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Matters of "Conscience":

The Politics of Reproductive Healthcare in Poland

The fall of state socialism in Poland in 1989 constituted a critical moment that redefined policies regulating reproductive health and access to care. As the Polish state adopted the discourse and agenda of the Catholic Church in its health policies, reproduction and sexuality became sites of moral governance through the implementation of the Conscience Clause law, which permits healthcare providers to deny medical services citing conscience-based objections. Based on ethnographic fieldwork, this article explores the effects of the implementation of the conscience clause and argues that the adoption of this law for individual use paved the way for restrictions on reproductive healthcare on a systemic scale. The special status afforded to the church is highly significant for access to health services deemed by the church to be matters of morality. The Polish case raises concerns about the place of women's rights in postsocialism and the nature of Polish democratization.

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Since the fall of state socialism in 1989, access to reproductive health services has become a major concern for women in Poland. As the Polish state adopted the discourse and agenda of the Catholic Church on reproduction in its health policies, reproduction and sexuality became sites of moral governance via the Conscience Clause law *(Klauzula Sumienia),* which allows doctors to refuse health services because of conscience-based objections, and the abortion ban that followed. On the basis of ethnographic fieldwork, I trace the shaping of the church-influenced restrictions on reproductive services, and then examine the ways in which the new policies are affecting Polish women's access to abortion and family planning, and how women circumvent the new legislation by pursuing services clandestinely. Despite significant protests, the postsocialist reproductive policies have been implemented without a referendum, even though opinion polls at the time indicated that the restrictions do not reflect the will of the population. The Polish state has not balanced the rights of women to reproductive welfare and self-determination against the political agenda of the church to enforce its religious morality through policies. The case of Poland not only raises concerns about the place and the

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future of women's rights in postsocialism, but it also highlights the limits of liberal democracy.

The fall of state socialism in Poland in 1989 constituted a critical moment that redefined not only political and economic rule but also policies regulating reproductive and sexual health and rights. During the pre-1989 state socialist period, the state considerably increased women's reproductive and sexual autonomy, and, most critically, abortion for socioeconomic reasons was legalized in 1956 for pregnancies up to 14 weeks and was offered free of charge in all public hospitals. Approximately 97 percent of all abortions were performed on social grounds between 1956 and 1989 (Niemiec 1997; Zielińska 2000). The state openly endorsed family planning and sex education and established subsidies for both. In 1959, a law was passed requiring doctors to inform women who had just delivered a child or had an abortion about their contraceptive options, and the state's healthcare system began to cover 70 percent of the cost of prescription contraceptives. The Society for Conscious Motherhood *(Towarzystwo Świadomego Macierzyństwa)* formed with the explicit approval of the state, and the group began receiving subsidies for its nationwide network of family planning clinics (Mazur 1981:5). Sharply breaking with the previously dominant discourse on the primacy of motherhood, the Polish state offered women greater reproductive and sexual autonomy, keeping in step with the socialist gender equity rhetoric. These shifts also reflected the secular ideology of the regime, which exercised the first separation of church and state in Poland's history.

Simultaneously, the political involvement of the Catholic Church was restrained by the secular state as the two entities entered into a relationship best characterized as, what anthropologist Mart Bax calls, "antagonistic interdependency," whereby the state recognized the church's national importance owing to its historical participation in struggles against foreign occupiers, and the church understood its own dependence on the state for survival in socialism (Bax 1991; Gautier 1997; Swatos 1994). The antagonistic character of the two institutions was rooted in their competing visions of secular modernity and Catholic traditionalism, with tensions displayed in both rhetorical and practical terms. To establish some terms of coexistence, the church and the state signed a Modus Vivendi—a working agreement containing several compromises. The state gave in on the issues of public worship, religious education in schools, and the retention of church property but held its position on liberalized family planning policies, among other things. The church's disagreement with the state's reproductive policies was evident in direct appeals to parishioners by the clergy who spoke strongly against abortion but rarely attacked the policy itself (Swatos 1994). The Polish Church was silent on the issue until 1984, when Cardinal Józef Glemp waged the first serious campaign to outlaw abortion. Małgorzata Fuszara, a prominent Polish gender studies scholar and a sociologist, recalled it in the following way:

> The Church didn't talk about abortion before '89. The Pope, when he was in Poland in '79, didn't talk about abortion. He talked about it in the US and in Western Europe, but never in Poland. As soon as the political situation changed, the first projects were to restrict abortion. Clearly, the Church was waiting for the right moment. [interview, Małgorzata Fuszara, 2002]

Indeed, the immediate postsocialist period between 1989 and 1993, strongly influenced by Catholic nationalism, brought critical transformations in policies regulating reproductive and sexual health and rights. The rise of nationalism so evident at this time was not unusual for Poland as many nations of the region began to redefine themselves as sovereign (Gal and Kligman 2000; Nagengast 1994). Given that the Polish Catholic Church provided substantial support to the oppositional Solidarity *(Solidarność)* movement—itself a Catholic–nationalist organization—during the 1980s against the state socialist regime, it was not surprising that the church had a major say in the postsocialist reforms once Solidarity-derived politicians assumed power. The involvement of the church in Polish politics resulted from a long-term effort of the church, beginning in 1918, to establish itself as a political actor not just in relation to the state, but also within the state structure itself. After 1989, the clergy secured positions of experts on bioethics in the Ministry of Health consequently involving the church in matters of "morality," that is, reproduction and sexuality.[1] Current laws reflecting the role of the church in the moral governance of reproduction over the last 19 years include a near-total ban on abortion instituted in 1993, restrictions on contraceptives, and the elimination of sex education from schools.

Of particular importance in regulating reproductive and sexual conduct was the implementation of the Conscience Clause law. The clause, written into the postsocialist Medical Code of Ethics in 1991, provides that "a physician can withhold healthcare services which are not in agreement with his conscience," but must make a referral elsewhere where there are "realistic possibilities of obtaining such healthcare" (Nesterowicz 2001:340). It will become evident that, although the clause was designed for individual use, it facilitated the withholding of medical services on a systemic scale, and ultimately served paved way for the abortion ban of 1993.

These restrictions on access to family planning in Poland are best understood within the broader economic context of postsocialism. Polish women experienced dwindling financial resources as a result of neoliberal transformations to the market economy because of harsh reductions in maternity and social service provisions since 1989 (Domanski 2002; Fodor 2002; Fodor et al. 2002:477–483; Kocourkova 2002; Tarkowska 2002). In fact, although women across East Europe became the new economic "underclass," the situation is far worse in Poland where women have twice the likelihood of falling below the poverty line than men (Domanski 2002:393) and constitute the majority of the unemployed because of particularly acute gendered discrimination in the workplace (Molyneux 1995; UNICEF 1999; Zajicek and Calasanti 1995). Cutbacks in social services and the worsening economic situation of women further confine their reproductive choices, because, as will be explained later, women with sufficient financial means have greater ability to circumvent restrictions on abortion by pursuing services clandestinely.

This study reveals the reciprocal effect of how politics affects reproduction and how reproduction is used instrumentally and symbolically in the political process of power consolidation, which remains underexplored in anthropological literature of East Europe, although it has been examined elsewhere in Europe, especially in Italy and Ireland (Gal and Kligman 2000:17; Kolchevska 2005:2). Feminist scholar Natasha Kolchevska argues (2005) in her recent review of gender as an analytic category in Slavic Studies scholarship that research on East Europe continues to

be dominated by topics of national identity and nationalism, whereas gender remains an understudied area. Sociologist Gail Kligman's ethnographic study (1998) of reproductive rights restrictions in Ceauşescu's state socialist Romania constitutes the only notable ethnography of East Europe that demonstrates both the effects of pronatalist laws on Romanian women and the ways in which political agendas have been molded by reproduction. Specifically, Kligman's study investigated the effects of Ceauşescu's pronatalist regime on women's ability to control their reproduction and maintain health in state socialist Romania. The ethnography revealed the workings of a severely oppressive antiabortion state in the Soviet bloc (and the only one that banned abortion) and its impact, which included a surge in maternal mortality because of illegal abortions, a rise in infant abandonment, and an epidemic of infant HIV infections.

Demonstrating the ineffectiveness of even the most restrictive abortion policies in stimulating birth rate (which Ceauşescu had hoped would result), Kligman showed how women turned to clandestine abortions even under the most dire and risky of circumstances, and how physicians, risking imprisonment, subverted the law by providing care. She observed that, although these "duplicitous practices" by Romanian women and doctors were "structurally determined survival mechanism[s]" and were intended to manipulate the system that also manipulated them (Kligman 1998:14–15), they created a kind of public complicity with Ceauşescu's regime. As compared to the postsocialist restrictions on abortion in Poland, the main difference lies in the role of religious institutions in shaping reproductive regulation—Ceauşescu's thrust was to maximize population growth as a way to achieve national greatness, while the emphasis in Poland has been on the morality of reproductive conduct.

This study therefore, also contributes to scholarship on the influence of institutions on women's health, in particular the influence of religious institutions on shaping policies regulating reproduction and sexuality. A recent review of the major themes on the topic of women's health in ethnographic literature reveals substantial scholarly attention to the way local religious and moral constructions influence women's health, but it also points to a relative dearth of studies examining the influence of religion as an institution (Inhorn 2006). Studies of religion often focus on systems of meanings, but a lesser emphasis is placed on power. Considerations of power in the context of church–state relations and reproduction are especially relevant in cases of Ireland and Italy.

Ireland's restrictive reproductive policies in a strongly Catholic context offer an instructive comparison with Poland. Abortion became a criminal offense in Ireland in the 19th century, and the current law is the most severe in Europe, making the doctor and the woman liable to life imprisonment (Yishai 1993:212). Even though Ireland's constitution contains a clear church–state separation, the law explicitly incorporates Roman Catholic morality and language. Irish women primarily rely on abortion tourism to England and Wales where they receive the services legally. The analysis of the rise of the Catholic Church in Ireland by Tom Inglis (1991) shows that in the 19th century the church assumed a major political role when the colonizing English State shifted its policy from repression to pacification and control of the Irish people.

England saw the church and its increasing organization as a competent vehicle through which the Irish could "become civil and morally respectable as other

modern Europeans" (Inglis 1991:56). Thus, the church was given control of social services, especially education, health, and social welfare—the perceived vehicles of civility. The case of Ireland is instructive as juxtaposed against that of Poland: while the Irish Church enjoyed an uninterrupted rein since the 19th century and therefore easily maintained its political power to regulate reproductive laws, the Polish Church suffered 50 years of political weakness in matters of reproductive policies, yet it resurged with a remarkable force in postsocialism, which calls attention to the church's political astuteness and its long-term vision.

David Kertzer's historical investigation (1993) of ways in which Catholic morality shaped Italian policies regulating women's bodies in the 19th century offers another valuable study of church–state relations and their impact on reproductive options and behavior. Kertzer's archival research revealed a pervasive abandonment and subsequent high mortality of infants in Italy in the 1800s. Because unwed mothers were perceived as morally corrupt by the Catholic Church, the church, working in tandem with the Italian state, institutionalized the abandonment of infants into foundling homes as a way of "atoning for their [mothers'] sins, avoiding 'public scandal,' and preventing a child from being raised outside the church-approved family" (Kertzer 1991:11). Women were policed by state officials, often working through local midwives, who aimed to ensure that unwed mothers gave up their "illegitimate" children. When it became apparent that lactating women were needed to sustain the infants, many of the same unwed mothers were coerced into becoming wet nurses at foundling homes but prevented from nursing their own babies because the authorities feared they might become emotionally attached.

The trauma that was inflicted on women is captured by anthropologist Elizabeth Krause in her ethnographic examination of memory of "the trade in milk and foundlings," which suggests that the suffering that women endured led many to eventually embrace small families, which in turn might be reflected in today's very low birth rate in Italy (2007:414). Whereas the Italian state was the primary executor of the foundling policy, the religious regime played a decisive role in infusing the policies with religious gender norms and promoting the system of surveillance.

Relative to the case of Poland, the analyses of Ireland and Italy are inspiring in the way they reveal the need to better understand the relationship between the church and the state, and its various and complex effects that are reflected in contemporary reproductive policies and behaviors.

Therefore, in this study I demonstrate, borrowing from anthropologists Mart Bax (1991:9–10) and Eric Wolf (1991), that the institutional regime of the Polish Catholic Church is "a political constellation" involving "the formulation of ideologies and the working out of tactics and strategies of 'how to fight and how to win'" to expand power from a centralized structure to broadly dispersed mechanisms of control. I show that these mechanisms are situated at the level of reproductive healthcare and reveal the ways in which such methods have a gender-specific target and effect, ultimately calling attention to the implications of Poland's embrace of the church and its rejection of women's concerns for the democratization process.

In the first section below I describe the research methods and the sample population. The second section examines the reproductive rights reforms and explains how the Conscience Clause law paved the way for systemic limitations on access to reproductive healthcare. Third, I demonstrate the effects of the new policies and

the way women negotiate the new environment; in particular I investigate the emergence of the abortion underground. The final section connects these findings to some present-day developments and the broader context of postsocialist democratization in Poland.

Methods

The findings in this article draw on 19 months of ethnographic fieldwork in Krakow, Warsaw, and Gdańsk. I conducted research in the summers of 2000 and 2001, throughout 2002, and in the summer of 2007. This article relies on findings from participant-observation and in-depth interviews with 123 women from a range of socioeconomic backgrounds (36 women of lower-, 63 of middle-, and 24 of upper-socioeconomic stratum). In addition to drawing the sample from a number of initial contacts (seeds) I established in 2000 and 2001, I conducted fieldwork in two social service offices in Krakow in neighborhoods of Podgórze and Nowa Huta. My interviews with women generated rich qualitative data about life stories, memories of state socialism, reproductive desires and decisions, experiences with family planning and medical care, and understandings and meanings of abortion policies, feminism, and women's activism.

I also interviewed 26 physicians specializing in obstetrics and gynecology and six family planning instructors in three major healthcare facilities: the Greater Krakow OB-GYN Clinic, the Wawel Medical Specialty Clinic, and the Małopolska Pro-Family Health Clinic. Being a native Polish speaker allowed me to conduct all of the research in Polish. These interviews probed the meanings that doctors attached to the reproductive health reforms implemented in the 1990s and the effects such meanings had on their provision of women's care. In particular, I focused on whether doctors identified with the Catholic restrictions on reproductive healthcare and on the degree to which their own provision of care was governed by their religiosity. For the purposes of this article, I focus on religiosity as it is manifested in the public rather than private realm, that is, as the individual intensity with which doctors embraced Catholic tenets in their medical practice.

Additionally, I conducted research in three women's rights NGOs: Women's Foundation eFKa, Women's Rights Center, and the Federation for Women and Family Planning. I spent a significant amount of time conducting participant-observation, semistructured interviews, and informal conversations, as well as reading documents and archived press articles on issues concerning women's and reproductive rights and health. I also analyzed demographic, statistical, and policy documents generated by the Polish state, the European Union, and the Vatican.

The names of all interviewees have been changed, except for those who agreed to speak on record—Wanda Nowicka, Kazia Szczuka, and Małgorzata Fuszara. The addresses of clinics and their names have been modified or given pseudonyms.

From Individual Objections to Systemic Restrictions

When the state socialist regime fell in 1989, the primary goal of the church's lobbying was to restrict access to abortion. Women quickly found that the security of their rights during the socialist era was predicated on a particular political rhetoric of

gender equity granted in a top-down approach by the socialists,[2] and they learned of their rights' fragility only when the church regained dominance after the power shift of 1989. According to Wanda Nowicka, the director of the Federation for Women and Family Planning (FWFP), women's shock at the new proposals was profound:

> It was as if people simply couldn't get their minds around the idea that an abortion ban could happen, that such a thing is possible. Many people, especially on the left, were simply unprepared to respond to the upsurge of the right-wing Church machinery and the wave of moralization that came with it, despite the whole debate, so it came as a shock. [interview, Wanda Nowicka, 2007]

Within a year of the transition, under the pressure from the church, the state acquiesced by implementing an executive order requiring women seeking abortions to get permissions from two gynecologists, a physician, and a psychologist, rather than from just one physician, as was the case until then. Abortion was still permissible on social grounds alone, but the new difficulties in accessing the service set off a fierce protest from the Solidarity Women's Section; the group was promptly dissolved for divisive "politicking" (Long 1996:171; Nowicka 2001:232–233; Penn 2005:288–290).

Although the new mandatory consultations were state subsidized, it took a considerable amount of effort and time to carry out all four visits before the 14-week time limit elapsed. Moreover, if any of the providers denied permission (judging, for example, that the economic hardship presented as the reason for seeking abortion sounded unconvincing or was not sufficiently severe), the time that lapsed seeking further appointments made it difficult to complete the required visits in the allotted time, thus placing considerable limits on the right to seek abortion.

The most crucial development in restricting family planning access was the implementation of the Conscience Clause. In 1991, the church pressured the medical establishment to modify their ethics regulations by mobilizing the Catholic factions within the medical community. As a result, an emergency conference to discuss new medical ethics was organized by a group of Catholic physicians, and the resulting Extraordinary National Assembly of Physicians concluded with the adoption of the new Medical Code of Ethics. The new code included two relevant elements: the Conscience Clause law and a restrictive new code specifically on abortion, which stated that only life- or health-threatening circumstances or a pregnancy from a crime could warrant a termination. A substantial group of doctors at the Assembly strongly opposed the latter, in particular since the restriction proposed in the code was in direct violation of the Polish abortion law, which at that time still allowed socioeconomic hardship reasons for the procedure. Forty delegates walked out of the Assembly in protest of the proposal's undemocratic process, effectively excluding themselves from the vote on the new code, which ensued anyway. Thus only doctors who favored abortion restrictions voted on the code (Nowicka 1994; Regulska 1998; Szawarski 1992). The dispute between the Catholic Assembly and Poland's Civil Rights Ombudsmen, Ewa Łętowska and later Tadeusz Zieliński, about the legitimacy of the new Medical Code of Ethics continued for a while, but in the meantime the Catholic Members of the Parliament proposed a bill banning abortion

(Rich 1992:1221). Strikingly, the limitations on abortion in the Medical Code of Ethics was nearly duplicated two years later, in 1993, by the new law banning abortion in nearly all circumstances.

The Conscience Clause inscribed in the new Medical Code of Ethics triggered a surge of refusals of services in cases of abortion in hospitals (still permissible for hardship reasons until 1993, and then narrowed to a few exceptions), prescription contraceptives, and emergency contraceptives (Nowicka 2008a:34–35). The clause specifies the following regulation of a conscience-based objection:

> A physician can withhold healthcare services which are not in agreement with his conscience (with the exception described in Article 30). He has the obligation to indicate realistic possibilities of obtaining such healthcare services from another physician or in another healthcare facility as well as he has the obligation to substantiate and document this fact in the medical documentation. The physician who works in a capacity of an employee also has the obligation to inform his superior in writing prior to declining the service.[3]

Although it specifies the allowance for an individual physician, the clause quickly became a tool of denying care on a more systemic scale than if an objection was utilized by a particular doctor in a particular case. In fact, in the years before the ban took effect, the clause was used to restrict abortions that were still legal; the large drop of legally performed procedures recorded by the state from 105,333 in 1990 to 11,640 in 1992 reflects this phenomenon (U.S. Census Bureau 1995).

The shift from individual objections to systemic restrictions became evident as entire healthcare facilities began to withhold abortion services via directives imposed on gynecologists by the management. The example of the Greater Krakow OB-GYN Clinic is emblematic of how the clause was used in the early 1990s as recalled by one of the managing doctors of the facility whom I interviewed about the events following the implementation of this law:

> Author: How did the healthcare community here react to the Conscience Clause?
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> Dr. Dembski: This building where we're talking right now on Szopena Street number 78, the Greater Krakow OB/GYN Clinic, was one of the first in Poland where we adopted a moratorium on abortion in accord with the new Conscience Clause [policy]. So even before the law banning abortion was in place, in this building abortions for social reasons were no longer performed. That's because people who didn't want it done here began to have a voice.
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> Author: You mean doctors?
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> Dr. Dembski: Yes, of course doctors, but also the society.
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> Author: And that was before the abortion ban?
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> Dr. Dembski: Yes, it was two or three years before, because we had the so-called moratoria and this was done in two or three hospitals besides ours

> in Krakow. And a number of clinics also decided to adopt a moratorium on abortion.

Another doctor in the same facility recalled the situation as follows when I asked her how the Conscience Clause policy was received:

> We received the news of the [Conscience] Clause with great joy. Granted, a number of doctors here used abortion for financial profit, but the rest of us felt that our conscience was being violated because, truth be told, everyone who participated in abortions, or who assisted, be it a doctor or a nurse or an anesthesiologist, acted unethically.

Not all doctors agreed with this view. Some understood the law as a divisive wedge and an imposition of a particular morality on the medical community. As one doctor explained, "the Conscience Clause and the subsequent abortion law polarized the medical community because of the severity of the restrictions that were suddenly in place but also because the laws were ideologically driven." Another doctor noted that "in Krakow, the restrictions are especially ideology based because the bishop and the clergy are particularly vocal against contraception and abortion."

The Conscience Clause paved the way for the abortion ban implemented in 1993. At the outset, the Polish Episcopate lobbied Members of the Parliament belonging to the Polish Catholic and Social Association to draft and file the "Law on the Legal Protection for the Conceived Child." Opponents of the ban requested a nationwide referendum given that public opinion surveys at the time showed 82 percent of Poles opposing a total ban on abortion, and 60 percent favoring legal access to abortion with no or minimal restrictions (Nowakowska and Korzeniowska 2000:219–225). At the height of the debate, women's organizations led by the Federation for Women and Family Planning formed the Committee to Create a Referendum and collected 1.3 million signatures (well surpassing the 500,000 signatures needed under the Polish Charter of Civil Rights) to put the bill to a nationwide vote. Nevertheless, the conservative Prime Minister Suchocka (who later became the Polish ambassador to the Vatican) rejected the petition; a referendum was never held and the abortion ban was passed in 1993 (Fuszara 1991; Nowakowska and Korzeniowska 2000; Sieminska 1994; Zielińska 2000).

The abortion debate continued, however, and in 1996 the Polish Parliament, temporarily holding a left-leaning majority supported by President Kwaśniewski, passed the Family Planning Act, which liberalized the 1993 law by permitting abortion for socioeconomic reasons. But only a year later, parliamentary power shifted once again in favor of the Catholic–nationalist Solidarity Election Action (AWS), which promptly took the liberalized abortion law to the Constitutional Tribunal. The Tribunal restricted the law back to its 1993 form, claiming socioeconomic reasons for abortion to be unconstitutional and justifying its unilateral action by declaring that moral issues cannot be subjected to a popular vote (Zielińska 2000:34). The position of the Tribunal, consistent with the dominant rhetoric of the early 1990s when the initial restrictions were being implemented, made it clear that reproduction was now firmly established in the political rather than the health realm. The Tribunal, embracing the absolute morality of the church, depicted all matters of reproduction

and sexuality as proper objects of political regulation, rather than decisions that can be left to an individual's conscience.

Many women in the feminist movement recalled a sense of having lost the language with which to speak about reproductive rights during this time; as one activist remarked, before 1989 "abortion wasn't weighted down by the language of morality, that it's the killing of the unborn. Before, it was a normal thing, part of everyday life. Since then it became a sin" (interview, Renata Dąbrowska, 2002). Kinga Dunin, a long-standing feminist activist and a journalist, recalled her experience: "The language with which we talked about abortion was taken away from us. It became 'life is sacred' and 'killing is bad.' So if I'm agreeing that abortion is bad because I'm killing, then every argument in favor of abortion access doesn't work, because: If it's bad, then why do it?" (interview, Kinga Dunin, 2002).

The current law makes abortion illegal in all but three cases: when the woman's life or health is in danger, when a prenatal test shows a serious incurable fetal deformity, or when the pregnancy is the result of rape or incest and has been reported to the police. Because of potential complications, all terminations in the first two cases can only be carried out in a hospital.

Although the church was decisive in initiating and shaping the law, the Episcopate was displeased with the three exceptions contained in the final version of the bill as the church wished for a complete ban, even in life-threatening cases. However, opinion polls suggested that the life, health, severe fetal deformity, and crime exceptions were strongly favored by the population, the majority of which opposed restrictions on abortion to begin with. In the end, the church backed away from insisting for a total ban (Nowakowska and Korzeniowska 2000:219–225). Despite these exceptions, the Polish abortion law is the most restrictive in Europe outside of Ireland.

Just as the Conscience Clause paved the way for the abortion ban, the law continues to be evoked to further limit the narrow range of abortions still legally permissible. According to Wanda Nowicka, the research conducted by the FWFP showed that physicians who choose not to perform legally permissible abortions typically also do not refer women to other facilities, leaving them without recourse, even though doctors are legally obligated to provide a "realistic possibility" for the procedure elsewhere. Here she explained how this law translates into a denial of reproductive care on a large scale in public hospitals:

> The most problematic issue is that the Conscience Clause objection is practiced by the entire hospital, not by individual doctors, [. . .] which, of course, goes against the individually based nature of the Clause. If the head of a particular hospital is against abortions, he or she declares on behalf of the whole personnel that abortions are not performed in this hospital. Period. End of conversation. Individual doctors who have opposing opinions never speak up in favor of abortions because they risk losing their jobs. Doctors who participated in the two studies that we did confirmed that such practices exist to a great extent. [interview, Wanda Nowicka, 2002]

The FWFP has been forwarding their survey results to the Ministry of Health hoping to spotlight the routine denial of legally sanctioned services. In 2003, the Minister of Health, Marek Balicki, himself a physician, publicly acknowledged the existence of this phenomenon and released a formal letter to the governors of all provinces in Poland urging that they "remind the public healthcare facilities providing gynecological and obstetrical services [. . .] about the unconditional obligation to adhere to the [abortion] law," which allows for three circumstances under which abortions are legal. He noted that "it was disconcerting to see that women have difficulty in exercising their right to obtain abortions in those cases that are permitted by the law," that they lack "free access to information" and "free access to means of family planning."[4] He also stated that the clause may not be applied "at will." Instead, he said,

> [it] refers exclusively to a specific physician in a specific case, and under no circumstances could be used by an entire clinic or hospital based on the idea of collective conscience of the facility via a general directive of the head of the clinic.[5]

Despite Balicki's statements, no obvious or tangible consequences to his action emerged given his negligible power and means to enforce the law. Although he was a member of the Democratic Left Alliance (SLD) Party and served in a leftist administration ruling at the time, he was in the minority in his public advocacy for reproductive rights and thus had little power to enforce his position. Violations of the clause per se have not been challenged in court thus far, though several cases of violation of the referral requirement have been reported. Most recent of these was the case of Agata, a 14-year-old girl who got pregnant as a result of rape and, with the help of her mother, pursued abortion in the local hospital in Lublin. During the short time that Agata was admitted to the hospital to await the decision of the director, priest Krzysztof Podstawka was called, who then attempted to convince Agata to carry the pregnancy to term. The hospital's director, Jacek Solarz, declared that the doctors in his facility would not perform the procedure or provide a referral. The Federation for Women and Family Planning appealed to the Minister of Health, the Bureau of Patient's Rights, and even the Prime Minister Donald Tusk, but Dr. Solarz responded when asked about denying Agata the referral by saying: "We have not been looking thus far for another hospital. I'm not afraid of legal sanctions because ethics is above the law" (Szlachetka and Pochrzest 2008). In the end, according to the media, Agata and her mother traveled to another city to obtain the procedure. This highly publicized case demonstrates but one instance of what appears to be a common practice of using the Conscience Clause as the means by which an individual provider makes a decision on behalf of the entire hospital as well as other possible providers in an effort to curtail the access to the service.

Pro Humana Vita: Application of Catholic Directives in Medical Practice

The widespread use of the Conscience Clause also curtails access to contraceptives. Although contraception (except sterilization) is legal, and thus theoretically accessible in Poland, the church strongly opposes it. The church holds that all hormonal

contraceptives act as abortifacients by preventing a fertilized egg from attaching to the uterine wall, and therefore their use is a grave sin. The Vatican cites the following statement by Pope John Paul II to argue this position:

> It is being demonstrated in an alarming way by the development of chemical products, intrauterine devices and vaccines which, distributed with the same ease as contraceptives, really act as abortifacients in the very early stages of the development of the life of the new human being.[6]

Furthermore, sex for nonprocreative purposes is viewed by the church as sinful, and thus any form of contraception is forbidden, except for periodic abstinence, popularly referred to in Poland as the "calendar" *(kalendarzyk)* method.[7] My research with the providers at the Małopolska Pro-Family Health Clinic illuminates how this approach to birth control is conceptualized as both beneficial to the woman and scientifically sound.[8] The clinic is known for its Catholic approach to healthcare and its embrace of the tenets of the *Encyclical of Pope Paul VI on the Regulation of Birth* released by the Vatican on July 25, 1968, which urged Catholic medical communities around the world to provide reproductive and sexual healthcare that centers on procreation.[9] In the waiting room of the clinic, the crucifix hung prominently above the reception desk and the Pope John Paul II calendar was affixed to the waiting room wall. The dominant themes that emerged from these narratives were the moral unacceptability and health risks of contraceptives, and the scientific basis for the effectiveness and safety of the calendar method. Dr. Malina's interview excerpts are emblematic of this approach. I broached this topic by asking about his view on *natural contraception*—a term that is often used interchangeably with *the calendar* in popular discourse:

> Dr. Malina: Look, there's no such thing as *natural contraception,* that's the wrong word. We support methods of *observing fertility* that give the spouses a sense of when they are fertile. I don't at all give out contraceptives because I don't want to, in some sense, take on that responsibility. I'm a believing [in God] person [*jestem wierzący*]. I believe that contraception is wrong. Approaching it scientifically, contraception totally upsets the woman's hormonal system. While taking contraceptives, 10 years later there's a greater frequency of breast cancer and cancers of the reproductive system, therefore it's a factor that impedes health. Everything can happen: there might be epileptic attacks, joint pain, migraines, water retention, mood disturbances, agitation, aggression, hunger, sadness.
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> Author: Are you now talking about all contraceptives or just hormonal ones?
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> Dr. Malina: Yes, hormonal, so pills or injections, but the same is true about barrier methods and IUDs, and these have the effect of early miscarriage . . . Additionally, the foreign body in the womb causes a reaction—a lesion and a discharge of mucus. It's as if you held something in your mouth—with time a sore will form, there might be an inflammation. Similar thing happens in the womb.
>
> Author: What about condoms?

> Dr. Malina: That's another issue. Psychological fear. *All* contraception solidifies the fear of the child in spouses because people start using contraceptives to avoid pregnancy. They fear the pregnancy and that it will destroy their well-arranged lives. This fear gets transferred onto the child. They fear, to put it simply, they begin to fear the child. Throughout the long period of time when they use contraception this mechanism solidifies in their subconscious minds. We know from statistics that people who use contraception are more likely to decide to get an abortion because in their subconscious the association is: child–enemy. The child becomes the source of fear; that's the psychological consequence of contraception. That's why we talk about the psychological term "contraceptive conscience." [interview, Dr. Malina, 2002]

Another gynecologist at the clinic, Dr. Górska, explained that the clause allows her to follow particular ways of conducting her medical practice according to her own sense of religious commitment and asserted that "here in our clinic we completely do not condone contraception because those are the rules of how we provide care." She validated her position by saying that since "patients who believe [in God] choose against contraception," and, since "sex education should be carried out by the church" not doctors, she was justified in declining to prescribe contraceptives to those patients who requested them [interview, Dr. Górska, 2002].

In general, the doctors I spoke to interpret the clause as encouraging providers to let their religiosity play a significant role in the provision of care.[10] Indeed, Dr. Górska's explanation suggests that the clause allows condoning, or not, behaviors deemed immoral by the church, regardless of whether or not the service is formally included in the state-sanctioned medical care (as with provision of contraceptives). Therefore, the disciplining effect inherent in the use of the clause by a physician promotes a form of religious governmentality. The notion of governmentality, which I borrow from philosopher Michel Foucault (1991) to denote specific institutional mechanisms of disciplinary power, is constructive in thinking in the context of these findings.

In particular, the focal element of governmentality—the attention to institutions creating constraining effects in specific ideological ways—is highly relevant to the ways in which the Polish Church functions as a disciplining and surveilling institution.[11] The clause offers an implement with which individual doctors sympathetic to the church's agenda voluntarily promote a distinct form of religiously sanctioned reproductive morality. Simultaneously, the law and the doctors operate as tools of coercive power that legitimize and reproduce the moral authority of the church, by making the clause compulsory in some hospitals regardless of the desires of individual doctors and by narrowing women's reproductive options to the parameters set by the Vatican.

White Coat Abortion Underground

The abortion ban and use of the Conscience Clause fueled the growth of a clandestine abortion underground *(podziemie aborcyjne)* as physicians who previously provided the procedure in public hospitals began to offer it illegally in their private offices,

creating a "white coat" underground, staffed mainly by experienced gynecologists.[12] [3;10.5] Since then, abortions in Poland have been readily available for a fee of about 1,000 to 3,000 *złotych* ($303–$757) and are advertised in newspapers, including the largest Polish daily *Gazeta Wyborcza*.[13] The ads are short and often contain only a mobile telephone number and one of the following phrases signaling abortion services: "all services provided," "vacuum method," "anesthesia," "menstruation induced," "complex procedures/discreet," etc. A woman can call the number to find out the price and location, and she can schedule the procedure for the same or the next day. Abortions require the synchronization of a gynecologist and an anesthesiologist given that they are performed under general anesthesia, and in most cases the more invasive dilation and curettage (D and C) is used, rather than the newer vacuum method.[14]

Despite the obvious existence of the underground, until recently the authorities rarely policed clinics and almost never followed the trails of newspaper advertisements. Typically neither the doctors nor the women want to reveal the information unless something goes awry, in particular if health complications or death results. These situations seem to be relatively infrequent, likely because of the "white coat" nature of the underground. Nevertheless, the use of general anesthesia and D and C subject women to unnecessary risks. A few cases in which the woman's partner called the authorities in an effort to stop the procedure have also been reported. Occasionally a clinic might be placed under police surveillance because of someone in the community who informed against the doctor. In the recent few years, however, a handful of radical politicians on the political right have begun to demand greater policing of the underground, responding in part to the accusation that the ban drives abortions underground rather than preventing them. But even so, there have been few arrests, and those cases that went to trial ended in suspended sentences, fines, and temporary suspension of license to practice medicine, none of which appear be deterring the doctors (Nowicka 2008a:29–30). Despite the accessibility of clandestine services and the clinical setting in which abortions are performed, the experience is harrowing; I offer the following story of Hania, a 22-year-old tour guide in Krakow.

When I first interviewed Hania she had been getting ready for her summer job in Greece as a tour guide for Polish tourists traveling to Athens. She moved from the rural Wieliczka to Krakow in 2002 to pursue studies at the Academy of Tourism and Recreation and viewed tourism as a secure and lucrative job and a chance to travel outside of Poland. Hania's mother, herself a nurse, partially supported Hania, but their finances were limited since Hania's father had died two years earlier and the family had incurred debts during his illness. Her summer job was a valuable opportunity to earn money and gain work experience, particularly since the main alternative among her peers was far less desirable fruit-picking seasonal work in Spain. Hania dated Marek for only four months when she unintentionally became pregnant. She said they typically used condoms because the pill was too costly but occasionally relied on the less effective withdrawal method to prevent pregnancy. I asked Hania how she reacted when she realized she was pregnant:

> I wanted to get an abortion *that* day. I knew they made it so we can't have them anymore, but I went to Dr. Jacob at the Academy who prescribed my

> [birth control] pills in the past hoping she'd give me a referral, but she told me to pick a doctor from the newspaper. So I got the paper and started calling. I called two ads that said: "vacuum method." One doctor was in Katowice and he wanted 1200 [złotych] and the other was in Krakow and wanted 1400; both could see me that day. I came up with a thousand but had to borrow the rest from two friends, as an emergency favor, and I chose the Krakow clinic since he let me bring a friend. The first friend I called couldn't come; the second met me right away. The clinic told me I was to meet their driver at a specific location, and to hold an empty plastic shopping bag in my left hand. A man pulled up in an old car and told us to get in. We got in, frightened but we got in. The situation felt anxious and secretive, I don't know, but basically he tried to be pleasant as he drove us outside the city to the doctor's private house. The sign at the gate said: "Doctor of Gynecology," which calmed me a bit. The office was very elegant: it was tiled and the older woman anesthesiologist was quite friendly. She said the procedure is easy, like pulling a tooth. She came from her hospital just for this . . . I never learned the doctor's names. When I woke up from the anesthesia, he wanted my phone number in case of complications and told me to return for a checkup, but later I decided I didn't need to come back. My friend and I were dropped off on the same street corner, and from there I took the bus home. I was glad to have it behind me.

Even legally permissible abortions are often performed clandestinely in private offices by doctors who otherwise decline to perform them in hospitals, thus not all doctors who refuse to provide abortions are actually opposed to the procedure based on their religiosity. In many cases the law serves as a way to protect oneself from church harassment since doctors who perform legally permissible abortions in public hospitals expose themselves to scrutiny by colleagues sympathetic to the church's agenda. Therefore, sometimes what appears to be a "conscience" issue is actually the fear of going against the religious norms. According to Dr. Zaremba, the fear of harassment from the clergy is in fact one of the main reasons abortions are refused in hospitals:

> Here [at the hospital] the most drastic situation is with abortions—gynecologists here refuse to do them due to fear; and that's the majority of gynecologists. [. . .] There are entire hospitals where it's no longer done. [. . .] In the early years of the right-wing state it was very severe, then when we got the leftist government the priests exerted their influence from the shadows taking advantage of established connections. If you live in a smaller community like me, you fear that the neighborhood priest will find out and say from the pulpit: "Don't go to this doctor!" It's not worth it for me financially; my private practice will suffer, it will cost me. Sometimes you see doctors having to shut down their offices in small towns and open elsewhere; they have to liquidate. That's what happens. [interview, Dr. Zaremba, 2002]

Although Dr. Zaremba's hospital is near Krakow's center and her private practice is in her house on the edge of the city 11 miles away, her concern of being targeted

by the church in her home community for activities at the hospital is well founded. The clergy routinely urge parishioners to both boycott providers of abortions and contraceptives, and to spread the word about their practices. Ironically, it is easier for Dr. Zaremba to perform abortions illegally right in her private office because she believes that her patients would not expose her. Ultimately, the state has no mechanism to ensure that the abortion law is followed on either end of the spectrum: to prevent illegal abortions or to ensure that abortions permissible under the law are in fact available. The state denies that the abortion underground is significant and therefore gathers no data regarding the number of illegal abortions or medical complications resulting from them.

Although women with sufficient financial means can circumvent abortion restrictions rather easily by paying for clandestine services, low-income women have a more difficult task. Many low-income women I spoke to said they would "organize" *(zorganizowałabym)* the money if the need arose. Similarly to Hania, who had to borrow 400 of 1,400 złotych from two of her friends, women with fewer resources borrow or make arrangements to pay doctors in payments. Some providers offer a sliding fee scale. Furthermore, doctors in smaller cities charge less—Hania had the option of taking the train to Katowice for a less expensive procedure. Recently, the Federation for Women and Family Planning has been reporting a new wave of newspaper advertisements for medical–pharmacological abortions presumably offering RU-486 (fake pills have been reported); these services are less expensive and can start from 400 złotych. Simultaneously, some international NGOs began to offer RU-486 online for only 200 złotych and report selling primarily to Polish women (Nowicka 2008a:25–27).[15] In some cases however, an unwanted pregnancy results in infant abandonment, which surged after the 1993 abortion ban and continued to climb steadily since then, as well as in infanticide, which was the highest recorded between 1991 and 1994 but has declined considerably in recent years.[16]

Many women can also circumvent barriers to contraceptive access resulting from the Conscience Clause by pursuing doctors willing to prescribe the pill, but a low-income woman faces larger barriers. She can become trapped in situations in which her regional doctor, similar to Dr. Górska, is unwilling to prescribe contraceptives, but she cannot afford to pursue care privately with another provider. In such situations, Catholic teachings narrow her contraceptive options to less reliable methods of periodic abstinence, withdrawal, and condoms and consequently dictate the quality of care she receives.

Conclusions

After the fall of state socialism in 1989, abortion was one of the first issues raised by the church and the Catholic–nationalist state in Poland. Nineteen years later, the politics of reproduction continues to occupy a central place in Poland's political debates—in March 2007 the Catholic League of Polish Families party (a coalition member) called for an amendment to the Constitution that would ban all abortions. On April 13, 2007, the Polish Parliament rejected the amendment. In September 2008, the Polish Federation for Women and Family Planning reported that the minister of health, Ewa Kopacz, proposed a legislative action that would

register all pregnant women and monitor them to ensure that registered pregnancies were brought to term. This move was explained as a way to curb the abortion underground. In a response, Nowicka aptly argued that the pregnancy-monitoring proposal harks back to "the times of Ceauşescu," and that "under the pretext of caring about women and their health, the Minister wants to tighten the system of control over women, over their reproductive functions and decisions."[17] Although, Romania's locus of repressive power was situated at the level of the socialist state, in Poland the socialist state actually restrained the authoritarian power of the church on issues of reproduction. "Communism gave us a feeling that there was equality; abortion was legal and so on" offered Kazia Szczuka, a feminist author and historian (interview, Kazia Szczuka, 2002).

However, when the regime fell, the church began to impart its agenda through state policies—acting de facto as a parastate—and to demonstrate clearly the ways in which both the postsocialist state and religious forms of institutional power have had a repressive effect on women's rights, raising questions about the nature of Polish democratization.

The politics of reproduction in Poland is significant because it dramatically impacts not only women's experiences with health and body autonomy but also women's position in the society. Exploring this topic anthropologically informs our understanding of the postsocialist transformations of institutional power and the ways in which these dynamics give shape to Polish domestic and international reproductive rights agendas. This study is revealing on two distinct levels: it exposes the actual process through which specific church-inspired policies were written into law, and it reveals the detrimental effects these policies have had on women's access to care and on the emergence of abortion underground. These findings suggest that, for the Catholic Church as an institutional regime, the Conscience Clause was a critical political tool to expand the confines of its centralized power by incorporating subtle forms of regulation through which the ubiquity of power becomes less visible as it is broadly dispersed via a wide range of processes and techniques of control, rather than being directly wielded by the clergy (Foucault 1977, 1991).

The findings further demonstrate that the church regime as a political power constellation was primarily legitimized by religious understanding of an absolute morality and what can and cannot be subjected to a popular vote, as well as "propagated by religious specialists," namely doctors (Bax 1991:9). What emerges from this study is instructive regarding the larger policy trends in East Europe, given that the Vatican has recently been calling for incorporating the Conscience Clause into medical laws in other nations of the region, especially Slovakia where abortion is legal, thereby providing a way for some doctors to circumvent the liberal abortion law currently in place.

Despite the sporadic international media coverage of Polish abortion struggle, the prevailing view of postsocialist Poland in the eyes of the West is one of a "successful democracy," a view that conflates democracy with free market economics. In fact, as of 2004 funding linked to Title VIII, Soviet–Eastern European Research and Training Act of 1983—which sponsored studies aimed to "promote democracy" in the post-Soviet region—was discontinued, except for the Balkan nations, suggesting that nations to the north "achieved" democracy (Hamilton 2003:1). In reality, the democratization process in Poland has been wrought with contradictions of an

emerging democracy, on the one hand, and a religious regime intolerant of individual rights (esp. women's rights) and political and religious pluralism, on the other hand. This study challenges the metanarrative of a "successful democracy" by revealing some of the repressive effects of the prevailing, but not always visible, mechanisms of power.

This study also asks broader questions about the role of women's rights in a liberal state. The hallmark of Polish postsocialist politics has been the disregard for women's concerns, including the rejection of Solidarity Women's Section's protests about restrictions on abortion in 1990, the rejection of the petition with 1.3 million signatures calling for a referendum on abortion in 1993, the implementation of a law that according to surveys was clearly in conflict with the will of the people, and the denial of the existence of an abortion underground. In the words of journalist Kinga Dunin, Poland is suffering from "the lack of political culture, the inability to think in categories of a liberal state, in which if I think it's bad and you think it's good then we need the kind of law that allows me to do what I want, and you [to do] what you want. Therefore discussion about abortion shouldn't be about morality but about how to organize a state that represents people with a variety of perspectives" (interview, Kinga Dunin, 2002).

Philosopher and a feminist scholar Nanette Funk proposes (2004) that it is the lack of political individualism in Poland that translates into the lack of support for women's rights. Funk notes (2004:700) that even some of the most prominent liberal thinkers in Poland "recognized collective goods and rights and emphasized individual duties, obligations of sacrifice and responsibility to others, the nation, family, God, and the state; these goods could override individual rights." Thus, she contends, the secondary status of individual rights ingrained in Polish political culture prevents the legitimation of women's rights in postsocialism.

Gila Stopler, a feminist and legal scholar whose scholarship is particularly relevant to the case of Poland, suggests, however, that it is not the lack of political culture or political individualism alone but the special status of the church that undermines the liberal tenets of egalitarianism. Stopler argues that "the relationship between patriarchal religion and the state in liberal democracies adversely affects the rights of all women, and the liberal states cannot live up to their commitment to women's equality without significantly changing their relations with patriarchal religions" (2005:191). Stopler also asserts that a mere legalistic separation of church and state, as in Ireland or the United States, for example, does not predict the degree of political influence of religion. Instead, she proposes, "in the modern Western liberal democracies it is religion's access to politics that determines its access to power and its ability to impose its agenda, not its institutional relationship with the state" (Stopler 2005:204). Therefore, the "liberal bind"—the conflict between certain religious agendas and women's rights—cannot be simply resolved by a legalistic separation of church and state. As the case of Poland makes clear, the special status and recognition afforded to the Catholic Church (resulting esp. from its historical role in the resistance against the communist regime) is highly significant for women's rights, because the church traditionally chooses to intervene in those policies that mainly pertain to women, including reproductive rights and family policy. Consequently, Stopler's work suggests that to resolve the "liberal bind" the states must consider

disestablishing religion from state matters in every way, including symbolically and financially, or risk undermining the political legitimacy of democracy.

At present, the Polish state's endorsement, rather than disestablishment, of religion suggests a continued momentum of close church–state cooperation. The state's approval of the politics of morality specifically targeting women's autonomy "[makes] the basic citizen of democracy *male*" (Verdery 1996:13), and raises concerns about the nature and future of Polish democratization.

Notes

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1. Examples of Catholic priests in the Ministry of Health include Father Wojciech Bołoz (The Bioethics Committee) (http://www.kb.mz.gov.pl/index.html, accessed March 14, 2009); Father Stefan Gralak (The Council of the Healthcare Worker in Warsaw—a nationwide organization of health professionals) (http://www.mz.gov.pl/wwwmz/index?mr=m111111&ms=1&ml=pl&mi=7&mx=0&mt=&my=356&ma=02395, accessed March 14, 2009); and Father Arkadiusz Nowak (the national section on AIDS and drug use) (http://www.bip.aids.gov.pl/, accessed March 14, 2009).
2. Unlike in the West, where feminist movements struggled for women's rights to abortion, education, and employment, these rights were granted by the socialist state in Poland and elsewhere in Eastern Europe.
3. Article 30 of the Medical Code of Ethics obliges physicians to provide care if a delay could endanger the life or cause serious "derangement of health" of the patient Article 39, Medical Law, 12/5/1996, # 28, #152 (Nesterowicz 2001:340).
4. See Balicki (2003).
5. See Balicki (2003).
6. See Pope John Paul II (1995).
7. Periodic abstinence (or natural family planning) might simply mean calculating the infertile days based on the length of the previous menstrual cycle, but it might also include basal body temperature measurement and the observation of the viscosity of vaginal discharge.
8. The doctors I interviewed estimated that 25–35 percent of physicians routinely use the clause to withhold services. It is difficult to confirm this estimate given that some physicians oppose abortion but allow contraception, and some who prescribe contraceptives conceal this practice for fear of harassment, whereas others claim that they allow contraceptives in principle but in practice encourage women to refrain from either.
9. See Pope Paul VI (1968).
10. Despite the popular media depictions of Poland as a monolithic nation of devout Catholics (the Catholic affiliation of Poles is indeed high at 89%), only 51 percent declare themselves to be "regularly practicing Catholics." This discrepancy suggests that individual

religiosity, as manifested in adherence to religious practices, varies widely (Centrum Badania Opinii Społecznej 2005).

11. Unlike Foucault, however, I relate the analysis to the ways in which such methods have a gender-specific target and effect, rather than viewing power as simply ubiquitous and target blind.

12. This is an interesting point of difference as compared to the U.S. abortion underground before *Roe v. Wade*: U.S. doctors were not trained in abortion per se in contrast to Poland, where doctors drew on decades of experience performing legally sanctioned procedures.

13. The FWFP estimates that 80,000–200,000 illegal abortions are performed annually, although it is difficult to confirm these calculations. Abortion tourism to border nations plays a smaller role, given that procedures are readily available in medical clinics throughout Poland. Recently, medical abortion using RU-486 is beginning to be offered on the Internet.

14. Abortions in the United States and most of Europe are performed under local anesthesia using the vacuum method (medical abortions are only gradually becoming more common). The doctors I interviewed in Poland explained they used general anesthesia and dilation and curettage because physicians are most familiar with these traditional procedure and they receive no training in the vacuum method since abortion became illegal. Some doctors also mentioned that they believed that women expect to be put to sleep for the procedure. A minority of doctors use the vacuum method.

15. It should be noted that because this research was situated in urban areas, it does not include some of the poorest populations of women that reside in rural areas, which constitute approximately 38 percent of Poland.

16. See Policja (Polish Police 2009).

17. See Nowicka 2008b.

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