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Ways of (Un-)Being and Ways of (Un-)Belonging in the Transnational Opioid Field of Ukrainian Forced Migrants in Poland

Abstract: This study examines how Ukrainians living with Human Immunodeficiency Virus (HIV) and/or using opioids access care after their forcible displacement to Poland following Russia's invasion of their country. Drawing on 37 qualitative interviews with health care providers, NGO workers, and displaced Ukrainians, we analyze how forced migration reshapes practices and identities within a transnational field of opioid use and HIV care. Using Levitt and Schiller's framework of transnational social fields, we focus on "ways of being" and "ways of belonging" to understand the everyday practices of accessing care and the identity work required for it. Our findings reveal that displacement often disrupts established treatment and support routines, resulting in a sense of "un-being" when familiar strategies become ineffective or risky. Simultaneously, the analysis illuminates the dynamics of "un-belonging" demonstrating how the institutional identities required to negotiate specialized care intersect with systemic stigma, moral judgment, and the anticipation of sanctions. These processes are shaped by the interaction between Poland's fragmented, semi-peripheral harm reduction regime and the prior experiences of migrants within Ukraine's strongly donor-driven care system. We argue that understanding access to care requires attention to the transnational circulation of practices, identities, and stigma. We also highlight the need for more responsive, culturally informed harm reduction services in receiving countries.

Keywords: Poland, Ukraine, forced migration, people who use opioids, people living with HIV, transnational social fields

Introduction: Between Peripheries and Cores

Although once a country from which people emigrated, Poland has become a destination for migrants due to its rapid economic growth and also due to geopolitical developments, most notably the war in Ukraine (Kindler & Tygielski 2025; Fihel et al. 2023; Okólski 2021). Amid intensified return migration, Poland is currently experiencing a migration transition (White 2024). Incoming migrants may face challenges such as limited social connectedness, labor market marginalization, constraints in access to housing, and differential treatment (Kindler & Wójcikowska-Baniak 2019; Jaskulowski & Pawlak 2020; Narkowicz et al. 2025).

Poland can be characterized as a migration semi-periphery (King 2019; Stola 2001). As an EU borderland, it receives a significant portion of immigration from peripheral regions while simultaneously remaining a source of emigration to the global core. In terms of migrant inclusion and institutional preparedness to function as a receiving country, Poland

has a specialized non-governmental organization (NGO) sector and exhibits periodic societal effervescence, but it also faces challenges in the implementation of migrant services and assistance (Kindler & Tygielski 2025). The need to receive Ukrainians fleeing the Russian invasion resulted in heightened social solidarity (Bhabha et al. 2025). However, it has also been demonstrated that such solidarity can be selective (Bialasiewicz et al. 2025) and shaped by the interplay of securitization and human rights approaches (Caballero-Vélez 2023).

Although forced migration and refugee issues gained rhetorical prominence in Poland following the so-called 2015 refugee crisis, they remained largely marginal in practice (Klaus 2017; Sobczak-Szelc et al. 2022). This shifted after Russia's full-scale invasion of Ukraine in 2022 led to the arrival of approximately one million displaced Ukrainians in Poland (Wanke 2023). In response to the increased presence of Ukrainian forced migrants, the government passed a bill granting them access to education, health care, social services, and the labor market (see Kindler & Tygielski 2025), in alignment with the European Union's Temporary Protection Directive. More broadly, EU integration policy combines inclusion with boundary-reinforcing practices (Dodevska 2023), a pattern that is also evident in the Polish case.

Poland reportedly received 3.6 million forced migrants from Ukraine late May 2022, though by a year later, less than a million remained. They were predominantly young or middle-aged women, or children (Kubiciel-Lodzińska et al. 2024; Kohlenberger et al. 2023). Receiving them involved considerable challenges, including in connection with various vulnerabilities and risks, as would have been characteristic of the receipt of any population of such a size.

One such vulnerability is associated with the use of psychoactive substances and the potential availability of treatment-related services for migrants (De Kock 2020). While the topic of drug use may encompass a wide range of substances, the present study focuses specifically on opioid users. These people rely on highly institutionalized, medicalized Opioid Agonist Therapy (OAT) systems, making their legal, clinical, and social navigation distinct from that of users of other illicit substances. Access to substance use treatment in Poland is shaped by a fragmented policy environment that in certain ways may lead to the stigmatization of people who use drugs (Malinowska-Sempruch 2016).

Prior to the war, Ukraine had developed extensive, donor-funded services targeting people living with Human Immunodeficiency Virus (HIV) and people using opioids (Ompad et al. 2017; Trickey et al. 2020). Although these groups face different challenges and life conditions, they are connected through support networks. Moreover, services for these individuals are often co-located in Ukraine due to the prevalence there of individuals who have both HIV infection and use opioids (Zelenev et al. 2019). Following the 2022 full-scale invasion, the public health infrastructure in Ukraine demonstrated significant resilience; through rapid legislative modifications and centralized mobilization, the government swiftly adjusted protocols to ensure the continuity of care. This included increasing medication storage capacities at local facilities and expanding unsupervised take-home OAT dosing limits to 30 days (Ivanchuk 2023; Morozova et al. 2023). While these emergency measures successfully sustained thousands of patients within government-controlled territories, intense domestic displacement, localized medication shortages, and

the total shutdown of programs in occupied regions ultimately destabilized individual treatment pathways (Morozova et al. 2023), driving the transnational navigation of care observed in this study.

Prompted by recurring reports concerning forced migrants' access to health services in Europe, including in Poland (Nikitin et al. 2023), our study addresses an intertwined, resettled population of people who live with HIV and/or use opioids (Owczarzak et al. 2023). These groups share a social field—a network of social relations and power positions through which they interact and in which they are embedded. Applying Levitt and Schiller's (2004) concept of a transnational social field, we examine how this landscape of HIV and opioid care is reconfigured following displacement. Specifically, we analyze forced migrants' everyday practices (“ways of being”), and identity expressions across origin and host societies (“ways of belonging”), to uncover how structural barriers and persistent stigma operate within the Polish context. Ultimately, by connecting these transnational dynamics to on-the-ground experiences, our goal is to illuminate what hinders and what enhances access to care for this population.

In the following sections, we will first review the limited literature on migration and drugs. We will summarize the barriers that migrants and forced migrants face when accessing health care services, with a focus on stigma. Next, we introduce the concept of the transnational opioid field to shed light on the power struggles associated with changing and maintaining drug-user identities and practices during migration. Through an exploratory, qualitative, interview-based study, drawing on accounts of specialized health care providers, NGO staff, and key displaced Ukrainian informants, we examine the dynamics of HIV care and the treatment systems for opioid use. We explore ways of being in and belonging to the Polish health care system within the transnational social field to capture how systemic practices and identity boundaries are negotiated across borders. Ultimately, we argue that despite the existence of services and formal pathways to access them, further work could be done to increase system navigation and accessibility for this vulnerable population.

Literature Review and Conceptual Framework: The Transnational Social Field of Opioids and HIV—Migration, Stigma, and Access to Care

The prevalence of HIV infection in Ukraine is among the highest in Europe (European Centre for Disease Prevention and Control/WHO Regional Office for Europe, 2025). It was estimated to be 26.5 cases per 100,000 people in 2024, which was lower than in 2021 (37.0 cases per 100,000). These rates were substantially higher than those found in Poland (4.0 cases per 100,000 in 2021; 5.5 cases per 100,000 in 2024) (European Centre for Disease Prevention and Control/WHO Regional Office for Europe, 2025). In 2022, HIV infections across the European Union and the European Economic Area rose by 31% over the preceding year, which was in part due to the relocation of previously diagnosed forced migrants from Ukraine (Niedźwiedzka-Stadnik et al. 2024). In Poland, 3,552 forced migrants from Ukraine were receiving antiretroviral therapy for HIV in 2023 (Niedźwiedzka-Stadnik et al. 2025). Poland was at the time the host country with the

largest number of these patients in the European Union (Kuchukhidze et al. 2024). That year, 530 individuals with Ukrainian citizenship were diagnosed with HIV in Poland, representing 22% of all cases diagnosed that year, with 44% of the individuals having a prior diagnosis from Ukraine (Niedźwiedzka-Stadnik et al. 2025). There were also 63 individuals with Ukrainian citizenship diagnosed with AIDS in 2023, representing 36% of the cases newly identified that year (Niedźwiedzka-Stadnik et al. 2025). In terms of people who inject drugs, data from the Global State of Harm Reduction 2024 report estimated the numbers to be 14,664 individuals in Poland and 350,000 in Ukraine, of whom around a fifth were infected with HIV across both countries (Harm Reduction International, 2024). Although statistics on the citizenship of people in OAT were not provided, the European Drug Report 2026 noted that there was a 42% increase in the number of recipients in Poland from 2019 to 2024 (European Union Drugs Agency, 2026).

Divergent Institutional Landscapes: Drug Policy in Poland and Ukraine

As a member of the European Union and a participant in the work of the European Union Drug Agency (EUDA, formerly the EMCDDA, the European Monitoring Centre on Drugs and Drug Policy), Poland has been formally engaged with the strategic goals and policy discourse on harm reduction. However, the EU itself cannot be considered central to global harm reduction dynamics (Jeziorska et al. 2025), and in Poland, drug laws are prohibitionist and punitive in nature, there are limited harm reduction policies, and monitoring efforts and strategies related to harm reduction are not widely implemented (Malinowska-Sempruch 2016; Struzik 2021). Many structural barriers persist, ranging from societal attitudes to levels of funding (Kender-Jeziorska 2019).

Recent developments in Polish drug policy and politics can be considered a product of the country's semi-peripheral location (Malinowska-Sempruch 2016). Poland's approach was once shaped by the Soviet view of drug use as a "bourgeois" and marginal issue, requiring medicalization and compulsory treatment. Combined with Poland's lack of civil society, this Soviet legacy produced post-transition shock after 1989. Simultaneously, policy-makers rapid adoption of the Western model of criminalization, exemplified by the tightening of legislation and moralizing the discourse about "narcomania," created an environment in which the use of psychoactive substances was stigmatized and repressed, with limited attention from public health institutions (Krajewski 2004). This produced a "doublethink" situation (Allaste & Lagerspetz 2005) for people who used drugs in Poland in that they were subject to punitive laws and discourses, while at the same time they were operating in globally interconnected, highly normalized environments and had mediated or migratory experience of liberal drug contexts (Wanke et al. 2024).

Such institutional "doublethink" appears clearly in the specific context of opioid use, where the current political and social climate creates an array of issues for people who use opioids, as well as for the organizations that provide assistance to them in Poland. Struzik (2021) argues that harm reduction is morally sanctioned and often misrepresented and reduced to the "promotion of drug use," making service providers "maneuver" in order to adhere to acceptable health or human rights frameworks. According to research conducted

by Klingemann (2017), some individuals receiving opioid agonist therapy in Poland have reported experiencing fear of criminalization, loss of autonomy, and humiliation, as their care was risk-focused and abstinence-oriented. Furthermore, it was noted that limited OAT coverage was an effect of fragmented and weakly integrated substance use treatment and mental health care services (Klingemann 2017), which has contributed to reports of stigma and rights violations (Helsinki Foundation for Human Rights et al. 2024).

In contrast to Poland's punitive trajectory, prewar Ukraine embraced intensive harm reduction programs, which were predominantly provided and financed by external actors. These programs include needle and syringe exchanges, HIV and hepatitis C (HCV) testing, and linkage to OAT and HIV treatment (Trickey et al. 2020). Nonetheless, access challenges remain and have been affected by the war. Paradoxically, Ukraine's relatively progressive drug policy is partly due to the HIV crisis of the 1990s and 2000s, which led to substantial funding and expertise being aimed at combatting the epidemic (Parczewski & Gökengin 2024).

Carroll (2019) notes that despite Ukraine's extensive network of internationally funded services for opioid users and people living with HIV, it has a deeply ingrained Soviet-era cultural and political "addiction imaginary" that frames substance use as a pathology. This cultural stigma is further reflected in health care and social services, where a subset of people who inject drugs report facing barriers, including negative stereotypes and discrimination. As highlighted by Burlaka and colleagues (2026), some health care professionals may hold biased views of people who inject drugs, associating them with moral failure or poor hygiene, which in turn limits their access to appropriate levels of treatment. Additionally, structural barriers, such as rigid regulations, service fees, and a shortage of medical personnel, continue to hinder access to harm reduction services and OAT (Bojko et al. 2015; Polonsky et al. 2015).

The Intersection of Migration, Forced Displacement, and Health Care

When individuals operating within these disparate national systems are displaced across borders, they enter a distinct legal and social matrix comprising the double semi-peripherality of migration and drug policy. Nevertheless, research on migration and drug use is an emerging field (van Selm et al. 2023). Empirical studies tend to focus on either ethnic populations with a migration background (Williams et al. 2017; Shabalah et al. 2025) or vulnerable, mobile populations with problematic substance use in retention centers (De Kock 2024; Pouille et al. 2024). Due to facing layered stigma (Henkel et al. 2008) and intersectional vulnerabilities, people who migrate and use drugs are an especially hard-to-reach population outside of visible groupings or institutional settings, and they are not closely monitored (De Kock 2021). Therefore, little is known about this population because their drug use does not attract societal or institutional attention, and they are not typically viewed as a priority in terms of drug-related health risks by the societies in which they have relocated (Lemmens et al. 2017).

This broader migration vulnerability became an acute reality in 2022, prompting recent studies to examine access to health care among refugees in Poland, particularly after

the arrival of Ukrainian forced migrants in 2022 (Pędziwiatr et al. 2024; Follis 2025; Kędziora 2024; Toczyski 2025). Access to health care is a fundamental human right, and Poland guarantees this right to Ukrainian forced migrants under the Special Act on Assistance to Ukrainian Citizens in Connection with the Armed Conflict in Ukraine. The Act makes migrants eligible for medical care, social services, and health insurance.¹ However, in practice, some individuals may face greater challenges in accessing care than others, as Kędziora (2024) demonstrated in the context of structural and policy disparities. Access to care is further supported by NGOs, social networks, and capacity-building initiatives such as Mental Health and Psychosocial Support (MHPSS) training programs (Toczyski 2025). Barriers that persist include administrative hurdles, language limitations, uneven distribution of information, institutional overload, and socioeconomic constraints (Kędziora 2024; Follis 2025).

Traveling Stigmas and War-Induced Disruptions

People who migrate from one context to another adhere to a double frame of reference. In the case of Ukrainians who are living with HIV or using substances, they transition from one highly stigmatized environment to another when relocating to Poland. Stigma is a social process in which specific attributes, behaviors, or conditions are devalued, resulting in discrimination, exclusion, or internalized shame. Stigma frequently intersects with marginalized identities, as documented among people living with HIV and those using substances in the United States (Henkel et al. 2008). Stigmatizing processes operate in both directions: individuals and institutions stigmatize people living with HIV, opioid users, and migrants, while those affected experience and internalize this devaluation, which in turn shapes their interactions, access to care, and social integration (Pouille et al. 2023, 2024). For migrants and displaced populations, stigma can travel across borders. Experiences of marginalization in Ukraine or other sending contexts influence how individuals navigate health services and social networks in Poland (Owczarzak et al. 2023). In Ukraine, the use of opioids and living with HIV are subjects of profound moralization, a phenomenon stemming from the Soviet-era legacies of drug policy and social attitudes. Some of the authors claim that these attitudes construct substance use as “deviant” and individuals living with HIV as “morally suspect” (Dubov et al. 2024; Parczewski et al. 2025; Carroll 2019). Ukrainian migrants subsequently bring these stigmas with them to Poland, where they intersect with the challenges of migration and create overlapping barriers to harm reduction and health care access. It is critical to understand these complex and transnational stigmas in order to capture the lived experiences of Ukrainian migrants who use opioids or live with HIV. This knowledge is essential for designing responsive care regimes in semi-peripheral contexts (Henkel et al. 2008; Owczarzak et al. 2023).

Against the backdrop of high prewar prevalence rates and the fragile specialized treatment infrastructure in Ukraine (Ministry of Health of Ukraine 2025; Scaturro 2024), mass displacement forced individuals living with HIV and/or using opioids to navigate

¹ Temporary protection mechanisms are scheduled to be phased out following legislative updates in 2026, which will inevitably alter access to care for the most vulnerable.

the difficulties of ensuring continued care across borders. The war has had a disruptive effect on these services, particularly in occupied and conflict-affected territories, including due to the destruction or closure of clinics, the displacement of medical personnel, and the interruption of OAT and HIV treatment (Dubov et al. 2024; Karagodina et al. 2023). People on OAT faced sudden disconnection from their medications, difficulties transferring prescriptions, and the fear of withdrawal or overdose during displacement. People living with HIV encountered difficulties in maintaining their antiretroviral therapy, accessing laboratory monitoring, and attending clinical appointments. These challenges were often exacerbated by incomplete medical records, and bureaucratic barriers in host countries (Dubov et al. 2024; van Bremen et al. 2024; Nikitin et al. 2023). The disruptions were further complicated by constrained transportation alternatives, financial instability, and the emotional distress associated with fleeing, which resulted in disrupted treatment regimens, deteriorating health, and a heightened susceptibility to HIV transmission. Despite these challenges, some displaced people maintained links to care through transnational networks, NGOs, and informal support systems. This enabled them to cope with complex bureaucracies and health systems in order to continue treatment (Owczarzak et al. 2023; Nikitin et al. 2023; van Bremen et al. 2024).

The Theoretical Framework: Transnational Social Fields and (Un-)Belonging

For the purpose of this analysis, people living with HIV and people who use opioids are considered to be partially overlapping groups, although it is important to note that not all individuals belong to both categories. Nonetheless, they navigate the same care infrastructures and encounter similar structural barriers and facilitators in accessing treatment (Owczarzak et al. 2023; Karagodina et al. 2023; van Bremen et al. 2024). The grouping of these populations facilitates the examination of shared transnational practices, forms of marginalization, and strategies of care engagement. This framing underscores how the nexus of migration, health vulnerability, and stigma produce barriers to care and transnational strategies of resilience.

In order to theorize these cross-border dynamics of practice, identity, and power, we draw on the work of Levitt and Schiller (2004), who shifted discussion of migration research away from linear, one-directional thinking. They did so by adopting the Bourdieuan concept of “the field” to theorize the simultaneous affiliation of migrants with their country of origin and their destination country. They challenged the periphery-to-core vector of migration by emphasizing the multi-directionality of migratory experiences and demonstrating how remittances and cultural flows operate within migration fields. By distinguishing between ways of being and belonging to the transnational field, Levitt and Schiller illustrated how fields structure practices and habitus:

Ways of being refers to the actual social relations and practices that individuals engage in rather than to the identities associated with their actions. Social fields contain institutions, organizations, and experiences, within their various levels, that generate categories of identity that are ascribed to or chosen by individuals or groups. [...] In contrast, ways of belonging refers to practices that signal or enact an identity which demonstrates a conscious connection to a particular group (Levitt & Schiller 2004: 1010).

Ways of being and of belonging are embedded in the field and contingent on its institutions, positions, and hierarchies, which produce inequalities. In this paper, we consider the realms of opioid use and HIV infection as fields and examine their transnational navigation in the context of forcibly relocated Ukrainians who use opioids and/or are living with HIV. We base our reflections on interviews conducted with individuals with knowledge of the specialized treatment landscape and health care access. “Ways of being” in the social field are the actual practices and routines through which migrants express their identity in daily life, such as seeking harm reduction services or obtaining medication. Conversely, “ways of belonging” to the field are manifestations of being a person living with HIV or a person who uses opioids.

Due to the prevailing stigma in this specific field and the inherent challenges associated with its transnational expansion, the present analysis proposes a theoretical framework that explores the concept of “ways of (un-)being” and “ways of (un-)belonging.” This conceptual framework aims to shed light on the negative: the barriers that constrain access to health care, and the transnational stigmatization of identities. The utilization of this analytical tool facilitates the highlighting of the imbalanced distribution of power and the vulnerability evident among the population under study.

Methodology:

A Qualitative Study of Access to Health Care Among Forcibly Displaced Ukrainians

This study examines how forcibly displaced Ukrainians living with HIV and/or using opioids navigate access to care in Poland and how this process is shaped by the transnational reconfiguration of the opioid and HIV fields introduced earlier. We designed this embedded study as an exploratory qualitative project and were thus able to trace the complex, sometimes contradictory, experiences of individuals positioned differently within these fields.² Our objective was to generate situated knowledge that would illuminate how access to care is structured, negotiated, and constrained within a semi-peripheral context.

We conducted semi-structured interviews with a total of 37 participants divided into two groups. The first group comprised 27 male and female professionals working in organizations involved in mental health services and substance use treatment, harm reduction, or HIV care. They included members of the staff of non-governmental organizations, international NGOs, intergovernmental organizations, or public health care institutions, with a mix of frontline and managerial roles. Some of these participants also had a migration background themselves. The second group comprised 10 forcibly displaced Ukrainian women aged 37 to 62. This sample included both long-term residents who had settled in Poland prior to 2022 and those who had fled immediately after the February 2022 invasion, providing a spectrum of experiences ranging from recent displacement to long-term familiarity with the system. These individuals were purposively recruited as key informants because of their extensive experience navigating the broader Polish health care, humanitarian, and social support sectors. To be included, individuals had to be acquainted with

² This study was conducted as part of a larger research project entitled “Access to specialized mental health and psychosocial support services among refugees from Ukraine in Poland” <https://mhpsref.cm-uj.krakow.pl/en>

the sphere of mental health and substance use treatment in Poland. This selection allowed us to ground the specialized insights of service providers within a wider, lived context of post-displacement realities. Participants were recruited based on their familiarity with substance use and HIV care systems and their knowledge of the needs of displaced Ukrainians. They were also purposively recruited from Polish urban centers of varying sizes and regions, including Warsaw, Krakow, Opole, Białystok, Toruń, and Zielona Góra. Because the study explored a sensitive topic, the empirical focus on specific OAT and HIV trajectories relied primarily on the accounts of the service providers. No financial compensation was provided to the participants, but all were offered information regarding local support resources.

The interviews were conducted by all the authors and collaborators between March and May 2025, in Polish, Ukrainian, Russian, or English, depending on the preference of individual participants. The interviews explored perceptions of the needs and characteristics of the displaced population, experiences with substance use treatment and HIV care, strategies for seeking assistance, comparisons between the Polish and Ukrainian systems, and perceived barriers and facilitators in accessing services. Each participant provided informed consent to take part in the interview, which lasted approximately one hour and was recorded and transcribed verbatim. The Ethical Committee at Jagiellonian University in Poland granted ethical approval for this study [decision no. 118.0043.1.78.2025, issued February 20, 2025]. All the participants received information in their preferred language about the study's objectives, its data handling procedures, and their rights as research participants. Written informed consent was obtained before each interview. The participants were free to choose the format and location of the interview, and all identifying information was removed during transcription and analysis. The study adhered to the principles of the Declaration of Helsinki (1964) for medical research involving human participation.

We adopted an inductive thematic analysis approach, utilizing the structural coding and theming protocols outlined by Saldaña (2013). Two team members conducted open coding to generate an initial set of categories, which we then refined through collective discussion. The analytic process was primarily shaped by our interest in how displacement reshapes positions within the opioid use and HIV treatment fields. The thematic structure that we developed reflected recurring patterns across the interviews, including population profiles, substance use treatment trajectories, displacement-related challenges, service availability, cross-border differences, and barriers to accessing assistance. The codes captured experiences with OAT and MHPSS, interruptions in HIV treatment, homelessness, relational strain, differences in medication protocols, and the multiple forms of stigma described by the participants. Although we referred to COREQ criteria (Tong et al. 2007) to ensure transparent reporting, our analysis remained grounded in a critical, field-sensitive interpretation of the participants' accounts.

The information produced here reflects the perspectives of care providers and forcibly displaced Ukrainians. Although providers occupy institutional positions shaped by professional norms and organizational directives, their perspectives are not uniform. Some of the providers working in the system were migrants themselves, bringing their experiences with mobility, linguistic negotiation, and marginalization into their professional roles. Their accounts offered insight into how institutional logics operate in practice and how frontline

workers navigate the tensions between formal procedures and the realities of displacement. Forcibly displaced Ukrainians, in turn, based on their interactions with the broader Polish health care system, contributed experiential knowledge of disrupted treatment, fragmented services, and the consequences of stigma and mobility. We treat these perspectives as complementary viewpoints within the same transnational field of care rather than as competing ones. Together, these perspectives reveal how displacement disrupts established notions of access to service and treatment pathways among persons who use opioids and/or have HIV, and demonstrate how individuals must adapt to these changes while living in the conditions of a semi-periphery.

Our own positionality as researchers shaped the material produced in this study. We are a team of four Poland-based scholars, all trained in sociology or public health. Only one of us specializes in drug research. None of us has personal experience of forced displacement. These backgrounds inevitably distance us from the everyday realities faced by forcibly displaced Ukrainians, especially those seeking HIV care or OAT amid war and resettlement. At the same time, our diverse disciplinary backgrounds and long-standing engagement with inequities in health systems have informed our shared commitment to epistemic care. Throughout the study, we approached participants as experts in their own experiences and in the institutional landscapes through which they move. We also reflected critically on the power asymmetries that determine who gets to speak for, interpret, and represent the experiences of others.

Results—the Transnational Opioid Field of Ukrainian Forced Migrants

Building on the inductive, field-sensitive analysis of interviews with forcibly displaced Ukrainians and care providers described above, this section examines how access to HIV and opioid-use care is negotiated within a transnational field shaped by displacement, regulatory changes, and unequal institutional environments. Through the participants' situated accounts, we identify two interrelated dimensions: disrupted care practices conceptualized as ways of un-being, and tensions connected with identity performances that generate un-belonging. These dimensions structure the following results.

Navigating Two Different Fields as One

The following analysis draws on the concept of the transnational social field to examine how forcibly displaced Ukrainians living with HIV and/or opioid use disorder navigate care in Poland. An inductive interpretation of interviews with care providers and displaced Ukrainians revealed two interrelated processes. First, the participants described disruptions to their routine practices of accessing treatment, medication, and support. We conceptualize these disruptions as moments of un-being, when established, embodied strategies no longer functioned across contexts. Second, the accounts highlighted tensions around identity performance within the field of care, producing forms of un-belonging, as necessary identities became sources of vulnerability. The results are organized in connection with these two dimensions.

Ways of (Un-)Being: Disrupted Practices

Levitt and Schiller's (2004) notion of "ways of being" in a transnational context helps us conceptualize how forcibly displaced Ukrainians navigate HIV and opioid use care in Poland. The ways of being of these populations are often disrupted, resulting in what we refer to as "ways of un-being": instances where individuals encounter obstacles to care, and the familiar strategies from their home context become ineffective. Displacement interrupts established routines and expected pathways of access, creating uncertainty and risk. In practice, this manifests as a reliance on previously learned ways of "doing"—they expect services, procedures, and support structures to operate as in Ukraine, but encounter a system that is organized differently and deems those practices counterproductive.

One major aspect of un-being is the considerable difference in support structures. In Ukraine, the prevalence rates of HIV and opioid use are higher than in Poland, and the system is supported by international programs. In Poland, the number of programs is smaller in comparison, and the services are more concentrated in urban centers, which creates gaps for people who were used to more continuous and accessible care. A professional described this contrast:

When it comes to differences between Ukraine and Poland, the main one is in the context of HIV infection: in Ukraine, there are 250,000 people living with HIV, while in Poland at that time there were 25,000 people living with HIV. In Poland, all people who are infected and have Polish public insurance...have access to antiretroviral drugs...Secondly, 80% of people in Ukraine have access to generic therapy. In fact, all of them are on the same regimen—those 80%. This regimen does not exist in Poland because these generic companies do not operate in Poland (P15, NGO, management role, female).

Medication schemes are another realm of un-being. People encounter new regimens, regulatory changes, and interruptions in access to generic therapies that have provided them with treatment stability. These disruptions are further complicated for individuals who are highly mobile and frequently cross borders. As one manager explained it:

The actions of the WHO and UNAIDS led to these [generic] drugs being imported in [Poland] in 2022 [...] But in 2023, these drugs had to be stopped and the original drugs introduced. This was also a medical dilemma [...] whether the person would continue this treatment here (P15, NGO, management role, female).

For mobile populations, such interruptions were more than just an inconvenience. They could lead to a deterioration in health, an increase in withdrawal risk from opioids, a higher risk of HIV transmission, or the development of Acquired Immunodeficiency Syndrome (AIDS).

Finally, ways of un-being are shaped by the availability (or absence) of targeted guidance and support in the host country. In Poland, navigating the health care system requires both knowledge of the bureaucratic processes and access to informal networks. These networks, which are often recreated transnationally by peers and volunteers, are vital in helping displaced Ukrainians find clinics, understand procedures, and maintain continuity in treatment. One frontline worker described this practice:

The first thing that interests them is the procedure for obtaining [OAT] treatment [...] If they know my phone number, they contact me; it doesn't even matter where they are, in which city. I can, for example, immediately provide a list of Polish clinics with addresses and contact details (P11, NGO, frontline role, male).

These networks demonstrate the crucial role of social ties and trust in survival and care when institutional support is limited or unclear. They enable individuals to carry their knowledge and practices from Ukraine to Poland despite new regulations, different medications, and unfamiliar systems. These informal, cross-border adaptations highlight how structural un-being is actively navigated and mitigated by the community via transnational peer support.

Un-being emerges when the social practices, routines, and support structures that people rely on in Ukraine no longer function as expected in the Polish context. Familiar ways of seeking care, obtaining medications, or connecting with support networks are disrupted, creating gaps that must be negotiated under conditions of uncertainty and mobility. In this sense, un-being is relational. It arises from the tension between prior embodied knowledge of the field and the institutional and social constraints in the host country, highlighting both vulnerability and adaptive strategies.

Ways of (Un-)Belonging: Frictional Identities

In the transnational social field of HIV and opioid use care, belonging is achieved through identity work, whereby forcibly displaced Ukrainians present themselves as people living with HIV infection or as opioid users to access networks, support, and treatment. However, this identity poses risks. It carries stigma, moral judgment, and criminal consequences in some conceivable contexts. Therefore, belonging to this field is paradoxical: Individuals must perform and make visible an identity that enables them to navigate care and social networks, while that identity simultaneously exposes them to social and institutional sanctions, marginalization, and anticipatory fear. This tension produces what we describe as forms of un-belonging in the transnational field.

It became apparent that the most significant culturally constructed barrier to seeking help was the anticipated stigma connected with mental health conditions, especially problems related to substance use. This stigma is multidimensional and affects multiple spheres of displaced people's lives. Work is particularly critical as a source of income and stability. Our participants claimed that employment affects decisions about whether to disclose a health condition. The prospect of losing a job due to substance dependence, treatment for a mental health condition, or living with HIV makes forced migrant employees reluctant to reveal their status. One frontline worker explained the situation in this manner:

The doctor does not always understand that the patient needs to arrange certain conditions with their employer for not coming to work tomorrow because they have things to do. Not everyone feels comfortable discussing these topics, (...) people are concerned that they may lose their jobs or housing if others learn that they have an addiction, are living with HIV, or are undergoing treatment for tuberculosis (P01, NGO, frontline & management role, female)

Beyond employment, the fear of real or imagined formal consequences shapes identity work. Some forcibly displaced individuals hesitate to disclose their opioid use or HIV status in Poland, as prior to migrating, they were acquainted with surveillance, the sharing of medical records, or deportation to one's country of origin. A manager said that

We noticed in our harm reduction program that people from Eastern Europe and Central Asia did not want to talk about testing at all and did not want to be tested, even though testing was anonymous and free. Later, they would

come to us regularly to exchange equipment, so we talked to them, gave them food, and it only came out during subsequent conversations that in their countries, when people find out that they are addicted, it is recorded in their files, which are then circulated to their employers. Plus, if someone has, I don't know, tuberculosis or HCV, in many countries they are simply deported. So many people are simply afraid of deportation, even though it's not a real possibility in Poland, right? (P15, NGO, management role, female).

This anticipatory fear of institutional tracking directly manifests as a form of transnational un-belonging, where the visible identity required to access health care is perceived as a profound legal and social liability.

Cultural understandings of mental health also influence identity work. Based on the interviews, seeking psychiatric care in Ukraine has historically been stigmatized, framing the individual as “mentally ill.” This background influences how displaced people approach psychological and substance use services in Poland, where the norms are arguably different:

In Ukraine, it was not common or socially accepted—if someone went to a psychiatrist, there was a stigma, like “you must be mentally ill.” I heard that a lot, growing up. Here, in Poland, people are used to the idea from childhood—that it's normal. If there's a problem, they go to a psychologist. And they're not ashamed to say it. They don't have the same kind of mental “frameworks” we were raised with. Younger generations in Ukraine are more relaxed about it, but people born in the 1990s—we were raised in stricter mental patterns (R08, forced migrant, female, 37).

Finally, stigma can limit opportunities for remote support. Forced migrants living in group settings may be reluctant to participate in phone or video consultations with specialists. Some professionals have reported providing psychological support under alternative labels in shelters to reduce the stigma of seeking care and to encourage engagement.

Across these contexts, un-belonging emerges when the identities that are necessary to navigate care also become sources of vulnerability. To access support, people must activate and perform their identities as individuals living with HIV or as opioid users, but these same identities expose them to social scrutiny, discrimination, and the anticipation of negative consequences. This tension reflects the relational nature of un-belonging, which does not arise from an absence of identity but rather from the friction between relevant, embodied identities and the structural, social, and moral constraints of the host context.

Discussion: Un-Being and Un-Belonging—the Challenges of Displaced Ukrainians in the Polish Health Care System

Our findings, which are drawn from the structural mapping provided by frontline professionals and the contextual narratives of displaced Ukrainian informants, reveal the complex ways in which forcibly displaced Ukrainians navigate HIV or opioid care in Poland. These findings highlight the tensions between embodied practices, institutional regimes, and the moral frameworks that shape access to treatment. Drawing from Levitt and Schiller's (2004) concept of “ways of being,” we demonstrate that displacement frequently disrupts established routines, resulting in a sense of disconnection or “un-being”: instances where familiar methods of acquiring medications, connecting with support networks, or maintaining the continuity of treatment are ineffective or inaccessible. These disruptions are compounded by differences in medication regimens and regulations, as well as the concentration of services

in urban centers. Simultaneously, “un-belonging” emerges in the transnational care field when individuals disclose identities—such as being HIV-positive or opioid-using—that are necessary for accessing support yet at the same time expose them to stigma, moral judgment, and potential legal or social consequences. These processes are mediated by transnational networks, peer knowledge, and the moral and normative frameworks that migrants carry with them, and show how care, identity, and moral economies intersect transnationally.

The Polish context, which is shaped by the country’s semi-peripheral position, contributes to these experiences of un-being and un-belonging. Harm reduction services are fragmented, risk-focused, and abstinence-oriented, producing situations in which individuals may fear criminalization, the loss of autonomy, or stigmatization (Klingemann 2017; Klingemann et al. 2025; Struzik 2021). This structural landscape directly aligns with our empirical observations regarding the anxiety about administrative tracking and data sharing reported by the participants based on past experiences. Even when formal pathways exist, uneven service distribution and information flows amplify vulnerability and uncertainty (Malinowska-Sempruch 2016; Owczarzak et al. 2023). Our data demonstrate how access to care is restricted by these dynamics, as well as by the fact that past experiences of institutional stigmatization in Ukraine travel transnationally, shaping the expectations, practices, and interactions of forced migrants in the host country. These structural and social constraints create embodied dilemmas, where legal, moral, and medical regimes converge, producing tension between survival, health, and identity (Tedeschi et al. 2022; Castañeda 2012).

Within this field, forcibly displaced Ukrainians navigate a moral economy of care, expecting continuity, respect, and non-penalizing treatment, yet encountering a system that is fragmented and sometimes morally prescriptive (Chiubrinskas & Glick Schiller 2025). As we learned through the interviews, disruptions in ways of being and the frictions in ways of belonging—when individuals perform necessary but socially risky identities—reveal the embodied and relational dimensions of un-being and un-belonging. Transnational networks, peer knowledge, and informal support structures emerge as crucial mediators, allowing individuals to negotiate access despite structural barriers (Bräuchler et al. 2021; Kashnitsky et al. 2025; Pouille et al. 2024).

This study is limited by the relatively small number of interviews conducted with forcibly displaced Ukrainians who are acquainted with the services for migrants using opioids and/or living with HIV. The study relies more heavily on the perspectives of service providers. While this approach means that the paper overviews the structural and institutional configurations of the care field rather than tracing the clinical experiences of individual patients, it enables us to map institutional logics and transnational care infrastructures. Due to the limited firsthand experiential accounts, future research should engage more extensively and directly with these hard-to-reach populations to provide further depth and nuance to the findings. This work could be supplemented with service provision and utilization statistics to contextualize the qualitative insights, but such research must be carefully designed to avoid reinforcing stigma.

Building on Levitt and Schiller’s (2004) framework of transnational social fields, this study extends the concepts of ways of being and belonging by introducing the complementary notions of “un-being” and “un-belonging.” As reported in the interviews conducted with service providers, these concepts capture the disruptions and frictions

experienced by forcibly displaced Ukrainians as they navigate HIV and opioid care across national contexts. “Un-being” emphasizes the disruption of established practices, routines, and access strategies in the host country. “Un-belonging” sheds light on the moral, social, and institutional tensions involved in performing identities that are crucial for care yet potentially stigmatizing. This study contributes a relational and dynamic understanding of transnational fields by emphasizing how prior experiences, stigma, and structural inequalities travel across borders to shape practices and identities. Moreover, situating these insights in a semi-peripheral context, such as Poland, highlights the role of uneven and prescriptive service infrastructures in transnational care. By foregrounding the negative or absent dimensions of being and belonging, the framework can better account for vulnerability, resilience, and adaptation in transnational health research.

The response to the arrival of forcibly displaced Ukrainians serves as a “breaching experiment” (Scambler 2020), revealing that fragmented and prescriptive service infrastructures limit access not only for migrants, but also for local populations who depend on harm reduction and HIV care. These findings suggest that systemic improvements in service delivery—wider geographic access, culturally and linguistically sensitive guidance, and efforts aimed at reducing stigmas—would benefit both displaced and resident populations. Formal pathways alone, such as legal provisions under the Temporary Protection Directive and state-regulated OAT clinic entry procedures, are insufficient. Effective care requires integrating transnational, peer-informed knowledge with flexible protocols, and recognizing patients’ prior experiences (Pouille et al. 2024). The arrival of Ukrainian forced migrants also highlights the untapped potential for improving services based on transnational practices and the application of lessons learned from other jurisdictions. Although the formal inclusion of the migrants in the health care system was facilitated by legal measures, practical access has not always been optimal. The structural barriers detailed in our results—specifically the high geographic concentration of programs in major urban centers and the abrupt termination of imported generic drug schemes—vividly reveal the limited and complex nature of service provision. There is significant potential for the application of transnational practices and pathways through which displaced individuals and networks could influence policy, advocate for improved services, and suggest avenues for more inclusive and responsive care.

These findings reaffirm that transnational social fields may be the sites of cross-border adaptation, embodied negotiation, and sometimes, friction. The practices, identities, and expectations of forced migrants from Ukraine become destabilized in Poland, producing forms of un-being and un-belonging that are deeply relational and context-dependent. Our findings highlight the importance of recognizing migrants’ prior knowledge, moral claims, and embodied experiences when designing harm reduction and health care services, especially in semi-peripheral contexts where formal structures are fragmented or constrained.

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Appendix

Table 1

Participants' characteristics

Health professionals and staff								
Interview Count	Participant Count	ID	Gender	Sector of role	Type of role	Participant code + characteristics		
1	1	P01	F	NGO	Mixed	P01, NGO, Front-line & Management role, Female		
2	2	P02	M	NGO	Management	P02, NGO, Management role, Male		
3	3	P03	F	Healthcare system	Front-line	P03, Healthcare system, Front-line role, Female		
4	4	P04	M	IGO	Front-line	P04, IGO, Front-line role, Male		
5	5	P05	M	Healthcare system	Mixed	P05, Healthcare system, Front-line & Management role, Male		
6	6	P06	M	Healthcare system	Front-line	P06, Healthcare system, Front-line role, Male		
7	7	P07	F	NGO	Front-line	P07, NGO, Front-line role, Female		
8	8	P08	F	IGO	Management	P08, IGO, Management role, Female		
9	9	P09	F	NGO	Management	P09, NGO, Management role, Female		
10	10	P10	F	Healthcare system	Mixed	P10, Healthcare system, Front-line & Management role, Female		
11	11	P11	M	NGO	Front-line	P11, NGO, Front-line role role, Male		
12	12	P12	F	NGO	Front-line	P12, NGO, Front-line role, Female		
13	13	P13	F	Healthcare system	Front-line	P13, Healthcare system, Front-line role, Female		
14	14	P14	F	Healthcare system	Front-line	P14, Healthcare system, Front-line role, Female		
15	15	P15	F	NGO	Management	P15, NGO, Management role, Female		
16	16–20	P16	F	NGO	Management, Frontline	P16, NGO, Front-line & Management role, Females		
17	21–26	P17	M/F	NGO	Management, Frontline	P17, NGO, Front-line & Management role, Male & Female		
18	27	P18	F	NGO	Front-line	P18, NGO, Front-line, Female		
Forced migrants								
Interview Count	Participant Count	ID	Gender	Age	Education	Arrival date	Role	Participant code + characteristics
1	1	R01	F	44	Higher education	2019	Refugee	R01, Female, 44
2	2	R02	F	47	Higher education	2014	Refugee	R02, Female, 47
3	3	R03	F	43	Higher education	2018	Refugee	R03, Female, 43
4	4	R04	F	43	Higher education	02/2022	Refugee	R04, Female, 43
5	5	R05	F	46	Higher education	02/2022	Refugee	R05, Female, 46
6	6	R06	F	39	Higher education	02/2022	Refugee	R06, Female, 39
7	7	R07	F	45	Higher education	03/2022	Refugee	R07, Female, 45
8	8	R08	F	37	Higher education	03/2022	Refugee	R08, Female, 37
9	9	R09	F	62	Vocational	07/2023	Refugee	R09, Female, 62
10	10	R10	F	42	Higher education	03/2022	Refugee	R10, Female, 42