OŚRODEK BADAŃ NAD MIGRACJAMI CENTRE OF MIGRATION RESEARCH

UNIWERSYTET WARSZAWSKI

CMR Working Papers

122/180

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UNDERSTANDING HEALTH-SEEKING BEHAVIORS AND BARRIERS TO HEALTHCARE ACCESS AMONG UKRAINIAN MIGRANT WOMEN WORKING IN THE DOMESTIC SECTOR IN WARSAW, POLAND (A QUALITATIVE STUDY)

August 2020
www.migracje.uw.edu.pl

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Abstract

Research on migration and health shows that immigrants, especially those with precarious legal status, encounter barriers to accessing healthcare. In Poland, migrants' interactions with the healthcare system remain understudied. This study begins to fill the gap by focusing on healthcare use and access strategies among Ukrainian migrant women working in the domestic sector, whose access to services remains uncertain due to legal status, circular migration patterns, and the informal nature of their work.

This explorative qualitative study, based on 10 semi-structured interviews with Ukrainian migrant workers in Warsaw, found that women had difficulties accessing healthcare in Poland and that they often cycled through various insurance statuses. Women were found to deliberately navigate their healthcare options and to strategically use care in both Poland and Ukraine in response to systemic barriers and personal needs. The main barriers to access were lack of formal employment in Poland, healthcare costs, wait times, discrimination, inadequate tourist insurance, language, and fear of legal consequences. Facilitators included access to the national healthcare system, social networks, and the behaviors of some employers.

This paper concludes that Ukrainian domestic workers skillfully leverage available access options, but formal employment remains the primary barrier to healthcare. Circular migration patterns and Poland's lack of cohesive integration policies encourage informality and perpetuate dubious relationships with employers, often leaving migrants uninsured. Recommendations include creating frameworks for low-cost insurance schemes, creating better systems for formalized employment, and ensuring healthcare access is not neglected within the emergent immigration policies.

Key words: Ukrainian migration, Poland, healthcare access, domestic work, health-seeking behavior

Streszczenie

Badania dotyczące migracji i zdrowia wskazują, że imigranci, zwłaszcza ci o niepewnym statusie imigracyjnym, napotykają bariery w dostępie do opieki zdrowotnej. W Polsce, zagadnienia związane z kontaktem migrantów z systemem ochrony zdrowia pozostają niezbadanym obszarem badawczym. Prezentowane badanie uzupełnia wiedzę na ten temat, skupiając się na strategiach korzystania z opieki zdrowotnej Ukrainek pracujących w sektorze usług domowych, dla których dostęp do systemu ochrony zdrowia pozostaje utrudniony ze względu na ich status imigracyjny, kontunuowanie migracji cyrkulacyjnej oraz nieformalny charakter wykonywanej pracy.

Prezentowane badanie jakościowe, oparte na dziesięciu wywiadach z Ukrainkami pracującymi w Warszawie, wykazało, że mają one trudności z dostępem do opieki zdrowotnej w Polsce, przy czym często zmienia się posiadany przez nie status ubezpieczenia. Badane Ukrainki strategicznie korzystają z opieki medycznej zarówno w Polsce, jak i na Ukrainie, reagując w ten sposób nie tylko na własne potrzeby w zakresie usług medycznych, lecz również na napotykane bariery o charakterze systemowym. Główne bariery w dostępie do usług medycznych w Polsce związane są z brakiem formalnego zatrudnienia, kosztami opieki medycznej, napotykaną dyskryminacją, posiadaniem nieodpowiedniego ubezpieczenia (turystycznego), barierami językowymi oraz obawami przed konsekwencjami prawnymi. Z kolei czynniki ułatwiające korzystanie z opieki zdrowotnej w Polsce obejmowały dostęp do świadczeń w ramach bezpłatnej opieki medycznej (NFZ), więzi społeczne oraz zachowania niektórych pracodawców.

Wyniki badania wskazują, że Ukrainki pracujące w sektorze usług domowych umiejętnie wykorzystują dostępne im opcje korzystania z opieki zdrowotnej w Polsce, przy czym brak formalnego zatrudnienia pozostaje podstawową barierą w dostępie do systemu ochrony zdrowia. Dominacja migracji cyrkulacyjnej i brak spójnej polityki integracyjnej w Polsce sprzyjają nieformalnemu charakterowi zatrudnienia migrantek i asymetrycznym relacjom z pracodawcami, co prowadzić może do braku ubezpieczenia. Rekomendacje sformułowane w oparciu o prezentowane wyniki badania obejmują stworzenie systemu tanich ubezpieczeń zdrowotnych, sformalizowanie zatrudnienia Ukraińców oraz uwzględnienie dostępu do opieki zdrowotnej w polityce integracyjnej Polski.

Słowa kluczowe: migracja z Ukrainy, Polska, dostęp do zdrowia, sektor prac domowych, strategie zdrowotne

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1 Acknowledgments

I want to give my thanks my two LSHTM tutors, Oliver Bonington and Vanessa Er, for providing support and guidance throughout this project, as well as to the staff and researchers at the Centre of Migration Research for their warm welcome. I would especially like to thank Marta Kindler for her trust in me and her continuous support, as well as Weronika Kloc-Nowak without whose help I would not have gotten local ethics approval.

I am also grateful to the countless individuals who helped me refine my project (in formal and informal ways), from my professors, neighbors, friends, and family, to the receptionists at Ukrainian House willing to chat about community problems. Thank you particularly to those who connected me to all the Ukrainian women you know, thus making this project possible. Most of all however, I thank the Ukrainian women who agreed to be interviewed, for their honesty, vulnerability, and laughter as we talked about some pretty intimate things.

2 List of Abbreviations

CMR – Center of Migration Research

EU – European Union

HIV – Human Immunodeficiency Virus

LSHTM – London School of Hygiene and Tropical Medicine

NGO – Non-governmental organization

NHF – National Health Fund

OOPs – Out-of-Pocket Payments

TB – Tuberculosis

UK – United Kingdom

UN – United Nations

3 Background

3.1 Migration and Health

This paper explores the barriers and facilitators to healthcare access, as well as the health-seeking behaviors, of Ukrainian migrant woman working in the domestic sector in Warsaw, Poland. Work in the domestic sector remains largely informal, meaning these migrants often lack access to the Polish national healthcare system.

The global acceleration of migration has been accompanied by increased demands to protect migrant workers. The UN's Sustainable Development Goals call for the protection of workers worldwide, with particular emphasis on migrant women with precarious employment (Norredam, Agyemang 2019). The European Union Agency for Fundamental Rights (2011) has also advocated for increased attention to healthcare access issues, with migrants of irregular status being a particular concern.

At the same time, an EU report on healthcare inequalities found many European countries still struggle with guaranteeing healthcare access to all, and identified Poland as having particular trouble providing coverage for migrants in non-standard employment (Baeten, Spasova, Venhercke, Coster 2018). Other studies have confirmed worldwide patterns of incomplete healthcare coverage for migrants. A recent systematic review of healthcare use among undocumented migrants in Europe found low service utilization rates by immigrants due to cultural barriers, fear of deportation, and high healthcare costs (Winters, Reche, de Jong, Pavlova 2018). Studies of Eastern Europeans in the UK similarly point to cultural differences pushing migrants away from the UK's national health system into private and transnational care (Madden, Harris, Blickem, Harriosn, Timpson 2017; Osipovič 2013). Moreover, studies from Czechia, whose healthcare system and immigration context resembles Poland's, found that Ukrainian migrants underuse healthcare services due to a lack of entitlements to the national system (Malmusi, Drobohlav, Dzurova, Palencia, Borel 2014; Hnilivova, Dobiasova 2011). Lastly, a study in Greece found that Ukrainian domestic migrant workers become so embedded in the informal economy that they find it psychologically difficult to transition to using formal public services (Psimmenos 2007).

Protecting the health and rights of vulnerable populations is important in its own right and should always be treated as such, though it is also important to acknowledge that mass migration poses health risks to both migrants themselves and to host populations. Unfortunately, too often these risks become politicized, framed in exclusionary language focused on national security, and galvanized to discriminate against migrants. In the public health context, however, it is important to treat these risks seriously, not as arguments against migration, but as strategic challenges that needs to be addressed for the health and wellbeing of populations, local and migrant alike.

In Poland, 'population movements and [the] spread of some communicable diseases' over the eastern border from Ukraine must become a serious consideration, both nationally, and in the rest of Europe (Coker, Atun, Mckee 2004). High rates of drug resistant TB

(Pavlenko, Barbova, Hovhannesyan, Tsenilova, Slavuckij, Shcherback-Verlan, Zhurilo, Vitek, Skenders, Sela, Cabibbe, Cirillo, Colombani, Dara, Dean, Zignol, Dadu 2018), recent spreads in the HIV epidemic (Vasylyeva, Liulchuk, Friedman, Sazonova, Faria, Katzourakis Babii, Scherbinska, Theze, Pybus, Smyrnov, Mbisa, Paraskevis, Hatzakis, Magiorkinis 2018), and the under-vaccination for measles (Wadman 2019) in Ukraine all pose serious epidemiological threats to the local population, but also to Ukraine's neighboring countries and, by extension, the European Union as a whole.

Solutions, however, cannot be based on xenophobic exclusion, as this is both impossible to achieve in a global economy and would undermine the benefits that come with migrating populations. Instead, finding ways to safeguard migrant health, and provide access to services, mitigates risks and leads to healthier communities. Unless immigrants from the East, including Ukrainians, have access to formal healthcare services even when migrating only temporarily, Poland could become a European gateway for infectious disease (Nowicka 2018; Zielonka 2016), especially with close to two million Ukrainians within Polish borders (Górny, Kindler 2018).

Yet despite this evidence of growing urgency to address immigrant healthcare access in Poland, little is known about the healthcare needs and health-seeking behaviors of Poland's immigrant populations (Cianciara, Dudzik, Lewczuk, Pinkas 2012). While migrant health is a rapidly growing field, much of it globally is devoted to refugee health and temporary economic migrants are often left understudied. In Poland, most studies of temporary immigration have focused on labor market forces. Only occasionally do qualitative studies on Ukrainian labor migration touch on difficulties in accessing healthcare. Kindler, Kordasiewicz, and Szulecka (2016), for example, focus on how labor regulations lead to limited access to public services, noting that migrants 'are usually uninsured; being unable to access public health-care'. Others have mentioned the lack of legal status as a barrier to healthcare access (Tolstokorova 2009), and the need to 'incorporate migrants' problems into the range of public health in Poland' (Cianciara et al. 2012). None of these studies, however, have specifically aimed to understand migrant health-seeking behavior or the interaction of migrants with the Polish healthcare system.

Immigration to Poland is a relatively new and understudied phenomenon (White 2018). It is also a mass phenomenon which Poland's immigration policies have failed to seriously address, instead relying liberally on short-term migrants for labor, but neglecting issues of long-term settlement and integration. (Lesińska, Duszczyk 2018). While a national migration policy was put in place in 2012, it was suspended in 2016 when the conservative *Law and Justice* party came to power. Since then, no national migration policy has been established, leaving a strategic void which is only now being re-addressed with a highly criticized policy proposal released during the course of this study (Pedziwiatr 2019). Moreover, neither the old, nor the proposed new policy truly address the role of public service use, including healthcare access, as part of successful integration.

For a migration policy to be successful in both protecting the rights of vulnerable populations and reducing the health risks of mass migration, there is an urgent need to better understand the health-seeking behaviors of Ukrainian immigrants in Poland. This paper

begins to fill this knowledge gap and to build a preliminary understanding of how Ukrainian migrants interact with the Polish healthcare system.

3.2 Immigration of Ukrainian Domestic Workers into Poland

Ukrainians constitute the largest immigrant group in Poland. While precise numbers are difficult to establish, studies suggest that between those permanently settled, and those migrating temporarily for work, there could be close to two million Ukrainians in the country (Górny, Kindler 2018). The majority of this immigration is economic, with migrants working predominantly in three sectors: agriculture, construction, and domestic labor (Chmielewska, Dobroczek, Panuciak 2018). In large cities like Warsaw, demand for domestic labor (which includes cleaning, childcare, and care for the elderly) has been steadily increasing with the growth of Poland's middle and upper classes and because the country has not developed the institutional capacity to provide care services for its aging population (Kindler et al. 2016).

As in most of the world, Ukrainian domestic workers in Poland are predominantly female, and some may have completed higher education or professional qualifications prior to migrating (Kloc-Nowak 2007; Krajewska, Piłat, Potkańska, Sobiesiak-Penszko 2015). Many of them have had previous careers in Ukraine and come to Poland in search of higher wages or as a way to generate additional income after retirement (Iglicka, Gmaj, Borodzicz-Smoliński 2011). Significantly for care work, nursing is a common profession left behind in favor of the Polish domestic sector (Iglicka et al. 2011).

Poland has been facing a shortage of labor and, as a result, has been encouraging such labor migration from Ukraine (Ustawa z 12 grudnia 2013). Since 2007, short-term labor migrants may work for up to 6 months a year on a simple 'declaration to hire' from a Polish employer, avoiding the more complicated procedures required for a full work visa (Brunarska, Kindler, Szulecka, Toruńczyk-Ruiz 2016). Another avenue for working in Poland is obtaining the so-called Polish Charter, a document issued to foreigners who can prove 'ancestral belonging' to the Polish Nation and which allows immigrants to reside and work in Poland without restriction (Ustawa z 7 września 2007). Lastly, since June 2017, visa-free travel for those with a biometric passport is permitted for stays of up to 90 days, allowing migrants to come in as tourists and find short-term informal employment.

Because of the relative ease with which Ukrainians can repeatedly enter and leave Poland, only about 30% of Ukrainian immigrants apply for any form of residency or settlement status (Brunarska et al. 2016). The majority maintain circular patterns of migration, coming to Poland to work only for a few months, before returning with their earnings to families in Ukraine. This leads to what Okólski (2001) terms "incomplete migration", or the short-term movement of temporary migrant workers across borders with the primary aim to earn money abroad and return with it to their country of origin, typically doing so within the informal sector and without complying to labor regulations.

Critically, this sort of incomplete migration, characterized by a dependence on the informal economy, lends itself well to unregulated employment within domestic work and social care in Poland. In fact, in Poland 'informal care is unambiguously the preferred option'

with more than 70% of Poles declaring a preference for informal provision of domestic labor (Bartha, Fedyuk, Zentai 2015). In part, this is due to the high cost of formal contracts for the employer, but there is also a cultural reluctance to formalize domestic work and elderly care outside of the 'family' (Kindler et al. 2016). As a result, the employment of domestic workers is typically driven by the needs of individual households and unregularized by formal labor contracts, making it additionally difficult to estimate the size of the sector (Krajewska et al. 2015).

Domestic migrants thus find themselves in a tricky legal situation. To prevent complications at the border and to warrant an easy return to Poland in the future, they often ensure their entry and short-term stay are legal. Their work, however, often does 'not comply to administrative rules and [they] sojourn in host countries in order to earn money in their "shadow zones"' (Grzymała-Kazłowska, Brzozowska 2017). In 2011 it was estimated that only around 22% of domestic workers are employed in ways fully compliant with the law (Iglicka et al. 2011). As healthcare entitlements in Poland are tied to formal employment, this greatly complicates the ability of migrant domestic workers to seek medical attention.

3.3 Legal Frameworks of Healthcare Access

Poland's national healthcare system is based on a 9% payroll tax earmarked for health and paid for by the employee. Those formally employed, or those married to someone who is, are guaranteed primary, secondary, tertiary, and emergency care, free at the point of access (Segan, Panteli, Borkowski, Domowski, Domański, Czyżewski 2011). The rest, whether migrants or Poles, have no entitlement to public healthcare, creating significant gaps in coverage. Table 1 illustrates the various way individuals can receive NHF entitlements (Cianciara et al. 2012; Kindler et al. 2016; Ustawa z 12 grudnia 2013).

In addition to the public NHF services, private care is available to anyone, independent of legal status. Private providers accept both out of pocket payments for single visits and offer provider-based insurance packages, though the latter are usually only purchased as additional benefits for employees by large companies. Use of private care is widespread among Poles who commonly mix OOPs and NHF services (Golinowska, Tambor 2012) and is the only available option (beyond emergencies) for those without insurance, including migrant workers.

Table 1 – Basis for Entitlements to National Health Fund Services

<table>
<tr><th colspan="2">Group</th><th>Basis for entitlements to
National Health Fund Services</th></tr>
<tr><td rowspan="2">Polish Citizens AND Immigrants with permanent residence, settlement status, or work visas AND individuals possessing the Polish Charter</td><td>Formally employed salaried workers</td><td>• Mandatory payroll tax earmarked for health.</td></tr>
<tr><td>Not formally employed OR employed based only on a task-specific temporary contract</td><td>• Possibility of full entitlements through salaried spouse or parent.
• State guaranteed coverage for those receiving unemployment benefits, children under 18, students of state universities, and pensioners.
• Option for voluntary monthly contributions into the system.

For those left uninsured, emergency care should be provided but will be billed for later.</td></tr>
<tr><td colspan="2">Ukrainian Immigrants entering based on a ‘declaration to hire’
(as part of simplified immigration procedures)</td><td>Must have tourist insurance until the commencement of their employment to cover any healthcare costs. After the start of employment, should be covered under mandatory payroll tax. However, many Ukrainian migrants enter the country based on purchased documents and forgo formal employment once in Poland (Brunarska et al. 2016) moving into the informal sector and remaining uninsured.</td></tr>
<tr><td colspan="2">Immigrants entering as tourists
(with no right to work)</td><td>Must have tourist insurance to cover healthcare costs for predicted duration of stay, yet such insurance can be left to lapse leaving migrants uninsured.</td></tr>
</table>

4 Research aim and objectives

4.1 Aim

This research explores the interactions between Ukrainian female migrant domestic workers in Warsaw, Poland, and the Polish healthcare system in order to better understand the health-seeking behaviors of migrants, and the obstacles they face in accessing healthcare. As Poland's integration policies do not explicitly address migrant access to health, this research aims to bring attention to the topic and provide evidence to inform future policy solutions.

4.2 Objectives

1) To explore the perceptions of Ukrainian female migrant domestic workers about the quality of healthcare provision in Poland as compared to that of Ukraine.

2) To identify existing barriers and facilitators to healthcare access for these migrants based on their past experiences of healthcare use.

3) To explore the range of healthcare-seeking behaviors among Ukrainian female migrant domestic workers in Warsaw in the context of their experiences and perceptions.

5 Methodology

5.1 Study Design

The scarcity of research specifically addressing healthcare issues among Ukrainian migrants in Poland means this study has to be exploratory in nature, investigating the general attitudes and experiences of domestic migrant workers in Warsaw. A qualitative methodology was thus chosen as appropriate, as qualitative research is especially good at producing new insights 'instead of testing hypothesis of relationships which are already known' (Faltermaier 1997). For data collection, semi-structured interviews were chosen over focus groups, because interviews allow for in-depth conversations about personal healthcare experiences while giving participants a greater degree of privacy and the ability to adjust interview times to personal work schedules. Interviews roughly followed a topic guide *(Appendix I)* and included questions about perceptions of healthcare in Poland, past healthcare experiences, and ease of healthcare access.

5.2 Recruitment

This study met its recruitment target of 10-15 participants, with 10 women being successfully recruited using a mix of convenience and snowball sampling. Participation was limited to Ukrainian migrant women 18 years or older who were either currently working as domestic workers or had worked in the sector within the past year. Six women were recruited through personal connections and contacts obtained from the Centre of Migration Research.

Information about the study was also posted (in Polish, Ukrainian, and Russian) on informal, public Facebook groups designed as social spaces for Ukrainian women in Warsaw, yielding three more volunteer participants. Lastly, a final interview was scheduled, upon recommendation, with a participant's roommate. None of the women were previously known to the researcher. Recruitment took place in over two weeks in June/July 2019 and was concurrent with early interviews.

5.3 Interviews

All ten interviews were conducted in Polish between June 25th and July 7th, 2019, in Warsaw. The interview setting was chosen by the participants and included public parks, local cafes, and their place of employment (with the employer's permission). The interviews lasted 30–75 minutes depending on the ease of the conversation and participants work schedules. All but one of the interviews was audio-recorded on a secure device.

The interview process was approached reflexively with consideration towards how the interviewer may have influenced the knowledge production process (Braun, Clarke 2013). Significantly, the initial contact with participants often happened through their employer, thus the initial relationship featured an important power imbalance and may have led to the avoidance of certain topics, especially those concerning the women's current employment circumstances. On the other hand, disclosing that the researcher is also a migrant (albeit from Poland to the UK), often shifted conversations into a more intimate, personal tone, which was additionally eased by a shared gender identity.

5.4 Ethics

Participants in this study can be considered particularly vulnerable due to their low socio-economic status, as well as their often-unregulated legal situation in Poland and the frequency of their work in the informal sector. Because of this, special attention was paid to data protection and consent taking. Both verbal and written information about the project was presented to study participants *(Appendix II)* and written consent was obtained from all participants using a pre-approved consent form *(Appendix III)*. If participants were uncomfortable disclosing their full name, consent forms were anonymously initialed. One participant did not consent to being audio-recorded and extensive notes were taken as an alternative. Most importantly, consent was treated as a continuous process, with frequent check-ins and ongoing communication. As healthcare access was anticipated to be a challenge for many respondents, the provided information sheet included contact information for two organizations which provide free and confidential advice on legal and healthcare issues to Ukrainian migrants in Warsaw.

Ethical approval was granted by both **LSHTM (ref. 16966)** and **CMR (ref. CMR/EC/2/2019)**, to be compliant with both UK and Polish law. All interview data was anonymized and kept securely on an encrypted computer to be delated in September 2020. Pseudonyms for participant names were used for the final project report.

5.5 Analysis

Interviews were transcribed verbatim using Microsoft Word, allowing for a familiarization with the data, and a preliminary record of possible themes. Transcripts were then coded paragraph-by-paragraph using an inductive thematic analysis approach. Initial coding was done by hand, after which NVivov12 software was used for code organization, grouping, and simplification. Finally, codes were grouped into barriers, facilitators, perceptions, and behaviors to correspond with the study objectives. When analyzing the interviews, themes were revisited multiple times in order to identify patterns of social interaction and behavior from the data, and to capture a broader picture of health-seeking behavior among Ukrainian domestic migrant workers.

6 Results

6.1 Participant Demographics

Ten interviews were collected in total from Ukrainian women matching recruitment criteria. Nine of the women were 40 years or older with previous careers in Ukraine, matching the common demographic of the domestic sector as described in the background; four of the women had professional nursing experience. Eight immigrated to Poland with the intention to work in the domestic sector, while the remaining two immigrated either to study or to follow a spouse who had been hired in Poland, finding work in the domestic sector only as an additional part-time occupation. As part of their employment duties, all the women were required to clean (either private households or larger office buildings). Two of them prepared meals, four took care of the elderly (both through live-in and live-out arrangements), and one was a nanny. This provided the study with a good diversity of domestic labor experiences for analysis.

The legal status of the women varied considerably. Six of the women were well established in Poland, having been in the country (though not always continuously) for at least the past 10 years. The remaining four had been in Poland shorter periods of time, but all had substantial knowledge about life in Poland as well as proficient language skills. Seven of them held some form of residency status at the time of the interview, giving them a right to legal employment. Nonetheless, three of the seven continued working entirely in the informal sector. The remaining three participants had no basis for legal employment.

Significantly however, all participants, even those whose legal status is currently formalized, recall periods of either their residency, employment, or both being informal or otherwise not complying with the law. This finding is especially important as it is consistent with the existing literature on the extent of informal market activity among Ukrainian domestic workers (Brunarska et al. 2016) and underscores the fluidity of legal status and healthcare access options available to this population.

6.2 Healthcare Needs

Eight of the women talked about specific, personal healthcare needs. Some of the commonly listed ailments, such as arthritis, hemorrhoids, and kidney stones can be linked to the slightly older age profile of this migrant group. Others were connected to gender. Many participants mentioned hormonal disruptions (possibly connected to menopause), gynecological needs, and past pregnancies or miscarriages. Lastly, some medical needs seem to be directly linked to the domestic labor these women perform, with back pain, workplace accidents like falling off stools while cleaning windows, and allergies to cleaning chemicals being common themes. One participant, Valentyna, explained: 'After two years of working in an office cleaning Monday to Friday I now have a very weak sense of smell... I lost it… [due to the chemicals].'

Mental health was also jeopardized by the labor these women perform, especially among women taking care of the elderly. All four of the women who worked in elderly care referred to the emotional stress of the job. 'I also cried… […] every night I cried into my pillow' (Iryna). Unlike with many of the other needs, mental health was never addressed in a formal manner. Instead participants looked to friends and religious networks for support.

6.3 Perceptions of Healthcare in Poland

Perceptions of healthcare quality in Poland among the interviewed women were generally positive, with one interviewee even stating that 'there are a lot of people who come to Poland specifically to be treated' (Halina), although this statement didn't apply to migrant domestic workers whose primary purpose of migrating to Poland was for work.

Women with NHF access expressed pleasant surprise that, if the tax contribution is paid, the care is indeed free at the point of access. This can be contrasted to the situation in Ukraine, which was described by all the women as a system that functions on bribes, and where there is an expectation in both the public and private sectors to make side payments to doctors. Olga described her experiences in a Polish public hospital: 'It was all free. From a financial side everything was ok. He [the doctor] didn't ask for anything more, we didn't discuss any bribes… I'm wondering what it would be like back home [in Ukraine], how much money would I lose.'

However, while the women mostly praised the skills of the doctors and accountability of the system, they also complained about structural inefficiencies, most commonly the sluggishness of the Polish system, the long wait times, and the inability to see a specialist directly.

Occasionally the perceptions of medical care in Poland as both better delivered and more poorly organized got conflated, with women jumping back and forth between praising healthcare in Poland and complaining about how difficult it is to navigate.

6.4 Accessing Healthcare in Poland

The ten participants interviewed discussed various ways of accessing healthcare services in Poland, both in the context of their own needs and talking about their friends. The most important finding in this study has been the immense fluidity with which the interviewed women have moved in and out of various insurance statuses, making it extremely difficult to generalize health-seeking behavior and patterns of access not only across interviewees but also within individual timelines.

Table 2 illustrates the various ways in which healthcare was accessed by the ten interviewees. It demonstrates the great variety of healthcare access strategies, as well as their fluidity over time. Many women had access to NHF funded care, either through their own legal employment or through a family member. However, paying into the system voluntarily without the benefits being linked to employment was always deemed too costly.

Access to private health insurance was gained almost exclusively through family members, mostly grown children with successful careers in Poland, because paying for private insurance was considered to be prohibitively expensive. Both OOPs and returning to Ukraine to seek healthcare seem to serve dual roles: supplementing care accessed in Poland and as an act of last resort for those with no form of insurance. Lastly, while Ukrainians who enter Poland as tourists are required to purchase tourist insurance, the women found it unreliable and rarely used it to access medical care.

Finally, it is also significant to note that three of the interviewees engaged in illicit and informal arrangements with their employers, which will be discussed later.

Table 2 – Access Strategies Among Interviewed Ukrainian migrant domestic workers

		Kateryna	Anastasiya	Daria	Valentyna	Iryna	Halina	Olga	Tetyana	Tanya	Yana
NHF Access (contingent on legal stay in Poland)	through tax on formal employment		*** #	*** X	X	X		#	X		
	through a family member					#	X	X			
	through voluntary contributions										
OOPs for Private Care in Poland	used in addition to an existing form of insurance	X		X		X	X	X	X		
	used out of necessity due to no other form of insurance			#		#			#	X	X
Polish Private Insurance	provided through work					***					
	provided through a family member			X		X		X			
	paid for individually										
Return to Ukraine (to use both private and public care)	used in addition to an existing form of insurance	X		X		X	X	X	X		
	used out of necessity due to no other form of insurance		X	#	#	#			#	X	X
Use of public emergency care in Poland despite lack of NHF access (this would result in costs being billed later)		X				#				X	X
Tourist Insurance	used to access medical services			#							
	purchased only for visa purposes with little intention to use	X				#		#	#	#	

X – current status of healthcare access strategy, experienced at the time of the interview
– healthcare access strategy used in the past
*** – indicates some illicit informal arrangement with private employer

NHF – National Health Fund
OOPs – Out of Pocket Payments

6.5 Barriers to Healthcare Access

Various barriers to healthcare access were identified as themes during the interview process. Importantly, these barriers shouldn't be seen simply as factors directly impeding healthcare use, but as factors affecting the various health-seeking strategies, behaviors, and insurance statuses that Ukrainian domestic migrant workers navigate during their time in Poland.

6.5.1 Access to Legal Employment

By far the most significant factor affecting these migrants' ability to securely access healthcare services was their access to legal employment in Poland. Sometimes this lack of access arises from a lack of legal status, but often it is a consequence of individual Polish households being unwilling to provide a formal contract and/or the circulatory patterns of migration that make a formal contract impractical. Those working entirely in the informal sector cannot access public care, leaving the often-expensive private provision as their only alternative in Poland. Tanya, who works entirely illegally, said: 'You know, those who work officially, who are registered, go to the doctor just like you do [referring to the Polish interviewer], and there's no problem. The problem is with women like me.'

This situation is additionally complicated by the fact that Ukrainians who do want to legalize their work status often wait for months to have their paperwork approved, sometimes without results: 'Your system works in a way where he [a friend] works, he wants to pay social security, taxes, […] but he's been waiting half a year...' (Daria).

This uncertainty of legal status is aggravated by the circular nature of much of the Ukrainian migration into Poland, as some of the interviewed women found it impossible to justify formal employment given how often they needed to return to Ukraine on short notice. Anastasiya explained: 'This social security tax, I refused it. And now… I like it that now I am at home a bit in Ukraine […] … it works like that, because if I was here full time, then I would pay the tax.'

Those who did manage to access a legal contract and were in a circumstance to take it felt the contract gave them an overall sense of stability, including stability of medical access: 'When you have official work in Poland, it's really easy to think of the future and solve some problems' (Valentyna).

Ultimately however, as Daria described: 'the big problem is with the ability for foreigners to have access to the health fund, even in an emergency, so that they're not afraid. It's like this that… the problem is to get, to find work with a work contract. […] it's here that the country has problems with the system.'

6.5.2 Costs

The second biggest factor affecting Ukrainian domestic workers in Poland was healthcare costs, both in terms of the costs of formal tax payments and the costs of private one-off doctors' appointments. Interviewees were extremely consistent in citing prices of about 400zł (£85) a month for social security tax contributions, and 150–300zł (£30-60) per private doctor

appointment. They also consistently reported that the average monthly salaries of domestic workers ranged between 2000–3000zł (£420–630). These figures suggest that even for women who may have the legal ability to access NHF care, such payments may be prohibitively expensive. In fact, women with legal permission to work often chose to keep only one job in the formal sector, or rely on family coverage, leaving the majority of their incomes undeclared to pay lower tax contributions.

The financial situation may be even more dire for those without any form of health insurance, as they are forced to pay for private care when faced with medical needs. While many of the interviewed women did indeed decide to pay out of pocket to see a doctor privately, they also recalled situations in which this would not have been possible: 'I don't know… I don't know how I would have handled that. I would have had to quit work and go back to Ukraine. Because there's no chance. I was making 600zł then, so to pay 150 for a visit…' (Iryna).

In fact, as in the example above, the ability and willingness to pay for a private visit was often connected to the possibility for continued work. If the illness was short and treatable, then perhaps the visit was worth the cost. However, for more complex medical conditions that required multiple visits and time off from work, the mounting costs combined with lost income made treatment in Poland inefficient: 'You understand, it's the costs, to come [to Poland] and work, and then one can no longer work, but nobody is going to pay for them' (Tanya).

Lastly, while insurance costs or the costs of an appointment are in some ways predictable, the prospect of unexpected costs, such as the possibly of needing to be taken to the emergency room, generated fear and unease among the women. In fact, during her friend's medical emergency, Anastasiya recalled that 'they wanted to take her to the hospital, and she refused. She knew it would cost her, [...] that the hospital is expensive.'

6.5.3 Wait Times

Appointment wait times, queues, and the general lack of doctor availability within the Polish public healthcare system was a constant theme with all interviewees. The omnipresence of complaints about the unresponsiveness of healthcare in Poland was so great that even women who had never seen a doctor in Poland themselves recalled horror stories of their friends waiting for months for appointments: 'Queues! … we don't have queues like that [in Ukraine]. For you [in Poland] I've heard that you can wait up to 2 years for a doctor. I'm sorry but you will croak and just never live to see a doctor' (Anastasiya).

These queues, however, mostly affect those who have NHF insurance and use the public system, as it is often possible to bypass the queue by scheduling a private appointment. 'Privately you go at once. […] I went today, today and I got an appointment for tomorrow' (Iryna). Hence, this barrier was directly experienced less frequently by women with precarious legal statuses because they are less likely interact with the public system.

6.5.4 Discrimination

The interviewed women all claimed they never felt personally discriminated against. Some women even emphasized that they ‘never met anybody in Poland who would tell me that you’re from Ukraine and you are some sort of second-class person’ (Valentyna). However, a few disconcerting accounts with regards to emergency medical needs emerged.

Two of the interviewed women described situations in which an ambulance wouldn’t respond to their call. In one case, Daria was nannying a child while the parents were away. She called emergency services when the child suddenly got very ill. But her request for an ambulance was met with a resistance and harsh questions about whether she was the child’s legal guardian. Only after emphatically explaining ‘I’m just the nanny, the child is Polish, he’s a Pole!’ was the ambulance dispatched.

Anastasiya similarly had a story of a dispatcher refusing to send an ambulance after one of her flat mates needed emergency medical care. ‘Immediately, he immediately felt the accent’ she claims. Only after asking the Polish landlord ‘you call, call as a Pole […] call the ambulance’ did the paramedics arrive.

These instances seem to arise from a fear on the part of the hospital staff that the women are uninsured and will not be able to pay. Although according to Polish law, first aid should still be administered and billed for later regardless of insurance status, the frequency with which Ukrainian women in Warsaw are uninsured seem to be affecting the behavior of hospitals and their dispatchers.

6.5.5 Inadequate Tourist Insurance

For women who enter Poland as tourists, obligatory tourist insurance is necessary to cross the border. This tourist insurance however, while giving the impression of a medical safety net, can be considered as a formality. In fact, the women described it almost exclusively as a labor market strategy to enter Poland legally: ‘If you get a visa you now have to, it’s obligatory this insurance. But you buy it for some period, for three, four, five days, maybe a month. But when I stay here for three months, then it’s all over.’ (Tanya)

In fact, the women often expressed uncertainty about whether this health insurance was actually functional and ignored it when accessing care: ‘I heard that this insurance which they buy in Ukraine that, in Poland, that it doesn’t really work.’ (Kateryna)

6.5.6 Language

Unsurprisingly, language proficiency was also commonly cited by women as a factor influencing their healthcare access. The inability to explain things to a doctor generates stress and makes understanding diagnoses difficult. Even women with proficient every-day Polish skills mentioned this issue: 'for me the hardest thing was the… medical terminology. Did I get it right to describe the problem’ (Valentyna). Online translators were mentioned as a common solution, although not perfect: ‘this Google can’t transliterate everything. It’s not always right.’ Women further mentioned that most information about the system was available online, but only in Polish.

6.5.7 Fear of Legal Consequences

For women without full legal status, accessing healthcare was further impeded by a fear of legal consequences. While this fear generally did not come off as overwhelming during the interviews, some of the women mentioned that their peers 'think someone in the hospital will find out that they're working illegally' (Kateryna) and that this may affect their willingness to seek care.

6.6 Facilitators to Healthcare Access

The facilitators which emerged from the interviews aided in directly accessing healthcare, widened the scope of insurance possibilities, and increased the ability for Ukrainian women in the Polish domestic sector to make informed choices about seeking medical care.

6.6.1 Access to NHF Insurance

The biggest predictor of frequent healthcare use in Poland was having formal access to NHF services. Women who had NHF access through their own payroll contributions, or through a family member, reported much more regular patterns of healthcare use, including regular check-ups, monitoring of chronic conditions, and quick emergency response. Ultimately, despite being connected to regular costs, and despite the queues and inefficiencies of the healthcare system presented as barriers 'those who pay it [tax contributions], they have it good. Insured, you sleep peacefully' (Anastasiya).

6.6.2 Networks of Ukrainian Women

Strong networks and bonds between female Ukrainian migrant workers are a huge contributor to successfully navigating the Polish healthcare system. For the women interviewed, the most common source of knowledge about life in Poland was other Ukrainian domestic workers with greater migration experience: 'Right, now if I don't know something I ask for advice, I ask [friends] do you know what to do, where to go?' (Iryna). This advice included what doctors to go to, how to fill out legal paperwork, and what medicines to buy.

However, these networks go beyond simple advice. Often, friends with higher language proficiency skills will accompany each other to medical appointments – 'you go, explain what your friend wants, you help' (Halina) – to aid with translations and provide moral support. They will also pool money for others' medical needs in times of crisis or become the primary caretakers if someone ends up in the hospital. The women also become each other's only available mental health support system, because 'between friends we can talk, complain, cry… where else could we go?' (Tanya).

Additionally, women with nursing experience are in a prime position to distribute medical advice. One of the women interviewed explained that 'in Ukraine I worked as a nurse; Yes, so what I do is give all my friends shots' (Yana). This finding is perhaps especially important given the growing role of Ukrainian migrants in elderly care. While the women interviewed claimed their nursing experience wasn't mentioned when they were hired as carers, some revealed circulating medical advice not only to friends, but also to employers.

6.6.3 Benevolent Poles

Many of the interviewees had stories of Poles stepping in with aid at times of medical needs. Most commonly these were Poles with some kind of pre-existing formal relationship to the Ukrainian women they were helping: landlords, neighbors, and teachers at a child's school. Often, they provided crucial information about how healthcare in Poland functions: 'Across [the stairwell] there was a really nice neighbor and I would knock on her door and ask how and what' (Iryna). Other assistance including help calling an ambulance, getting advice on hospitals, or helping prepare for visits by translating medical terms.

Aid was also given by medical professionals. Women mentioned doctors recommending where to get discounted medication, and one woman even mentioned that 'I was supposed to pay 150zł for the [private] visit. But the doctor saw we were from Ukraine and gave us the price of 120' (Halina).

While seemingly small gestures, this help can be lifesaving in situations where costs, language, or lack of knowledge pose significant barriers to healthcare access.

6.6.4 The Employer

The relationship between a domestic worker and her employer can be a valuable facilitator in accessing healthcare. Employers are quick to give advice, drive their employee to the hospital, and even pay out-of-pocket for their care: 'The guy, where she was cleaning, he came, with a car, took her to the hospital, got her an x-ray. Listen, that cost her… he paid that guy, 300zł!' (Anastasiya). Employers were also described as using their own networks to help arrange backdoor appointments, or adding their domestic worker onto their private health insurance package as an unofficial family member: 'my boss had a package also at Lux-Med. So, I was also in this Lux-Med' (Iryna).

In addition to generous acts of kindness however, the relationships between the employer and the domestic worker over healthcare access can become questionable. First, it is important to state that the same employers who pay for one-off medical appointments do not offer formal work contracts to their workers claiming the high healthcare contributions make such contracts too expensive. This can lead to illicit employment practices, forcing the worker to pay both the worker and the employer tax contribution in exchange for a legal contract. 'She [the employer] said to me that she will not pay my social security, because it's a large sum. So, the social security, on paper she's paying, but really you pay it yourself' (Daria).

This practice is against the Polish law and is exploitative. Yet the interviewed women saw it as great help, as they believed otherwise a legal contract with healthcare benefits would be unattainable. Thus they saw this illicit practice as a way for the employer to facilitate labor protections, claiming that 'Of course I didn't want to [pay extra] because it was hard for me, but on the other hand I was calm [as I had official work]' (Anastasiya).

6.7 Health-Seeking Strategies and Behaviors

Combinations of the above barriers and facilitators, as well each woman's personal circumstances, influence the type of health seeking strategies and behavior Ukrainian domestic migrant workers engage with. These strategies are fluid and range from avoiding care all together to complex ways of using multiple systems.

6.7.1 Avoiding Care in Poland

All of the interviewed women mentioned at some point avoiding care in Poland when uninsured. For women with no NHF access, the main healthcare strategy was simply not to get sick: '[I just hoped] nothing is going to happen. That everything will be ok' (Tanya). To help prevent illness, home remedies, medication brought from Ukraine, and advice given by Polish pharmacists were used interchangeably.

This of course posed problems in urgent medical situations. OOPs were used occasionally as 'privately, it's when it's like me, unregistered. Where it's private the doctor will accept me because I'll pay for the visit' (Tanya), however the high costs of such private visits meant that they were often too expensive for women in difficult financial situations. Many hoped that if something terrible were to happen, the Polish emergency services would be responsive, even asking the interviewer 'If something sudden happened I would go to the hospital. They should accept me, shouldn't they?' (Yana).

6.7.2 Returning Home to Ukraine

When staying healthy and avoiding emergencies failed as a strategy, many domestic workers chose to return to Ukraine. This choice was often forced by a combination of previously described barriers. As the purpose of migration was economic in the first place, experiencing illness which limited the ability to work was often the final push convincing women to go back home, especially that daily living costs in Warsaw are higher: 'You understand, it's costly [to live in Warsaw], and then to come here and work, and then you can't work, but nobody will pay for you' (Iryna).

The tensions between needing to work and addressing medical needs contributed to the circularity of migration. Tanya described a pattern among many of her friends which illustrates how work and health needs push women back and forth across the border: 'You know, it's often like this… they see they have these allergies [to cleaning chemicals]. So, they go home [to Ukraine]. They do the tests, but have to go back to work, go back to it all. They get treated and then they work. There's no choice. Back and forth.'

6.7.3 Strategic use of both healthcare systems

The situation looks quite different among the women who did have access to NHF services. These women often used the Polish system extensively and were knowledgeable about how and where to make appointments, where appointments can be made quicker, and where the better doctors are. Like many Poles, they occasionally chose to supplement NHF care with OOPs for private visits, as 'Whomever has money, then they can also go quicker, privately'

(Halina). But unlike Poles, they also have the ability to additionally go back to Ukraine to seek care.

Health conditions for which long wait times are not detrimental, such as occasional monitoring of kidney stones or annual blood tests were addressed in Poland, as were health needs which may require specialist equipment like surgery. However, needs that Polish services would fail to address promptly (such as allergy consultations), were scheduled for visits in Ukraine during return trips to see family. Dental work, which the Polish public system doesn't cover, was especially commonly brought up as 'Dental work is easier [in Ukraine]" (Olga) and "it's cheaper with us' (Anastasiya). While the corruption in the Ukrainian system was continuously brought up, the costs nonetheless remain lower than those for private care in Poland.

6.7.4 Transporting Drugs

A similar leveraging of both systems occurred with drug purchases, both among those with insurance in Poland, and those without. As medications 'that I buy in Ukraine, they just don't work' (Kateryna) due to high levels of fraudulent drugs being sold in the country, over-the-counter medication such as Aspirin, Nurofen, or child Tylenol were bought in Poland and transported to families in Ukraine.

On the other side, however, Poland's prescription policies mean it is often difficult to get certain mediation without first seeing a GP and then waiting for a specialist appointment. As this can both take time and is expensive if done privately, drugs requiring a prescription in Poland are often bought over-the-counter in Ukraine, despite the knowledge that they may be lower quality: 'I buy a lot [of medication in Ukraine]. And my friends ask me to buy a lot to. Only for you here [in Poland], you know, for you everything is by prescription' (Anastasiya). Worryingly, this was most common for antibiotics.

Polish employers of domestic workers were also mentioned as participating in this drug exchange. They sometimes sent medication to their workers in Ukraine on request, but also asked for Ukrainian medications in return, as they similarly struggled with the wait times for appointments in the Polish system. In the most extreme case, a group of Ukrainian women transported Russian cancer drugs not covered by the NHF for the dying wife of their landlord, claiming 'It's easier to get in Russia than here. So, we would go home, buy it there, and bring them to him […] The medication we had to transport on ice' (Anastasiya).

6.8 Examples of Healthcare Choices

Ultimately, the movement of women through the different access pathways and insurance statuses was contingent on their own perception of need, their personal migration journeys, family ties, and the opportunities presented to them. At the same time, these choices remained constrained by the structures of healthcare access, migration status, availability of formal employment, and economic sustainability. Thus, women navigating healthcare while in Poland expressed personal agency by making choices that suited their needs, but also faced

structural limitations on the choices that were available to them. Examples of how these women navigated choice pathways are presented below:

Daria first arrived in Poland over 20 years ago with no documentation and small children left behind in Ukraine. Initially, her stays in Poland were temporary and she avoided medical care when possible. For more serious medical needs, she returned to Ukraine, including returning for multiple years when back problems made domestic labor impossible. With time and labor experience, she gained residency status and a right to work, and brought over one of her two children to Poland. She now maintains one job in the formal sector giving her access to NHF care which she uses frequently, while her other work remains informal. She also has access to a private insurance package as part of her daughter's work plan. She thus mixes public and private provision in Poland, occasionally paying for quicker appointments while regularly returning to Ukraine for dental work in addition to seeing her family. Although she has residency status in Poland she doesn't remain fully settled, maintaining property in Ukraine and considering retiring there.

Valentyna came to Poland with the intention to settle. Initially undocumented, she had no access to insurance and used OOPs sporadically when needed. She eventually managed to get a job cleaning a large office building with a company that helped her apply for legal status and formalize her employment. Since then she has worked only in the formal sector, claiming that 'Formal work means stability and access to health insurance.' This stability allowed her to bring her whole family to Poland and she intends apply for citizenship.

Halina's legal situation has always been formalized giving her consistent right to employment. She was granted the Polish Charter Card and her husband works legally in Warsaw. Given her access to NHF services through her husband's employment and the stability of her legal situation, she chooses to work entirely in the informal sector, relying on her husband's coverage, occasional OOPs, and trips to Ukraine for dental work.

Anastasiya first began seasonally working in Poland, trying to maintain one formal contract to have NHF access, in addition to informal work. More recently, while she continues coming to Poland, her trips are becoming shorter and more sporadic, leading her to forgo the legal contract and work only informally, saying: 'if I didn't have to take this step, that I have to be home for two months, and those two months someone works for me here, then I would continue paying this tax, the social security, and I wouldn't regret it…' however with short term stay formal insurance is impractical and too costly.

Yana only started coming to Poland a few years ago. She has no legal status and thus no insurance. She occasionally pays OOPs to see a doctor privately but mostly returns to Ukraine with medical needs. She hopes in case of an emergency the Polish emergency services would still treat her, but she is uncertain.

7 Discussion

Ukrainian migrant women working in the domestic sector in Poland interviewed in this study were found to negotiate and leverage the various healthcare options available to them across both the Polish and Ukrainian healthcare systems in response to encountered barriers and facilitators. Personal circumstances such as legal status, financial stability, individual history, and familiarity with Poland all influenced healthcare access choices, often leading to conscious and well-informed decisions balancing risks, costs, and needs.

This finding is consistent with literature on health-seeking behavior, which increasingly underlines individual agency in how migrants navigate healthcare systems (Philimore, Bradby, Knecht, Padilla, Pemberton 2018). The specific factors affecting migrants' choices are also comparable between studies. Phillimore et al. (2018), write about superdiverse neighborhoods in Europe saying 'whether [migrants] are entitled to access formal healthcare, if they have to pay, the extent to which they can chose doctors, tests and specialists, waiting times and levels of discrimination shape engagement' with healthcare services. Other studies similarly point to costs, legal entitlements, and system structures as the most commonly encountered barriers (Winters et al. 2018; Philimore, Klass, Padilla, Hernández-Plaza, Rodrigues 2016; Green, Davison, Bradby, Krause, Morente Mejias, Alex 2014). Additionally, interviews with Polish medial personal revealed language and cultural barriers, as well as the lack of clarity around entitlements, as key challenges when working with migrants (Jabłecka 2013), pointing to mutual difficulties on both the patient and provider side in accessing and delivering care.

In Poland, the major factor affecting health-seeking behavior among Ukrainian domestic workers is their ability to access formal employment in which employers are willing to take on the costs of the legal contract and the wages make paying social security affordable. Those working informally (unless they can rely on a spouse of child) are left uninsured and face almost total exclusion from NHF services, relying on periodic returns to Ukraine to meet their health needs. While such transnational healthcare use exists in other contexts (Osipovič 2013), in Poland these Ukrainian women become 'trapped into circularity' (Iglicka et al. 2011), irrespective of any possible preference to settle. They are the most vulnerable, as they remain excluded both from the formal labor market and from access to social services. They become an entirely 'invisible migration' (Kindler et al. 2016). Only in true emergencies does their exclusion become apparent. It is in the emergency room or during an ambulance dispatch where they may be faced with unexpected costs, as well as experience discrimination. In moments like these they are dependent on the kindness of those they encounter: friends, neighbors, doctors, and employers.

Women with NHF access are in a much better position to navigate the healthcare options available to them. Like many Poles, they mix public and private provision, showing a willingness to pay for private visits to bypass queues (Golinowska, Tambor 2012). However, they also take advantage of the proximity of Ukraine and often return for select healthcare services, such as dental care, strategically balancing costs, wait times, and quality. Social networks are an important mediator of these choices, generating collective knowledge on

how to best interact with the healthcare systems (Pemberton, Humphris 2016), as well as becoming the only mental health support.

Importantly however, women rarely fall neatly into those formally employed and with access to the NHF, and those working in the gray economy with no access to the NHF. Instead, their statuses are fluid and unstable. While there seems to be a tendency for women to gain legal status with increased time spent in Poland, this is neither a universal nor linear trajectory. Costs, convenience and experience navigating the labor market also push established women back into the informal sector, especially if they engage in circulatory migration by choice in an effort to maintain roots and families in Ukraine. Thus, the women in this study wavered between legality and informality, often deliberately avoiding the contracts that would grant them healthcare entitlements.

Individual employers play an important role in how these decisions are made. In the eyes of the women interviewed, the employers were often the ultimate enablers to accessing health services through paying for private visits or driving their workers to a hospital. It is these same employers however, that paradoxically refuse formal contracts, or push their workers into illegal contractual arrangements: Being asked to cover employer tax contributions from the base minimal wage salary was entirely normalized among the interviewees who saw this practice as generosity, not exploitation.

This complex relationship between employer and employee in a domestic setting is not uncommon. Kindler (2009) notes that the intimacy of domestic labor and care work forces women into a liminal role, where they are 'someone between a worker and a family member.' This kind of 'familiarization' can jeopardize advocacy for full labor rights placing 'the migrant at risk of labor exploitation' (Kindler 2011).

Yet while individual relationships and personal trajectories are critical in understanding how Ukrainian migrant domestic workers engage with Polish healthcare services, there is always a 'tension between [system] structure and [individual] agency' (Oleinikova 2015). On one hand, there's a 'need to incorporate life-course concepts' into studies on health-seeking behavior (Pemberton, Humphris 2016) and to acknowledge how individuals 'negotiate systematic restrictions to care' (Green et al. 2014). On the other hand there's a need to use the study of health-seeking behavior 'a tool for understanding how populations engage with health systems, rather than using health-seeking behaviors as a tool for describing how individuals engage with services' (Mackian, Bedri, Lovel 2004). Ukrainian women and Polish employers make choices based on their own needs, but legal frameworks make it difficult to hire a domestic worker on a contract with full social security benefits (Brunarska et al. 2016), and the lines between willful avoidance and systemic exclusion in healthcare are often blurred by costs and regulation (Philimore et al. 2018).

In Poland, the largest structural questions center around labor market regulations and migration policy. Currently, these regulations encourage short-term migration from Ukraine, making it easy for immigrants to come into Poland for bursts of work, while at the same time not encouraging long-term settlement and integration (Iglicka et al. 2011; Szulecka 2016; Górny, Kindler 2018). In fact, some argue that Poland's migration policy is especially

designed to impede integration, thus gaining the necessary labor without gaining a diverse immigrant group (Stefańska 2015). If this is indeed the case, careful consideration must be made as to how the wellbeing of migrant workers can be protected, beyond simply utilizing their labor.

Ultimately, Poland is at a turning point with regards to creating immigration policy as it moves from being a country of emigration to one with significant immigrant populations within its borders (White 2018). Currently there is no single institution responsible with ensuring immigrant integration and this task now largely falls to municipal governments and NGOs (Mikulska-Jolles 2019).

The most recently published proposal for a Polish migration policy, which attempts to fill a gap after the previous policy was abolished in 2016, was commissioned by the Ministry of Interior and Administration and released while this project was taking place. It mentions access to healthcare only in passing, suggests no vision for what migrant access should look like, and focuses less on immigrant wellbeing and more on preventing exploitation of the NHF (Zespół do Spraw Migracji 2019). It assumes that there is an 'appropriate way to use health services which new arrivals or visible minorities […] fail to follow' (Bradby, Brand 2016) instead of seriously considering whether there are better and more efficient way to organize services for migrant use.

Moreover, the official discussions of migration in Poland, make no mention of the possible health risks that are associated with hosting large groups of circulatory migrants who do not have regular access to healthcare. The failure to consider both the wellbeing of economic migrants (Stefańska 2015) and the inherent risks tied to the presence of uninsured populations is both sad and dangerous.

Yet these issues will have to be addressed. As a UN member Poland has committed to the Sustainable Development Goals, including those on protecting the health of migrant workers (Norredam, Agyemang 2019). Moreover, continuous attempts have been made by the EU to place migrant workers under a protected status (Kindler 2011). Finally, the influx of immigrants from the East, such as Ukrainians, but also Belarusians, Chechens, and Russians, has already posed questions about epidemiological safety (Coker et al. 2004).

This is additionally worrying if, as this study suggests, immigrants are bringing a steady flow of Ukrainian-bought antibiotics over the border, especially with the prevalence of drug-resistant TB in Ukraine (Zielonka 2016). Additionally, conflict on the Eastern border has already caused the spread of HIV towards the west with internal migration (Vasylyeva et al. 2018), but has also caused increased immigration to Poland form Eastern Ukrainian regions (Chmielewka, Dobroczek, Puzynkiewicz 2016). In turn, Poland's aging population is increasingly reliant on immigrant carers, such as the Ukrainian women interviewed in this study (Bartha et al. 2015). It is thus apparent that Polish healthcare policy and migration policy should be treated as deeply intertwined, and labor market strategies should not be divorced from conversations about healthcare access, need, and use.

7.1 Recommendations

This study only begins to fill the gap of understanding on how Ukrainian immigrants in Poland interact with the Polish healthcare system, and further studies are necessary to move beyond a preliminary understanding of access issues.

Further evidence is needed on the behaviors of other groups (such as men working in construction), epidemiological data on specific health needs and service use, as well as deeper economic understanding of the price point at which migrant workers and employers are likely to choose formal contracts. Support should thus be provided to research institutions such as the Center of Migration Research or the National Institute of Public Health to both conduct such research and ensure the issues of public health are not divorced from migration policy.

Predicated on further research, the following actions should be considered:

1. The Ministry of Health should aim to alleviate healthcare access barriers for Ukrainian migrants by investing in solutions such as distributing information in Ukrainian and Russian and providing translation services in major hospitals. Moreover, the ministry should support NGO's already actively distributing healthcare information and consider collaborating directly with such NGOs on healthcare projects.

2. The Ministry of Health and National Health Fund should consider establishing a short-term, low-cost insurance scheme to replace inadequate tourist insurance purchased in Ukraine. This scheme could provide immigrants with reliable pre-paid access to emergency care, shield against the use of private provision, while simultaneously protecting the NHF from treating uninsured patients. This scheme could utilize the fact that most Ukrainian migrants enter Poland legally, and be based on a single payment tied to the legal maximum stay (either 6 months for those with 'declarations to hire', or 90 days for those entering as tourists).

3. The Ministry of Foreign Affairs, currently responsible for visa policies, should collaborate with the Ministry of Health and state medical universities to acknowledge the potential of an influx of trained nurses from Ukraine to Poland. Especially given the shortage of medical personal in Poland (Segan et al. 2011), a system of accreditation and formalized hiring could allow Ukrainian step into official domestic career roles at higher wages and better conditions.

4. The Ministry of Foreign Affairs should consider establishing a system of short-term, flexible, legal employment for domestic workers, in which not all of the contract costs fall to individual households. This could be done by following an agency model of hiring, such as in the UK, Canada, or Belgium (Bartha et al. 2015; Fudge, Hobden 2018), where immigrants are hired by private agencies which are then contracted by individual households for cleaning and care services. While the exact nature of the employment

process and level of protection will vary by context, such models can promote the formalization of domestic work.

5. The Polish government should consider appointing a single body in charge of monitoring immigration affairs across sectors and coordinating immigration projects between ministries, public institutions, and NGOs.

7.2 Limitations

First, it is important to remember that Ukrainian women working in the domestic sector in Warsaw do not constitute the whole of Ukrainian immigration into Poland, and as such the results cannot be applied to Ukrainian immigrants overall.

The nature of the recruitment further limited the study. As interviews were conducted in Polish, study participation was limited to women who are more established in Poland, have gained proficient language skills, and may thus be more practiced in navigating the Polish healthcare system. Moreover, women with unregulated legal status or those working in the informal sector may have been less likely to participate in the study from fear of disclosure. Thus, the study may have missed the most vulnerable of Ukrainian domestic migrant workers.

Lastly, given that some of the recruitment happened via the women's employers, interviewees may have limited the conversation topics they were willing to discuss, especially those connected to workplace exploitation.

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9 Appendix I – Topic Guide

Interviews conducted as part of this study were semi-structured around the following themes and questions:

General opinions on healthcare in Poland

- What are your opinions of healthcare in Poland?
- How do you think Polish healthcare services compare with those in Ukraine?
- If you can or could use healthcare in both places, which would you prefer and why?

Experiences of using Polish healthcare services

- Have you used healthcare services in Poland?
- Which services have you used?
  Probe: going to the doctor, going to the hospital, or asking for help at a pharmacy?
- Can you tell me the process you went through to get this/these service(s)?
  Probe: ease/difficulty.
- Would you use the same services again and why? If you haven't accessed healthcare services in Poland – why not?

Access to healthcare services in Poland

- Do you feel like you can access medical services easily when you need / want them? What helps to facilitate your access to them?
  Probe barriers: e.g. health system, legal, personal, language, work, etc.
- What would make access easier?
- How would you go about finding a doctor and making an appointment if you needed medical care? Would you go to a family doctor? Would you go to the hospital?
- Where would you go for information about what doctor to use and how to make an appointment?

Last healthcare-seeking experience

- When was the last time you needed / wanted medical care?
- What did you do in this situation? Did you seek medical care in Poland?
- Did you seek medical care somewhere else (like Ukraine)?
- What influenced this choice? Is this what you would normally do? Is this what you would do again?

Topics Added during the interview process

- Have you bought medicine in Poland? What about Ukraine? Do you travel with this medication?
- Have you ever felt discriminated against while seeking medical care?
- Have you ever been helped by an employer when you needed medical care?

Thank participant to end.

10 Appendix II – Information Sheet Provided to Participants

This information sheet was provided in English, Polish, Ukrainian, and Russian, depending on the participant's choice:

Study Title: Understanding health-seeking behavior and barriers to healthcare access among Ukrainian domestic migrant workers in Warsaw, Poland

Information Sheet

We would like to invite you to take part in this research study on Ukrainian migrant domestic workers' health-seeking behavior and access to healthcare in Poland. Before you decide we would like you to understand why the research is being done and what it would involve for you. We will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish and ask us if there is anything that is not clear.

It is up to you to decide to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

Why would we like to talk to you?

We are trying to understand what Ukrainian migrants working in the domestic sector do when they are faced with a medical concern, and what healthcare services are accessible to them. We are interested in understanding your experiences with needing and using healthcare during your stay in Poland. We are interested in hearing from you about any form of care you needed in the past (or think you might need in the future): taking medicine, visiting a doctor, going to the dentist, being in the hospital, or others. We would like to know how you accessed such healthcare, where you accessed it, what were the factors affecting your choices, and if you encountered any difficulties along the way.

Who is carrying out the study?

This study is being undertaken by Alexandra Levitas, a master's student at the London School of Hygiene and Tropical Medicine and will form part of her degree qualification. While in Poland, Alexandra Levitas will also be working with the Centre of Migration Research, University of Warsaw. Once finished, results of this study might be used in a journal article and/or conference presentation.

Who can take part?

In order to take part in this research, you should be:

- A Ukrainian female migrant
- Aged 18 years or older
- Proficient in Polish or English
- Currently working (or have worked in the past year) in the domestic sector

What is involved?

If you consent to take part in this research, we will interview you face-to-face to ask some questions about your experiences accessing healthcare in Poland. The interview can take place in a place you choose – such as a community center, café, office, Centre of Migration Research, etc. The interview should take no more than one hour.

With your consent, the interview will be recorded. After the interview, the recording will be used only for analysis and only be accessible by the researcher and her supervisors. The recording will be typed up and written quotes from the interview may be used in the researcher's MSc thesis, conference presentation(s), or journal article(s). These quotes will not enable you or any other research participant to be identified and none of your personal information will be shared. This study will be conducted in Poland and data will be analyzed and stored both in Poland and in the United Kingdom. Recordings and transcripts will be stored securely and deleted in September 2020, one year after the research project is finished.

You can withdraw from the research and ask us to remove your data at any time without any negative consequences.

This research project has been reviewed and approved by the LSHTM ethics committee, as well as by the ethics committee of the Centre of Migration Research.

Reference Number:
LSHTM MSc 16966
CMR/EC/2/2019

Is the research confidential?

Yes. Any personal data, information and experiences that you agree to share (including the information we used to contact you) will only be seen by the researcher. All information will be stored securely. When we write up the findings of the study, we will not use your real name or any personal information you disclose to us.

The only information that we may have to pass on is in the rare event that you tell us that you or someone else is at risk of serious harm (suicide or serious physical harm).

What are the benefits of taking part?

You will be contributing to a study that aims to find out more about issues Ukrainian migrant domestic workers in Poland face in accessing healthcare. Hopefully this information will then inform improvement of service access in the future.

What are the risks of taking part?

There are no risks in taking part. You can withdraw at any point, and you can choose not to discuss any topics that you do not wish to talk about.

Do I have to take part?

No. If you decide not to take part it will not have an effect on any of the services that you receive.

Further information

For further information about the project or about how your data will be stored and used, please contact Alexandra Levitas. *[contact information provided]*

You should also contact Alexandra Levitas if you would like to withdraw all, or part, of your data from this study.

Additional Support
If you find yourself needing support in accessing legal or medical services, the following organizations work with Ukrainian migrants in Poland:

Ukrainian House
(Dom Ukraiński)

Ukrainian House is a community organization which offers a range of social activities for Ukrainian migrants and free consultations concerning legal issues for Ukrainians in Poland. While they do not specialize in advice on healthcare access, they give general advice on life in Poland and will be able to direct you to the appropriate institution with help for specific problems.

ul. Zamenhofa 1
00-153 Warszawa
tel. (22) 258 40 18

biuro@ukrainskidom.pl

Polish Migration Forum
(Polskie Forum Migracyjne)

The Polish Migration Forum provides general information to migrants about services available in Poland as well as free individual consultations by appointment on a variety of migrant legal issues. If needed, they will provide support and advice on access to medical care as well as other needs.

ul. Szpitalna 5
02-672 Warszawa
tel. 692 913 993

http://www.forummigracyjne.org/pl

11 Appendix III – Consent Form

This consent form was provided in English, Polish, Ukrainian, and Russian, depending on the participant's choice:

Consent Form for Interviews

Thank you for reading the information sheet about this study. If you are happy to participate then please complete and sign the form below.

	Please tick box:
I have read the information sheet concerning this study and I understand what will be required of me and what will happen to me if I take part in it.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences.	☐
I have had the opportunity to ask questions and my questions concerning this study have been answered by Alexandra Levitas.	☐
I understand that some of the questions asked may involve sensitive topics around my health or healthcare use and access. I understand that this data is being collected only as part of public health research and will not be used for any other purposes.	☐
I understand that I do not have to answer any particular question and I can decline without giving a reason and without there being any negative consequences.	☐
I understand that my personal data and my responses will be kept strictly confidential. I understand that my name will not be linked with the research materials and will not be identified or identifiable in any reports that result from the research.	☐
I agree for this interview to be audio recorded. I understand that the audio recording made of this interview will be used only for analysis from which I would not be personally identified.	☐
I agree that anonymized written quotes from the interview, from which I would not be personally identified, may be used in the researcher's MSc thesis, any conference presentation(s), or journal article(s) developed as a result of the research.	☐
I agree to take part in this study.	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Investigator	Date	Signature

This consent form to be retained securely by the investigation team;
the Information Sheet is to be retained by the participant.