

LEGALIZING HIV-POSITIVE MIGRANTS IN THE RUSSIAN FEDERATION

**Regional Expert Group on Migration and Health
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Writing team

Mikhail Bakulin,

“Center Plus” Regional Public Organization, Moscow, Russian Federation

Kirill Barsky,

Regional Expert Group on Migration and Health,
Regional Charity Public Fund to Fight AIDS “Steps”, Moscow, Russian Federation

Anna Fedoryak,

Regional Expert Group on Migration and Health, Moscow, Russian Federation

Alexander Kalinin

Regional Charity Public Fund to Fight AIDS “Steps”, Moscow, Russian Federation

Daniel Kashnitsky

Regional Expert Group on Migration and Health,

Institute of Social Policy, National Research University “Higher School of Economics”,
Moscow, Russian Federation

Vladimir Mayanovsky

All-Russian Association of People Living with HIV, Moscow, Russian Federation

Anastasia Pokrovskaya

Federal Scientific and Methodological Center for AIDS Prevention and Control,
Federal Budgetary Institution of Science, Central Research Institute of Epidemiology
of *Rospotrebnadzor*, Moscow, Russian Federation

Igor Pchelin

Regional Charity Public Fund to Fight AIDS “Steps”, Moscow, Russian Federation

Valery Yumaguzin

Institute of Demography, National Research University “Higher School of Economics”,
Moscow, Russian Federation

Shakhnoz Yusupova

Regional Expert Group on Migration and Health, Moscow, Russian Federation

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Executive summary

In the 1980s and 1990s when HIV was perceived as a new and fatal disease, many countries banned the entry, stay and residence of people living with HIV. Today, we know far more about HIV transmission and treatment, such that HIV represents a chronic condition. Modern science grants people living with HIV a normal lifespan, allows us to understand how to prevent transmitting HIV to the partners of HIV-positive individuals and how to deliver healthy children born to mothers living with HIV. Therefore, many countries reversed migration-related discriminatory restrictions, although such regulations remain in effect in the Russian Federation (hereafter, Russia). HIV-positive migrants are unable to work, obtain a temporary residence permit or apply for a residence permit or citizenship. In addition, an HIV-positive migrant risks deportation and subsequently bans from entering the country. These measures contribute to migrants remaining “underground” and restricting their access to antiretroviral therapy, thereby increasing the risk of further spreading HIV.

The legalization of HIV-positive migrants in Russia would reduce the spread of HIV within a key population group – labor migrant. Decriminalization would also partially solve economic and demographic burdens since migrants carry both labor and reproductive potential. In addition, the decriminalization of HIV-positive migrants would facilitate slowing the HIV epidemic in Russia, since it would allow many foreign citizens living with HIV who have remained in Russia illegally for years to come out of the “shadows” and receive HIV-related treatment, care and support services. Simultaneously, sending countries are ready to take on the responsibility of providing their citizens with HIV-related treatment.

It is also important to understand that Russia is not likely to take on the additional costs related to treatment of international migrants with HIV. at the same time, most home countries of labor migrant, such as Kyrgyzstan, Moldova, Tajikistan, Ukraine, and Uzbekistan, provide their citizens with antiretroviral therapy even when they leave their homeland for extended periods of time.

Furthermore, removing HIV from the list of dangerous diseases may improve the lives of current and future students. However, the primary achievement of decriminalizing people living with HIV would lie in recognizing their right to the freedom of movement, their right to privacy and their freedom from discrimination.

In accordance with the 'State Strategy to Counter the Spread of HIV for the Period of up to 2020', the Government of the Russian Federation has committed to reducing the number of new HIV cases and to increasing coverage of antiretroviral therapy access for people living with HIV. Yet, these targets will not be achieved without a comprehensive approach to reach the entire population, including migrant workers living in the Russian Federation.

The first edition of this report was prepared in 2018. This second edition was updated in June 2020.

Glossary and abbreviations

AIDS – Acquired immune deficiency syndrome

ART – Antiretroviral therapy

CD4 – Or receptor cells, the quantity of which is measured to monitor the health status of a person living with HIV

FBIS – Federal Budgetary Institution of Science

FSMC – Federal Scientific and Methodological Center

HIV – Human immunodeficiency virus

MSM – Men who have sex with men

NCO – Non-commercial organization

OMI – Obligatory medical insurance

PLHIV – People living with HIV

Reserve First-Aid Kit – A stock of ART medications, collected by NCO activists, which can be used by an HIV-positive person when therapy is interrupted or there is no possibility to acquire medications from another source

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Background

In June 2008, at the United Nations High-Level Meeting on HIV, the UN Secretary-General Ban Ki-Moon and the Executive Director of UNAIDS Peter Piot deemed discrimination against people living with HIV (PLHIV) unacceptable and called upon member-states to abandon country-level entry restrictions to HIV-positive people (UNAIDS 2008). However, such regulations remain in force in Russia, restricting the rights and freedoms of migrant workers living with HIV. In accordance with the provisions of the federal laws “On preventing the spread of the human immunodeficiency virus in the Russian Federation” and “On the legal status of foreign citizens in the Russian Federation”, when obtaining a Russian visa for a period longer than three months, acquiring a *patent*, registering a temporary resident permit, obtaining a residence permit or applying for citizenship, a foreign national is required to submit a certificate stating that they are HIV-negative (FZ-38).

Under existing laws, an HIV-positive migrant must be deported and receive a lifetime ban from re-entering Russia (FZ-38). In cases when a migrant is already in Russia and learns that they are HIV-positive, they receive a life-long ban on re-entering Russia from the border control.¹ Simultaneously, as a rule, no one will purposefully look for the individual. However, s/he will be included in the list of individuals banned from entering Russia, representing a so-called mild deportation.² During her/stay in Russia, with no access to the necessary medications or if they opt for self-treatment as well as do not take measures to prevent the further spread of HIV, an individual may threaten their own health and the health of those who may be at risk of becoming infected. Failing to cope with a new diagnosis as HIV-positive independently adversely affects the physical and psychological state of the person.

¹ After becoming a Russian citizen, a foreigner gains access to OMI and free HIV treatment. Therefore, it is impossible to exclude the possibility that some migrants obtain citizenship through fake marriages. Through adoption of the law on decriminalizing migrants living with HIV, they would be able to receive treatment in a less complex and risky way.

² They may be subject to actual deportation under completely different circumstances, for example, if they have been held administratively liable twice within one year for committing an administrative offense that infringes upon the public order and public safety or if they have been held administratively liable twice within three years.

Unsurprisingly, “attempts to curtail the spread of HIV by imposing restrictions often have the reverse effect” (Mishina 2017b). Instead of developing the national strategy on protecting the health the Russian population, we find policies that pose a threat to Russians’ health. HIV travel restrictions do not protect the health of Russian society, and a ban on the entry of people living with HIV has no rational justification vis-à-vis national health systems (UNAIDS 2019b). The most appropriate solution would be legalization of HIV-positive migrants, followed by expanding access to treatment provided either by the health authorities of their home country or by the authorities of Russia.

Among the key objectives of the migration policy of the Russian Federation for the period 2019 through 2025 adopted by the President of Russia in October 2018 is increasing “entry into the Russian Federation and stay within its territory of foreign citizens who seek to develop economic, business, professional, scientific, cultural and other connections; who wish to study the language, history and culture of our country; and who are able to contribute to the economic, social and cultural development of Russia through their work, knowledge and competence.”

Several preconditions are required for the successful implementation of this objective. Given the current state of antiretroviral therapy, HIV is no longer an obstacle to full-time work, giving birth to healthy children or being an active member of modern society. We believe that abolishing the deportation of HIV-positive foreigners would represent an extremely positive step for the Russian Federation.

In 2018, the Ministry of Health of the Russian Federation approved the guidelines “Development of a model interagency program on HIV among key population groups”³, which includes an entire chapter dedicated to preventing HIV among migrants. “Social support measures for migrants should aim to facilitate access to medical services, documents, legalizing their stay in the Russian Federation, HIV treatment, supporting adherence to antiretroviral therapy and monitoring through early treatment centers in cases in which an HIV-positive migrant may not leave the territory of the Russian Federation.”

³ Guidelines “Development of a model interagency program on HIV among key population groups” <http://rushiv.ru/wp-content/uploads/2018/11/MR-2018.pdf>

However, in rare exceptions when an HIV-positive migrant has a close relative (FZ-38)—typically, a Russian citizen—a migrant is required to leave Russia or is forced to violate the law regarding remaining in the country. Therefore, in order to fully implement the new methodological recommendations of the Ministry of Health, it is essential to create the conditions necessary for HIV prevention and treatment among migrant communities. Thus, it is necessary to bring legislation in line with recommendations, including abolishing the deportation of HIV-positive migrants.

HIV situation in the EECA region and Russia

While much of the world is experiencing a decline in HIV morbidity and mortality, by contrast, the Eastern European and Central Asian (EECA) region (Armenia, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) are experiencing expanding epidemics. The incidence of HIV increased by 25% between 2001 and 2011 in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan (DeHovitz et al. 2014). In 2019, 150 000 (160 000–200 000) new HIV cases were identified in EECA. The total number of new HIV cases has increased by 60% compared to 2010, with 80% of new cases occurring in Russia alone. An estimated 1.7 million (1.5 million–1.9 million) people currently live HIV in the EECA region (UNAIDS 2019a). According to the Federal AIDS Center, by May 2020, 1 087 050 Russians were registered as living with HIV, confirmed through laboratory testing (FSMC AIDS 2020).

In Russia, HIV-related mortality has rapidly increased since the 2000s (Figure 1), representing one of the top 10 causes of premature death (Beyrer et al. 2017). In 2017, HIV accounted for more than 60% of deaths from all infectious diseases (Rosstat 2018a), and one in 10 Russians aged between 25 and 44 who died in 2017 did so because of HIV (Shchur & Timonin 2019). International experience in responding to HIV has not been taken into consideration in Russia and, regrettably, preventing new infections has proved relatively ineffective.

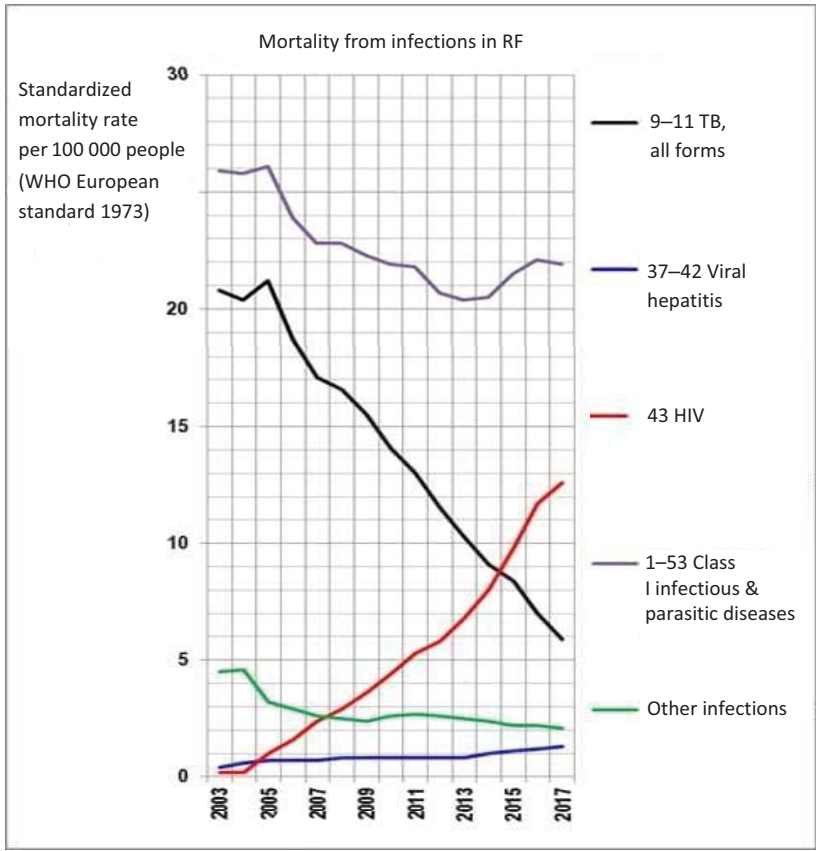


Figure 1. Standardized mortality rate from infectious diseases in Russia, 2003–2017, per 100 000 population (Alexey Raksha, SRI)

The structure of HIV transmission is changing in Russia. According to Vadim Pokrovsky, the Head of the Federal Scientific and Methodological Center for AIDS Prevention and Control, “HIV has spread beyond key population groups and is actively being transmitted among the general population, such that more than half of patients in 2017 were infected through heterosexual contact (53.5%)” (Mishina 2018).

Migrants as a key population group

Migrants, along with people who inject drugs, men who have sex with men, sex workers and prisoners, represent key populations at an increased risk for HIV (UNDP 2018, Beyrer et al. 2017). A low socioeconomic status, limited access to various services, low risk awareness, stress associated with distance from one's family and limited integration in the host country all increase migrants' vulnerability to HIV (Amirkhanian et al. 2011, Jing et al. 2013, DeHovitz et al. 2014). In a study in St. Petersburg, 30% of male migrants reported having several female sexual partners in the previous three months. The frequency of condom use, however, remained, low, ranging from 35% of individuals reporting regular condom use with a regular partner to 52% frequently using a condom with a casual partner (Amirkhanyan et al. 2011). In addition, that study found that migrants from Central Asia had a very low awareness of HIV, high levels of depression, low levels of social support and moderate sexual risk. Migrants from Eastern Europe were better educated about HIV, but also reported higher levels of alcohol and drug use and higher levels of sexual risk. Specifically, they reported having more sexual partners, were less likely to use condoms and were twice as likely to have casual partners compared with Central Asian migrants (Amirkhanian et al. 2011).

Between 2012 and 2016, 9284 HIV-positive foreigners were identified (Mishina 2017 b), while in 2016, 1736 HIV-positive foreigners were identified (Mishina 2017a). Yet, these figures likely underreport the real numbers, since not all migrants are tested or know their HIV status. While the initiative to decriminalize HIV will directly affect HIV-positive migrants only, indirectly all migrants will benefit from decriminalization, since they will no longer fear undergoing testing, the only way to identify migrants requiring treatment.

Discrimination, stigma, and restricted access to treatment

During interviews with Tajik migrants working in Moscow (Jiang et al. 2013), respondents reported not buying condoms in pharmacies for fear of being caught by the police. The fear of interacting with police is associated with language barriers, ignorance of their rights and existing laws and risks associated with extortion and deportation. Criminalization

is common not only for migrants, but also for people who use drugs and other key populations all of whom fear arrest when seeking medical treatment for HIV. This reluctance to seek treatment promotes several issues simultaneously: deteriorating reproductive health (including abortions, unplanned pregnancies, and HIV transmission), as well as restrictions to the right to maintain one's health. Discrimination against HIV-positive migrants is also closely tied to this fear. Migrants themselves attract much attention, and openly purchasing HIV medications at a pharmacy may further increase negative stereotypes regarding migrants and xenophobia towards them. This is particularly the case in small communities, where they may be asked needless questions from acquaintances. Buying medicines online is quite risky as well since the seller is not responsible for any resulting harm. Additionally, there is a high risk of fraud through the sale of fake medicines (Rykova 2017). Low levels of awareness regarding their HIV status, poor quality medications and the use of unreliable methods of contraception all contribute to the rapid spread of disease, as well as unwanted pregnancies and abortions.

According to a report from the European Center for Disease Prevention and Control (ECDC 2017), poor testing rates and high rates of late-stage diagnosis (when the CD4 count falls below $350/\text{mm}^3$) are common among migrants. These realities pinpoint obstacles to providing HIV testing, of which the primary obstacle remains a lack of funding, the remoteness of medical testing centers and discrimination from medical personnel among others (ECDC, 2017). Late-stage HIV diagnosis in the Russian reality is largely facilitated by the neglected state of migrants given their fear of deportation as migrants and undocumented workers.

Moreover, people living with HIV in Russia face stigma. For example, in St. Petersburg, 25% of people living with HIV were denied medical assistance, 11% were denied employment, 7% were fired and 6% were kicked out of their homes (DeHovitz et al. 2014). Among migrants, these numbers are likely higher, both in Russia and in their home countries. Migrants are pushed out of their homeland not only by economic factors, but also by sociopolitical issues. Migrants persecuted because of their sexual orientation (for example, men who have sex with men) represent a key population at increased risk (DeHovitz et al. 2014), since they face a triple stigma (being HIV-positive, a migrant and a homosexual). Such migrants

cannot even count on the support of their diaspora and friends with the same nationality (Wirtz et al. 2014).

Shifting views on legislation restricting the movement of PLHIV

Many countries banned the entry, stay and residence of HIV-positive people in the 1980s and 1990s as they faced a new and fatal disease (LATHAM 2013). Such restrictions were determined by the low levels of expertise in the field of HIV and the existing limited treatment options at that time. Looking back, however, it was clear that fear and a lack of scientific knowledge about HIV prevailed in attitudes towards people living with HIV.

Since the adoption of restrictive laws, healthcare systems have learned to cope with new infections, and clearly understand the routes of HIV transmission, primarily: through contact with blood or blood products, the sharing of injecting equipment, unprotected sexual contact and from mother to child. There is no risk of HIV transmission through shaking hands, spitting, or scratching, and, according to the US Centers for Disease Control and Prevention, no documented transmission of HIV has occurred through saliva. Therefore, restrictive laws relied on outdated knowledge and perceptions of HIV transmission (LATHAM, 2013). Currently, a wealth of information exists on how HIV spreads, as well as about advancements in preventing HIV transmission (such as through pre-exposure prophylaxis, or PrEP). Despite this, laws criminalizing people living with HIV remain in force in Russia and in a number of other countries. Such laws are meaningless and have long since outlived their usefulness. In addition, these bans are discriminatory (UNDP 2019).

Changes relate not only to the perception of HIV as a fatal disease, but also to the role of foreigners in the spread of HIV. Prior to 1987 in Russia, only foreign citizens were HIV-positive, no cases were reported in the Soviet Union. At that time, a concept took shape whereby HIV transmission stemmed from migrants, creating the notion that it was necessary to isolate ourselves from the outside world in order to protect ourselves from infection. Yet, in 1988, the World Health Organization (WHO) stated that “since HIV is already present in every region and almost every major city in the world, the complete prohibition of movement between

countries (foreigners and citizens crossing borders) cannot prevent the emergence and spread of HIV" (IAS 2007). Currently, HIV is more prevalent among Russians than foreigners. According to the Federal Center for AIDS Prevention and Control, approximately 100 000 Russian citizens in 2016 were diagnosed as HIV-positive, only 1736 of whom were foreign-born (Mishina 2017a). That is, the proportion HIV cases among foreign-born residents represented less than 2% of all cases. In 2014, the incidence among Russians was 307.1 per 100 000 tested blood samples, while among foreign citizens the figure was considerably lower, at 201.1 per 100 000 tests (FSMC 2015).

Effectiveness of antiretroviral therapy

Modern methods of treatment (antiretroviral therapy), as well as preventing HIV transmission (through condom use and the use of clean injecting equipment) reduce the risk of forward transmission. For example, among HIV discordant couples, where one partner is living with HIV who is taking antiretroviral therapy, the risk of HIV transmission to a healthy partner is reduced by 96%. Cuba as well as Armenia, Belarus, Moldova, and Thailand have all successfully eliminated the risk of mother-to-child transmission of HIV. Medication is also now available for HIV-negative people which prevents HIV transmission (both before and after a potential exposure, thusly known as pre- and post-exposure prophylaxis, or PrEP and PEP) (Chan 2017).

In the UK, the expected age of death for a 35-year-old man who initiates antiretroviral therapy currently stands at 71 to 78 years, depending upon his CD4 count. This age is comparable to adult mortality and life expectancy among men in general of 78 years (May et al. 2014). Yet, in UK, life expectancy among people living with HIV at 35 may only reach 38 to 44 years (UNDP 2018). Between 1996 and 2010, the life expectancy of 20-year-old patients in Europe and North America increased by 9 years for men and 10 years for women. This was achieved through a shift to less toxic medications, stricter adherence to antiretroviral therapy, preventive measures and controlling comorbidities and complications (*The Lancet* 2017).

National security

In Russia, Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing implements a significant number of activities aimed at preventing the spread of infectious diseases including HIV among foreign citizens entering the country for employment purposes. Between 2007 and 2017, more than 16.7 million foreign citizens underwent medical examinations. In total, more than 89 000 patients with infectious diseases were identified, including 19 611 (21.8%) with HIV. During the same period, *Rospotrebnadzor* issued more than 17 500 decisions on foreign citizens for whom it was undesirable for them to stay (that is, reside) in the Russian Federation, among whom 38% were related to HIV. The citizenship of individuals for whom these decisions applied were as follows: Republic of Uzbekistan accounted for 41.7% of decisions, Tajikistan 18.2%, Moldova 5.6%, Azerbaijan 4.6%, and Armenia 3.6% (Aizatulina 2018).

According to the Federal Scientific and Methodological Center for the Prevention and Control of AIDS of the FBIS of the Central Research Institute of Epidemiology of *Rospotrebnadzor* (FSMC, AIDS), in recent years, HIV-positive cases occurred more frequently among Russians than among foreigners. For instance, in 2015, among Russians, 346.7 per 100 000 tests were positive; among foreign citizens, 196.3 per 100 000 tests were positive. In 2016, these figures were 332.3 positive per 100 000 tests among Russians and 123.8 positive per 100 000 tests among foreigners (FSMC, 2018). Between 2011 to 2017, the detection rate of HIV among migrants decreased 1.4-fold, from 113.2 to 80.4 per 100 000 population (Aizatulina 2018).

Figure 2 shows (in blue) the growth in the number of foreigners examined. Despite the annually increasing number of tests, the number of newly detected HIV cases among migrants has not increased; on the contrary, the rate has decreased over the last three years.

On the one hand, the data provided indicate a higher prevalence of HIV among Russians compared to foreigners coming to Russia. On the other hand, we can exclude the possibility that foreign citizens aware of their HIV-positive status or who suspect the possibility of being HIV-positive deliberately avoid testing so as not to be deported in case of an HIV-positive test result.

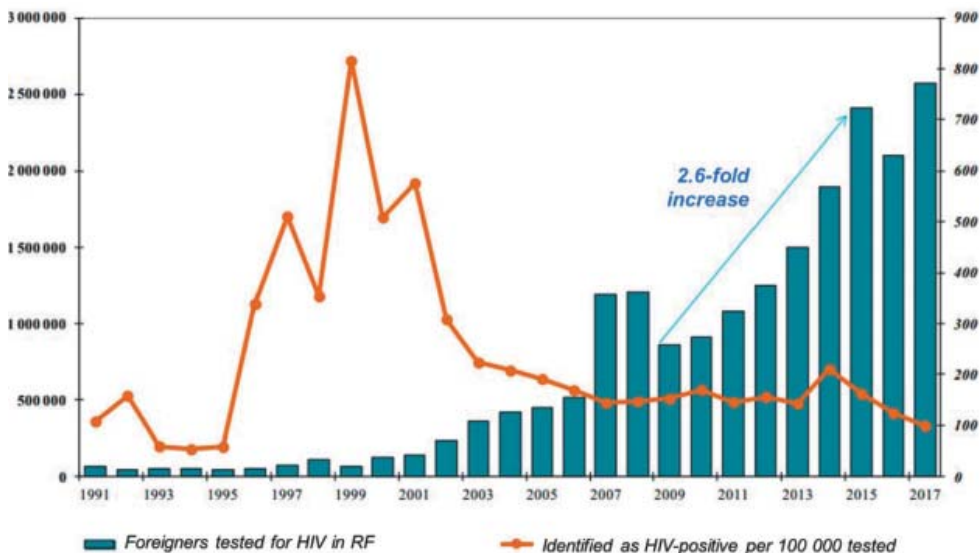


Figure 2. Results of HIV testing among foreigners in the Russian Federation (from a presentation by N. N. Ladnaya, Senior Researcher at the Federal Scientific Methodological Center for AIDS).

Today, the volatile political and economic situations globally lead individuals to migrate and to changes in migratory routes. Legal regulations regarding the status of migrants, including those living with HIV, are also shifting. The abolition of regulations on the deportation of foreigners if they test positive for HIV in some countries only began in the last 10 years (e.g., US in 2010, China in 2010, Armenia in 2011 and Ukraine in 2015). Still, many countries mandate HIV testing in order to obtain a long-term visa, work permit, residence permit and many other circumstances that imply a long-term stay in a country. HIV detection, however, does not restrict the entry and stay in these countries. In addition, the issue of specialized medical care and obtaining antiretroviral therapy for illegal immigrants varies from country to country. But an increasing number of countries provide antiretroviral therapy to foreign migrants regardless of their legal status (UNAIDS 2019b).

In Russia, there are no restrictions on the entry and short-term stay of foreign citizens living with HIV. HIV testing is mandatory when you receive a visa for a stay of more than 90 days, for a student or work visa and for a residence permit. If a foreign citizen or stateless person is found to

be HIV-positive, they must be deported from the Russian Federation. In 2015, an amendment to Federal Law No 38 was adopted stating that “no decision is taken on the undesirability of a stay (residence) with respect to foreign citizens and stateless persons having a disease caused by the human immunodeficiency virus (HIV), if these foreign citizens and stateless persons have family members (spouse), children (including adopted) or parents (including adopted) who are citizens of the Russian Federation or foreign citizens or stateless persons permanently residing within the territory of the Russian Federation” (FL–38). Thus, a law that partially restricts the possibility of HIV-positive foreign citizens to remain within the territory of the Russian Federation is unlikely to be effective from an epidemiological point of view. That is, such a law targets foreign labor migrants and students rather than protects the health of the country’s population. This often results in illegal stays among migrants who are suspected of being HIV-positive or who have already been diagnosed as HIV-positive. Such individuals will avoid contact with migration and medical services, thereby creating a hidden epidemic and a threat to their own and the public’s health.

The study “Portrait of a Patient”, conducted in six countries from the Commonwealth of Independent States (CIS) (Armenia, Azerbaijan, Belarus, Kyrgyzstan, Tajikistan, and Uzbekistan) surveyed 4023 people receiving HIV-related medical services in these countries. This study revealed that 10% of people worked outside their country of citizenship as labor migrants. No more than 2% of the HIV-positive citizens of Azerbaijan, Belarus and Kyrgyzstan reported working in another country, while higher rates were reported by respondents from Armenia, Tajikistan, and Uzbekistan—12%, 11% and 14%, respectively (Pokrovskaya 2015). Given that the majority of migrant workers most likely work in Russia, we may assume that they live in Russia illegally, calling into question the effectiveness of legislative and anti-epidemic measures.

HIV prevalence among migrants in the European Union and the USA

In most English-language studies on migration and HIV, the term “migrant” refers to a person born outside the country of their current residence, regardless of the duration of their stay, legal status, or reasons for migration. Accordingly, the social, legal, and economic situation of

a foreign student, a legal migrant worker and an internally displaced person remains unequal, leading to different realities among specific subgroups of migrants vis-à-vis the HIV epidemic.

According to UNAIDS estimates, in 2016, the global rate of new HIV cases among all ages decreased by 16% compared to 2010. The most significant decline between 2010 and 2016 was observed in eastern and southern Africa (by 29%), followed by the Asia-Pacific region (by 13%), western and central Europe and North America (by 9%). Simultaneously, the overall increase in new HIV cases in Eastern Europe and Central Asia between 2010 and 2015 reached 57%. Russia and Ukraine remain most affected by the HIV epidemic in this region (UNAIDS 2017). Between 2011 and 2015, the annual increase in the number of new cases of HIV in the Russian Federation was on average 10%, falling to 4.1% in 2016 and 2.2% in 2017. As of June 30, 2018, the cumulative number of registered cases of HIV among citizens of the Russian Federation stood at 1 272 403 (according to preliminary data). At the end of the first half of 2018, 978 443 Russians were living with HIV in the country, excluding the 293 960 individuals who tested positive, but have since died (FSMC 2018).

Thus, the HIV epidemic in Russia has continued to expand, while many countries' epidemics have stabilized or declined over the past decade. These declines in other countries stem not from restrictive migration measures, but result from adequate and effective preventive measures, regardless of migration flows, for example, to European countries.

Currently, permanent, or temporary migrants, primarily from countries with a generalized HIV epidemic, continue to constitute a large proportion of people living with HIV in the European Union. Most HIV diagnoses initially occur in Europe, although the acquisition of the virus can occur both in one's home country, and the country of residence. In 2015, a review and epidemiological surveillance study analyzed data on HIV in 30 European countries. Examining the probability of becoming HIV positive after moving to Europe, the primary the study aimed to understand the effectiveness of HIV prevention programs and policies in the region. As a result, the authors found that rates of HIV acquisition following migration to Europe varied greatly, ranging from 2% among sub-Saharan Africans in Switzerland to 62% among black men who have sex with men from the Caribbean region living in the UK (Fakoya 2015).

A more recent study indicates that more than half of migrants in Europe become HIV positive after arriving in their new country of residence. Among HIV-positive migrants identified in 2015 in 9 European countries, 63% were infected outside their country of birth. Transmission following migration was higher among migrants from other European countries (71%) and from Latin America and the Caribbean (71%) compared to migrants from sub-Saharan Africa (45%). This proportion was also higher among men who had sex with men compared to heterosexual men and women (72% of men who had sex with men, 58% of heterosexual men and 51% of heterosexual women). Thus, the authors suggest introducing more active HIV testing and counseling among foreign citizens arriving to the country (Alvarez-del Arcoa 2017).

Work based on a mathematical model showed that heterosexual immigrants from Africa carry a greater risk of becoming HIV-positive while living in the Netherlands than in their home countries. Furthermore, HIV is being transmitted from their fellow citizens from Africa. Simultaneously, the risk of HIV transmission from an African woman to a Dutch native is extremely low, since heterosexual Dutch men prefer to have sexual relations with ethnic Dutch women (Xiridou 2010). In another study, the prevalence of sexual relationships and the risk of HIV transmission between migrants and non-migrants in Europe appeared rather low. For example, sub-Saharan Africa migrants in France typically reported having sex with people from Africa rather than with ethnic French people (Marsicano 2013).

Given these findings, we can assume that despite the presence or absence of restrictive measures against HIV-positive migrants, HIV spread in all countries around the world and led to a global epidemic.

Antiretroviral therapy for undocumented migrants in Europe

In 2016 in the WHO European region (not including Russia), 37% of new HIV cases occurred among migrants (ECDC 2017)—that is, people born outside their country of residence—including 25% of people born outside Europe. Among these, 15% originated from countries with a high HIV prevalence. Furthermore, there is growing evidence that migrants from high prevalence countries are at risk of acquiring HIV after migrating to Europe.

According to data from 2016, almost all countries in the WHO European region provided antiretroviral therapy for legal migrants, and almost half—or 21 countries in total (14 European Union (EU)/European Economic Area (EEA) member-states and 7 non-EU/EEA countries) reported providing free access to antiretroviral therapy to undocumented migrants (ECDC 2017) (Fig. 3).

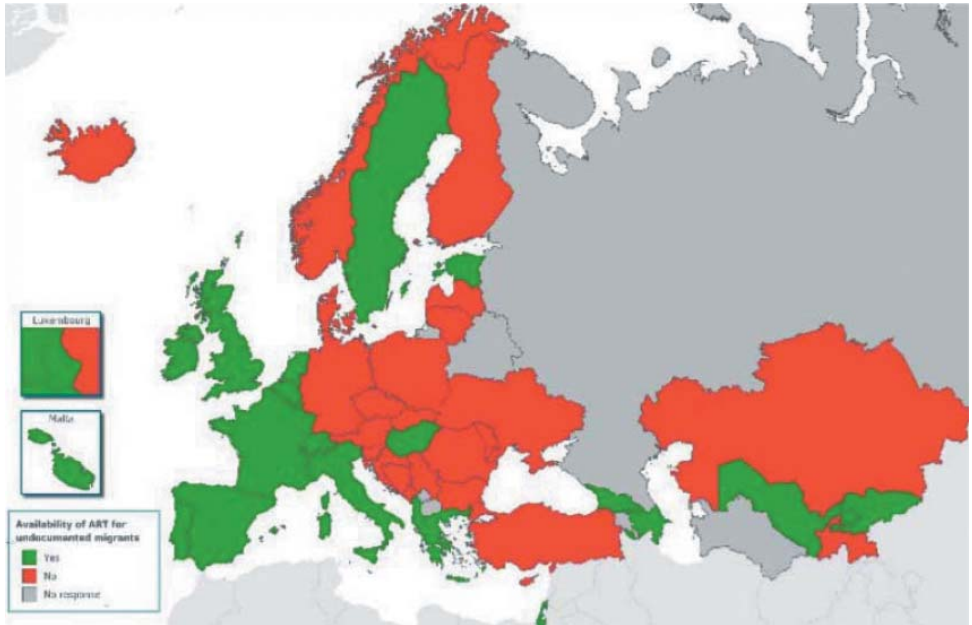


Figure 3. Access to antiretroviral therapy among undocumented migrants in Europe and Central Asia (ECDC 2017).

For example, in France, Italy, the Netherlands and the United Kingdom, undocumented migrants may receive free HIV testing and diagnosis, HIV treatment (except for Italy), emergency care and testing for sexually transmitted infections (Legal Forum 2018). However, not all of the processes work smoothly even in these countries. For instance, factors such as bureaucracy, migrants’ ignorance of their rights, fear of being detected by migration authorities and physicians’ unawareness regarding eligibility to treatment may complicate migrants’ access to services (Legal Forum 2018).

Both the WHO and UN argue that restrictions on the movement of people living with HIV should be revoked (Mishina 2018), since HIV is no longer considered an epidemic, but, rather, a disease which does not restrict an individual from a full and healthy life when antiretroviral therapy is accessible and available. HIV is classified as a chronic and well-controlled condition (Chan 2017). The global community now understands that migrants do not cause HIV transmission. However, imperfect laws, barriers to the provision of prevention, care, and treatment services as well as the cost of treatment increase migrants' vulnerability to HIV (UNDP 2018).

In what follows, we highlight the main risks of practices related to criminalizing migrants with HIV. Then, we examine in more detail at the epidemiological, demographic, sociopolitical, economic, and moral considerations of decriminalizing migrants with HIV and further steps necessary towards doing so.

Risks associated with designation as an HIV-positive migrant

The following list includes the risks associated with being identified as an HIV-positive migrant.

1. The main threat relates to the spread of HIV in Russia and upon their return to their home countries given the low frequency of condom use, as well as insufficient knowledge regarding HIV, routes of transmission and treatment, including:
 - a) when they are unaware of their status, and
 - b) when they are aware of their status, but do not receive treatment.
2. In their countries of origin, the wives of male migrants remain the most vulnerable to HIV (Amirkhanian et al. 2011), since they may be accused of adultery following detection of HIV in a family, even though their husbands initially contracted HIV when in Russia.
3. Interactions among key populations (such as sex workers, people who inject drugs and men who have sex with men) create complications, since some migrants also belong to these groups.
4. Complications may result in obtaining adequate treatment offered by a physician, resulting in possible negative consequences stemming from self-treatment.

5. One's health may deteriorate for various reasons unrelated to HIV, owing to fear of visiting a hospital and undergoing testing, which hypothetically can indicate the presence of HIV. The most common HIV-related diseases include tuberculosis and hepatitis C, especially among people who inject drugs (Beyrer et al. 2017, Denovitz et al. 2014).
6. Problems associated with transporting medicines across borders due to the fear of revealing one's HIV status. In this case, disrupting one's antiretroviral therapeutic regimen leads to the development of a resistant form of disease (reducing the effectiveness of treatment) and relapse. International organizations advise people living with HIV to "repackage medicines in neutral packages" (Deutsche AIDS-Hilfe 2010, 2011). Furthermore, depending upon the situation, individuals transporting medications are encouraged to also carry a certificate indicating that the medication is prescribed by a physician, although the certificate need not indicate the diagnosis. When crossing national borders where no restrictions exist for HIV-positive people, individuals are encouraged, however, to refrain from specifying any disease upon entry forms, as well as informally declaring their status by wearing a red ribbon (Deutsche AIDS-Hilfe 2010).
7. Premature death may occur either while waiting for deportation in a special detention center because of a lack of access to treatment or because of difficulties in obtaining and following a treatment regime, as well as postponing treatment.

Epidemiological considerations

We now outline the primary considerations and consequences of decriminalizing entry by migrants living with HIV from an epidemiological perspective. These considerations are as follows:

1. The migrant's own health may improve, and the risk of HIV transmission may decline.
2. Increasing public awareness about one's HIV status:
 - a) The development of mobile HIV testing stations is important, including ensuring such laboratories are accompanied by a therapist, translator and volunteers who, if necessary,

can provide medical advice regarding which physician to contact for a particular problem, identify medical centers and volunteer organizations and provide advice on disease prevention as well (Anderson et al. 2016).

- b) Building trust between healthcare professionals and key populations where HIV is spreading can be strengthened, such that outreach activities do not involve the police and the staff interacting with key populations should be permanent and trained to not judge patients, to find information related to legal or illegal stays and to prevent violations to medical confidentiality among others (Anderson et al. 2016).
3. The epidemiological burden may diminish through early diagnosis and timely treatment.
4. HIV-related diseases such as tuberculosis and hepatitis C may decline.
5. Innovative testing methods such as at-home test kits and self-administered tests may be developed.
6. Collect data to better understand risk factors and create targeted HIV prevention programs to aid in the development of prevention programs for migrants from key populations (men who have sex with men, sex workers and people who use inject drugs). Cultural differences among migrants from predominantly Christian Eastern Europe and Muslim Central Asia should be considered when developing prevention measures to mitigate the risk of transmitting HIV (Amirkhanian et al. 2011). A wide range of interventions should include measures internationally recognized as effective including opioid substitution therapy and needle and syringe exchange programs (Beyrer et al. 2017).
7. HIV should be excluded from the list of diseases that are considered dangerous for other people (RofG-715).
8. Combat HIV discrimination including among migrants. Being in a position that restricts access to medical services, an individual is more susceptible to accepting inaccurate information about diseases.
9. Improve requirements related to the quality of antiretroviral therapy, including the use of less toxic and more convenient-to-take medications. Modern medications allow individuals to take just one tablet daily, yet some patients in Russia take 10 different tablets (Ruzmanova 2017), reducing adherence to the treatment regimen.

10. Ensure an uninterrupted supply of medication.
11. Informing migrants, regardless of their legal status, of their right to maintain their health. Healthcare workers should be regularly informed regarding the rules for aiding and examining migrants.
12. Providing subsidized or free antiretroviral therapy to all migrants, regardless of their legal status in the Russian Federation.
13. Attaining the goal of 90-90-90 (UNAIDS 2017), whereby 90% of all HIV cases are detected, 90% of all cases receive treatment and 90% of patients receiving treatment undergo virological testing.

Treatment for HIV during the early stages of disease is much cheaper and can save lives. According to the Ministry of Health of the Russian Federation, the cost of outpatient treatment for HIV using first-line antiretroviral therapy reaches $\text{R}16\,700$ annually (185 EUR, exchange rate of Oct 2020). Emergency treatment during the advanced stages of disease is most expensive, especially when hospitalization is necessary, when a migrant cannot be denied treatment for a life-threatening condition. Disregarding the importance of treating HIV-positive migrant workers during the early stages of disease, society risks much higher costs later.

Demographic considerations

Given its shared historical and cultural past, Russia maintains close migration ties with the former Soviet republics. Moreover, Russia plays a major role in these migratory movements (Karachurina 2012). In the 2000s, a primary direction of permanent migration flowed to Russia from Kazakhstan, Ukraine, and Uzbekistan (Fig. 4). Altogether, these three countries accounted for 58% of the growth in migration to Russia from CIS countries between 2001 and 2016. In total, 3.3 million people from CIS countries migrated during this period (Rosstat 2018a).

Since 2011, migration has declined due to the economic crisis and sanctions against Russia, as well as the economic development of its neighbors, including Azerbaijan, Belarus, and Turkmenistan. Kazakhstan in particular overtook Russia in terms of per capita GDP in 2015, US\$25 900 versus US\$24 500 (Zakharov 2017).

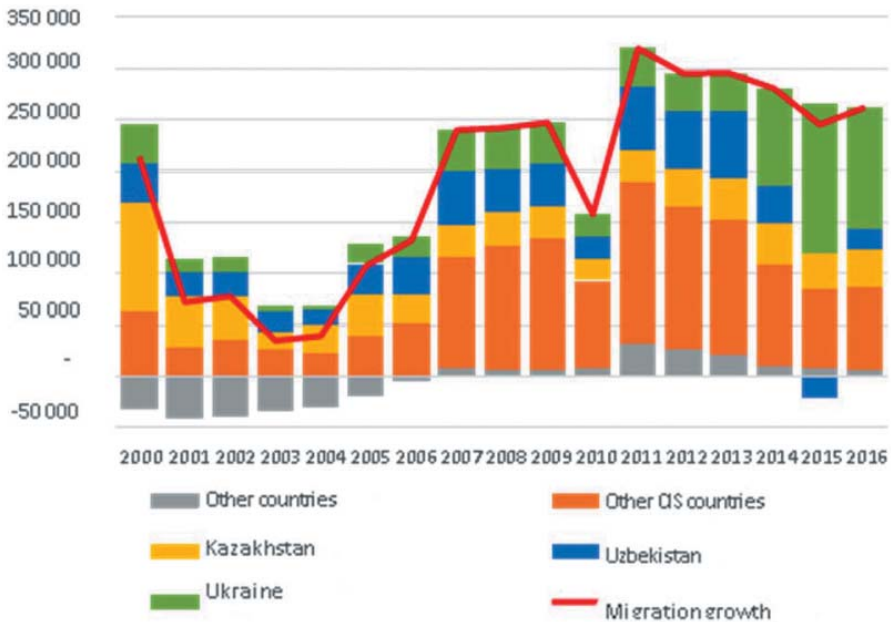


Figure 4. Growth of migration to Russia, 2000–2016 (Rosstat 2018a)

The CIS countries also play an important role in labor migration. In 2015, these countries accounted for about 90% of labor migrants (Zakharov 2017). Migrants occupy their own niche (e.g., construction, services, and trade), virtually not competing with the local population for jobs. Furthermore, labor migrants work in sectors of the economy in which local residents are unwilling to work, whereby Russians are better positioned to find more interesting creative or intellectual work.

In general, in the era of globalization, migration is more likely to increase. Due to the gradual decline in the birth rate in Central Asia and population growth in China and India, an increasing number of people from Asia, the Middle East and Africa are expected to enter the Russian labor market.

Demographically, migrants represent a significant labor resource for Russia. Between 2011 and 2015, Russia experienced a “large-scale loss of labor resource potential in Russia, totaling 5 million people” (Zakharov 2017). In the coming years, this negative trend will continue (losing about half

a million people a year) due to the peculiarities of the demographic structure (demographic waves) and Russia's aging population. The population of European countries continues to grow only thanks to migrants. According to most forecasts, it would be quite nearsighted to rely on natural population growth alone without attracting migrants to Russia. The most feasible population forecasts through 2035 indicate an annual natural population loss of 200 000 to 400 000 people (Rosstat 2018b). The projected growth from migration amounting to about 250 000 to 300 000 people is insufficient for population growth; on the contrary, by 2035, according to this forecast, the population will decline by 1 million individuals, falling to a total of 145.9 million people. The natural growth rate is only based on the higher forecast; until 2029, it will not exceed 100 000 people, with the average forecast not exceeding 50 000 people per year. None of the forecasts envisions a total fertility rate exceeding 2.1 children per woman, thus resulting in a long-term decrease in the population.

The demographic burden is growing in Russia. For every 1000 people of working age, the number of dependents consisting of children and the elderly continues to increase. In all versions of the Rosstat forecast, this burden will grow at a particularly rapid pace until 2024. Ironically, the highest forecast shows the highest burden, since that forecast includes higher birth rates (leading to a higher number of children), as well as high life expectancy targets (leading to a higher number of elderly individuals).

The most active migrants are young people, who can quickly fill workforce shortages. Today, HIV-positive people can live long and productive lives, rendering them full-fledged participants in the labor market. Thus, HIV-positive people may be in high demand in the labor market as well. Countries that offer the most comfortable living and work conditions, including treatment and healthcare maintenance, will more likely attract such migrants.

Labor migrants also represent a reproductive potential for the country. Under medical supervision and with appropriate antiretroviral therapy, an HIV-positive person may have healthy children. The children of migrants who obtain citizenship in Russia will also become Russian citizens, positively impacting the population growth, and diminishing problems related to integration. Furthermore, children born in Russia speak the Russian language.

In principle, it makes sense to remove entry restrictions for HIV-positive people. Currently, both labor migrants and students are required to provide a certificate verifying an HIV-negative status in order to enter the country. Yet, the latter represents a scientific potential for the country, since foreign students are quite likely to remain in Russia and apply their knowledge here, thereby expanding the country's human capital, especially given Russia's own "brain drain" to other countries. Foreign students will integrate into our society much more quickly. If they leave for their home countries, they become "agents" of Russian culture and language.

Sociopolitical considerations

Migrants from the countries of the Eurasian Economic Union—Armenia, Belarus, Kazakhstan and Kyrgyzstan—do not need a *patent* (work permit for labor migrants coming from countries of the Commonwealth of Independent States) to work in Russia nor do they need to provide an HIV-status certificate. Thus, a ban on remaining within the territory of Russia for HIV-positive labor migrants only partially works, since it applies to only a portion of the migrants. The decriminalization of entry to HIV-positive migrants would eliminate this discrepancy.

What other sociopolitical consequences can we expect?

1. The decriminalization of migrants living with HIV will contribute to their ability to retain a legal status.
2. Migrants living with HIV will be able to freely transport HIV medications for their personal use or for use by family members and friends.
3. Removal of the requirement to confirm the absence of HIV would also extend to individuals wishing to obtain a multiple-entry study or tourist visa, as well as fellow citizens participating in a resettlement program.
4. Confidential medical care would be available to undocumented migrants and key population groups (e.g., men who have sex with men, sex workers and people who inject drug users) who would otherwise face restrictions and the risk of arrest.
5. Bureaucratic obstacles to receiving medical care would diminish.

6. Foreigners would be permitted to remain in the country if they are unable to receive effective treatment in their country of origin.
7. Campaigns aimed at eliminating discrimination towards HIV-positive people in Russia would be strengthened. For example, testing positive for various life-threatening diseases, including hepatitis and tuberculosis, is not criminalized. Thus, the entry ban against HIV-positive migrants is discriminatory towards them.
8. The list of jobs for which HIV-positive people are prohibited from working could be amended or removed. Currently, in Russia restrictions exist for professions in which direct contact with blood occurs. However, in the United Kingdom in 2013, HIV-positive people were allowed to work as surgeons, dentists, midwives, and as other medical workers. Previously, this restriction led to layoffs and the loss of income; now, such restrictions are considered outdated. Furthermore, when announcing the changes to the policy, the country's chief physician Sally Davies noted that the probability of being struck by lightning was higher than the risk of being infected from medical personnel (Boseley 2013).

In addressing these issues, Russia will be internationally recognized for meeting health standards and respecting the rights of people living with HIV. This will also indicate a commitment by Russia to the international response to HIV and support for policy that extends to HIV-positive foreigners.

Economic considerations

The economic benefits of decriminalizing the entry ban of HIV-positive migrants carries both personal and social benefits, which often overlap.

Labor migrants bring considerable income to the state treasury. In 2013, migrant workers produced ₺1.4 trillion at 2008 currency levels, comprising 3.12% of Russia's GDP.⁴ If we consider migrants' expenses related to purchasing *patents* and consumption costs, then their contributions

⁴ According to Vladimir Volokh, professor at the State Management University, migrant labor contributes 7–8% to the total GDP. This includes the costs of products produced by migrants, the fees they pay (*patents*), fees related to attracting foreign labor paid by employers (₺6000 per person) as well as fines (Volokh 2013).

to the Russian economy would be even higher (Riazantsev 2016). For example, in 2017, the state received more than ₺50 billion from the sale of *patents* to migrant workers (TASS 2018). In addition, in 2010, the Director of FMS, K. O. Romodanovsky, stated, “Every dollar earned by a migrant worker brings US\$6 to the Russian budget” (Riazantsev 2016). These estimates did not consider illegal migration, which also contributes to the country’s economic development. Decriminalizing HIV-positive migrants would decrease illegal stays in the country and result in an increase in tax revenues. With the economic benefits of migrants’ activities in mind, the financial expense of providing treatment to migrants in Russia should prove less problematic. However, multiple options exist here as well. Vadim Pokrovsky argues that “it is essential to establish a relationship with other states in order to transfer the costs for treatment or to create an international fund that allocates money for this purpose” (Khetagurova 2018). The primary countries supplying migrant workers to the Russian Federation are ready to cover the costs of antiretroviral therapy (Ashchenko 2018a).

Ethical considerations

Considering HIV-positive migrants as economic or demographic resources and attempting to calculate their usefulness for the country as a whole, we neglect ethical considerations—namely, recognizing migrants as members of our community. Everyone has rights and freedoms, including the right to a decent life, to health and medical care and to the freedom of movement. The right to protect one’s health is a fundamental human right, which does not depend upon citizenship (Legal Forum 2018). People living with HIV should enjoy the same right to plan their education, establish themselves within a profession and determine their own career path. Migrant workers suffer the most from restrictive laws. Too often, they spend what remains of their savings or borrow from their community in order to move. As migrants, they financially support their families in their home countries. Restrictions related to an HIV-positive status deny migrants further legal recourse (e.g., a visa, *patent*, temporary residence, residence permit or citizenship), thus exposing them to deportation (as falling beyond the law) and their HIV status becomes public. “This is very destructive, both financially and emotionally, leading to the complete loss of financial resources and

returning them to a society where discrimination continues because of their HIV status. Eventually, they may become the outcasts” (IAS 2007). Furthermore, “People living with HIV are constantly at risk of losing what they have gained: their jobs, financial well-being, access to healthcare, their home, friends, and family and, most importantly, their lives!” (Deutsche AIDS-Hilfe 2010).

People living with HIV need treatment. When they find themselves in a difficult situation, a stable job to cover their medical expenses is most needed. After decriminalizing entry bans and residence to migrants living with HIV, such individuals will be able to receive greater protections and timely treatment. However, when obtaining medications requires constant travel to their country of origin, migrants carry additional time-sensitive and financial burdens. Therefore, it is essential to provide such migrants with everything they need within the Russian territory.

Some migrants cannot return home, because the local community treats them badly, even threatening to kill them. There is still an outdated perception that HIV is a disease of “drug addicts, prostitutes and gays”. For example, a study conducted in Tajikistan on stigma and discrimination directed at people living with HIV found that many respondents believe HIV-positive people do not have the right to work (42% of law enforcement officers and officials, 29% of teachers, 23% of judges and lawyers, 20% of *Hukumats* members (local executive authority)). In addition, 77% of respondents stated that people living with HIV do not have the right to work in the service sector. Moreover, one-third of respondents felt that a person could be fired because of their HIV-positive status, and about one-half of respondents stated that children living with HIV should not study in regular secondary schools (UNDP 2018).

In addition, the European Court for Human Rights has defined the deportation of people with life-threatening diseases as “inhumane or humiliating and a form of punishment, particularly when deported to a location where treatment is unavailable” (IAS 2007).

Decriminalizing HIV-positive migrants would also educate two groups of people: the older generation who still consider HIV a deadly disease, and the younger generation who know little about HIV.

Moreover, the entry ban on HIV-positive people violates their freedom of movement, their right to privacy and their freedom from discrimination (Ordover 2010) in the following ways:

- Freedom of movement refers to detaining or restricting the movement of persons solely because of their HIV status.
- The right to privacy refers to disclosing the results of a mandatory HIV test to various immigration officials and declaring (through a refusal to grant stamps in passports) the HIV status of travelers to border guards, family members, fellow travelers, employers and other authorities requiring state identification, and also violates the principles of medical confidentiality.
- The freedom from discrimination excludes HIV-positive people without legal grounds. The UN Declaration on Universal Human Rights states that restricting movements or one's choice of residence based on their HIV status is discriminatory and unjustified based on public health reasons (Ordover 2010).

Dynamics of modifying regulations in relation to HIV-positive migrants in recent years

According to Article 9 of Federal Law №230 dated 18 October 2007 from the preamble of Federal Law № 38-FZ dated 30 March 30 1995 "On the prevention of the dissemination of the disease caused by the human immunodeficiency virus (HIV) in the Russian Federation", the phrase "remains incurable and leads to inevitable death" was amended to describe HIV as "chronic" (FZ-38). This is consistent with international evidence and understanding that HIV is now considered a chronic and manageable disease (Chan 2017).

In December 2015, the Constitutional Court of the Russian Federation allowed foreigners living with HIV to remain in Russia or to enter it, provided that their parents, children, or spouses were Russian citizens or permanently resided in Russia (Forum 2016).

In February 2017, Russian Deputy Prime Minister Olga Golodets instructed the Ministry of Health, the Ministry of Internal Affairs, and *Rospotrebnadzor* to consider modifying the conditions for entry and the residence of foreign citizens living with HIV in the Russian Federation (Mishina 2017b).

In June 2017, the Constitutional Court of the Russian Federation stated that the inability of people with HIV or hepatitis C to adopt a child, who, due to family circumstances, already lives with them, contradicts the Constitution of the Russian Federation (Selezneva 2017).

The final statement of the VI International Conference on HIV in Eastern Europe and Central Asia, held in Moscow in April 2018, contains the following objective: “to promote access of migrant workers to programs on the prevention, diagnosis and treatment of HIV and related diseases through the development of transnational cooperation and improving legal mechanisms in all countries in the region” (EECAAC 2018).

Examples of the decriminalization of entry among HIV-positive migrants

In 2001, the UN General Assembly on HIV/AIDS adopted the following declaration: “By 2003, we pledge to submit, approve and enact appropriate laws and other measures aimed at eliminating any form of discrimination to which people living with HIV and other vulnerable groups are subject to, and to ensure that they have full access to all fundamental rights and freedoms” (IAS 2007).

According to the global database on HIV-related travel restrictions, the following eight countries have entry bans for HIV-positive people: Brunei, Equatorial Guinea, Iran, Iraq, Jordan, the Solomon Islands, the United Arab Emirates (UAE) and Yemen. Russia is also included in this list, although the directory notes that only those foreigners who intend to remain in the country for more than three months must provide a medical certificate of an HIV-negative status. However, if a foreigner is found to be HIV positive, s/he must leave the country within three months (Deutsche AIDS-Hilfe 2010). Restrictions on short-term (up to 90 days) and long-term (more than 90 days) stays in addition to those mentioned above exist in several other countries. As of 2008, “about 63 countries, territories and regions ban the entry, stay and residence of HIV-positive people only on the basis of their HIV status” (IAS 2007).

In March 2016, the European Court for Human Rights stated that Russia is the only country in the Council of Europe and one of 16 countries

globally that deports HIV-positive foreigners. In Strasbourg, the necessity of completely eliminating discrimination towards HIV-positive people in Russia was stressed (Mishina 2017b).

In fact, several countries have decriminalized the entry of migrants living with HIV since 2004. Specifically, El Salvador passed such a law in 2004, and Bolivia followed suit in 2006 (Deutsche AIDS-Hilfe 2010). In 2009, the Czech Republic announced mandatory HIV testing for people from a number of countries (mainly, from African and Asian countries), although this initiative was terminated following numerous HIV community protests across Europe. The US and South Korea decriminalized migrants living with HIV in early 2010 (Hasenbush & Bianca 2016, Lederer 2010) after removing HIV from the list of “infectious diseases of public health significance”. In March 2010, Bulgaria followed these examples (Deutsche AIDS-Hilfe 2010), and, in April, China joined this initiative (UNAIDS 2010). Subsequently, Armenia (UNAIDS 2011) and Ukraine (MOH 2015) joined the list of countries removing travel restrictions to HIV-positive individuals.

In 2010, United States President Barack Obama, announcing an historic policy change, stated: “Twenty-two years ago, a decision was taken, rooted in fear rather than fact, by the United States to impose a prohibition to enter the country for people living with HIV. Now, we are talking about reducing the stigma of this disease, still continuing to treat guests with this disease as if they are bringing a threat. We are leading the world when it comes to responding to the AIDS pandemic; however, we are one of only a dozen countries that still do not allow people with HIV to enter the country. If we want to be a global leader in the response to HIV, we must lift this ban. Therefore, on Monday (November 2), my administration will publish a final regulation that eliminates the travel ban, which comes into effect immediately after the New Year...” (Price 2010).

The decriminalization of migrants living with HIV, together with other measures, resulted in a reduction in the incidence of HIV in most of these countries, except in Bulgaria, where an increase occurred, which is now much lower than it was in 2010 (UNAIDS 2017).

Conclusions

Rather than ensuring health security for Russian citizens, the deportation of migrants living with HIV carries the opposite effect: migrants fall out of reach of the legal field given their fear of being deported, they do not apply for medications and medical services and they enjoy limited access to the therapy they need, all of which result in increased risks of further transmitting HIV. Thus, advocacy aimed at decriminalizing HIV-positive migrants from entering or living in Russia is becoming quite urgent. Furthermore, such legislative changes have taken place in many countries, including the United States and China. People living with HIV face multiple issues: delayed access to medications, insufficient awareness (regarding their rights, HIV transmission routes and HIV prevention), face discrimination and receive limited social support. Simultaneously, all of these problems become even more acute for migrants given problems related to integration in the host society. Migrants represent a key population at risk for HIV, alongside people who inject drugs, sex workers and men who have sex with men. Migrants belonging to one of these other key populations face another set of complex problems. The fear of arrest and deportation restricts access to medical care, leads to a deteriorating health condition and increases stress. This also deprives them of access to reliable information about HIV prevention and treatment and increases the risk of HIV transmission to other people, including Russian citizens. Thus, decriminalizing migrants living with HIV will prevent them from becoming a hidden population and going underground and likely diminish the risk of the further spread of HIV.

Decriminalizing HIV-positive migrants should be followed by other steps, all aimed at providing antiretroviral therapy to foreigners living with HIV, including undocumented migrants. If we hope to control the HIV situation within Russia, we must not exclude anyone from accessing the care and services they need. This is crucial, since the decriminalization of migrants living with HIV primarily addresses issues surrounding those planning to come to Russia or those who wish to remain in Russia legally. There are also people who already exist “underground”, since they cannot obtain a *patent* or were refused a temporary residence permit, a permanent residence permit or citizenship because of their HIV-positive status. Yet, they decided to remain in Russia (fearing being unable to enter Russia again). Migrants who violate regulations regarding their stay in Russia can

be fined and deported (FZ-38). Therefore, we must consider how to legally resolve this situation for such migrants.

Furthermore, policymakers and service providers must also consider how to ensure coordination of HIV prevention, the decriminalization of migrants living with HIV and the provision of the necessary treatment at the transnational level together with the scientific community and nongovernmental organizations. However, despite the important role of diasporas and religious organizations in providing support and integration, their knowledge of HIV and their attitudes towards people living with HIV have changed little since the adoption of laws restricting the movement of migrants living with HIV (Ivashchenko 2018b). In this regard, sexual education is very much needed.

It is also important that all of the primary countries of origin for migrant workers, such as Kyrgyzstan, Moldova, Tajikistan, Ukraine and Tajikistan, provide their citizens with antiretroviral therapy when they leave their home countries for extended periods of time. By doing so, this ensures that Russia will not absorb the additional expense associated with removing regulations on the deportation of HIV-positive migrants.

The future requires sustainable solutions aimed at ensuring migrants have access to HIV-related services. Creating an international fund or cross-country settlement mechanism might assist in related decisions. Any such solutions should consider the existing effective system of therapy and medications delivery (for a protracted period of three to six months) within the CIS countries, particularly those supplying migrants.

Accordingly, the humanitarian prerequisites and legal considerations related to the freedom of movement and privacy, as well as the freedom from discrimination following the decriminalization of HIV-positive migrants accompany significant economic benefits. Ensuring access to HIV prevention and treatment services among migrants in the destination country will similarly improve the quality of life of migrants and the public health situation in general.

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Annex 1. Narratives from people facing restrictions to their private life due to current regulations on the deportation of HIV-positive foreigners

Below, we present ten narratives from migrants originating from various countries who are currently living with HIV in Russia. The full names of these individuals have not been provided in order to protect their identity and preserve their medical confidentiality and anonymity.

1. A., 31-year-old man from Uzbekistan

A. arrived in Russia two years ago. A year later, he was diagnosed as HIV positive.

He has undergone testing at the Fund to Fight AIDS (when possible, to determine his CD4 count). Blood testing for biochemistry and indicators necessary for receiving antiretroviral therapy are carried out fraudulently in city clinics. For instance, using someone else's personal information (e.g., passport, medical insurance information, etc.), friends and acquaintances will sign up for blood testing. Otherwise, he attends clinics where he can be examined anonymously for a fee.

For some time, A. has felt so poorly that he could not walk, eat and satisfy his own physiological needs (such as using the toilet, etc). But he did not visit a medical institution and or call a physician because he feared disclosure of his HIV status and further deportation.

Resulting from stress, A. suffers from a bipolar disorder, strongly fearing others will discover his HIV status and begin avoiding him. A's condition is deteriorating, such that his CD4 count has fallen to 247, 150 less than two months ago.

He obtains antiretroviral therapy through acquaintances who share their stocks or from organizations that can provide a small amount of medication. The remainder he purchases independently, costing approximately ₺3500 each month.

A. fears deportation. Treatment for HIV-positive people in his home country remains less than optimal. According to A., “If they find out about your [HIV positive] status, they immediately lock you in the hospital”. The police will visit you and have a “conversation”. He believes that treatment for HIV in his home country does not exist or is of a very poor quality. Quickly, information about a patient’s HIV status will reach their relatives, who may avoid him, viewing an HIV-positive relative as an outcast. The HIV-positive person experiences severe discrimination and is afraid to leave their house.

A. says that conditions are better in Russia than in his home country. He does not wish to return and receive treatment in his home country even if conditions improved.

After learning that he was HIV positive, A. contacted law enforcement agencies and the migration service in order to receive antiretroviral therapy in the Russian Federation, but he received no response nor the opportunity to access quality medical care.

2. I., 27-year-old man from Tajikistan

I. arrived in Russia about six years ago, and he does not speak Russian well. He learned about his HIV status six months ago during outreach work carried out by the “Steps Foundation”, when employees conducted rapid testing.

After confirming the diagnosis, he sought help from a private medical organization and a charitable foundation. He feared contacting government agencies, because he believes that after detecting his HIV status, he will be immediately sent home, and his status would be reported to relatives and friends, causing multiple problems for him potentially resulting in his family rejecting him. He is certain that state institutions would be unable to provide him with assistance similar to that provided by nongovernmental organizations.

I. receives free antiretroviral therapy from a for-profit medical facility under the constant supervision of a physician. Testing for his viral load and CD4 count is carried out on a for-fee basis. On average, these cost ₺4000 to ₺5000 per month.

He fears deportation from Russia and being unable to return. I. feels more comfortable and freer in Russia. He plans to return home only for a short visit (to see his family and friends), but does not wish to permanently return to Tajikistan, since he does not believe he will gain access to appropriate HIV-related assistance.

I. feels that people living with HIV, including himself, should be able to move freely between countries without experiencing problems associated with their HIV status. HIV-positive people should be able to access treatment regardless of their citizenship and remain legally within the state territory. He wants to work in Russia officially, but does not have that opportunity yet. He is certain that HIV tests are necessary but feels that one's HIV status should not justify deportation from the country.

3. K., 34-year-old man from Turkmenistan

K. arrived in Russia eight years ago to study at the university and graduated in 2018. In 2014, K. was diagnosed as HIV positive.

K. did not receive treatment for several years, and as a result, his condition became quite critical. He showed signs of Kaposi's sarcoma and was diagnosed with multiple opportunistic infections. When being treated for syphilis, his physicians contacted the "Steps Foundation", requesting HIV-related assistance.

K. undergoes free and anonymous testing in the nongovernmental organization, and rarely, when possible, via public institutions through an organization. He receives antiretroviral therapy from a "reserve first-aid kit", and his friends sometimes help using "their personal supplies". Quite often, he must buy the necessary medications himself, which cost on average about ₺2500 each month.

K. fears deportation following disclosure of HIV status. He understands that he will be unable to access the necessary medical treatment in his home country. He already applied to the local AIDS center, which told him that he is not HIV positive. According to K., no activities are carried out to prevent or treat HIV in Turkmenistan, such that Turkmen doctors

know nothing about the disease. Furthermore, it is impossible to obtain antiretroviral therapy in Turkmenistan.

He has not contacted state services, since he understands that he may be immediately deported from Russia without notifying anyone and without his personal belongings. He strongly fears leaving his house during city events. For example, during the World Cup, he remained in his apartment for several days, fearing detention. Similarly, he rarely uses public transportation.

K. would not mind returning home and being close to his family. But he understands that, once he leaves, he will be unable to return to Russia and unable to receive therapy and the medical care he needs. He would like to work in his chosen field, but a certificate stating the absence of HIV is required. Furthermore, in his home country, he will not receive the treatment he needs.

4. G., 46-year-old man from Abkhazia

G. arrived in Russia in 1991. In 2000 in St. Petersburg, he was diagnosed as HIV-positive.

For 16 years, G. did not apply for any assistance from anywhere. When his health significantly deteriorated, he turned to “Civil Assistance”, a refugee assistance nongovernmental organization, which redirected to him to the organization “Center Plus”, where he continues being observed. He initiated antiretroviral therapy in 2016.

G. does not receive medical care. He buys his antiretroviral medications from third parties, relying on assistance from others whenever possible. He undergoes testing exclusively through a nongovernmental organization and spends about ₸8000 each month on treatment and testing.

He fears deportation, does not seek medical assistance and avoids encounters with the police.

Returning home is not an option for G., because there is nowhere to go. According to G., Georgian citizens who lived in Abkhazia were automatically evicted from their homes during the conflict in North Ossetia.

G. believes that obtaining Russian citizenship would be beneficial, along with the possibility of refugees receiving treatment. He works illegally since he does not possess residence or travel documents. He thinks those living with HIV should be offered refugee status.

5. B., 30-year-old man from Kazakhstan

B. arrived in Russia three years ago, partially due to nationalism among the indigenous population of Kazakhstan. Since B.'s parents were Russian, he decided to move to Russia.

He was diagnosed as HIV positive one year ago. Since his CD4 count was below normal, he immediately initiated antiretroviral therapy.

B. receives medical care and undergoes the necessary testing through a nongovernmental organization (the "Steps Foundation"). He buys antiretroviral therapy at his own expense, normally spending around ₰4000 each month for his medication. Whenever possible, he gets them from friends or receives them through the foundation from the "reserve first-aid kit".

B. does not plan to return to Kazakhstan, since he was pressured by the Kazakh population. In addition, he feels certain that high-quality HIV-related assistance remains unavailable there. According to B., treatment for HIV in Russia is more convenient and better than in Kazakhstan, since they have not reached the same level of the response to HIV as in Russia.

B. fears deportation from Russia. Thus, he avoids medical examinations including HIV tests. He wants to live in Russia officially.

He believes that discrimination against HIV-positive migrants could be decreased in Russia by raising awareness among employers and the general population about HIV. Namely, communicating that being HIV positive is not a death sentence to fear and a person should not be immediately expelled from the country because of their diagnosis. HIV is a chronic disease with which one can safely live.

6. L., 36-year-old woman from Georgia

L. arrived in Russia 20 years ago to care for her brother, a person with a disability. Later, L. assumed guardianship over her brother's son, her nephew, since his father's location was unknown at that time. She was diagnosed as HIV-positive eight years ago.

After learning her status, she did not apply to state institutions for treatment, since she was busy raising her adopted son. Initially, she tried to take him from an orphanage; and then, she sorted a package of guardianship documents. And then, she helped her relatives.

When L.'s vision changed drastically and her health deteriorated, she sought assistance. A few months ago, with help from a social worker from the "Steps Foundation", she gained access to medical and social support, confirmed the HIV-positive diagnosis and underwent CD4 count testing. As a result, L. received her first treatment for HIV at a private clinic, the cost of which was covered by an existing nongovernmental organization program. In the future, she plans to receive therapy and undergo testing at a private clinic, but to also use the organization's "reserve first-aid kit".

L. had not previously considered the possibility of being deported from the country. Returning home is not an option for L., since her family (i.e., her adopted child) and relatives are in Russia. No one remains in Georgia.

She believes that a tolerant attitude among the people around her would help her live with her HIV-positive diagnosis. According to L., "I would like to see greater transparency related to HIV, interact with more groups and communities of people living with HIV and see them share their status without fear." Her primary concern relates to potentially losing her child after deportation, and his subsequent placement in an orphanage.

7. N., 29-year-old man from Tajikistan

N. moved to Russia 10 years ago because he was not satisfied with his life. He could not move freely; he was pressured by his family and was only allowed to leave home only once a week. As a result, N. bought a one-way ticket to Russia.

He first underwent an HIV test in a hospital a year and a half ago, upon which he was diagnosed as HIV positive. Subsequently, he turned to a familiar activist who sent him to a charity organization responding to the HIV epidemic. He is still in contact with the organization, sometimes seeking medication and immune status testing through it.

He accesses antiretroviral therapy primarily free of charge from “reserve first-aid kits” and from a private clinic, where he undergoes medical examinations and testing (free of charge and on for-fee basis).

In Russia, he has a wife. However, he cannot receive a Russian passport due to mistakes made by state officials in his documents. N. appealed to the courts but did not complete his case. All appeals to state services have led nowhere. Given various discrepancies in his documents, N. has been detained by the police several times.

Currently, he is experiencing difficulties moving around the city. He fears using public transportation and walking around the city with friends. He is constantly anxious, fearing being stopped by the police, who may detain him, not allow him to contact his wife and deport him from the country. He does not intend to return home because there is no freedom of movement in Tajikistan.

He hopes for a better future with his wife, with the possibility of obtaining Russian citizenship and being able to access the medical care he needs and secure official employment.

N.’s primary problem associated with living with HIV in Russia relates to continually searching for medication. “Reserve first-aid kits” are a great help, since N. does not have a permanent job and saving money for medication is rather difficult. Another distressing issue relates to the mistakes by the migration service impeding his ability to obtain citizenship even with a Russian wife.

8. S., 31-year-old man from Tajikistan

S. came to Russia from Tajikistan three years ago. He was diagnosed as HIV-positive in 2017 during anonymous rapid testing for HIV.

Fearing deportation from Russia, S. did not apply for medical assistance from the AIDS center or state institutions, so he is not receiving any medical care and treatment.

S. is afraid of deportation. He remains in Russia illegally. Because he is HIV-positive (which he acquired in the Russian Federation), he cannot renew his work permit. One of his friends was deported from Russia because of their HIV-positive status.

S. is a drug user who uses psychostimulants.

In Russia, S. has a permanent job in road construction, which allows him to support his family at home. S. does not think about returning home in the near future. His work permit expired long ago. If this is revealed, he will be unable to return to Russia for three years following deportation.

S. believes that obtaining citizenship would help him to live with his HIV diagnosis.

9. Z., 27-year-old woman from Uzbekistan

Z. arrived in Russia six years ago. She tested positive for HIV following a blood test at an AIDS center 14 days ago. According to Z., "I just recently found out about my status. I came to an organization assisting sex workers and had a rapid saliva test, which was positive. Therefore, a worker from the center accompanied me to another organization to have a blood test."

Z. has provided sexual services for 4.5 years. She says she always uses condoms, but sometimes they break. After learning her HIV status, she revealed that she used to provide her services without a condom for an additional fee of ₺500. Z.'s main clients were migrants from Central Asia. She was absolutely certain that she would not become infected despite engaging in unprotected sex. She knew nothing about HIV and the routes of HIV transmission.

Since Z. is in Russia illegally, she does not receive antiretroviral therapy as do citizens of the country. She plans to undergo the necessary tests,

and then to purchase antiretroviral medications. She believes that these medications will cost her an average of ₺3000 to ₺5000 per month, while testing every three months will cost her another ₺10 000 to ₺12 000.

She fears returning to her home country. First, she fears her family's reaction. According to Z., her family will most likely reject her. She is unaware of any state services in her home country and does not have high expectations for them. According to Z., there were discussions about sterilizing HIV-positive women in Uzbekistan. She does not plan to return home soon—no jobs exist there, and she would be unable to hide her HIV status.

Currently, Z. is attempting to accept her HIV-positive status. She thinks that living with HIV in Russia would be easier for her, even if she does so illegally, since here she can hide her status and can continue to live and work, purchasing antiretroviral therapy.

10. V., 28-year-old man from Vietnam

V. arrived in Russia from Vietnam in 2013 to study at Moscow University of Electronics. Each year, the Vietnamese government sends talented students to study abroad. V. was among the students sent to Moscow to study. Currently, he is a graduate student in the Faculty of Mathematics and Programming.

Two months ago, V. learned that he is HIV-positive after undergoing HIV testing in a private clinic. Currently, he is not receiving therapy or treatment, since he has not undergone all of the necessary medical examinations.

Upon receiving the results of his HIV test, he went to a clinic, but did not take further action since the clinic staff did not explain what he should do next. Through his Moscow friends, he found a nongovernmental organization that deals with HIV-related issues and asked for assistance. There, he completed an immune status test, which determined that his CD4 count was 445, a below-normal result. Specialists in the organization learned that at the age of 28, V was unaware of condom use (he has never used one), but that he has a permanent partner, a Russian woman. In the near future, together with a social worker, he will visit an infectious

disease specialist for a consultation about further necessary actions (possible initiation of therapy).

V. planned to return home after graduation but realizes that now he will not be able to work in his profession, since in Vietnam entering the civil service requires undergoing examinations for infectious diseases. He will not be allowed to work if his HIV status is revealed. Thus, V. will most likely take a lower status job. He now hopes to remain in Russia and work in the field in which he is trained.

V. understands that HIV can affect his standing within the graduate school. He fears that his student visa will not be renewed because of his HIV status. He is also quite anxious about the medical examination at the university and has no idea how to avoid it without breaking the law.

Additionally, he is concerned about possible deportation due to his HIV status. He worries about arriving home, fearing rejection from his parents, since an HIV-positive person is considered "dirty" in Vietnam. Furthermore, he is quite distressed by the fact that the state opens a special file on HIV-positive persons, thereby creating numerous additional problems.

V. sincerely hopes that foreigners living with HIV will receive access to assistance and care in Russia.