers that migrant women encounter when accessing maternity care in Ireland.

The same barriers that impact migrants' access to healthcare services in general, also play a role in shaping migrant women's access to maternity care. Migrant women accessing maternity services struggle not only with the language barrier, but they are also likely to be labelled by healthcare professionals as abusers of the healthcare system. Indeed, as shown by a 2008 study on maternity services providers in Dublin (Lyons et al. 2008), healthcare providers identified a language barrier as one of the major difficulties when caring for migrant women. They not only found it difficult to obtain the medical history from patients with limited language proficiency, but they also worried that they were not able to effectively explain procedures to the women (Lyons et al. 2008). Although healthcare providers sometimes used professional interpreters to help them communicate with non-Irish patients, they were concerned about the quality of these services (Lyons et al. 2008). They questioned whether the professional interpreter had enough knowledge of medical terminology in order to be able to understand and explain the issues to patients. In addition, it frequently happened that the interpreter was male. As maternity care often involves intimate questions, the healthcare professionals raised doubts whether the gender of the interpreter did not cause additional difficulties for migrant women.

The study by Lyons et al. (2008) also showed that some of the healthcare professionals working at the maternity hospital in Dublin held several assumptions about migrant women. For example, they thought that migrant women were more dramatic and louder than Irish women when coping with labour (Lyons et al. 2008, p. 267). Healthcare professionals believed that this was because migrant women often wanted to labour without an epidural, and, as a result, required more attention than Irish women who used pain relief (Lyons et al. 2008, p. 267). Furthermore, healthcare providers complained that

migrant women did not follow the “unwritten rules” of how to use the maternity services in Ireland. For example, they asked for more prenatal ultrasound scans or were more likely to visit A&E departments than Irish women (Lyons et al. 2008). In this sense, they were perceived as being more demanding than other patients and as putting an extra burden on maternity services in Ireland.

Assumptions that migrant women put an extra burden on the host country’s maternity services may lead to migrant women being discriminated against when accessing healthcare services. This, coupled with language problems, migrants’ limited knowledge about Irish healthcare services and their relatively weaker social position, greatly impact migrant women’s access to care and makes them a particularly vulnerable group among healthcare users. In order to overcome at least some of these problems, migrant women engage in a variety of strategies. Thus, in the next part of the chapter, I turn to discuss the various practices that Polish migrant women engage in during pregnancy and childbirth in Ireland. I look at the pathways that women choose within the maternity services available to them in order to ensure what they believe is optimal care for them and their children. However, before doing that, in order to situate my study in the larger context of research conducted in the area of Polish migrants health and healthcare, I review studies that looked at recent Polish migrants through the lens of health and healthcare. I draw lessons from them and identify the gaps that my research seeks to fill.

6.2 Exploring the barriers to healthcare services and searching for patterns among the “messy” healthcare pathways? Drawing a lesson from the studies on Polish migrants in the UK and Ireland

There is a growing number of studies that look at the post-accession Polish migrants’ health status and healthcare practices. Most of these studies focused on Polish migrants to the UK (see for example Lakasing and Mirza 2009, Kozłowska et al. 2008) but there are also studies conducted among Polish migrants in Ireland (see for example Kabir et al. 2008) and Northern Ireland (see for example Kouvonen et al. 2014). These studies focus on patterns of unhealthy behaviours such as rates of alcohol consumption or smoking among Polish migrants (Kabir et al. 2008) or their health status in comparison to the non-migrant populations (Lakasing and Mirza 2009). In general, these studies show that post-accession Polish migrants are more likely than non-migrant populations to engage in unhealthy behaviours such as smoking (Kabir et al. 2008) and tend to have poorer health outcomes. This is also true for mental health indicators. Studies from the UK reported particularly high

levels of depression, anxiety and stress among recent Polish migrants (Kozłowska et al. 2008, Kouvonen et al. 2014, Selkirk et al. 2012, Smoleń 2013). They linked these poor mental health outcomes to migrants' relatively weaker socio-economic position in the host country (in this case the UK), especially low living standards and overcrowded accommodation, unstable work status, very long working hours, loss of social networks and feelings of alienation in the new country. However, despite these high health needs, these studies showed that Polish migrants tend to underuse the healthcare services in the UK (Kouvonen et al. 2014, Selkirk et al. 2012). This is especially true for GP services. As suggested by these studies, when suffering from mental health problems, Polish migrants preferred to seek help within their social networks or contact Polish private practitioners in the UK or Poland rather than access British GP services. Thus, they showed similar patterns of preferences for their home country's healthcare services and underuse of host country's medical services as other studies looking at migrants from Eastern Europe (MacFarlane and de Brún 2010, Migge and Gilmartin 2011, Stan 2015).

Goodwin et al. (2012) investigated Polish migrants' experiences with healthcare services in the UK and found that 69 per cent of the participants in the study stated that they would prefer to receive treatment in Poland than in the UK. However, they were not equally critical of all the British healthcare services. For example, Polish migrants tended to be much more satisfied with hospital services than with GP services. While 61 per cent of the respondents were highly satisfied or satisfied with the treatment they received in British hospitals, only 26 per cent said the same about the treatment they received from their British GP (Goodwin et al. 2012, p. 162). Many believed that GPs were reluctant to run extensive tests and instead advised their patients to take paracetamol as a cure for most problems. Furthermore, while Polish migrants tended to be rather critical of British doctors' competence, and especially of GPs' competence, they were very complimentary about the administrative services and the attention they received in British healthcare facilities (Goodwin et al. 2012, p. 162). They believed that British doctors were generally friendlier and nicer to their patients than doctors in Poland. This shows that Polish migrants' attitudes to British healthcare services are complex and cannot be reduced to the simple preference for either Polish or British healthcare services. Instead, they are highly dependent on the concrete healthcare setting and treatment migrants avail themselves of.

While a few studies addressed barriers, preferences and attitudes towards the host country's health services of post-accession Polish migrants (Goodwin et al. 2012, Selkirk et

al. 2012), much less attention has been given to migrants' particular pathways and healthcare practices within the host and home countries' healthcare services. The study by Osipovič (2013) is an exception. She distinguishes four main health-seeking behaviours among recent Polish migrants in London. First, some migrants, particularly those engaged in casual, undocumented employment, strongly avoided using any type of healthcare services in the UK. In case of minor issues, they tried self-medication, often by using medicines brought back from Poland. They also attempted to contact their friends or family members for advice and delayed seeking professional medical help in the UK. In some rare cases, Polish migrants went to private Polish doctors practicing in London. As they had to pay for these consultations, only migrants who could afford to pay for this type of care did so. Information about Polish surgeries was widely available in Polish shops and media, or, in some cases, migrants made contact with Polish doctors in London through their doctors in Poland. Many migrants accessed healthcare services on the occasion of their trips back to Poland and some even travelled specifically to consult particular specialists. As they usually did not have Polish public health insurance, they used private surgeries and clinics and paid out-of-pocket for the consultations. Finally, Polish migrants also used services in the British healthcare system (NHS). However, as recent migrants, they had a rather limited knowledge of the services and their entitlements. As a result, they often ended up using A&E departments as their first points of contact with the British healthcare services. In this sense, Polish migrants used the British healthcare services as a safety net or a back-up plan when they exhausted other options.

Osipovič (2013) showed that recent Polish migrants living in London used the British and the Polish healthcare services concurrently and interchangeably, making any generalisation on specific patterns of health-seeking pathways among Polish migrants particularly difficult. However, despite the "messy" picture of health-seeking pathways, Osipovič (2013) identified migrants' socio-economic position and their length of stay in the UK as important factors that impact on their healthcare practices. She found that migrants in undocumented work were particularly likely to avoid British healthcare services. They feared possible charges and worried that their undocumented status may be revealed. Also, the longer migrants were living in the UK, the more likely they were to access British doctors. As the author of the article suggests, while at the beginning of their life in London the most obvious pathway for migrants was to go to Polish doctors or to travel back to Poland, with time they built up a better knowledge of the British healthcare system and other services available to them and found the most suitable pathways for themselves

within British healthcare. Thus, Osipovič (2013) seems to suggest that these “messy” pathways of recent Polish migrants in the UK and the concurrent usage of both Polish and British healthcare services may be just a temporary phenomenon. Once settled, Polish migrants are likely to find more established pathways within the available sources of care. However, this does not mean that they will limit their healthcare practices to the British healthcare services (Osipovič 2013, p. 110). They may continue to use the Polish healthcare, but, as suggested by Osipovič (2013, p. 110), they are less likely to engage in several systems concurrently.

The studies looking at recent Polish migrants and their health and healthcare practices seem to bring two main lessons that I can draw on. First, they point to migrants’ strong preference for Polish healthcare services. Indeed, it is not only access or lack of it that shaped migrants healthcare practices, but also their preferences. Second, they also point to what Osipovič 2013 calls the “messiness” of Polish migrants’ healthcare pathways and their employment of a variety of healthcare sources, including healthcare services in their host and home countries. I now turn to discuss the particular pathways that Polish migrant women take during pregnancy and childbirth in order to ensure the best care for them and their children.

6.3 Polish outpatient clinics: a new point on the Polish migrants’ map of access to healthcare services in Ireland

Since the increase of Polish migration after the 2004 EU enlargement, new clinics run by Polish doctors started to operate in major cities in Ireland, adding new services to the availability of the Polish migrants’ access to healthcare. In 2014 there were more than a dozen individual and group private practices run by the Polish doctors. They are usually located in Dublin, Galway and Cork. They offer several healthcare services including GP services, specialist consultations (mainly paediatric, obstetric and gynaecological, dermatological or dental) and several diagnostic procedures, including ultrasound scans, vaccinations, electrocardiography or laboratory diagnostics. Most of their services are fee-based but many clinics also offer publicly funded programmes such as Medical Card, the Maternity and Infant Care Schemes, vaccinations or Cervical Check. According to the information provided on their websites, all doctors working at these clinics are registered in the Medical Council in Ireland, so they are eligible to provide medical care in Ireland. They offer their services to everyone, but the overwhelming majority of patients seeking care in these clinics are Polish migrants living in Ireland.

These Polish clinics in Ireland do not differ considerably from many of the regular single-handed or group practices operating all over Ireland. They are usually open from Monday to Friday from morning to evening. Some also stay open over the weekend. To book a visit, one needs to call the reception or send an e-mail. In some cases there is an online booking system available through the clinic's website. All this can be done in Polish as typically the whole staff of the clinic is Polish.

One of the major differences between clinics run by the Polish doctors and other GP surgeries and specialist clinics in Ireland is that Polish clinics offer patients direct access to specialists. Only a few of the doctors working in Polish clinics are GPs. The majority of them have specialisations in medical fields such as paediatrics, obstetrics and gynaecology, dermatology, cardiology and orthopaedics. In order to see any of the doctors working in the Polish clinics, a patient does not need to have a referral letter from a GP. Anyone can just directly book an appointment with a specialist they believe is most competent to advise them on their health issues. Typically, a parent with a sick child will book an appointment with a paediatrician or a pregnant woman will go directly to an obstetrician/gynaecologist. In some cases these specialist doctors are also GPs¹¹. Waiting times for appointment are usually no longer than a few days. In the case of GPs, the consultation may often be arranged on a daily basis.

In 2011, a consultation at the Polish clinic in Ireland costed between EUR 80 to EUR 100. However, depending on the specialist and the diagnostic procedures carried out costs might rise considerably. For example, in 2011, a regular GP consultation cost from EUR 50 to 60 EUR¹². An appointment with a specialist costed up to EUR 150 and more depending on the diagnostic procedures carried out by the physician. Most of the participants in my study reported paying between EUR 80 to EUR 160 for specialist consultations at Polish clinics. In comparison, according to the research poll conducted by Irish insurance companies, in 2013 a GP consultation in Dublin cost on average EUR 53.29 (Finn 2013). According to a survey conducted in 2009 by the Consumers' Association of Ireland, a specialist consultation cost on average between EUR 150 and EUR 200 (Hunter 2009). These data suggest that although the Polish clinics in Ireland seem to be more expensive

¹¹ As I discuss in Chapter 7, this results from the structure of the Polish healthcare system where the specialisation of family medicine (the equivalent of the general practice in Ireland) developed only over the last two decades. Many internal medicine specialists or paediatricians additionally specialised in family medicine in order to work as family physicians in GP surgeries. For detailed discussion on the structures of primary and specialist care in Poland please see Chapter 7.

¹² I based this estimation on what I was told by the participants in my study as well as on my personal communication with clinics operating in Dublin.

than regular Irish GP surgeries, they also offer cheaper specialist care than Irish private specialist clinics.

Polish migrants living in Ireland are the most frequent users of the clinics run by Polish doctors. However, other migrants, especially those coming from the other CEE countries seem to use their services as well. In many instances I have been told by the Polish women I spoke with, that it is not only Polish migrants that attend these clinics. One of the participants in the study told me that her two neighbours, both young mums, one Irish and the other Filipino, regularly go to the Polish paediatric clinic with their children when they are sick. Another migrant woman told me about her Irish husband whom she encouraged to register with a Polish laryngologist when he suffered persistent colds and ear infections for weeks. He went to a number of different GPs who prescribed him a variety of treatments but nothing seemed to be effective. At the Polish clinic a doctor took a swab from his ear and then prescribed an antibiotic. After a few days the infection went away. Polish clinics encourage other groups besides Polish migrants to attend their services by, for example, making all the information available in both Polish and English or by stressing that all doctors working there are fluent English speakers with a good knowledge of the workings of the Irish healthcare services. Although they have some success in attracting other groups to use their services, the majority of patients continue to be Polish migrants.

For those Polish migrants who can afford to pay for private consultations, clinics run by Polish doctors became a new point on their map of access to healthcare services. In some cases, they also become an alternative to seeking help within the mainstream Irish healthcare services. By accessing care at clinics run by Polish doctors, Polish migrants could overcome some of the barriers that they faced when seeking help within the Irish healthcare services.

Obstetric care is particularly popular among the various services that Polish clinics offer. Generally, there are two different ways pregnant women can access maternity care at the clinics run by Polish doctors. First, they may register with obstetricians for consultations. In this case they will be charged from 80 EUR to 160 EUR for each visit depending on the additional tests (such as ultrasound scans) that may be carried out during a visit. Second, depending on availability, women may sign up for the Maternity and Infant Care Scheme that some Polish clinics offer. In this case, during the scheduled visits they will be seen by one of the Polish GPs and they will not be charged any fees. In some rare cases, instead of GP visits, Polish clinics may offer obstetrical visits under the Maternity and Infant Care

Scheme. This means that instead of attending GPs for the scheduled maternity visits, a pregnant woman will attend Polish obstetricians and will not be charged any consultation fees. However, they may be charged for additional tests that are not part of the regular GP consultations such as ultrasound scans or additional blood tests. These types of arrangements, where women are seen by obstetricians instead of GPs, seemed to be quite popular during the first few years of existence of Polish clinics in Ireland. It seems to me that some clinics used this as a way of encouraging Polish women to use their maternity services. However, at the time I carried out my research in 2011, clinics started to withdraw from this and only a few offered this type of arrangement. Thus, women registering for the Maternity and Infant Care Scheme at the Polish clinics were more likely to be seen by the Polish GP than obstetricians for their prenatal appointments.

Below, I take a closer look at the maternity services Polish women living in Ireland accessed during their pregnancy and childbirth. I identify pathways that women take in their health-seeking practices. However, before I do that I need to explain what I mean by terms “Irish” healthcare services and “Polish” healthcare services. By “Irish” healthcare services I do not mean the nationality of the healthcare provider, but the fact that these services are provided in the mainstream healthcare units in Ireland. These mainstream healthcare units include hospitals, specialist clinics and GP surgeries that do not focus their services on a specific ethnic group (as is the case with clinics run by Polish migrants in Ireland) but cater for a general population in Ireland. In this sense, the “Irish” healthcare services may be provided by a healthcare professional who does not have Irish nationality, but works in the mainstream Irish healthcare unit. By contrast, by “Polish” healthcare services I mean two types of healthcare services. First, services provided in mainstream hospitals, clinics and surgeries in Poland. Second, by services provided by doctors working in the Polish clinics in Ireland. Although these clinics in a way belong to the official healthcare services in Ireland (doctors working there are registered with the Medical Council in Ireland and some of these clinics provide publicly funded programmes), nonetheless, they do not belong to the mainstream healthcare facilities in Ireland. This is because, despite some of their efforts to provide services to other groups, they cater mainly to Polish migrants. Also, their workings as well as their structure (such as direct access to specialist doctors) are closer to the structure of clinics in Poland. In this sense, although belonging to the official healthcare services in Ireland, Polish clinics in Ireland are closer to “Polish” healthcare services.

6.4 Relying on Polish or Irish maternity care: Polish migrant women's pathways within maternity care in Ireland

My research shows that Polish migrant women living in Ireland took two pathways within outpatient maternity care. One pathway led Polish migrant women to mainly rely on Irish healthcare services and treated the Polish healthcare services or clinics run by Polish doctors as an addition to care provided by the Irish services. A second pathway led Polish migrant women to mainly rely on Polish clinics and to treat the Irish healthcare services as an addition to the services provided by Polish doctors. Although some women had private health insurance in Ireland, none of the migrant women I spoke to used private or semi-private maternity services.

More than half of the women who participated in my study attended Polish clinics regularly. Other women attended obstetrical consultations with Polish doctors only occasionally, either at the Polish clinics or during their visits in Poland. All women attended maternity hospitals for their scheduled visits but none of them relied solely on services provided by "Irish" healthcare units. They all planned to give birth in Ireland. However, one migrant woman developed complications while pregnant and decided to move back to Poland because she believed Irish healthcare services were not providing her with optimal care. She regularly visited clinics when in Poland and moved back a few weeks before her due date in order to give birth at a Polish hospital. This shows, that Polish migrant women living in Ireland, while using maternity services provided within the "Irish" healthcare units, also strongly relied on the services provided by Polish doctors.

Below I present three cases that illustrate the patterns of access to maternity care Polish women living in Ireland take. In the first case, the migrant woman relied mainly on the Irish healthcare system throughout her pregnancy but went to Polish clinics twice for obstetrical consultation. In the second case, the migrant woman used both, the Polish clinic as well as Irish GP surgery and outpatient care. In addition, on the occasion of her trips to Poland, she also consulted an obstetrician working in Poland. Finally, in the third case, the migrant women relied mainly on the services provided by Polish doctors in Ireland. She attended the maternity hospital for the scheduled visits, but she treated them more as an addition to the care provided by the Polish obstetrician. Thus, the three cases presented below illustrate the variety of women's experiences and their link to women's social position.

Karolina is a university graduate historian in her mid-30s and mother of one child. When I first met her for the interview in spring 2011 she was due to give birth to her first baby

within the next few weeks. She came to Ireland in 2009 to join her Irish husband whom she met in another EU country where they had both worked as researchers but decided to move to Ireland. Since moving to Ireland, Karolina did not manage to secure permanent employment. She worked on a few temporary contracts as project assistant but could not find a permanent position that would match her qualifications. Her husband, by contrast, got a managing position at an IT company and became the breadwinner of the family. At the time of the interview they were seeking to buy a house and planned to stay in Ireland for good.

Before becoming pregnant Karolina had never been to a doctor in Ireland. She did not have a GP or much knowledge of how Irish maternity care worked. While reading Polish internet forums in Ireland, she learned about the clinics run by Polish doctors in Dublin. As this seemed to be the easiest way to avail herself of perinatal care, she registered for her first visit with an obstetrician at a Polish clinics in Dublin. Although happy with the consultation, Karolina found it very expensive and decided she did not want to pay from 80 EUR to 160 EUR for each visit throughout her whole pregnancy. As she explained to me, this was mainly because she felt perfectly fine and did not see the need to spend so much money if all seemed to be going well. She asked an Irish friend to recommend a GP surgery where she could sign up for the Maternity and Infant Care Scheme. She registered with the recommended doctor and attended the scheduled visits both to this GP and the maternity hospital. Although generally happy with the care, Karolina was quite surprised by how few tests she was offered during the first few months of her pregnancy. She also worried that her first ultrasound scan was scheduled for the 22nd week of the pregnancy. She found this to be much later than is typical for the first scan in Poland. Thus, she decided to register once more for a consultation at a Polish clinic in Dublin to have an extra ultrasound scan around the 12th week of her pregnancy. However, apart from these two visits at the clinic run by Polish doctors, Karolina relied on the “Irish” healthcare services. As she explained, it took her some time to get used to it, mainly because the Irish healthcare services seemed to offer fewer tests and had a more relaxed attitude towards maternity care than the Polish one. After the initial confusion and once she got used to it, she started to like it. As a fluent speaker of English, she did not have any major communication problems. She liked her GP and appreciated her relaxed approach to pregnancy. As we met for the interview towards the end of her pregnancy, Karolina questioned whether the Polish healthcare services are not too medicalised and she was quite convinced that, if she was pregnant again, she would not feel the need to visit a Polish clinic.

Similarly to Karolina, Kamila relied mainly on the Irish healthcare services, especially during her second pregnancy. She came to Ireland with her then boyfriend in 2006, two years after her graduation with a degree in biology. Since then she has been working different jobs, all below her qualifications. When I met her for the interview in 2011, she was unemployed and thinking of going back to university in order to do a second degree and improve her chances of getting a job that matched her qualifications.

During her first pregnancy Kamila signed up for the Maternity and Infant Care scheme offered in one of the Polish clinics. For her prenatal visits, she attended a Polish GP and the maternity hospital. As she explained to me, she decided to go to the Polish clinic because a friend of hers recommended it to her. She did not know any other clinics in Ireland, so she just decided to follow her friend's advice. It seemed to be the simplest solution. She was happy with the services, but as she stressed, she had a very uneventful pregnancy and she felt fine. During her second pregnancy, Kamila decided to switch to the Irish GP surgery for her maternity care. As she explained, it was mainly because the Polish clinic was located far away from the place where she lived and she did not want to travel far for her maternity appointments. Although she was generally happy with the care she received, she decided to access more care on the occasion of her travels back to Poland to visit her family and friends. During her first pregnancy she was in Poland twice and on both occasions she went to the obstetrician for a consultation and to have an ultrasound scan. During her second pregnancy she was in Poland once, and again, went to the obstetrician. As she explained, these visits were cheaper than those offered by Polish clinics in Ireland so she could easily afford them. Thus, she thought that her travels to Poland were a good opportunity to access obstetrical services.

Unlike Karolina, during her two pregnancies Asia relied very strongly on healthcare services provided by Polish clinics in Dublin. She came to Ireland in 2008 to join her Polish husband who migrated earlier and worked as a technician for an internet provider company in Dublin. Before leaving Poland, Asia completed a postsecondary course in pedagogy and worked as a preschool teacher. When she came to Ireland she spoke very little English and decided to first learn the language in order to find a job that would better match her qualifications. Meanwhile, she became pregnant and postponed her plans to find work. When I met her for the interview in 2011 she was a stay-at-home mum and expecting her second child. During both her pregnancies Asia regularly attended an obstetrician at one of the Polish clinics in Dublin. As she explained, it was the most obvious solution because she

spoke very little English and had little idea about the workings of Irish maternity care. She chose a Polish clinic where she could register for the Maternity and Infant Care Scheme with obstetrical consultations instead of GP ones. In this arrangement she was charged between EUR 50 and EUR 80 for tests that were not considered to be part of standard consultations under the Maternity and Infant Care Scheme (such as ultrasound scans). Apart from these regular visits, Asia went a few times to another Polish clinic to check with another obstetrician that the baby was developing fine. She also wanted to have a 3D ultrasound scan. In this case she paid EUR 160 a consultation including a scan. In addition, Asia attended the scheduled visits at the maternity hospital of her choice. She complained she could not have relied only on these latter visits because they were “rather rare” and “offered very few tests”. She treated visits at the maternity hospital as an addition to the care provided by the Polish clinics. As she explained to me, she could have done without them because the care provided by the Polish clinics was enough for her. Nonetheless she attended them in order to get to know the hospital and obtain yet another opinion whether all was fine with the baby.

Karolina’s, Kamila’s and Asia’s pathways represent important examples of how many Polish migrant women living in Ireland access maternity care. Women either relied mainly on the Irish healthcare services and occasionally consulted Polish obstetricians, or they frequently accessed services provided by the clinics run by Polish doctors in Ireland. Some women also consulted Polish obstetricians when they travelled back to Poland. However, typically women did not travel more than once or twice during their pregnancy. Thus, consultations in Poland constituted a rather marginal share of all the prenatal care that migrant women access.

The pathways that women take in maternity care in Ireland are also strongly linked to the position women occupy in Irish society. Thus, in the last section of this chapter I explore the link between women’s socio-economic position and the healthcare practices that women engage in.

6.5 The link between migrant women’s social position and their pathways within maternity care in Ireland

Relying on Polish clinics in Ireland for perinatal care costs money. As already mentioned, a private consultation with an obstetrician may cost from around 80 EUR to 160 EUR depending on the diagnostic tests performed. Even if a woman manages to find a Polish doctor that offers maternity care covered by the Maternity and Infant Care Scheme, she is

usually offered additional tests (such as for example ultrasound scans) that cost additional fees. Although it is up to the woman to decide whether she wants any additional tests, most women usually decide to have them done. In consequence, most women who avail themselves of the Maternity and Infant Care Scheme in the Polish clinics, end up paying for additional ultrasound scans (around 50 EUR) or other diagnostic tests during each consultation.

This would suggest there should be a strong link between the migrant women's income and the pathway in maternity care services. Women with higher income (usually correlated with better education and higher social position) should be more likely to use the services provided by the Polish clinics whereas women with lower income (middle-skilled, unskilled or unemployed) should be more likely to rely mainly on Irish healthcare services. Among the migrants I interviewed, unemployed women with vocational education and women in unskilled employment were indeed less likely to regularly attend Polish clinics. Only one out of the four women in that group went regularly to Polish clinics for perinatal care. She registered for the Maternity and Infant Care Scheme and was not charged any fees for consultations and paid only for the additional tests. The other three women went to Polish doctors only once or twice, usually at the very beginning of the pregnancy, and paid around 160 EUR each for these visits. After these initial visits they started to rely mainly on Irish healthcare services. As they explained, they had done so mainly because they could not afford to go to the Polish clinics and pay for regular check-ups.

Women with secondary and post-secondary education were as likely to attend Polish clinics as women with university degrees. In each group, six out of the total eight women in the group relied mainly on the services provided by the Polish clinics. The rest of the women visited Polish clinics occasionally or consulted an obstetrician in a private clinic during their holidays in Poland. In explaining their decisions to rely on Irish healthcare services, women with secondary and university education put less stress than women with vocational education on the financial strains. Although they all mentioned that consultations at Polish clinics were expensive and impacted on their budget, they also declared that they generally felt taken care of by Irish healthcare services.

However, apart from the financial strains, some women saw their reliance on the Irish maternity services as a sign of their successful integration into Irish society. In this case, they were quite proud to declare that they did not need Polish healthcare services in order to feel taken care of. They also stressed their distinctiveness from these Polish migrant

women who, according to them, attended Polish clinics because they either had not integrated well with Irish society or they did not speak English.

Indeed, the language barrier was commonly mentioned among Polish migrants as a major reason why Polish women attend Polish clinics in Ireland. In numerous informal conversations I had with healthcare professionals and non-healthcare professionals both in Poland and in Ireland, they all seemed to think that the language barrier is the most important factor when it comes to making decisions about the use of the healthcare services. According to many, women choose Polish obstetricians because they can easily communicate with them and there is no danger of misunderstandings. However, contrary to this common belief, none of the migrant women I talked to listed language as a decisive factor when it came to registering with the Polish clinics. They usually mentioned it as something that played a secondary, or at least not as important as generally believed, role in the whole decisive process.

However, women did experience language problems when accessing maternity care in Ireland. Many of them were afraid that they will miss something during consultations conducted in English. They admitted that there were moments when they struggled for words or were unable to say what they wanted during consultations with Irish physicians. In order to overcome the language barrier, they developed various strategies. For example, they took their friends or spouses for medical visits, asked other Polish women waiting in the waiting rooms of the hospitals to interpret for them or they requested professional interpreters. Some women admitted that sometimes when leaving the examination room, they were unsure what exactly the doctor or the midwife had said. However, they believed they got the most important information out of the conversation with the healthcare professional.

Another aspect that seems to support the idea that although important, the language barrier played a secondary role in women's decisions to register with Polish clinics is the fact that women who attended Polish clinics were often fluent or good speakers of English. Among the participants of my study there was a strong link between women's education and their language competence. All women with university degrees declared themselves to be good or fluent speakers of English, compared to three out of four women with vocational education who declared themselves to be poor or very poor speakers of English. Out of the twenty two migrant women, five declared they had problems communicating in English. Three out of these five women had vocational education and no stable

employment. The other two had secondary education. One of them worked in a shop and the other was a stay-at-home mum. Because of the strong link between the education, employment situation and language competence, women with poor English were also the ones with fewer resources, thus less likely to attend the Polish clinics. In other words, for the women for whom the language barrier might have played a particularly important role, private consultations with Polish obstetricians were least accessible due to the lack of resources. In fact, most of the women who went to the Polish clinics were fluent or communicative speakers of English. In contrast, out of the five women who declared themselves as poor speakers of English, only two regularly attended the Polish clinics. The other three, despite poor language competence, relied mainly on the Irish healthcare services.

Migrant women's pathways within maternity services suggest that in order to understand the complexity of Polish migrant women's healthcare practices we need to also look beyond the "formal" and "informal" barriers that migrants experience when accessing healthcare services in Ireland. For many migrant women, Polish maternity services constitute a point of reference. Women compared and contrasted the Irish and Polish healthcare services and they assessed them in relation to one another. Even those women who relied mainly on the Irish maternity services, constantly compared them with the Polish ones. In this sense, Polish migrant women used Polish healthcare services as "a mirror" in order to comment on Irish healthcare services (and the other way around). Thus, in order to better understand women's pathways within maternity care and the reasons behind them, it is necessary to look beyond the power configurations in the host country's healthcare services. It is the structure and inequalities of the Polish healthcare services and particularly the Polish maternity services that can shed more light on the reasons behind women's "messy" health-seeking pathways and their reliance on Polish healthcare services.

Chapter 7: Polish healthcare and maternity services: “personal” (but unequal) biomedical regime

In the previous chapter I looked at Polish migrant women’s healthcare pathways and the way migrant women often referred to Polish healthcare services. As I argued, this reference to Polish services should not be seen only in terms of barriers of access women encounter in the host country, but also in terms of women’s preferences for particular types of care. In this sense, women’s use of Polish maternity care is also an expression of their preference for it over the care provided in Ireland. Thus, in this chapter I discuss the working of the Polish healthcare services and analyse the lines of division that run across them. As in Chapter 5, in which I discussed the working of the Irish healthcare system, I start with the general overview of the healthcare services and then move to maternity care. I explore the main patterns of access to Polish maternity services and show how inequalities that characterise provision of maternity care in Poland mediate women’s access to particular forms of care.

7.1 The structure of the Polish healthcare services and inequalities in access to them

Unlike in Ireland, in Poland the healthcare services were organised for decades on the principles of free and universal access. However, although in theory universal, the socialist healthcare system in Poland was built on various lines of divisions that influenced the allocation of funds and entailed various degrees of inequality among different socio-economic groups. For example, urban clinics were generally better equipped than those located in the rural areas. Also, company-based facilities for the employees of certain sectors of socialist state economy (e.g. heavy industry) tended to provide higher standard of care than clinics intended for general population. In addition to these inequalities, access to healthcare was often negotiated through the network of social relations and informal payments. In search of higher standard and more attentive care, people made connections with doctors through friends and acquaintances or offered gifts. Thus, although in theory universal, access and the standard of healthcare very much depended on a person’s place of residence, their employment situation, their occupation as well as their social connections and their ability to skilfully navigate these connections.

In 1999 the financing of the healthcare services was transferred from the state budget to a system based on universal and obligatory health insurance contributions that continues to

operate today. This reform introduced two categories of eligibility to healthcare services in Poland: people covered by the public health insurance and those not covered by it. The first are entitled to free healthcare at the point of delivery and the latter, in some situations, may be charged fees when accessing public healthcare services. As insurance premiums are deducted from taxable income, with some groups of the population having their premiums paid by the state (e.g. registered unemployed, people in full time education, or the homeless), the great majority of the Polish population is covered and entitled to free healthcare at the point of delivery. However, some groups (e.g. Polish migrants working abroad, or those neither in full-time education, nor in the labour force) may be not covered.

Primary care in Poland is provided in primary health clinics [Podstawowa Opieka Zdrowotna] (POZ). They may take the form of individual practices or health centres with a team of family doctors (GPs), nurses and midwives providing care. Before 1999 the network of public health centres that provided primary care was underdeveloped and largely underfunded (EOHS 1999). Many people bypassed health centres and went directly to polyclinics where internal medicine specialists, paediatricians and gynaecologists delivered primary care. The introduction of the public health insurance was to change this practice by separating primary and specialist care and by introducing the figure of the family doctor (an equivalent of a general practitioner) who was to act as a gatekeeper to specialist care (polyclinics) and to guide their patients through the healthcare system (Golinowska 2006).

However, the reform was not followed by any substantial rise in the standards of care in public primary care facilities. This was seen by many doctors and private investors as an opportunity to start their own business. Following the launch of the reform in 1999, many doctors, often internal medicine specialists and paediatricians who used to work in public health centres or polyclinics, set up their own private POZs. At present, as many of these private POZs have contracts with National Health Fund [Narodowy Fundusz Zdrowia] (NFZ) they provide care to both public patients (those insured who access services for free) as well as private patients (who pay for consultations). Public patients, as it is a case in Ireland, must register with a particular POZ. People who pay out-of-pocket can seek medical advice from any surgery.

Family doctors set up their charges individually. As many of them have specialisation in internal medicine or paediatrics¹³, their fees may vary. Depending on the doctor and the location of the surgery, the consultation fees may range from less than PLN 100 (less than EUR 25) to over PLN 150 (over EUR 38)¹⁴. However, as private clinics in Poland usually offer a direct access to many specialists, it is not uncommon for patients paying out-of-pocket to bypass the primary care and go directly to a doctor with a particular specialisation.

Family doctors are supposed to act as gatekeepers to the healthcare services in Poland and, if needed, refer their patients to specialist care. However, there are several specialisations that patients can access directly. This includes gynaecologist/obstetricians, dentists, dermatologists, oncologists, psychiatrists and ophthalmologists (EOHSP 2011, p. 123). As these specialists do not require a referral letter from a family doctor, patient may contact a particular clinic and register with these specialist directly. For those covered by the public health insurance, specialist care is free at the point of delivery.

Specialist care in Poland is provided in clinics that may be located on or off the hospital grounds. Before 1999, specialist care was mainly provided in polyclinics assigned to territorial administrative districts. These polyclinics were often located in or close to hospitals, so some of the specialists consulting patients in these polyclinics were also working on hospital wards. They were owned by regional or national authorities and, as many other public healthcare facilities, they were largely underfunded. The introduction of the public health insurance did not improve their financial situation and many started to generate debts. As with primary care, this was seen by some investors as an opportunity to start their own business. After 1999, some of the public clinics were privatised and the number of private for-profit specialist facilities started to rise and. As many of them signed contracts with the NFZ, they provided care for free at the point of delivery for patients covered by the public health insurance as well as offered private consultations for fee-paying patients. In 2010, over 60 per cent of specialist consultations provided to public patients took place in private for-profit facilities (GUS 2011).

Although slower than outpatient care, over the last two decades inpatient care has also gradually been transferred to private facilities. Throughout the 1990s most hospitals remained public and there were only a few private facilities. However, since 1999 the number of private hospitals that sign contract with the NFZ and provide care to public as

¹³ Specialisation in family medicine is not very popular in Poland and internal medicine specialist and paediatricians are allowed to work as primary care providers (EOHSP 2011, p. 124)

¹⁴ My own calculations on the basis of information provided by several surgeries.

well as private patients has steadily been increasing. In 2000 about 3 per cent¹⁵ of hospitals and less than 1 per cent of hospital beds were private (GUS 2001). In 2005 the share of private hospitals rose to 22 per cent, and the share of private beds rose to 4.5 per cent of all beds covered by the public health insurance in Poland (GUS 2006). In 2010 the share of private hospitals was around 36 per cent, providing over 13 per cent of the total number of beds covered by the public health insurance (GUS 2001, 2006, 2011).

The complicated mix of private and public services that followed the healthcare reforms introduced in the 1990s, triggered new lines of division that characterise access to care in Poland. Indeed, like in Ireland, speedy access to specialist care and many diagnostic procedures is strongly dependent on patients' ability to pay for private care (see for example Watson 2006). Unable to access care in the public system because of the long waiting list, people who can afford it attend private polyclinics or pay for procedures in public facilities. It is not unusual that in some hospitals patients have to wait several months to access some scans under the public health insurance. The same scans can be accessed within weeks if the patient pays for them.

The same applies to ambulatory specialist care. Some patients have to wait several months for consultations with specialists covered by the public health insurance. They are also likely to be seen in overcrowded facilities. In contrast, if a patient pays for a private visit waiting times are usually no longer than a few days or weeks.

Furthermore, the gradual transfer of inpatient care to private facilities had a significant impact on the way inpatient care is provided in Poland. For example, private hospitals may offer additional services for which patients who access care under the public health insurance can pay for out-of-pocket. This leads to the situation where, for an extra fee, public patients may access additional services such as single rooms, more attentive care or, as I discuss in more detail in the next part of this chapter, in case of maternity wards, epidurals.

Whereas inequalities that were inherent in the socialist healthcare system lost their significance over the last two decades, new lines of division appeared. Although profession or place of residence no longer formally limits access to healthcare facilities (as it was the

¹⁵ Statistical data provided by GUS does not reflect the differences in sizes of hospitals. Private hospitals tend to be smaller than public hospitals and that is the reason why the share of private beds is significantly lower than the share of private hospitals.

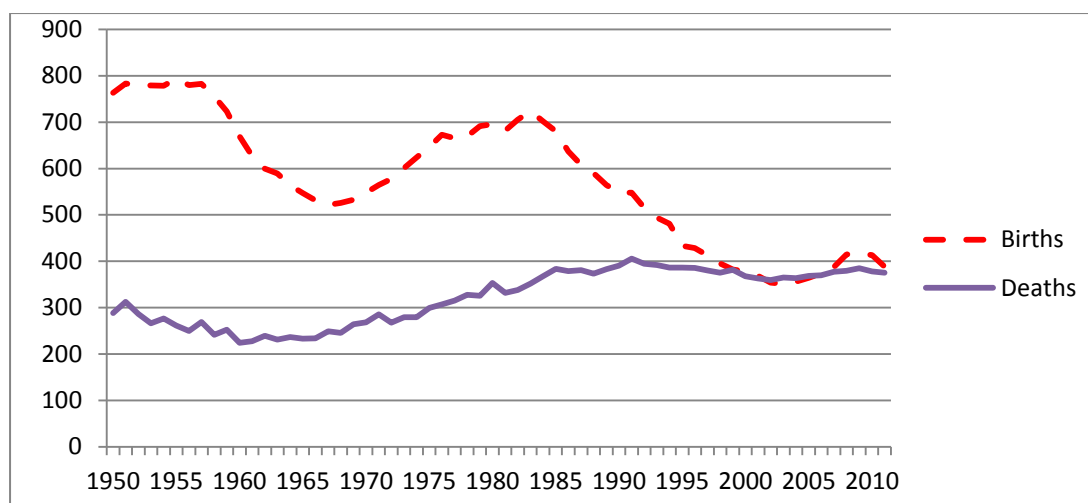
case in socialist Poland), patients' financial resources play now a determining role. Patients who are able to pay for services can access care faster and often of higher quality by, for example, paying out-of-pocket for certain procedures in hospitals providing care under the public health insurance or by paying for procedures in private hospitals. In addition, access to care continues to be moderated by other practices including seeking personal connections that may facilitate speedier access to some services or to more attentive care.

The same lines of division prevail in maternity care where, as I show in the next part of this chapter, ability to pay for private services as well as women's social connection play a very important role in mediating the type of care women receive. Thus, I now turn to discuss the provision of maternity care in Poland. Before doing that, I briefly discuss the demographic trends and ways they influence the workings of maternity services.

7.2 Maternity care in Poland

In the period between the end of the war in 1945 and the collapse of the socialist regime in 1989, Poland experienced slow but rather constant population growth with peaks in the mid-1950s and mid-1970s. Since 1989, population growth slowed down significantly, mainly due to the considerable fall in the number of births (Kocot-Górecka 2014). Whereas in 1980 695,500 children were born, in 1990 the number dropped to 547,700 and reached the lowest level in 2003 when 351,100 births were registered (GUS 2014). Since then it has been slowly increasing, but over the last few years the number of births decreased again (Graph 3). In 2011 388,400 children were born in Poland resulting in a birth rate of 10.1 (GUS 2014) – slightly below the average birth rate of 10.4 for the EU-27 (Eurostat 2015a). In comparison, in Ireland, a birth rate in 2011 was 16.2 (CSO 2015a). In 2011, the total population of Poland was just over 38.5 million people (GUS 2014).

Graph 3: The number of births and deaths registered in Poland (1950-2011) (in thousands)

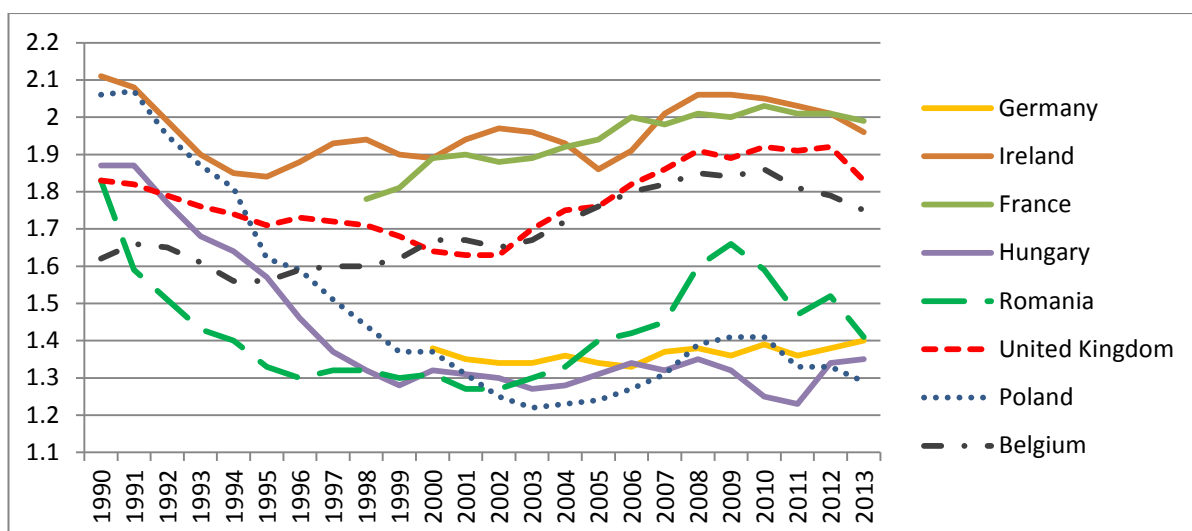


Source: GUS 2014

At the beginning of the 1990s Poland had one of the highest total fertility rates¹⁶ (TFR) in Europe. However, over the past two decades it has been decreasing, recently reaching one of the lowest fertility rates in Europe (Graph 4). In 2011 the fertility rate in Poland was 1.33 (Eurostat 2015c), which is considered very low (Kocot-Górecka 2014, p. 12). In comparison, in Ireland, a country with one of the highest fertility rate in Europe, the fertility rate was 2.03 in 2011 (Eurostat 2015c). The trends in fertility rates over the last two decades in some European countries are presented in Graph 4. It shows how since 1990s fertility rates in the former socialist countries dropped significantly and are currently lower than in many western European countries. This is especially true for Poland, where the drop has been particularly sharp.

¹⁶ The total fertility (TFR) rate is a “mean number of children that would be born alive to a woman during her lifetime if: (1) she were to experience the exact current age-specific fertility rates; and (2) she were to survive from birth through the end of her reproductive life. The total fertility rate is obtained by summing the single-year age-specific rates at a given time” (Eurostat 2015d)

Graph 4: Total fertility rates in selected countries in Europe (1990-2013)



Source: Eurostat 2015c

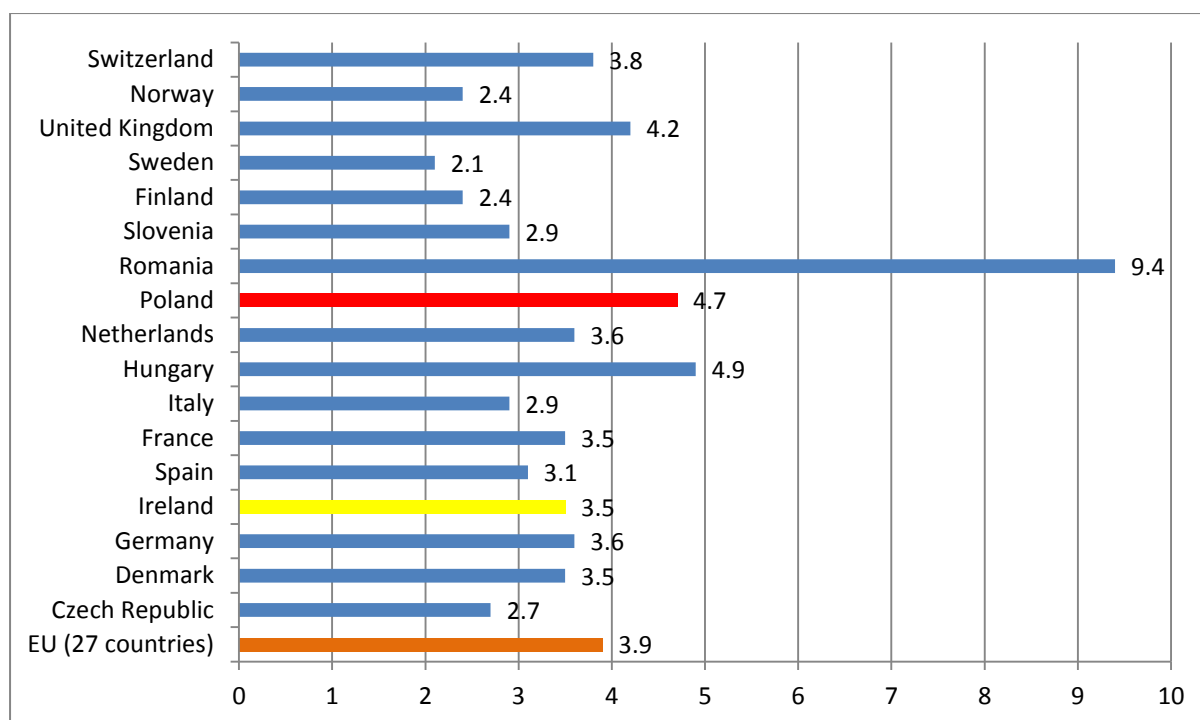
One of the very positive trends observed in Poland is the constantly decreasing infant mortality rate (IMR). Whereas in the 1950s the infant mortality rate was as high as 111.2 infant deaths per 1,000 live births, in 1990 it was 19.3 and in 2011 it further decreased to 4.7 (Table 13). In the same year, the average infant mortality rate for 27 EU countries was 3.9 (Eurostat 2015b). However, there are considerable differences between EU countries with some countries such as the Czech Republic (IMR 2.7) or Sweden (IMR 2.1) having the lowest infant mortality rates in Europe, while others such as Romania (IMR 9.4) or Bulgaria (IMR 8.5), having some of the highest. Although constantly improving, the infant mortality rate in Poland is still higher than in most countries in Western Europe (Graph 5).

Table 13: Infant mortality rates in Poland (1950-2011)

1950	1960	1970	1980	1990	1995	2000	2005	2006	2007	2008	2009	2010	2011
111.2	54.8	36.7	25.5	19.3	13.6	8.1	6.4	6	6	5.6	5.6	5	4.7

Source: GUS 2014

Graph 5: Infant mortality rates in selected European countries in 2011



Source: Eurostat 2015b

Similarly to infant mortality rates, maternal mortality rates¹⁷ are also decreasing in Poland. Whereas in 1991 the maternal mortality rate in Poland was estimated at 15 per 100,000 births, in 2000 it decreased to 7.7 and in 2004 it further decreased to 6.7 (Troszyński 2007). However, as already mentioned in Chapter 5, in order to explore the actual challenges women face when accessing maternity care, other aspects such as the structure and provision of maternity care, as well as patterns of access should be analysed.

In Poland, maternity care is overwhelmingly obstetrician/gynaecologist driven. It is usually provided in outpatient clinics that may be located on, but often are off hospital grounds. All women covered by the public health insurance, as well as those not covered but who are Polish nationals and reside in Poland, are entitled to access maternity services that are publicly funded and free at the point of delivery (Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych 2004). In order to access publicly funded care women should register with outpatient clinics that provide maternity services under the public scheme. There, they are entitled to a minimum of seven or eight prenatal consultations during the whole pregnancy, typically every four to five weeks. Usually, during each consultation women see the same obstetrician that they chose while

¹⁷ Maternal mortality rate is the number of maternal deaths calculated per 100,000 births

registering with the clinic. The Decree on the Standards of Perinatal Care (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012) introduced in Poland in 2012 specifies the minimum number of tests and prenatal screenings that the maternity care provider is obliged either to carry out or to refer pregnant women to. As many clinics providing maternity services are located off hospital grounds and are not affiliated with any particular inpatient maternity unit, the choice of the outpatient clinic does not determine the choice of the hospital where women will give birth. It is quite common for pregnant women in Poland to not attend maternity hospitals before going into labour.

Instead of public care, pregnant women may choose to attend private clinics for their prenatal visits. To do so they need to register with any of the many private surgeries that offer obstetrical care in Polish towns and cities. During each visit they will typically be seen by the same obstetrician/gynaecologists of their choice. They will be charged from around 100 PLN (25 EUR) up to several hundred PLN for each consultation¹⁸. In some cases they may also be additionally charged for screenings such as ultrasound scans. Taking into consideration that the average gross wage in Poland in 2011 was PLN 3399 (GUS 2015) private consultations can pose a significant financial burden on household budgets. However, despite the considerable costs they involve, according to surveys conducted by the Institute of Maternity and Child in seven Polish maternity units (Troszyński 2013), in 2012 over 43 per cent of pregnant women in Poland accessed private prenatal care. As in the case of public services, the choice of an outpatient clinic does not determine the choice of the hospital. Thus, many women who chose private prenatal care give birth in public maternity wards.

As already mentioned, maternity care in Poland is overwhelmingly obstetrician/gynaecologist driven. Although the Decree on the Standards of Perinatal Care (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012) allows midwives to be the primary maternity care providers for healthy pregnancies¹⁹, this is very rarely the case. Midwives working in local health centres and providing care under the public health insurance rarely provide prenatal care. In practice, their role is mainly limited to providing postnatal home visits. Although there are some midwife-led clinics

¹⁸ Prices may differ considerably among cities and clinics. In one of the popular private outpatient clinics in Warsaw the prices for maternity consultations start from PLN 100 (about EUR 25) but, depending on doctors, they may be as high as PLN 250 (about EUR 63).

¹⁹ In this case a midwife is obliged to refer women to the obstetrician/gynaecologists for a consultation once in every trimester (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012).

where women can access prenatal care, they are very scarce and usually located in big urban centres. Furthermore, very few women are aware that midwives can provide prenatal care. Thus, in practice, women using public health insurance or living outside large cities have access only to obstetrician/gynaecologist driven care.

According to the Decree on the Standards of Perinatal Care (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012), between the 21st and 26th week of the pregnancy the doctor providing maternity care, should refer the pregnant woman to see a community midwife so she can advise the expectant mother on issues concerning labour, breastfeeding, healthy diet or infant care. As community midwives are also responsible for providing at least four postnatal home visits, the consultation during the pregnancy allows the pregnant woman to meet her community midwife prior to these visits. However, although obliged to refer their patients to the community midwife, doctors very rarely do so. The recent report issued by the Supreme Chamber of Control (NIK 2011) showed that only 1.3 per cent of surveyed women chose their community midwife as a result of a doctor's referral. Although the majority of women had chosen their community midwife, usually when registering with a particular clinic, they rarely remembered doing it, did not know who their midwife was and did not know how to get in touch with her (NIK 2011). This suggests that women treated registering with a community midwife as a formality and were not encouraged to avail themselves of midwifery care. In general, the report shows a very low level of utilisation of midwifery services in Poland (NIK 2011). Women very rarely consulted their community midwives during pregnancy and most of them only met their midwife during scheduled postnatal home visits.

In Poland, as in other European countries, the overwhelming majority of births take place in hospitals. In order to receive care for free, women can choose any of the obstetric/gynaecological units that provide care covered by the public health insurance. In 2011 there were 532 obstetric/gynaecological inpatient units that offered 18,487 beds (GUS 2011). Out of these, 380 were public and 182 were private (GUS 2011). However, as some private units have contracts with the National Health Fund (NFZ) they also offer beds covered by the public health insurance.

To add to the complicated mix of private and public inpatient maternity care, some hospitals offer additional private services to women who access care as public patients. In other words, women who access free maternity care covered by the public health insurance may pay for some additional services such as "family birth", private rooms,

epidurals on demand or individual midwifery or doctor care that are not offered as standard procedures under the public health insurance. There is a good deal of variation among hospitals in the range and price of the private services they offer. While some hospitals may offer a whole range of private services, others may offer only single rooms and yet others may not offer any of these services at all. Thus, women using free public inpatient care have the possibility to avail themselves of additional private services in some hospitals.

One example of the private services that some hospitals charge additional fees for are so-called “family births”. These are births during which the woman in labour is accompanied by a family member or a friend. Whereas up to the 1990s hospitals rarely allowed birth partners in the labour ward, over the last decade they started to accommodate them and family births have become very popular. However, some hospitals treated family births as a private service and charged fees for women who wanted to be accompanied by partners during labour. As with other private services, fees differ considerably among hospitals and women have been charged from around PLN 100 (EUR 25) up to PLN 300 (EUR 75), depending on the hospital.

Over the last few years, the number of hospitals treating “family births” as a private service decreased and many facilities stopped charging additional fees if women in labour were accompanied by their partners. However, some hospitals, instead of charging for “family birth” started to require refunds for the costs that the hospital had to bear as a result of the presence of birth partners. As a result, in some hospitals birth partners have to pay, for example, for the disposable clothes they need to wear while accompanying women in labour, or for the instructions they receive from the healthcare personnel. For example, in 2012, in one of the biggest hospitals in Poznań, a person accompanying a woman in labour was required to pay PLN 150 (EUR 37.5) to the hospital in order to refund the costs the hospital had to bear (Żbikowska and Roik 2012). As explained by the hospital lawyers, this fee included disposable clothes, instructions on how to cut the cord, or the healthcare personnel’s readiness to provide medical help to the accompanying person if the need arose (Żbikowska and Roik 2012). Furthermore, while most hospitals do not allow birth partners to attend during caesarean section, one of the biggest hospitals in Warsaw permits this but only for a fee of PLN 200 (EUR 50). Thus, while in theory hospitals claim they do not charge any additional fees for family birth, in some facilities birth partners may face some charges.

Another procedure that some hospitals charge additional fees for is the so-called epidural on demand – that is, when a woman in labour requests an epidural during a vaginal birth. As with other private services, there are considerable differences among hospitals. While some hospitals do not offer epidurals during vaginal births at all, others treat it as a standard procedure and offer it for free, and yet others offer it for a considerable fee. According to the 2010 report published by the Supreme Chamber of Control (NIK 2010), 12 per cent of the controlled hospitals offered epidurals for an additional fee and charged from PLN 300 (EUR 75) to PLN 660 (EUR 165). Thus, while in some hospitals women can access epidurals without any additional costs, in others they are either unavailable or women have to pay for them.

Over the last years, apart from family births and epidurals for an extra fee, some hospitals have started to offer private, high-standard rooms for women during labour or where they can stay after the labour. In some hospitals private rooms are very nicely decorated, have private bathrooms, kitchen facilities or an extra bed. Some of them are more like a hotel than a hospital room. As with any other private services, availability and prices differ considerably among facilities. For example, one of the biggest maternity hospitals in Warsaw offers private rooms that cost PLN 300 (EUR 75) for 12 hours or PLN 500 (EUR 125) for 24 hours. Women can stay there with their partners after the labour and, for an additional fee, can for example request different meals than those served on the public ward. In this way, women who access inpatient maternity care under the public health insurance, may access higher standard accommodation for additional fees.

Finally, some hospitals also offer so-called individual care that is provided either by midwives or by doctors. This means that prior to labour a pregnant women can choose and meet with midwives or doctors who will provide care for them during labour. Again, as with other private services prices differ among hospitals. For example, in one hospital in Warsaw, individual midwifery care during labour costs from PLN 2,000 (EUR 500) to PLN 3,000 (EUR 750). Women who decide to pay extra have the chance to meet with their midwives prior to going into labour and they can contact them with any questions.

In 2010, the Supreme Chamber of Control published a report in which it stated that public hospitals could not offer private services to public patients for a fee (NIK 2010). According to the Supreme Chamber of Control, charging for services such as private rooms, epidurals or individual midwifery care violates the principle of equal access to healthcare financed from public sources. In the report, the Supreme Chamber of Control urged hospitals to stop

offering any extra services to their patients (NIK 2010). However, this only concerns the decreasing number of public hospitals. As already mentioned, private and commercialised hospitals (*spółki handlowe*) can offer their public patients extra services for additional fees. Thus, while some hospitals stopped charging additional fees for certain services such as private rooms or offering individual midwifery care, other hospitals introduced even more private services, as private payments contribute to balancing their budgets.

Apart from inpatient care provided under the public health insurance, women in Poland can also avail themselves of fully private hospitals that do not provide care under the public health insurance. These are usually located in big urban centres and typically offer higher standards of accommodation than public hospitals (including private rooms with bathrooms, TV, etc.). Depending on the hospital, charges may vary considerably. In the biggest private hospitals in Warsaw childbirth and the subsequent hospital stay costs from around PLN 8,000 (EUR 2000) to PLN 12,000 (EUR 3000).

7.3 Inequalities in access to maternity care in Poland and women's quest for "personal biomedicine"

Although formally structured on the principles of equality and universal access, the Polish maternity services are characterised by various inequalities that run across them. The most obvious line of division runs between public and private services. A recent study on the differences between women attending private and public outpatient clinics for maternity care showed that private patients tend to receive more care than public patients (Rogala et al. 2014). For example, while the average number of obstetric/gynaecological consultations for women attending public clinics was 8.28, the average number of consultations for women attending private clinics was 10.53 (Rogala et al. 2014, p. 14). This means that, on average, women attending private clinics had two more consultations than women attending public clinics. Also, the average number of prenatal screenings was higher for private patients. For example, women using private care were more likely to have more blood tests than women using public care. Private patients were also far more likely to be referred to other specialists (Rogala et al. 2014, p. 15). However, the biggest difference between private and public care was illuminated in the number of ultrasound scans offered to patients. While women in public clinics had on average 3.93 prenatal ultrasound scans, women in private clinics had on average 7.88 scans (Rogala et al. 2014, p. 15). This means that women using private care had on average almost four scans more than women using public care. As Rogala et al. (2014) showed, women in private care were far more likely to

attend more screenings and consultations than women in public care and had more scans than recommended by the Polish Gynaecological Society [*Polskie Towarzystwo Ginekologiczne* (PTG)]²⁰.

Furthermore, certain services are only available in the private sector. For example, as already mentioned, midwife-led clinics are not only very scarce but also do not provide care under the public health insurance. Thus, women who want to attend midwives for their prenatal visits have to pay for consultations as public care normally only provides obstetric/gynaecological driven care. Also, as already mentioned, some hospitals charge additional fees if women request epidurals during vaginal deliveries. Thus, women who cannot afford to pay for epidurals may not be in a position to receive them. In this sense, women's financial position and ability to pay for certain services determines their access to some maternity care services.

Finally, by accessing private care and by paying for private services in the hospital, women want to ensure what they believe to be better quality of inpatient care. Polish obstetric services in general, and public inpatient maternity care in particular, have rather a poor reputation among Polish people. *Childbirth with Dignity*, an NGO formed in the 1990s with the aim to improve the situation in Polish maternity wards, points at the lack of respect, indifference among healthcare personnel and disempowerment of women as the main problems experienced by women on Polish maternity wards (Wochna-Tymińska 2012). Although over the last decade the situation in maternity care has greatly improved, mistreatment of women in labour has not been completely eliminated. Internet discussion forums for expectant parents are full of stories of women who had been mistreated by hospital staff while giving birth to their children. For example, these complaints include unfriendly or rude healthcare personnel, lack of information offered to women, or medical personnel carrying out procedures without asking for women's consent. In addition one of the major Polish dailies quite regularly publishes articles presenting stories of misconduct on various Polish maternity wards (Łabutin and Konopacki 2012, Watōła 2013). These articles, as stories presented on the internet discussion forms, include examples of doctors disrespecting women's requests, being rude to women and their partners or refusing to provide them with sufficient information. Thus, despite great improvement, the popularly held belief that women in labour are particularly vulnerable to mistreatment on Polish maternity wards remains very strong.

²⁰ I discuss the use of ultrasound technology in prenatal care in Ireland and in Poland in Chapter 11.

The recently published report by *Childbirth with Dignity* showed that, although most women had positive experiences with maternity units and the healthcare personnel, there were still women who experienced disrespectful treatment while giving birth to their children (Rodzić po Ludzku 2015). Women complained about doctors dismissing their concerns, laughing at their birth plans²¹ or not providing them with sufficient information (Rodzić po Ludzku 2015, p.10). This resulted in feelings of confusion and vulnerability (Rodzić po Ludzku 2015, p. 10). In general, the report showed that women who recently gave birth paid very little attention to the standards of accommodation on maternity wards, but were far more concerned with the behaviour of the healthcare personnel and the way they approached and cared for women in labour (Rodzić po Ludzku 2015). This concern continues to be a key aspect in Polish maternity care. Despite improvements, pregnant women continue to fear the possibility of being treated with a lack of respect while labouring on Polish maternity units. In order to minimise the risk of mistreatment, they employ various strategies that they believe improve their chances of getting respectful and attentive care.

Thus, attending private outpatient clinics and accessing private services on maternity wards, especially individual midwifery care can be understood as two of the strategies women engage in to avoid the disrespectful treatment and to ensure better quality of inpatient care. By going for regular check-ups to the private practices of doctors who also work on the public maternity ward, some women hope to get to know particular doctors better and become acknowledged as their private patient during their hospital stays. As fees for private maternity consultations for many obstetrician/gynaecologists constitute a considerable part of their income, women hope that doctors will feel obligated to treat them with respect and provide them with more attentive care. In this sense, some women interviewed treat going to private clinics for prenatal care as a form of “pay off to the doctor for best services during their hospital stay”. They hoped that, in this way, they would have a better chance of being treated with greater respect and care during their labours. For the same reason, some women pay for individual midwifery care. They hope that having what they call “their midwife” on the ward will give them a better chance of attentive and respectful treatment. In addition, paying for individual midwife care ensures

²¹ The birth plan is a new document in Poland. It was introduced by the Decree on the Standards on Perinatal Care (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012). It is part of the prenatal documentation that women are expected to have with them when arriving at a hospital. The birth plan includes a woman’s expectations about labour and should be filled in by the woman and her prenatal care provider.

continuity of care during labour and allows women to get to know their midwife in advance.

This illustrates a very important aspect of private services in maternity care in Poland, namely its embeddedness in social relations. Although many women, especially middle-class women, tend to describe their use of private care in consumer-like terms of “free-choice making” to access particular services, the focus of their endeavours seems to be informed not so much by the consumer subjectivity of free-choice makers. Rather, women’s use of private services seems to be informed by their quest for particular social relations that women engage in with the healthcare personnel. In other words, by paying for private services women not only seek to receive particular services (such as a private room in the hospital) but more importantly, they seek to enter in a particular relation with the healthcare personnel that would ensure more personal treatment and access to medical technology. As women see it, being anonymous to hospital personnel (often described in Polish as “being somebody simply from the street”) puts them in a vulnerable position where they become very prone to mistreatment and disrespect. Thus, through accessing private services women seek ways to escape this anonymous position of a patient and establish more personal relations with a member of the healthcare personnel. In this way accessing private services becomes what Rivkin-Fish (2005, p. 154) in her study on Russian maternity care calls “personalising strategy” – a way of transcending an anonymous doctor-patient relation and making it part of one’s personal relations.

The type of care that women seek through this “personalising strategy” is what I call “personal biomedicine”. This particular kind of biomedical care involves two main elements – personal relation with a healthcare personnel and access to highly technologized treatments or screening procedures. Some women, in order to access personal biomedicine, instead of paying for private services use their social connections. They attend physicians or midwives they found through their social networks. However, whatever “personalising strategy” they use (be it attending private practices, paying for individual care on the ward or finding a doctor through the network of acquaintances) the goal remains the same – to access personal medicine that ensures respectful treatment and sufficient use of medical technology. Having established personal relations with midwives and doctors, women are no longer “someone simply from the street” but they are in a strong social position vis-à-vis other patients and members of the hospital staff. In this way,

they hope to ensure the sufficient use of medical technology and increase their chances of receiving respectful treatment.

As I have shown in this chapter, Polish healthcare services are built on various inequalities. Indeed, patients' social connections, financial position and their ability to pay for private services play a very important role in determining the care women will receive. In maternity care, women's social position plays a very important role in mediating access to personal biomedicine. Women with social connections and those who can afford to pay for private care have better access to personal biomedicine than women who attend public care. Personal biomedicine not only gives women better access to medical technology (in the form of frequent prenatal screenings or consultations with specialists). Women with social connections or the money to pay for private care have also better chances of building personal relations with healthcare personnel and thus, accessing more respectful and compassionate care.

In the next chapter, I turn to Polish migrant women living in Ireland and look at their healthcare practices associated with pregnancy and childbirth. As I mentioned in Chapter 6, migrant women very strongly rely on Polish healthcare services and treat them as a point of reference. By engaging in transnational healthcare practices, they bring together two biomedicines (as they are practiced in Poland and in Ireland), providing an excellent opportunity for comparing these two regimes. Thus, in Chapter 8, I try to answer the question whether migrant women, similarly to women in Poland, engaged in the quest for personal biomedicine. Taking into consideration their mobility, I look at how their strategies differed from those of women living in Poland.

Chapter 8: Engagements with biomedicine: Polish migrant women in search for “personal biomedicine” in Ireland and in Poland

In Chapter 7 I discussed the structure of Polish healthcare services. I showed how women’s healthcare practices and their search for a specific type of healthcare, namely personal biomedicine, were embedded in the structure and inequalities that characterise Polish healthcare services. In this chapter, I turn to Polish migrant women to see how their healthcare practices differ from those of Polish women living in Poland. Furthermore, in Chapter 6 I discussed the most common pathways that migrant women took within maternity care. As I argued, they either relied mostly on the Irish maternity services and only occasionally consulted Polish doctors (either in Poland or in Ireland) or they relied mostly on Polish doctors in Ireland and treated Irish prenatal care as an addition to the care they received from Polish doctors. In this chapter, I explore women’s particular practices within these pathways and the reasons behind them. In the case of outpatient (prenatal) care, women often employed Polish healthcare services by accessing healthcare back in Poland or by registering with Polish clinics in Ireland. By looking at how women manoeuvred between Irish and Polish healthcare services and, by doing so, how they compared and contrasted the two biomedicines, I aim to establish what factors shape women’s experiences with healthcare and what type of care (such as personal biomedicine, similarly to women in Poland) migrant women tended to search for. Given the fact that these practices are embedded in the local realisations of biomedicine, the analysis sheds more light on the way these local realisations control women’s (pregnant) bodies.

8.1 Polish migrant women’s quest for personal biomedicine in Poland.

In September 2011 I attended a public debate on the new standards in maternity care in Poland. Six months earlier a new regulation on maternity care had been introduced (Rozporządzenie Ministra Zdrowia w sprawie standardów postępowania medycznego 2012), specifying the tests and medical procedures that doctors and midwives should carry out while caring for a woman in an uncomplicated pregnancy and labour. The debate was organized by one of the main national dailies, *Gazeta Wyborcza*, and an NGO, *Rodzić po Ludzku*, (*Childbirth with Dignity*). Among the invited panellists were the Minister of Health, consultants in obstetrics and midwifery, as well as midwives and obstetricians working on several maternity wards in Poland. The general tone of the debate was moderately

optimistic: although the new regulation was a good step forward in bringing Polish maternity services closer to world (i.e. “western”) standards, it would take several years for Poland to catch up with other western European countries. At some point during the discussion, one of the consultants pointed to what he believed was proof that the Polish obstetric care was in a better state than many tended to believe. While he recently travelled from London to Warsaw, a considerable share of the passengers on the plane were Polish pregnant women who presumably lived in the UK and travelled back to Poland for their obstetric check-ups. They were doing so not because they did not have access to the British healthcare services, but, as the consultant believed, they preferred the Polish healthcare services. The Polish Minister of Health reacted in a very enthusiastic manner to these observations. She said she was very happy to hear that not everyone thinks that the Polish healthcare system is bad and that some women even prefer it to the “western” systems. As she suggested, the Polish healthcare system might be in a better state than many believed.

The remarks made by the minister and the consultant illustrate what seems to be two commonly shared beliefs about the Polish maternity services. The first belief sees Polish healthcare and maternity services as being in the long process of “catching up” with western Europe. According to this belief, healthcare services in the “west” are of a higher standard than those in Poland. The second belief concerns Polish women and their healthcare practices. According to this belief, despite the shortcomings of Polish healthcare, migrant women prefer Polish healthcare services to the services in their host (i.e. western) countries. They demonstrate this preference by travelling to Poland in huge numbers to access the healthcare services there. This particularly includes pregnant women, who presumably travel in large numbers to give birth at Polish maternity hospitals.

If the mentioned consultant had travelled on the flight from Dublin to Warsaw, he would have been very likely to come to a similar conclusion on the practices of Polish migrant women living in Ireland as he had on those of migrants living in the UK. Indeed, there are often many pregnant women and families with small children travelling from Ireland to Poland. Most of them are Polish migrants who came to Ireland after Poland joined the EU in 2004 – part of the same cohort as those who migrated to the UK during the same period. As discussed in Chapter 4, recent Polish migrants are relatively young and many of them started their families while living in Ireland. Some of them may indeed be travelling back to

Poland for their obstetric consultations, but, what is more likely is that the consultation is not the main purpose of the travel. Indeed, although some women access maternity services in Poland, they do so usually on the occasion of their trips to Poland for holidays or family visits.

All of the migrant women that I interviewed declared that they had accessed healthcare services in Poland while living in Ireland. As mentioned above, they usually did so on the occasions when they travelled on holidays or to visit family and friends in Poland. Most commonly women reported visiting gynaecologists (to have smear tests or just for regular check-ups) and paediatricians (for their children's check-ups). Some also reported going to dentists in Poland and one woman said that she regularly visited a dermatologist. Apart from regular check-ups, women also access doctors in Poland in order to confirm diagnoses made by Irish doctors. In rare cases, women travelled to access particular treatments. In most cases women went to private clinics in Poland. They usually did not consider going to public clinics because, they did not have the public insurance or they did not want to wait for an appointment in the public clinic. In addition, women usually believed that private clinics provide higher standards of care. Thus, they declared that going to a private clinic on the occasion of their trips to Poland seemed the simplest solution.

In terms of maternity care, only four migrant women declared that, while pregnant, they accessed obstetrical services during their trips to Poland. As they explained, they did so because they wanted to have additional scans or they wanted an opinion from the doctor they trusted and knew from before moving to Ireland. As with other healthcare services, they went to private clinics and paid out of pocket for their obstetrical consultations.

Kamila, a university graduate who before becoming a mum worked in a coffee shop, declared that she accessed healthcare several times on the occasion of her trips to Poland, including three obstetrical consultations during her two pregnancies, regular visits to a gynaecologist she knew from before moving to Ireland and a few consultations with a dermatologist. Kamila had a skin condition that needed regular consultations. Kamila heard that a friend of hers had a similar condition and was treated by her Irish GP. However, when Kamila compared the treatment she received from her Polish dermatologist to the one her friend received from the Irish GP, she concluded that she much preferred the care from the Polish dermatologist. Thus, from time to time when going to Poland, she would

register for a consultation with her dermatologist at the private clinic. She also attended a gynaecologist for regular check-ups because she believed that this was good practice in illness prevention. Thus, when she went on holiday to Poland while pregnant, without thinking much, she registered for a visit. As she explained to me: “I was there [in Poland] anyway, so why not go [to the gynaecologist/obstetrician]?”. In Ireland Kamila regularly attended a maternity hospital and her GP so she treated these visits in Poland as an addition to the care she received in Ireland. She just wanted to have an additional scan and confirm with the doctor she trusted that the baby was developing fine.

Wiktoria and Łucja, both university graduates, also reported visiting specialist doctors while on holiday in Poland. Wiktoria’s son was born with a minor condition that required regular check-ups in order to make sure everything was fine. The condition was detected during a prenatal screening at the Irish maternity hospital and Wiktoria expected that once he was born, doctors would run a series of tests to detect whether all was fine. Indeed, the doctors ordered some tests after the baby’s birth but Wiktoria found them insufficient. She worried that they were too basic to detect possible problems. Thus, she decided to seek more care in Poland. Wiktoria decided to use her connections in her home country and, through acquaintances, contacted a specialist clinic near her home town. She believed that, by using her connections, her son would have a better chance to receive the best care. On the first occasion of their visit to Poland, they went for a check-up. The doctors at the clinic ran a number of different tests and prescribed a treatment. As Wiktoria explained, over the next few years, they continued to visit this clinic in Poland for check-ups in order to make sure that all was fine. Wiktoria’s son did not require any specialist treatment but regular check-ups were recommended. Wiktoria was slightly disappointed by the Irish healthcare services and believed that they should have prescribed more screenings when the baby was born.

Similarly to Wiktoria, Łucja also found that the care offered by the Irish healthcare professionals was insufficient once her son developed a minor stomach problem. When she told the midwife that she was concerned, the midwife told Łucja that it was normal. However, Łucja did not find it reassuring, because, as she explained, the midwife carried out few investigations. She worried that something serious might be wrong and consulted a Polish paediatrician practicing in Ireland who recommended an ultrasound scan in order to detect whether there was a need for any intervention. On the first occasion of a trip to

Poland, Łucja went to a private clinic for an ultrasound scan and a check-up. As she explained, she just wanted to make sure that all was fine and the problems would pass. The ultrasound scan confirmed that the issue was minor and that Łucja's son would just grow out of it. However, the doctor showed Łucja a few practical tips that she could use in order to minimise the child's discomfort. Łucja was very happy with the advice and admitted that it helped her. At the same time she felt the Irish healthcare services did not do enough to find out whether the problem was not more serious than it seems.

Only one of the women I interviewed travelled to Poland solely with the aim of accessing specialist care. This was Alicja, a university graduate with a degree in physiotherapy. Early in her pregnancy, she developed an illness that could have negatively affected the development of her baby. It was detected during a routine test ordered by the obstetrician at the Polish clinic in Ireland where Alicja went from the very beginning of her pregnancy. The Polish obstetrician referred Alicja to a specialist outpatient clinic at the hospital in Dublin and also prescribed her medication. Because this medication was not available in Ireland, Alicja asked her family in Poland to send it to her in Ireland. After the visit at the specialist clinic, Alicja was very disappointed with the Irish doctors. Although the doctors ran a series of tests which confirmed the diagnosis by the Polish obstetrician, they did not offer any specific treatment. Their only recommendation was to continue taking the medication she received from Poland. Alicja did not feel reassured by this because she expected the doctors to start some kind of treatment. To make matters worse, she had a feeling that the consultant was dismissive and knew little about the condition Alicja suffered from. The consultant told Alicja that the illness was really rare in Ireland and usually diagnosed among women from ethnic minorities. This made Alicja very angry because she believed contracting the infection had nothing to do with her nationality. On the contrary, she believed she contracted the illness because she lived in Ireland. As she told me:

I remember this lady [the consultant] was very surprised [by the diagnosis] and there was a student there or someone who was learning, and she said to this person that this is a very exotic illness and does not occur in Ireland. She was not able to offer me anything (...) So she just said that it was good that I have this antibiotic from Poland and I should continue taking it and that's it. She was not able to offer me anything else. So they treated it as an exotic illness and I had a

feeling she knew little about it. (...). At that time I knew I won't stay in Ireland to give birth. (Alicja, early 30s, mother of one, university graduate)

After the consultation at the hospital Alicja decided that the Irish healthcare services were not able to provide her with the treatment she was expecting. She was afraid that if the doctors thought her illness was exotic and rare, they probably had very limited experience in dealing with cases like hers. Alicja contacted a doctor in Poland and soon after she travelled for a consultation. There, she felt she was provided with more competent care. This was because doctors did not treat her illness as exotic. They also offered her diagnostic procedures, including an amniocentesis, on which further treatment was to be based. As a result, Alicja decided that the best and the safest solution for her and her baby was to give birth in Poland. She came back to Ireland but discontinued visits at the maternity hospital. She stayed in contact with doctors in the Polish clinic and in Poland and towards the end of her pregnancy she and her husband moved back to Poland. Alicja gave birth to a healthy boy soon after her return. During the interview, a couple of years after the move, Alicja declared that if not for the complications during the pregnancy and the following lack of support from the Irish healthcare services, they would have stayed longer in Ireland. They had been planning to return to Poland at some point in the future, but the experience with the Irish healthcare services resulted in them returning much faster than anticipated.

The cases that I presented above illustrate some of the most common healthcare pathways that Polish migrant women engaged in in Poland. They seem to fall into two main categories. First, women engaged in preventive care. This included periodic tests in gynaecological clinics (such as smear tests or breast examinations), regular check-ups with dentists or, in cases of women with long term health issues, with other specialists that they used to visit regularly before moving to Ireland. Second, apart from preventive care, women also sought treatment in Poland. They went for consultations in order to confirm the diagnosis given by the Irish doctors or to access treatment they could not (or did not want to) access in Ireland.

The obstetrical consultations that some of the women accessed in Poland can be included in the "prevention care" group of healthcare practices. The women accessed these services in most cases not because they needed any specialist treatment, but in order to have an additional ultrasound scan and to get a second opinion, from a specialist, that the baby was

developing fine. They attended the gynaecologist/obstetricians they either knew and had visited before getting pregnant (sometimes even before moving to Ireland) or that was recommended to them by their friends or relatives in Poland. Contrary to the popular assumptions held by some of the healthcare professionals and people in Poland, they did not travel only for the purpose of these consultations. They did it in addition to the care they received in Ireland and on the occasion of their holidays “back home”.

However, obstetrical consultations were not the only services that women sought in Poland as part of preventive care. The character of the practices associated with preventive care is very well encapsulated in the words of Michalina, a migrant with a university degree who returned to Poland. As I met her for the interview in one of the cafes in Warsaw, she told me about the times when she lived in Dublin and came for holidays in Poland. She remembered how quickly these holidays passed and the many things she always had to do while in Poland. While visiting friends and family was the main purpose of the visit, she also used her time in Poland to take care of her appearance and her health. On each visit back home she tried to visit a hairdresser, a beauty salon and a gynaecologist – “the Holy Trinity” as she called it.

This approach to healthcare and wellbeing seemed to be particularly prevalent among women with university degrees. Indeed, women with third level education were more likely than women with secondary and vocational education to declare that during their trips to Poland they visited doctors (especially gynaecologists) as well as beauticians. As some women mentioned, their Irish friends found it rather strange when they declared that they regularly visit gynaecologists for check-ups, and this was not because of any particular problems but as part of preventive care.

It seems that this approach to health and wellbeing, in which regular visits to gynaecological clinics are seen as part of “what women should do”, is part of a wider debate on women’s health in Poland. As already mentioned in Chapter 7, obstetrician/gynaecologists in Poland are responsible for many aspects of care that in Ireland are provided by GPs. Polish family doctors rarely deal with issues linked to women’s health and reproduction such as contraception, pregnancy, smear tests or breast examination. Thus, to access this care, women have to register with an obstetrician/gynaecologist. For example, if a women wants to choose a birth control

method or have a smear test, she would typically go to the gynaecological surgery not to her GP. Although, in theory some of this care could have been provided by the family doctor, in practice Polish GPs do not prescribe contraceptives or advice women on any aspects of reproductive health. Thus, women in Poland are strongly encouraged by doctors to visit gynaecologists at least once a year as part of their regular check-up (see for example Rigamonti 2014, Moskal 2015). One of the rhetorical tools used in this encouragement is a comparison between a check-up at the gynaecologist and a visit to a beauty salon. Both of these are markers of middle-class, educated women's responsibility. For example, in an article published in a popular Polish daily, a doctor urged women to not postpone their regular visits to a gynaecologist surgery, as they, presumably, never postpone visits to a hairdresser (Moskal 2015). In this sense, gynaecological check-ups in private clinics become markers of what smart and responsible (and middle-class) women do.

The second type of healthcare services that migrant women sought in Poland were consultations aimed to confirm the diagnosis or treatment (or lack of it) prescribed by Irish healthcare professionals. Some women, not convinced by what the Irish healthcare professionals prescribed (or more often what they did not prescribe), contacted doctors in Poland in order to get a second opinion. Indeed, women were especially likely to seek treatment in Poland when Irish healthcare professionals claimed that no further care is need. A lot of women worried that doctors in Ireland approached their case too "light-heartedly" and carried out too few examinations. As a result, women strived to get a second opinion from doctors in Poland. They either went to private clinics or they tried to access care in public clinics. In the latter case, in order to escape the anonymous doctor-patient relations, they tended to use their connections through family or friends to get in touch with doctors. They believed that contacting doctors through their acquaintances would increase their chances of getting the best treatment and more attentive care.

Apart from the commonly shared assumption among people in Poland that migrant women frequently travel to Poland only with the purpose of accessing healthcare services, another commonly shared assumption seems to be that women do it because healthcare services are cheaper in Poland. In other words, it seems that many people in Poland assume that Polish migrants' access healthcare services in Poland simply because they are cheaper than in their host country. Indeed, consultations that women accessed in private clinics in

Poland were usually considerably cheaper than services provided in Polish clinics in Ireland or in mainstream Irish private clinics. For example, the cost of a visit at a private obstetric/gynaecological clinic in Poland starts from approximately PLN 100 to 200 (EUR 25 to 50), but it may cost considerably more depending on the procedures prescribed. As already mentioned, at Polish clinics in Ireland the cost of a visit starts from around EUR 80 but often costs twice as much because of additional procedures such as ultrasound scans. However, women themselves very rarely reported prices as a major reason for accessing the healthcare services in Poland.

In additions, as I described above, women often perceived the services that they accessed in Poland as unavailable in Ireland. This perceived unavailability resulted not so much from the costs involved in accessing these services in Ireland, but from the differences in structures of the Irish and Polish healthcare services or from the way biomedicine is practiced in these locations. In other words, women accessed certain healthcare services in Poland not only because they were cheaper than they were in Ireland, but also because these services were not commonly available in Ireland (or they were perceived by Polish women as not being commonly available). An example of these services are regular check-ups with gynaecologists. Many women perceived them as “something that women in Ireland just don’t do”, so in order to access them, migrant women used Polish services. In this sense, their transnational healthcare practices go beyond “seeking a better deal” and should be analysed in terms of seeking a specific type of healthcare.

Polish migrant women’s use of healthcare services in Poland can be analysed in terms of women’s quest for a specific form of healthcare, namely a highly medicalised care that not only involves frequent use of medical technology but also allows for the building of a personal relationship with healthcare personnel. As illuminated by women’s healthcare practices that I have discussed above, women embraced a highly medicalised approach to their or their family’s health. This involved regular preventive consultations with specialists and a strong preference for use of medical technology during these consultations. Indeed, women were very distrustful towards doctors who did not use “enough” medical technology or who did not prescribe any treatment. In this case, they actively engaged with medicine by disregarding the advice these doctors offered and by searching for doctors who, they believed, would provide them with more screening procedures or prescribe

some form of treatment. In this sense, women not only embraced highly medicalised approaches to health, but they also actively encouraged the use of medical technology.

Furthermore, when accessing care in Poland women usually engaged in strategies that would allow them to build personal relationships with healthcare providers. They did this either by accessing doctors whom they were put in contact with by their acquaintances or by going to doctors whom they knew and visited before moving to Ireland. Alternatively, those women who did not use their social network in order to ensure more personal contact with healthcare personnel, went to private clinics and paid out-of-pocket for their consultations. By engaging in these strategies women hoped to build for themselves a strong social position that would allow them to form a personal relationship with healthcare personnel. As I have discussed in detail in Chapter 7, in Poland this personal relationship with healthcare personnel is often perceived as a way to ensure more attentive, compassionate and technologized medical care.

However, not all women had the same access to highly medicalised and technologized care as well as the same opportunity to build personal relationships with healthcare personnel. As I described above, preventive care and regular visits to a gynaecologist are not only depicted in Poland as something that responsible and educated women do, but they are also seen as a domain of private care. In other words, Polish women are encouraged to regularly attend a gynaecologist for check-ups but they are also expected to do it by attending private clinics. In addition, in case of migrant women living in Ireland who are often no longer covered by Polish public health insurance, access to free at the point of delivery healthcare services is highly restricted. Thus, for women with fewer economic resources or limited social connections in healthcare, access to highly technologized personal biomedicine is highly restricted. Thus, it seems that these women were far less likely than wealthier women to access services in Poland or to seek more medicalised and technologized care. As a result, these women were more likely to rely on the Irish healthcare services.

8.2 Polish migrant women's quest for personal medicine in Ireland

Contrary to popular beliefs held in Poland, Polish migrant women's transnational healthcare practices are not limited to occasional visits to clinics in Poland, but are mostly manifested by migrants' use of Polish clinics in Ireland. Indeed, as mentioned in Chapter 6,

all but one of Polish migrant women I talked with visited Polish clinics in Ireland at least once during their pregnancy and many of them attended these clinics regularly throughout their pregnancy. Among the most common reasons for registering with Polish clinics, migrant women mentioned direct access to gynaecologist/obstetricians as primary providers of prenatal care, more prenatal screenings and more time designated for consultations. By explaining their reasons for going to these clinics, women not only expressed their expectations with regard to maternity care, but also commented on Irish (and Polish) healthcare services. Thus, in this section, I look into each of the reasons given by women for attending Polish clinics. As in the previous section, I discuss these reasons in order to answer the question about women's expectations concerning maternity care and its local realisations.

8.2.1 “All is fine. Thank you and goodbye”: Polish migrant women in search of specialist care

One of the reasons given by Polish migrant women for attending clinics run by Polish doctors in Ireland was the clinic's provision of direct access to specialist care provided by gynaecologist/obstetricians. Many women I talked with showed reluctance towards Irish combined maternity care in which prenatal appointments under the Maternity and Infant Care Scheme are also provided by GPs. Taking as a point of reference Polish maternity services where maternity care is provided by gynaecologist/obstetricians, many Polish women thought that GPs were not competent when it comes to pregnancy. There was a general perception that GPs are mainly trained to deal with minor health issues such as colds, fevers or flus, but they are not competent in prenatal care. According to the women I talked with, the only competent maternity care providers are gynaecologist/obstetricians. Thus, in order to ensure the continuity of obstetrical care, women registered with Polish clinics to have direct access to these specialists.

Once registered with the Polish clinics, many women ceased visiting their GPs as they no longer perceived this as a necessity. These women who continued attending their GPs despite frequent visits to a Polish obstetrician, usually did so more because they felt obliged to follow the schedule of maternity care visits than because they believed a GP is competent to pick up on any possible problems. In case of any doubts or complications, these women very rarely went to their GP's surgery, but instead went to Polish clinics or searched for help at the emergency departments of maternity hospitals. If asked by the healthcare personnel at the maternity hospital whether they discussed these problems

with their GPs first, Polish migrant women tended to get annoyed or frustrated. They believed GPs were not competent to advise them on problems related to pregnancy and they did not see any reason why they should “waste time” going to a GP surgery.

In some cases, this opinion went beyond the nationality of the physician. Some women thought that when it comes to prenatal care, the Polish GPs working in Polish clinics were equally incompetent to the GPs working in local Irish surgeries. This was the case for Olga, a former office assistant with secondary education and a stay-at-home mum. Once she discovered she was pregnant, Olga went for a visit to the private surgery of a Polish obstetrician in Ireland. She also went to her GP, who worked in another Polish clinic in Dublin, to register for the Maternity and Infant Care Scheme. She regularly attended her private obstetrician, the GP and the maternity hospital for the scheduled visits. Olga was hesitant whether her GP played any role in the overall care. She thought the visits were very brief and she did not really trust her doctor’s competence. For example, she complained about the way he checked her blood pressure. As she described it, the whole procedure lasted only a few seconds and, according to her, it was way too short for the doctor to measure it correctly. Each time she was told by her GP her blood pressure was perfect. The problem was that Olga believed she had low blood pressure. This is what she has been told by her gynaecologist/obstetrician that she attended privately. As she had trusted him more than she had trusted her GP, Olga did not really treat her GP’s words seriously and continued going for the visits because she felt obliged to follow the schedule. In her words:

My GP? I did not tell him [about low pressure], but it all made me laugh. He would put the band on [to measure the blood pressure] and in 3 seconds he would tell me I have a perfect pressure! I would always ask what is my blood pressure and he would always answer that it was 120/80. So I did not say anything to him [about low blood pressure]... What should I say?. (Olga, late 20s, mother of one, secondary education).

When, during the second trimester of her pregnancy, Olga developed some complications, she went directly to the A&E department in the maternity hospital. When a doctor from the hospital told her that she should go to her GP in the first place, Olga became annoyed. She tried to explain to the doctor at the emergency department, that her GP was not

competent in prenatal care and that she was convinced he will not help her. As she explained to me:

I told her [a doctor at the A&E department at the maternity hospital] that I did not go to my GP, but that my GP would have had no idea what to do. She said nothing. I knew that a GP is free when you are pregnant, but I wanted to go to the hospital because I knew my GP was not going to help me with this. She [a doctor at the A&E department at the maternity hospital] examined me, asked me a few questions and told me that she doesn't know what is it and that I need to go to my GP. (Olga, late 20s, mother of one, secondary education).

Olga felt the doctor at the hospital was dismissive. She left the A&E department without any prescription to follow but the advice to see her GP. As a result, she searched for help in one of the private Polish clinics, where she paid for the visit out of her pocket to see a specialist.

To illustrate what they saw as the incompetence of at least some of the GPs, a few women told me anecdotes. This included stories about doctors googling symptoms to find out what may be the problem or recommending waiting until "the cough will stop by itself" or "the fever will go away". There was a general belief among Polish women that GPs can advise on minor health issues such as cold or fevers, but are not competent to deal with maternity care.

In most cases, women who relied mainly on the Irish healthcare services for their maternity care and attended GPs in the local surgeries for their prenatal appointments under the Maternity and Infant Care Scheme, did not managed to build an enduring and trustful relationship with their GPs. Only a few women told me they were confident their doctors were competent and they trusted their advice on health issues related to pregnancy. One of these women attended her GP regularly prior to pregnancy due to the chronic illness that she suffered from for years. The rest of the women had rather limited trust in their GPs' abilities to provide maternity care. Although they attended them regularly, and were generally happy with the care they received, they also stressed that this was mainly because they all had non-problematic, straight forward pregnancies and they did not feel the need to have more tests. As other migrant women, they doubted whether GPs would

have been able to pick up on any abnormalities with their general knowledge and during the brief maternity visits.

Kamila, a university graduate biologist who before getting pregnant worked in a shop, was rather happy and had no major complains about the GP consultations she had during her two pregnancies. During her second pregnancy, apart from going to the maternity hospital, she attended a local Irish GP surgery for her maternity care visits. At the beginning she was quite surprised how quick the visits were and how little examination was involved. She said that the Polish GP may have ordered a few more tests than the Irish one, but generally she felt she had fewer examinations and tests during both her pregnancies than her friends in Poland who attended obstetricians. When I asked her how she assesses the maternity care in Ireland she was quite unsure. She had no complications during her two pregnancies and thought that GPs were relatively good physicians. However, she also felt that in case something had gone wrong, the Irish healthcare services would not have picked up on it. As she explained to me:

I don't know... In Poland there is an obstetrician and they check everything... Here [in Ireland] I went to a GP. He [the Irish GP] would feel my tummy, say everything is ok and that was it...good bye. (Kamila, early 30s, mother of two, university graduate)

In order to avail herself of more tests, on the occasions when Kamila travelled back to Poland to visit her family, she went to the private surgery of an obstetrician in Poland where she had the ultrasound scans. These visits were cheaper than those offered by the Polish clinics in Ireland and Kamila could easily afford them.

The opinion that GPs are not competent to provide prenatal care was shared by many Polish women. In general, Polish migrant women did not trust that GPs (either Irish or Polish ones) were knowledgeable enough to pick up on the possible abnormalities and complications that may occur during pregnancy. The briefness of the visits under the Maternity and Infant Care Scheme (women reported that their appointments usually lasted just a few minutes) did not help to change their impression that GPs played a minor role in maternity care and therefore visits to them could be omitted. Most Polish migrant women with whom I talked, seemed to be more confident with Polish maternity care. In the latter

family doctors are almost completely excluded from providing check-ups to pregnant women and prenatal care is almost exclusively provided by gynaecologist/obstetricians. Thus, in order to ensure access to gynaecologist/obstetricians, Polish women registered with clinics run by Polish doctors in Ireland.

8.2.2 “The magical touching of my belly [...] was not enough”: Polish migrant women in search of more medical and screening procedures

One of the most common reasons given by women for attending Polish clinics in Ireland was access to the tests and prenatal screenings and treatment that these clinics offered. In general, Polish migrant women I talked with believed that Irish maternity care offered fewer screenings than the Polish services. For example, some women complained that Irish maternity services provided fewer blood tests than Polish maternity services. Often, they were not sure which blood tests that were offered by the Polish maternity services were not offered by the Irish one. Some women listed a test for toxoplasmosis and for what some of them called “other dangerous viruses” as examples of standard procedures in Poland that were not provided regularly in Ireland. Apart from blood tests, women also mentioned a lack of regular pelvic examinations and lack of treatments (usually in the form of hormonal treatment) during the early stages of pregnancy in order to prevent miscarriage. They believed that, although very important, these procedures were not provided within the Irish maternity care. Finally, women were very concerned with what they believed was a scarcity of prenatal ultrasound scans. In general, women perceived consultations at maternity hospitals as very “relaxed” and lacking the “medical dimension”. This lack of “medical dimension” was reflected in the type of procedures and screenings carried out during maternity appointments.

For example, most Polish migrant women were quite surprised by the lack of pelvic examination. They considered this to be a standard procedure in Poland, typically carried out by gynaecologist/obstetricians during each maternity care consultation (Rozporządzenie Ministra Zdrowia z sprawie standardów postępowania medycznego 2012). Indeed, in Poland pelvic examination is a standard procedure during each maternity care consultation. Women reported that in Ireland, with rare exceptions, they did not receive pelvic examinations during their visits to the maternity hospital. One of the participants said that the obstetricians she saw at the Irish maternity hospitals “did not act as gynaecologist/obstetricians”, indicating her assumption that a gynaecologist/obstetrician

should carry out pelvic examination during a maternity appointment. This lack of pelvic examination made some women confused and anxious that doctors may not pick up on possible problems that may be dangerous for them or their babies.

Patrycja, a mother of one and a shop assistant in her 20s, questioned whether the lack of standard pelvic examinations within Irish maternity care could have resulted in premature labour in her case. She attended the scheduled visits at the maternity hospital and her GP. At the maternity hospital she never had a pelvic examination but each time she was told that all was perfectly fine. In fact, she was offered the possibility of attending a clinic run by midwives in a local health centre that offers care only to healthy women in uncomplicated pregnancies. Patrycja happily agreed to this offer. Additionally, once a month, she attended a Polish obstetrician. During a standard pelvic examination, her Polish obstetrician diagnosed her with a cervical problem. This, according to her, was a serious complication that could trigger premature labour. The Polish obstetrician advised Patrycja to stay in bed for a few weeks. She never said anything about the diagnosis to the midwives at the local clinic or to her GP, but she continued to attend them for the scheduled visits. She rested two months and in the end had a healthy baby at full term. If she had not attended the Polish clinic, Patrycja believed that there was a chance she could have gone into premature labour. As other women, she was quite surprised that pelvic examination was not a regular procedure in the Irish maternity care and thought that in her case, this may have been a mistake.

Apart from the lack of pelvic examination, women also mentioned that they were quite surprised by what they saw as Irish doctors' unwillingness to prescribe treatment in case a women in early pregnancy developed symptoms that suggested she may be at risk of miscarriage. There was a general belief among Polish women that Irish obstetricians avoided prescribing any medications to women during the early stages of pregnancy. Women often described this approach in terms of "natural selection" where the strongest survives and the fate of the weakest is left for nature to decide. In this sense, they believed that, unlike Polish, by restraining from using biomedicine and not prescribing treatment, Irish maternity care "allows" for early miscarriages²². As a result, some women who

²²According to the Miscarriage Association of Ireland (MAI 2015), each year there are about 14,000 miscarriages in Ireland. Considering that each year there are about 70,000 births (CSO 2015a), it seems that for about every five live births, there is one miscarriage. In comparison, in Poland in 2005

believed they may be at risk of early miscarriage, instead of attending Irish maternity hospitals or surgeries, went to the clinics run by the Polish doctors.

This was the case for Tonia, the social worker and a mother of one. She believed that if it were not for the obstetrician from the Polish clinic, she might have had an early miscarriage. As she explained, at the very beginning of her pregnancy, she developed symptoms that indicated she was at risk of miscarriage. She knew from her friends that it was very unlikely that doctors at the maternity hospital would prescribe her any medication. She decided to go directly to the Polish clinic in her city to see an obstetrician because she was afraid she might suffer a miscarriage. At the clinic she was prescribed a hormonal drug that was supposed to help her avoid the miscarriage. She took it for a few weeks and the symptoms passed. In the end, all was fine and she had a healthy baby born at full-term. According to Tonia, if she did not go to the Polish clinics, she would not have been prescribed the medications and would possibly have miscarried. As she told me:

From what I know, they [Irish obstetricians] don't prescribe women drugs to avoid miscarriage. They don't prescribe this drug I got from my doctor when I had some symptoms at the very beginning of the pregnancy. I took this drug for three to four weeks because my Polish obstetrician prescribed it to me. And then all was fine. I had a very good pregnancy. And I know there are very many early miscarriages here. Doctors do not prescribe this drug here because they assume there is 'natural selection'. (Tonia, early 30s, mother of one, university graduate)

Tonia continued attending a Polish obstetrician throughout the pregnancy because she thought the Irish healthcare services offered too few tests and she found it very difficult to rely on it in case of any complication with her pregnancy. She doubted whether with these limited number of tests doctors would have been able to pick up on any possible problems, or, if they had found any problems, whether they would have acted on them. By attending a Polish clinic she felt she was on the safe side: more tests made it more probable that possible problems would be picked up on and acted upon.

In order to describe the lack of interventions within the Irish approach to early pregnancy, some women said that until a certain point, for example the 12th or 20th week, the

(the latest data available), there were 40,754 miscarriages and 364,400 live births (Niemić 2007), resulting in a rate of about one miscarriage for every ten live births.

pregnancy “does not exist” for the Irish maternity care. Women quoted different “moments” before which the pregnancy supposedly does not exist for Irish healthcare services. Most women said that it was until the 12th week that Irish obstetricians would “do nothing” in order to avoid miscarriages. But there were also women who quoted the 20th or even the 24th week as a marker before which a women at the risk of miscarriage would not be prescribed treatment within the Irish maternity care.

One of the migrant women I talked with, told me a story of a friend of hers who developed complications during the early stage of the pregnancy. She went to the Irish maternity hospital but, as she explained, she was sent home without any medication or help. Desperate to avoid the miscarriage, she went to the Polish doctor. The doctor prescribed her medications that she continued to take throughout the pregnancy. Kamila told me that her friend did not finally miscarry and, at the time of the interview, was due to give birth soon. As she told me:

(...) They [the Irish healthcare professionals] don’t care about miscarriages until the 24th week, they don’t do anything. This friend of mine had serious problems and they did nothing to save the pregnancy. They did not care. So she went to the Polish obstetrician and she [the Polish obstetrician] was the first one who started to do things... They [the Irish healthcare professionals] would not help her. They would not do anything. (Kamila, early 30s, mother of two, university graduate)

Kamila had mixed feelings about this situation. She felt sorry for women who struggled to get pregnant and then were not provided with any support in case of early complications. She believed they should be provided with more medical support and, according to Kamila, Irish maternity care did not do enough for these women. But, she also believed that children born from pregnancies that develop complications at the very beginning tended to be sicker and weaker. In this sense, she thought the Irish maternity services approach that Kamila believed was characterised by limited medical interventions at the early stages of pregnancy, might have its advantages.

This ambiguous approach to early medical interventions in pregnancy were shared among many women I talked with. For example women believed that some miscarriages occurred because the foetus was sick. In this case, women worried that early interventions to avoid

miscarriage may lead to sicker and weaker children being born. In other words, women thought that some miscarriages happen for a reason and in some cases it is better to “leave it to nature to decide”. However, they also thought that the Irish maternity care was too relaxed in “leaving it to nature to decide” for early miscarriages. Thus, some of the women treated Polish clinics as a form of a back-up where they could receive help in case they developed complications in early pregnancy.

Apart from the lack of pelvic examination and supposed reluctance to medical interventions at the early stages of pregnancy, Polish migrant women were also troubled by what they saw as the scarcity of prenatal screenings offered in the Irish maternity care. Some of them worried that the procedures carried out during consultations at the maternity hospital were “not serious enough” or were of questionable medical quality. This included procedures such as measuring the belly with a tape or checking on the baby by feeling the abdomen. Women were particularly concerned with the latter type of examination which they saw as out-dated and not very accurate. To describe the procedures of checking on the baby by feeling the abdomen, women often used the expression “magical hands” or “magical touching”. In this manner they wanted to indicate the backwardness of this type of procedure. They expected these procedures to be just an addition to the “real” consultation, not its essence. In their opinion, the Irish maternity care offered very little except what they saw as out-dated and not very scientific procedures. One of the women I talked with stressed what she believed was a lack of medical dimension in the Irish maternity care and described it as “Flintstone-like”. As a result, women decided to register with Polish clinics in order to have access to more screenings and more “serious” and scientific consultations.

Łucja, a university graduate and a stay-at-home mother of one, assessed her visits at the Irish maternity hospital as far less medical than those offered in the Polish maternity care. During her consultations at the maternity hospital in Ireland she did not feel taken care of and properly screened for what she thought were potentially dangerous conditions. She assessed the Irish healthcare services as far too relaxed and “light-hearted”. As she told me:

I talked to some Irish women who attended only GPs and used only Irish maternity hospitals and it leaves much to be desired. At the hospital they measure your belly,

take your urine sample, check your blood pressure and there is only one scan. (...) That's it. No, I didn't feel safe. The magical touching of my belly in the 37th week was not enough for me to believe that everything was fine. (...) They are not doing any scans and they don't check anything. (Łucja, late 20s, mother of one, university graduate)

In order to “feel safe” Łucja registered with one of the Polish clinics in Dublin and attended a Polish obstetrician for frequent visits. She found a clinic where she could attend a Polish obstetrician as part of the Maternity and Infant Care Scheme which meant that she did not have to pay extra for her maternity visits. During these consultations she was offered more “Polish-like” maternity care. The latter included standard pelvic examinations, some blood tests and an ultrasound scan during each visit. She believed the Polish obstetrician she attended carried out more tests than she was offered at the Irish maternity hospital. As a result, she felt properly taken care of and trusted that, if anything was wrong, it would have been picked up by the Polish doctor. As she stresses, if she had had to use only the Irish maternity care, she would have been very nervous that doctors might have not picked up on possible problems. That said, she also stressed that she had a very unproblematic pregnancy.

One of the most salient examples of prenatal screening procedures that Polish migrant women lacked in Irish maternity services were ultrasound scans. Indeed, access to ultrasound scans was the most frequently given reason by Polish migrant women for attending Polish clinics for maternity care. Most women were very surprised by the limited number of ultrasound scans carried out by the Irish maternity care. They reported that within the Maternity and Infant Care Scheme, they were offered one, sometimes two scans. Women also reported that they usually had their first scan between the 18th and 22nd week of pregnancy and that, after that, if they did not develop any complication, they were not offered any more. This made women very anxious, because they believed that scans constitute very important prenatal screenings that should be carried out if not at every visit, then far more frequently than only once. Thus, many of them attended Polish clinics in Ireland mainly because they wanted to have frequent ultrasound scans.

This was the case for Asia, a stay-at-home mum of two with a post-secondary course in pedagogy. As she declared, she found her visits at the maternity hospital very “light-

hearted” mainly because of the lack of ultrasound scans. She felt that she could have checked herself all the parameters checked by the doctors and midwives at the maternity hospital, so she did not feel that the Irish maternity services really took care of her. Thus, from the very beginning of her first pregnancy, she attended the Polish clinic in addition to her visits at the maternity hospital. As Łucja did, she found a Polish obstetrician who provided maternity care under the Maternity and Infant Care Scheme, so she did not have to pay for the consultations. However, as her Polish doctor offered her an ultrasound scan during each consultation, she always paid extra in order to have a scan. Thanks to these regular scans, she felt reassured that all was fine. As she reported to me:

We were going to a Polish doctor only because of the scans. There was nothing wrong, I had no health problems, so we just went there because of the scans. And at the hospital, I don't know how it is in Poland, but here for a check-up they feel your tummy, check your blood pressure and ask whether you feel fine. And if you feel fine, they invite you, let's say, in three weeks for a next visit. So I felt we were missing the scans. I cannot say I was dissatisfied with the care I receiving there [in the maternity hospital], but for me it was just a waste of time to go there every two weeks so they can feel my tummy and ask me whether I am fine. [...] ok, so she [the midwife] checks the heartbeat. Fine, but for me that's not enough. I can check that myself. I can buy this device in Argos, because they have these devices. The same is with my blood pressure and weight, I can check it myself. So I think this is not enough. [In Irish maternity care] there is only one ultrasound scans during a whole pregnancy. (Asia, early 30s, mother of two, post-secondary education)

Asia treated visits at the maternity hospital as an addition to the visits at the Polish clinic. She trusted her Polish obstetrician to the point that she said she could have discontinued going to the maternity hospital (which she did not), because visits at the Polish clinics were enough for her to believe that all was fine with her baby.

Many migrant women believed that the limited number of ultrasound scans was a serious shortcoming of the Irish maternity care. To prove the importance of regular scans, some women shared with me the stories they heard from other people. For example, Tonia told me about her Irish colleague who went for the first scan only for her doctor to discover that her baby had died several weeks earlier. Tonia was shocked that her colleague carried a

dead foetus for weeks and nobody discovered that earlier. She was convinced that within the Polish maternity care this would have been very unlikely because the doctor would pick up on it much earlier during a regular scan. As she shared with me:

She was only told that the foetus was dead when she was 14th weeks pregnant. And it had been dead for weeks. And they went, the whole family, for a scan to have a look at the baby and the baby was dead. If they went for regular visits to the obstetrician as it is in Poland, they would have known sooner. Because in Poland you have a scan during every visit, every few weeks. (Tonia, early 30s, mother of one, university graduate)

Justyna, also a mother of one and a bank worker with a university degree, shared with me the story of a friend of hers whose baby was in the breech position. It was only discovered very late on in the pregnancy and she was automatically scheduled for a caesarean section. Justyna's friend believed that if she had had a scan earlier in the pregnancy, she would have had more time to do exercises that would have helped to turn the baby to the right position. She was convinced that there was a chance to prevent this C-section, had the breech position been discovered earlier. Justyna called the lack of regular scans "a mistake" of maternity care in Ireland that led to the possibly preventable operation. As she said to me:

I have a friend who attended only through the Irish healthcare services and they [doctors] didn't do many scans. So about a month before the birth they did the scan and they realised that the baby was very weirdly positioned. So they scheduled her for a Caesarean section. And she was angry! Because if they would have realised earlier, she could have done some exercises or yoga to... maybe the baby would have changed the position. So in this case it was a very obvious mistake of the system because they did too few scans. (Justyna, mid 30s, mother of one, university graduate)

Finally, some women questioned whether the Irish midwives and doctors treat ultrasound scans seriously enough. They shared with me some stories from the maternity hospitals that left them confused and doubtful in regard to the professionalism of the Irish healthcare personnel. For example, Asia was left confused after her scheduled visit at the

maternity unit of a local hospital near Dublin. She and her husband wanted to know whether they were having a boy or a girl and they assumed they would be able to find out during the scan at the hospital. However, according to Asia, the doctor who was doing the scan told them that he did not know how to recognise the sex of the baby on the ultrasonographic picture. She was very surprised to hear that, as she believed, recognising the sex of the baby was a standard skill for a doctor who carried out ultrasound scans. As she shared with me:

Yes, we had a scan at the hospital... but the scan.... We wanted to know who is inside [a boy or a girl] and this doctor showed us: this is the baby and this is the heart. So we asked him about the sex and he said that he does not know, it's not in his expertise to know that. So we found it out only when we privately went to the Polish doctors. (Asia, early 30s, mother of two, post-secondary education)

As Asia explained, she was not upset about this situation because she could find out the baby's sex during her regular scan at the Polish clinics. Asia laughed about this incident, but it confirmed her beliefs that ultrasound scans are not treated very seriously in the Irish maternity care. At the same time she stressed that she did not think that the doctor who carried out the scan was not being professional, on the contrary, she was rather positive about the professionalism of the doctor. She just thought that he was not treating the scanning as "an important" procedure.

In general, women rarely accused Irish obstetricians of being unprofessional or not knowledgeable enough. On the contrary, apart from a few exceptions, women believed that if something was wrong, particularly at the later stages of pregnancy, Irish obstetricians had the knowledge to act on it. However, women often felt that Irish obstetricians were far too relaxed and "light-hearted" and the screening procedures they used were out-dated and not very serious. Thus, they were afraid that they may easily overlook if something was wrong.

8.2.3 "Everything was like a mass production" Polish migrant women in search of time and continuity of care

Apart from access to specialist care, a greater number of screenings and medical procedures, another reason given by the participants of the study for attending Polish

clinics in Ireland was the fact that Polish clinics allegedly offered longer consultations than those offered by Irish maternity services. In general, migrant women were surprised how short the visits were at maternity hospitals. With a few exceptions, they complained that doctors seemed to rush them out of the examination rooms because they were in a hurry to see other women who were waiting for their appointments. As reported by most of the migrant women I talked with, apart from the first visit during which a midwife took a detailed medical history, the remaining visits were very brief. As sometimes they waited for several hours for the scheduled visit, women felt disappointed at how brief appointments were and how little information they received during the visit. Also, some women complained they had very little chance of asking questions or they felt that their questions were not welcomed by the healthcare personnel.

Among the women who thought consultations at the maternity hospital were too short was Halina – a care assistant who quit her job once her son was born and became a stay-at-home mum. Although she generally had a high opinion of the maternity services in Ireland, she agreed that the briefness of consultations at the maternity hospital sometimes left her confused. During one of the visits, after a quick scan, she felt rushed out of the room by one of the doctors. As she told me:

A very quick scan. What surprised me was that when I went with my husband to have my scan done, everything went so fast. The doctor did the scan and he said “there is head, there is head” and that was it. Thank you and good bye. So we went out and my husband said to me, “What was it all about? Were there two heads, or what?” I think it is like that because they have so many patients and they have to rush. So you go in and out, in and out, in and out... (Halina, early 30s, mother of one, secondary education, stay-at-home mum)

Because there was so little time to ask questions and each time she was seen by a different doctor, Halina did not manage to build a meaningful relationship with the healthcare personnel of the maternity hospital. She attributed the rush at the maternity hospital mainly to the large number of women and the scarcity of the healthcare personnel. In contrast to consultations at the maternity hospital, she felt that during consultations at the Polish clinic, she had time to ask questions and discuss any doubts that she had. As she was seen by the same doctor each time she managed to build a relationship with her

obstetrician. The doctor she attended did not provide consultations under the Maternity and Infant Care Scheme, so she paid out-of-pocket for each visit at the Polish clinic. However, as she stressed, it was her first pregnancy and she did not want to miss something.

Similarly to Halina, migrant women often attributed the rush during consultations to the way the maternity care is organised in Ireland. To describe it, women often used the comparison of the factory production line. They complained that a great number of women, who sometimes were waiting for several hours for their appointment, were seen by a handful of healthcare personnel. The end result were a very brief consultation, during which, as described by many women, patients just go in and out of the examination rooms. Each time, women were also seen by different doctors or midwives. As a result they felt that they were wasting their time by answering the same questions they have already answered before or during previous consultations. In this setting, there was no time for a meaningful and trustful relationship to be developed between a pregnant woman and the healthcare personnel. Many women quoted this lack of meaningful relationship as one of the main reasons why they have decided to register with the Polish clinics.

Tonia, a social worker in her 30s and a university graduate, when asked what she disliked about the Irish maternity care, without hesitation answered that the lack of continuity of care and the rush during visits at the maternity hospital were the main downsides of Irish maternity services. She compared visits at the maternity hospital to mass production where everyone is hurrying patients out of the examination rooms so the next women can be seen. Tonia felt that she did not have a chance to ask questions during these visits. She had many concerns, but the haste of the visits did not make her comfortable to ask questions. She felt even that some doctors found her questions annoying. As she told me:

Everything was really like mass production: How are you? Is everything all right? Quick tummy examination and a scan quickly interrupted because they [doctors] were saying everything is alright. I was asking questions, but it all depended who was seeing me, because I saw my questions were annoying them. And I think maybe they would be happier if I couldn't communicate with them? Everything was like mass production but this is how the system is organised here. This is the only hospital in the city or even the county, so there are always so many women. At 9

am the numbers [the tickets that women pick up in order to be seen by healthcare personnel] were already up to one hundred. Every time [I went to the hospital] I had to wait one to two hours before having my consultation. (Tonia, early 30s, mother of one, university graduate)

Tonia felt that she was not provided with enough information during her visits at the maternity hospital. As almost each time she was seen by a different midwife or doctor, she did not manage to establish a more enduring relationship with the healthcare personnel. In addition, she felt that doctors did not try to establish a relationship with her. On the contrary, they seemed to be annoyed by Tonia's questions. Tonia had the feeling that that they would prefer her not to ask any. In this sense, she felt that they would prefer her not to speak any English.

Tonia also worried that during these brief visits, doctors may not be able to pick up on any possible problems. All these put together made her decide to attend a Polish gynaecologist/obstetrician for regular check-ups. She paid out-of-pocket for each visit. She hoped that in the Polish clinic she would have more time to share her concerns and ask questions. She also liked being seen by the same doctor. Thanks to this continuity of care, she was able to create a more enduring relationship with the healthcare provider. Overall, Tonia was really happy with the maternity care services she accessed in Ireland. What she considered to be the shortcomings of the Irish healthcare services (particularly brief visits and the lack of the continuity of care), she could overcome by attending services provided by Polish clinics.

Polish migrant women often complained about the briefness of the visits at the maternity hospital outpatient clinics that left some of them confused or worried that doctors in such a rush may not be able to pick up on possible abnormalities in their pregnancies. They often felt rushed out of the examination room and compared the Irish maternity hospitals to processing factories where pregnant women are processed similarly to products on an assembly line. In order to overcome these problems, as well as to ensure continuity of care during their pregnancies, they attended the clinics run by Polish doctors in Ireland. Consultations at these clinics were usually longer and women had more opportunity to ask questions or share their doubts. They were also typically seen by the same doctor each time they went for a visit, except for a few cases when doctors were on leave. This

continuity of care supported the building of an enduring relationship between pregnant women and doctors. Many participants found this continuity of care important, helpful and most of all, contributing to reducing their stress concerning their pregnancy.

Clinics run by Polish doctors in Ireland play an important role in Polish migrants women's healthcare practices. Similar to migrant women's use of healthcare services in Poland, women's use of Polish clinics in Ireland can be seen as their quest for a specific form of biomedicine – highly technologized medicine that also allows for building a personal relationship between patients and healthcare providers.

Indeed, Polish migrant women's healthcare practices show that women embraced the medical approach to pregnancy. Despite women's often repeated claims that "pregnancy is not an illness" and "it [pregnancy] is natural", women talked about their pregnancies as risky processes during which, at any stage, "something may go wrong". They perceived close medical supervision as a necessary element in order to ensure that these possible risks are minimised. Thus, women believed that doctors equipped with modern medical technology were the most competent group to advise them on their pregnancies and monitor for any possible abnormalities. In this sense, women embraced the approach to pregnancy in which doctors are seen as experts on a process and are expected to use their medical knowledge and medical technology to ensure that pregnancy follows standard patterns (see for a similar argument in the case of childbirth Davis-Floyd 1992, 1993).

As women embraced the medical approach, they did not completely surrender their agency to follow the medical personnel's advice. On the contrary, they usually actively engaged with modern medicine. However, their engagement very rarely meant refusing or questioning medical procedures, but, more often, meant seeking ways to enhance medical interventions and supervision. An example of women's active engagement with medicine and their quest for close medical supervision is women's distrust towards GPs and their strong preference for specialist doctors. Indeed, as I have discussed above, women rarely saw GPs as knowledgeable enough to provide maternity care. Thus, they often disregarded GP's advice or discontinued going to GPs for maternity care and turned to specialists for advice. In this sense, women's reliance on specialist doctors who are less likely than GPs to take an encompassing perspective on health and more likely to use medical technology and

provide medical interventions (see for example Lynch and Malone 2007) illuminates women's active quest for more medical approach to their pregnancies.

Apart from seeking specialist care, another way in which women actively engaged with medicine and, by doing so, enhanced medicalisation, was women's quest for more screening procedures and frequent use of medical technology. The most salient example of these practices was women's demand for ultrasound scans. Indeed, as I have described above, women sought different ways to increase the number of ultrasound scans carried out during their pregnancy. This screening procedure, as will be discussed in Chapter 11 occupy an exceptional status among other prenatal screenings procedures because it "produces" what women see as "seemingly" an objective image. In this way ultrasound screenings "escape" the human subjective (and thus prone to mistakes) doctors' judgement and provide what women see as the most accurate (because technologized) proof that the pregnancy is developing fine. In this way, by seeking to increase the number of prenatal ultrasound scans, women even further enhanced medicalisation of their pregnancy.

The analysis of Polish migrant women's healthcare practices showed that women very strongly relied on modern medicine. Rather than seeking ways to minimise the role of medicine in their pregnancy, similarly to women in Poland, they sought ways to increase it. However, as already mentioned, it is not any type of medicalisation that women sought. On the contrary, they sought very specific type of medicalisation, namely one that would allow them to build an enduring and personal relationship with healthcare providers. Indeed, as I have discussed above, women actively sought healthcare services that, for example through continuity of care, allowed for building more personal relationships with doctors.

This approach to care is linked to women's reference to the way biomedicine practiced in Poland is embedded in social relation. As I have described in detail in Chapter 7, building more personal relationships with healthcare personnel is a common strategy to ensure more attentive and compassionate care. In order to build these personal relationships patients either use social connection and seek doctors through acquaintances, or they pay for private care. Migrant women's turn to Polish clinics in Ireland represents the latter strategy. Women's willingness to pay for private consultation at Polish clinics in Ireland may be seen as a strategy through which women try to escape the anonymity of Irish healthcare

services. By doing this they want to ensure what they see as better and more attentive care.

As discussed above, Polish migrant women's transnational practices in the form of travelling to Poland or, more often, registering with Polish clinics in Ireland can be seen as a quest for personal biomedicine. However, not all women have the same access to personal biomedicine. Indeed, women's ability to enhance the medicalisation of pregnancy and to build personal relationships with healthcare personnel is dependent on the position they occupy in the society. As I have already discussed in Chapter 6, attending Polish clinics in Ireland or travelling to Poland cost money. Thus, poor women who lacked access to financial resources were far less likely than middle-class women to access these services. As a result, they were also far less likely to seek ways to enhance medicalisation and to access more medical and screening procedures. Also, they were less likely to seek ways to build personal relationships with doctors and midwives. They tended to rely on the Irish maternity services and rarely manoeuvred between the Polish and Irish services. Thus, it seems that it was mainly middle-class women and those with access to financial resources that engaged in seeking to enhance medicalisation and building a personal relationship with healthcare personnel.

This takes us to the next point, namely the importance of looking at women's healthcare practices (and their quest for personal biomedicine) in the broader context of structural forces, mainly privatisation and commercialisation of healthcare services that have been taking place in Poland and in Ireland (as well as in other European countries). Indeed, as argued in Chapter 2, the growing popularity of some medical technology (such as prenatal scans) is increasingly linked to the privatisation of maternity services and to the growing importance of private healthcare providers (Gammeltoft and Nguyễn 2007, Roberts 2012). In the case of Polish clinics in Ireland, where women have to pay additional fees for screening procedures (such as ultrasound scans), these procedures generate revenues for private clinics. Thus, women's quest for technologized approach to pregnancy and personal relationships with healthcare personnel should not be seen as disconnected from the growing importance of private healthcare providers. On the contrary, it should be looked at from the perspective of social relations in healthcare, where, in the last decades, market relations have been growing in importance. Thus, in the next chapter, I take a closer look at the way women perceive the role and the position of Polish clinics in Ireland and how

these perceptions influence their expectations concerning services provided by these clinics. In view of the fact that women tend to go to Polish clinics in Ireland in order to receive personal biomedicine, in the next chapter, I also try to answer the question of whether Polish clinics live up to women's expectations.

Chapter 9: A rip-off or a blessing? The ambiguous position of Polish clinics in Ireland as providers of “personal biomedicine”.

Despite their popularity among migrant women, Polish clinics in Ireland occupy an ambiguous position. Although numerous women used their services, even those who frequently visited Polish clinics and paid out-of-pocket were sometimes very critical of the services provided. Some women complained about particular doctors. They doubted their professionalism, medical knowledge and interpersonal skills. Other women complained more generally about Polish clinics in Ireland. These women usually questioned the quality and genuineness of services provided in those clinics. In this sense, the popularity of Polish clinics in Ireland did not necessarily translate into positive opinions about them. In other words, Polish clinics did not always fulfil women’s expectations concerning personal biomedicine.

Some women critically assessed the services provided by some Polish doctors. Often, before registering with a particular clinic, women searched for reviews on particular doctors. They usually did so by asking their friends or relatives, or by reading internet forums, where women widely discussed their experiences with obstetricians working in Polish clinics in Ireland. If unhappy with the initial consultation, women usually changed their obstetricians and attended a different clinic. Women reported, among the most common reasons for changing the physician, the fact that doctors were dismissive with them, did not answer their questions, prescribed tests or medications that women saw as unnecessary, or, alternatively, did not prescribe tests or medications that women saw as important.

For example, Kinga, a shop assistant with a secondary education, was very unhappy with her first visit to a Polish clinic. Before falling pregnant, she never needed healthcare in Ireland, so had little idea where she should go when she found out that she was pregnant. She decided to register with one of the Polish clinics because it seemed to her the most obvious solution. However, after the consultation she left the clinic very confused and disappointed. Not only had the doctor told her that she needed an immediate treatment because of a condition that she was not aware of, but he also dismissed most of her questions concerning advisable lifestyle changes to be made during pregnancy. For

example, when Kinga asked him whether she should introduce any changes to her diet, the doctor told her to read about it on the internet. Kinga found it very difficult to trust his opinion and decided to go to another Polish doctor where she was told to discontinue the expensive treatment she had been prescribed by the first doctor. Although happy with the second clinic, Kinga decided that it was too expensive for her to attend Polish doctors throughout the pregnancy. Instead, she registered with the local GP clinic where she did not have to pay for visits under the Maternity and Infant Care Scheme.

Apart from women who complained about particular doctors, a few women criticised more generally clinics run by Polish doctors in Ireland. Women questioned the quality of services provided in these clinics mainly on two grounds. First, they were afraid that Polish clinics are primarily profit driven and want to earn as much as possible on their patients. In this sense, women were afraid that they may be pushed into doing tests that are not necessary, but profitable for the clinic. Thus, even women who regularly attended Polish clinics, questioned the genuineness of some of them. Second, migrant women also worried that doctors practicing in these clinics were not as good specialists as those who stayed in Poland. They assumed that doctors who migrated to practice in another country had done so because they were not good enough to become successful in Poland. Thus, women believed that care provided by migrant doctors may be of a poorer quality because migrant doctors may lack professional knowledge and experiences.

9.1 Ambiguous marketisation: Doctors as profit-makers?

The issue that some women brought up during their interview was the genuineness of healthcare providers in the Polish clinics. Women questioned if doctors' prescriptions to carry out some of the tests were not primarily profit driven. As Polish clinics in Ireland are private, for-profit businesses, their income also depends on the number of appointments and procedures they carry out. Women were afraid that some doctors, in order to generate revenues, might have prescribed them more tests and encouraged more visits than necessary. For example, Halina, a stay-at-home mum with secondary education, believed that Polish clinics take advantage of Polish women by prescribing more tests and charging high fees for services that are either available for free within Irish healthcare services or are simply unnecessary.

Lidia, also a stay-at-home mum, was similarly concerned that doctors at Polish clinics may be more focused on financial benefits than on the wellbeing of their patients. As she explained, in order to have a scan, she always had to pay additional fees at the Polish clinic where she saw a Polish obstetrician for maternity care under the Maternity and Infant Care Scheme. At the Irish maternity hospital, when she reported that she was concerned that something may be wrong with the baby, she was given a quick scan without any additional charges. Thus, she found that Polish clinics treated ultrasound scans more as a form of entertainment that they provide to the future parents for high fees. Instead, Irish maternity hospitals were focused more on ensuring that the pregnancy is developing without complications. As she commented:

In the Polish clinic they did the scan only after you paid. At the hospital, they did not do the scans but if you went to them and said that you are worried and wanted to know, they would do a very quick one. You heard the heartbeat and saw the child. They would not give you any pictures though. And the Polish doctors are here only for the money. This is my opinion. And now I don't even go to the Polish clinics with my little son but to the Irish GP. (Lidia, late 20s, mother of one, secondary education, stay-at-home mum)

However, Lidia continued to attend Polish clinics throughout her pregnancy mainly because she worried that the number of ultrasound scans offered at the Irish maternity hospital was insufficient. She discontinued attending the Polish clinic after she gave birth to her son.

Wiktoria, a psychologist and mother of one, was unlike Halina and Lidia, rather enthusiastic about Polish clinics in Ireland. She attended one of them for regular check-ups throughout her pregnancy. She developed a very good relationship with her obstetrician, trusted her and thought that she was very professional. Wiktoria also followed all her suggestions concerning additional tests. This included seven additional scans for which Wiktoria paid EUR 50 each. When I mentioned that some women reported feeling financially taken advantage of and charged more than initially expected, Wiktoria defended Polish clinics and declared that she never felt talked into doing more tests that she wanted. She described accessing additional scans in consumerist terms of "free-choice making". As she explained, her obstetrician always gave her a choice whether to have a scan (and additionally pay for it) or not. Wiktoria always opted to have one, because, as she declared,

she liked looking at the baby. In her opinion, it was her (as it is other women's) deliberate decision to have additional tests or scans and no one pushed her into doing something she did not want. She argued that Polish clinics, as private businesses, have the right to benefit from the services they provide and no one can expect them to provide these services for free. As she commented:

Business is business. This is their [Polish migrant women's] deliberate decision and no one encourages them to anything. This is your choice and if you want to have a look at the baby, you pay big money for it. But you don't have to do it, it is not compulsory. It depends on the woman. (Wiktorja, late 20s, mother of one, university graduate)

Despite stressing that "it depends on the woman" and explaining their healthcare strategies in consumerist terms of "free choice making", Wiktorja also noticed that Polish migrant women find themselves in a vulnerable position. As migrants, they tend to have limited social support because many of their friends and relatives, on whom they could have relied for advice, live back in Poland. In this situation, as suggested by Wiktorja, women tend to lean on healthcare professionals and medical technology in order to make sure that all is fine. Thus, they are more likely to search for additional tests and pay for them. In the words of Wiktorja:

[...] women want them [the frequent scans] because they are over sensitive. They are far away from their homes, they don't have their close relatives, their mums, they don't have sisters, grandmas here. They are here by themselves and often they are the first ones [to become pregnant] among their friends. Friends have no previous experiences so they have to blaze the trail [*przecierać szlaki*]. I also learned from my own mistakes and had to blaze the trail so my friends then knew what to do. This is why women go and check because they are afraid. (Wiktorja, late 20s, mother of one, university graduate)

In this sense, Wiktorja shifted her perspective from the area of consumerist relations, where women simply purchase healthcare services to the area of social relations. As she declared, because of limited social support, she also felt at a loss while pregnant. Her mother and sisters were back in Poland and her friends from Ireland did not have children

yet. She had no one to ask for advice or lean on and, partly because of that, she leaned strongly on her obstetrician. As she argued, migrant women with little social support, that is with families living back in Poland, are likely to access more screenings and scans than women who have strong support networks and, at any time, can ask their families for advice. This is because migrant women, according to Wiktoria, have to rely only on themselves in any process of decision making thus, they feel extra pressure not to neglect anything. Polish clinics in Ireland, according to Wiktoria, partly benefit from women's vulnerable position. However, as long as they did not put pressure on women to have scans (and Wiktoria believed that they do not), this type of arrangement, according to her, was perfectly fine.

Some Polish migrant women interpreted the role and the position that Polish clinics occupied in Ireland as providing them with choice. Indeed, women talked about the services they accessed in Polish clinics in consumerist terms of "choosing the best care". They stressed, that thanks to clinics run by Polish doctors, they could access services that they saw as unavailable, expensive or of poor quality within the Irish healthcare system. In this sense, women felt more "in control" of the care they received. This is particularly important in the context of the popular discourse, very strong in Poland, that stresses individuals' responsibility for health and wellbeing. In this sense, women interpreted the position of Polish clinics in Ireland as giving them a better chance to access the type of care that women wanted.

However, some women also tried to distance themselves from the consumerist relation between them and the healthcare providers. They declared feeling abused by Polish clinics. They linked this feeling of exploitation to the unique position that Polish clinics occupied in Ireland vis-à-vis the relatively weak position of migrants. Migrants not only encountered barriers in accessing Irish healthcare (for example language, cultural presuppositions, lack of knowledge of how things work in the host country) but many of them also had little social support. In this sense, women accused Polish clinics of abusing this weakness of migrants resulting from their lack of adequate social support. In this sense, although they tended to talk about accessing healthcare services provided by Polish clinics in terms of "free-choice making", they also stressed the uniqueness of their relations with Polish clinics that escapes the traditional market relations.

Women's interpretations of the position of Polish clinics in Ireland may be seen in terms of their general critique of commercialisation in healthcare. Indeed, despite their declared consumerist approach to healthcare services provided by Polish clinics, women also criticised their commercial character. They did not want to be simply customers who purchase healthcare services, but wanted to establish personal relationships with healthcare providers in order to ensure more genuine treatment. Although they agreed to pay for technologized biomedical care (such as ultrasound scans), they also expected healthcare providers to assume some form of social responsibility. In other words, by engaging in consumer-like practices, women aimed to form social relationships with doctors that would be immune to market mechanisms (or, more precisely, to profit-making mechanisms) and guided by social responsibility. Thus on the one hand, considering the particularly vulnerable position of migrants in the host society, women expected Polish clinics to assume even more social responsibility. On the other hand, however, they accused them of abusing their unique position in Ireland and of focusing on profit-making instead of taking social responsibility.

9.2 Migrant doctors: "othering" the migrant

Another issue that a few women mentioned during interviews was the incompetence of Polish doctors. Indeed, as women declared, in the case of Polish doctors in Ireland, with some rare exceptions, migration is a sign of incompetence and lack of professionalism. This is so because, as they argued, competent doctors have good salaries and fulfilling jobs in Poland, so they have no reason to migrate to another country. Those who migrated have done so because they did not have fulfilling jobs and good salaries. This is because, according to these women, they did not have the skills and professional knowledge to become successful. Women expressed this assumption by saying that "good doctors have good lives in Poland" or "patients would never let a good doctor migrate". As a result, according to these women, with rare exceptions, Polish doctors practising in Ireland were less competent than those who stayed in Poland.

Despite this opinion, the women who were most critical about Polish clinics in Ireland also attended Polish doctors for regular check-ups. This was for example the case for Lidia, a stay-at-home mum with secondary education who before getting pregnant worked in a cafeteria. She was very critical of the doctors working in Polish clinics and believed that they were very incompetent and unprofessional. She believed that they migrated to Ireland because they were not good enough to get a good job in Poland. According to Lidia, this

was especially true for doctors who came to Ireland later in their careers that is at the stage when they should have been established with thriving careers in Poland. As she declared:

I don't trust them here [the Polish doctors practising in Ireland]. I don't trust Polish doctors abroad. In my opinion, the worst doctors came here. It is different if they come here to study to become doctors. It is different if they are here from the very beginning, not when they are 40 and they come here after a job. (Lidia, late 20s, mother of one, secondary education, stay-at-home mum)

Despite being highly distrustful towards the Polish clinics, Lidia continued to attend a Polish obstetrician throughout her pregnancy. As she explained, she preferred and trusted the care she received at the Irish maternity hospital, however, she worried that the number of scans offered at the hospital was insufficient to pick up on possible problems. As a result, she continued her visits at the Polish clinic, because they ensured frequent scans. At the same time, she was very unhappy with the services at the Polish clinic. Although she was promised continuity of care, almost every time she was seen by a different obstetrician. During a postnatal visit she thought that the doctor was too quick while examining her son. In addition, she had to wait several months for the scheduled vaccination because the Polish clinic had to order them. As a result, she decided to discontinue attending the Polish clinic. She changed her GP to one in a local Irish surgery and, as she declared, she had no complains about the latter.

Similarly to Lidia, Halina also accused Polish doctors working in Ireland of being unprofessional and lacking knowledge mainly on the grounds of doctors being migrants. During the interview she repeated several times that Polish doctors who came to Ireland, in her opinion, have done so either because they were not good enough to get a job in Poland or they were charged with malpractice and tried to escape the charges. Thus, according to Halina, the care provided by them was of a questionable standard. Based on her own experience and what she heard from her friends and other Polish women on the internet forums, Halina questioned the need for Polish clinics in Ireland and advocated that women should use Irish healthcare services instead of going to Polish clinics. According to Halina, choosing this pathway not only saves women money, but also prevents unnecessary problems such as misdiagnosis. According to her:

I went first to confirm the pregnancy and I really regret it because Polish clinics in Ireland take advantage of Polish migrants. I think if a woman gets pregnant she should go directly to the hospital and just stay under the care of this hospital. They do test there as well. And these additional things are just not worth it. (...) You know who [what Polish doctors] came here [to Ireland]? Those who could not make their living there [in Poland] or those who did something [malpractice]. A good doctor would not come here. (...) maybe for a short time, to get an experience (...) and how many Polish paediatricians are here and mothers take their children to them and then they complain because there was something [a child had an illness] but it was not diagnosed properly. And then you have a problem. I see one thing, many Polish losers came here (Halina, mother of one, secondary education, stay-at-home mum).

Despite her declarations that she regretted going to the Polish clinic, Halina continued going to a Polish obstetrician throughout her pregnancy. As Lidia, Halina also wanted to have frequent scans and believed that the only (and simplest) way to have them was by going to a Polish clinic. She knew from her friends that women in Poland have more scans than those offered within the Irish public maternity care scheme and this made her worry that something may be overseen by the Irish doctors. She also believed that her Polish obstetrician was an exception among the Polish doctors in Ireland. She found her professional, knowledgeable and generally good at her job. Nonetheless, once she gave birth to her son she registered him at the local Irish surgery and attended an Irish GP whenever he needed medical help.

Both Lidia and Halina took migration, particularly among doctors who migrated later in their career, as indicating a lack of professionalism and as being proof that they did not manage to establish a successful career in Poland. This perception links to the wider discussion on recent Polish migrants and their perceptions on professionalism (or lack of it) and success (or failure) among fellow Poles (Nowicka 2014). Nowicka (2014) showed that Polish migrants in the UK, even if they worked below their qualification, still tended to describe their migration in terms of success. They contrasted their own situation with the situation of “the other” Polish migrants who, according to them, failed. In this sense, we can see the Polish migrants’ interpretation of doctors’ migration as a form of applying a differentiated view of what it means to migrate and be successful. Women saw being

adventurous and brave enough to move to another country as positive in their own case. However, in the context of healthcare professionals, these aspects lost their positive meaning and became markers of failure. In the same vein, if women explained their motivations for coming to Ireland in terms of the poor situation of the labour market and bad working conditions in Poland, they also explained healthcare professionals' reasons for migration in terms of their lack of knowledge that did not allowed them to "make it in Poland". In this way, Polish migrant women tried to assert their social position vis-à-vis Polish doctors by a process of "othering" where migration negatively indexes on Polish doctors professional status.

As some women in my study viewed migration of healthcare professionals as a sign of lack of professionalism, they deemed Polish clinics in Ireland unable to provide personal biomedicine. Indeed, personal biomedicine, apart from allowing to build personal doctor-patient relationships, requires a certain level of professional knowledge on the part of the doctors. Women measure this level of knowledge using various tools, including their interpretations of the positions doctors occupy vis-à-vis other doctors and healthcare services. In Poland, women rely on local hierarchies and opinions when assessing the position of a given doctor. They turn to their social networks for recommendations and rely on opinions concerning particular hospitals or clinics these doctors work for in order to find "good" professionals. In other words, they use "local knowledge". In the case of migrants, these local hierarchies and knowledge are distorted. As a result, women from the study found it difficult to situate Polish doctors working in Ireland vis-à-vis other doctors and healthcare services. In order to assess doctors' knowledge, they made use of their belief in migration as an indicator of doctors' professionalism. Whenever they viewed migration as a sign of failure (as did some participants of my study), they automatically assessed migrant doctors as lacking professional knowledge, and thus unable to deliver personal biomedicine.

In this chapter I demonstrated how Polish migrant women interpret the role and the position of Polish clinics in Ireland with regard to their ability to provide personal biomedicine. Despite their popularity among migrant women, Polish clinics occupy an ambiguous position. In the study, women questioned Polish clinics' ability to provide personal biomedicine based on two key factors. First, as Polish clinics are for-profit businesses in a unique position of catering mainly for a migrant population, women questioned whether this arrangement allows for building personal doctor-patient relations.

Second, women questioned the professionalism of care provided in these facilities based on the assumption that doctors who migrate are not very good in their profession. In this sense, although many migrant women attended Polish clinics in Ireland, the care they received has not always lived up to their expectations. This shows that contrary to the early feminist approach to medicalisation, women are not passive victims. On the contrary, they have very specific expectations concerning maternity care they receive. This is especially true in the case of middle-class women who criticised not only Irish doctors, but also Polish medical services.

So far I have focused on prenatal care. I showed that women believed Irish healthcare services to be lacking personal biomedicine as opposed to Polish ones. In the case of care during labour, the situation seems to be reverse. It was Irish healthcare services that migrant women saw as approximating their ideal of personal biomedicine. Thus, in the next chapter I try to answer the question of which elements are important for women in care during labour. I determine the ways in which women conceptualise personal biomedicine when thinking about care during labour. I also consider the factors that make Irish in-patient services fulfil women's criteria on the matter, as opposed to the Polish facilities.

Chapter 10: Engagements with biomedicine: Polish migrant women's quest for "personal biomedicine" during labour in Ireland.

The focus of this chapter is care during labour. As in the case of prenatal care, Polish migrant women had certain expectations concerning the ways in which they wanted to be cared for during labour. They also engaged in strategies aimed at fulfilling these expectations. However, in contrast to prenatal care, labour care is deemed better in Irish, and not Polish hospitals. Thus, in this chapter I discuss the elements that shape women's experiences of care during labour and show how these elements are embedded in the larger structural configurations of maternity services in Poland and in Ireland.

Apart from Alicja, who moved back to Poland in order to give birth and whose story I have discussed above, none of the migrant women I talked with travelled back to Poland to give birth. In fact, all the women declared that they did not even consider travelling to Poland in order to give birth there. As women explained, it would have been logistically difficult. They would have had to travel well in advance of their due date because airlines usually refuse to carry women after the 34th or 36th week of pregnancy. In most cases, women's husbands or partners would have been unable to accompany them because of work arrangements. Moreover, women were also concerned that they would have to spend weeks (or months) in Poland after the birth to get a passport for their child that would allow them to travel back to Ireland. Then, upon their return to Ireland, they would have to engage in additional paperwork to apply for a PPS number for their new born baby. As all women agreed, travelling to Poland to give birth would have been a huge hassle.

However, it was not only logistical difficulties that kept women from travelling back to Poland to give birth. In fact, most women declared that they did not see any reason why they should travel back to Poland in order to give birth. In contrast to Irish prenatal outpatient care, in the case of which women had mixed opinions, Polish migrant women had generally very positive opinions about the care women received during labour at Irish hospitals. As they explained, many of their friends or relatives living in Ireland who had had children before them, were very happy with the care they received in the labour ward. Thus, women did not see the reason to go into the hassle to travel back to Poland to give birth.

Indeed, out of all the migrant women that I interviewed, only Wiktoría had mixed feelings about the care she received during her labour at the Irish maternity hospital. As she explained, she did not get along very well with her midwife who, in Wiktoría's opinion, seemed to be rather indifferent and a bit inexperienced. Wiktoría also complained that she had to wait several hours to receive the prescribed medication, a fact which, in her opinion, could have slowed down her labour. Although she constantly asked for the drug, she was told by one of the midwives that they were short of staff so she needed to patiently wait her turn. To make matters worse, due to the lack of communication in the labour ward, Wiktoría's husband was not allowed on the ward for much of Wiktoría's labour. All of these incidents left Wiktoría feeling alone and frustrated and generally very disappointed with the care she received during labour. However, as she stressed during the interview, most of these shortcomings resulted from the unlucky coincidences rather than anyone's bad intentions.

Apart from Wiktoría, the rest of the migrant women I interviewed declared they had very positive birth experiences. They assessed the care they received during labour at the Irish maternity hospital as very good. Among the factors that women pointed as being the most important in shaping their positive experience were friendly, professional and helpful healthcare personnel, free epidural on demand, the possibility to have a birth partner with no additional costs or problems, no hidden costs of any services linked to labour care and, finally, well organised labour wards. Although not all women agreed on the last aspect and some actually thought that the maternity wards were not very well organised, it did not change their perception that the care they received during labour was very good. In general, the women had rather good memories from the Irish maternity hospitals and they often contrasted their appreciation of Irish hospitals to what they believed was the situation in labour wards in Poland. Below I discuss each of the aspects that the Polish migrant women mentioned as important in shaping their experiences with care during labour.

10.1 In search of personal relationships: the friendliness of healthcare personnel

The majority of the participants stressed that one of the most important and appreciated aspects of hospital care was the friendliness and helpfulness of the healthcare personnel.

Women stressed that midwives were very nice to them, treated them with respect, motivated them along the way, asked their permission before performing procedures and reacted to the women's requests and needs in a timely manner. For the women, being treated with respect was particularly important. The women also liked being motivated during labour and several of them stressed how great it was that they had someone to motivate them along the way. This was often contrasted by women with the situation in Polish maternity hospitals, where midwives and doctors were thought to be rude and unresponsive to women's needs.

Łucja, a university graduate and a stay-at-home mum stressed how important it was for her that everyone at the hospital treated her with respect. Throughout her pregnancy Łucja attended a Polish obstetrician/gynaecologist because she thought that Irish maternity care offered too few tests. Despite being very critical about prenatal care offered in public hospitals in Ireland, Łucja declared that she had never considered going back to Poland to give birth. Her husband would not have been able to accompany her to Poland because of his work commitments and Łucja did not want to go to Poland by herself. Moreover, she heard many positive birth stories from her friends living in Ireland that convinced her that Irish maternity hospitals offer good care during labour. And indeed, she was very happy with the care she received. She felt really taken care of and thought that the personnel was very friendly and respectful towards her and her needs. As she told me:

But really, here [in Ireland] people in the hospital are very friendly, very helpful and whatever you want you will get. There is no such thing that they will refuse you pain relief or anything. Whatever you want, you will get it. (...) Doctors are nice, nurses are nice. And I even got a dinner [when admitted to the hospital]. They were telling me: 'Here you are, please eat because there is a long way ahead of you'. No one was rude, nothing was refused me. Everything was happening in a positive atmosphere. (...) And in Poland nobody asks you whether they can do this or that, whether they can examine you. Here every time they would ask me and explain to me what and why they were doing. And they don't do it very often, like they do it in Poland. (Łucja, mother of one, stay-at-home mum, university education).

Łucja declared that she got along with her midwife very well after being admitted to the hospital. The midwife quickly responded to her needs. Generally, thanks to the positive

atmosphere in the hospital and the fact that she did not suffer from any complications during and after labour, Łucja had a very positive birth experience. She was convinced that in Poland, midwives and doctors would not be as responsive and positive as they had been in Ireland. Judging on her previous experience with Polish healthcare services and on what she had been told by other people, Łucja believed that healthcare professionals in Poland spent less time explaining to their patients the procedures that they were carrying out, what is happening and what they are planning to do next.

Similarly to Łucja, Olga, a former office assistant with secondary education, had very positive opinions about the behaviour of healthcare personnel in the labour wards. She also stressed that she really liked that doctors and midwives in Ireland were very friendly and caring. As she said, most of the Irish healthcare professionals she met during her pregnancy and labour were, as she put it, “sweet and smiling as if they did not see you for ages”. Olga also very much appreciated how midwives motivated her throughout labour. She contrasted this to what she believed was the situation on Polish maternity wards.

Here [in Ireland] is nice because everyone motivates you. They tell you that you are great and that you are coping well and that you are doing great. And hey, this is very motivating! And in Poland they only make you miserable. (Olga, late 20s, mother of one, secondary education).

Olga, as many other participants, believed that healthcare personnel working in Polish labour wards were far less compassionate than Irish midwives. Although she never experienced it herself and based her judgment on the stories she heard from her friends who had given birth in Poland, she feared that doctors in Poland were rude and did not motivate women during labour as they did in Ireland.

Apart from helpful and friendly personnel, another aspect that some women mentioned as very important in shaping their experience from labour wards was the possibility to have a birth partner. In fact, the majority of women during labour were accompanied by a partner. A few of them mentioned that they very much appreciated that at Irish maternity hospitals no one made any problems of this. On the contrary, according to them, healthcare personnel encouraged them to come to the hospital with their partners and did not make the partners feel unnecessary or standing in the healthcare personnel’s way. As with other

aspects that I have discussed above, women contrasted it with the situation in Poland. They believed that in Poland husbands are not very welcome on the labour ward and they are sometimes treated as a burden by healthcare personnel. Some women also mentioned that they could be charged additional fees for their partner's presence during labour. Indeed, as explained in detail in Chapter 7, some Polish maternity units charge additional fees if a woman is accompanied by a birth partner during labour.

Tonia, a university graduate, very much liked the fact that her husband could accompany her during labour. She also appreciated that no one made any problem of that, required any specific clothing for him to wear or treated him as a burden. In some hospitals in Poland, as I have described in Chapter 7, birth partners are required to wear disposable clothing that they sometimes have to pay for. In contrast to the situation in Poland, as Tonia described, her husband was not required to pay or wear anything special and was made very welcome by the midwife who treated him as a valuable member of the team. As stressed by Tonia, this allowed her and her husband to experience the birth of their first child together. After the labour, they were both given breakfast, which made them feel very nice. In general, Tonia believed that the healthcare personnel at the Irish maternity hospital treated women in labour as partners. As she explained:

My husband was with me and he did not have to have any specific clothes. (...) and it was obvious for everyone that he is with me and I didn't have to register him anywhere prior to labour. And he was really treated [by the healthcare personnel] as a partner. No one treated him as he was something [a problem]... The midwife kept her distance so we could experience this together. (...) After the birth we both got something to eat, coffee and toasts. Both of us. Those are little things, but they make you feel good because we were both really tired after so many hours. So all was really nice. (Tonia, mother of one, university graduate, social worker)

Tonia doubted whether her husband would have been treated like that if they had decided to give birth in Poland. She thought that it was more probable that he would have been treated as a burden standing in the way of healthcare personnel. Although she had no previous experiences with maternity care in Poland, she based her opinion on the stories she heard from her friends who had given birth there. As she concluded, although the situation has changed for the better, many women in Poland are still being treated with a

lack of respect by doctors and midwives. Thus, she never really considered going back to Poland to give birth.

There was a general assumption among Polish migrant women that it was easier to establish a relationship based on partnership with midwives working in labour wards in Ireland than it was with midwives working in labour wards in Poland. According to the women, this partnership relationship extended also to women's partners who accompanied them during labour. Indeed, women stressed that their partners were not only simply "allowed" in the wards, but they were included in the care. In this sense, women assessed the care provided in Irish labour wards as better than care provided in labour wards in Poland because it also included women's partners who were treated as a valuable addition.

10.2 In search of medical technology: epidural on demand

Another aspect of care that many Polish women found particularly important was access to pain relief, especially epidural on demand and without any additional costs. As some of the women stressed, although they hoped to give birth without an epidural, the knowledge that they could request and receive one if necessary, lowered their anxieties and made them more confident that their labour would proceed without major problems. They also liked the idea that in case they requested an epidural, it would be provided to them without any additional charges so they did not have to worry whether they can afford it. There was a general assumption among the women that at hospitals in Poland access to epidurals was very limited. They believed that in Poland epidurals were available only to women who could pay for them or, in some hospitals, it was not available at all to women giving birth. To support their statement, the women usually recalled stories of their friends or relatives living in Poland who either had to pay for pain relief or were refused it altogether.

Olga, whom I have already mentioned above, was very happy with the care she received during labour at the Irish maternity hospital. As she declared, although she initially hoped she would manage without an epidural, during labour she decided she wanted to have an epidural. She received it very quickly, for free and without any problems. She appreciated that she did not have to declare anything in advance in order to receive pain relief. As she explained, this was not the situation in Poland. Olga believed that in some hospitals in

Poland women were actually forced to book their epidurals prior to going into labour. To prove her point, Olga told me the story of a friend of hers who requested an epidural earlier in the labour but then decided she did not need one. However, the doctor did not listen to Olga's friend and forced her to have the epidural anyway, because, as Olga suggested, it was booked and already paid for. This, according to Olga, would probably never happen in Ireland, because epidurals are free and the women does not have to book anything in advance. As she told me:

I hoped I will manage [without an epidural]. But I did not know [whether I would need one]. In Poland you have to know months in advance whether you want an epidural. And you have to pay for it. But how do you know whether you will need it or not? And here [in Ireland] you can just request it at the last minute. [...] This girl [a friend of Olga from Poland] declared that she wanted an epidural and then, when they were actually giving it to her, she said that she did not want it any more. She felt that the baby was coming and the doctor told her not to move. And she said that she doesn't want the epidural, but he [the doctor] continued [the procedure]. So it was a traumatic experience for her [...] But let's stop talking about Poland because when I hear how [bad] it is in Poland I don't want to hear it because it makes me angry. (Olga, late 20s, mother of one, secondary education)

In general, Polish migrant women believed that epidurals were far more accessible in labour wards in Ireland than they were in Poland. Although many women stressed that they initially did not want any pain relief, they appreciated the idea that during labour they could request and receive an epidural. In this sense, they assessed inpatient Irish maternity services as much better and more reliable than Polish ones. The latter aspect was based on the commonly shared idea among Polish migrant women that healthcare personnel in Polish labour wards are more likely than in Ireland to refuse women epidurals.

Finally, apart from friendly personnel, inclusion of birth partners in care and access to epidural on demand, migrant women also praised the way labour wards were organised in Ireland. They thought that they were efficient and there was always someone ready to answer women's questions. For example, Łucja compared the organisation of labour wards to the army, indicating the great order and high speed at which everyone worked. She was

impressed by how everyone knew what they were supposed to do and how quickly everything was happening.

However, some women had opposite impressions from the labour wards. They complained about the organisation of the wards and believed that labour wards in Ireland were rather badly organised and thus, inefficient. For example, Wiktorja, whose story I have already discussed above, complained that she found it very difficult to get anyone's attention when she needed something. Moreover, on the day she was scheduled to leave the hospital, due to what Wiktorja believed was staff shortages, there was a delay in the discharge process of patients. As a result, Wiktorja had to wait several hours in order to be allowed to go home. She thought that it was not due to anyone's bad intentions, but rather because of the poor organisation of the ward that had to provide care to too many women. However, Wiktorja did not think that in Poland the organisation on labour wards was any better. On the contrary, she believed that it might actually be even worse.

When assessing their experience in Irish labour wards, women very rarely mentioned the use of medical technology. In fact, women mostly focused on the friendliness of the healthcare personnel as the most important factor that shaped their experience. This may be, partly because in the majority of cases the women I talked with had rather uncomplicated labours that did not require any exceptional medical interventions. However, even Halina, a former care-assistant who developed very serious complications during her pregnancy and ended up needing emergency care, focused on non-medical aspects while describing her experience with the Irish maternity hospital. As she told me:

I had nothing to complain about [when it comes to care she received at the Irish maternity hospital]. [...] I was so scared. I screamed to one of the anaesthesiologists that something is not working here, but he held my hand and in this nice, calm voice he told me not to worry, that everything will be alright. I did not have a choice but to trust these people here, but the care was fantastic! [...] They were all very understanding and they all supported me. [...] From Poland nobody even called because they [the family members] were so scared. But here [in Ireland], what I really liked was that they [the healthcare personnel] all congratulated me. And no one [from the healthcare personnel] made a big deal out of it [...] The care was just superb. (Halina, early 30s, mother of one, secondary education)

Despite all the complications and medical emergencies, she had very positive memories from the hospital and stressed that it was mainly because of the non-medical aspects of care. She was very impressed with the respectful and compassionate care was she received at the Irish hospital.

As with prenatal care, Polish migrant women's practices associated with childbirth, namely their strong reliance on services provided by Irish hospitals, can be analysed in terms of women's quest for technologized biomedicine that allows for building personal relationships with healthcare personnel. However, while in prenatal care the use of medical technology seemed to play a particularly important role, in inpatient care, personal relations with healthcare personnel seemed to become the more important aspect. Indeed, contrary to prenatal care, when assessing the care they received during labour, migrant women primarily focused on the non-medical aspects. They explained their decision to rely on Irish care during labour mostly in terms of building a trustful, personal and friendly relationship with the midwives and doctors working on the ward. Most of them believed that a major difference between the care offered in Poland and in Ireland lay in the healthcare personnel's approach to women in labour and to their partners. In general, migrant women believed that the personnel on the labour wards in Ireland were much friendlier than the personnel in Poland.

Although for migrant women the use of medical technology did not seem to play an important role during labour as in the case of prenatal care, it continued to be an important aspect. In general women embraced the medical model of childbirth and believed that close medical supervision is necessary in order to ensure safe birth. Indeed, none of the migrant women considered giving birth in less medicalised environments than a hospital. Their quest for medical technology was also manifested in their search for epidural on demand. In this case, it was the Irish healthcare services that provided women with this type of medical technology.

In general, there was a strong sense among Polish migrant women that the care during labour that is offered at the Irish maternity hospitals is of a higher quality than that offered to public patients in Poland. Women thought that in order to ensure a similar level of friendliness on the Polish maternity wards, receive an epidural or be accompanied by a

birth partner they would have had to pay for private care. Thus, there was a strong sense that public care in Ireland included elements of care that are only accessible to private patients in Poland.

This takes us to the next aspect, namely the role of women's social position in shaping their access to personal biomedical care during labour and women's perceptions of the differences between public, semi-private and private care schemes in Ireland. Indeed, none of the Polish migrant women I talked with accessed the semi-private or private care schemes within the Irish maternity care. This included three women who had Irish private health insurance. As they explained, they did not see much difference between private and public care. Women believed that the extras offered in private and semi-private care schemes were limited to the type of accommodation provided during their hospital stay. As they cared very little about hospital accommodation and some women even mentioned that they preferred shared rooms because they could always talk to someone, women did not see the reason why they should pay considerably more (up to several thousand euros) to access private or semi-private schemes. In addition, women also believed that all the elements of care that they found important (friendly staff, access to epidurals and the possibility to be accompanied by their partners during labour), were included in the public care scheme. Thus, none of the women saw much sense in paying for private or semi-private maternity care schemes in Ireland.

As already mentioned, women believed the situation to be different in Poland. Indeed, as already discussed in Chapter 6, in Poland accessing private care is a popular strategy used by women in order to ensure respectful treatment by healthcare personnel during labour. In other words, many women believe that as private patients they have a better chance of being treated with respect and having their needs met while in labour. Migrant women believed that healthcare personnel in Irish maternity care were in general very friendly. As a result, they thought that they had a good chance of building a personal relationship with healthcare personnel even as public patients. Thus, they did not really see a reason to pay considerable fees for private or semi-private care schemes.

As I have shown in Chapters 8, 9 and 10, Polish migrant women in Ireland often sought healthcare services outside the mainstream Irish healthcare system. Some healthcare personnel and ordinary people in Ireland considered migrants coming from poorer

countries as potentially frequent users of the host country's healthcare system. However, Polish women very rarely relied only on the Irish healthcare services. This was particularly true for prenatal outpatient care. Indeed, many Polish migrant women I talked with attended clinics run by Polish doctors in Ireland for at least some of their maternity care. Apart from accessing clinics run by Polish doctors, some women also accessed maternity services during their trips back to Poland. However, despite the popular assumptions held by some healthcare professionals in Poland, these constituted a relatively small share of Polish migrant women's healthcare practices during pregnancy. Finally, in contrast to outpatient maternity care, migrant women rarely sought alternatives to inpatient maternity care. In fact, most women were very happy with the care they received during labour at Irish maternity hospitals. They were particularly impressed by the friendliness of the healthcare personnel and the ability to receive epidurals on demand.

The picture of migrant women's healthcare strategies points to various ambiguities. On the one hand, women were usually very critical of Polish maternity care. This was particularly true for care that women believed was provided during labour on Polish labour wards. They imagined it as hostile and lacking respect and almost every woman I talked with had at least one scary story about how some of her friends or family members had been mistreated by healthcare personnel in Poland. On the other hand, women found it very difficult to rely only on Irish maternity care, particularly when it came to prenatal, outpatient care. They found it too light-hearted or even backward. Thus, as I have suggested in this chapter, Polish migrant women's transnational healthcare practices and their manoeuvring between Irish and Polish services should be analysed in terms of women's quest for a particular kind of biomedicine – the one that provides a proficient use of medical technology and allows for building personal relationships with healthcare personnel.

In the case of prenatal care, it was Polish maternity services that provided women with personal biomedicine. As they offered continuity of care, a higher number of scans and specialist-driven care, Polish prenatal services were closer to the ideal model of personal medicine. In the case of care during labour, Irish healthcare services were closer to this model. They not only offered epidurals on demand and allowed for birth partners, but, what seemed particularly important for migrant women, ensured friendly personnel and

respectful treatment – elements that women saw as particularly lacking within the care offered by the Polish maternity services.

Polish migrant women's transnational healthcare practices show that women use Polish and Irish healthcare services as "mirrors" to illuminate the elements that they find particularly important in shaping their experiences with maternity care. By comparing the two systems, women stressed the deficiencies and used them as a point of departure to criticise the way biomedicine is practiced in Ireland and Poland. However, their criticism was mainly focused on the individual level of doctor-patient relations and rarely included the inequalities that characterise both systems. In other words, women based their evaluations of care on doctors' empathy, their willingness (or lack of it) to prescribe prenatal screenings and their professional knowledge, not on the lines of division that run across these systems.

So far, I have discussed the power configurations and focused on the position Polish migrant women occupied vis-à-vis Irish and Polish healthcare services. In the next chapter I look at these power configurations as specific to particular enhancements of biomedicine. In order to do that, I take a look at the use of prenatal ultrasound scans – one of the most significant examples of prenatal medical technology – and compare its use and importance across healthcare services in Poland and Ireland. Indeed, the proliferation of prenatal ultrasound technology over the last decade has not only influenced the position pregnant women occupy vis-à-vis healthcare professionals, but it also revolutionised the common perception of the foetus and allowed future parents to "see" their future baby. As a result, ultrasound technology has become one of the most commercialised elements of maternity care in Poland and Ireland. As the two countries have developed different traditions in the use of prenatal scanning, the analysis of these differences provides a very interesting window into looking at the wider forces (such as privatisation) that shape these two biomedical regimes and at the way these two biomedical regimes control women's (pregnant) bodies.

Chapter 11: Engagements with medical technology: the role of structural aspects in shaping the use of ultrasound screenings

In Chapters 8, 9 and 10 I suggested that Polish migrant women's healthcare practices and, in the case of prenatal care, their frequent use of Polish healthcare services can be seen in terms of women's quest for "personal biomedicine", a type of care that combines the possibility of forming personal relations with healthcare personnel with access to frequent use of medical technology. In this chapter, I look at women's engagement with biomedicine in Poland and Ireland by focusing on the second element of personal biomedicine, namely on medical technology. I attempt to shed more light on the way prenatal technology is realised in Poland and in Ireland. I do that by taking the case of ultrasound scans – a medical technology that Polish migrant women frequently searched for. Indeed, ultrasound scans were brought up in almost every conversation I had with migrant women regarding maternity services in Ireland. As I discussed in Chapter 8, women believed that Irish maternity services offered fewer scans than Polish healthcare services. In order to have more scans, they often turned to Polish healthcare services. In this chapter, I adopt an approach complementary to the one I used in previous chapters. Thus, while in Chapters 8, 9 and 10 I started from women's strategies and then situated them in the larger context of healthcare services in Ireland and Poland, in this chapter I start from structural factors influencing women's use of ultrasound scans in the two countries. Indeed, first I compare how ultrasound scans are used in prenatal care in Ireland and in Poland. In order to do that, I look at the national guidelines that regulate the use of ultrasound technology in prenatal care in both countries, as well as reports, articles, and data I collected during my research that illustrate the use of ultrasound scans. Then, I suggest that one of the possible ways to better understand the differences in how this medical technology is practiced in Ireland and Poland, is by looking at some of the structural aspects within the Irish and Polish maternity care services. These structural aspects include, most notably, abortion laws, trends in workforce and the delivery of maternity care, particularly the division into private and public care and, therefore the commercialisation of prenatal ultrasound technology. As products of wider socio-cultural, political and economic contexts, these aspects shape both national guidelines and "traditions" (i.e. guidelines in use) of how prenatal ultrasound scans are used in Poland and in Ireland.

11.1 Safe, easy and affordable? The proliferation of ultrasound scanning in prenatal care

Over the past few decades ultrasound scanning has become a common screening procedure in prenatal care. Many countries, including Poland, developed national guidelines to regulate the use of ultrasound technology in obstetrics. In many countries, it is recommended that women have at least one or two ultrasound scans during pregnancy as part of the prenatal screening programme in order to assess the risks of anomalies in the foetus (ACOG 2009, NHS 2013). Indeed, the overwhelming majority of pregnant women in developed countries have at least one prenatal ultrasound scan and many have several during pregnancy.

In general, the ultrasound machine became one of the most commonly recognised medical technologies linked to maternity care. As shown by several studies (Garcia et al. 2002, Georges 1996, Mitchell and Georges 1997), ultrasound scans are regarded by many expectant parents and healthcare professionals as a relatively safe, enjoyable and reliable way to find out whether the baby is healthy. Indeed, at present, there is no evidence suggesting that ultrasound scanning is harmful to the foetus or to the mother. However, as stressed by the International Society of Ultrasound in Obstetrics and Gynaecology (ISUOG) “ultrasound involves exposure to a form of energy, so there is the potential to initiate the biological effects” (ISUOG 2010). As a result, in their joint statement published in 2010 the ISUOG and the World Federation for Ultrasound in Medicine and Biology (WFUMB) warned against using ultrasound scanning for non-medical purposes such as the production of keepsakes (pictures or videos of a foetus) or the entertainment of the parents (ISUOG 2010). However, despite this warning the average number of scans that women have during their pregnancies is increasing in many countries.

As shown by the growing body of anthropological literature, the proliferation of ultrasound technology in prenatal care has a considerable impact not only on the position pregnant women occupy vis-à-vis biomedicine and healthcare professionals, but also on the conceptualisation of the foetus and the way future parents may experience pregnancy. Thus, before discussing the way ultrasound technology is practiced in Ireland and Poland, I review some of the anthropological studies that explored the issue of prenatal ultrasound technology. Many of these studies belong to the larger discussion on medicalisation of pregnancy that I discussed in Chapter 2. However, taking into consideration that ultrasound

technology is a very specific form of medicalisation and specifically looking into the existing anthropological debate on this will help me to better grasp the social dimension of ultrasound scanning and the ways local biomedical “traditions” in using ultrasound scanning are shaped.

In their analysis of ultrasound technology in maternity care, early feminist scholars, as in the debate on medicalisation, focused on the medical establishment. They saw ultrasound technology as yet another tool that allowed medical doctors to exercise increasing control over female bodies (see for example Oakley 1984, Petchesky 1987). In this case, control meant the ability to render women’s bodily knowledge unimportant. Feminist scholars argued that ultrasound technology allowed medical professionals to “bypass” women and their bodies in order to learn about the wellbeing of the foetus (see for example Oakley 1984). In this sense, women with their bodily knowledge and experiences became unnecessary and invisible in the medical encounter as doctors no longer needed to rely on women’s knowledge to monitor the movement and the growth of the foetus. With the help of the ultrasound machine, they could “look into” women’s wombs and assess the wellbeing of the foetus without asking women about their bodily experiences.

This takes us to the next aspect of ultrasound technology that feminist scholars pointed to, namely, the idea that ultrasound imagining “separated” the foetus from the womb. Indeed, the proliferation of ultrasound images decontextualized the foetus from the woman’s body. The form of the ultrasound picture that focuses on the foetus and conceals the body of the pregnant woman, changed the way the foetus started to be perceived in society. While the female body was “lost” in the picture, the foetus came to be shown as an independent being (Petchesky 1987). As argued by feminist scholars, this decidedly influenced the public debate on abortion and threatened women’s reproductive rights. This was because decontextualized foetal images started to be used by anti-abortion campaigners in order to create a public perception of foetal “personhood” with the foetus having its own rights and needs (Palmer 2009, Petchesky 1987, Roberts 2012, Taylor 1992). As described by these feminist scholars, blurred black and white ultrasound images (unintelligible to most members of society) were presented and translated to the public in such a way as to encourage the “personhood” of the foetus. This was done, for example, by assigning the foetus with certain “humanising” behaviours such as smiling, playing or waving. In this way, ultrasound imagining became a means through which the foetus was

“humanised” and given its own rights that could be situated in opposition to the rights of the woman who carried it. This subsequently was used by anti-abortion campaigners to support the ban on abortion.

Thus, the studies that I have discussed above provide a very important insight into the role of ultrasound scanning in the shifting position of pregnant women vis-à-vis healthcare personnel and the foetus. However, by focusing on the more general level of public debate and power relations in the healthcare settings, they rarely looked into how women themselves perceive, use and relate to the routine use of ultrasound technology. Therefore, I now turn to discuss the anthropological studies that explored the pregnant women’s individual experiences and the way that they have been influenced and transformed by the introduction of routine prenatal scanning.

Several feminist studies that focused on women’s individual experiences (see for example Georges 2006, Mitchell 2001, Taylor 2000) continued to highlight the importance of visualisation as a crucial transformative factor in the conceptualisation of pregnancy. In doing so they relied on women’s accounts of how the visualisation of the inside of their womb had transformed pregnancy for them. As some of these studies argued, for many pregnant women, ultrasound scans (especially when women “see” the foetus for the first time) are very pleasurable experiences (Mitchell 2001). Women also rely heavily on them for reassurance. Thus, instead of seeing women as passive victims of medical technology, some scholars argued that women may be more accurately seen as active consumers of medical technology (Georges 1996, Taylor 2000, Roberts 2012). “Seeing” the foetus before they can actually feel the foetal movement, makes pregnancy more “real” for many women and gives them the reassurance that the foetus is healthy (Mitchell and Georges 1997). Also, prenatal ultrasound scanning may play an important role in creating the bond between the mother and the foetus (Taylor 1998) or future fathers and the foetus (Sandelowski 1994, Draper 2002) by making the future baby more “real” for both of them. This can potentially have an impact on their decisions regarding the future of the pregnancy (i.e. whether to keep it or terminate it) or on the way they will deal with a possible miscarriage.

This brings us to the next aspect of prenatal ultrasound technology that some scholars point to, namely the fact that the proliferation of ultrasound screening may have

contributed to making some future parents unprepared for hearing the diagnosis that the foetus is not developing well (Mitchell 2004). As argued by Mitchell (2004), many future parents came to perceive ultrasound scanning more as a social event than a medical procedure during which potential foetal abnormalities may be detected. Thus, when coming for an ultrasound scan, they expect to be shown an image and given pictures of a healthy baby, rather than to be told that something may be wrong with the baby. Hearing the diagnosis that the baby is not developing well may be all the more unexpected. In addition, ultrasound scans may produce both false positives and false negatives. This means that by using ultrasound images, doctors may mistakenly find problems where there are none, or, alternatively, not find any where there are abnormalities. Taking into consideration that modern medicine still has very little in the way of treatment options to offer in case of foetal abnormalities, ultrasound diagnostics have become a very complex issue that may significantly increase the anxiety levels of future parents. In the case of foetal abnormalities, the choices, if any, are often limited to whether to terminate the pregnancy or to keep it and give birth to a potentially sick baby. This puts women in the position of what Rapp (1999) called “moral pioneers”, where they have to make decisions no other generation were offered or forced to make. As a result, these women have no previous patterns and experiences on which to base their choices, but continue to be judged for their decisions by society.

The studies discussed above, stressed the importance of “seeing” and visualisation as crucial elements in making ultrasound technology a very powerful tool of medicalisation. The visualisation of the inside of the womb by using ultrasound machines fundamentally changed not only the position of women and their bodily knowledge vis-à-vis medical personnel and the foetus, but also the way women experience pregnancy and are reassured that the baby is healthy. Indeed, many women tend to value ultrasound scans over other screenings procedures such as urine or blood tests. However, at the same time, they find ultrasound scans very enjoyable and treat them more as social events during which they can bond with the baby, rather than medical procedures. All of these aspects have a fundamental impact on the way women engage with medical technology.

However, women’s encounters with medical technology take place in particular structural configurations. These structural configurations may encourage as well as discourage the use of medical technology. In order to understand the way women engage with medical

technology, it is necessary to consider not only women's individual perceptions and expectations, but also the structural configurations they are embedded in. Thus, in the next part of the chapter, I look at the structural aspects that shape the use of ultrasound technology in Ireland and in Poland.

11.2 National guidelines on the use of ultrasound technology in prenatal care in Poland and Ireland

In 2011, the Polish Gynaecological Society [*Polskie Towarzystwo Ginekologiczne* (PTG)] published its recommendations on the use of ultrasound scanning in prenatal care in the medical journal *Polish Gynaecology* [*Ginekologia Polska*] (PTG 2012). According to these recommendations, woman should have at least three ultrasound scans carried out by the healthcare personnel trained in ultrasonography (PTG 2012) during uncomplicated pregnancies. The first scan should be carried out between the 11th and 14th week of pregnancy, the second between the 18th and 22nd week and the third between the 28th and 32nd week of the pregnancy (PTG 2012). Furthermore, according to these recommendations, during the first scan women should be offered the Nuchal Translucency (NT) scan to identify the risks of chromosomal conditions such as Down syndrome. Interestingly, the PTG's guidelines comment only on the minimum number of scans women in Poland should be offered within the maternity care programme and do not regulate the maximum number of scans.

Available data suggest that the actual use of ultrasound scanning in uncomplicated pregnancies is much higher than the recommended minimum of three scans. In the already mentioned study by Rogala et al. (2014), the average number of prenatal scans among women attending public clinics in Poland was 3.93 and among women attending private clinics was as high as 7.88. This means that most women had more than the recommended minimum of prenatal scans and women attending private clinics had almost twice as many scans as women attending public clinics. In fact, many of the women whom I interviewed in Poland reported having ultrasound scans during each of their prenatal visits, i.e. every 4-5 weeks. This was especially true for the women who attended private surgeries and paid for each visit. In most cases, the latter had between 7 and 9 ultrasound scans during their pregnancy. Women who participated in my study and attended public clinics in Poland tended to have less ultrasound scans than women who attended private clinics. Nonetheless, they tended to have more than three scans.

Among the women whom I interviewed in Poland, there were two who reported having only two scans throughout their pregnancies. Both of them attended public clinics. In the first case, the woman said that the clinic she attended did not have any free slots to register her for the NT scan during her first trimester so she just missed it. She was advised to search at other clinics for free slots, but she just decided to wait for the next scan. The other woman did not know that she should have a minimum of three scans. When she went into labour and arrived at the hospital, the doctor who admitted her complained that the results from her first scan were missing from her medical documentation. She explained, that she did not know that she should have had more scans than the two she had (in the second and the third trimester) and the doctor she attended never offered her a scan in the first trimester. Nevertheless, among the women I talked with in Poland, the majority had more than the three recommended scans.

Apart from the interviews and the informal conversations that I had with numerous Polish women, the analysis of Polish internet forums also suggests that many women have considerably more than three ultrasound scans during pregnancy. For example, out of the twelve women who discussed the number of ultrasound scans during their pregnancies on one of the parenting forums on the portal Kafeteria.pl, four declared that they had three scans and eight declared that they had more (with some of them having between 8-10 scans) (Kafeteria.pl 2013). In another “conversation” on the portal edziecko.pl, out of the eight women taking part in the conversation, seven declared that they had “many” scans (usually one during each prenatal visit) whereas only one woman said that she had only three scans (eDziecko 2007). As the latter explained to the other women on the forum, she did not feel the need to have more scans and her doctor did not encourage her to have more than three. Yet in another “conversation” on the same internet forum, seven women declared that they had many scans (some more than ten) and only two said that they had three (eDziecko 2005). In most cases women did not link more frequent ultrasound scans to any complications they developed during their pregnancies so we can assume that most of them had uncomplicated pregnancies. However, women often linked more frequent scans with attending private clinics. Indeed, they often mentioned it as one of the advantages of private clinics. For example, one woman who attended a private clinic during her first pregnancy and then, during a second pregnancy, decided to attend a public clinic, complained that in the public clinic she was offered far fewer scans than in the private one.

In general, the analysis of the internet forums shows that women had much more than the three recommended ultrasound scans. This was especially true for women who attended private clinics. As they often explained, their doctors suggested to them that ultrasound scans are a safe and reliable way to check whether the baby was healthy. In the majority of cases these women reported that after each of these scans they felt reassured that the pregnancy was going well. However, even women who attended public clinics also tended to have more than three ultrasound scans.

The benefits of frequent prenatal ultrasound scans are also promoted by some of the top consultant obstetricians in Poland. For example, in a long interview published in the form of a book, Marzena Dębska a high-profile obstetrician/gynaecologist from a large teaching hospital in Warsaw explained that she believed that the recommended three ultrasound scans are the absolute minimum, but that they do not allow doctors to pick up on some of the possible foetal abnormalities (Rigamonti 2014, p. 25-27). In her own practice, as she explained, she performs ultrasound scans during each visit. As she stressed, she does it not to entertain the expectant parents but because it is the most reliable way to check the well-being of the foetus (Rigamonti 2014, p. 25-27). However, as she declared, during her own pregnancy she also frequently “watched” her baby through the ultrasound machine because she really enjoyed it (Rigamonti 2014, p. 25).

Finally, the internet survey carried out by the Polish NGO *Childbirth with Dignity* in 2009 on the number of prenatal ultrasound scans showed that 80 per cent of the respondents had more than three ultrasound scans during their pregnancies with 20 per cent of them having at least ten scans (Baranowska 2014).

All of the above data suggest that women in Poland have considerably more than the three recommended scans during pregnancy. This seems to be especially true for women who attend private surgeries, where they are often offered an ultrasound scan during each of their prenatal visit. In many cases, these women pay additionally for the scans. However, some gynaecologist/obstetricians do not charge additionally for the scans but include the costs in the fees they charge for the consultation. Now, in order to compare the way ultrasound technology is used in prenatal care, I turn to Ireland to discuss the use of ultrasound scans there.

In contrast to Poland, Ireland has no national guidelines on the number of ultrasound screenings that should be carried out during pregnancy (Walsh et al. 2013)²³. A study by Walsh et al. (2013) that investigated all birth units in Ireland, found considerable differences between birth units in respect to what scans were offered at which stage of a pregnancy and to whom. For example, the first trimester scans were offered to all women only in 65 per cent of birth units in Ireland. The mid trimester anomaly scans were offered to all women only in 35 per cent of the birth units (Walsh et al. 2013). The NT scans were generally not offered to women in hospitals in Ireland. 70 per cent of the birth units declared that they do not offer NT screening as part of their standard screening package (Walsh et al. 2013). As signalled by the authors of the article, this might be linked to the strong religious (i.e. Catholic Church) tradition and to the unavailability of abortion services in Ireland (Walsh et al. 2013). In other words, the lack of screening procedures that aim to determine the risks of chromosomal conditions in the foetus may result from the fact that should risks be detected, women still cannot legally terminate the pregnancies in Ireland.

Despite inconsistencies among Irish birth units in the provision of ultrasound scans to pregnant women, the “Growing Up in Ireland” report (Williams et al. 2010) which used a nationally representative sample of over 11,000 infants and their families showed that almost all women (99.8 per cent) reported having at least one ultrasound scan during their prenatal care. The mean number of ultrasound scans per pregnancy among the surveyed women was 4.8 but some women had as many as twenty scans (Williams et al. 2010, p. 44). This included women who attended private and public clinics. However, similar to the situation in Poland, women who attended private services had on average more scans (6.6 per pregnancy) than women who attended public care (Williams et al. 2010, p. 44). According to the report (Williams et al. 2010, 44) women attending public care had on average as many as 4.4 scans per pregnancy.

The findings of this report (Williams et al. 2010) contrast with the declarations of Polish migrant women. As discussed in Chapter 8, Polish migrant women frequently complained about the limited number of ultrasound scans offered by the Irish maternity services. All of the women I talked with attended Irish public clinics and, if there were no complications,

²³ The National Maternity Strategy, launched in January 2016, among other changes, recommends the introduction of nationally consistent and standardised prenatal care, including nationally consistent provision of ultrasound services (Department of Health 2016)

they were offered one or two scans during their pregnancies. In the majority of cases they had their first scan between the 18th and 22nd week of the pregnancy, that is, usually during the first scheduled visit at the maternity hospital. For women who did not have any complication it was usually the first and the only scan they had in the maternity hospital. Other women declared that they had one more scan either in the last trimester or if they developed symptoms such as bleeding or pain and attended the A&E department of the maternity hospital. There were also a few cases when doctors had doubts about the development of the foetus and, in order “to keep a close eye” on the foetus, referred these women for additional scans. Only one participant in the study declared that she had frequent scans at the Irish maternity hospital. However, she had a high risk pregnancy due to a chronic condition she suffered from. The frequent scans were most probably linked to this chronic illness.

Discrepancies in the provision of ultrasound scans among hospitals in Ireland as well as the differences between public and private care are partly reflected on internet forum discussions. In a discussion on the number of ultrasound scans during pregnancy (Mum2be.ie 2012) on the Mum2be.ie parenting portal, out of eleven women participating in the discussion seven declared that they had one or two scans performed during the first and second trimester of pregnancy. Another four women declared that they were offered three or more scans and two of these had scans during each visit at the hospital outpatient clinic (i.e. every 6-8 weeks). Some women said that scans were offered to them because doctors were worried about something and wanted “to keep an eye on the baby”. Other women were not sure why they were offered more (or less) scans than others taking part in the discussion (as they could find no obvious explanation such as complications).

Similar to the situation in Poland, discussions on the internet forums showed that women who attended private care were far more likely to declare they had ultrasound scans during each of their appointments with the consultant. Interestingly, frequent scans were often mentioned as one of the advantages of a private maternity scheme in Ireland. For example, in a “conversation” on the portal Mum2be.ie (2013), women who attended the public scheme reported going to private ultrasound clinics to obtain more ultrasound scans. They found the number of scans offered by the public scheme to be insufficient and wanted to have more scans. They reported paying for these private scans between EUR 100 to 200 depending on the clinic they had attended and the type of scan they obtained.

Interestingly, unlike many of the women taking part in discussions on Irish parenting forums, Polish migrant women did not associate private care offered by the Irish healthcare system with more frequent scans. As already mentioned, all of the migrant women I talked with chose public care, although a few of them had private health insurance. Even those women who had private insurance declared that they never really considered private or semi-private care. As discussed in Chapter 6, in their view the difference between the latter and public care was “marginal” and therefore, not worth spending money on. They usually mentioned hospital accommodation as being the major difference and declared that they did not care enough about accommodation to spend money on it. None of the women considered more frequent ultrasound scans as being an advantage offered by semi-private or private care schemes.

Furthermore, none of the Polish women I talked to considered attending or even mentioned the fact that there are Irish private clinics offering ultrasound scans for a fee. There was also no mention of Irish private ultrasound clinics on the Polish internet forums. In order to have additional ultrasound scans, Polish migrant women most often went to the private clinics run by the Polish doctors where many of them had ultrasound scans during each prenatal visit. As a result, many migrant women I talked with had frequent ultrasound scans but only one or two of these scans were carried out in the Irish maternity hospital and the rest were carried out at the private clinics run by the Polish doctors.

The fact that the Polish migrant women I talked with did not attend private Irish ultrasound clinics to access additional scans may be partly due to the differences in prices. For example, as already mentioned, women taking part in the discussions on the Irish parenting forums declared paying between EUR 100 and 200 for private scans at the Irish private clinics. At the same time, the obstetrical consultation with a scan at the Polish clinic cost between EUR 100 and 160. However, unlike the visit at the Irish private ultrasound clinic, the visit at the Polish clinic, apart from the ultrasound scan, also included a consultation with the obstetrician. Thus, scans at the Polish clinics in Ireland were relatively cheaper than scans at the Irish private clinics.

As I have shown above, there are differences in the way ultrasound scans are used in Poland and in Ireland. The analysis of my interviews and discussions on the internet forums

suggest that women in Ireland attending public care tended to be offered fewer ultrasound scans than women attending public care in Poland. The majority of Polish migrant women I talked with declared having one or two ultrasound scans done under the Maternity and Infant Care Scheme. However, these findings are not confirmed by the study by Williams et al. (2010) that reported a high number of 4.4 ultrasound scans per pregnancy among women attending a public care scheme in Ireland. Furthermore, whereas in Poland the national guidelines recommend the minimum of three scans (and most of the women I talked to in Poland had at least these three scans), in Ireland there are no national guidelines that would regulate the number of prenatal scans. It is up to the hospital and the consultant whether, when and to whom the ultrasound scans should be offered. Finally, in both countries, women attending private care tended to have considerably more scans than women who attended public clinics.

In the next part of the chapter I turn to structural forces that shape the provision of maternity care in Ireland and in Poland and explore how they can influence the provision of ultrasound scans in both countries. I start by looking at the national abortion policy and the possible ways it can influence the practices associated with ultrasound screenings. Then I turn to the structure of the workforce in Ireland and in Poland and explore the differences between the two countries and the way it possibly links to the differences in the use of medical technology. Finally, I look at private care and the commercialisation of ultrasound technology in both countries and discuss in what way they may contribute to the more frequent use of ultrasound scans.

11.3 Abortion, workforce structure and commercialisation of ultrasound technology: The factors shaping the use of ultrasound technology in Ireland and in Poland

The national abortion policy potentially has a huge impact on the way prenatal technology is practiced in particular countries. Access to abortion services, or lack of, can influence national guidelines and local “traditions” in the provision of prenatal ultrasound scans. This is because, the result of prenatal tests may potentially lead women and their partners to decide to terminate the pregnancy. As a result, restrictive abortion laws in a particular country may lead to the limited access to prenatal screenings. Thus, in order to explore this link and its potential influence on the provision of ultrasound scans in Poland and in

Ireland, in this part of the chapter I discuss the differences in abortion laws in these two countries. Both Ireland and Poland have very restrictive abortion policies. As argued by several analysts, these policies are strongly influenced by the Catholic Church that in both countries plays a prominent role (Mishtal 2009, Kramer 2009, McDonnell and Allison 2006, Smyth 2005, Zielińska 2000). However, as I discuss below, there are also important differences between abortion laws in these two countries that may play an important role in shaping the differences in the provision of ultrasound screenings in these two countries.

Ireland has a long tradition of restrictive reproductive health laws, including the ban on contraceptives that was only lifted in 1973 and the criminalisation of abortion that was introduced in 1861 and remains in place today (Bloomer and O'Dowd 2014, IFPA 2014b). According to the Eight Amendment of the Irish Constitution passed in 1983, the foetus has an equal right to life as the woman who carries it (IFPA 2014b). In other words, in case a woman's life is at threat as a result of pregnancy, the Eight Amendment leaves it up to the court to decide whose (the women's or the foetus's) life is a priority (Bacik 2013, p. 24-25). In 1992, in what came to be known as the X case, using the Eight Amendment, the court ruled that a 14-year-old girl who was raped and subsequently became pregnant could not travel to legally obtain an abortion in the UK. This decision was later overruled by the Supreme Court, who found that the girl's life was at risk due to the threat of suicide and established that in this case the pregnant woman's right to life was in direct conflict with the right of the unborn, the woman's right should prevail (Bacik 2013, p. 25). With this court decision, the girl was legally entitled to obtain an abortion in Ireland (Bacik 2013, p. 25) but, despite that, she and her parents chose to travel to the UK to access termination of pregnancy. Later that year, the Irish government held a referendum on the availability of abortion services and passed two amendments to the Irish Constitution in regard to the abortion law. The first amendment guaranteed women the right to travel abroad in order to terminate a pregnancy. From that moment on, Irish authorities could no longer stop anyone from travelling to another country in order to access abortion services. The second amendment regarded the freedom to obtain and make available information on abortion services outside Ireland (IFPA 2014b). In other words, since 1992 under certain conditions women in Ireland can legally obtain information on abortion services outside of Ireland and they cannot be stopped from travelling abroad if they wish to avail themselves of these services.

Despite the urgent need to clarify the legal situation in Ireland and provide clear guidelines on the circumstances under which women are eligible to obtain an abortion in the state, for over two decades consecutive government have refused to legislate for abortion. Only in 2012, the case of Savita Halappanavar, a woman who died from sepsis at the University Hospital Galway caused public outrage, putting pressure on the Irish government to regulate the provision of abortion. Ms Halappanavar attended the hospital with back pain. Despite the doctors' diagnosis that she would inevitably miscarry this pregnancy, and her numerous requests, she was denied an abortion because of the presence of a foetal heartbeat (see for example Duffy 2013). In the aftermath of this case, the Irish government passed the *Protection of Life During Pregnancy Act 2013* that intended to provide clear guidelines regarding the circumstances under which doctors could provide women with an abortion. Under this regulation abortion remains illegal and criminalised in Ireland, except when "there is a real and substantial risk of loss of the woman's life" (*Protection of Life During Pregnancy Act 2013*).

In other words, women in Ireland can only legally access abortion services when they face a substantial risk of dying if they continue with the pregnancy. This also includes the threat of suicide. In all other cases, for example when the pregnancy results from rape or in the case of foetal abnormalities, women are not eligible to legally access an abortion in Ireland. According to the Irish Family Planning Association, before the *Protection of Life During Pregnancy Act 2013*, due to a lack of clear regulations on how to determine whether the woman's life is under threat, doctors did not provide abortion services even to women who could legally be entitled to it (IFPA 2014a). For decades, several pro-choice and women's right groups put pressure on the Irish government to legislate for a law that would clarify under what circumstances the pregnancy may be terminated in Ireland, but prior to the passing of the *Protection of Life During Pregnancy Act 2013* there were not clear guidelines on the subject.

Abortion remains inaccessible to most people in Ireland. Thousands of women facing crisis pregnancies and wishing to access abortion services are forced to travel to the UK or other states where for substantial fees they can legally terminate a pregnancy (Best 2005, Bloomer and O'Dowd 2014, IFPA 2014c). According to IFPA, between 1980 and 2013 at least 158,252 women living in Ireland travelled to England and Wales to access safe abortion services (IFPA 2014a). Because of the costs involved (e.g. flights, hospital fees) and

the need to travel overseas, this situation puts women with limited financial resources and restricted rights to travel (such as asylum seekers) in particularly difficult situations.

The restrictive abortion law and the unavailability of legal abortion services in cases of foetal anomalies may have an impact on the number of prenatal scans offered within the Irish healthcare services. In other words, the fact that abortion is not accessible in Ireland in case of foetal anomalies, may translate into the lack of universal access to scans. This seems to apply particularly in the case of NT scans where the main aim is to check whether a foetus may be at higher risk of chromosomal conditions such as Down Syndrome. Despite not carrying any additional risks for the mother or the foetus than a regular ultrasound scan, NT scans are not universally available in Ireland.

In Poland the abortion law is less restrictive but access to legal termination of pregnancy is also very limited. Abortion in Poland is illegal except for three cases: 1. when a pregnancy endangers the life or health of the pregnant women; 2. when it results from a criminal act (e.g. rape or incest) or 3. in the case of severe foetal anomalies. Unlike Ireland, Poland has a tradition of liberal abortion legislation. From 1932 abortion was legal in Poland for medical (e.g. when a pregnancy posed a threat to a women's life) and legal reasons (e.g. when pregnancy resulted from rape) (Zielińska 2000, p. 25). From 1956 until 1993 women were also entitled to terminate the pregnancy for social reasons (e.g. difficult living conditions) (Zielińska 2000, p. 25). During the latter period, abortion was generally widely available to women in Poland and the majority of reported terminations were due to social reasons (Okólski 1983). Okólski (1983) estimates that by the end of 1970s the number of abortions performed in Poland might have been somewhere between 310,000 and 510,000 per year which results in a rate of around 48-50 abortions per thousand women aged 15-44 (Okólski 1983, p. 266). From 1989, that is since the fall of the socialist regime, the political debate on restricting abortion gained a new momentum. In 1993 the Polish government, strongly influenced and supported by the Catholic Church (Mishtal 2009), passed the Law on Family Planning, Legal Protection of the Foetus and the Conditions of Permissibility of Abortion (*Ustawa o planowaniu rodziny, ochronie płodu ludzkiego i warunkach dopuszczalności przerywania ciąży* 1993). This law severely restricted access to legal terminations, for example, by making terminations for social reasons illegal. Taking into consideration the relatively high number of terminations in Poland and the fact that the overwhelming majority of them were due to social reasons, this law had a huge impact on women's lives.

Abortion due to difficult living conditions stopped being provided legally at hospitals in Poland. However, as argued by several researchers and women's rights groups, abortion services started to be offered clandestinely for high fees in private gynaecological surgeries (Mishtal 2010). This put many women with limited financial resources in a very vulnerable position. However, even the women who were able to pay the high fees, were forced to use services of dubious quality.

Although over the last two decades there were several attempts to both liberalise and even further restrict the abortion law in Poland, the 1993 act continues to regulate the provision of abortion services in Poland and access to legal terminations remains very limited. As pointed out by many researchers (Mishtal 2010), women who want to terminate their pregnancies are forced to either seek abortions illegally at private gynaecological surgeries in Poland or to travel abroad. According to the report by the Ministry of Health (Ministerstwo Zdrowia 2012b), in 2011 669 legal abortions were performed in Poland. Out of these, 620 were carried out because of foetal abnormalities detected during prenatal screenings (Ministerstwo Zdrowia 2012b). The remaining 49 procedures were carried out because the pregnancy posed a significant risk to the woman's life or health (Ministerstwo Zdrowia 2012b).

Despite very restrictive abortion laws, ultrasound scans are widely available in Poland. This includes NT scans which, according to national guidelines (PTG 2012), should be routinely offered to all women during the first trimester of their pregnancies to determine the risk of foetal chromosomal abnormalities. This difference between the way ultrasound scans are practiced in Poland and in Ireland (where, as I have already stated, NT scans are not universally available), may be partly explained by the fact that, unlike in Ireland, in Poland abortion is permitted in cases of foetal abnormalities. However, there are two aspects that add to the complexity of this situation, namely the fact that the availability of NT scans is often not followed by the availability of further diagnostic procedures (such as amniocentesis) and the fact that access to legal abortions in Poland in the case of foetal anomalies is very limited.

Indeed, as reported by studies (Kramer 2010, Nowicka 2008), access to some of the diagnostic procedures (such as amniocentesis) is very limited in Poland. In practice, women who are found to be at risk of carrying a foetus with anomalies are often refused for

further diagnostic referrals by doctors. Furthermore, as shown by reports (Bodnar 2008, Nowicka 2008) and illustrated by several cases described in the media in the recent years (see for example Bierut 2014), women are also being denied abortion services that they are entitled to. In a recent, highly-publicised case, a woman was denied an abortion even though the foetus was diagnosed with multiple anomalies and had no chance of long-time survival (see for example Siedlecka 2015). Her high profile doctor denied the woman an abortion using the conscience clause. Although obligated by law, he did not refer her to another clinic where she could access the services that she was entitled to. By the time she had found another doctor, she was over 24 weeks pregnant and, according to Polish law, it was too late for her to have an abortion. As a result, she was forced to give birth to a severely malformed and terminally ill baby.

Another aspect that adds to the complexity of prenatal screening in Poland and in Ireland is the fact that in both countries, despite restrictive abortion laws, prenatal diagnostic (including foetal anomaly scans, NT scans and other) is more easily available within the private sector. In both countries, women who can afford to pay high consultation fees, can access diagnostic services that are not available within the public care. In Ireland, where NT scans are not widely provided in public care, women who wish to find out whether their baby is at high risk of chromosomal conditions may do so by paying for NT scans and blood test at private laboratories. Furthermore, in both countries, non-invasive DNA tests that provide a highly accurate result are widely available for those who can afford to pay for them in private clinics. This leaves women with lesser financial resources without access to screening procedures to estimate the risks of foetus anomalies.

As I have shown above, abortion laws may provide some explanation for the way ultrasound technology is practiced in Ireland and in Poland. However, apart from the abortion laws, there are also other structural aspects that influence the way medical technology is practiced in particular biomedicines. As already mentioned, this includes, for example, the structure of the healthcare workforce. Thus, in the next part of this chapter I look into who delivers maternity care in Ireland and in Poland and in what way this may encourage or discourage the use of ultrasound technology.

Poland has comparatively more obstetrician/gynaecologists per 10,000 women than Ireland. Although over the last decade the number of doctors with this specialization has

been constantly decreasing, in 2012, obstetrics/gynaecology was still the fourth largest specialisation in Poland (more doctors were only in surgery, internal medicine and occupational medicine) with 4,584 doctors registered with this specialisation that year (Ministerstwo Zdrowia 2013). This means that in 2012 there were over 2.3 obstetrician/gynaecologists per 10,000 women in Poland (my own calculations on the basis of GUS 2013 and Ministerstwo Zdrowia 2013). At the same time, according to the Medical Workforce Intelligence Report, in 2012 in Ireland there were 605 doctors who worked mainly in the area of obstetrics and gynaecology (Medical Council 2012). However, only 225 of these doctors were registered as obstetrician/gynaecologists and the rest were registered with general specialisation (Medical Council 2012). This means that in 2012 Ireland had 0.9 obstetrician/gynaecologists per 10,000 women (my own calculations on the basis of CSO 2012 and Medical Council 2012), considerably less than Poland. Furthermore, when we relate the number of obstetrician/gynaecologists to the number of births, the difference between the two countries becomes even more dramatic. In Poland in 2012 there were roughly 387,000 births (GUS 2013) which gives slightly fewer than 85 births per obstetrician/gynaecologist (Table 14). In Ireland in 2012 there were roughly 72,000 births (CSO 2012) which gives the considerably higher number (of 321 births per obstetrician/gynaecologist) in Ireland than in Poland. Due to the lack of reliable data on the number of practicing midwives in both countries, it is difficult to make similar comparisons between.

Table 14: Number of OB/GYN specialists, births and births per OB/GYN specialist in Poland and Ireland in 2012

	OB/GYN specialist	Number of births	Births per OB/GYN
Poland	4,584	387,858	84.61
Ireland	225	72,225	321.00

Source: My own calculations on the basis of Ministerstwo Zdrowia (2013), Medical Council (2012), GUS (2013) and CSO (2012)

The available data suggest that Poland has considerably more obstetrician/gynaecologists per women than Ireland. In addition, in Poland doctors with general specialisations (i.e. family or internal medicine) rarely deal with issues related to pregnancy, where maternity care is almost exclusively provided by obstetrician/gynaecologists. In an overwhelming majority of cases women in Poland attend obstetrician/gynaecologists for their maternity

care appointments. As discussed in Chapter 7, only some of the outpatient clinics providing maternity care offer midwife consultations and doctors rarely seem to refer women for these type of consultations.

By contrast, in Ireland, the delivery of maternity care seems to more often involve general practitioners. According to the Perinatal Statistics Report (ESRI 2013), only 22 per cent of women in Ireland decided to avail themselves of consultant driven maternity care and over 77 per cent of women chose the combined GP/hospital care. Combined care includes regular visits to the family doctor alternating visits at the maternity hospital where women are seen by hospital obstetricians and midwives. As discussed in Chapter 5, as part of maternity care some hospitals also offer midwife led clinics for healthy women (Bump2babe 2011). This suggests that in Ireland women are more likely to be seen by midwives or family doctors than they are in Poland where obstetrician/gynaecologists are the primary providers of all prenatal care.

These differences in the structure of the healthcare workforce and the way maternity care is delivered in Ireland and in Poland, may influence the way ultrasound technology is practiced. Indeed, as pointed out by some researchers (Lynch and Malone 2007, Mitchell 2001), the number and type of prenatal screenings prescribed by maternity care providers also depend on their specialisation. For example, a study on prenatal screenings in Ireland (Lynch and Malone 2007) found that consultant obstetricians and specialist registrars were more likely than GPs to declare that ultrasound screenings should be offered to all women irrespective of risk factors. Consultant obstetricians and specialist registrars were also far more knowledgeable than GPs on the conditions that may be detected by the ultrasound screenings (Lynch and Malone 2007, p. 405). In other words, specialist doctors and registrars seemed to have a greater understanding, better access and be more in favour of prenatal technology than GPs.

Similarly, in her study on the use of prenatal ultrasound screenings in Canada, Mitchell (2001) noticed that the frequency of ultrasound screenings offered to pregnant women differed depending on the specialisations of doctors who provided maternity care. Mitchell (2001) argued that one of the reasons why women in Montreal were offered more scans than in other regions of Canada may also be due to differences in the specialisations of the doctors who provide the scans. While in the Quebec region (where Montreal is located) the

provision of prenatal screening was dominated by specialists, in other regions it was provided by general practitioners (Mitchell 2001, 66). Again, as suggested by Mitchell (2001), the fact that the prenatal screenings were offered by specialists resulted in the higher number of prenatal scans.

The same mechanism may be at play in Poland and Ireland. Maternity care exclusively provided by obstetrician/gynaecologists may be a factor that encourages more frequent use of ultrasound technology in Poland. The higher number of scans may result from stronger support of prenatal technology and a better understanding of their workings by specialist doctors. Also, specialists doctors are more likely to encounter and deal with pathology. Thus, they may be more likely to scan their patients regularly, expecting that physiology may turn into pathology. In Ireland, while maternity care is also obstetrician/gynaecologist driven, the care of pregnant women is at least partly shared between hospital based obstetricians, midwives (either at the hospital or at the midwifery clinic) and GPs. In this sense, this shared model of maternity care in which women are also seen by other healthcare providers than obstetrician/gynaecologists may result in less frequent use of ultrasound scans.

The next aspect that seems to play a role in shaping the use of medical technology is the commercialisation of maternity services. As I have already discussed above, in Poland and in Ireland women attending private care tended to have more ultrasound scans than women attending public care. One of the ways in which to look at the popularity of scans in private care is through the lens of revenue that ultrasound technology brings to private providers. Indeed, in Poland, a prenatal consultation during which women have ultrasound scans may be more expensive than regular prenatal consultations. Depending on the clinic and the doctor, women may be charged from PLN 100 to 200 (EUR 25 to 50)²⁴ or more for a scan. Considering that many private clinics invest considerable sums of money to buy ultrasound machines, they expect their investments to bring in revenues. This may encourage some doctors to offer women ultrasound scans during each consultation.

In Ireland, over the last decade, ultrasound scans have also become increasingly commercialised. Several private clinics started to operate, offering a range of prenatal screenings, including NT scans, 3D and 4D scans, as well as scans to determine the baby's

²⁴ My own estimations on the basis of pricelist of several outpatient clinics offering maternity care services.

gender or to check on its wellbeing. Depending on the clinic and the type of scan, the prices range from about EUR 100 to 230²⁵ for a scan. Women can book an appointment without a referral from their GP or their obstetricians. As in the case of Polish clinics, using the fact that many pregnant women enjoy “looking at their baby”, these private clinics may also encourage women to access more frequent scans than medically necessary.

This takes us to the next aspect, namely the role that women play in encouraging the use of ultrasound technology in prenatal care. Indeed, the commercialisation of ultrasound scans in prenatal care puts future parents in the position of consumers who, depending on their financial resources, can actively avail themselves of this medical technology. Considering the fact that future parents in general enjoy “looking at the baby”, ultrasound scans have become a purchasable commodity that can be enjoyed like other commercial goods.

11.4 Women’s role in the increased use of ultrasound technology in prenatal care

As I have already described in Chapter 8, the women I talked with rarely sought ways to limit the scans. On the contrary, they often actively engaged in strategies to increase their number. They chose doctors who offered more scans, registered with private clinics where they had a better chance of having an ultrasound scan during every visit or, during their regular consultations asked their doctors to provide them with additional scans.

All Polish migrants I interviewed used the Maternity and Infant Care Scheme and in case of healthy pregnancy, reported having one or two ultrasound scans at the Irish maternity hospital. However, in order to have more scans women either visited obstetric surgeries on the occasions of their trips to Poland or attended Polish clinics in Ireland and requested doctors to perform scans. Although scans were usually not part of a regular consultation at Polish clinics, obstetrician/gynaecologists offered them for an extra fee. The women explained to me that the doctor would typically ask them during a visit whether they wanted an ultrasound scan. Most of the women opted to have a scan and paid for it between EUR 10 and 80, depending on the clinic and doctor. As they put it, this was because they liked “looking at the baby”.

²⁵ My own estimations on the basis of pricelist of several private clinics offering prenatal ultrasound scans.

Women found it exciting to observe how their babies were developing. They really liked being shown different parts of the baby's body and having the doctor explain how their baby had changed. Łucja, a mother of one who regularly attended a Polish private clinic for maternity check-ups, appreciated that her Polish obstetrician, by using ultrasound images, gave her a lot of information on the baby's development. She compared her experience with other pregnant women she met during her visits at the maternity hospital and was quite surprised to find out they did not know similar things about their own babies. As she told me:

They [the women who attend only Irish healthcare services] thought that this [the standard maternity care offered by Irish public maternity services] is all fine. They do not know that things may be different. The women I met [in the maternity hospital] didn't know, for example, that the doctor can tell you by looking at the scan how big the baby is: how long it is and how much it weighs. I was there [at the maternity hospital] telling these women: you know, my son already weighs 2.5 kg and is developing fine and they were surprised that I know it because doctors never told them things like that. (Łucja, late 20s, mother of one, university graduate)

As many Polish migrant women, Łucja, greatly appreciated all the information on the foetus that she was getting from her Polish obstetrician. She was surprised how little information Irish doctors gave women who attended only public care. She felt much more informed that the women who attended only Irish maternity services.

Women usually declared that they found looking at the images of the foetus very enjoyable. Thus, if they had a chance to have a scan, they happily agreed to it. If not suggested by the doctor during the consultation, they asked the physician whether it was possible to have one. Most of them wanted to find out the baby's sex as soon as possible and kept the printouts of the foetus as souvenirs that they could give as presents to future grandparents. In one case, as a gift for the future parents, the future grandmother paid for a consultation at a clinic where they could obtain a 3D scan.

However, apart from the "enjoyable" side of ultrasound scans, all the women I talked with also stressed the fact that this was just an addition to the real reason for scans: to provide information on the development of the baby. Women seemed to believe that scans were

the most important, precise, simplest and safest screening procedure. They also believed that the procedure lacked side effects and allowed them, and most importantly, the healthcare personnel to “see” whether the baby was developing without complications. Women often declared that regular “looking at their baby” helped them feel reassured that the foetus was healthy. For many of them, ultrasound screenings seemed far more important than other procedures such as blood or urine tests, blood pressure checks or abdominal examinations (see also Chapter 8). Women tended to minimize the importance of other procedures and to maximise that of ultrasound scans to the point where they did not feel confident if the consultation did not involve “watching the baby”. They considered examinations during which midwives or doctors checked on the baby by feeling the abdomen as being backwards or strange. To describe this type of examination, they often used the phrase “magical touching” or “examination with their magic hand” and felt that it could not be accurate.

This exceptional status of ultrasounds vis-à-vis other prenatal screenings seems to result from its characteristic of joining the visual and scientific elements. Women perceive the images produced by the ultrasound machine as objective representations of foetal reality (Georges 1996, Petchesky 1987, Roberts 2012). In other words, during routine screening procedure, scientific technology in the form of an ultrasound machine produces images that are commonly perceived as representations of reality. These perceptions contrast with the perceptions of medical examinations that involve feeling the abdomen. The latter is often seen as an interpretation of reality. Indeed, Polish migrant women believed that “feeling the tummy”, a procedure carried out and interpreted by a human being, was extremely unreliable. By contrast, they perceived the picture produced by the ultrasound machine as “scientific” and more reliable. Thus, the ability to “see” into the woman’s womb and photograph the baby, as opposed to “feel” it with hands, makes ultrasound technology especially appealing and trustworthy for women.

In her study on the use of ultrasound screenings in Greece, Georges (1996) suggested that women enjoyed ultrasound screenings because they could in this way not only bond with their future baby but also because no other procedure reassured them about the wellbeing of the foetus in the same way as ultrasound scans did. This is especially important in the context of contemporary discourse on pregnancy and childbirth that stresses the woman’s responsibility for the wellbeing of the foetus, and, at the same time, constructs pregnancy

as a risky process that needs constant medical supervision (Lazarus 1994). In this context, women's search for frequent scans can be seen as a way to meet the social expectations of what "responsible" mothers do to ensure the wellbeing of their children. Thus, women's demand for scans may be seen as not only a way to provide reassurance or pleasure to the future parents, but also as an affirmation of social responsibility.

However, women's social responsibility is strongly linked to their position in society. As in the case of regular visits to gynaecologists that I described in Chapter 8, frequent ultrasound scans also seem to be part of the wider debate on what "responsible" and *middle-class* women should do. As already mentioned, private clinics tend to offer more ultrasound scans than public clinics. In addition, consultations with scans are usually more expensive. Although sometimes women complained about the high price that they paid for scans in the private clinics, they usually declared that "when it comes to health (and especially their children's health), one is not looking at money". In this sense, frequent ultrasound scans become middle-class markers – practices that women from better-off backgrounds are just expected to engage in and spend money on.

The analysis of the structural forces characterising the Polish and Irish biomedical regimes shows that these forces play an important role in shaping the use of medical technology in the two countries. Indeed, as I argued in this chapter, abortion laws, trends in workforce structure, and the forms of delivery of maternity care may encourage to various degrees the use of medical technology in various biomedical regimes. The forms of delivery of maternity care and the division into public and private care seems particularly important in the contexts of the intense commercialisation of healthcare services taking place in Ireland and in Poland (as well as in wider Europe). As ultrasound scans constitute a very particular example of medical technology that is very much enjoyed by future parents, they also constitute an attractive commodity and potential source of revenue for healthcare providers. Thus, commercialisation of healthcare services also plays an important role in encouraging the use of medical technology. The end result is not only differences in the way medical technology is practiced in Ireland and Poland, but also in the ways it is practiced in public and private care.

Chapter 12: Conclusions

The 2004 EU enlargement and the subsequent migratory movements of citizens from the NMS to old EU countries created a new transnational space. As migrants gained new social and economic rights, they engaged in new patterns of mobility, bringing face to face different areas of social life differently realised in their home and host countries. In this study, I explored the new transnational space created by the migratory movements of Polish women living in Ireland and their healthcare practices associated with pregnancy and childbirth. I used these practices as a lens to reflect on the power configurations characterising healthcare, particularly maternity services, in the two countries. I aimed to answer a twofold research question. First, how Irish and Polish healthcare services regulate women's (pregnant) bodies. Second, how Polish migrant women engaged with these regulatory regimes via concrete practices and how these engagements were influenced by the position they occupy in larger power configurations in the host and home countries.

In this concluding chapter I first summarise the main findings of the study. Then, I draw some more encompassing conclusions. Finally, I discuss the limitations of this study and indicate possible future areas of research.

12.1 Polish migrant women and their transnational healthcare practices

In Chapter 2 I outlined the theoretical perspective I took in this study. I looked at healthcare services as important regimes of power in which doctors occupy powerful positions that allow them to exercise control over areas of human life defined as "medical problems". In order to unpack the power relation characterising healthcare and maternity services, I explored theories of medicalisation, particularly those developed in feminist scholarship. These theories looked at pregnancy and childbirth as one of the most thoroughly medicalised areas of "normal" life. Once defined as "medical problems", pregnancy and childbirth ceased to be areas controlled mainly by women and became doctors' areas of expertise.

Despite this shift in power relations and women losing, at least partly, control over their pregnant bodies, most of them embraced the medical approach to pregnancy. As feminist scholars argued (Lock and Kaufert 1998), this was because women started to see medicine as their best chance for healthy pregnancies. However, the degree to which women could continue to exercise control over their bodies and influence their encounters with biomedicine greatly varied and depended on their social position. Indeed, women from

better-off backgrounds had better chances of shaping to their liking their encounters with biomedicine. Thus, while looking at Polish and Irish healthcare services, I conceptualised them as powerful regimes of control that, depending on who engages with them, can be shaped to a different degree.

The concept of medicalisation proved to be a very useful tool in looking at power relations within a single biomedical regime. However, migrant women's transnational healthcare practices bring together two different biomedical regimes (Polish and Irish), therefore need to be approached also from the perspective of healthcare pluralism. The concept of healthcare pluralism allowed me to look at Polish and Irish healthcare services as different "socio-cultural mediations of biomedicine" (MacFarlane and de Brún 2010) that, similar to different healthcare sectors (Kleinman 1980), may offer different interpretations of health problems, treatment options and allow for building different relations between healthcare users and healthcare providers.

In Chapter 3 I detailed the methodological approach I used in this study. As my perspective required attention to larger structural forces as well as to the lived experiences of women, I argued that qualitative methods of research inspired by ethnography provide the most appropriate set of tools to collect data on both these levels. These tools include semi-structured interviews, elements of participant observation and analysis of secondary sources of information. In addition, as I looked at practices that stretched across different locations (various cities in Ireland and Poland) and were informed by ideas and power configurations produced in different places, I employed multi-sited ethnography (Marcus 1995). This method of research allowed me to contextualise the findings from one site with those from the other. In this sense, using Gallo's (2009) terms, my fieldwork in Poland "cross-fertilised" my fieldwork in Ireland and vice versa.

Having set the perspective and the tools of my enquiry, I have then moved, in Chapter 4, to painting a situated picture of the subjects of my study, namely Polish migrant women. As the overwhelming majority of them arrived after the 2004 EU enlargement, I focused on the effect the newly gained social and economic rights had on Polish migrants' trajectories and on the position they occupy in their host society. Indeed, no longer limited by resident and work permits, and with better access to social security services, Polish migrants in Ireland are more likely than their pre-accession counterparts to build their careers or start their families in the host country, or engage in family migration. However, despite these newly gained rights, Polish migrants continue to occupy a much weaker position on the

Irish labour market than the non-migrant population. This is particularly true for migrants with lower levels of education who are much more likely to experience unemployment or engage in the informal economy in order to make a living. Thus, Polish migrants in Ireland constitute a heterogeneous group, ranging from highly-skilled migrants who tend to work closer to their qualification, to migrants with secondary education employed in semi-skilled or unskilled position, to those with vocation education who are more likely than the other groups to find themselves in a precarious position. This heterogeneity in education and employment situations resulted in a heterogeneity of healthcare pathways. Thus, in order to account for this variety, in my study I looked at migrant women from various educational and economic backgrounds, including highly-skilled women, women with secondary education and those with vocational education.

However, in order to understand how migrants' social position influences their healthcare practices, it is first necessary to understand the workings of the healthcare services available to them. This is because the inequalities embedded in healthcare structures determine the impact that social positions have on people's healthcare practices. Thus, in Chapter 5 I discussed the structure of the Irish healthcare services. I showed how the two-tier system resulted in inequalities of access to services. In the case of maternity care, inequalities are partly overcome by the principle of universal access encapsulated in the Maternity and Infant Care Scheme that entitles all women living in Ireland to free maternity services. However, some lines of division persist. In maternity care they are manifested in the continuity of specialist care that is only available to private and some semi-private patients. Also, semi-private and private patients have access to more medical technology than public ones. The type of care women receive strongly depends on their ability to pay for it. As an end result, we have different types of care available to different social groups. This shows that there is no one, universal biomedical regime in Ireland, but there are many different regimes. The most explicit division line runs between patients attending private and public care.

Due to additional barriers that migrants experience in their host country, inequalities in access to healthcare services are exacerbated among migrant populations. Thus, in Chapter 6 I discussed the most important barriers in accessing healthcare in Ireland experienced by Polish migrant women. These barriers included language problems, cultural stereotypes and lack of knowledge of how things work in the host country. At the same time, taking into consideration Polish migrant women's social position, I looked into the different types

of care available to them. I showed how migrant women, in order to overcome the barriers they experience in Ireland and access what they believe is a “better type of care”, turned to Polish healthcare services, either by attending clinics on the occasion of their trips to Poland or by accessing clinics run by Polish doctors in Ireland.

Considering that women’s use of Polish healthcare services, apart from being a response to the barriers women experienced in Ireland, resulted also from women’s preferences for certain types of care available in Poland, in Chapter 7, I discussed the workings of the Polish healthcare services. Although modelled on the principle of universal access, Polish healthcare services are also characterised by sharp inequalities in access. Over the last two decades these inequalities intensified particularly along the division line between patients attending private and public healthcare services. In the case of maternity care, this is most sharply manifested by better access to medical technology, and to more attentive, respectful and “personal” care in private healthcare services. In this sense, private services seem to offer what I called “personal biomedicine” – a type of care that ensures frequent use of medical technology and allows for building personal relations between women and healthcare personnel. Apart from private services, another factor that strongly mediates access to personal biomedicine is social connections. Thus, access to specific enactments of maternity care, out of which personal biomedicine seems to be the preferred one, is strongly mediated by women’s social position, particularly their social connections and ability to pay for private care.

In Chapters 8, 9 and 10 I looked at migrant women’s concrete healthcare practices associated with pregnancy and childbirth as they unfolded in the context of the enlarged EU. I argued that, similar to women living in Poland, migrant’s healthcare practices can also be seen in terms of a quest for “personal medicine”, albeit realised with different tools and in a larger transnational context. In the case of migrant women, this quest takes the form of manoeuvring between Irish and Polish services. Indeed, as I showed in Chapter 8, Polish migrant women did not see Irish prenatal care as offering personal biomedicine and, in order to access this specific type of care, they turned to Polish maternity services. They either used private clinics in Poland or they registered with clinics run by Polish clinics in Ireland. However, as access to those services cost money, poor women were far less likely than middle-class women to seek personal biomedicine by turning to Polish healthcare services. In this sense, for migrant women access to Polish maternity care was also mediated by their social position and dependent on women’s ability to pay.

However, not all migrant women who accessed Polish clinics in Ireland, found them to provide personal biomedicine. As I discussed in Chapter 9, based on the specific position Polish clinics occupy in Ireland, some women questioned their ability to provide personal biomedicine. First, women considered Polish clinics' status of for-profit business catering mainly for migrant population as ruling out the possibility of forming personal relationships between healthcare users and providers. Second, based on the assumption that good doctors make a good living in Poland and those who engage in migration must provide care of questionable quality, women doubted Polish clinics ability to provide their patients with high quality specialist care. Thus, despite their relative popularity among migrant women, Polish clinics in Ireland were not always seen as providers of personal biomedicine.

Finally, in the case of care during labour, it was the Irish, and not Polish, biomedical regime, but Irish one that migrant women perceived as providing them with personal biomedicine. Thus, as described in Chapter 10, women rarely travelled to Poland in order to give birth. Contrary to the popular assumptions held in their home country, Polish migrant women usually relied on Irish inpatient maternity services. Indeed, they perceived Irish care to provide them with much sought specialist care (in the form of epidural on demand) as well as to allow them to build personal relations with healthcare personnel. In this sense, in the case of care during labour, Irish biomedical regime was much closer to migrant women's expectations in regard to personal biomedicine.

As women constantly moved between Polish and Irish healthcare services, they contrasted and commented on the differences between the ways in which these two biomedical regimes regulate women's (pregnant) bodies. While in Chapters 8, 9 and 10 I looked at women's strategies and then situated them in the broader context of Polish and Irish healthcare services, in Chapter 11 I complemented migrant women's perspectives on the differences between the Irish and Polish healthcare services by taking a more structural approach. I showed that certain practices regulating women's (pregnant) bodies, such as the use of prenatal ultrasound scans, and the way women engage with them, may be partly explained by looking at the structural forces. I thus showed how higher rates of specialist doctors and the exclusion of GPs and midwives from the provision of maternity care (as is the case in Poland) may play an important role in encouraging frequent use of prenatal scans. The same applies to the commercialisation of healthcare services (taking place both in Ireland and in Poland), which also encourages the use of medical technology. In contrast, restrictive abortion laws (particularly true for Ireland) may play an important role in

decreasing the use of prenatal ultrasound technology. In this sense, these structural forces play into women's use of ultrasound screenings.

12.2 The diversity of Polish and Irish biomedical regimes

Despite popular assumptions about biomedicine as a “universal” form of healthcare immune to local variations, there are considerable differences among local enactments of biomedicine in terms of what services and therapeutic options they offer to patients in these locations (Good 1995). As my study showed, this is also the case for Polish and Irish maternity services. Informed by different power configurations, Polish and Irish maternity services vary in the ways they regulate women's (pregnant) bodies. This variety is manifested, for example, in diverse screening procedures and therapeutic options offered to pregnant women. Furthermore, women are also likely to be seen by different healthcare professionals or form different relations with their maternity care providers.

In both countries pregnancy is seen as a risky process that requires medical supervision. Irish and Polish biomedical regimes embrace a medical approach to pregnancy and childbirth that considers these processes to be potentially pathological and in need of constant medical control. Thus, in both countries doctors are seen as experts who advise women on these processes, while women are expected to follow doctors' medical advice. There is also very little space for alternative ways of approaching pregnancy and childbirth. However, this medical supervision is differently realised in Ireland and in Poland.

These different realisations are manifested, for example, in the division of responsibility for the provision of maternity care. In the case of prenatal care, in Ireland, visits are usually shared between GPs and obstetricians working at maternity care clinics. Pregnant women attend GP surgeries and maternity care clinics at the hospital, where, if using public care scheme, they may be seen by a different obstetrician or a midwife each time. Thus, apart from visits to their GPs, women using public care scheme in Ireland are not provided with continuity of care and they have very small chances of building personal and enduring relationships with their maternity care providers. In contrast, Polish maternity care services ensure continuity of care. In most cases, women are seen by the same doctor each time they attend a maternity clinic for their scheduled visit. In addition, obstetricians are almost exclusively responsible for the provision of maternity care, because, unlike in Ireland, in Poland GPs are excluded from providing care to pregnant women.

There are also differences in the screening procedures offered to pregnant women. As my study showed, Polish healthcare services seem to offer relatively more prenatal tests than clinics in Ireland. This includes, for example, ultrasound scans and pelvic examinations. Unlike in Ireland, in Poland the latter constitute a standard procedure of every prenatal visit. Furthermore, although there are no explicit data that would confirm the average number of scans offered by the Polish healthcare services to be higher, it was a general perception among the participants of my study that Irish maternity care offers fewer scans than the Polish one.

Control over the female body is also differently realised in care provided during labour. Although in both countries an overwhelming majority of births takes place in hospitals, the two regimes offer different care options. For example, in Ireland epidurals are typically available on demand and without any additional costs. In contrast, in Poland only some hospitals offer epidurals on demand and many of them charge additional fees for it. Furthermore, Irish hospitals typically allow for birth partners to accompany women during labour without any additional costs. In Poland, although the majority of hospitals also allow it, some treat the presence of a birth partner as a private service and charge additional fees.

Thus, this study showed, despite being commonly assumed to be “objective” and “universal”, biomedicine is realised differently in Poland and in Ireland. These different realisations are manifested not only by various therapeutic options that women are offered by healthcare services, but also by the types of relationships that they form with healthcare personnel.

Acknowledging the variety of biomedical regimes seems particularly important at a time of increased mobility fuelled by recent EU enlargements. As new mobile actors, migrants from the NMS often manoeuvre between their home and host countries' healthcare services. Their mobility created a new transnational space in which different biomedicines are brought face to face. Thus, my study argued that, recent Polish migrants, through their manoeuvres between Irish and Polish healthcare services that involved cross-border movement, created a new type of healthcare pluralism, namely, what I called “transnational healthcare pluralism”. As in Kleinman's (1980) model of popular, folk and professional sectors that can be seen in terms of healthcare pluralism because they coexist in a society, providing different interpretations of health problems and offering different solutions, Polish and Irish maternity services also provide different treatment options and

interpretations. Thus, biomedicines from Poland and Ireland can be seen as different healthcare sectors (Kleinman 1980) that are confronted with one another through migrant mobility. The transnational character of this healthcare pluralism is encapsulated in the fact that it is created by transnational movements of migrants.

However, in this study I also argued that variety in the enactment of biomedicine goes beyond the differences between the national realisations of biomedicine. Biomedicine, as it is realised in Poland or Ireland, is not “universal” in each of the two countries. On the contrary, it is prone to variation inside Ireland as well as inside Poland. I have identified two main types of variation: regional variations and variations between public and private care. In Chapters 5 and 7, in discussing the structure of healthcare services in each country, I showed how therapeutic options and types of care differ depending on the region in which they are offered. For example, in both Ireland and Poland midwifery-led care for healthy women is available only in a few places. In other regions healthy women do not have the option of attending midwives for prenatal care and are forced to attend specialist-driven care and give birth in highly medicalised hospital units. Furthermore, in both countries there are also considerable differences in the rates of Caesarean sections offered by maternity hospitals and in the types of medical interventions practiced.

Apart from regional differences, there are also considerable differences between the types of care offered in private and public services. Both Irish and Polish maternity care are characterised by strong divisions between private and private patients (and in Ireland also semi-private). Depending on the type of maternity care scheme that women access (whether they pay for private “packages” at the Irish maternity hospital, attend private outpatient clinics in Poland or pay for private services at public maternity wards in Poland), they are likely to receive different treatment. Indeed, this study showed that, in both countries women paying for private services are likely to experience more medical interventions and access more medical technology. This is most significantly manifested in the frequency of ultrasound scans offered to women in public and private care. Studies showed that women in private care have considerably more scans than women in public care.

Furthermore, women attending private care are also more likely to build more personal relations with their maternity care providers. In Ireland only semi-private and private maternity clinics offer a form of continuity of care. In Poland, although public clinics also offer continuity of care and women attend the same obstetrician at every visit, private

clinics, with longer time slots for consultations, foster relations between women and their healthcare providers. In Poland, these relations are also fostered by a number of private services, including individual midwifery care, that women can pay for in the labour ward. As a result, women paying for private services are more likely to receive more attentive care than women who attend public services.

In this study I looked at the differences in types of care provided in different regions as well as in private and public services in terms of the internal diversification of biomedicine and the resulting healthcare pluralism. This study argued that, taking this perspective allowed us to consider access to particular enactments of biomedicine as being related to social position, connections and the ability to pay for care. These factors lead to the existence of different enactments of biomedicine for different social groups of people.

Thus, apart from national differences in the enactment of biomedicine, biomedicines in Poland and Ireland are even further internally diversified. One of the most important processes that plays a role in this internal diversification of biomedicine is the commercialisation of healthcare. In the case of maternity care, whether women pay for services or access them for free influences the way in which biomedicine is practiced. This is particularly visible in the case of prenatal ultrasound technology and the way it is practiced in private and public care. The popularity of ultrasound scans in private care may be explained by its potential of being a commercial good. As I demonstrated in Chapter 11, apart from being a very important screening tool, ultrasound technology is a procedure that future parents particularly enjoy. This makes it an easy procedure to sell and a potentially important source of revenue for private clinics. In this sense, the internal diversification of biomedicine in the public and private care also stems from larger structural forces and the commercialisation of healthcare.

Migrants' access to particular enactments of biomedicine is even more complicated and unequal than for non-migrant populations. This results from the additional barriers that migrants encounter in the host country, which include language barriers, cultural stereotypes, and migrants' lack of knowledge about local healthcare services. As I showed in Chapter 6, these barriers may have a significant impact on migrants' healthcare pathways. In this sense, migrants are influenced not only by the division lines that characterise the provision of healthcare in their host and home countries and that result in the different availability of biomedicine to different social groups. They are also influenced

by additional barriers specific to migrants that impact on their access to specific forms of care.

Transnational healthcare practices may be seen as one of the ways that migrants use for overcoming these barriers. For example, migrants may travel to their home country to access healthcare services there because, due to language barriers or cultural stereotypes held by healthcare providers in their host country, migrants may assess certain services as unavailable for them in the host country. However, as this study suggested, migrants' transnational healthcare practices are more than just strategies to overcome barriers in access. They are also expressions of migrants' preferences (MacFarlane and de Brún 2010, Migge and Gilmartin 2011). In this sense, migrants' cross-border movement can be seen in terms of their active engagement with and preferences for particular enactments of biomedicine.

So how do migrant women engage with these different enactments of biomedicine? This study showed that they do so by engaging in transnational healthcare practices. These transnational healthcare practices take the form of either accessing healthcare services during trips to Poland or accessing clinics run by Polish doctors in Ireland.

However, Polish migrant women's transnational healthcare practices cannot be seen only in terms of simple preferences for a particular enactment of biomedicine (i.e. Polish or Irish). Rather, as I argued, they should be seen in terms of women's quest for a very specific form of biomedicine that cross-cuts national realisations of healthcare services. I called this particular enactment of biomedicine *personal biomedicine* and argued that it is characterised by two main elements. First, it allows women to build personal relations with their healthcare providers (hence "personal"). Second, it ensures frequent use of medical technology (hence "biomedicine").

Women's expectations towards *personal biomedicine* are at least partly embedded in the inequalities that characterise the provision of healthcare services in Ireland and Poland. The first element of *personal biomedicine*, namely the quest for personal relationships, stems from the assumption that it is only through these relations that women can ensure access to attentive care from the healthcare personnel. This assumption seems particularly true for Polish healthcare services that, as I described in Chapter 7, are strongly embedded in social relations. This embeddedness is manifested by the fact that social connections continue to play a very important role in ensuring access to respectful and attentive care.

“Being anonymous” to healthcare personnel is often perceived as one of the factors that make women particularly prone to mistreatment by hospital staff. Thus, in order to overcome anonymity and ensure better quality of care, women in Poland engage in a variety of “personalising strategies” (Rivkin-Fish 2005, p. 154) that range from paying for private care to attending doctors contacted through family networks and acquaintances.

The second element of personal biomedicine, namely the quest for technologized care, is based on the assumption that medical technology constitutes the most effective, if not the only, tool of minimising risks associated with pregnancy and childbirth. As already mentioned, in both countries the medical model of pregnancy and childbirth occupies a very privileged position. Private services usually offer more frequent use of medical technology than public clinics. Thus, women embracing this medical model often judged the quality of care they receive by the frequency of screening procedures. They engaged in various strategies to increase the use of technology, including paying for private care, attending doctors known for using more medical technology or during consultations asking doctors for additional tests.

The study showed that neither Polish nor Irish healthcare services fulfilled women’s expectations concerning personal biomedicine, but Polish women managed to approximate it between the two. In the case of prenatal care, Polish services seemed to be closer than Irish services to migrant women’s expectations. This was due to three differences between Polish and Irish maternity services that women found particularly important. First, as already mentioned, Polish maternity care ensures continuity of care that fosters personal relations between healthcare providers and women. Seen by different doctors during each of their prenatal visits at maternity hospitals, Polish women found it particularly difficult to build personal relationships with their Irish care providers. In order to ensure some kind of continuity of care, they turned to Polish healthcare services. Second, according to Polish migrant women, Polish maternity services provide more frequent scans than Irish ones. Women perceived Irish maternity care to be very restrained when it came to the use of medical technology. Thus, they turned to Polish services in order to access technology more frequently. Third, unlike in Ireland where GPs provide a part of maternity care, in Poland obstetrician/gynaecologists are exclusive providers of care to pregnant women. This exclusively specialist-driven care in Poland seemed to fulfil women’s need for close medical supervision and frequent use of medical technology.

By contrast, in the case of care during labour, Irish healthcare services seemed to be closer than Polish ones to migrant women's expectations regarding personal biomedicine. Again, as in the case of prenatal care, this was due to the perceived differences in the way care during labour is provided to women in Poland and Ireland. First, women perceived healthcare personnel working on Irish labour wards to be friendlier than those working on the Polish wards, a fact that seemed to satisfy women's need for personal relations. Second, the need for personal relations was also satisfied by what women described as a positive attitude towards birth partners by Irish midwives and doctors. Women believed that this approach contrasted with the one prevalent on Polish labour wards where partners were often perceived as a nuisance. Finally, unlike many hospitals in Poland, Irish labour wards usually offered women epidural on demand. This seemed to satisfy women's need for use of medical technology.

The study showed that, in the context of Polish migrant women's transnational healthcare practices, we cannot talk about simple preferences for either Irish or Polish healthcare services. Rather, we can talk about women's preferences for a particular type of care – “personal medicine” – that are partly fulfilled by both Irish and Polish services. This would suggest that biomedicines, as they are practiced in Poland and Ireland, are not monolithic blocks that can be identified as “more medicalised” or “more personal”. Rather, differences between the particular enactments of biomedicines should be seen in terms of different “areas” or “segments” that may be “more medicalised” or “more personal”. In this sense, prenatal care in Poland seems to be both “more medicalised” and “more personal” than prenatal care in Ireland. By the same token, Irish care during labour seems to be both “more personal” and “more medicalised” than care provided to women during labour in Poland.

12.3 Limitations of the study and directions of further research

As my study is based primarily on interviews with Polish women, it draws mainly on women's declarations and descriptions of their interactions with healthcare personnel and medical technology. One of the possible directions for further research in the area of migrant women's healthcare practices is methodological and includes a turn toward more systematic, long-term participant observation. Participant observation undertaken at outpatient maternity clinics could be a very interesting tool for gathering data on the way women interact with healthcare personnel and medical technology, as well as on the way women interact with other women when waiting for their consultation. This method of

data collection could unearth yet another portion of elements depicting power configurations that characterise biomedical regimes in Ireland and Poland.

Another possible direction of further research is to bring the voices of healthcare professionals to the picture of transnational healthcare practices. This study focused on women and their engagement with and perceptions of the power dynamics characterising biomedical regimes in Poland and in Ireland. Although present, the voices of healthcare professionals are greatly limited. It would be particularly interesting to turn to Polish healthcare professionals in Ireland – those working at Polish clinics as well as those working in mainstream Irish healthcare. It seems that it is through them that the two biomedical regimes meet most explicitly. Thus, looking at Polish healthcare professionals' interactions with the two regimes and their perceptions of these regimes may bring a very interesting insight not only into the way these regimes regulate women's (pregnant) bodies but also into their internal power dynamics. It is the latter point that seems to play a crucial role in situating Polish healthcare professionals (as migrants coming from the NMS) vis-à-vis other doctors working in Irish healthcare services.

This study focused only on women who relatively recently migrated to Ireland. As post-accession migrants constitute an overwhelming majority of all Polish nationals living in Ireland, the participants of this study belong to the majority of Polish migrants living in this country. In addition, as discussed in Chapter 4, due to their recent arrival as well as the new social and economic rights following EU enlargement, most of the participants of my study remained in what Eade et al. (2007, p. 34) called *intentional unpredictability*. One of the interesting research possibilities is to look at the group of more settled Polish migrants and their healthcare practices. Those who arrived in Ireland prior to the 2004 enlargement may constitute such a group. However, it is likely that over the next few years the share of those settled will be greater even in the post-accession migrant group. In the context of such newly settled post-accession migrants, one of the interesting possibilities is to look at how their healthcare practices change over time. It will be worth examining whether they will continue to manoeuvre between the Polish and Irish healthcare services or, as suggested by Osipovič (2013) in the case of Polish migrants living in the UK, their healthcare pathways will become less "messy" over time and more focused on a particular type of healthcare services (Irish or Polish).

Finally, future research may also focus on widening the perspective to include migrants from other NMS (particularly CEE countries). Studies of these migrants' healthcare

practices may provide significant insight into the similarities and dissimilarities between the different biomedical regimes practiced in various CEE countries compared to Irish services. In particular, such a line of research may indicate whether Polish migrants' "messy" healthcare pathways and their search for "personal medicine" are typical only of Polish nationals and, thus, stem from the particular configuration of the Polish healthcare services, or whether other CEE migrants also engage in this type of "mixed" activity. In this sense, a comparative perspective taking into account different CEE country migrants and their (transnational) healthcare practices may provide an interesting insight into the possible similarities (or differences) of how biomedicine is practiced in the East and whether or how it is different from the various enactments of biomedicine in the West.

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Appendix 1: Plain Language Statement (in Polish)

Dziękuję bardzo, że wyraziła Pani zainteresowanie moich projektem badawczym. Pani opinia pozwoli mi lepiej zrozumieć sytuację Polek mieszkających w Irlandii oraz ich doświadczenia z irlandzką i polską służbą zdrowia.

W moich badaniach przyglądam się kwestiom związanym z codziennym życiem Polek w Irlandii ze szczególnym naciskiem na oczekiwania w stosunku do służby zdrowia zarówno w Polsce jak i Irlandii. Staram się zrozumieć zależność pomiędzy zmieniającą się w Polsce sytuacją (zarówno zmieniającą się sytuacją kobiet jak i zmianami ekonomicznymi), migracją, a naszymi oczekiwaniami w stosunku do opieki zdrowotnej.

Ten projekt badawczy jest częścią moich studiów doktoranckich w Szkole Pielęgniarskiej (School of Nursing) na Dublin City University, gdzie studiuję pod merytoryczną opieką Dr Sabiny Stan.

Wywiad będzie trwał ok. godziny, a ja całkowicie dostosuję się do Pani preferencji co do miejsca i czasu. Jeżeli wyrazi Pani zgodę, chciałabym nagrać naszą rozmowę, a potem ją przepisać. Nikt oprócz mnie nie będzie miał dostępu do tych nagrań (po przepisaniu zostaną zniszczone) i przepisanych wywiadów. Wszystkie wypowiedzi będą poufne i anonimowe. Nie użyję prawdziwych imion, ani nie ujawnię żadnych danych, które mogłyby prowadzić do odkrycia tożsamości moich rozmówczyń.

Na każdym etapie naszej rozmowy może Pani odmówić udzielenia odpowiedzi.

Jeżeli, na jakimkolwiek etapie mojego projektu, zdecyduje się Pani wycofać, ma Pani do tego całkowite prawo, a wywiad z Pani udziałem zostanie zniszczony i żadne opinie nie zostaną użyte.

Jeżeli ma Pani jakiegokolwiek pytania, bardzo chętnie na nie odpowiem (Maria Węgrzynowska, maria.wegrzynowska@mail.dcu.ie). Jeżeli miałyby Pani jakieś uwagi, pytania, komentarze, może także skontaktować się Pani z moją promotorką (Dr Sabina Stan, sabina.stan@dcu.ie)

Jeżeli ma Pani jakieś uwagi i chciałaby Pani skontaktować z osobą niezależną, proszę o kontakt:

The Secretary, Dublin City University Research Committee, c/o Office of the Vice-President
for research, Dublin City University, Dublin 9. Tel 01-7008000.

Serdecznie dziękuję!

Maria Węgrzynowska, PhD Candidate, School of Nursing, Dublin City University

Appendix 2: Plain Language Statement (in English)

Thank you very much for expressing interest in my research project. Your opinions will help me understand the life of Polish women in Ireland and their experience of the Irish and Polish healthcare systems.

This research explores the experiences of Polish women in Ireland and examines the link between their usage of the healthcare system, the changing situation in Poland and Ireland, and migration.

This research is part of my PhD at the School of Nursing at Dublin City University, Ireland and it is supervised by Dr Sabina Stan.

The interviews will take approximately one hour at the time and place most convenient to the participant. If agreed by the participants, the interviews will be taped and then transcribed. I will be the only person with the access to tapes and transcriptions. All answers will be confidential and identities of the participants will be protected. I will not use the real names of the participants or reveal any information that can lead to the identification of a participant's identity.

You are free to refuse to answer any question or end the interview at any time.

If, at any time, you would like to withdraw, you are free to do so. There will be no penalty for withdrawing before all stages of the study have been completed.

If you had any question, please do not hesitate to contact me (Maria Węgrzynowska, maria.wegrzynowska2@mail.dcu.ie) or my supervisor (Dr Sabina Stan, sabina.stan@dcu.ie).

If you have any concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Committee, c/o Office of the Vice-President for research, Dublin City University, Dublin 9. Tel 01-7008000

Thank you very much!

Maria Węgrzynowska, PhD Candidate, School of Nursing, Dublin City University

Maria.wegrzynowska2@mail.dcu.ie

Appendix 3: Interview guide (migrant women)

Interviews themes for Polish migrant participants:

1. Socio-demographic information
 - a. Age, education, occupation (Poland and Ireland), marital status, place of origin in Poland, experience of previous migration
2. Migration to Ireland
 - a. Reasons and preparation for migration (job, apartment, money, family and friends networks)
 - b. Impressions about Ireland (lifestyle, socialising patterns, work)
 - c. Settling down in Ireland/maintaining connections with Poland
 - d. Plans for the future
3. Pregnancy and family plans
 - a. Migration and decisions about starting the family (Poland/Ireland comparison)
4. Healthcare
 - a. Polish healthcare – patterns of access to Polish healthcare services (how often/where/when; GP/specialists; private/public; use of alternative care (family, folk medicine etc.))
 - b. Use of Polish clinics in Ireland
 - c. Irish healthcare – experience with the Irish healthcare services (how often/where/when; GP/specialists; private/semi-private/public; use of alternative care (family, folk medicine etc.))
5. Perceived differences between Polish and Irish healthcare services and maternity care (midwives/ maternity programmes)

Appendix 4: Interview guide (healthcare professionals)

Interview themes for healthcare professionals

1. Socio-demographic information
 - a. Education, position, gender
2. Healthcare
 - a. History of engagement in the area of women's health
 - b. Experiences with other than Polish healthcare services (comparisons)
 - c. Experiences of caring for migrant groups (especially Polish migrant women living in Ireland)
 - d. Engagements with doctors working abroad
3. Perceived differences between Polish and Irish (or more generally western) healthcare services

Appendix 5: Migrant women participating in the study

Migrant women living in Ireland

No.	Pseudonym	Education and employment situation	Migration trajectory
1.	Karolina	Third level education in history, stay-at-home mother ²⁶ of one child.	Arrived in Ireland in 2009. Plans to stay in Ireland.
2.	Łucja	Third level education in banking, stay-at-home mother of one child.	Arrived in Ireland in 2006. Plans to move with her family to another country.
3.	Ewa	Vocational education, unemployed or in casual employment, mother of one child.	Arrived in Ireland in 2006. Plans to move back to Poland at some point in the future.
4.	Jagna	Secondary education, former factory worker, unemployed, at the time of the interview pregnant with her first child.	Arrived in Ireland in 2004. Plans to move back to Poland at some point in the future.

²⁶ Women whose employment situation I have described as “stay-at-home mother” were neither employed at the time of the interview, nor they were actively seeking employment. Most of them were employed before they had children and, during the interview, declared that they would like to find employment at some point in the future.

5.	Lidia	Secondary education, worked in a cafeteria, stay-at-home mother of one child.	Arrived in Ireland in 2006. Plans to move back to Poland at some point in the future.
6.	Halina	Secondary education, worked as a care assistant, stay-at-home mother of one child.	Arrived in Ireland in 2005. Plans to stay in Ireland.
7.	Patrycja	Secondary education, shop assistant, mother of one child.	Arrived in Ireland in 2007. Plans to move back to Poland at some point in the future.
8.	Kinga	Secondary education, shop assistant, at the time of the interview pregnant with her first child.	Arrived in Ireland in 2008. Plans to move back to Poland at some point in the future
9.	Monika	Vocational education, stay-at-home mother of three children.	Arrived in Ireland in 2008. Plans to move back to Poland at some point in the future
10.	Wiktoria	Third level education in psychology, administrative worker, mother of one child.	Arrived in Ireland after the 2004 EU enlargement. Plans to move back to Poland at some point in the future
11.	Natalia	Secondary education, receptionist, frequent user of healthcare services, no children at the time of the interview.	Arrived in Ireland in 2001. Plans to stay in Ireland or move to another country in the future

12.	Olga	Secondary education, former office assistant, stay-at-home mother of one child.	Arrived in Ireland in 2005. Plans to move back to Poland at some point in the future
13.	Sandra	Vocational education, fast food restaurant worker, mother of one child.	Arrived in Ireland after the 2004 EU enlargement. No fixed plans.
14.	Oliwia	Secondary education, receptionist, mother of one child.	Arrived in Ireland in 2010. No fixed plans.
15.	Asia	Secondary education, stay-at-home mother of two children.	Arrived in Ireland in 2008. Plans to move back to Poland at some point in the future
16.	Kamila	Third level education in biology, stay-at-home mother of two children.	Arrived in Ireland in 2006. Plans to move back to Poland at some point in the future
17.	Gabrysia	Vocational education, former shop assistant, stay-at-home mother of one child.	Arrived in Ireland after the 2004 EU enlargement. Plans to move back to Poland at some point in the future
18.	Tonia	Third level education in psychology, social worker, mother of one child.	Arrived in Ireland after the 2004 EU enlargement. Plans to move back to Poland at some point in the future

19.	Zuzia	Third level education in linguistic, IT company worker on maternity leave, mother of one child.	Arrived in Ireland in 2004. No fixed plan
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Returned migrants

No.	Name	Education and employment situation	Migration trajectory
20.	Alicja	Third level education in physiotherapy, physiotherapist, mother of one child.	Moved to Ireland in 2004. Returned to Poland in 2007 due to complication in her pregnancy.
21.	Michalina	Third level education in education, secondary school teacher, mother of one child.	Moved to Ireland after the 2004 EU enlargement. Returned to Poland in 2010 with her husband to pursue their careers and start a family
22.	Emilia	Third level education in psychotherapy, psychotherapist, mother of two children.	Moved to Ireland in 2006. Returned to Poland in 2008 with her husband to pursue their careers and reunite with their families.

