Barriers and informal strategies to access medical care for irregular labor migrants living with HIV in Russia

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Résumé en français

Titre :

Obstacles et stratégies informelles d'accès aux soins médicaux pour les travailleurs migrants en situation irrégulière vivant avec le VIH en Russie.

Dans mon projet de recherche doctorale, j'explore comment l'État exerce son pouvoir sur les migrants en créant un espace d'incertitude, produisant intentionnellement de l'« illégalité », ainsi qu'en contrôlant le corps des migrants. J'ai analysé ce phénomène sur l'exemple de la façon dont les migrants d'Europe de l'Est et d'Asie centrale accèdent aux services de santé en Russie, un pays central de la région qui accueille des millions de travailleurs migrants et de réfugiés internationaux. Le faible accès aux services médicaux, la séparation d'avec la famille, la pauvreté et la sensibilisation limitée aux comportements à risque contribuent à la grande vulnérabilité des migrants au VIH et à d'autres maladies transmissibles. La Russie interdit l'entrée des étrangers séropositifs. Par conséquent, une part importante des étrangers séropositifs en Russie doivent cacher leur statut sérologique et résider en tant que migrants irréguliers sans accès aux services. L'étude est basée sur des entretiens qualitatifs avec des professionnels d'ONG et sur l'analyse d'histoires de vie de migrants internationaux séropositifs en situation irrégulière en Russie. Dans la partie discussion, je problématise les implications épidémiologiques, économiques et sociales de cette interdiction de séjour de longue date liée au VIH à la lumière de l'approche de l'État russe en matière de gestion des migrations dans le but d'éclairer les recherches futures et les prochaines étapes du plaidoyer de la société civile. Les résultats de l'étude ont été publiés dans le Journal of Public Health Policy dans un article intitulé « L'interdiction de séjour en Russie et le contrôle étatique des migrations ».
Cette thèse comprend les articles précédents de Daniel Kashnitsky : « Contextualisation des stratégies des migrants pour obtenir des soins médicaux en Russie » (Deminseva & Kashnitsky 2016), « Cliniques kirghizes » à Moscou : Centres médicaux pour les migrants d'Asie centrale » (Kashnitsky & Demintseva 2018), « L'interdiction de résidence pour les migrants vivant avec le VIH en Russie et le contrôle étatique de la migration » (Kashnitsky 2020) et enfin « En bref, nous vous expulserons » : Temporalités perturbées des migrants séropositifs en Russie » (Kashnitsky & Richter 2021).

Mots-clés : Russie, Migrants d'Asie centrale, travailleurs migrants, VIH, pratiques informelles, exclusion sociale, migrants irréguliers, stratégies d'adaptation, illégalité.

Demintseva, E. et D. Kashnitsky 2016 Contextualiser les stratégies des migrants en recherche de soins médicaux en Russie. International Migration 55(2) : 29-42.

La Russie est une destination importante pour les travailleurs migrants des pays de l'ex-Union soviétique, en particulier des pays à faible revenu d'Asie centrale : Kirghizistan, Tadjikistan et Ouzbékistan. La vie des migrants d'Asie centrale en Russie se caractérise par la rareté des ressources et l'exclusion sociale. L'accès limité aux soins de santé est aggravé par les attitudes négatives et la discrimination auxquelles les migrants sont confrontés lorsqu'ils ont recours aux hôpitaux et cliniques publics. Dans notre étude, nous visons à décrire l'infrastructure médicale disponible pour les migrants à Moscou. Nous étudions comment les migrants utilisent des stratégies formelles et informelles pour surmonter les obstacles sur leur chemin pour recevoir des soins médicaux en milieu urbain. L'étude est basée sur l'analyse d'entretiens qualitatifs avec 60 travailleurs migrants de pays d'Asie centrale et 23 soignants travaillant dans des établissements médicaux basés à Moscou tels que des hôpitaux publics, des cliniques externes, des stations ambulatoires et des centres médicaux privés, y compris les soi-disant cliniques kirghizes.

Kashnitsky D. et Demintseva E. 2018. « Cliniques kirghizes » à Moscou : Centres médicaux pour les migrants d'Asie centrale. Journal of medical anthropologie, 37(8).

L’isolement social limite l’accès des migrants aux soins de santé, fournissant le contexte pour l’émergence de leur propre infrastructure médicale. Dans cet article, nous explorons les ainsi dénommées cliniques kirghizes - des centres médicaux privés à Moscou fondés par des médecins venant du Kirghizistan et destinés spécifiquement aux travailleurs migrants des pays d'Asie centrale, en particulier du Kirghizistan, de l'Ouzbékistan et du Tadjikistan. Ces cliniques kirghizes fournissent à la fois des services médicaux abordables et permettent aux médecins migrants de guider les patients migrants à travers l'infrastructure médicale de la Russie, dans le contexte de ressources limitées, de manque d'assurance maladie, de faible connaissance des services disponibles et d'autres obstacles aux soins.

Kashnitsky, D. (2020). L'interdiction de résidence du VIH en Russie et le contrôle étatique de la migration. Journal of Public Health Policy, 41(4)

Dans cet article, j'explore comment l'État exerce son pouvoir sur les migrants en créant un espace d'incertitude, en produisant «l'illégalité», ainsi qu'en contrôlant le corps des migrants. J'analyse ce phénomène sur l'exemple de la façon dont les migrants internationaux sont privés d'accès aux services liés au VIH en Russie, le plus grand pays d'accueil de migration dans la région

d'Europe de l'Est et d'Asie centrale qui interdit le séjour des étrangers séropositifs. Une part importante des migrants séropositifs en Russie doivent se cacher et résider en tant que migrants irréguliers sans accès aux services. Les organisations non gouvernementales régionales ont tenté de plaider en faveur de la levée de l'interdiction de séjour liée au VIH en Russie, mais les responsables gouvernementaux ont longtemps résisté à les entendre. L'étude est basée sur des entretiens qualitatifs avec des professionnels d'ONG et sur l'analyse d'histoires vécues de migrants internationaux séropositifs en situation irrégulière en Russie. Dans la partie discussion, je problématise les implications épidémiologiques, économiques et sociales de cette interdiction de séjour de longue date liée au VIH à la lumière de l'approche de l'État russe en matière de gestion des migrations dans le but d'éclairer les recherches futures et les prochaines étapes du plaidoyer de la société civile.

Kashnitsky D., Richter J. M. « En bref, nous vous expulserons » : Temporalités perturbées des migrants séropositifs en Russie // Santé publique mondiale. 2021. P. 1-20.

Les migrants sont confrontés à plusieurs défis en route vers ou dans leur pays d'accueil. La législation actuelle en Russie impose une interdiction permanente aux migrants internationaux séropositifs d'obtenir un permis de séjour en Russie. En utilisant une méthodologie qualitative, nous avons mené des entretiens semi-structurés avec 15 migrants internationaux qui ont vécu avec le VIH en Russie et 12 entretiens avec des prestataires de soins de santé en Russie. À l'aide du cadre temporel de Bonnington, l'étude constate que le statut séropositif des migrants devient un événement biographique qui interrompt leur cycle migratoire, entraînant ainsi la perturbation de leur parcours de vie normal qui se traduit par une « planification à court terme » et une instabilité. Bien que la plupart des personnes vivant avec le VIH soient confrontées à des défis similaires, la loi russe concernant les migrants internationaux vivant avec le VIH aggrave leur expérience de vie en Russie. Les migrants internationaux vivant avec le VIH sont en outre confrontés à l'exclusion sociale, à une grave stigmatisation et à la discrimination. Les résultats montrent que la demande du pays pour que les migrants séropositifs quittent le pays afin de réduire la propagation du VIH en Russie est contre-productive : elle ne mobilise pas le comportement de recherche de santé parmi les migrants. Par conséquent, cette législation doit être amendée pour encourager les migrants internationaux séropositifs à accéder à des services adéquats en matière de VIH.

Mots-clés : Russie, Migrants d'Asie centrale, travailleurs migrants, VIH, pratiques informelles, exclusion sociale, migrants irréguliers, stratégies d'adaptation, illégalité.

Abstract

Title:

Barriers and informal strategies to access medical care for irregular labor migrants living with HIV in Russia

Abstract: In my doctoral research project, I tried to explore how state exercises power on migrants by creating a space of uncertainty, intendedly producing 'illegality', as well as holding control over migrants' bodies. I analyzed this phenomenon on the example of how migrants from Eastern Europe and Central Asia access healthcare services in Russia, a central country of the region to host millions of labor migrants and international refugees. Low access to medical services, separation from families, poverty, and limited awareness of risk behaviors contribute to migrants' high vulnerability to HIV and other social diseases. Russia bans entry of HIV-positive foreigners. Therefore, a significant share of HIV-positive foreigners in Russia must hide their HIV-status and reside as irregular migrants with no access to services. The study is based on qualitative interviews with NGO professionals and analysis of live stories of irregular HIV-positive international migrants in Russia. In the discussion part I problematize the epidemiologic, economic, and social implications of this longstanding HIV-related residence ban in the light of the Russian state approach to handling migration in an attempt to inform further research and next steps of civil society advocacy. The study results were published in the Journal of Public Health Policy in an article called The Russian HIV residence ban and state control of migration.
The current dissertation includes an overview of the previous articles by Daniel Kashnitsky: 'Contextualizing Migrants' Strategies of Seeking Medical Care in Russia' (Demintseva & Kashnitsky 2016), 'Kyrgyz Clinics' in Moscow: Medical Centers for Central Asian Migrants' (Kashnitsky & Demintseva 2018), The Russian HIV residence ban and state control of migration (Kashnitsky 2020) and finally 'In Short, We Will Deport You': Disrupted temporalities of migrants with HIV in Russia (Kashnitsky & Richter 2021).

Keywords: Russia, Migrants from Central Asia, labor migrants, HIV, informal practices, social exclusion, irregular migrants, coping strategies, illegality.

Acknowledgements

Primarily, I would like to thank the international labor migrants who participated in the study for sharing about their life stories, hardships, and achievements with me. That required a lot of courage, and I value this trust given to me. I also thank doctors and NGO professionals who supported me in the recruitment of study participants, in particular, Kirill Barskiy, Andrey Petrov from the Moscow-based "Shagi" foundation, Nasyiat Kemelova from Kyrgyzstan Republican AIDS Center, Ilhomjon Nematov from NGO Dina in Tajikistan, and Sergey Uchaev from community-based organization Ishonch va-Khayot in Uzbekistan. I am thankful for their valuable support in finding participants and building trust with them.

Many thanks to my academic director Ekaterina Demintseva, head of the Centre for Qualitative Social Policy Research at the Higher School of Economics, Russia, for inspiring me and guiding me through my long journey that started back in 2015 when I joined the Center as an intern and started my fieldwork until my graduation from the Doctoral School of Sociology at HSE in 2021. I will always keep in my heart the supportive and respectful attitude of Olga Savinskaya, the director of the doctoral school and Prof. Mikhail Denisenko, director of the Institute of Demography at the Higher School of Economics.

I would also like to thank Anna Bredström from the Division of Migration, Ethnicity and Society (REMESO) at the Linköping University, Sweden, for hosting me as an exchange student during the 2019-2020 schoolyear as well as for productive discussions and a thorough feedback provided to the draft my articles 3 and 4 provided in this thesis.

I am expressing a deep gratitude to Catherine Bourgain, director of the Centre for research on medicine, science, health, mental health, and society, Paris Cité University and Laurence Simmat-Durand, my academic supervisor at the ED624 Doctoral School of Social Sciences at the Paris Cité University for generously hosting me as a last-year doctoral student. Their willingness to support me allowed me to complete the current manuscript and prepare for my thesis defense being an asylum seeker in France in the years 2022-2023. Finally, I would like to thank the PAUSE program that supports scientists and artists in exile living in France that provided me and my family with a crucial financial and institutional support during the final year of my doctoral project.

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Acronyms

ART – antiretroviral treatment

CA – Central Asia

CBO – community-based organization

CSO – civil society organization

HIV – human immunodeficiency virus

EECA – Eastern Europe and Central Asia

ECDC - European Center for Communicable Diseases

FMS – Federal Migration Service

HSE – Higher School of Economics, National Research University, Russia

IOM – International Organization of Migration

ILO – International Labor Organization

MoI – Ministry of Interior

MoH – Ministry of Health

NGO – non-governmental organization

OECD - The Organization for Economic Co-operation and Development

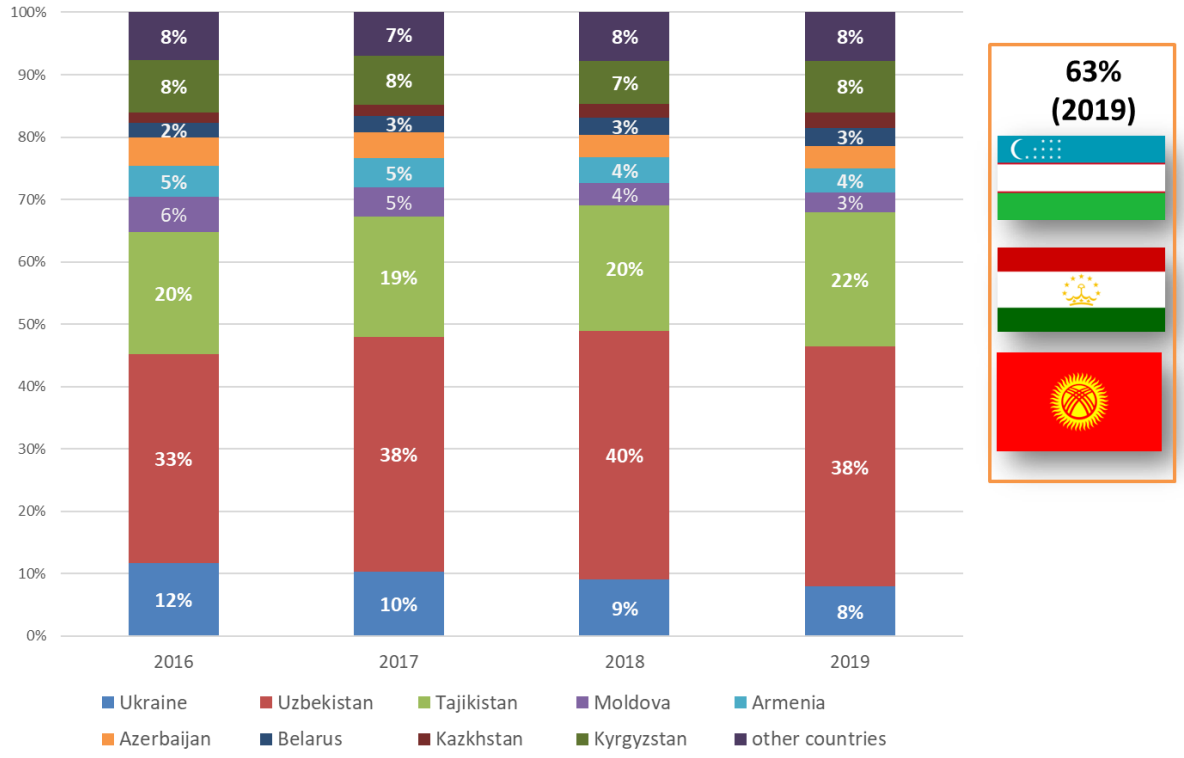
UNAIDS – Joint United Nations Programme on HIV/AIDS

WHO – World Health Organization.

Introduction

Russia has had one of the highest numbers of international migrants in the world (11,4 million) following after US, Germany, and Saudi Arabia (IOM 2022). Most of them come from the states of the former Soviet Union, including the countries of Central Asia. Uzbekistan has been the largest donor of labor migrants to Russia followed by Ukraine, Tajikistan, Azerbaijan, and Kyrgyzstan (FMS 2021). Following the collapse of the Soviet Union, Russia has been attracting millions of labor migrants from neighboring countries of Eastern Europe due to the visa-free policy in the post-soviet countries as well as the common experience and good knowledge of institutional practices and labor market (Dave 2014; Reeves 2015; Abashin 2015). The mass labor international migration into Russia in recent years has been also driven by a significant economic gap between Russia and the countries of Central Asia and South Caucasus, as well as the non-transparent employment practices including recruitment of labor migrants (Ivanov 2011: 39).

***Figure 1*: Origin of international migrants in Russia** *(according to official data from MoI, 2019), migrants from Uzbekistan, Kyrgyzstan, and Tajikistan altogether accounted for 63% of the total number of labor migrants in Russia in 2019.*



Regulations related to right to work and reside in Russia lack clarity and frequently change. Many migrant workers persist in a state of legal uncertainty. This situation keeps them as an oppressed and submissive population (Calavita 1999; Sassen 1988).

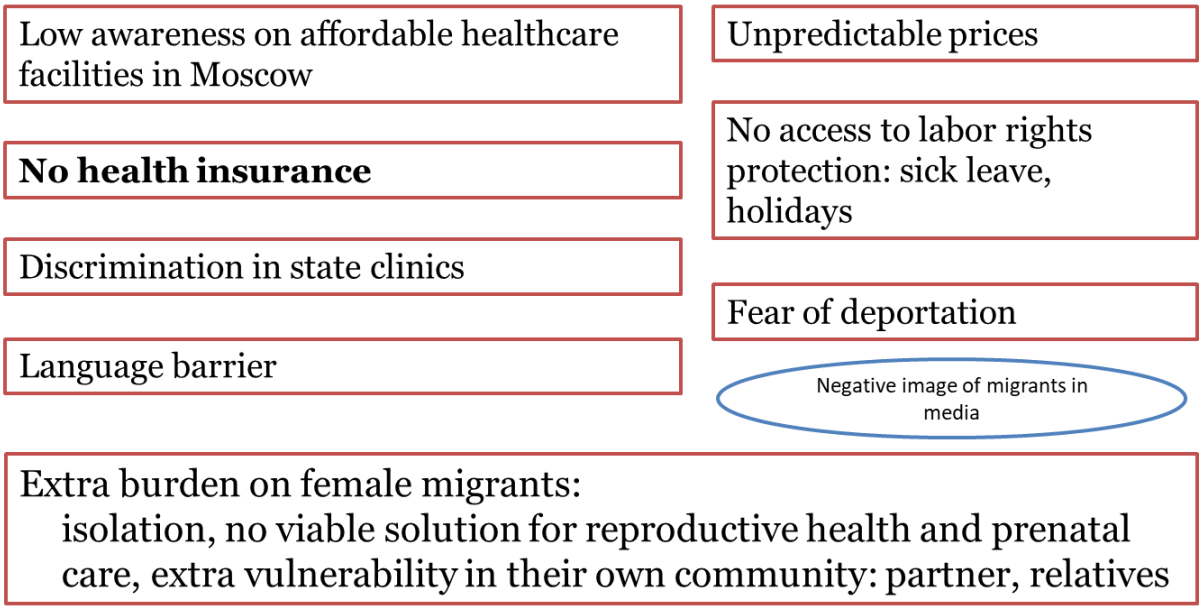
Worldwide, except for emergency medical services, migrants use public health services in the host country less frequently than citizens (Cooper et al. 1998; Zeeb et al. 2004; Axelsson 2006). They also tend limit stays in hospitals after receiving the most urgently needed assistance. Studies of the health conditions of migrants in countries such as Canada (McDonald and Kennedy 2004), the US (Singh and Siahpush 2001), Germany (Razum, et al. 1998) and France (Cognet et. al, 2012; Desgrées du Loû & Lert 2017) show that newly arriving migrants usually have reasonably good health. However, over time, poor living conditions, poor nutrition, stress, and physically hard work led to poorer health, impacting their ability to work (see, for example Markides 1986; Abraido-Lanza et al. 1999). Migrants often live in sub-standard housing, tend to earn less than native-born workers, and often have limited regular access to health care. When ill, treatment is expensive, and this results in delays in treatment seeking.

The barriers migrants face primarily relate to their legal status in the host country (Davies et al. 2006). Not all migrants have the necessary residence documents or work permits (Holzmann, et al. 2005; Collantes 2007). Other barriers include the lack of economic means (d'Isanto et al. 2016; Massey et al. 1994); and unfamiliarity of migrants with their rights, including to medical assistance (van Ginneken and Gray 2015; Marmot 2012) and of the health system in general (Larchanché 2012) and discrimination. There are also important cultural (Bäärnhielm and Ekblad 2000) and language (Wilson 2005; Sundquist 1993) barriers that prevent migrants from accessing health care. Migrants may experience discrimination from doctors and worry about treatment regimens and procedures that might be new to them and potentially clash with their religion or culture. The experiences of African women in France, Turkish women in Sweden, members of Asian Muslim communities in the UK (Al-Shahri, et al. 2002; Sauvegrain 2012; Dyck 2006), and others, all demonstrate how cultural boundaries, especially those underpinned by religion, play out in medical treatment. Low language proficiency also makes it difficult for the migrants to communicate with doctors (Zanchetta and Poureslami 2006) without help from an interpreter-mediator.

International migrants' access too social services, in particular, medical care and health insurance, is a serious problem in Russia. Necessary legal provisions and migrant-sensitive programs are almost missing in the country. This situation is aggravated by largely present discriminatory practices from the side of the host society, especially, by public institutions. Undocumented migrants and other vulnerable groups among international migrants are subject to

segregation and disregard in the state medical institutions (Demintseva & Kashnitsky 2016). Female migrants have additional barriers related to the lack of viable solutions for reproductive health and prenatal care in Russia (Kuznetsova & Mukharyamova 2013; Demintseva & Kashnitsky 2016). They also have additional vulnerability as they a large share of them are engaged in unprotected domestic labor hence they often face a higher level of isolation in addressing their health needs and searching for timely solutions (Peshkova, V. and A. Rocheva 2013).

***Figure 2*: Barriers in access to healthcare for international migrants in Russia.**



There are three regions in the world today where morbidity and mortality from HIV/AIDS continues to rise steadily, and one of among them is the EECA region which has the largest time gap between a positive HIV test result and the start of treatment. Only 41% have suppressed viral load. On average, only 63% of those in need receive therapy in the region. There has been a 72% increase in new cases since 2010, and a quarter increased deaths from AIDS (Kashnitsky 2020, UNAIDS 2020).

It is increasingly recognized that the long-lasting neglect of the health needs of vulnerable groups and key populations in Russia led to hidden epidemics in the country (Meylakhs et al 2017).

Russia remains the only country in Europe to keep a residence ban for HIV-positive migrants which means they can enter the country but cannot get a residence permit. Russia secures only emergency care for any migrants. Migrants who were identified with HIV cannot reside legally in the country; they often remain invisible for years in search of informal strategies

to access treatment (Pape 2018; Pokrovskaya et al. 2020).

The Russian Federation has the highest HIV incidence rate in the region of Eastern Europe and Central Asia –55 new cases per 100 000 population. Compared to the countries of origin where most migrants come from: Armenia – 15 per 100 000, Tajikistan – 14 per 100 000, Kyrgyzstan – 13 per 100 000 population– (ECDC 2019) we can clearly observe that Russia is likely to be the source of the epidemic spread in the EECA region, and not the other way around. According to the 2019 data of epidemic surveillance in Tajikistan, the prevalence of HIV among returned labor migrants in Tajikistan was 0.4% compared to 0.2% among the adult population. Considering that Russia is by far the top destination of migration for Tajikistani labor migrants we can see that returned migrants become a key population that contributes to the spread of the HIV epidemic in the sending countries.

In the last UNAIDS report (2022) confirmed Russia had the 5th Highest HIV Infection Rate in the world which becomes a concern for the whole EECA region considering the migration flows that remained high despite the Russian full-scale war against Ukraine.

Dissertation Organization

The current dissertation is centered on four articles written by Daniel Kashnitsky independently or with co-authors: (1) ‘Contextualizing Migrants’ Strategies of Seeking Medical Care in Russia’ (Demintseva & Kashnitsky 2016), (2) ‘Kyrgyz Clinics’ in Moscow: Medical Centers for Central Asian Migrants’ (Kashnitsky & Demintseva 2018), (3) The Russian HIV residence ban and state control of migration (Kashnitsky 2020) and, finally, (4) 'In Short, We Will Deport You': Disrupted temporalities of migrants with HIV in Russia (Kashnitsky & Richter 2021).

These articles analyze the results of a long-lasting ethnographic research project (2015 - 2021) that aimed to understand how healthcare for international migrants is organized in Russia. The first two articles, outline the barriers in access to healthcare by migrants, find out the coping strategies migrants use to solve their health-related issues as well as describe the infrastructure designed to meet specific healthcare needs of the migrants (migrant clinics).

Daniel co-authored articles 1 (2016) and article 2 (2018) with his colleague and supervisor Ekaterina Demintseva at the Institute of Social Policy, Higher School of Economics, Moscow, Russia where he worked as a junior researcher from 2015 to 2022.

Articles 3 and 4 are dedicated to exploring a hidden population of migrants living with HIV in Russia who are by law excluded from access to medical services and a legal residence. By showing the experiences of this almost clandestine group I am trying to reflect on the biopolitical dimension of the Russian migration policy.

Article 3 (2020) was written by Daniel Kashnitsky independently and the last article 4 (2021) was co-written with Jibril Mohammed Richter, a master student from Ghana in Russia who contributed to the fieldwork, analysis and drafting the article.

Overall, all four papers were supported by the Basic Research Programme at the National Research University Higher School of Economics (HSE), Moscow, Russia.

I have to mention that I did not include two of my papers also published during my doctoral studies due to the limits of the current dissertation, but to mention:

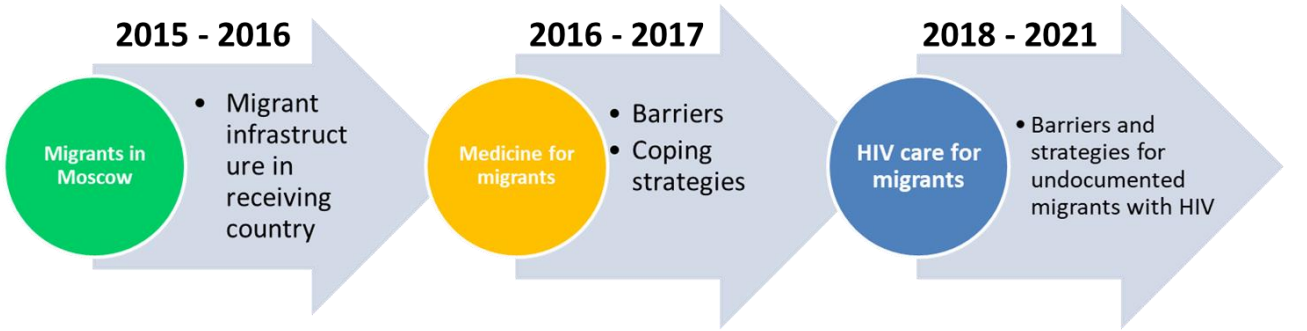
Kashnitsky D. 2018. Les femmes migrantes centrasiatiques à Moscou: développement de strategies formelles et informelles pour accéder aux soins de santé / Cahiers d’Asie Centrale. (in French). Available at: https://journals.openedition.org/asiecentrale/3676?lang=en

Kashnitsky D. 2022. “Performance of Illegality” Toward Migrants Living with HIV in Russia: From Social Exclusion to Deportation. International Political Economy Series book series (IPES) Available at: https://link.springer.com/chapter/10.1007/978-3-030-82499-0_5

Finally, it is important to mention that I started my dissertation at the Higher School of

Economics, Russia, and was planning to defend it in 2022. However later in April 2022 I had to leave Russia because of the war it started against Ukraine, so I could not defend my work. Therefore, thanks to the support of the doctoral school ED624 I am presenting the current manuscript to the rapporteurs for evaluation in February 2023.

<u>Figure 3</u>: Evolution of my research



Demintseva E., Kashnitsky D. Contextualizing Migrants' Strategies of Seeking Medical Care in Russia // *International Migration*. 2016. Vol. 54. No. 5. P. 29-42.

Kashnitsky D., Demintseva E. 'Kyrgyz Clinics' in Moscow: Medical Centres for Central Asian Migrants // *Medical Anthropology* 2018. Vol. 37. No. 5. P. 401-411.

Kashnitsky D. The Russian HIV residence ban and state control of migration // Journal of Public Health Policy. 2020. No. 41. P. 453-463.

Kashnitsky D. Richter JM. 'In Short, We Will Deport You': Disrupted Temporalities of Migrants with HIV in Russia // Journal of Global Health. Nov 2021 doi.org/10.1080/17441692.2021.2002923

Methodology

A qualitative study design was chosen to allow for an in-depth exploration of migrants' experiences and perceptions of healthcare services in Russia as a receiving country.

In the first phase of our study (2014-2015), our team interviewed international labor migrants who were citizens of Kyrgyzstan, Uzbekistan and Tajikistan working in Moscow in trade, service, cleaning, and repair works aged from 18 to 40 – the most represented age group among the labor migrant (Demintseva & Peshkova 2014). The migrants were newly arriving or circular migrants – returning to work in Russia every year. We chose Moscow as the field for our study because it is the largest city in Russia, attracting international migrants in large numbers and offering them a variety of jobs. We conducted 60 semi-structured interviews using a protocol. We asked them about their lives in the capital of Russia, about their work and leisure, and most importantly, about their health and experiences with Moscow's health facilities. We were also interested in their knowledge and perceptions of Russian health services. Interviews were conducted in Russian, and some were also conducted with the help of an interpreter from Kyrgyz and Uzbek into Russian.

Although we did not encounter language barriers in communicating with migrants from Central Asia – a vast majority of them speaks Russian fluently, some participants refused to be interviewed. Central Asian migrants are often the target of discrimination by media, especially before election campaigns and in times of political crisis.

We decided to complement our analysis of migrant experiences and perception with those of the Russian caregivers who provide services to migrants. We categorized migrants' experience and formulated questions for the caregivers that would reveal their experience and perceptions treating migrants in Moscow. We also wanted to explore doctor-migrant communication and identify formal and informal migrant strategies of seeking medical care in Moscow. We conducted 23 semi-structured interviews with physicians, nurses, clinic administrators, pharmacists, and informal helpers in Moscow who provide medical care or counseling to Central Asian migrants. We interviewed nurses at the facilities that the migrants mentioned in their interviews (hospitals, private clinics, outpatient clinics, pharmacies). We also found professionals responsible for the health problems mentioned by the migrants.

In the second phase of our study (2015 - 2016), we selected the two largest migrant clinics in Moscow that migrants themselves mentioned most often, and three smaller medical centers, while we targeted labor migrants from Central Asia. We conducted 31 interviews with doctors

and administrative staff, of which 12 interviews were conducted with administrative personnel and medical staff of the Kyrgyz clinics (three interviews with directors and managers, three with gynaecologists, and two with dentists).

For the third article, in 2017 and 2018, I interviewed 10 experts and activists from leading civil society and community organizations from Eastern Europe and Central Asia both from sending countries (Tajikistan, Kyrgyzstan, Uzbekistan, and Armenia) and from receiving countries (Russia and Kazakhstan). These experts and activists had to have experience with the migrant health on the practical level. Talking to them aimed to understand what the barriers and coping strategies were implied by international migrants living with HIV in both sending and receiving countries. In addition to the interviews, I analyzed 10 cases depicting lives of HIV positive migrants who lived in Russia. These migrants were clients of the Moscow-based Shagi Foundation whose case managers recorded migrants' individual circumstances and barriers as well as and solutions they were able to provide. Migrants' names were not revealed at any moment of either fieldwork or analysis.

Lastly, for the fourth article I interviewed 15 migrants in 2020. These were migrants living with HIV who were in touch with some type of HIV care organizations which leaves a potential group of migrants who learned about their HIV-positive status but who never approached any care provider. This is the most hard-to-reach and underprivileged group of migrants with HIV. Interview guidelines included a set of questions on the migrants' encounter with HIV, their use of healthcare facilities in Russia, their strategies in accessing HIV services, their life plans, as well as the attitudes of healthcare providers. All interviews included questions that allowed participants to reflect on their biographical events and their daily experience concerning HIV stigma while living in Russia.

Semi-structured individual interviews in all four stages of the fieldwork lasted between 10 to 90 minutes. The interviews were held in Russian, audio-recorded and transcribed verbatim. Written notes were taken by the interviewer during the interview to record non-verbal information such as laughter and long pauses. All the interviews were conducted either in the medical facility or in an informal setting such as café or city gardens. For the last paper about migrants living with HIV we conducted all the interviewed in the midst of the COVID-19 epidemic. Hence, all the communication was held online via messengers. Some of the participants shared that they preferred online communication for being more intimate and easier to plan due to tight work schedule.

We analyzed the transcripts of the interviews to gain an insight into the meanings of phenomena,

and to conceptualize perceptions, opinions, and life stories. The authors did multiple reading to pick out meaning units and identify themes. Then we compared the findings. A phenomenological analysis (Dowling 2007: 132) was used to outline barriers in migrants' access to medical services in the city and identify formal and informal practices. Later we discussed the findings with several researchers of different backgrounds in social sciences to get their critical insights.

I had an extensive experience of migration at several phases of my life. Apart from my academic work I was engaged in civil society activism in the public health NGOs which allowed me to create trust with HIV-service NGOs and doctors in Russia and other countries of Eastern Europe and Central Asia. This was an important entry point to the fieldwork and an opportunity to triangulate the study data with the case database of migrants who have received services from an NGO in Russia. The limitation of my fieldwork had to do with my inability to speak and understand the languages spoken by labor migrants in Russia, in the case of my field, Kyrgyz, Uzbek, and Tajik. However, most migrants learned Russian at school and practiced it daily at work and in other areas of their life in the receiving country.

Chapter 1: Contextualizing Migrants' Strategies of Seeking Medical Care in Russia

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Russia is an important destination for labor migrants from the former Soviet Union republics especially Central Asian low-income countries: Kyrgyzstan, Tajikistan, and Uzbekistan. The life of migrants from Central Asia in Russia is characterized by scarce resources and social exclusion. Limited access to healthcare is aggravated by negative attitudes and discrimination that migrants face when visiting state hospitals and clinics. In our study, we aim to describe the medical infrastructure available for the migrants in Moscow. We investigate how migrants use formal and informal strategies to overcome the barriers on their way to receiving medical care in the urban environment. The study is based on the analysis of qualitative interviews with 60 labor migrants from Central Asia countries and 23 caregivers working in Moscow-based medical facilities such as state hospitals, outpatient clinics, ambulance stations, and private medical centers including the so-called Kyrgyz clinics.

INTRODUCTION

Russia has one of the highest rates of international migration. According to the United Nations' Department of Economic and Social Affairs Russia was visited by over 11 million foreign nationals in 2013 (UN 2014). Most of them come from the states of the former Soviet Union, including the countries of Central Asia. Uzbekistan has been the largest donor of labor migrants to Russia followed by Ukraine, Tajikistan, Azerbaijan, and Kyrgyzstan (FMS 2012). Migrants' access too social services, especially, to medical care and health insurance, is a very pressing issue in Russia. This issue is particularly relevant as extensive foreign labor migration is a relatively recent phenomenon in Russia. As a result, necessary legal provisions and social programs aimed at both documented and undocumented migrants are often lacking (Kuznetsova & Mukharyamova 2013). This situation is exacerbated by widespread discriminatory practices towards migrants by the host society and by public institutions. Undocumented migrants are particularly vulnerable to discrimination and other barriers and risk factors (Zayonchkovskaya et al. 2014, Demintseva & Kashnitsky 2015: 216).

The large influx of migrants to Russia in recent years has been driven by a combination of several factors: a significant wage gap between Russia and the neighboring countries, the visa-free policy with the Commonwealth of Independent States and non-transparent labor practices including the employers' flexibility to recruit migrants disregarding the Labor Code (Ivanov 2011: 39).

A significant share of labor migrants come to Russia from countries that have a reciprocal agreement of visa-free entry to Russia. According to a new amendment to the Law on the Legal Status of Foreign Citizens (Federal Law #127 as of January 2014) foreign citizens of the CIS

countries "may stay in Russia for up to 90 days within the period of six months. This significantly complicates the opportunities for migrants to stay in Russia.

<u>Figure 4</u>: Main routes from Central Asia to the Moscow area as the top destination of migration in Eurasia.

The red figures indicate GDP per capita (in USD) in three sending countries: Kyrgyzstan (3200), Tajikistan (2500), Uzbekistan (5200) and Russia (24000) as a destination country as per World Bank data as of 2017.

Access to medical care is one of the most sensitive issues related to migration. Many researchers (Hills et al., 2002; WHO, 2010) argue that limited access to healthcare should be regarded in conjunction with a wide phenomenon of migrants' *social exclusion* which is the fundamental cause of health issues and the lack of access to medical services.

Research on migrants' access to healthcare in Russia is very scarce. Kuznetsova & Mukharyamova (2014: 9) who conducted a study in the city of Kazan, Russia suggests that self-treatment and treatment by caregivers within the migrant community are the only available strategies for the migrants when they fall ill. This is enhanced by migrants' very low awareness on available healthcare in Russia coupled with the risk of little knowledge about communicable diseases and other health issues (Sergeev et al. 2015: 214).

In our study, we focused on the following research questions:

- What strategies do Central Asian migrants use to receive medical care in Russia? How do migrants implement these strategies?
- What factors influence these strategies?

In the remainder of the present paper, we aim to answer these questions by analyzing the findings of our qualitative study.

Migration health policy in Russia

In recent years, Russia enacted several changes in labor policy that forced the migrants to purchase health coverage on their own. We should mention two key changes in the Russian health policy towards migrants in Russia. Before 2010, employers were obliged to purchase health insurance for labor migrants. As of 2010, it became the responsibility of the foreign employees and no longer of the employers (Russian Federal Law No 212 as of Jul 27, 2009). However, it should be noted that both before and after 2010 most migrants did not have an official contract with the employer, as official employment of foreign employees was a financial burden for the employer. Another important milestone in labor policy for migrant workers happened in 2015 when they became obliged to purchase basic health coverage as a part of the work permit (Russian Federal Law No 357 as of Nov 24, 2014). The basic requirements to health coverage are unique for all foreign citizens working in Russia.

Free emergency care is available for foreigners who do not have health insurance and is limited to the Minimal List of Medical Services (1999) that is emergency care, transportation, and intensive care in acute conditions. Moscow hospitals usually limit in-patient care for migrants to

up to three days (although this provision is not official, it belongs to the informal practices of the hospitals of Moscow). Further stay in the hospital should be paid, which can be a serious burden on the patient.

Planned medicine is not available for migrants unless they purchase expensive voluntary health insurance which most of them cannot afford (Kuznetsova & Mukharyamova 2014: 16).

Migrants and access to health care– previous studies

Looking at the Model of the Social Determinants of Health (CSDH 2008) we can see that migration affects the human life at all levels: individual and lifestyle factors, social and community networks, living and working conditions (education, work environment, water and sanitation, housing) and general socio-economic conditions. Despite the fact that migrants are often exposed to greater health risks such as work-related injuries (Davies et al. 2006: 10) or tuberculosis (IOM 2012: 2) they have poorer access to healthcare and have to often use informal strategies to receive medical help or postpone treatment (Collantes 2007: 9).

Considering international studies on migrant health, it should be noted that the lack of health insurance is not the only barrier regarding migrants' access to healthcare. Other barriers include administrative complications in clinics and hospitals, lack of information about the health system, poor 'health literacy', language barriers and discrimination, as well as the threat of being reported to the authorities in the case of undocumented migrants (Collantes 2007: 9).

Nielsen & Krasnik (2010: 370) have found out that migrants in the European Union are disadvantaged in their self-perceived health as compared to local population even after controlling for age, gender, and socio-economic factors. They identified eight factors that contribute to migrants' access to healthcare. These are language barrier, challenge in the organizing healthcare for the migrants, deprivation and traumatic experiences, lack of familiarity with healthcare of the host country, cultural differences, different perception of the disease and treatment, negative attitudes between caregivers and patients, lack of access to migrants' medical records.

The World Health Organization (2008) recommends addressing health inequalities between migrants and the local population by aiming to ensure a universal right to health. This is the ethical point of reference in our study.

METHODS

With all the diversity of migration flows from the former republics of the Soviet Union to Moscow, we decided to focus on migrants from Kyrgyzstan and Uzbekistan. First of all, migrants from these countries represent the largest group of foreigners (FMS 2012) living in Moscow. Secondly, these migrants are the most vulnerable to discrimination both from the official state institutions and from the host society. They are identified as "visible migrants" (Kazemipur and Halli 2000: 92). Third, the Russian media predominantly present migrants from Central Asia as "a threat to the Russian society" (Zayonchkovskaya et al. 2014).

<u>Figures 5-6</u>: Sadovod wholesale market in the South-East of Moscow one of the largest informal employers for labor migrants from Central Asia in Russia.

In the first phase of our study, we interviewed labor migrants who were citizens of Kyrgyzstan and Uzbekistan working in Moscow in trade, service, cleaning, and repair works aged from 18 to 40 – as this is the most represented age group among the labor migrant (Demintseva & Peshkova 2014). The migrants were newly arriving or subsequent – returning to work in Russia every year on average for 10-11 months. We chose Moscow as a field for our study. Among the variety of Russian regions, the Russian capital has been the key destination for labor migrants in the recent years (Zayonchkovskaya 2009: 10). We conducted our interviews in four districts of Moscow that are different by their socio-economic status: two of them are centrally located and two others are located more remotely. In each district, we interviewed 15 migrants, 60 in total.

Moscow has been developing according to a Soviet Union's principle of equal opportunities in urban development. This predetermined the lack of striking socio-economic contrasts across the city (Smith 1996: 72). This feature was preserved in the post-socialist development of the city. Recent research demonstrates that migrants live all across Moscow in very similar socio-economic conditions preferring to rent accommodation as close as possible to where they work (Demintseva & Peshkova 2014).

In the second phase of our project, we decided to interview the Russian caregivers. We composed our protocol based on the themes emerged in the interviews with the migrants. We categorized migrants' experience and formulated questions for the caregivers that would reveal their

experience and perceptions treating migrants in Moscow. We also wanted to explore doctor-migrant communication and identify formal and informal migrant strategies of seeking medical care in Moscow.

We assumed that the use of medical infrastructure by migrants in Moscow is influenced not only by limited awareness about health infrastructure and the lack of medical insurance, but also by the discrimination practices that they encounter.

We held 29 semi-structured interviews with doctors, nurses, clinic administrators, pharmacists, and informal helpers in Moscow who provide medical care or advice to Central Asian migrants. We interviewed caregivers in the facilities that the migrants mentioned in their interviews (hospitals, private clinics, ambulance stations, pharmacies). We also found specialists relevant to the health problems mentioned by the migrants (gynecology, surgery, neonatal care etc.).

The interviews with the migrants took place in summer 2013 and those with the caregivers in summer 2014. We used chain sampling (Dahlgren et al., 2004) to recruit our study participants. The selection criteria were such that participants had to be caregivers, community workers or pharmacists working who were exposed to migrants in their daily work. Please, see table one in the appendix for details.

In both parts of the research, a qualitative study design was chosen to allow for an in-depth exploration of the participants' experiences and perceptions. In addition, the scarcity of studies exploring the analysis of migrants' and caregivers' perspective on providing healthcare to migrants supports the notion that a qualitative study can help explore the question and give indications concerning further research.

FINDINGS

1. The study of migrant infrastructure in Moscow, the migrant perspective

Though migrants are highly involved in the urban life, they feel excluded from the rest of the society. This is largely due to Muscovites' negative attitude towards people from Central Asia and the Caucasus region of Russia (Zayonchkovskaya et al. 2014). There are no migrant neighborhoods in Moscow, but migrant infrastructure has emerged - clinics, cafes, restaurants, markets – visited by migrants living in any part of the city. These migrant places include the so-called Kyrgyz clinic – medical centers founded by natives of Kyrgyzstan to provide specialized medical care tailored to migrants from Central Asia.

As our research target group were migrants from Central Asia mostly aged 18 to 40 years, they

were brief in describing their medical experiences. Most of our respondents had to see the doctor once or twice if something serious happened, mostly work-related injuries. As for conditions described as cold, malaise or headache, migrants seek advice from the nearest pharmacist to buy the cheapest drugs to treat the symptoms of the disease. In the first part of our study, we identified the following strategies of seeking medical care and addressing medical issues by the Central Asian migrants.

(1) « Healthy migrants – no time and money to see the doctor»

One of the most common answers we heard from the migrants in the first part of our study was:

> *I am not ill and need no treatment.*

Researchers in migration studies often use the term "healthy migrant effect" (Kennedy et al. 2006: 1) which is based on the fact that predominantly young people engage in migration. The healthy migrant effect goes hand in hand with the belief that migrants can be only strong, hardworking and healthy people who rarely fall sick and never, or almost never, need to see a doctor. In fact, this belief often results in a denial of illness. This strategy often leads to ill-health and can eventually result in an acute emergency condition.

> *I spent three days without consciousness. How do you call it? Bronchitis. Then I treated myself on my own. I always take care of myself; I do injections for myself. (Uzbek male, 38 y.o., construction worker).*

(2) Emergency care

Migrants use emergency care in the case of an injury or acute pain, when the migrant does not see any alternative way out of the situation, as this migrant worker commented:

> *My wife had a stomachache, we called the ambulance, we went to the public hospital; they gave her injections and suggested that she stays for 4-5 days, but my wife said she wanted to go home. (Kyrgyz male, 42 y.o., security guard).*

Migrants know that in the case of a severe illness or an injury they can rely on Moscow hospitals and receive free treatment as long as they have an acute, life-threatening condition. However, many tend to avoid going to the hospital, or they leave as soon as they can, fearing they might be billed for their hospital stay.

If the patient does not have medical insurance, Moscow hospitals can charge a fee after three days of hospital stay or later depending on condition and caregivers' judgment. So, patients with

no insurance do not know in advance at which point in their hospital stay they might be asked to pay.

(3) Planned medical care

If it is not an emergency, migrants from Central Asia try to access planned medical care looking for doctors from their countries of origin. The main advantage of Central Asian doctors is that they understand migrants' socio-economic situation, speak the same language and share the same culture. The so-called Kyrgyz clinics are owned and run by natives of Kyrgyzstan. The doctors are all of Kyrgyz or other Central Asian origin. Many migrants have positioned these clinics as "health centers for migrants" whereas these clinics are just as ordinary private clinics as other that do not target migrants. One of the interview participants shared:

> *I have nothing serious. Recently, my daughter had a hemorrhage, so we went to the Kyrgyz clinic at VDNH [metro station] where they prescribed treatment. I gave injections to my daughter myself and I am a nurse. (Kyrgyz female, 54 y.o., babysitter with a background in nursing).*

Sometimes a Kyrgyz clinic is regarded as a good place to consult the doctor and then continue with the treatment at home based on the doctor's prescriptions. The doctors are aware of migrants' socio-economic conditions when prescribing medicines. In case of emergency, the clinic caregivers call the ambulance.

However, some migrants go to neither type of clinic, trying to save money or fearing trouble because of their legal status.

(4) Informal strategy

Informal strategy is used when migrants look for someone who could provide medical care outside the clinics or provide access to a city clinic using informal networks.

When symptoms of diseases occur, migrants search for caregivers among friends and acquaintances with medical background who often work in Moscow in cleaning or construction. This interview participant shared a typical solution when a health issue occurs:

> *I have a distant relative; she used to work as a nurse in Kyrgyzstan. I ask her, it really helps. Once I got sick, so she would come to see me at my place and give me shots. I never contacted the hospital. In all these years, I got sick only once. (Kyrgyz female, 34 y.o., salesperson).*

Some migrants have mentioned informal helpers available within the migrant community. Their contacts are typically spread by word of mouth as suggested by this comment:

> *I know good migrant doctors. They are bonesetters… Well, they are not doctors, but good people. They have helped many people. They are also from Kyrgyzstan. (Kyrgyz male, 46 y.o., street cleaner).*

We were told about a Kyrgyz female who "helped" migrants who needed medical care. Back home in Kyrgyzstan, she used to work as a midwife. Now in Moscow she works as a street keeper. As her second informal job she gives consultation on sexual and reproductive health, and she is also known as someone who can treat the effects of hard drinking. This final service is only offered for payment.

Occasionally, migrants may be referred to some Russian doctors with whom they have informal contact.

(5) Returning home

Returning home is the ultimate method applied when there is no other means to find treatment in Moscow. If the migrant falls seriously ill that means, he or she cannot continue to earn his or her living. Hence, the only possible solution to leave Moscow to seek medical help at home and receive social support from relatives and the native community. This is one of the most common strategies in the case of a serious illness.

2. The caregivers' perspective on migrants' strategies of seeking medical care in Moscow

We have identified five strategies of addressing medical issues that the migrants mentioned in the interviews. So, in the second part of our study, we decided to go further and interview the caregivers in medical facilities such as public hospitals, ambulance stations, state outpatient clinics and private clinics in order to discover more about the barriers migrants face and reconfirm the strategies for seeking medical care we identified interviewing the migrants.

(1) «Healthy migrants – no time and money to see the doctor»

The pharmacists confirmed that many migrants come to seek advice at the pharmacy as their first-hand means to alleviate the symptoms of disease. They often buy the cheapest medicines that cost up to 100 rubles (less than two Euros) like paracetamol or other medicines used for the relief of pain. A pharmacist at a market shared:

They ask for vitamins, pain killers. Sometimes they say, 'I have headache, can you give me something?' "I try to explain that you need to know the reasons for your headache, so you need to see a doctor. Some of them go to the clinic and some do not have time.

Migrants often disregard the disease and in fact let it develop further up to the moment when they need urgent care.

(2) Emergency care

City hospitals receive a significant share of migrants with acute conditions. Emergency care is provided to everyone with no exception, regardless of their legal status or availability of documents. Being in the emergency or intensive care unit is free of charge for the migrants – the city pays for them. However, further hospital treatment (if one does not have health insurance) is most often, limited to up to three days. This is common practice in Moscow. However, we could not find any official reference defining this period. A further stay in the hospital is normally charged so most migrants prefer to leave the hospital and continue the treatment elsewhere.

Migrants either arrive at the emergency unit of hospitals by ambulance or show up on their own. Not being able to afford planned treatment, they often show up in emergency units in a serious condition. A Russian surgeon at the emergency unit of a state hospital for children shared:

"Unlike others, they seek help when it is really serious. For example, a dislocated bone in arm. They do not come here with minor stuff".

The main reasons for seeking emergency treatment among males are associated with occupational injuries, most often, on a construction site, and for women, pregnancy or gynecological issues. All the migrants typically have problems such as renal colic, stomach ulcers and other problems with the gastrointestinal tract because of poor nutrition. Women frequently experience neuropathic reaction. Since most migrants are aged from 18 to 45, cardiovascular and other non-communicable diseases are not prevalent in this group of patients.

Migrant females show up at hospital emergency units for regular pregnancy checkups. This happens if a female cannot afford antenatal care, which is not available for migrants in state clinics free of charge. Some women come to the emergency units for a first diagnosis. An ultrasound specialist at the emergency unit of a state hospital commented:

They [migrant women] say, 'Here I feel the pain'. We do the blood test, the urine test, ultrasound, call the urologist and the gynecologist, but finally they refuse hospitalization... it is just for the sake of the checkup. Almost everyone from the CIS

countries - who do not have documents all come to us. Since nobody will receive them, except for us here.

(3) Planned medical care

Based on the results of the first part of the study, we can the divide the strategy of planned medical care into *formal* and *informal*. The formal strategy is used when migrants go and seek paid outpatient care in state outpatient clinics where paid services exist. They are in great demand among the migrants due to lower prices as compared to private medical centers. A doctor at the construction site told:

"Some private medical centers… are such a rip-off... Once our worker went to a private clinic with such an obvious symptom and he was given a lot of unnecessary procedures for money, and they begin to insist if you try to refuse".

Another way to get an appointment with a state outpatient clinic is to negotiate informally with the doctor. This can be possible through personal recommendation. In our interviews with the migrants, we often heard that it is important if the doctor is an acquaintance. In this case, migrants pay directly to the doctor, which is often two, or three times lower than the official price. A community NGO staff member confirmed that such informal practices are widespread in state outpatient clinics. Such informal practice is quite common among internal Russian migrants who do not have registration in Moscow (Chirikov & Shishkin 2014) so they have hard time receiving planned outpatient care under their compulsory insurance plan.

The so-called Kyrgyz clinics (owned and administered by natives of Kyrgyzstan) are among the most popular medical destinations for migrants in Moscow. This is largely because they are promoted in the migrant newspapers. Another important channel is word of mouth.

About twenty private Kyrgyz clinics are currently active in Moscow. They are staffed with doctors from Kyrgyzstan, mostly graduates of the Bishkek Medical University.

Two relatively large clinics were opened with the support of the Embassy of Kyrgyzstan. They have almost all the key specialists: neurologist, gynecologist, cardiologist, dentist and others. The rest of Kyrgyz clinics in Moscow look like rented offices with one or two small rooms, where specialists receive patients mainly on the weekends when migrants are more available to come.

The patients are mainly people from Kyrgyzstan who reside in and around Moscow. Migrants from Uzbekistan and Tajikistan also often use these clinics. Occasionally local Russians, especially elder people, from the local neighborhood, also come to seek relatively inexpensive dental care.

The main languages of communication between the doctors and the patients are Kyrgyz, Uzbek, and Russian.

Overall, Kyrgyz clinics have lower prices: on average 20-30 per cent lower than other private clinics. As noted by the doctors, if a patient needs a second appointment for the same issue they do not pay twice. However, price is not the only reason why Kyrgyz clinics are popular. Another comparative advantage is the lack of psychological barriers in patient-doctor communication. Doctors from Central Asia are more familiar with the social and psychological problems of migrants. A young Kyrgyz male therapist working in a Kyrgyz clinic shared:

> *Here at work, I do not limit myself to the role of a physician, I am also a psychologist. I understand the problems of migrants; I found a common language with them.*

As both the doctors and the patients of Kyrgyz clinics pointed out, the important thing is that the doctors are sensitive to the traditions of the patients. For instance, if the husband wants to stay with his wife during the ultrasound clinic personnel allow that.

Migrant women tend to go to a Kyrgyz gynecologist, as there is no cultural barrier while discussing family relationships and sexual health. A female gynecologist from a Kyrgyz clinic stressed in her interview that she understands the context and tries to come up with appropriate solutions. For example, when a woman is diagnosed with a sexually transmitted disease it is important that her husband undergo testing, too. In this situation, a male doctor has an appointment with the husband to convince him to be tested.

(4) Informal practices

Informal practices are common among the migrants. Migrants often seek planned medical care among other migrants: former nurses, midwives etc. who are no longer employed in Russia as medical professionals. One of the key reasons why migrants seek informal help is low awareness of their rights and the city medical infrastructure. Newcomers and pregnant females are those who go to informal helpers most often.

An informal helper can help draft an action plan, refer to a doctor from the community or suggest treatment and recommend medicines. A visit may be either free of charge for friends and relatives or may cost something. For some helpers this is a second job. They can do simple procedures like giving injections. An informal community helper who also works as an administrator in a state outpatient clinic commented:

> *A woman came to me in tears, she had a stomachache. After two days, the pain was still strong, so I had to call the ambulance. She was taken to the hospital. Two days later, she*

called and said they suggested that she stays in the hospital for 2000 rubles per day. Instead, she preferred to come to me every day and I gave her injections for only 1000 rubles for ten visits. We keep it as a secret. This is how I help them.

Informal helpers have a special role when it comes to young females who come to informal helpers in pregnancy or after being tested positive for sexually transmitted diseases. They come to share their anxiety with the helper and seek advice.

Informal care can sometimes appear in a more structured form. A medical hotline is available for the Tajik community residing in greater Moscow. This service is supported by an international foundation. Calls are answered by a qualified therapist from Tajikistan, who is fluent both in Tajik and in Russian languages. Depending on their complaints, she refers them to one of the volunteers as she commented:

We have 23 of them, they are from Tajikistan. We call them volunteers but, in fact, they are all doctors. They work in city clinics and have different specializations. We refer these volunteer doctors who prescribe treatment for them for minimized costs when possible.

The Tajik doctors see the patients and, if necessary, redirect them to their Russian colleagues who agree to receive them for a better price. Thus, limited social capital and lack of health insurance is partly compensated by this hotline service and a network of volunteer doctors. A number of Moscow-based NGOs provide similar community services, but they are too few. Yet, the migrants are not always aware of these NGOs spending all the time at work and in the neighborhood where they live and work.

(5) Returning home

The return-home strategy was widely confirmed by doctors who follow up migrant patients. The doctors often recommend migrants to return home in case of a serious ill health, such as, for example, tuberculosis. However, it often happens that migrants cannot leave immediately as they have obligations at work or need to borrow money for the return ticket and, hence, they face additional hazards that create even more serious risks for their health. The return-home strategy keeps seriously ill migrants at home. This is likely to contribute to the salmon bias effect, the selective return of less-healthy migrants to their home country keeping labor migrant population young and relatively healthy (Pablos-Mendez 1994).

DISCUSSION

Like in other host countries that receive, a large number of migrants (Nielsen & Krasnik 2010:

360) Central Asian migrants in Russia are also disadvantaged about their health. Analyzing the eight barriers that contribute to migrants' access to healthcare in receiving countries migrants from Central Asia face the same problems: challenge in organizing healthcare for the migrants, deprivation, lack of familiarity with healthcare of the host country, negative attitudes between caregivers and patients, lack of access to migrants' medical records. Likewise, they face social exclusion and have limited access to health infrastructure as compared to local population. However, the case of Central Asian migrants we did not find major cultural differences in health practices and different perception of the disease and treatment as Central Asian countries had had comparable standards of public health during 70 years of being republics of the Soviet Union. Hence the use of modern medicine, health practices and expectations of Central Asian population became comparable to the rest of population of the Soviet Union (Abashin 2015: 408) especially, in the case of serious health issues such as work-related injuries, pregnancy and reproductive health, dentistry and other the expectation is to use modern medicine. Even using informal strategies migrants seek opportunities of inexpensive treatment in official health facilities and not traditional medicine. For example, pregnant Central Asian women when they ask for informal helper's advice, they typically look for affordable gynecologist, professional abortion, or delivery in a budget clinic. Contrary to our expectation, doctors did not mention it as a concern that some migrants do not speak Russian well. Those who have language barrier take along an interpreter from the community. So, in most of the situations Russian doctors do not have a significant problem talking to migrants.

We could observe in our interviews that negative attitudes between caregivers and patients are an important barrier that largely predetermines migrants' priority to use ethnic clinics as well as informal strategies. Russian doctors and nurses often shared their stereotypical vision of migrants in Moscow: they are typically male labor migrants, often coming from countries of Central Asia or the Caucasus who have difficult life conditions and limited access to medical care. "We" and "they" are the most commonly used references when talking about migrants. "We" implies the norm and "them" refers to something deviant from the norm.

We could see that migrants are perceived as a group of patients with distinct social attributes. It is interesting that doctors speak about migrants referring first of all to their life conditions and social status, and second, their ethnicity. Generalized ethnonyms such as Tajik or Kyrgyz are used by health professionals to describe low-paid workers who often live in poor conditions and have restricted access to social benefits. Even when migrants have all the correct documents, it often takes time and efforts to break through the negative attitude coming from the caregivers and administrative staff.

These barriers contribute to the social exclusion of migrants making them look for alternative strategies within their ethno-social community such as visiting informal helpers or using ethnic clinics where they have fewer barriers in doctor-patient communication.

CONCLUSION

Russia does little to integrate migrants on a systematic level. Health policies in Russia do not regard migrants as a group of patients who need special consideration. Unlike in OECD countries with relatively strong migration policies and decades of experience integrating migrants (Cattacin 2010), it was challenging to analyze migrant health in Russia from the institutional or political perspective. On the other side, most migrants in Russia are seasonal workers who usually do have an intention to root. Hence, they rarely unite to advocate for their health rights preferring to create healthcare solutions within the migrant community.

Chapter 2: ‘Kyrgyz Clinics’ in Moscow: Medical Centers for Central Asian Migrants.

Kashnitsky D. and Demintseva E. 2018. ‘Kyrgyz Clinics’ in Moscow: Medical Centres for Central Asian Migrants. Journal of Medical Anthropology 37(8).

ABSTRACT

Social isolation limits migrants' access to health care, providing the context for the emergence of migrants' own medical infrastructure. In this article, we explore the so-called Kyrgyz clinics, private medical centers in Moscow founded by doctors from Kyrgyzstan and targeted specifically for labor migrants from Central Asian countries, particularly Kyrgyzstan, Uzbekistan, and Tajikistan. These Kyrgyz clinics both provide affordable medical services and enable migrant doctors to guide migrant patients through Russia's medical infrastructure, in the context of limited resources, lack of health insurance, low awareness of available services, and other barriers to care.

INTRODUCTION

> *I think it is our mission to attract Kyrgyz people. We must explain (to them) where they can seek care, raise their awareness on healthy lifestyles. [We tell them] that they need to create a quality life for themselves, to live a good life. If they come here to live, they need to be literate, they need to know their rights* (Doctor at Kyrgyz clinic).

So explained a doctor, at the Kyrgyz clinic, who had moved to Russia a few years earlier as a labor migrant from Bishkek, Kyrgyzstan. Her medical diploma was recognized by the state, and she was able to get a job at the clinic. She talked about her work with patients, mostly migrant workers from Central Asia; she explained that she understood her role as not only treating her patients, but also advising them how to navigate large cities such as Moscow.

Mass migration from Central Asia to Russia is a relatively recent phenomenon; it really kicked off only from around 2000. Not surprisingly, studies addressing the health issues faced by migrants in Russia are scarce, with researchers focusing on themes such as social exclusion (Kuznetsova and Mukhariamova 2013; Demintseva and Kashnitsky 2016; Rocheva 2014) and women's health (Agadjanian and Zotova 2014; Peshkova and Rocheva 2014). None deal with medical infrastructure created by migrants: in this article we offer an overview and explore the role of the clinics that Central Asian migrants create.

Below, we consider the case of Kyrgyz clinics, private medical centers founded by migrants from Kyrgyzstan. Such clinics first appeared in Moscow around 2010 and, within a few years, had gained wide popularity. Migrants from Uzbekistan, Kyrgyzstan and Tajikistan prefer to come to these clinics for health problems, rather than seeking care from municipal health facilities (Demintseva and Peshkova 2014; Demintseva and Kashnitsky 2016). We use the concepts of "place" and "social exclusion" to analyze the role of these Kyrgyz clinics in the lives

of labor migrants, and in doing so, are able to analyze the circumstances that influence the way some places attract people, and how they are associated with emotions, a sense of security, freedom, and participation (Massey 1985). The attachment of particular social groups to certain places can be linked to their status, estrangement, or social exclusion from the host society (Hummon 1992). For some communities, such places become a component of their social capital; the information about them circulates from one person to another. The concept of "social exclusion" includes several components that interact, such as poverty and cultural marginalization (Davies 2005; Hills et al. 2002; Fassin 2009), which lead to barriers in access to health care services.

Migrants may be unwilling to adapt to the norms of the health care system in the host country, and instead seek their own ways of treatment, turning to doctors in their own community or to traditional medical practice (Escandell and Tapias 2010). Social networks play an important role in shaping migrants' strategies of treatment as well as building in migrant communities a sense of security and supporting participation (Massey 1985). Creating medical infrastructure of their own is an important part of their response to difficulties in getting medical assistance in host countries. This has received limited attention. In our study, we aimed to explore the role of the Kyrgyz clinic in the lives of labor migrants in Moscow. We attempted to address why they preferred these clinics, and what doctors in the clinics saw as their roles and duties to their patients.

METHODOLOGY

We came across the concept of "Kyrgyz clinics" or "clinics for the Kyrgyz" in the course of interviews we conducted from 2014 to 2015 as a part of a larger study of the daily life of labor migrants from Central Asia living in Moscow. Overall, we conducted 96 interviews with labor migrants, exploring such issues as apartment rental, buying food and clothing, and how they spent weekends in the city (Demintseva and Peshkova 2014; Peshkova 2015; Rocheva 2015). Interview guidelines included a set of questions on their use of health services and the course of action they took in the case of illness. Based on our interviews, we were able to identify the barriers they faced in accessing medical care (Demintseva and Kashnitsky 2016), the strategies they pursued when ill, and the types of medical assistance that they sought (Demintseva and Kashnitsky 2015).

Labor migrants who did not use municipal health facilities spoke of alternative health care providers they were advised to use by friends; their friends' experiences; and information about these centers that was available online, in the newspapers published by the Kyrgyz diaspora, and on social network sites such as the Russian language site VKontakte (lit. in touch). They pointed to well-known Kyrgyz clinics, even if they could not tell us whether these were private institutions or not, nor whether they had been created specifically for migrants. They only knew

that treatment there was inexpensive compared to other hospitals, and that the clinics employed Kyrgyz doctors who spoke Kyrgyz and Uzbek languages. The migrants who had received treatment at these clinics spoke of the positive attitudes they experienced from the medical personnel, and their willingness to help.

Our interviews with labor migrants from Central Asia led us to speculate that the "Kyrgyz clinics" not only provided medical services for migrants, but also, that visiting a clinic was a kind of "coming home," where the worker would find him- or herself in a familiar and comprehensible environment. The questions we explored, therefore, related to why migrants preferred to be treated in these Kyrgyz clinics? What role do doctors working in these medical centers believe they play? How do migrant communities create such clinics? We also investigated strategies pursued by migrants with health problems, and the barriers encountered by them in accessing appropriate care.

What are the Kyrgyz clinics?

Large-scale migration from Central Asia to Russia began following the collapse of the USSR (Abashin 2014). Labor migrants, mostly Kyrgyz, Uzbeks, and Tajiks, started arriving in Russia's large cities in search of work in the early 2000s (Brusnina 2008). While most were men of working age, in the 2010s increasing numbers of women joined them in response to a growing demand for female migrant workers in retail, cleaning services, and as domestic workers (Poletaev 2014). At the same time, migrant workers from Central Asia started to create their own infrastructure in Moscow, including cafés, hairdressers, travel agencies, real estate agencies, and, most recently, medical centers. These establishments provide services to migrant workers and are staffed by them (Demintseva and Peshkova 2014; Reeves 2016; Varshaver, et al. 2014).

At time of writing (2017), there were more than two dozen Kyrgyz clinics in Moscow, all private medical institutions, officially registered and licensed in Russia. Typically, Kyrgyzstan nationals who have Russian citizenship head these institutions. The doctors employed in the centers may or may not have Russian citizenship, and are migrants from Kyrgyzstan, either recruited from the Kyrgyz migrant community in Russia or directly from Kyrgyzstan. Most are of Kirgiz origin, but some are Tajik. All doctors speak the language of their ethnic origin; in addition, some speak Uzbek.

Older doctors who received their medical degrees during the Soviet era, and younger doctors from Kyrgyzstan who continued their education in Russia, do not need their diplomas recognized in Russia. They can start working as soon as they arrive and find work; medical postgraduate students studying in Russia also sometimes work part-time in these Kyrgyz clinics. Doctors trained in Kyrgyzstan or elsewhere abroad need to have their degrees recognized, at the

cost of 2000 Euros in 2015. One doctor who we interviewed explained that it took her about a year to have her medical license fully recognized in Russia. On the other hand, some doctors had come to Russia under a state program for foreign professionals, which included the recognition of diplomas, and so provides a better start for a medical career in Russia. For example, one doctor from Bishkek had arrived in Russia under this program and had worked for several years in a public hospital in a small town in the Ural Region. She had obtained Russian citizenship, and at the end of her contract, she moved to Moscow, where she found work in a Kyrgyz clinic.

The first Kyrgyz clinic, called Daryger (doctor in Kyrgyz) opened in 2010 and was in the Kyrgyzstan hall of Moscow's "Exhibition of Achievements of the National Economy" (VDNKh), a large area of Moscow created in the Soviet period to celebrate different ethnic groups living in the Soviet Union. The clinic quickly gained popularity among migrants, as it was set up near other establishments catering to Kyrgyz people: food stores selling Kyrgyz products, travel agents, a national cuisine restaurant, and other commercial venues. As a result, the pavilion became an important part of Kyrgyz infrastructure in the city.

<u>Figure 7</u>: Kyrgyzstan Hall at VDNKH - the Soviet Exhibition of Peoples Progress where one of the first two private clinics for labor migrants was founded.

Another clinic, called Mayak (Lighthouse in Russian), opened in 2011. The clinic was in a rented space on the fourth floor of a converted industrial building in Moscow's Mar'yna Rosha district, an industrial area near downtown. Fifteen specialists in different fields were employed in the clinic: a dentist, a gynaecologist, a surgeon, a neurologist, an endocrinologist, a cardiologist,

and other specialists, although there were no psychiatrists in this or any other Kyrgyz clinic. The clinic had an inpatient ward able to accept patients during the daytime. However, patients could be hospitalized there for several days, and migrant patients from other cities could stay overnight if needed instead of finding a hotel. At the time of the study, Mayak was the largest Kyrgyz clinic in Moscow.

Most newly opened Kyrgyz clinics, however, were located in small rented facilities on the ground floors of residential or gentrified industrial buildings, with small signboards in Russian without reference to the Kyrgyz focus of the clinic. Once inside, however, it was clear that the clinic focused on non-Russian clients: advertisements were in Kyrgyz and Uzbek languages, there were stands with community newspapers. These clinics usually comprised one or two rooms and a small corridor, with a few seats for patients waiting to be assessed or admitted. No prior appointment was required to see these specialists. Typically, the staff included several specialists, most commonly a general practitioner, a gynaecologist, a dentist, and a surgeon, most trained at medical universities in Kyrgyzstan. In interviews, both the migrants and the doctors of these clinics emphasised that the services were in high demand among migrants.

Figure 8: a waiting hall at the Kyrgyz clinic and a community center in Maryina Rosha district of Moscow, the largest one at the time of the fieldwork

While there are numerous Kyrgyz clinics operating in Moscow, during our interviews we heard of no ethnic clinics in Moscow other than Kyrgyz clinics, for example, no Uzbek or Tajik clinics. In this context, the Embassy of the Kyrgyz Republic arguably played an important role. It actively supported the opening of the first clinics; assisted the clinics to obtain necessary permits

and licenses from the Moscow city authorities; and helped them with promotion. Information about the clinics appeared in all newspapers published by Central Asian communities in Moscow and the Moscow Region, and leaflets were distributed at Moscow's railway stations at the point of arrival of trains from Central Asia. To some extent, this was possible because of the relatively close political relationship between Russia and Kyrgyzstan, against the backdrop of negotiations about the latter's accession to the Eurasian Customs Union (Malakhov et al. 2015). Additionally, through a special agreement between Russia and Kyrgyzstan, many Kyrgyz doctors received Russian citizenship, making it easier for established clinics to hire them and to open new clinics (Malakhov et al.2015). The emergence of Kyrgyz clinics in Moscow was primarily associated with the support of the Embassy of Kyrgyzstan, but also from the city government of Moscow. These clinics became one of the links in a chain of good relations between Russia and Kyrgyzstan. An important milestone in the improvement of life of Kyrgyz migrants was the accession of Kyrgyzstan into the Eurasian Economic Association: migrants from this country received access to the Russian labor market as did Russian citizens, although they were not covered by obligatory health insurance as the Russians were. The absence of Uzbek clinics in contrast perhaps reflected the unwillingness of the Uzbekistan government to recognize the large flow of emigrants to Russia, and the hesitation of migrants from Uzbekistan to be visible.

The term Kyrgyz clinics implies restrictions for patients on ethnic grounds, but any anyone, regardless of citizenship, could attend these clinics. However, in our observations, patients were rarely Russian, reflecting different strategies of accessing medical care by Russian citizens and labor migrants. In Soviet times, every citizen could access free state-funded medical care. Private clinics expanded in the post-Soviet period, and in general they have better services, facilities, and equipment. Meanwhile, state-supported medical services have significantly reduced in number, and state clinics have begun to charge fees for services (Kochkina et al 2015). Today, Muscovites, particularly middle class and wealthy people, are increasingly using the services of private clinics and hospitals rather than state clinics. However, poorer Muscovites still predominantly use state-funded services. Citizens are covered by obligatory medical insurance, allowing them to be admitted to public hospitals free of charge, and poor patients as well as those in need of emergency care increasingly use public hospitals for their health care (Kochkina et al 2015).

The situation with migrants is different. Although migrant workers from Central Asia are one of the most economically disadvantaged social groups, their treatment strategies differ from those of poor citizens. When we asked labor migrants from Central Asia where they had received treatment in Moscow, most commonly they responded that they "had not been sick yet and had

not been treated" (Demintseva and Kashnitsky 2016: 5). Some of our interlocutors, however, did mention having visited a doctor once or twice since migrating, mostly in emergency cases such as for injuries or cases requiring surgery.

Several strategies are pursued by migrants when they require medical assistance (Demintseva and Kashnitsky 2016), mostly, consistent with the above, seeking emergency medical care by calling for an ambulance and receiving help on the spot or at the hospital. Once at the hospital, they could decide to be hospitalized or return home after receiving urgent attention, depending on the advice they received from doctors and their ability to pay for hospitalization. The key issues here were uncertainty and lack of information. Migrants did not know what kind of medical assistance they could receive free of charge. "[In the mid-2000s], I knew that if you get [to a hospital], then three days would be free," explained one doctor from a relatively small Kyrgyz clinic:

> *I would advise [my patients]: 'Call an ambulance if you are very sick... do not be afraid, explain your situation! They will take you in anyway. You will be treated for three days, then you can be discharged from the hospital. If they offer you further treatment, you can decide whether it is necessary for you'. This is what I used to say. Now I no longer say so, because patients then call me and complain: 'We were sent elsewhere.' And it keeps happening again and again.*

Rules were often opaque and incomprehensible to migrants and could be easily broken by staff at public hospitals. As a result, while all migrants said that they knew that they had the right to three days of free treatment, at a hospital they were never sure that they would not be handed a bill. "Some patients say that when an ambulance arrives, the paramedics ask them: 'Do you have insurance, are you eligible for free [hospitalization]?'," a doctor at a Kyrgyz clinic commented. Further, among those who were taken to a hospital by an ambulance, some migrants reported being refused admission due to the lack of health insurance covering hospitalization.
Doctors at Russian public hospitals as well as migrants were not always aware of what kind of free health care was available to migrants, nor the amount they could be charged for specific services. Doctors often referred to verbal orders from their supervisors (head physicians), who set locals rules of admission for foreign patients. In practice, the situation varied from one public hospital to another. A therapist working in an international NGO that supports migrants in Moscow described childbirth at public hospitals for migrant women: "Sometimes they pay about 15 thousand [rubles] or 20 thousand [rubles]. And sometimes, for reasons I don't understand, they

are not charged anything." Such unpredictability was common with other types of care as well.

We were told of cases when migrants avoided hospitalization as they were afraid that they would have to pay for the hospital stay, and sometimes for the treatment, since many did not have insurance that would cover hospitalization. In our opinion, they were afraid and uncertain how much they would have to pay and whether management of their condition would become too expensive for them.

Why migrants prefer to be treated at Kyrgyz clinics

Many migrants said that the Kyrgyz clinics were a little cheaper than other private medical institutions in Moscow; we estimate they were about 20 percent lower. However, they were not the cheapest available option in Moscow, public hospital clinics, for example, charge even less for the same services.

During interviews, paramedics at Russian public hospitals told us that the use of traditional medicine was common among older Russians, who would try different herbs and potions to cure themselves. This was not the case among migrants, and the Kyrgyz clinics we visited did not offer traditional medicine. Doctors at the Kyrgyz clinics confirmed this, although they also complained about the widespread use of dietary supplements such as biologically active additives (BAA). Doctors explained that nutritional supplements were successful among migrants due to their marketing strategy, with migrants involved in their distribution and assured that the supplements would prevent "all diseases." Doctors at the Kyrgyz clinics told us that migrants often confused dietary supplements with medication and ended up taking the former instead of the latter, with negative impact on their heath.

Migrants also attended the Kyrgyz clinics because the doctors could speak their own languages. Although this turned out to be important, neither migrants nor doctors mentioned this as the key advantage of 'Kyrgyz' clinics and Central Asian migrants, for example, from Uzbekistan and Tajikistan, often spoke to the doctors and administrative personnel in Russian or were accompanied by people who could help them with interpretation to Russian. As doctors at the emergency section of a public hospital noted, Central Asian migrants usually had no problem communicating with them: older migrants (> 30 years) usually spoke Russian, and they helped younger migrants to communicate with medical personnel. What was important however was that migrants felt they could talk to doctors who understood their problems, traditions, and religious

norms:

> *"I often talk at my work not as a physician or a cardiologist, but as a psychologist. I understand the problems that the migrants face; I can find a common language with them"* (therapist at a Kyrgyz clinic, Kyrgyz, 30 years old).

Labor migrants presented at the Kyrgyz clinics knowing that people like them were expected there, and that doctors would not ask embarrassing questions about their legal status in Russia or their living and working conditions. Doctors drew our attention to this and said that they needed to take account of the cultural context to engage with their patients. This included gender relations, particularly among Muslims, whereby husbands might want to stay with their wives during ultrasound examinations or might object to their wives being examined by a male doctor:

> *We have fewer such situations with women from Kyrgyzstan, while with those from Uzbekistan it is more common, especially when they come with their husbands. If they do not agree to be examined by me, then I call the female gynaecologist, and she helps. [She does all the manipulations, while] I look at the computer screen. And so, the two of us, we perform the diagnostics* (ultrasound diagnostics specialist, male, Kyrgyz, 28 years old).

Doctors tried to anticipate these issues and plan how to interact with patients. A female gynaecologist, for example, often has to treat women who come to be examined and are diagnosed with a sexually transmitted disease.

> *We explain to them [the methods of treating the infection]. However, sometimes it is very difficult for them to explain the situation to their husbands. A woman approached her husband, but he said: "No, I am totally fine. I am not infected. It all comes from you… This is what happens. He does not want to do the test. So, we told the women: "Never come to pick up the test results alone." We say: "Next time come with your husband" or: "Is your husband here now? – Yes. – Tell him to come in." We invite him to come in and send him to the urologist right away. If we are lucky, he comes; if we are not, he just walks away.*

In such contexts, doctors agreed on the importance of prevention to help their patients, given their level of awareness of various diseases, and the fact that migrant women were more

exposed to risks as a result of gender inequalities (Agadjanian and Zotova 2014: 87). In addition to paying attention to the traditions and cultural norms of their patients, doctors also attended to the ways in which these traditions were transformed in the context of migration. Living alone, far from their family, in a society that was new to them, migrants often took up new patterns of behaviour, including modes of sexual relationships. Since they might lack information about health risks that might arise (Agadjanian and Zotova 2014: 103), doctors also considered it their duty to provide their patients with sexual and reproductive health information. Gynaecologists particularly mentioned that discussing sex was regarded as taboo in the communities from which their patients came, so that young migrant women often lacked basic knowledge of contraception, which they associated with unwanted pregnancies and sexually transmitted diseases.

Doctors at the Kyrgyz clinics often acted as 'mediators' between migrants and other medical centers in Moscow, both public and private. Because the Kyrgyz clinics did not provide a full range of medical services, they had agreements with other medical centers (for example, to perform tests) or referred patients to other clinics where they had contact with certain specialists.

Doctors assumed the role of advisors to their migrant patients: "There are patients to whom it must be explained that the state of their health requires them to spend money on medications rather than travel home". The goal of doctors at the Kyrgyz clinics, as they defined it, was not only to prescribe medicine, but also to educate their patients about the risks to their health, determine a strategy of treatment that a migrant patient might need to pursue, determine whether to go back to his home country for treatment or go to the local hospital, and convince them to go to a hospital if necessary. "All our personnel are trained to deal with the ambulances. And [the paramedics who work at the ambulance], they know us very well. We are friends with them" (director of a large Kyrgyz clinic).

Doctors also offered psychological support to their patients, trying to understand their life circumstances, and offering them the kinds of services they require. "If the patient says that he has no money, we try to prescribe cheaper medicines. For example, I go to the pharmacy and ask about the prices. I compare the prices and then suggest certain medicines to my patients," one doctor at Kyrgyz clinic explained.

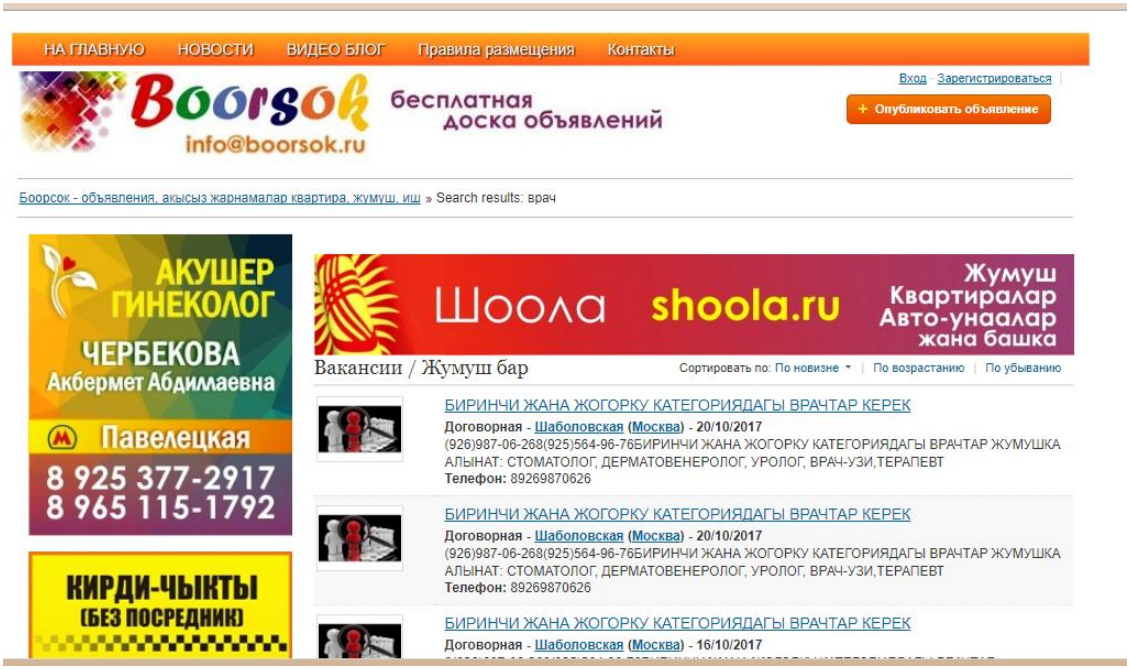
To sum up, doctors at the Kyrgyz clinics described their mission as not only diagnosing the illness, assigning a treatment, and prescribing medication, but also as providing the migrant with advice:

> *People are all tired here. They are all nervous. When I was working in Kyrgyzstan, there was poverty and unemployment, but people [I treated] were at home and they knew where*

to go in case of illness ... Over there they were not as stressed out as here. Migrants are constantly working, they are tired. Many of them are tired mentally. A special approach is required. (Gynaecologist, Kyrgyz clinic)

Both migrants and doctors noted that it was the ability to understand the problems of migrant patients and their socio-economic situation, rather than their ability to speak the same language, that was key to the popularity of these medical centers.

***Figure** 9: Boorsok.ru - website for free announcements, aimed at promoting services within the Kyrgyz diaspora in Russia,*
some thematic announcements are written in Russian, some in the Kyrgyz language.



CONCLUSION

Labor migrants play a vital role in Russia's national economy, and they pay a monthly fee to ensure they are legally in the country. They pay the equivalent of state taxes but are deprived of access to state-funded medicine. The Kyrgyz clinics are the first private medical institutions in Moscow, created by migrants from Kyrgyzstan and tailored to the needs of labor migrants from Central Asia, among the most discriminated groups in Russia. Migrant doctors from Kyrgyzstan have created a safe place for treatment (Massey 1985) that has become part of the infrastructure for labor migrants from Central Asia. These places attract migrants experiencing social exclusion.

Many Central Asian migrants working in Moscow learned about the Kyrgyz clinics by word of mouth. Although labor migrants still have to pay for treatment at Kyrgyz clinics, they preferred to go there when they fall ill. The term Kyrgyz clinic is not used in any documents, but it is firmly established in colloquial use. The clinics do not provide ethnic specific treatment, nor traditional medicine; rather, they are Kyrgyz in terms of the patients for whom they cater.

As we have described it, migrants choose these clinics for several reasons. First, they know that these clinics are expecting people like them, from the same social status (Hummon 1992), and that the personnel of these medical centers were aware of their low incomes and poor living conditions in Moscow. Migrants believed that these doctors would offer them a treatment strategy that suits their life circumstances and constraints. Second, the services offered at the clinics are considered appropriate to the socio-economic conditions of Central Asian labor migrants. The clinics employed such medical specialists as urologists, gynaecologists, and surgeons, who were in high demand by young people coming to work in Moscow, for instance, for help managing a pregnancy or for advice regarding problems with fertility. Since they lacked access to free medical advice, migrants preferred to go to the Kyrgyz clinics for such help, knowing they would be offered minimum necessary services (in contrast to the more expensive and expansive programs in Moscow's private clinics).

Third, a Kyrgyz clinic is a place where migrant patients see migrant doctors. Workers from Central Asia were attracted to the clinics because the doctors were of Central Asian origin, with their own stories of migration. Some came to Russia as labor migrants; others came to study in Russian universities. Labor migrants knew that the doctors would understand them, not only in terms of language but also cultural norms and their everyday lives. The doctors therefore had two tasks: first, curing their patients, and second, helping them in their new lives and to negotiate new types of social relations and experiences.

Chapter 3: The Russian HIV residence ban and state control of migration

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ABSTRACT

In this article I explore how state exercises power on migrants by creating a space of uncertainty, producing ‘illegality’, as well as holding control over migrants’ bodies. I am analyzing this phenomenon on the example of how international migrants are deprived from access to HIV services in Russia, the largest host country of migration in the region of Eastern Europe and Central Asia that bans residence of HIV-positive foreigners. A significant share of HIV-positive migrants in Russia have to hide and reside as irregular migrants with no access to services. Regional non-governmental organizations have been trying to advocate for the lift of the HIV-related ban on residence is Russia, but government officials have been protractedly resistant to listen. The study is based on qualitative interviews with NGO professionals and analysis of live stories of irregular HIV-positive international migrants in Russia. In the discussion part I problematize the epidemiologic, economic, and social implications of this longstanding HIV-related residence ban in the light of the Russian state approach to handling migration in an attempt to inform further research and next steps of civil society advocacy.

HIGHLIGHTS

- HIV testing is obligatory for migrants who reside in Russia.
- International migrants with HIV have no treatment; many of them never leave.
- Russian authorities keep migrants low-profile, illegal but tolerated.
- Civil society and authorities from home countries provide limited support.

INTRODUCTION

An overwhelming majority of international labor migrants come to Russia from neighboring countries of East Europe and Central Asia such as Ukraine, Moldova, Armenia, Uzbekistan, Tajikistan, and Kyrgyzstan that all have a visa-free regime with Russia (FMS 2019). International labor migrants have to get work permit which serves as a residence permit in the country. However, one needs to prove an HIV-negative status as a condition to be eligible to apply for work permit and hence, residence permit. If an international migrant is found HIV-positive he or she will not be granted permission to work, but instead, be subject to “undesirable stay” and deportation (Inverardi 2018). Hence people living with HIV who plan migration either have to fake a negative-result certificate or remain irregular and no work permit confined to work in the black market in fear of deportation (Agadjanian and Zotova 2014). As Foucault formulated it, "the existence of a legal prohibition creates around it a field of illegal practices" (Foucault 1979).

In this article, I attempt to answer the question why the Russian state is persistent to keep the HIV residence ban for international migrants. I problematize the epidemiologic, economic, and social implications of a 24-year-old HIV residence ban for international migrants in the light of the Russian state approach to handling migration. By looking at the lives of different types of migrants I want to showcase the untold stories of people living with HIV who in spite of having an opportunity to get free antiretroviral treatment in their home countries prefer to stay in Russia in limbo for years.

By analyzing this specific example of health policy, I want to conceptualize the biopolitical dimension of the state approach to control migration (De Genova 2002; Reeves 2015). I also aim to contribute to the academic discourse on uncertainty and the space of ambiguity between life and state law (Reeves 2015; Schenk 2018).

BACKGROUND

Migrants with HIV are just a small part of the larger group of undocumented labor migrants in Russia, roughly estimated as 3-5 million people who work in informal market with the main reason to support their household back home (Schenk 2018; Zayonchkovskaya et al. 2014; Dave 2014).

There are many more other reasons, apart from having HIV that make migrants fall into bureaucratic pitfalls and that can easily delegitimize them in Russia. However, being HIV positive is the only reason of becoming irregular for life with no second chance to re-apply for work and residence permit.

Migrant "illegality" effectively emerged from the law, but it is also often sustained due to discursive formation (Carter 1997). Irregular migrants are denied fundamental human rights often with little or no opportunity to seek protection from the law (De Genova 2002). Regulations related to work permits and registration lack clarity and subject to frequent changes which means that many migrant workers persist in a state of legal uncertainty, ‘illegal’ but tolerated (Reeves 2015_ looking for coping strategies and some manage to access treatment with no sustainable health solutions. At the results, irregular migrants stay silent and submissive (Calavita 1990; Sassen 1988); they remain socially excluded and have multiple barriers in access to healthcare services (Hills et al 2002; WHO 2010; Demintseva and Kashnitsky 2016).

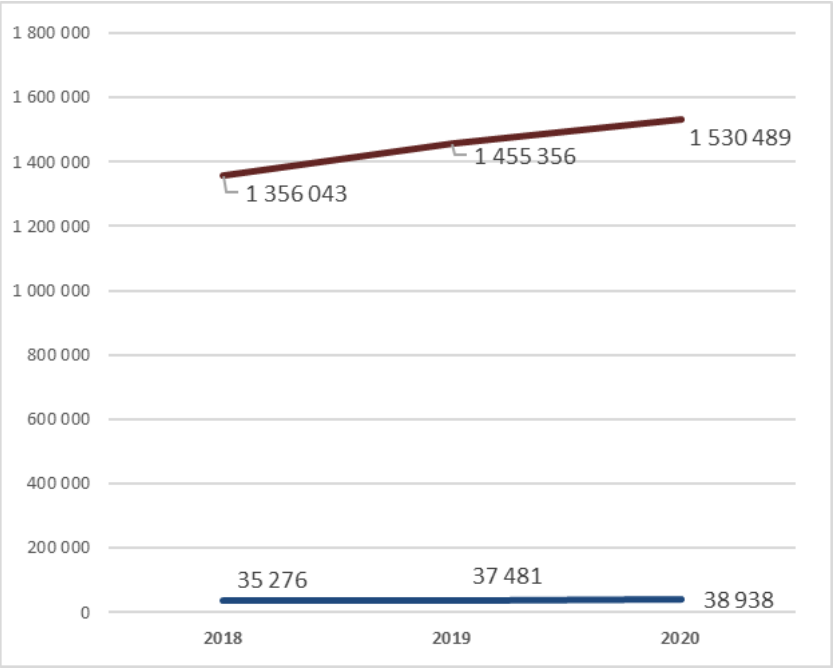
Entry restrictions for people living with HIV/AIDS have been debated among politicians, public

health officials and health experts since the early days of the epidemic in the 1980s. Governments justified them by reasons of epidemiologic security and protection of domestic population, on the one hand; and on the other hand, by making a reference to economic arguments: permitting HIV-positive people to enter on a long-term basis and reside in the country implies significant economic costs on the national health economy due to the implied obligation to provide them with life-long treatment. Another group of arguments deeply rooted in the public misconceptions about HIV/AIDS is related to fear of letting in key populations: sex workers, men who have sex with men and people who inject drugs (Ooms and Kruja 2019).

In fact, HIV bans on entry, and residence do not protect domestic populations but pose a serious threat to HIV prevention and treatment (UNAIDS 2019a). These restrictions violate the rights of people with HIV to health, privacy, equality, and non-discrimination. In 2016, Member States of the United Nations signed an agreement to get rid of HIV-related travel restrictions. In 2019, still around 48 countries had some form of HIV-related travel restriction and 19 countries had legal norms on deportation of HIV-positive international migrants, including Russia. Many countries liberalized legislation regarding the rules of entry and stay of migrants with HIV in the last decade (UNAIDS 2019b), but not Russia.

Russia's HIV residence ban was introduced back in 1995 (Inverardi 2018) when HIV was still considered a deadly infectious disease. State authorities introduced it as a means of epidemiological control, no antiretroviral therapy was provided by the state to suppress the human immunodeficiency virus at that time. At that time, HIV prevalence rate in Russia was much below 0,1 cases per 100000 (AIDS Center 1995). Now after more than 20 years of the HIV epidemic in the region the situation dramatically changed: on one hand, HIV/AIDS is no longer associated with mortality as long as antiretroviral therapy is adhered (UNAIDS 2017a); on the other hand, Russia has now the highest burden of the HIV epidemic in East Europe and Central Asia region with over 1% population being HIV-positive while Central Asian countries have 5-6 times lower prevalence rate: Uzbekistan - 0.16%, Tajikistan - 0.3%, Kyrgyzstan - 0.2%, Moldova - 0.2% of the adult population (UNAIDS 2017a) as compared to Russia. This means, that even if borders could protect local populations from the influx of epidemics, this HIV residence ban is no longer beneficial for Russia from both epidemiologic and national security points of view.

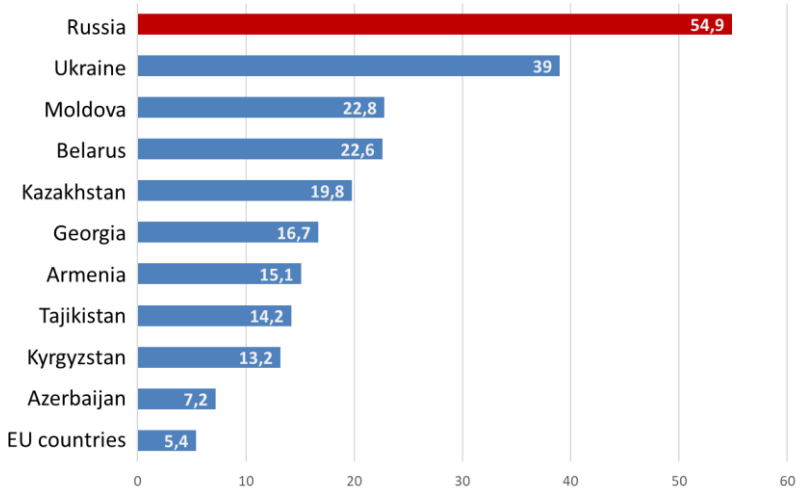
***Figure 10*: The cumulative number of registered HIV-positive people in the Russian Federation compared to the cumulative number of foreign citizens diagnosed with HIV in the Russian Federation.**



Explanation to the graph: the red line is the cumulative number of registered HIV-positive persons in the Russian Federation, the blue line is the cumulative number of foreign citizens with HIV infection in the Russian Federation.

In 2019, Russia and Turkmenistan remained the only countries of the WHO European region that deported or delegalized HIV-positive migrants (UNAIDS 2017a).

***Figure 11*: New HIV infections per 100,000 population in EECA countries, 2019, ECDC data, 2019**



In 2016, an estimated number of 190 000 new cases of HIV were detected in the region of Eastern Europe and Central Asia, whereas HIV growth rate by 60% compared to 2010. 80% of new cases from this number are registered in Russia making it the absolute leader both in terms of incidence and prevalence (UNAIDS 2017b). Bearing in mind these figures, we can see that migration-sending countries do pose no evident threat in terms of epidemiological security. There are other urgent measures Russia needs to take to curb down the HIV epidemic, like recommended by Prof. Michel Kazachkine (Cohen 2018), UN Special Envoy for HIV/AIDS in Eastern Europe and Central Asia - to amplify prevention, in particular, among key populations, and improve access to treatment. Russian prevention programs although quite expensive are deemed inefficient by many international public health for they do not take little account of international evidence-based programs such as, for example, harm reduction and sexual education in schools (Meylakhs et al. 2017; Cohen 2010).

It is not only the fact that effective and inexpensive antiretroviral therapy became available in most countries, including Russia, allowing people living with HIV had a healthy and productive life, but it is also that banning HIV-positive migrants is inefficient. The Population and Development Center of Université de Paris (CEPED) conducted a bio-behavioral study of HIV-positive migrants from sub-Saharan Africa living in France. As the result, 58% of migrants had HIV before arriving in France, 42% were infected after migration, most of whom acquired HIV in the first six years after moving to France. Researchers attribute the increased risk of infection to difficulties with adaptation, lack of legal status and poor access to health services in the first years of life in migration. The research team strongly recommends increasing access to testing and treatment services among migrants, regardless of their legal status (Gosselin et al. 2019).

There is no full national statistics about incidence or prevalence of HIV among international migrants. It is only limited to migrants from countries outside the Eurasian Customs Union (Treaty 2014) as they have to take the obligatory HIV test in order to apply for residence permit. Migrants from such countries as Armenia, Belarus, Kazakhstan, and Kyrgyzstan do not need to receive a residence permit according to the regulations of the Customs Union. But event fragmented data we have corroborates the assumption that it is not the migrants to be blamed for the spread of HIV in Russia. In 2014, HIV incidence rate was 307.1 per 100 000 blood tests among Russian citizens, and 201.1 among foreign citizens per 100 000 and this is much lower level (AIDS Center 2015).

METHODOLOGY

In 2014-2016 the author conducted 30 semi-structured interviews with doctors, nurses, clinic administrators, pharmacists, and informal helpers in the city of Moscow who provide medical care or advice to Central Asian migrants. Participants were recruited using a combination of purposive and snowball sampling techniques (Dahlgren et al. 2004).

Later in 2017 and 2018 I interviewed 10 experts and activists from leading civil society and community organizations from Eastern Europe and Central Asia (please, see details of the interviews in table 2 of the Appendix)

These experts and activists had to have experience with the migrant health on the practical level. Talking to them aimed to understand what the barriers and coping strategies were implied by international migrants living with HIV in both sending and receiving countries.

I read and analyzed the transcripts of the interviews several times to pick out meaning units and identify themes and so conceptualize perceptions and expert opinions. A phenomenological analysis (Dowling 2007) was used to outline three themes: 1. Stigma, fear of deportation and little information, 3. Migrants wives and regional spread of HIV, and 3. Persisting legal uncertainty. Later I discussed the findings with several researchers of different backgrounds in social sciences and received feedback from civil society experts.

In addition to the interviews, I analyzed 10 cases depicting lives of HIV positive migrants who lived in Russia. These migrants were clients of the Moscow-based Shagi Foundation whose case managers recorded migrants' individual circumstances and barriers as well as and solutions they were able to provide. Migrants' names were not revealed at any moment of either fieldwork or analysis.

There is a particular focus on migrants from Central Asia as they constitute the largest and the most vulnerable group of international labor migration in Russia (Demintseva and Kashnitsky 2016). Central Asian migrants face a particular burden of discrimination in the host society, stigma from the origin communities and are more vulnerable to public opinion because of the negative image they receive in the media (Agadjanian and Zotova 2014).

All interviews were tape-recorded on condition of participant's consent, and later transcribed. Written notes were taken during field observations. The interviewing process was informed by

saturation (Glaser and Strauss 1967) of data, i.e., when data essential for understanding of each theme is fully collected.

THE LIFE CYCLE OF A MIGRANT WITH HIV

3.1. Stigma, fear of deportation and little information

It has been largely researched those migrants coming to Russia play an important role in the economic life of the country and are play an important role in the daily life of large Russian cities (Demintseva and Peshkova 2014). At the same time, they are deeply engaged in the life of their home countries: they keep connections, send remittances, develop institutions, and influence community development (Portes et al. 1999). The simplistic image of labor migrants in Russia would be to conclude that they are young, busy, and healthy. It is linked with the "healthy migrant effect" (Kennedy et al. 2006) which explains the perceived effect that migrants rarely fall sick and very rarely see a doctor. In fact, this often results in a denial of illness, ill-health and can eventually result in an acute emergency condition (Demintseva and Kashnitsky 2016).

Deportation is very rarely enacted in Russia as this is very costly to deport people, but migrants are aware that immediately after being tested at the government testing facility and if HIV is found their names are included into the blacklist of the Federal Migration Service. That means an international migrant if found HIV would not be able to re-enter Russia for life once he or she has left Russia. Low information about HIV, stigma, and fear to deceive relatives not meeting economic expectation of family members keeps many migrants with HIV locked in Russia for years getting their health deteriorated in spite of the fact that free treatment is available in all main home countries of migrants working in Russia due to remaining presence of international donors in support of healthcare services and supply.

Fear of return is quite often driven by lack of referral system between Russia and home countries of the migrants as well as little availability of counselling. A community activist who provides social support for people living with HIV in Uzbekistan commented in her interview:

This is a typical situation when migrants learn about their HIV status, have very little information and fear return home where they can life-saving therapy free of charge. This is where we can help. No need to go back to the family, one can receive treatment confidentially and avoid all the trouble. (female social worker from Uzbekistan, 39).

After learning about their HIV status in migration migrants typically know very little about the

disease, available support, and treatment options in their home countries. The shocking news about being HIV-positive strikes many migrants, they are seldom provided with no after-test consultation when this is the moment when they need it most.

Although migrants with HIV have no option to get legalized in Russia, they often prefer to stay and some of them manage to find coping strategies to access healthcare and receive therapy.

An undocumented HIV-positive migrant from Uzbekistan living in Russia shared that for the moment he considers no option of return fearing disclosure of his HIV status.

Very quickly, information about the patient's HIV status reaches relatives, and the person experiences severe discrimination. Relatives begin to avoid you and treat you as an outcast (male migrant from Uzbekistan, 31).

He remained in Russia undocumented with no access to treatment. At some moment of time, he felt so ill that he could not walk, eat and go to the toilet but he still refused to call a doctor, as he was afraid of a possible deportation. After being referred by a friend to a support service for HIV-positive people provided by a Moscow-based NGO Shagi he now receives a part of the needed antiretroviral therapy from other patients, and another part he manages to buy from the commercial pharmacy. This solution, although unstable, allowed him to stabilize his health condition and resume working. He has no plans to return to Uzbekistan in the near time fearing not to be able to find work back home and possible disclosure of his status to the relatives and community.

Some migrants with HIV do not consider a return option due to insoluble legal barriers back home.

Another case of a young man from Turkmenistan, aged 34, who has been living in Russia with HIV for 8 years. He had come to Russia as a student migrant in 2010 and 4 years later got tested positive on HIV. It was just in time to allow him to complete his degree but after graduation he remained in Russia undocumented with no perspective to receive a residence visa. He now receives limited support from a local NGO. Living in illegality he shares that he has a strong fear of leaving home during large public events in the city. For example, during the World Cup in 2018 he did not leave his apartment fearing of being detained. He rarely uses public transport, afraid of document checks. Unlike the young migrant from Uzbekistan, he would like to go back to his home country and live with his family, but Turkmenistan provides no antiretroviral therapy to its citizens. Apparently, he has not even a shady perspective to live a healthy life in his home country for HIV positive people are nor recognized as a group. Russia is his only hope after all because of the regular support he receives at the community NGOs.

A similar story of a student from Vietnam, aged 28, who won a scholarship to go to Russia to do study at the doctoral program in math and computer science. Half a year ago he was found HIV-positive after doing an anonymous test in a private clinic. He fears the moment when he needs to extend his student visa as he will have to pass the HIV test again. He is perplexed and does not know what he has to do. After graduation, he was planning to return home, but now he understands that he would not be able to do civil service as he planned before. The Vietnamese government has obligatory testing for infectious diseases and refuses to employ should HIV be detected. As a result, he would have to accept a lower-paid job. He is hopeful that he would be able to stay in Russia and find employment in his profession. For the moment the situation for him looks insoluble. He is also apprehensive of talking about his status with parents back home, as stigma towards people living with HIV is persistent.

These cases illustrate how the Russian government keeps international migrants in legal uncertainty as people who remain in limbo, discriminated but still participating in the economic life of the country. With no access to regular antiretroviral therapy their deteriorating health is the price that they pay for the hope of a better life. In spite of being irregular some of them use informal coping strategies to access therapy but these solutions are provisional and instable.

3.2. Migrants' wives and regional spread of HIV

The situation with migrants being infected with HIV has a trickle-down effect. Many of them end up traveling back home. Because of the stigma they often do not talk about their diagnosis to their wives. The wives of migrants are at high risk of being exposed to HIV. Hence, labor migrants contribute to the acceleration of an epidemic in their home countries (Luo et al. 2012). This is especially widespread in the countries of Central Asia that provide up to a half of international migrants to the Russian Federation.

A female human rights activist discussed this issue from the geopolitical perspective:

> *"It's related to gender. She [the wife] will have to accept what I have as she is dependent on me, and she takes no decisions. This is a human right issue".* Later she is hopeful that Russia will find a solution as *"[Tajikistan] is situated in the geopolitical realm of Russia, and I assume that Russia would not like to lose its influence in the country"* (female, human rights activist, Tajikistan).

Although Russia limits access to migrants with HIV, they are largely present in the country, remaining completely invisible to the state, so we could even discuss the epidemiologic aspect of

the problem in terms of spread of the HIV from Russia to other countries of the region. This brings us to the question that migration and HIV is a global transnational issue and solutions should be mitigated on international level putting more focus on evidence-based interventions that have an aim to easy access to testing and treatment for all, especially, vulnerable groups, including migrants (Demintseva and Kashnitsky 2016; Ooms and Kruja 2019; Cohen 2018).

3.3. Persisting legal uncertainty

Although Russia officially keeps deporting international migrants with HIV, in 2016 following a decision of the Constitutional Court it introduced an indulgence for HIV-positive foreigners married to Russian citizens: they can apply for a residence permit in Russia. However, this newly introduced norm does not work in practice, except for a few cases that went through court hearing. According to feedback from a Moscow-based NGO, many more migrants who tried applying for residence permit under this family reunification scheme, were denied submission of their applications on the basis of violation of administrative law.

> *"The Ministry of Internal Affairs is looking for any reason for deny migrants' rights by imposing fines, finding fault in overstaying in the country, etc.". They do everything to refuse applications from HIV positive migrants who have a Russian family"* – shares a program coordinator from a Russian health NGO.

It corroborates with other studies that show migrants' vulnerability towards state officials and police. Reeves (2015) and Dave (2014) explicitly show how state can exercise power on migrants by creating a "space of uncertainty" and producing 'illegality' instigating corruption and shadow implementation mechanisms for those who can use them. As it is vividly seen for other groups of migrants who are rarely deported, most migrants with HIV can stay in the country for years using a multitude of survival mechanisms however pitiful their plight might be.

The current situation allows for a lot of power excess and violation of law by state officials on the ground.

> *"A citizen from Tajikistan was detained with antiretroviral drugs by the Russian border control at the airport, she was forced to admit that she was carrying the drugs for herself and deported on suspicion of being HIV positive"* – a community activist from Tajikistan was sharing about her client.

This is definitely a violation of the law by the border control official but quite a typical one in the context of the deportation norm that rarely works but consistently results in the criminalization of

migrants with HIV.

Hence, we can note that the coping strategies on the community level, however inventive, are rather precarious and do not provide a reliable long-term solution for migrants with HIV living in Russia.

DISCUSSION

Low awareness and behavioral factors contribute to high vulnerability of migrants in Russia in regard to HIV (Amirkhanian et al. 2011). People living with HIV face stigma and multiple discrimination both in Russia and in their home countries. After getting to know about being HIV-positive migrants sometimes fear to return home and prefer to remain undocumented in the host society trying to secure treatment using grassroots transnational networks or even remain without treatment. This is especially exacerbating for female migrants living with HIV who endure the most serious stigma (Agadjanian and Zotova 2014). Another reason that turns HIV-positive migrants away from returning home is the fact the once the Russian government learned they had HIV, their names are included into a blacklist that bans them from re-entering Russia, if they travel away from the country and later want to come back. The HIV entry ban has no expiry date which means HIV-positive migrants are banned to re-enter Russia for life. Therefore, they think carefully before leaving Russia – even being undocumented they often have better opportunities to earn their living in Russia compared to their home countries like Tajikistan, Uzbekistan, Kyrgyzstan, Moldova, or Ukraine – all lower-income countries compared to Russia with fewer job opportunities, especially in rural areas.

It looks like no one really benefits from the Russian residence ban for HIV-positive migrants: migrants with HIV are deprived from their right to health and agency. testing, whereas the Russian government does not know the actual scale of the problem it has very limited health statistics on migrants.

Another important circumstance in this constellation is the fact that all countries of East Europe and Central Asia (as discussed above, except for Turkmenistan) provide HIV-positive citizens with free antiretroviral life-saving drugs (in most of the countries still purchased from international funds). According to many testimonies from migrants and community activists, health authorities in sending countries cooperate with migrants and provide them with therapy on the condition that they are initially registered with them and that they regularly send them fresh HIV tests to check the viral load and level of immune cells. This is a widely used informal practice on the level of state medical institutions.

Therefore, if Russia decides to repeal the HIV residence ban, even if it does not pay for migrants' treatment, they will still benefit from legality and will be able to receive therapy from the AIDS centers of their home. Beyond this Russia will have thousands if legal taxpaying migrants who will benefit the state budget. it looks like Russia would not have to incur any economic and political losses after repealing the ban.

Chapter 4: ‘In Short, We Will Deport You’: Disrupted Temporalities of Migrants with HIV in Russia

Kashnitsky D., Richter J. M. 'In Short, We Will Deport You': Disrupted temporalities of migrants with HIV in Russia // Global Public Health. 2021. P. 1-20.

ABSTRACT

Migrants experience several challenges en route to or in their host country. Current legislation in Russia imposes a permanent ban on international migrants with HIV obtaining a residence permit in Russia. Using qualitative methodology, we conducted semi-structured interviews with 15 international migrants who have lived with HIV in Russia and 12 interviews with healthcare providers in Russia. With the help of Bonnington's temporal framework, the study finds that the HIV-positive status of migrants becomes a biographical event that interrupts their migration cycle, thereby leading to the disruption of their normal life course which results in "short term planning" and instability. Although most people living with HIV face similar challenges, Russian law concerning international migrants living with HIV worsens their living experience in Russia. International migrants living with HIV further face social exclusion, serious stigma, and discrimination. The results show that the country's demand for migrants with HIV to leave the country to reduce the spread of HIV in Russia is counterproductive: it does not mobilize heath seeking behavior among migrants. Therefore, such legislation has to be amended to encourage international migrants living with HIV to access adequate HIV services.

INTRODUCTION

Data from the Joint United Nations Program on HIV/AIDS suggests that, in 2019, approximately 1.4 million people in Eastern Europe and Central Asia were living with HIV and this number is still on the rise (UNAIDS, 2020). The primary factors that have contributed to the spread of the virus in the region over the past 20 years include the stigmatization and marginalization of vulnerable groups, and the absence of evidence-based prevention and treatment policies and programs needed for controlling the spread of HIV (Cohen, 2010; Pape, 2019; Meylakhs 2017). Limited access to antiretroviral therapy has also magnified the spread of HIV in the EECA region, including the migrant population (Kashnitsky, 2020; Weine & Kashuba, 2012; Agadjanian & Zotova, 2019).

The HIV epidemic in the EECA region originated in the context of the political transition after the demise of the Soviet Union. The general healthcare of the population and the pervasion of infectious diseases were profoundly impacted by the sudden, significant political and socio-economic changes that occurred in 1991 (Cook, 2013; Kainu et al., 2017; Rechel, et al., 2014). The prevalence of the virus in the region is uneven. For instance, in 2019, 80% of the new infections in the region occurred in Russia (UNAIDS, 2020). This is largely due to criminalization of key populations and the failure of the Russian government to adopt evidence-based measures

to prevent the spread of the virus among vulnerable groups across EECA (Kashnitsky, 2020; Clark, 2016; Burki, 2015; Altice et al. 2016).

Russia is usually the destination of labor migration within the region. A significant majority of labor migrants from countries such as Armenia, Kyrgyzstan, Moldova, Ukraine, Uzbekistan, and Tajikistan move to Russia (FMS, 2021). In 2019, among the top country destination for immigrants, Russia placed fourth, behind Germany, the US and Saudi Arabia (IOM, 2020). Because of the decline in the adult working population, Russia increasingly depends on international labor migrants, who, in 2017, contributed about 6.4% of the GDP of Russia (Aleshkovsky et al., 2019).

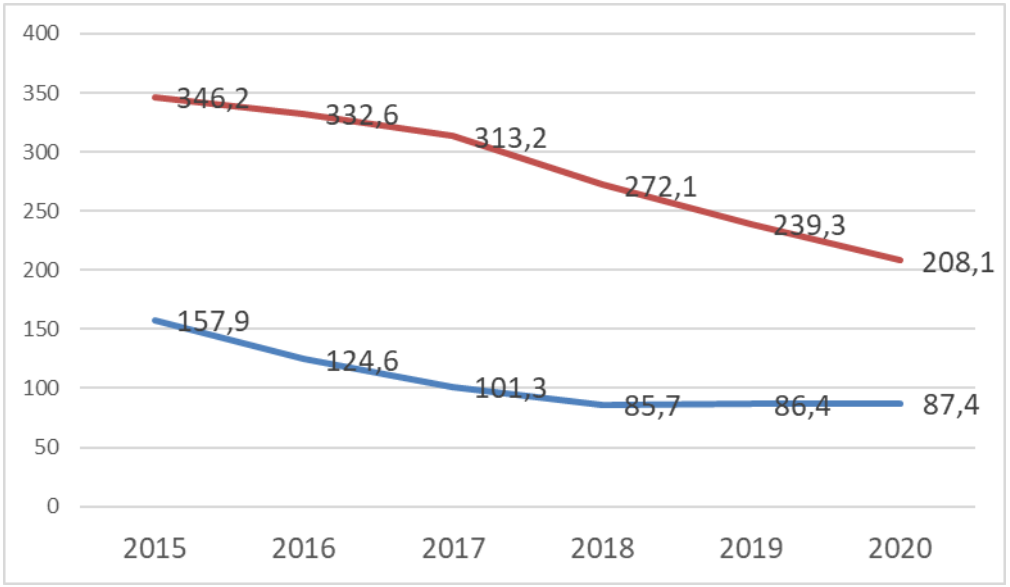
Migrants come to Russia for several reasons: to search for economic opportunities and realize strategic life goals, for example, build houses, support the education of children (Peshkova, 2015; Malakhov et al., 2015) acquire education or new skills, or escape social stigma back home (King et al., 2019). These socio-economic reasons are also true for immigrants with HIV. Most labor migrants who come to Russia are circular migrants – they spend most of the year working in Russia and they return home for one or two months to spend time with their families.

National epidemiologic surveillance conducted in the last five years from several sending countries of the EECA region suggests that returned migrants were at higher risk of acquiring HIV compared to the general population: 0.5% HIV prevalence among returned migrants in Armenia compared to 0.2% in adult population of the country, 0.6% prevalence in returned migrants in Georgia compared to the general population prevalence of 0.4% in adult population (Davlidova et al., 2020). In Central Asia and the Caucasus – because of mobility, seasonal migration and risk exposures combined with limited knowledge about ways of transmission of HIV – migrant populations and their sexual partners are considered high-risk (DeHovitz et al., 2014; Weine & Kashuba, 2012).

Russia's immigration policy and health policy are intertwined. Foreigners who apply for a residence permit must prove HIV-negative status. According to Russian Federal Law No. 38, an immigrant diagnosed as HIV-positive is ineligible to be granted a residence permit (FZ-38, 1995), and becomes ineligible to work legally in the Russian Federation. They are subject to deportation. This compels people living with HIV who want to stay in Russia to remain in the country as undocumented migrants to remain the breadwinner for their families back home (Kashnitsky, 2020; Ghimire et al. 2011). Many undocumented migrants with HIV seek medical care; however, the arrangements are usually unstable (Demintseva & Kashnitsky, 2016; Agajanian & Zotova, 2019) and greatly hindered by their low social capital (Bromberg et al., 2021). The Russian state does not provide them with HIV services. Instead, they are only advised to go back to their home

countries where they can legally seek antiretroviral therapy and other HIV services. These migrants, if they decide to remain in Russia, generally remain undocumented. They face social exclusion from society and confront various challenges when seeking health services. Migrants with HIV remain hidden with no access to free antiretroviral therapy, thereby heightening the risk of the spread of the virus both in the host country and in their home countries (Luo et al., 2012; Latypov et al., 2013).

***Figure 12*: Number of identified positive HIV tests among tested foreign citizens compared to the total number of positive tests among tested citizens of the Russian Federation (rate per 100,000 population)**



*The **red line** is the total number of positive tests per 100,000 among Russian citizens, the **blue line** is the number of positive tests per 100,000 among foreign citizens.*

A small group of international migrants with HIV who can legally reside in Russia are migrants from the countries of the Eurasian Economic Union (Armenia, Belarus, Kazakhstan, and Kyrgyzstan). They do not need to apply for a residence permit according to the Treaty of the Eurasian Economic Union (2014); however, if they are diagnosed with HIV by a state clinic, their health data is transferred to the migration authorities so they will be sought for deportation. In reality, physical deportation occurs in rare cases given the low capacity of the government to trace and deport people (Schenk 2018), but those migrants' names would be excluded from the right to access residence and work permits in Russia. Like any other foreign citizen, they will have no access to state-funded HIV services in Russia. All international migrants, no matter what their citizenship is, are vulnerable to exclusion and deprived of life-saving treatment,

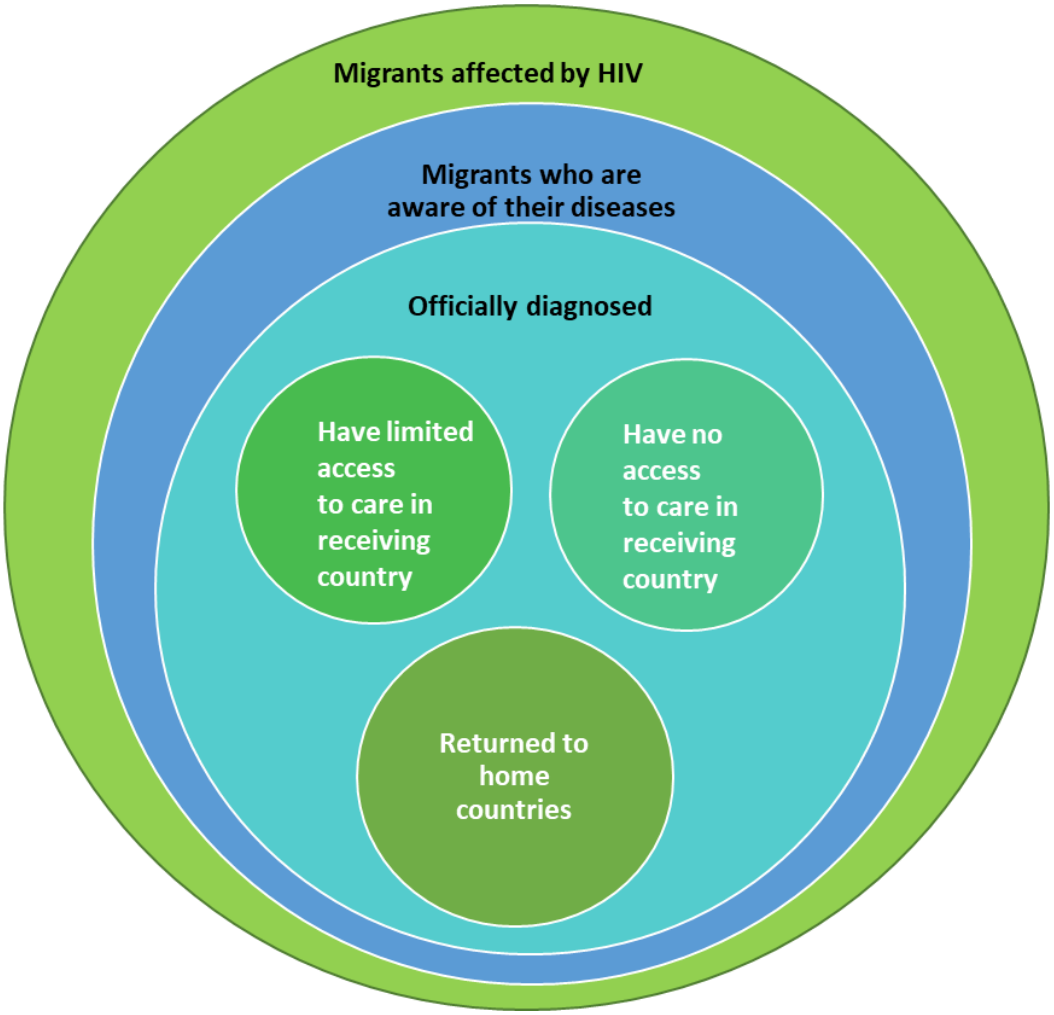
unless they decide to return to their home country (Amirkhanian et al., 2011; Luo et al., 2012). The hostile HIV policies toward labor migrants in Russia (UNAIDS 2019) have implications for the spread of HIV in the EECA region, particularly in Central Asia – home to over half of all labor migrants in Russia (UNAIDS, 2020). Returned migrants in Central Asia, in addition to people who use injection drugs and sex workers, are the key contributors to the spread of HIV in Central Asia (El-Bassel et al., 2013; Degenhardt et al., 2017). While in Russia, unsafe living and working conditions (Round & Kuznetsova, 2016), family separation (Weine & Kashuba, 2012), sexual exploitation (Weine et al., 2013), lack of social support (Karpova & Vorona, 2014), and social isolation (Weine et al., 2013; Wirtz et al., 2014) make labor migrants more vulnerable to HIV and therefore might be the bridge population for the transmission of HIV from high prevalence Russia to low prevalence Central Asia (Pape, 2019; UNAIDS, 2020). Moreover, these multiple social inequalities that characterize the life of migrants are intersectional and result in multiple dimensions of marginalization that include migrants' ethnicity, class, and gender (Kuran et al., 2020). Female migrants are particularly marginalized and experience multiple intersecting vulnerabilities that include the most severe stigma related to HIV (Agadjanian & Zotova, 2019; King et al., 2019).

A limited number of migrants are aware of their HIV-status before migration, so they can be officially registered with a local AIDS clinic at home and can receive a stock of antiretroviral medicines (ART) for several months ahead of their migration journey. The next portion of ART can be shipped by relatives or close friends. Most migrants who knew about their positive status prior to arrival in Russia cannot be legalized in Russia; however, they can at least access a transnational network of ART provision (Kashnitsky, 2020). Migrants who test positive in Russia do not have this option. They must either buy ART in commercial clinics or return home to receive treatment in their countries. All countries of EECA (except for Turkmenistan) provide HIV services to their citizens free of charge – either from domestic budgets or with the support of international donors (Pokrovskaya et al., 2019; Kashnitsky, 2020).

In this paper, we use Bonnington's temporal framework (2017) to understand the impact of HIV on the experiences of migrants living with HIV in Russia throughout three temporalities: *everyday* - repetition of daily stigma events, *biographical* – important instances in the lifetime of the person living with HIV that limit their chances or projects related to their personal life, career, migration trajectories, and *epochal* – important events related to HIV/AIDS treatment developments or major shifts in HIV policy that influence stigmatizing interactions. This breakdown into three temporal dimensions allowed us to split the experiences of migrants into 1. everyday repetitive experiences due to HIV that shape migrants' routine in the host country; 2.

biographical events that affect the life course of the migrant; and 3. the effect of *epochal time circumstances* on migrants' experiences. This model allowed us to conceptualize how the experiences of stigma shaped the perception of the Russian HIV residence ban by migrants and how it affected their coping strategies and health-seeking behaviors.

***Figure 13*: Schematic representation of groups of HIV-positive migrants in Russia (size of the bubbles does not indicate a numeric proportion).**



METHODOLOGY

This analysis is based on a qualitative study undertaken with international migrants who experienced life with HIV in Russia (N = 15). The interviews took place in November-December 2020 and were conducted over Zoom or WhatsApp because of COVID-related restrictions. The participants were recruited either via Russian health NGOs or through infectious disease specialists, social workers, or NGOs in sending countries. Some migrants resided in Russia at the time of the interview and spoke about their current barriers and coping strategies while some participants were back in their home countries and shared their recent living experience as migrants in Russia. All interviews allowed the reconstruction of key moments in participants' biography related to their HIV status in relation to their experience of migration to Russia. Please, see details of specific interview in the Appendix.

The interviews were complemented by expert interviews with care providers in Russia – infectious disease doctors, social workers, psychologists and the staff of Russian healthcare NGOs in Moscow and Saint Petersburg (N = 12). We chose Moscow and Saint Petersburg as our field of study as these are the two largest Russian cities which are key destinations for labor migration from EECA (Zayonchkovskaya, 2009; Mukomel, 2013; Demintseva & Kashnitsky, 2016). Most well-developed NGOs that provide health services to migrants are also located in these two cities. All the interviews lasted between 20 and 90 minutes and were conducted in Russian. All study participants spoke fluent Russian and were willing to speak Russian. There were no difficulties in communication because of the lack of translation. However, we realize that interviews with migrants from Central Asian countries could have been richer if they were conducted in the native tongues of the participants. Participants consent to the recording and the use of data was sought orally before the interview. Interviewers reminded participants of their ability to stop the interview at any time.

The authors read and analyzed the transcripts of the interviews several times to identify themes and to conceptualize migrants' experiences, attitudes, and the opinions of care providers. Thematic analysis (Lorelli et al., 2017) was used to outline themes and subthemes presented in the results section. The aims, and goals of the study were explained to each participant in detail, and they gave an oral consent for the interview and for further publication of anonymized selected quotes. Transcripts of the interviews were anonymized and stored on a password-protected hard-drive. No personal information of the participants was left in the transcripts to ensure full confidentiality. Quotes used in the article were translated into English, by the authors.

Based on our interviews, we were able to identify the barriers they faced in accessing medical care and the coping strategies they used to secure treatment when they could. We aimed to identify

daily encounters with stigma. We compared migrant experiences with the comments we collected from care providers. To achieve data saturation, the authors compared data from interviews against a database of 15 client case files from a database of a Russian, Moscow-based foundation, an HIV service civil society organization. These narratives depicting individual migrants' life trajectories, barriers faced, and services provided were written by a case manager in 2017-2019. The research team was supported by a representative of the community of people living with HIV and a representative of the migrant community who took part in the discussion of the emerging findings during and after data collection. Outlined themes and subthemes were discussed with community-based activists and researchers who routinely work with migrants living with HIV.

As noted in the introduction some international migrants with HIV might be technically legal residents in Russia, provided they are citizens of one of the countries of the Eurasian Economic Union. Alternatively, they could have received legal status before acquiring HIV. Despite being documented, they are still unable to receive HIV services in Russia. Should the Russian migration service learn about their HIV status, they will be issued a deportation notice. The ethical committee of the Moscow-based foundation provided an ethical approval of the study design.

RESULTS

HIV in biographical time

Learning about having HIV is a defining biographical event in the life of the migrant, which shapes the dimensions of their transnational life trajectory, defines self-perception, and often alters relations with their entire family and community.

Disruption of the migrant cycle

Labor migrants typically come to live in Russia to earn a living and support their families. Most migrants work for nine to eleven months a year and return home for the winter break to see their families. Every year they must apply anew for their residence permit where an HIV negative test is one of the requirements for their legal stay. Being tested positive for HIV in Russia means a sudden break in their legal residence and hence a failure of their traditional migration cycle. Migrants with HIV either must leave Russia with no right to return or remain undocumented with no or unsustainable access to self-purchased HIV care. A male migrant told us about an unfriendly consultation with an infectious disease doctor right after being diagnosed with HIV in a Russian state clinic:

> *[The doctor said] 'You need to leave [Russia] urgently, you know, you are not needed here!' I said, 'Why are you saying that? I came here to work. My mother is sick, I need to support her.' The doctor did not want to listen to anything. 'I want to receive treatment and stay here [in Russia]'. The doctor replied: 'No, no one can let you stay here, we will not give you a work permit ... in short, we will deport you'.* Male, 41 y.o. labor migrant from Uzbekistan.

Getting an official HIV test is a gamble with the authorities which can become a disrupting event. It puts the whole migration project at stake as the migrant risks being deported. Russia attracts many labor migrants from the former Soviet Union. Some migrants aim to become students in Russia to further capitalize on their bachelors and master's degrees and upgrade their careers. The HIV residence ban can become a serious barrier for student migrants and may jeopardize their education goals.

> *They told me: you must go home soon! But I had my university exams ahead, I also had debts. I could not just give up everything and go home. I did not even have the money to buy a plane ticket. My friends and classmates crowdfunded money for my ticket so that I could fly home.* Male, 29 y.o. labor migrant from Tajikistan.

Doctors in state clinics who do HIV tests for the migrants have to report positive test results to the migration authorities. In some cases, they either do not do that or the information is lost at some point, which means some migrants with HIV who left Russia can re-enter the country. This happened to the young man from Tajikistan, which helped him to complete his bachelor's degree in legal studies.

Some migrants had been living in Russia for almost their entire life prior to receiving a positive HIV test. Some people, especially from countries of the Eurasian Economic Union, such as Armenia, could live and work freely without the need to apply for a residence permit. For some young males from these countries postponing the application for Russian citizenship can be an efficient strategy to avoid obligatory military conscription to the Russian army.

> *I had everything here [in Russia]: my school years, my college, my work. I always imagined my future only here. Maybe later I would try Europe, or America, but not back in Armenia. I could not imagine anything else… here [in Moscow] everything is familiar,*

ordinary… what else can I say? … this is my home. Male, 20 y.o. student, citizen of Armenia.

Now he has to choose whether to go back to Armenia where he can have free access to HIV care or remain in Russia where he cannot be officially registered at an AIDS clinic. His situation is even more difficult as at the time of the interview he had not disclosed his HIV status to his parents (who he lived with). He had to speak in the street so that no one from his family could hear him. He was buying ART at a commercial clinic in Moscow, which cost a substantial share of his student-job salary.

Disruption of relations

HIV is still widely associated with stigma and social taboo. Several participants acknowledged that disclosure of their HIV-positive status led to a break in relations with their family as described in this interview:

My aunt has been living and working here for 25 years. [In a small Russian town close to Moscow]. She already has citizenship. At first, I worked with her, she has a grocery store. I worked with her all the time. Then after 4 months she found out [about my HIV status] – she opened an envelope with my medicines and that was it! She said that we would no longer talk. Bad women are sick with these diseases. I told her that she was mistaken. I told her a hundred times, but she did not want to listen. Now she does not talk to me at all. Later I found another job on my own: a family from Azerbaijan owned a minimarket selling clothes and shoes and they hired me. Female, 45 y.o., labor migrant from Uzbekistan

Instances of shame and estrangement are typical reactions towards many people living with HIV in Eastern Europe and Central Asia; however, the effect of such ruptures on migrants' biographies can be even more dramatic, as their social networks are extremely sparse in the host country and often imply financial dependence of family and friends from within the migrant community, especially in the case of female migrants.

No one of the participants were ready to leave Russia immediately after getting to know their positive test results, which indicates that the current Russian legislation leaves no viable option for the migrant to get uninterrupted access to HIV services.

Stigma embedded in migrants' daily routine

Migrants who knew about their HIV-positive status before coming to Russia could hide it from the migration authorities; still, they face instances of stigma in medical institutions when their health needs arise. Discrimination coupled with the outcomes of illegality is the daily routine of most migrants living with HIV in Russia.

> *I was registered in the Moscow region when I was diagnosed with HIV, and I was sent to the polyclinic in Moscow. I went there - a woman was sitting there, she began to be rude: 'you are a newcomer, you migrants are bringing the infection to us. She insulted me; she was as rude as she wanted.* Male, 29 y.o. labor migrant from Tajikistan

Migrants with HIV in Russia are more vulnerable compared to local people with HIV as their HIV status is complemented by legal restrictions, language barriers and discrimination towards visible ethnic minorities in the case of non-European migrants. This is the intersectional nature of discrimination that leaves them less protected when they are treated badly by state officials, by the police or by medical staff (Hankivsky & Christofferesen, 2008).

> *I did not like the hospital where I was giving birth. The attitude was completely biased. I stayed in a maternity clinic to preserve my pregnancy several times, and they always put me in a separate room. Also, when I gave birth, they placed the child and me in a separate ward. All the other females were in three-bed wards, and I was all alone. I tried to explain to them that my viral load was undetectable, so it was not transmittable to other people, but they insisted: 'It doesn't matter, let us be on the safe side'.* Female, 30 y.o., citizen of Moldova

It might have been that some medical staff do not have basic information about HIV transmission as vividly shown in the example below:

> *The doctor who came to see me after the coronavirus was a urologist. I asked him about the treatment. I told him what medicines I was taking, I asked him to examine me. But he hurried up to leave. When he heard that I had an HIV status, he thought he was at risk of being infected.* Male 33 y.o., labor migrant from Kyrgyzstan

Several participants mentioned instances when medical personnel broke their confidentiality.

When I had already left [the city public clinic] the doctor told my daughter that I had HIV. The doctor said it without warning: 'Well, your mom has HIV. They transferred her to Sokolinka [an infectious disease clinic in Moscow]. Female, 46 y.o. citizen of Belarus

Such human rights violations constitute the daily routine of migrants living with HIV in Russia and are typically repeated many times along the migration trajectory.

Social exclusion of migrants with HIV in the context of epochal relations

Epochal relations give a systematic context to everyday and biographical barriers (Bonnington et al. 2017). They reveal both the positive and negative features related to the perception and management of the HIV epidemic in the Eastern Europe and Central Asia .

The outdated perception of HIV as a deadly condition

When migrants learn they have HIV while in the host country they are not prepared. They have little access to modern information about the HIV epidemic and about therapy that can sustain a healthy lifestyle of an HIV-positive person (Trickey, et al., 2017). Their perception of the HIV epidemic is often shaped by low awareness, stigma, and fear of disclosure among undocumented migrants with HIV.

When I come home, I will discuss it [with my wife], and if we cannot agree, we will have to divorce. And that is it. I do not see another option. My wife and I planned to have our third child. We had already agreed on that, but now, I have this [HIV]… I do not even know what [HIV] programs we have (in Kyrgyzstan), I don't know how I will secure HIV [treatment] at home, now I am buying [ART] here and I'll keep doing so.
Male, 36 y.o. labor migrant from Kyrgyzstan

This dramatic self-stigmatizing perception of HIV as a fatal deadly ruinous disease overwhelms migrants who are newly tested with HIV in Russia. Many of them even do not know antiretroviral treatment is available free of charge in their countries when they return home. Stigma and fear to disclose their status prolongs the period of frustration and hinders their access to evidence-based modern information about HIV treatment.

Those migrants who have managed to secure access to ART in Russia seem emotionally exhausted. They stigmatize themselves and are unwilling to reflect on their identity as a person

living with HIV.

> *After four months, I already started to feel well, everything went fine, and now I live like a "normal person". I do not even consider myself "like that" [HIV-positive] any longer.*
> Female, 36 y.o., labor migrant from Kyrgyzstan.

Except for her boyfriend who also had HIV, this young woman was not looking for any kind of peer support. Neither did she seek the help of NGOs. While living in the daily struggle of a female migrant with HIV, she seemed as if she wanted to move away from the emotional experience of HIV.

Migrants from Central Asia who are visually distinct from 'native' Russians in Russia face persisting racial discrimination. It adds to the barriers of being an HIV-positive, as illustrated in this dialogue:

> *Migrant: I would like to communicate with someone. May be, I would like to join a peer group.*
> *Interviewer: Would you like to do that?*
> *Migrant: Yes, but first of all, no one will communicate with me as I am not Russian.*
> *Interviewer: Why? Have you had situations like that?*
> *Migrant: There were situations like that recently, quite a few.*
> male, 41 y.o., labor migrant from Uzbekistan

Some migrants have an understanding that HIV is a chronic condition rather than a deadly disease if treatment is accessible. They realize that a sustainable agreement between sending and receiving countries would allow a solution for them to access treatment wherever they live and work.

> *I would like, of course, to have formal agreements between the countries, between Moldova and Russia. People are hiding now. I would like to have some kind of legal agreement, so that we can officially get treatment here - via some organization or in a polyclinic.*
> Female 48 y.o., labor migrant from Moldova

Living with HIV in Russia means enduring an undocumented status in various situations. Because of this period of uncertainty and the lack of medical insurance, social exclusion extends

to a wider variety of health-related situations, not only in the context of HIV services.

> *If there is medical insurance, the attitude is the same as for an ordinary [Russian] patient – a non-migrant. So, they will stay in the ward until the case is resolved. And if it is a migrant and they do not have documents – this happens very often – I could see a strongly aggressive attitude of doctors. And small conflicts begin, like this: 'Why did you come to us? And why have you not got proper documents? And what country do you come from? You should be treated there!'*
>
> Male doctor in Moscow, urologist, works in a city public hospital.

What is next?

Labor migration is often linked to life projects such as building a house or investing in children's education or marriage.

> *In Tajikistan, salaries are small. Now I am getting a new passport, I am looking for options on how to re-enter Russia and get a job. The salaries there are, more or less, fine. You can live. And here you can only exist. It is difficult. Children grow up, the more they grow, the more expenses I have.* Returned labor migrant, 36 y.o. living now in Tajikistan

Another female migrant shared what life projects motivated her to stay in Russia no matter how difficult it was for her to sustain the daily routine of her irregular status.

> *I bought a plot of land in Tashkent, 5 acres. We must invest into construction. As soon as I build an apartment, I will organize my son's marriage. I will probably be in Russia for another year.*
>
> Female 45 y.o. labor migrant from Uzbekistan, left back to Uzbekistan in early 2020 because of worsened health condition but she is planning to return.

Many migrants do not see an alternative to being a labor migrant in Russia, mainly for economic reasons. Although banned from re-entering Russia they often look for opportunities to return and restore their transnational cycle of labor migration.

DISCUSSION

The residence ban on international migrants living with HIV in Russia has an impact on the

everyday, biographical, and epochal temporalities of migrants' lives in Russia, which makes them vulnerable to HIV-related diseases while living in the host country (Bonnington, 2017). These three interlinked temporalities help us structure migrants' experiences and provide a lens to analyze the effects of the HIV residence ban on the life course of migrants, the daily encounters with the barriers and discrimination against migrants, as well as to contemplate and reflect on how the lives of migrants with HIV fit the macro (epochal) events and the biopolitics of the receiving state (Schenk, 2020). Biopolitics is a concept proposed by Foucault, (2010) to show the relationship between state's power and the biographical features of a population in a state. According to Collier (2009), biopolitics is not a form of governmental reason, rather a problem-space concerned with a population's vital characteristics. HIV disclosure to the authorities turns out to be a turning point in the biography of the migrant, a 'disruptive event' (Bury, 1982) that has a significant emotional and social impact on the life course of the labor migrant in Russia. Primarily, HIV disrupts the labor migration cycle of migrants with HIV because they must leave the country or stay undocumented. HIV interferes with the plans to get legalized in Russia, acquire citizenship, apply for education, or extend a work permit. This is also a career obstacle because undocumented migrants can only work without a legal contract in the black market. These are all low-paid unprotected jobs where the risk to be sacked abruptly or be cheated by the employer is high; a situation which is especially worse for female migrants (Agadjanian & Zotova, 2019; King et al., 2019). More importantly, the group of migrants with HIV have a unique vulnerability that is different from the larger group of migrants and the larger group of people living HIV (Hankivsky, 2008).

Secondly, most labor migrants have financial obligations to families or debts which they must repay. This makes it difficult for many migrants diagnosed with HIV to leave Russia as prescribed by law (FZ-38, 1995). The life of undocumented migrants living with HIV becomes a race for survival. This is coupled with many repetitive experiences of stigma, fear and discrimination that enhance the structural barriers they encounter (Kashnitsky, 2020). Many of them refuse to leave the country due to the financial obligations to their families. Migrants who had been diagnosed with HIV prior to migration have an advantage of being registered with AIDS clinics back home. Therefore, they can secure regular provision of ART funded by their home country (Kashnitsky, 2020; Pokrovskaya et al., 2019). However, they know about their positive HIV status, so they are aware they cannot apply for a residence permit in Russia.

Being irregular sets a low threshold in terms of access to human rights and protected labor; although for some migrants, a black-market job in Russia is still a preferred option compared to a low wage or unemployment back home. Several studies of the Russian migration policy and

practice of exclusion have demonstrated that a significant share of migrants, even though socially excluded and undocumented, are tolerated by the host society because of economic exploitation (Reeves, 2015; Dave, 2014). The state, rather than deporting international labor migrants, prefers to exercise power on them by creating mechanisms of biopolitical control that keeps the migrant population on a low-profile under tough police and administrative controls (Schenk, 2020) as illustrated in the example of a sub-population of migrants with HIV who are missing an opportunity to become legal residents in the receiving country and eventually access HIV care (Bromberg et al., 2021). The fact that Russian policymakers have been reluctant to lift the HIV residence ban despite numerous pledges by the Russian civil society could be possibly explained within the larger restrictive context of the Russian migration policy (Karpova, G., & Vorona, M., 2014; Luo et al., 2012).

Being a migrant with HIV entails numerous instances of discrimination in state clinics and in police stations of the host country where fear and violations of human rights are embedded in the daily temporality of the migrants. Migrants must develop coping strategies based on hiding rather than negotiation (Round & Kuznetsova, 2016; Schenk, 2020). When discrimination and daily policing interferes with the daily routine of migrants, they often postpone HIV treatment with a very short time-planning horizon. After some time with no access to treatment, their immune system deteriorates, and become ill with severe opportunistic diseases (King et al., 2019; Pokrovskaya et al., 2019; Kashnitsky, 2020), thus, losing their health as a result of their inability to access HIV services.

Compared to the early days of the epidemic, people living with HIV can now benefit from modern antiretroviral treatment and enjoy a long and healthy life, if they adhere to treatment (UNAIDS, 2016). But labor migrants positioned at the intersection of migration and HIV in Russia are largely missing out on this life-saving opportunity. When the Russian HIV residence ban was introduced over 25 years ago (FZ-38, 1995), antiretroviral treatment was not available, and the HIV epidemic was only starting in the country. Mainly because of this persisting legal norm, migrants with HIV enter a phase of uncertainty in Russia and, at the same time, have very little information about available HIV care in their home countries (Luo et al., 2012). Exacerbated by self-stigma, fear of disclosure and undocumented status, their self-perception of being HIV-positive is rather extremely negative and even desperate.

The lockdown that followed the outbreak of the COVID-19 pandemic has led to a disruption of the transnational provision of antiretroviral drugs for many migrants who were receiving HIV treatment from their home countries. Those who wanted to return to their home countries could not leave Russia for several months of 2020. Although the total number of international migrants

halved by the end of 2020 as compared to the end of 2019 (FMS, 2021), the number of health-related requests to civil society organizations in Russia greatly increased over the same period. This analysis shows that it is important to lift the ban on migrants living with HIV in Russia as recommended by the UN Political Declaration (UNAIDS, 2016; 2021). Russia must prioritize awareness programs among migrants and create an enabling environment for migrants to get tested and start antiretroviral therapy in the host countries. As the HIV epidemic keeps growing in Russia, it is important to adopt evidence-based approaches to address the health needs of vulnerable groups including migrants (UNAIDS, 2016; Pokrovskaya et al., 2019) and allow migrants access to HIV services after getting tested positive on HIV (UNAIDS, 2021). This is the only way for Russia to meet Goal 3 of the Sustainable Development Goals and combat the HIV epidemic by 2030 (UNAIDS, 2020), and create an avenue for new generations of healthy migrants in Eastern Europe and Central Asia.

CONCLUSION

Our study examined how HIV shaped the experiences of migrants living with HIV in Russia. Using Bonnington's temporal framework that was developed specifically to explain HIV-related stigma (2017), the research splits the experience of migrants with HIV into three interrelated tiers; repetitive experience due to HIV that orient their daily lives in Russia, biographical events that affect their life course, and epochal time circumstances which provides context for everyday and biographical challenges. Our analysis suggests that the current Russian legislation towards international migrants with HIV makes the diagnosis of HIV-positive a disruptive dramatic event in their life trajectories. The expectation of the Russian state that migrants living with HIV would leave the country to secure treatment back in their home countries is not realized due to their economic needs and stigma at home. Many migrants with HIV keep staying in Russia against all the odds. The findings suggest that it is important to amend the current Russian legislation to allow international migrants with HIV access to testing and treatment services (UNAIDS, 2021) in Russia instead of deporting them or confining them in a state of uncertainty. Such legal change would be an important step towards eradicating the HIV epidemic in Russia and the broader region of Eastern Europe and Central Asia.

Conclusion and future research

The dissertation allowed to analyze Central Asian labor migrants' formal and informal strategies of using healthcare in Moscow by comparing their attitudes and experience with the experience of caregivers who work with the migrants. The lack of transparent and accessible planned medical services puts migrants in a situation when they have to disregard or alleviate first symptoms of an occurring disease and let it develop further up until they have to use emergency care. We could observe that migrants know that emergency care is basically accessible for them. However, they do not overuse it and keep it for the worse case because of the multiple barriers. For the same reason they rarely use specialized medical care in state clinics preferring to opt for ethnic facilities, the so-called Kirgiz clinics, as well as choose informal strategies to reduce costs and mitigate other barriers such as burdensome documentation and negative attitudes by caregivers. Returning home is a common involuntary strategy that seriously intervenes in the migrants' life and career plans sometimes for severe health issues but often for diseases that could be addressed locally.

We believe that further research should be conducted to identify health inequalities between migrant and local patients in specific health areas, such as treatment of social diseases, women and reproductive health and child health. Occupational health in migrant workers should be another priority area for investigation and policy change in Russia. It would be further interesting to measure where Russia's policy and practice of treating migrants stands in comparison with other receiving countries.

It also appears from our findings that Russia is not revoking the outdated residence ban for international migrants with HIV due to a combination of government's general intention to keep as many migrants low-profile as possible, "submissive but tolerated". It corroborates with other facets of migration and turns out to be a part of the biopolitical management of migration in Russia. This ongoing policy may be also explained by coordination between different branches of executive power and partly by discrimination towards people living with HIV. However, we can clearly see that there is no epidemiologic rationale behind it. Russian state officials do not provide public health arguments in their attempt to justify the residence ban for HIV-positive migrants. Civil society experts suggest that further advocacy steps should concentrate more on the economic arguments pointing to benefits that the Russian government will have. This should be supported by governments of the sending countries, ideally, by confirmed commitments to provide therapy while migrants are away in migration.

If Russia wants to curb the growing HIV epidemic and meet Goal 3 (Ensure healthy lives and promote well-being for all at all ages) of the Sustainable Development Goals and combat HIV by 2030 (UNAIDS, 2020) it has to change its approach to prevention and treatment fundamentally by considering the regional factors and by focusing attention to migrants' health along with key populations. If it does not do so, it risks remaining among the countries with the fastest growing epidemic in the world.

The dissertation contributes to new knowledge in public health with analysis of unique lived experiences of international migrants in the context of the Russian authoritarian state. For ethnic and migration health studies it provides an indispensable dimension to investigate integration and well-being of immigrants. Critical reflection on the implication of health policy may help formulate recommendations how to improve policy and practice of migrants' access to HIV services and more broadly addressing the health needs of migrants in the WHO Europe region to help countries progress towards a more inclusive healthcare system and a universal health coverage (WHO 2019).

AFTERWORD

The full-scale Russian aggression against Ukraine that started on February 24, 2022, led to one of the largest refugee crises in world since World War II. More than 7.8 million refugees from Ukraine (UNHCR 2022) have been registered in European countries since February 24, over 4.8 million refugees have been registered for temporary protection or other similar schemes in European countries (mainly under the EU directive on temporary protection of refugees from Ukraine). More than 2.8 million people were displaced or forced to travel to Russia on their own. Some monitoring data from human rights groups and healthcare NGOs (REG 2022) suggest that substantial part of Ukrainian refugees do not intend to settle in Russia and do not want to receive a residence permit in a hostile country however a lot of them keep staying in the country with neither a proper status, nor a clear access to healthcare. It is important to investigate their needs and create appropriate solutions as this immense group of unrecognized refugees' risks to become critically underserved.

Other important research priorities have to do with specific under-researched risk groups among migrants who have specific vulnerabilities such as LGBTK+ people, sex workers and people who use drugs. More research priority should be driven towards clearer understanding of the gender dimension of migration across the European region bearing in mind that the vast majority of

Ukrainian refugees are women. Also, it should be pointed out that transnational solutions in migrant health should be carefully documented and analysed, in particular, when services are provided in cooperation with countries of origin of migrants. Such cooperation becomes more in need considering that migrants' and refugees' trajectories become more complicated and include more frequent moves across the borders. Finally, it should be said that migrant health in Eastern Europe is another important and underinvested priority area considering the growing number of hostilities in the region.

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Appendix 1. Guide for migrants with HIV

Kashnitsky D., Richter J. M. 'In Short, We Will Deport You': Disrupted temporalities of migrants with HIV in Russia // Global Public Health. 2021. P. 1-20.

Personal data

- Age
- Education
- Citizenship
- Marital status

Before migration

- In what years did you live in Russia and in what region/s?
- Why did you decide you go to Russia? What plans did you have for migration?
- What did you do before migration?

First time in migration

- What documents did you have for your work and residence permit? Did you have difficulties getting them?
- Tell me about your living conditions in migration.
- Tell me about your work in Russia: what did you? Tell me about your working conditions. How many hours a day did you work? Did you have days-off? How many? Did you have a work contract?
- Do you have a spouse? Children? Where did they live when you were in migration?

Testing positively, first steps

- Why did you decide to get an HIV test? Was that your own will or a bureaucratic necessity?
- When and where were you tested positively for HIV? Was that before your arrival in Russia or in Russia?
- Did you have a pre and post testing consultation? Were there any information/recommendations given to you? Were any treatment solutions offered to you?
- What were your first thoughts and feelings when you learned you had HIV? Did you talk to anyone about that? What did you do first? Did you tell anyone?
- How did the HIV status affect your life? Did it affect your plans to stay in migration?

- Tell me about your life after you got to know about your status: what did you do to earn your living?
- Where did you live?
- Did you try seeking help in any civil society organization / clinic / with an informal caregiver?

Living in Russia with HIV

- How much time did you spend in Russia after getting to know you had HIV?
- Why did you decide to stay in Russia? Did you think of going back to your home country? Tell me about your apprehensions back then.
- Tell me if HIV affected your work, relations with people you lived with.

Access to general medical care

- How did you feel during that time? Did you have any health-related problems?
- Did you seek any medical help? Did you get treatment when you needed? Did you have situations when you needed emergency care? (pregnancy and delivery?)
- Did you buy any medicines at the pharmacy? What drugs do you buy most often?

Access to ART

- Did you try to get access to HIV services (treatment and ART)? If yes, tell me about this experience? Who were the people and organizations you approached and who helped you?
- Were there people/organizations in your life who helped you in this period?
- Did you meet other people who had HIV at that time?
- Did you know about ART options available in your home country? Could you get access to them?

Doctors' attitude

- How would you describe the attitude towards migrants by doctors and employees of public hospitals / clinics?
- Did you have situations when you had to tell you had HIV in medical institutions in Russia? Did that affect your access to treatment?
- Were you treated with respect and confidentiality to your HIV status?

Life of a returned migrant

- Tell me about your life after your return home.
- What affected your decision to go back?
- Do you have access to ART now? Please, tell me about the HIV services you get now.
- How do you feel now?
- Are there people and organizations outside HIV clinic who provide you support and consultation? Tell me about them.
- Who do you live with now?
- Do your close ones and family know about your HIV status now?
- Tell me about your work and plans for the future.
- Do you consider migration again? What country?

<u>Table 1</u>. List of participants: interviewed caregivers in Moscow

for chapters 1 and 2

	Profession	**Sex**	**Origin**	**Organization**
1	Clinic director	M	Kyrgyzstan	Private clinic Mayak
2	Head doctor	M	Kyrgyzstan	Private clinic Mayak
3	General practitioner	M	Kyrgyzstan	Private clinic Daryger
4	Gynecologist	F	Kyrgyzstan	Private clinic Daryger
5	Ultrasound specialist	F	Kyrgyzstan	Private clinic Daryger
6	General practitioner	M	Kyrgyzstan	Private clinic Medsanchast
7	Clinic administrator	F	Kyrgyzstan	Private clinic Medsanchast
8-10	Three social workers	F	Russia	State TB clinic, Moscow Region
11	Nurse in intensive care	F	Russia	District city hospital Kuntsevo, Moscow
12	Ultrasound specialist	M	Russia	District city hospital, South-East Moscow
13-14	Two pharmacists	F	Russia	Pharmacy, Moscow
15	Director	M	Russia	Pharmacy , Moscow
16	Pharmacist	F	Russia	Pharmacy at the large wholesale market
17	General surgeon	M	Russia	ambulance station, Moscow
18	Nurse	M	Russia	ambulance station, Moscow
19 – 20	Surgeon and nurse, pediatric team	F	Russia	ambulance station, Moscow
21	traumatology nurse	F	Russia	emergency room, Moscow
22	Surgeon	M	Russia	Pediatric emergency room, Moscow
23	Surgeon	F	Russia	Pediatric emergency room, Moscow
24 - 25	Two paramedics	M	Russia	emergency room at the large wholesale market, Moscow
26	Private helper	F	Russia	Home
27	district pediatrician	F	Russia	Polyclinic, Moscow
28	Doctor at a construction site	M	Russia	Construction site
29	therapist at the Tajik medical hotline	F	Tajikistan	Aga-Khan Foundation, Moscow

Table 2. List of experts interviewed

for chapter 3

From sending countries	Tajikistan - 2 Kyrgyzstan – 2 Uzbekistan - 1 and Armenia – 1
From receiving countries	Russia – 2 Kazakhstan - 2

Table 3. List of participants: interviewed migrants with HIV

For chapter 4

	Country of origin	**Age**	**Sex**	**Legal status in Russia**	**Access to HIV services while in Russia**
1	Armenia	20	M	Documented	Self-purchased in Russia
2	Belarus	52	M	Documented	Receives from AIDS clinic in sending country
3	Belarus	26	M	Documented	Receives from an AIDS clinic in sending country
4	Belarus	46	F	Stateless	Self-purchased in Russia
5	Moldova	30	F	Undocumented	Receives treatment from a local NGO
6	Moldova	48	F	Documented	Receives from an AIDS clinic in Russia
7	Kyrgyzstan	36	M	Documented	Self-purchased in Russia
8	Kyrgyzstan	33	M	Documented	Receives from an AIDS clinic in sending country
9	Kyrgyzstan	36	F	Undocumented	Self-purchased in Russia
10	Tajikistan	36	M	Undocumented	No treatment
11	Tajikistan	29	M	Documented	Self-purchased in Russia
12	Ukraine	40	F	Documented	Self-purchased in Russia
13	Ukraine	33	M	Undocumented	Receives treatment from a local NGO in Russia
14	Uzbekistan	45	F	Undocumented	No treatment
15	Uzbekistan	41	M	Undocumented	Receives treatment from other patients with the support of a local NGO in Russia

Appendix 2. Conclusion de l'Ecole Supérieure en sciences Economiques sur la thèse de Daniel Kashnitsky

Vice-Recteur de la National
université de recherche
"Ecole Supérieure d'Economie"
_____
Candidat en économie, professeur agrégé Roshchin Sergey Yurievich
« _ ___ » _____ 2022

CONCLUSION
État fédéral autonome
établissement d'enseignement supérieur
"Université nationale de la recherche
"Ecole Supérieure en sciences Economiques"[1]

La thèse de Daniil Savelyevich Kashnitsky sur le thème : "Barrières et stratégies informelles d'accès aux soins médicaux pour les travailleurs migrants sans papiers infectés par le VIH en Russie" a été achevée au Département de démographie de l' A.G. Établissement d'enseignement supérieur autonome de l'État fédéral Vishnevsky École supérieure d'économie de l'Université nationale de recherche (ci-après - École supérieure d'économie de l'Université nationale de recherche).

Pendant la préparation de la thèse, le candidat à un diplôme scientifique Kashnitsky Daniil Savelyevich a travaillé à l'établissement d'enseignement supérieur autonome de l'État fédéral "Université nationale de recherche" École supérieure d'économie ": du 01.02. 2017 à présenter en tant que chercheur junior à l'Institut de politique sociale de l'École supérieure d'économie de l'Université nationale de recherche.

En 2011, il est diplômé de l'Université de Lund, en Suède, avec une maîtrise en santé publique.

En 2021, il a terminé des études de troisième cycle à temps plein à l'établissement d'enseignement supérieur autonome de l'État fédéral "Université nationale de recherche" École supérieure d'économie "en direction du 39.06.01 "Sciences sociologiques", focus (programme éducatif) 22.00.03 "Sociologie économique et démographie".

Le conseiller scientifique - Ekaterina Borisovna Demintseva, Ph.D.

À la suite de la discussion, la conclusion suivante a été adoptée.

Pertinence du sujet

Recherche de thèse par D.S. Kashnitsky se consacre au thème de l'accès aux

[1] Pour commender le document original, veuillez contacter l'auteur par kashnitsky@gmail.com

services de santé parmi les travailleurs migrants étrangers en Fédération de Russie.

Dans sa thèse de recherche, Daniil Kashnitsky a tenté d'étudier les stratégies d'accès aux soins de santé formels et informels chez les migrants étrangers vivant avec le VIH en Russie. Sur l'exemple de ce groupe de migrants, il a étudié comment l'État crée un espace d'insécurité juridique, exerçant ainsi un contrôle sur les migrants. Il a également problématisé le manque de données réelles sur l'incidence et la prévalence de l'infection à VIH parmi les migrants étrangers en Russie.

La recherche est basée sur des entretiens qualitatifs avec des experts d'ONG, des médecins et des personnes séropositives ayant vécu en Russie en tant que migrants étrangers. Kashnitsky discute en détail des conséquences épidémiologiques, économiques et sociales de l'interdiction de séjour des migrants étrangers infectés par le VIH dans le contexte de la politique migratoire, formule des recommandations et tente d'identifier des jalons pour de nouvelles recherches scientifiques et scientifiques-pratiques dans ce domaine.

Validité des dispositions scientifiques

La validité des résultats obtenus découle de l'utilisation de toutes les données statistiques disponibles dans le travail, d'une revue à grande échelle de la littérature académique russe et étrangère existante, ainsi que de l'utilisation d'une méthode de recherche qualitative et ethnographique avec vérification de données multiples impliquant les communautés scientifiques et d'experts, ainsi que les praticiens de la société civile.

Participation personnelle du candidat à un diplôme scientifique à l'obtention des résultats énoncés dans le mémoire

La thèse est présentée comme un ensemble de trois articles scientifiques, dont deux ont été écrits en co-auteur et un a été écrit par un étudiant en thèse sans co-auteurs.

La collecte de données qualitatives a été menée par le doctorant lui-même à travers des entretiens semi-structurés avec des migrants, des professionnels de santé et des experts en politiques migratoires.

Le degré de fiabilité des résultats menés par le candidat à un diplôme de recherche

La fiabilité des résultats est confirmée par des publications dans trois revues académiques à comité de lecture en double/triple aveugle :
1. International Migration, *2. Medical Anthropology : Cross Cultural Studies in Health and Illness*, *3. Journal of Public Health Policy* . (indexé dans Scopus et inclus dans les premier et deuxième quartiles des revues sur les thématiques "Démographie", "Santé").

Nouveauté scientifique de l'ouvrage

Pour la première fois dans la littérature scientifique, des stratégies visant à surmonter les obstacles à l'accès aux services de santé pour les migrants étrangers en Russie ont été systématiquement décrites, et une étude ethnographique approfondie de la vie des migrants séropositifs en Russie a été réalisée. Des recommandations ont été faites aux autorités exécutives et législatives pour améliorer l'accès aux services liés à l'infection à VIH.

Signification théorique

La base théorique de l'étude est le modèle des déterminants sociaux de la santé de l'Organisation mondiale de la santé (Dahlgren et Whitehead 1992). Recherche Kashnitsky D.S. confirment que la migration elle-même ne doit pas être comprise comme un facteur de risque en termes de mauvaise santé, mais les obstacles identifiés (faible accès aux services de santé, séparation familiale, travail non protégé, vie dans de mauvaises conditions et sensibilisation limitée aux comportements à risque) affectent négativement les déterminants sociaux de santé et contribuent à la vulnérabilité des migrants au VIH, à la tuberculose, et contribuent également à l'augmentation des blessures et autres maladies.

L'importance pratique des résultats de la recherche menée par le candidat à un diplôme scientifique

Les résultats de l'étude contiennent une série de recommandations à l'intention des autorités exécutives et législatives de la Fédération de Russie et des pays d'origine des migrants. Ces recommandations ont été discutées lors de conférences scientifiques et pratiques et de réunions du Groupe régional d'experts sur la santé des migrants, ainsi que lors de nombreux discours de Kashnitsky D.S. lors de conférences de premier plan telles que

- Inégalités urbaines vs. Inclusion urbaine : migration, identité et espace public (Moscou). Présentation : Accès restreint aux services de santé pour les travailleurs migrants en Russie – économie de ressources, chaos ou incapacité à contrôler ? (2019)
- De l'informalité économique à l'informalité politique (Lund). Présentation : Travailleurs migrants en Russie : revendiquer leur droit à la santé - empêtré dans un tissu d'incertitude juridique (2019)
- 19e Conférence nordique de recherche sur la migration (Norrköping). Présentation : Un piège de l'illégalité forcée pour les migrants séropositifs en Russie (2018)
- Migration et droit international (Moscou). Présentation : Aspects moraux et éthiques de la régulation juridique des migrations internationales (2018)

et d'autres.

Intégralité de la présentation des documents de thèse dans les publications

Les principaux résultats de la recherche de thèse ont été publiés dans __ articles avec un volume total de 3,06 pp; la contribution personnelle de l'auteur est de 1,94 p.l.

Publication scientifique	**Contribution personnelle**	**La publication est incluse dans**		
		bases de données internationales et systèmes de citation (Web de Sciences / Scopus / MathSciNet …)	Liste des revues HSE recommandées**	Liste des revues scientifiques à comité de lecture recommandées par le HAC

Demintseva E., Kashnitsky D. Contextualisation des stratégies de recherche de soins médicaux des migrants en Russie // Migration internationale. 2016. Vol. 54. Non. 5. P. 29-42 .	1,11 p.l., contribution personnelle - 0,55 p.l.	scopus , Q1 (démographie)	Oui	Oui
Kashnitsky D., Demintseva E. « Cliniques kirghizes » à Moscou : Centres médicaux pour les migrants d'Asie centrale // Anthropologie médicale. Vol. 2018. 37. Non. 5. P. 401-411 .	1,09 p.l., contribution personnelle 0,6 p.l.	scopus, Q2 (santé-sciences sociales)	Oui	Oui
Kachnitski. D. L'interdiction de résidence du VIH en Russie dans le contexte du contrôle étatique de la migration, Journal of Public Health Policy, août 2020	0,89 p.l.	scopus, Q1 (santé publique)	Oui	Oui

Les publications sont pleinement cohérentes avec le sujet de recherche de la thèse et révèlent ses principales dispositions.

La valeur du travail scientifique du candidat à un diplôme scientifique

La valeur du travail scientifique du candidat réside dans la nouveauté du matériel présenté, dans les avantages scientifiques et pratiques pour les chercheurs et les organisations de la société civile travaillant dans le domaine de la santé publique, et est également confirmée par le niveau des revues dans lesquelles les articles sont publiés. Chacun des articles contient un riche matériel ethnographique et est basé sur une analyse des données sur la santé des migrants étrangers dans la Fédération de Russie et les pays d'origine des migrants.

Les trois articles, chacun une étude complète et autonome, révèlent différents obstacles à l'accès aux services de santé et décrivent l'infrastructure de santé disponible pour les migrants, mais sont en même temps des parties complémentaires d'une étude évoluant du premier article au troisième. Grâce à cela, le texte fait une impression solide et se lit en douceur.

La thèse de Daniil Savelyevich Kashnitsky sur le sujet : « Obstacles et stratégies informelles d'accès aux soins médicaux pour les travailleurs migrants sans papiers infectés par le VIH en Russie » est un travail de qualification scientifique achevé qui répond : aux exigences des paragraphes 3.1, 3.3, 3.4, 3.5 –3.8, 3.10 Règlement sur l'attribution des diplômes universitaires à l'Université nationale de recherche "École supérieure d'économie", Passeport du domaine de la science Sociologie dans la section " Démographie" dans les parties 12. Analyse démographique de la morbidité et de la santé. 18. Mobilité spatiale et migrations internes 25. Biodémographie, 29. Population et développement 31. Problèmes démographiques globaux, ainsi que les spécialités conformément à la nomenclature des spécialités des scientifiques agréée par le ministère de la science et de la démographie supérieure ».

La thèse de Daniil Savelyevich Kashnitsky sur le sujet : "Barrières et stratégies informelles d'accès aux soins médicaux pour les travailleurs migrants sans papiers infectés par le VIH en Russie" est recommandée pour la soutenance d'un diplôme candidat en sciences sociologiques.

La conclusion a été adoptée lors d'une réunion du Département de démographie de l'Institut de démographie. A. G. Établissement d'enseignement supérieur autonome de l'État fédéral Vishnevsky "Université nationale de recherche" École supérieure d'économie "13 décembre 2021, Protocole n ° 168.

Il y avait 10 personnes présentes à la réunion.
Résultats du vote : "pour" - 10 personnes, "contre" - 0 personnes, "abstention" - 0 personnes.

Chef du Département de Démographie,
Candidat en économie, professeur agrégé _____ Denisenko Mikhail Borisovich

Réunion conjointe du Conseil académique de l'Institut de démographie. A. G. Vishnevsky et le Département de démographie, École supérieure d'économie de l'Université nationale de recherche *(traduction de russe)*

École supérieure d'économie de l'Université nationale de la recherche

PROTOCOLE N° 168[2]

13 décembre 2021

Moscou

LISTE DES PARTICIPANTS:
SV Zakharov
KG. Karachurin
R.I. Mkrtchyan
E.A. Kvasha
TL Kharkova
VI. Sakévitch
SI. Abylkalikov
Yu.F. Florinskaïa
UN V. Ramonov
E.B. Demintseva
I. Kashnitsky
D. Kashnitsky
Y. Kashnitsky
M. Smirnova
I. Klimkine
M. Vergèles
N.Zotova

AGENDA : Pré-soutenance de la thèse de D. Kashnitsky (basée sur la totalité des travaux publiés) sur le thème "Barrières et stratégies informelles d'accès aux soins médicaux pour les travailleurs migrants sans papiers infectés par le VIH en Russie".
Conseiller scientifique : E.B. Demintseva, Institut de politique sociale, Centre de recherche qualitative sur la politique sociale
Réviseurs :
VivtoriaSakevich, Institut de démographie. Vishnevsky
Yulia Florinskaya, Institut de démographie. Vishnevsky
Natalia Zotova , Collège de médecine Albert Einstein

ÉCOUTÉ :

1. D. Kashnitsky avec la présentation de la thèse.

Des questions:

1. SV Zakharov : « Est-il possible d'appliquer les données recueillies sur la diaspora kirghize à d'autres groupes de migrants (ils ont aussi leurs propres cliniques, etc.) ?

- Il n'y a de cliniques kirghizes qu'à Moscou. Il y a de l'aide des diasporas dans les conseils sur

[2] Pour commender le document original, veuillez contacter l'auteur par kashnitsky@gmail.com

les questions de santé (Nur Foundation). De nombreux Kirghizes ont un passeport russe, ce qui les distingue. On ne sait rien des cliniques des autres diasporas.

2. M. Vergeles : "Quels groupes de migrants sont engagés dans la thérapie, continuez-la ?"

- Des études qualitatives sont nécessaires, mais les migrants légaux s'y engagent davantage.

3. VICTORIA Sakevich : "Combien de temps un migrant séropositif peut-il rester clandestin en Russie ?"

- Il n'y a pas de règle générale.

4. VICTORIA Sakevich :

- Y a-t-il des progrès en Russie concernant l'expulsion des migrants séropositifs ?

- à partir du 23/12/2021, une loi obligeant tous les étrangers séjournant en Russie plus de 90 jours à fournir un certificat d'absence de maladies infectieuses sera en vigueur. Le ministère de l'intérieur a une influence conservatrice.

5. SV Zakharov: "Quelle est la législation sur cette question dans d'autres pays, quelles sont les tendances?"

- Il existe des recommandations de l'UE sur la levée des interdictions de circulation et de séjour des personnes infectées par le VIH. Il reste 18 pays où les interdictions sont toujours en vigueur.

6. NV Mkrtchyan : « Y a-t-il des caractéristiques de sexe, d'âge ou de mariage lorsque les migrants reçoivent des soins médicaux ? »

- C'est plus facile pour les familles qui résident en permanence en Russie. Les personnes infectées par le VIH sont à peu près égales entre les hommes et les femmes. Le VIH vieillit, l'âge moyen des malades augmente.

7. N.V. Mkrtchyan : "Le manque de thérapie chez les migrants est-il lié au manque de médicaments, même pour les citoyens russes ?"

- Non, il y a assez de médicaments pour tout le monde.

8. KG. Karachurina : "S'il vous plaît, divulguez plus en détail le titre de l'ouvrage (Le rôle des réseaux transformationnels). Peut-être qu'il est logique de corriger le titre"

- Les réseaux de transformation ne sont qu'une des solutions. Les stratégies spécifiques sont beaucoup plus importantes. Le sujet sera mis à jour.

ENTENDU : Yu.F. Florinskaïa (critique)
Bon potentiel de recherche. Bien que les articles aient déjà été publiés, la recherche est en cours. Il est conseillé de faire un tableau sur les catégories de migrants et la disponibilité des soins médicaux pour eux.
Recommander le travail pour la protection.

ENTENDU : V. I. Sakevitch (commentaire)
Vous pouvez ajouter des restrictions d'étude (par exemple, la langue russe de l'enquête). Ajouter des programmes éducatifs parmi les migrants aux recommandations. Les données pour 2018-20 sont fournies. Il y a peut-être quelque chose de nouveau, des changements, des problèmes.
En général, le travail est bon, recommander pour la protection.

ENTENDU : N. Zotova (critique)
Il est nécessaire de corriger le titre du sujet de travail, de clarifier le statut des migrants et les obstacles pour chaque groupe, de décrire plus en détail les moyens de surmonter les obstacles, d'ajouter une description des recherches existantes comme base de développement de ce travail, d'ajouter limites de la recherche, pistes de développement.
En général, le travail est bon, recommander pour la protection.

ENTENDU : E.B. Demintseva (directrice de thèse)
D. Kashnitsky est un chercheur établi, ses travaux ont été publiés et acceptés par la communauté internationale des chercheurs.
Le travail devrait être recommandé pour la soutenance, en tenant compte des commentaires formulés.

CONCLUSION:

1. Recommander des travaux pour la défense, en tenant compte des commentaires formulés

Directeur adjoint de l'Institut de démographie
leur. A. G. Vishnevsky
doctorat SV Zakharov

secrétaire N.S. Jouleva