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'In Short, We Will Deport You': Disrupted temporalities of migrants with HIV in Russia

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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 mobilise heath-seeking behaviour among migrants. Therefore, such legislation has to be amended to encourage international migrants living with HIV to access adequate HIV services.

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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 (EECA) 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 stigmatisation and marginalisation of vulnerable groups, and the absence of evidence-based prevention and treatment policies and programs needed for controlling the spread of HIV (Cohen, 2010; Meylakhs et al.,2017; Pape, 2018). Limited access to antiretroviral therapy has also magnified the spread of HIV in the EECA region, including the migrant population (Agadjanian & Zotova, 2019; Kashnitsky, 2020; Weine & Kashuba, 2012).

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 (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 the criminalisation of key populations and the failure of the Russian government to adopt evidence-based measures to prevent the spread of the virus

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among vulnerable groups across EECA (Altice et al., 2016; Burki, 2015; Clark, 2016; Kashnitsky, 2020).

Russia is usually the destination of labour migration within the region. A significant majority of labour 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 labour 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 realise strategic life goals, for example, build houses, support the education of children (Malakhov et al., 2015; Peshkova, 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 labour 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 (Ghimire et al., 2011; Kashnitsky, 2020). Many undocumented migrants with HIV seek medical care; however, the arrangements are usually unstable (Agadjanian & Zotova, 2019; Demintseva & Kashnitsky, 2016) 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 (Latypov et al., 2013; Luo et al., 2012).

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 labour 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

labour 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 (Degenhardt et al., 2017; El-Bassel et al., 2013). 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 labour 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, 2018; UNAIDS, 2020). Moreover, these multiple social inequalities that characterise the life of migrants are intersectional and result in multiple dimensions of marginalisation that include migrants' ethnicity, class and gender (Kuran et al., 2020). Female migrants are particularly marginalised 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 legalised 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 stigmatising 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 conceptualise 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 behaviours.

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. The latter group of returned migrants left Russia not later than one year before the interview. It is important to note that the migrants who were recruited for the study were in one way or another in touch with some type of HIV care organisations which leaves a potential group of migrants who learned about their HIV-positive status but who never approached any care provider. This is potentially 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. 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.

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 labour migration from EECA (Demintseva & Kashnitsky, 2016; Mukomel, 2013; Zayonchkovskaya, 2009). 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 min 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 realise 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.

Both authors had extensive experience of migration at several phases of their lives. Apart from their academic work they are engaged in civil society activism in the healthcare sectors which allowed them to create trust with HIV-service NGOs and doctors in Russia and several sending countries. 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 authors read and analysed the transcripts of the interviews several times to identify themes and to conceptualise 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 anonymised selected quotes. Transcripts of the interviews were anonymised 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 organisation. 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 (Table 1).

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.

Table 1. Table of participants: interviewed migrants with HIV.

	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

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

Labour 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 labour migrants from the former Soviet Union. Some migrants aim to become students in Russia to further capitalise 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 jeopardise 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.

None 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 don't 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-stigmatising 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 hinder 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 stigmatise 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 realise 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?

Labour 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 labour 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 labour 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 et al., 2017). These three interlinked temporalities help us structure migrants' experiences and provide a lens to analyse 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 labour migrant in Russia. Primarily, HIV disrupts the labour migration cycle of migrants with HIV because they must leave the country or stay undocumented. HIV interferes with the plans to get legalised 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 of being 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 and Christoffersen, 2008).

Secondly, most labour 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 their 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 labour; 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 (Dave, 2014; Reeves, 2015). The state, rather than deporting international labour 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 policy-makers 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 & Vorona, 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 (Kashnitsky, 2020; King et al., 2019; Pokrovskaya et al., 2019), 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 labour 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 organisations 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 prioritise 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 (Pokrovskaya et al., 2019; UNAIDS, 2016) 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 realised 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.

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