



CHALLENGES OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND HIV SERVICES FOR INTERNAL MIGRANTS IN CENTRAL ASIAN COUNTRIES AND INTERNATIONAL MIGRANTS FROM CENTRAL ASIAN COUNTRIES IN THE RUSSIAN FEDERATION, KAZAKHSTAN, AND TURKEY DURING THE COVID-19 PANDEMIC

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Abstract

Challenges of access to sexual and reproductive health and HIV services for internal migrants in Central Asian countries and international migrants from Central Asian countries in the Russian Federation, Kazakhstan, and Turkey during the COVID-19 pandemic

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This paper presents and discusses the findings of a desk review on the state of migration and sexual and reproductive health (SRH) of the populations in migrant-sending countries, including Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. In addition, it considers the qualitative data on the access of Central Asian internal and external migrants to antenatal and perinatal care, family planning services, and contraception, including condoms, safe abortion (legal in all countries under consideration), treatment of sexually transmitted infections, and HIV infection prevention, diagnosis and treatment based on in-depth interviews with experts mobilized both in origin and destination countries. Case studies of relevant migrants' life situations are depicted. Evidence shows that access by migrants to SRH and HIV-related services is constrained compared to the permanent population. Generally, the public health services are inaccessible, unacceptable, and unaffordable to mobile populations, which, in addition, have a low awareness of opportunities to receive them and underestimate their significance.

In the era of the COVID-19 pandemic, the access of migrants to SRH care has become even worse, as they are still legally considered outsiders by all public health systems, while a significant decrease in their quality of life makes it unaffordable to seek private health care for almost all of them. The COVID-19 pandemic has become a significant impediment to developing and implementing programs aimed at improving access to HIV-related services for migrants under the recommendations of the Technical Workshop on HIV and Migration in Central Asia and the Russian Federation, conducted with the support of the United Nations Population Fund in Astana, Kazakhstan in February 2018.

The enrolment of most migrants from Central Asian countries into public SRH care and HIV services is either not ensured almost at all in any of the three host countries or provided to a limited extent in the Russian Federation for migrants from EAEU member countries. As a whole, migrants have low levels of legal entitlements to public health services. Policies of healthcare funding and budget discipline requirements in migrants receiving countries make the procurements of medicines and contraceptives, including condoms and lubricants in the numbers sufficient to meet the needs of the underserved populations impossible and distributing of health products among anonymous consumers with irregular migrants among them not legal. Other specific barriers to accessing

essential SRH services and products for migrants include linking health care to a residence permit and registration; xenophobia, stigma, and dual discrimination against key populations at higher risk of HIV acquisition and transmission; the requirement to deport migrants with HIV from Russia; overpricing of essential services, medicines, and preventive measures; a lack of migrants' awareness of rights to SRH care, including HIV-related services, at all stages of migration; and a lack of involvement and cooperation with migrant communities in addressing emerging issues.

The needs of internal migrants, who comprise a significant proportion of the present urban population in Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan, as well as international migrants coming from the Central Asian countries to the host countries of Russia, Kazakhstan, and Turkey, cannot be ignored in developing policies and strategies to achieve the Sustainable Development Goals. However, these populations, who are intrinsically vulnerable to SRH disorders and HIV transmission and acquisition, are still left behind.

Disclaimer

The opinions expressed in this publication are those of the authors and do not necessarily reflect the views or policies of the United Nations Population Fund, the International Organization for Migration and Joint United Nations Programme on HIV/AIDS. Errors and omissions excepted.

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1. FOREWORD

In September 2015, world leaders agreed on the Sustainable Development Goals (SDGs) in order to make the world free from poverty, hunger and disease by 2030. SDG 3, Good Health and Well-being, aims to ensure healthy lives and promote well-being for all at all ages. Several targets are set to achieve this goal. Target 3.1 aims to reduce maternal mortality; Target 3.3 leads to ending the AIDS epidemic; Target 3.7 is to ensure universal access to sexual and reproductive health (SRH) care services, including family planning, information and education, and integrating reproductive health into national strategies

(universal access is described as the absence of any geographic, financial, organizational, sociocultural, and gender-based barriers to care); Target 3.8 is to achieve universal health coverage (UHC). The World Health Organization (WHO) defines UHC as ensuring that everyone has access to quality health care, including access to health services and safe, effective, and high quality and affordable essential medicines and vaccines. Although SDG 3 aims to protect all people, the commitment of most countries to universal health coverage paradoxically cannot address some vulnerable groups, in particular migrants.



WHO considers the status of a migrant as a health risk factor, whose impact may depend on the type of migration, the migrants' living conditions and the stressful situations they inevitably face, as well as the provision of health care at places of their origin, transit and destination.¹ The UN 2030 Agenda "Leave no one behind" encourages governments to integrate migrant health needs into national plans, policies and strategies in all sectors.

The Russian Federation and Kazakhstan, emerged after the collapse of the Soviet Union in 1991, as larger economies with upper-middle gross national

¹ Sixty-sixth Regional Committee for Europe: Copenhagen, 12–15 September 2016: strategy and action plan for refugee and migrant health in the WHO European Region <https://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2016/strategy-and-action-plan-for-refugee-and-migrant-health-in-the-who-european-region>

income (GNI) per capita and wages much higher than in Kyrgyzstan, Tajikistan and Uzbekistan, became destinations for labour migrants from the above countries and, to a lesser extent, from Turkmenistan. Labour migration of Turkmen nationals mainly moves to Turkey, which is the only country in the region where they do not need a visa to enter, while the Turkmen and Turkish languages are mutually understandable. Besides international migration, internal migration in Central Asian countries has also progressed. Unemployment and low incomes in rural areas and small towns led to a redistribution of the labour force, with migrants moving to big cities.

International and internal migrants, among others, include people living with human immunodeficiency virus (PLHIV) and members of key populations: men who have sex with men (MSM), sex workers (SW), and people who inject drugs (PWID). In all Central Asian countries, HIV infection is concentrated in key populations and their sexual partners. Addressing the needs of these migrant groups in HIV services and working with their communities is crucial for an effective response to the HIV epidemic² that has claimed around 37.7 million human lives globally³. According to UNAIDS, key populations globally account for about half of new HIV infections. MSM were 22 times more likely to be infected with HIV in 2018 than all adult men; PWID were 22 times more likely to be infected with HIV than people who do not inject drugs; and SW were 21 times more likely to be infected with HIV than women aged 15–49 in the general population⁴.

On 19-20 February 2018, the United Nations Population Fund (UNFPA), in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and with support from the Government of the Kingdom of the Netherlands, organized a technical workshop on HIV and migration in Central Asia and the Russian Federation in the city of Astana (now Nur-Sultan), Kazakhstan. The workshop resulted in the dialogue between rights-holders and duty-bearers on how to bring national legislation and policies related to the HIV epidemic among migrants in line with international standards and best practices, with specific recommendations⁵ aimed at ensuring equal access to quality prevention, testing, treatment and care services for migrants. The participants expressed their commitment to strive to implement these recommendations.

The COVID-19 pandemic has raised stakeholders' concerns about the fulfilment of these commitments. Everywhere the public health resources have been refocused on responding to the COVID-19 pandemic that has caused a global crisis. Meanwhile, the HIV epidemic in Eastern Europe and Central Asia is growing and its primary driving force has shifted from illicit drugs injecting to

² Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, World Health Organization, 2016

<https://www.who.int/publications/i/item/9789241511124>

³ <https://www.unaids.org/en/resources/fact-sheet>

⁴ https://www.unaids.org/en/resources/presscentre/featurestories/2019/november/20191105_key-populations#:~:text=Key%20populations%20make%20up%20a,was%20among%20all%20adult%20men

⁵ HIV and migration in Central Asia and the Russian Federation. Report of the Technical Workshop 19-20 February 2018, Astana, Kazakhstan https://kazakhstan.unfpa.org/sites/default/files/pub-pdf/HIV%20REPORT_ENG_FIN.pdf

sexual transmission. Therefore, the quality of SRH services increasingly determines the pace of the HIV epidemic, which remains one of the critical public health concerns. Sexual transmission of HIV is directly linked to the use of condoms and lubricants, as well as prompt diagnosis and treatment of sexually transmitted infections (STIs) that increase people's susceptibility to HIV transmission. The success of eliminating mother-to-child transmission of HIV depends on family planning and antenatal care, of which diagnosis of HIV infection and prescription of antiretroviral treatment are part of the clinical protocol.

The effects of quarantine restrictions have compounded challenges in ensuring adequate responses to HIV, universal access to SRH services, and UHC due to resource constraints. Lockdowns and closures of national and administrative borders bring businesses to a standstill and disrupt supply chains. Imports of essential SRH commodities, including antiretroviral (ARV) drugs for treating and preventing HIV infection, condoms, lubricants, as well as hormonal contraception, intrauterine contraceptives, lifesaving drugs used to save mothers and new-born babies, etc. have declined.

To ensure that the impact of the COVID-19 pandemic does not reverse recent gains in access to SRH services and commodities for specific populations, the need to further expand access to these services and commodities to include migrants may be ignored.

The International Organization for Migration (IOM) draws attention to the fact that migrants can be highly vulnerable to COVID-19 because of their socio-economic status, including lack of funds to purchase face masks, medical respirators, and disinfectants; living in crowded spaces, limited rights and access to health services, vaccines and medicines at their destination, language barriers making it difficult to obtain information on prevention of infection, and the associated stigmatization. Migrants with irregular status who are afraid of seeking health care may face a drastic situation, especially when there is no “firewall” on data exchange between health, migration and law enforcement authorities.⁶

The COVID-19 pandemic has a direct negative impact on maternal health, while the share of women of reproductive age among migrants is quite significant. In 2015, about 31% of labour migrants registered in the Russian Federation were women from Kyrgyzstan, 13% from Tajikistan and 10% from Uzbekistan.⁷ Based on systematic reviews and cohort studies, pregnancy and recent pregnancy are recognised as conditions associated with an increased risk of severe COVID-19 that requires hospitalisation, intensive care, and artificial lung ventilation, which otherwise becomes fatal. Pregnant women with COVID-19 are also more likely to give premature births (before 37 weeks of gestation) and spontaneous abortions.⁸ Therefore, the COVID-19 pandemic highlights the importance of

⁶ Migration Factsheet No. 6 – The impact of COVID-19 on migrants
https://www.iom.int/sites/g/files/tmzbd1486/files/our_work/ICP/MPR/migration_factsheet_6_covid-19_and_migrants.pdf

⁷ Bouma G., Marnie S. COVID-19 and Central Asia: Socio-economic impacts and key policy considerations for recovery, UNDP, 2020

⁸ <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/underlying-evidence-table.html>

providing migrant women with access to relevant information, means of protection and specific prophylaxis, such as vaccination.

Moreover, the WHO report of July 2021 confirms that HIV infection is a significant independent risk factor for both severe course of COVID-19 and in-hospital death rate. The report based on clinical surveillance data from 37 countries showed that nearly a quarter (23.1%) of all people living with HIV, who were hospitalized with COVID-19, died.⁹ Therefore, ensuring that the migrants with HIV have access to health care, including uninterrupted ARV therapy, overcoming stigma and discrimination, poses an even greater challenge during the COVID-19 pandemic.

Meanwhile, the access to SRH and HIV services and commodities may decline during the pandemic. According to the UN Economic and Social Commission for Asia and the Pacific, 75% of Central Asian migrants were left without income¹⁰ at the peak of the pandemic in 2020, and could hardly afford quality medical care. This is particularly true of irregular migrants. The UN policy brief highlights the impact of the COVID-19 pandemic on women, who are more likely than men to undertake temporary work without formal employment contracts (this is particularly true of migrant women) and to lose their jobs and livelihoods. Women's increasing economic dependency, the stress caused by loss of income and social deprivation can also lead to an increase in domestic violence while many women are being forced to 'lockdown' at home with their abusers at the same time that services to support survivors are being disrupted or made inaccessible.¹¹

Despite the importance and relevance of knowledge about access to SRH services, including HIV services, for international migrants from Central Asia and internal migrants in Central Asia, there has been little data available on this. Indicators of how the system offering SRH services works and how migrants get and use these services have been measured neither during the COVID-19 pandemic nor before. Data on unintended pregnancies, SRH disorders, including HIV and sexually transmitted infections (STIs) prevalence among migrants are also lacking, except for some data on HIV infection among labour migrants from Tajikistan, which is not disaggregated by sex and key populations.

The report aims to provide an overview of access to SRH services, including HIV services, for internal migrants from Central Asian countries and international migrants from Central Asian countries in the Russian Federation, Kazakhstan, and Turkey during the COVID-19 pandemic. The report will subsequently keep stakeholders informed of the situation and take action to reach migrants with appropriate services more effectively, focusing specifically on HIV services.

⁹ <https://www.who.int/news/item/15-07-2021-who-warns-that-hiv-infection-increases-risk-of-severe-and-critical-covid-19>

¹⁰ <https://www.unescap.org/blog/good-bad-ugly-migration-north-and-central-asia>

¹¹ Policy Brief: The Impact of COVID-19 on Women, United Nations, 9 April 2020 <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406>



The report covers the following:

1. Analysis of the socio-economic situation, migration trends and indicators of sexual and reproductive health and HIV prevalence and response in migrant-sending countries, namely Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, and countries receiving migrants from Central Asia: the Republic of Kazakhstan, the Russian Federation and the Republic of Turkey.
2. Assessment of the provision of sexual and reproductive health and HIV prevention services and commodities, diagnosis and treatment for internal migrants in Central Asian countries and international migrants from Central Asian countries.
3. Barriers to accessing sexual and reproductive health and HIV services and facilities internal migrants in Central Asian countries and external migrants from Central Asian countries.

2. METHODS

The data on access to SRH and HIV services for international labour migrants from Kyrgyzstan, Tajikistan, Uzbekistan and Turkmenistan in Kazakhstan, the Russian Federation and the Republic of Turkey and internal labour migrants in Kyrgyzstan, Tajikistan, Uzbekistan and Turkmenistan with regular (legal) and irregular status (due to illegal entry/violation of entry conditions/expiry of legal grounds for entry and residence) were collected and analysed. Particular attention was paid to women, people living with HIV and key populations: men who have sex with men, sex workers and people who inject drugs.

A desk review of published documents, including legislation, statistics, articles and brochures, was conducted. Secondary data was collected on the socio-economic situation, migration, sexual and reproductive health services and access to SRH services and commodities in the above-mentioned migrant-sending and receiving countries.

Based on the desk review, hypotheses concerning access issues for different categories of migrants were developed and expert interviews¹² were conducted in each of the countries, except for the Republic of Turkey, based on which the hypotheses were tested and data were triangulated. In addition, in the course of the expert interviews, sensible details relevant to the report and the experts' standpoint on existing practices were ascertained.

In-depth interviews were conducted with 77 respondents - 14 experts from Kazakhstan (including 7 community representatives and NGOs, 7 service providers), 12 from Kyrgyzstan (including 7 community representatives, 5 service providers), 12 from Russia (including 9 community representatives, 3 service providers), 12 from Tajikistan (including 6 community representatives, 3 service providers, 3 international organizations), 13 from Turkmenistan (including 5 community representatives, 8 service providers), and 14 from Uzbekistan (including 6 community representatives, 8 service providers). The experts were independent professionals known for their high level of professionalism, experience in sociological surveys and focus groups, unbiased and honest, and having no conflict of interest related to the content of the report. The experts, because of their position, were aware of the specificities of migrants' health

¹² Bogner A., Littig B. Menz W. Interviewing Experts, Palgrave Macmillan, 2009.
https://www.researchgate.net/publication/284419200_Interviewing_Experts

seeking behaviour regarding SRH and HIV services, but also knew the functioning of systems providing migrants with relevant goods and services.

In-depth expert interviews were carried out individually and remotely by telephone or video link via Skype, Zoom, Google Meeting Tool, WhatsApp, and Telegram. Informed consent was obtained from each expert, including consent to audio and video recording. A questionnaire was drawn up for each expert, in which the expert's name was encrypted to ensure privacy; the questionnaire included information about the expert and his/her motivation for participating in the survey. The interviews were partially standardised as described in Annex 1. Respondents were asked questions within their field of competence. The interviews were documented by creating detailed written transcripts of the completed oral interviews.

The qualitative data laid out in each expert interview were processed as described in Annex 1. The expert assessments were presented following the median rule in judgement aggregation.

3. FINDINGS AND DISCUSSION

3.1 Socio-economic situation, migration trends, indicators of sexual and reproductive health, HIV prevalence and response in migrant sending and receiving countries

This section is based on published and in-service materials received from government authority bodies, as well as governmental and non-governmental organisations, and provides basic information to enable an understanding of the general situation and comparison of access to sexual and reproductive health services among the general population and among migrant groups. It is based on the right of everyone to enjoy the highest attainable standard of physical and mental health, in accordance with article 12 of the International Covenant on Economic, Social and Cultural Rights,¹³ as well as the right to receive perinatal health care and the women's rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights under articles 12 and 16 of the Convention on the Elimination of All Forms of Discrimination against Women.¹⁴ All the above countries are signatories to the above-mentioned conventions.

3.1.1 Socio-economic situation

Kyrgyzstan, Uzbekistan, Turkmenistan, and Tajikistan are the four Central Asian countries that are mainly migrant-sending. These countries differ considerably in population size, macroeconomic indicators, poverty and unemployment rates, and state systems (**Table 1**). Uzbekistan is Central Asia's most populous country and is rich in mineral resources; it has 5% of the world's cotton production. The country ranks 148th in the world (out of 190 countries and territories) in Gross National Income (GNI) per capita (ATLAS method) and 106th in the Human Development Index (HDI). Turkmenistan is a sparsely populated country with the world's fourth-largest natural gas reserves, at 10 percent of the world's total. Turkmenistan is 76th in GNI per capita and 111th in HDI in the world. Kyrgyzstan is a country where an urban population is significantly predominant, with more than half of it employed in services. The country ranks 160th in GNI per capita and 125th in HDI in the world. Tajikistan

¹³ https://treaties.un.org/doc/Treaties/1976/01/19760103%2009-57%20PM/Ch_IV_03.pdf

¹⁴ https://treaties.un.org/doc/Treaties/1981/09/19810903%2005-18%20AM/Ch_IV_8p.pdf

is a country with a predominantly rural population employed in agriculture. The country is ranked 164th in GNI per capita and 125th in HDI in the world. The International Labour Organisation (ILO) estimates that in 2019, in Tajikistan, a country with a high population growth rate, the ratio of the employed population to the population aged 15 and above was as high as 37%.¹⁵

Table 1: Economic and Population Indicators in the Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

	Kyrgyzstan	Tajikistan	Turkmenistan	Uzbekistan
Population, millions (2020)¹⁶	6.6	9,5	6.0	33.9
Rural population, %¹⁷	65	74	47	49
Average annual population growth (2015-2020), %¹⁸	2.0	2.2	1.5	1.8
GNI (ATLAS method), US\$ billion¹⁹	8.00	9.9	39.4	60.3
GNI per capita (ATLAS method), US\$²⁰	1 240 (2019)	1 070 (2019)	6 740 (2018)	1 800 (2019)
GNI per capita at purchasing power parity, US\$²¹	4 840 (2019)	4 250 (2019)	14 560 (2018)	7 450 (2019)
Population with incomes below the national poverty line, %²²	21	26	No Data Available	11
Population with incomes of less than \$5.5 per day at 2011 purchasing power parity, %²³	52.6	No Data Available	No Data Available	No Data Available
Nominal wages²⁴	16 427 KGS (\$236, 2018)	1 234 TJS (\$110, 2018)	1 403 TMT (\$325. 2017) ²⁵	2 324.500 UZS (\$237, 2019)

¹⁵ <https://data.worldbank.org/indicator/SL.EMP.TOTL.SP.ZS>

¹⁶ ADB Basic 2021 Statistics <https://www.adb.org/publications/basic-statistics-2021>

¹⁷ Data of national statistical agencies

¹⁸ ADB Basic 2021 Statistics <https://www.adb.org/publications/basic-statistics-2021>

¹⁹ World Bank statistics <https://databank.worldbank.org/source/world-development-indicators#>

²⁰ Ibid.

²¹ Ibid.

²² ADB Basic 2021 Statistics <https://www.adb.org/publications/basic-statistics-2021>

²³ World Bank statistics <https://databank.worldbank.org/source/world-development-indicators#>

²⁴ Global Wage Report 2020-2021, International Labour Organization, 2021 https://www.ilo.org/wcmsp5/groups/public/-ddgreports/-dcomm/-publ/documents/publication/wcms_762534.pdf

²⁵ The average monthly wage in Turkmenistan is calculated based on the official exchange rate of the new manat, Turkmenistan's national currency, into the US dollar, however, no exchange of manat into the US dollar is not available

The unemployment rate, % of the labour force	7.9 (2020) ²⁶	7.5 (2020) ²⁷	4.4(2019) ²⁸	7.3 (2019) ²⁹
HDI (2019)³⁰	0.697 (average)	0.668 (average)	0.715 (high)	0.720 (high)

According to the World Bank classification based on national income per capita, Turkmenistan is an upper middle-income country, while Uzbekistan, Kyrgyzstan, and Tajikistan are lower middle-income countries. The latter two countries have only recently crossed the GNI per capita line of USD 1 046 that separates them from the low-income group.

Kyrgyzstan, Tajikistan and Uzbekistan face a heavy burden of poverty and unemployment. One in four people in Tajikistan and one in five in Kyrgyzstan have an income below the national poverty line. More than half of Kyrgyzstan's citizens have an income of less than USD 5.5 per day in 2019 purchasing power parity. In Uzbekistan, one in ten people has an income below the national poverty line, yet wages for 7.3% of workers are below \$1.9 in purchasing power parity.³¹ Turkmenistan does not publish data on the number of people living below the poverty line. However, it is known that 42 out of every 1,000 children in the country do not survive to the age of age,³² which means that Turkmenian children under the age of 5 die four times more often than in neighbouring Kazakhstan. The Vatican's official website for refugees and migrants reports that 58% of Turkmenistan's population was poor in 2018.³³

Low incomes, especially in rural areas where hired workers are paid 1.5–2 times less than in urban areas, while the rural dwellers account for half or more of the population, unemployment, significant annual population growth and large families where women usually do not receive cash income, encourage international and internal labour migration, thus can be seen as a long-term trend.

The Central Asian migrant-receiving countries Russia, Turkey and Kazakhstan are upper middle-income countries. These countries also experience problems of poverty and unemployment (**Table 2**). Their economies are quite exposed to crises, which are bound to affect labour migration in the event of changing economic situations. Russia and Kazakhstan, for example, largely depend on the export of raw materials. Migrants, in their overwhelming majority, can only expect to fill those jobs in these countries that their nationals are unwilling to take.

to the population in Turkmen banks; on the widely used black market, the US dollar is sold at a rate several times higher than the official rate.

²⁶ <https://www.adb.org/countries/kyrgyz-republic/poverty>

²⁷ <https://www.adb.org/countries/tajikistan/poverty>

²⁸ <https://www.adb.org/countries/turkmenistan/poverty>

²⁹ <https://data.adb.org/dashboard/uzbekistan-numbers>

³⁰ <http://hdr.undp.org/en/content/latest-human-development-index-ranking>

³¹ <https://data.adb.org/dashboard/uzbekistan-numbers>

³² <https://www.adb.org/countries/turkmenistan/poverty>

³³ <https://migrants-refugees.va/country-profile/turkmenistan/>

Table 2. Economic indicators, size and growth of the population in Kazakhstan, the Russian Federation and Turkey ³⁴

	Kazakhstan	Russia	Turkey
Population, millions (2020)	18.5	144.6	84.3
Average annual population growth (2015-2020), %	1.3	0.1	1.6
GNI (Atlas method), US\$ billion (2019)	163,3	1.651,8	807,0
GNI per capita, (Atlas method), US\$ (2019)	8 820	11 250	9 630
GNI per capita at purchasing power parity, US\$ (2019)	24 040	28 260	26 860
Population with an income of less than \$5.5 per day at purchasing power parity in 2011 prices, %	4.6 (2018)	3.7 (2018)	10.2 (2019)
Nominal monthly wage (2019) ³⁵	187 500 KZT (\$490)	47 867 RUB (\$665)	3 960 TL (\$695)
Unemployment rate, % of labour force (2019)	4.8	4.6	13.7

The wages of migrants in migrant-receiving countries are significantly higher than in migrant -sending countries. According to the joint study conducted by the Federation of Migrants of Russia and Moscow State University in 2021, which covered 4.7 thousand respondents in different regions of the Russian Federation, the average wage of labour migrants in Russia was 47.1 thousand Russian rubles (about 650 US dollars) per month, and the median wage was 32.4 thousand Russian rubles (about 440 US dollars) per month. However, nearly 80% of labour migrants worked more than eight-hour shifts, with 22.4 percent working more than twelve-hour shifts³⁶. The money earned in migration is often the only source of income for traditionally large migrant families, while the migrants also support themselves with the same money, part of which they are forced to spend on travel and accommodation in the place of migration.

3.1.2 Brief overview of labour migration from and to Central Asia

Table 3 shows the number of migrants and the value of migration to Central Asian economies. According to the independent Migration Policy Institute in 2020, Russia was the world's fourth largest country by the number of hosted

³⁴ Based on World Bank data <https://databank.worldbank.org/source/world-development-indicators#>, except for data on average wages

³⁵ Global Wage Report 2020-2021, International Labour Organization, 2021
https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_762534.pdf

³⁶ Российская газета - Столичный выпуск от 13.12.2021 № 283 (8634) (in Russian)
<https://rg.ru/2021/12/13/sredniaia-zarplata-inostrannogo-rabochego-prevysila-47-tysiach-rublej.html>

international migrants (over 11.6 million, accounting for 8% of its population). Turkey (6.0 million migrants, 7% of the population) and Kazakhstan (3.7 million migrants, 20% of the population) were ranked 12th and 15th, respectively.³⁷ Large flows of migrants from Central Asia to these countries are determined by geographical proximity (which makes migration less expensive), some cultural commonalities, visa-free entry for citizens of Kyrgyzstan, Tajikistan and Uzbekistan going to the Russian Federation, the Republic of Kazakhstan and the Republic of Turkey (the latter hosting also citizens of Turkmenistan), the Russian language proficiency of the post-Soviet population, and mutual intelligibility of the Turkmen, Turkish, Uzbek, Kyrgyz and Kazakh languages.

Turkmenistan does not publish data on international migration. However, a report prepared in the framework of the Prague Process states that in 2014, almost 500 000 Turkmen nationals were residing in Turkey as regular or irregular migrants.³⁸ The official Vatican website for migrants and refugees claims that Turkey hosts an average of 20 000 to 25 000 Turkmen migrant workers a year.³⁹

All migrant-sending Central Asian countries recognise the importance of their migrants' earnings for their national development. In Kyrgyzstan and Tajikistan, migrant remittances contribute to GNI of Central Asian countries amounting to over a quarter of their Gross National Product (GNP), i.e., all goods and services produced in the territories of these countries in all sectors of their economy combined. These remittances largely sustain demand in their domestic markets, contributing to economic growth. The steady growth in international remittances recorded worldwide in recent decades was interrupted in 2020 by the COVID-19 pandemic.

Immigrants, in turn, contribute significantly to the host countries development by meeting their needs for labour, especially unskilled labourers, whose supply among the local population is considerably less than the local demand. Immigration is raising a nation's output and increasing its economic growth. Apart from significantly contributing to output and productivity both in the short and medium term, the immigrants bring into the labour market a diverse set of skills, which complement those of the local labour.⁴⁰

³⁷ <https://www.migrationpolicy.org/programs/data-hub/charts/top-25-destinations-international-migrants>

³⁸ <https://www.icmpd.org/file/download/48361/file/Turkmenistan%2520Migration%2520Profile%2520Light%2520EN.pdf>

³⁹ <https://migrants-refugees.va/country-profile/turkmenistan/>

⁴⁰ World Economic Outlook: The Great Lockdown Chapter 4 The Macroeconomic Effects of Global Migration, Washington, International Monetary Fund, 2020 <https://www.elibrary.imf.org/view/books/081/28950-9781513539744-en/ch04.xml>

Table 3. Number of registered migrants and volume of migrant remittances to their countries of origin

	Kyrgyzstan	Tajikistan	Turkmenistan	Uzbekistan
Number of regular international migrants in Russia ⁴¹	1.0	2.7	0.1	4.7
Personal remittances, US\$ bln ⁴²	2.2	2.2	0.1	7.0
Personal remittances, % GDP ⁴³	28.4	26.7	No data	12.1
Number of internal migrants by place of temporary residence, (in thousands)	men – 8.4; women – 16.4 ⁴⁴	men – 20.0; women – 21.0 ⁴⁵	No data	No data

Among international migrants from Central Asian countries in Russia, men predominate, but women labour migrants account for around one million. Women have the largest share in the group of Kyrgyz migrants at 35%, while among Uzbek and Tajik migrants their share is 14% and 10% respectively. The disproportionate distribution of women and men going to work abroad is obviously determined by stereotypic gender roles. However, with the development of the light industry and the service sector, the share of women among migrants is steadily growing.⁴⁶ The international migration of women from Central Asian countries, either together with their families or on their own, is obviously an important and complex phenomenon, but remains insufficiently documented owing to a lack of data. It is known that in many countries of the world women migrants can be at lower likelihood to be employed, face disadvantage in terms of the quality of the jobs they obtain, encounter a large gender pay gap and so on. Changes in the gender face of international migration must be considered both from economic and social perspectives, including the

⁴¹ Migrants registered at their place of residence for the first time and who extended their registration as required by Russian Federal Legislation (data from the Federal State Statistics Service of Russia).

⁴² <https://data.worldbank.org/indicator/BX.TRF.PWKR.CD.DT>

⁴³ <https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS>

⁴⁴ Женщины и мужчины в Кыргызской Республике 2016-2020, Национальный статистический комитет, 2021, с. 33 (in Russian) <http://www.stat.kg/media/publicationarchive/b057b115-c40b-4180-ae16-28ec7e459117.pdf>

⁴⁵ https://stat.wt.tj/posts/May2021/Tajikistan_Statistical_Publication.pdf

⁴⁶ Хиштовани Г. Обзор миграции и развития: роль местных органов власти в Центральной Азии, Институт Центрально-Азиатского регионального экономического сотрудничества, 2020 (in Russian) <https://www.carecinstitute.org/wp-content/uploads/2021/03/RUS-CAREC-Institute-migration-in-UZB-TAJ-KGZ-VFP2020.pdf>

growing needs of migrants to access maternity care and sexual and reproductive health services. Twenty-seven of migrant women from Kyrgyzstan interviewed in 2017–2018 reported that they had been pregnant while staying in Russia.

Many dwellers of rural areas and small towns in all Central Asian countries move within their countries to big cities, where they stay for different periods of time to earn a living. According to registration data, in Tajikistan the shares of women and men among internal migrants are almost the same, while in Kyrgyzstan women prevail over men, i.e., the profile of internal labour migration is largely female.

In both external and internal migration, men mostly work as construction and road workers, as well as drivers, loaders, street cleaners, housing and utilities workers and unskilled workers on various sites. Women are employed in markets, small private shops, food and clothing industry, car washes, hotels, hostels, cleaning companies, or hired as babysitters and carers for the elderly.

Statistical agencies underreport the number of migrants, both international and especially internal. Available data does not take into account the number of migrants with irregular status who infringe the rules of either moving to another locality within their countries by not registering at the place of temporary residence, or entry and stay in a foreign country (see below).

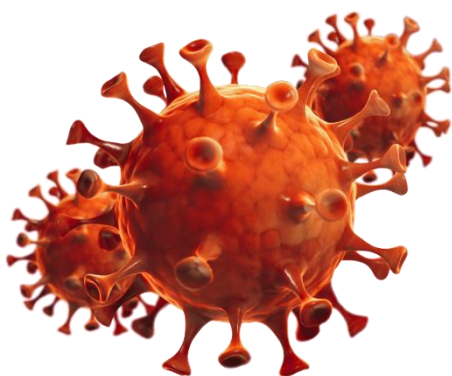
3.1.3 Impact of the COVID-19 pandemic on the socio-economic conditions of migrants

The Note by the Secretary-General dated 31 July 2021, circulated at the Seventy-sixth session of the UN General Assembly especially highlighted: "Migrants and their families, especially those already in vulnerable situations, have been disproportionately affected by the pandemic owing to ... interrelating factors that have exacerbated existing vulnerabilities. First, many migrants endure a low socioeconomic status. They live in precarious conditions and have limited access to health care and other essential services. Second, they often work in the informal economy, with unfavourable conditions of work and limited access to social protection systems, and are more exposed to exploitation, in particular women and girls..."⁴⁷

Many international migrants who were working legally in Kazakhstan, Russia and Turkey lost their jobs and could not pay rent, renew their patents or send remittances home. The large number of international and internal migrants returning to their places of origin cannot find work nor earn a living. Another significant part of migrants remains in migration, living in poverty and hoping that the situation will change for the better.

In April 2020, there was conducted a sociological survey in the Russian Federation, in a random sample of labour migrants over 18 years old, reaching 717 respondents on social networks Facebook and VKontakte. 84% of migrants reported a reduction or loss of income; more than half (65%) either lost their job

⁴⁷ <https://undocs.org/A/76/257>



(28%) or were on unpaid leave (37%), and therefore only 51% of those surveyed were able to send money home. The main problems for migrants were: inability to pay the rent – 64%; inability to find a job – 45%; lack of money for food – 43%; problems with the police – 20%; poor living conditions – 11%; and inability to pay for a patent – 2%. About 1% of the migrants interviewed said that they were ill with COVID-19 themselves and about 3% said that their relatives and/or friends were ill. Most migrants reported that they try to minimise their costs and they choose the cheapest places to live, which are unsuitable for self-isolation: every fourth migrant lives in a small room together with 5–9 other people.⁴⁸ Under these conditions, the migrants can hardly maintain social distancing and avoid the risk of SARS-CoV-2 transmission, which causes COVID-19.

Poverty and unemployment have been shown to increase both the risk of HIV transmission associated with increased frequency of unprotected sex, selling sex, gender-based violence⁴⁹ and the probability of rapid progression of HIV infection and the development of AIDS associated with malnutrition and discontinuation of antiretroviral therapy⁵⁰. It is recognized that health status declines as socioeconomic status, including income, declines and that the health gap between poor and non-poor people is related to the absence of financial and other resources that afford access to health care, including family planning. It has also been found that a low socioeconomic status aggravated by sources of stress such as undernutrition and financial hardships affects ovarian reserve. Both ovarian reserve parameters, namely anti-Mullerian hormone level and antral follicle count, exhibited a significant positive association with socioeconomic status. Positive association between follicle-stimulating hormone level and socioeconomic status was discovered as well⁵¹.

3.1.4 Sexual and reproductive health and HIV infection in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

Tajikistan and Kyrgyzstan have relatively high rates of maternal mortality (**Table 4**), although it is much less than the global average of 70 per 100,000

⁴⁸ Рязанцев С.В., Молодикова И.Н., Брагин А.Д. Влияние пандемии COVID-19 на положение мигрантов на рынках труда стран СНГ// Балтийский регион. 2020. Т. 12, № 4. С. 10—38 (in Russian) <https://doaj.org/article/1804aa73d713482ea7979d4dbba74742>

⁴⁹ Latkin C.A., German D., Vlahov D. Neighborhoods and HIV: A Social Ecological Approach to Prevention and Care Am Psychol. 2013, Vol. 68 Issue 4, P. 210–224 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717355>

⁵⁰ Kalichman, S. C., Pellowski, J., Kalichman, M. O., Cherry, C., Detorio, M., Caliendo, A. M., & Schinazi, R. F. Food insufficiency and medication adherence among people living with HIV/AIDS in urban and peri-urban settings. Prevention Science, 2011, Vol. 12, No 3, P. 324–332

https://pubmed.ncbi.nlm.nih.gov/?term=Caliendo+AM&cauthor_id=21607719

⁵¹ Barut M.U., Agacayak Elif, Bozkurt M. et al. There is a positive correlation between socioeconomic status and ovarian reserve in women of reproductive age//Med. Sci. Monit. 2016; 22: 4386–4392 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5123781>.

live births, to be achieved by 2030, as outlined in target 3.1 of SDG 3. Antenatal care coverage is acceptable in all countries except Tajikistan, where women rarely attend health facilities for antenatal care and one in every 19 women does not receive skilled perinatal care. In that country, one in every 17 live-born infants has a low birth weight. In other countries, antenatal care is provided by skilled health personnel at least once during pregnancy to > 99% of women, and by any specialist, at least four times during pregnancy to > 94% of women.

In general, the fertility rates in Tajikistan, Kyrgyzstan, Turkmenistan and Uzbekistan are quite high compared with the world average (2.4 children per woman) and Eastern Europe and Central Asia region average (1.7 children per woman, **Table 4**). About one in five women in Tajikistan and Kyrgyzstan have an unmet need for family planning services. This fact is consistent with the lower use of modern contraceptives in Tajikistan and Kyrgyzstan compared with that in Turkmenistan and Uzbekistan. In the latter two countries, intrauterine devices (IUDs) predominate over other methods of modern contraception.

In all Central Asian countries, induced abortions up to the 12th week of pregnancy are allowed at a woman's discretion, yet according to official statistics, abortions are rare, especially in Uzbekistan. Turkmenistan has stopped published data on induced abortions in recent years. In 2011, the country's recorded abortion rate was 12.4 per 1,000 women aged 15–49.⁵²

Table 4. Maternal, sexual and reproductive health in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

	Kyrgyzstan 53	Tajikistan 54	Turkmenistan 55	Uzbekistan 56
Maternal mortality ratio per 100,000 live births (2020)⁵⁷	24.8	21.9	7	18.5

⁵² Abortion Policies and Reproductive Health around the World, New York, United Nations, 2014, P. 42

<https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf>

⁵³ Kyrgyz Republic Multiple Indicator Cluster Survey: Survey Findings Report 2018, Bishkek, National Statistical Committee of the Kyrgyz Republic and UNICEF, 2019

<https://www.unicef.org/kyrgyzstan/media/6066/file/MICS%20Statistical%20Snapshots.pdf>

⁵⁴ Demographic and Health Survey, Rockville, Maryland. Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection of Population of the Republic of Tajikistan, Dushanbe, 2017. Dushanbe (if no other reference is made) <https://www.dhsprogram.com/publications/publication-fr341-dhs-final-reports.cfm>

⁵⁵ Turkmenistan Multiple Indicator Cluster Survey. Survey Findings Report 2019. Ashgabat, Turkmenistan: State Committee for Statistics of Turkmenistan and UNICEF, 2020 (if no other reference is made https://mics-surveys-prod.s3.amazonaws.com/MICS6/Europe%20and%20Central%20Asia/Turkmenistan/2019/Survey%20findings/Turkmenistan%202019%20MICS%20SFR_English.pdf)

⁵⁶ Report of the Republican Centre for Population's Reproductive Health of the Republic of Uzbekistan for 2020. (if no other reference is made).

⁵⁷ Data from national statistical agencies

Total fertility rate (2019)⁵⁸	3.3	3.6	2.7	2.8
Women aged 15–49 who are married or in partnerships, using modern contraception, %	37.8 (2018)	29.0 (2016)	47.3 (2019)	43.6 (2020)
Women aged 15–49 with unmet family planning needs, %	19.0 (2018)	23.0 (2016)	9.7 (2019)	No data
Incidence of induced abortions per 1,000 women aged 15–49	9.1 (2019) ⁵⁹	No data	No data	4.1 (2020) ⁶⁰
Number of induced abortions per 1,000 live births	96 (2020) ⁶¹	47.4	No data	No data
Women aged 15–49 with a live birth who received antenatal care provided by skilled health personnel (doctor or midwife) at least once during their last pregnancy (in the previous 2 years), %	98.8 (2018)	92 (2016)	100 (2019)	99.8 (2020)
Women aged 15–49 years with a live birth who received antenatal care four or more times during their last pregnancy (in the previous 2 years), %	94.3 (2018)	64 (2016)	97.6 (2019)	99.4 (2020)
Birth attended by skilled personnel, %	99.8 (2018)	95 (2016)	100 (2019)	100 (2020)
Low birth weight among live born infants (<2500 g), %	2.7 (2018)	5.8 (2016)	2.8 (2019)	3.3 (2020)

The reported HIV and syphilis prevalence among the general population in the Central Asian countries of migrants' origin is generally low (Table 5). Turkmenistan does not recognise the HIV epidemic on its territory, even though by 2017 there were 136 reported cases of HIV infection among Turkmen migrants

⁵⁸ <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN>

⁵⁹ Population health and the activities of health care organisations in 2020, MoH EHC, Table. 82. <http://cez.med.kg/%>

⁶⁰ <https://Gender.stat.uz/en/main-indicators/health-care/>

⁶¹ Women and men of the Kyrgyz Republic, National Statistical Committee, 2021, p. 164. <http://www.stat.kg/media/publicationarchive/b057b115-c40b-4180-ae16-28ec7e459117.pdf>

in the Russian Federation.⁶² Under Russian law, many of those people were deported back to Turkmenistan and their fate is unknown, although a network of HIV service organizations in Turkmenistan is formally in place.

In Central Asia, most of the people diagnosed with HIV infection belong to key populations. The HIV prevalence assessed by sentinel serological surveillance in these groups is significant. It is 20 times or higher in these groups than in the general population. Updated data on HIV prevalence among migrants is available only in Tajikistan, where it is four times higher than HIV prevalence in the general population. HIV prevalence among people who inject drugs (PWID) exceeds 10 per cent in Kyrgyzstan and Tajikistan. In all countries, however, sexual transmission has become a major driver of the HIV epidemic in the recent years. In 2020, the percentage of HIV sexual transmission in Kyrgyzstan, Uzbekistan and Tajikistan was 50, 82 and 83, respectively, among the new HIV cases (Figure 1). Compared to 2016, in 2020, sexual transmission of HIV, associated with the prevalence of unprotected sex in all countries, became even more dominant.

Table 5. Prevalence and incidence of HIV and syphilis among various population groups in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

	Kyrgyzstan ⁶³	Tajikistan ⁶⁴	Turkmenistan	Uzbekistan ⁶⁵
HIV incidence per 100,000 population without HIV	9.6 (2020)	12.0 (2020)	No data	8.3 (2020)

⁶² HIV and migration in Central Asia and the Russian Federation. Report of the Technical Workshop 19–20 February 2018, Astana, Kazakhstan https://kazakhstan.unfpa.org/sites/default/files/pub-pdf/HIV%20REPORT_ENG_FIN.pdf

⁶³ Data from the following sources are provided: "Здоровье населения и здравоохранение в Кыргызской Республике за 2020 год (статистический сборник) <http://cez.med.kg/%> ; Страновой отчет о достигнутом прогрессе – Кыргызстан. Глобальный мониторинг эпидемии СПИДа 2020 https://www.unaids.org/sites/default/files/country/documents/KGZ_2020_countryreport.pdf ; Materials from the official website of the Republican AIDS Centre under the Ministry of Health of the Kyrgyz Republic <https://aidscenter.kg/statistika/?lang=ru> (in Russian)

⁶⁴ Data from the following sources are provided: Страновой отчет о достигнутом прогрессе – Таджикистан Глобальный мониторинг эпидемии СПИДа 2020 https://www.unaids.org/sites/default/files/country/documents/TJK_2020_countryreport.pdf ; Official website of the State Institution "Republican Centre for AIDS Prevention and Control under the Ministry of Health of the Republic of Tajikistan <http://nac.tj/ru/statistika> (in Russian)

⁶⁵ Data from the following sources are provided: Report of the Republican AIDS Centre under the Ministry of Health of the Republic of Uzbekistan for the year 2020 (Service document); ; Страновой отчет о достигнутом прогрессе – Узбекистан Глобальный мониторинг эпидемии СПИДа 2020 (in Russian) https://www.unaids.org/sites/default/files/country/documents/UZB_2020_countryreport.pdf

HIV prevalence per 100,000 pregnant women	88.0 (2020)	78.0 (2019)	No data	82.2 (2019)
Percentage of adults and children with newly diagnosed HIV infection with CD4 cell count <200/μL or <350/μL	45 (<350/ μ L, 2020)	67 (<350/ μ L, 2019)	No data	24.4 (<200/ μ L, 2020)
HIV prevalence in the general population, %	0.1 (2020)	0.1 (2020)	No data	0.2 (2020)
HIV prevalence among labour migrants, %	No data	0.4 (2020)	No data	No data
HIV prevalence among MSM, %	6,6 (2016)	2.3 (2018)	No data	3.7 (2018)
HIV prevalence among SW, %	2.0 (2016)	3.2 (2017)	No data	3.2 (2018)
HIV prevalence among PWID, %	14.3 (2016)	12.1 (2018)	No data	5.1 (2018)
ART coverage among PLHIV, %	63 (2019)	84	No data	66 (2020)
Syphilis incidence per 100,000 population	3.4 (2020)	No data	No data	5.5

Cases of mother-to-child transmission of HIV are sporadically reported in all countries, while the number of pregnant women with HIV in Kyrgyzstan, Tajikistan and particularly in the highly populated Uzbekistan is measured in hundreds every year. In Uzbekistan, seven cases of HIV vertical transmission were reported in 2018. In Kyrgyzstan in 2020, 1,7% of pregnant women living with HIV gave birth to babies with HIV. Clinical protocols in all countries include two-time antenatal HIV testing.

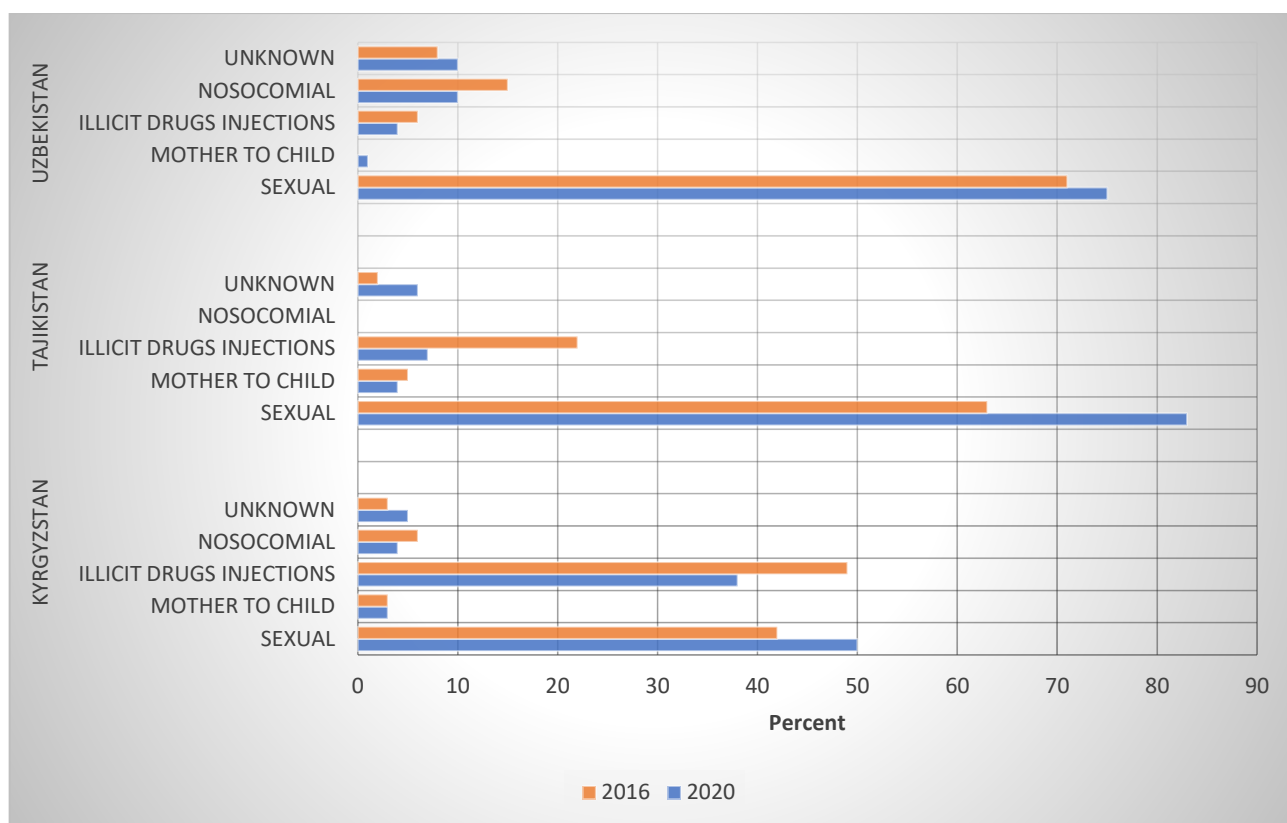


Fig.1 Structure of HIV transmission among newly reported cases of HIV infection in three Central Asian countries

Antiretroviral treatment coverage is not sufficient in all three countries. (Table 5). It nowhere comes to 90% of people who know they are living with HIV, as required by the UNAIDS 90-90-90 strategy (more recently 95-95-95). A large proportion of HIV cases are diagnosed at advanced stages. This means that people still have limited access to information and education and, most importantly, are not motivated to voluntarily test for HIV. In Tajikistan, only 48% of international migrants who are strongly encouraged to get tested for HIV were actually tested.

It is reasonable to assume that the relevant SRH indicators applicable to the general populations of Central Asian countries to a certain extent reflect the SRH situation among migrants originating from these populations, as well as the behaviour of migrants in terms of demand for reproductive health services and commodities, including HIV services. The SRH status of migrants, on the other hand, must be superimposed by migration conditions, which, as previously stated, are predictors of health issues. Simultaneously, the health-care systems of all Central Asian countries assessed until recently managed to provide essential SRH and HIV service packages to the vast majority of their populations.

3.1.5 Health care funding

As shown in **Table 6**, the level of health care funding in Tajikistan, Kyrgyzstan, and Uzbekistan is quite low, even given the fact that public spending accounts for less than half of the financial resources invested in the sector. The COVID-19 pandemic makes health systems in these countries particularly vulnerable, compromising the provision of quality SRH services primarily to the rural poor, where both domestic and a large proportion of international migrants come from. Low public spending resulted in an unusually high share of health care costs being passed on to households. The ratio of out-of-pocket health costs paid by citizens to total health care funding in Central Asian countries is one of the highest in the world.⁶⁶

Table 6. Health spending in Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan⁶⁷

	KG	TJ	TM	UZ	KZ	RU	TR
Current health expenditures, US\$ per capita, at current exchange rates (2018)	88	60	460	82	275	609	389
Current health expenditures, US\$ per capita, at current purchasing power parity (2018)	260	250	1275	459	783	1488	1170
Domestic public health spending, % of current spending	43	27	18	28	60	59	77

Note: Health spending in Turkmenistan is based on the official exchange rate of the new Turkmen manat (which the National Bank of Turkmenistan pegged to the US dollar) without adjustment for restrictions on the purchase of foreign currency for the cash national currency of Turkmenistan.

Responses to HIV infection, including ART in Kyrgyzstan, Tajikistan and Uzbekistan are supported by grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Each of these countries is a grant holder from this organisation⁶⁸ and is eligible to apply for support of national programmes.

In 2018 health spending by the governments of Kazakhstan, the Russian Federation and Turkey accounted for only 1.8%, 3.2% and 3.2% of their GDP⁶⁹

⁶⁶ COVID-19 crisis response in Central Asia, OSED, 2020 <https://www.oecd.org/coronavirus/policy-responses/covid-19-crisis-response-in-central-asia-5305f172/>

⁶⁷ World bank data extracted from <https://databank.worldbank.org/createreport>

⁶⁸ <https://data.theglobalfund.org/>

⁶⁹ <https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS>

respectively, which during the COVID-19 pandemic may also hurt adequacy of services, especially for the socially vulnerable groups to which migrants belong.

3.1.6 Legal and regulatory framework for sexual and reproductive health services and commodities as well as HIV prevention, diagnosis and treatment for migrants

In all countries under the review, alongside health legislation that guarantees rights to health care, including HIV, AIDS and SRH services, some laws and regulations impose limitations or preconditions on the provision of health care services, thus excluding part of the current population. The laws and by-laws regulating internal and external migration and the status of foreign nationals are examples of these limitations.

For instance, internal migrants in Kyrgyzstan, Tajikistan, Uzbekistan and Turkmenistan can use services at the primary health care level at their place of migration, provided that they are officially registered at their place of residence in migration and are assigned to a territorial health care organisation.



As for international migrants, in Russia, all immigrants are entitled to free emergency and urgent life-saving care as well as treatment of acute illnesses that pose a danger to their lives and the lives of others, namely diphtheria, measles, rubella, whooping cough, scarlet fever, chickenpox, parotitis, paratyphoid A, B, C, poliomyelitis, meningococcal infection, cholera, typhoid fever, acute progressive forms of tuberculosis (meningitis, miliary tuberculosis) until liquidation of a threat to the life of the patient and the conversion of sputum smears for the presence of mycobacteria, pulmonary anthrax, plague, viral haemorrhagic fevers, yellow fever, viral hepatitis A and E, malaria, influenza, COVID-19, and acute mental disorders (until elimination of the manifestations that can threaten patients and other lives). Emergency cases include, among others, obstetric care from the onset of labour until the end of the second hour of the postpartum period, provided the delivery was natural and not life-threatening for the woman (if the life of a woman and (or) a newborn is endangered, the care is extended beyond the third hour until the threat to their lives is eliminated).

The right to statutory (or 'mandatory') health insurance (OMS) covering antenatal and postnatal care, SRH and family planning services is only available to nationals of Eurasian Economic Union (EAEU) member states temporarily staying in Russia and, in particular, the citizens of the Kyrgyz Republic, provided they have legal employment contracts. In this case, their employer regularly pays the statutory insurance premiums. In order to receive antenatal care and SRH services, a migrant from Kyrgyzstan shall be assigned to a territorial outpatient clinic in the place of his/her registration. Migrants having statutory health insurance are entitled to free hospital care. STI treatment is not covered by statutory health insurance. Migrants' family members are not covered by statutory health insurance either.

Labour contracts with migrants from Uzbekistan and Tajikistan give them settled (legal) status, but do not entitle them to OMS. International migrants with regular status are required to get voluntary health insurance (DMS) policies. The cheapest annual DMS policy is around \$60 US, and does not include SRH care, which for migrants is available as a paid service only.

Irregular migrants who have neither employment contracts nor informal service agreements are not entitled to free antenatal care, family planning and SRH services, including STI treatment. They must pay for these services.

Migrants living with HIV are subject to deportation from Russia (except those having close relatives who are citizens of the country: wife, husband, children, and parents), regardless of whether they entered the country with the infection or contracted HIV during their stay in the Russian Federation. Foreign nationals living with HIV are not registered at the Russian public health care organisations and are not entitled to free medical care.

In Kazakhstan, as in Russia, all foreign nationals are provided with urgent medical care (which would include conditions requiring emergency and urgent care for pregnant women), as well as for infectious diseases that pose a danger to others. The list of these diseases is practically similar to the aforementioned Russian list on the same matter. The guaranteed scope of free medical care, consisting of a minimum set of services, which among other conditions includes antenatal care and HIV diagnosis and treatment, is provided only to those migrants who reside permanently in Kazakhstan (which practically does not apply to labour migrants).

Statutory (or mandatory) social and health insurance (OSMS), which provides a broader package of health services, including family planning, SRH and STI care, is available only for migrants with a permanent residence permit, subject to contributions from their employer or personal contributions from self-employed persons.

A precondition for granting work permits in Kazakhstan to citizens of Tajikistan and Uzbekistan is having voluntary medical insurance, but this policy does not necessarily include antenatal, postnatal care, and SRH services. Labour migrants from EAEU member states also need to have a voluntary health insurance policy in order to receive planned medical care.

Primary health care can be provided to migrant workers by getting assigned to an outpatient clinic of their choice based on the above-mentioned policy for the period of its validity. Irregular migrant workers can use only paid medical services for cases that do not require urgent interventions.

Foreign nationals living with HIV are not deported from Kazakhstan, but they are provided with ARV prophylaxis and HIV treatment at the government's expense only if they live in the country permanently. Migrants living with HIV can be provided with ARV drugs at the expense of donor organizations or their own expense.

In Turkey, migrants and their families are also entitled to receive free medical care to the extent necessary to save their lives or avoid irreparable

damage to their health, just as Turkish citizens are. Turkey's general health insurance scheme (Genel Sağlık Sigortası) mandates that all residents have a health insurance, whether public or private. Foreigners who have lived in Turkey for over a year are entitled to apply for general health insurance, subject to the payment of premiums. Foreign nationals working under service contracts are considered health insurance holders and pay the premiums. SRH and HIV services are provided under the same conditions as other health services.

Migrants with irregular status must pay for health services. However, they have free access to vaccination during the COVID-19 pandemic. Nevertheless, if an irregular migrant is reported to a health care provider, he or she can be deported, which prompts the migrants to avoid getting any health services. The irregular migrants' fear of seeking health services is further heightened during the COVID-19 pandemic, since all confirmed cases of the disease shall be registered.⁷⁰

3.2 Provision of sexual and reproductive services and commodities, as well as HIV prevention, diagnosis and treatment services to internal migrants in Central Asia and international migrants from Central Asia

3.2.1 Access to information

All experts interviewed agreed that migrants have very limited access to the SRH care information they need. Many international migrants find it difficult to overcome language barriers, as information in their mother tongue is available neither in the sending nor in the receiving countries.

According to experts, migrants usually do not know how to solve problems related to SRH - if they occur at their destination, including how to choose an appropriate medical organization to refer, what the approximate cost of services is, or where to go if they need legal, social, or psychological support. In Russia, many regular labour migrants from EAEU countries, in particular from Kyrgyzstan, are not aware of their right to obtain an OMS policy that would provide them access to free medical care.

As one expert said, although regular labour migrants from EAEU countries have been entitled to state-funded OMS for three years already, the relevant information is only spread by word of mouth in migrant communities. Neither the government of Kyrgyzstan nor the constituent entities of the Russian Federation take action to ensure that migrants have this information. *"If you have an OMS policy, you have no problem going to a maternity clinic, but if you don't, you need money to go there: you have to pay for everything. You can exercise your rights*

⁷⁰ Özvarışalır S.B., Kayı I., Mardin D. et al. COVID-19 barriers and response strategies for refugees and undocumented migrants in Turkey// Journal of Migration and Health, 2020, Vol. 1–2, P. 1-8
<https://doi.org/10.1016/j.jmh.2020.100012>

only if you know about them, but many people aren't aware of their right to OMS" (from an interview with an expert from St. Petersburg, Russia).


Another expert from Bishkek, Kyrgyzstan, reported that his non-governmental organisation (NGO) is currently implementing a project to support migrants travelling to Moscow. It helps make well-informed migration decisions and supports migrants during the migration period. Booklets in the Kyrgyz and Russian languages were developed to provide information on legal, social and health issues to migrants. The project is driven by donors who have allocated their funds for project implementation, being limited to key populations at high risk of HIV exposure and transmission.

Experts noted that many immigrants from Uzbekistan in Russia and Kazakhstan are completely unaware that they have to pay, while in migration, for routine health care, including antenatal care, family planning services and STI treatment.

Experts from Russia and Kazakhstan noted poor knowledge of migrants about HIV and STI transmission and its prevention. An expert from Turkmenistan, where even a discussion of SRH and HIV issues is taboo, and social media is blocked, noted that some migrants coming to the country's cities from rural areas knew nothing about condom use.

Experts from migrant communities in all countries also emphasise low demand for SRH information from both international and internal migrants, who do not place health on top of their priorities in life.

Lack of awareness on the prevention of sexual exploitation of migrant women was a specific topic that the experts paid attention to. All experts working for NGOs dealing with migrants were aware of cases when women from Central Asia, without a clear understanding of the cost of living, registration requirements, employment conditions, opportunities of support, access to health care, would come to the Russian Federation, Kazakhstan and Turkey, turn into sex slaves, have unwanted pregnancies and are denied of SRH services. The following are examples of typical cases provided by experts (all names are fictitious):


 *Nargiza, 23, a resident of the Fergana region of Uzbekistan, lived in the house of her husband Abdrazak, 27, who left for labour migration and did not return for a year. According to Nargiza's information, her husband worked on construction sites in Moscow. Nargiza decided to go to him to live together. She asked Ruslan, a mutual acquaintance of hers, who occasionally went to Russia to work and was planning to go there again to help her find her husband in Moscow.*

Together with Ruslan, Nargiza arrived in Moscow. The woman hoped to meet her husband on the day she arrived; she had no money to pay for accommodation, so Ruslan offered Nargiza, until he could track down Abdrazak, to live on credit on one of the premises of an abandoned sewing shop on the outskirts of Moscow. Several other women were living on the neighbouring premises. Nargiza noticed these women were being visited by different men and found out that the place she lodged in was an underground brothel (brothels are banned in Russia). However, Nargiza felt she had no choice but to stay there, waiting to meet her husband. She spent about a week like

that, ran out of money, her husband was still missing, and Nargiza started borrowing money from Ruslan, who would come to her from time to time for a modest meal.

Two weeks later, Ruslan began demanding repayment. Nargiza could not do so, and Ruslan offered to work off her debt by providing sex services, threatening physical violence if she did not do so. He also warned Nargiza, who did not speak Russian well, was new in the big city and feeling stressed, fearing that if she went to the police, she would be arrested for staying in Russia without mandatory registration for foreign nationals.

Nargiza agreed to be visited by migrant men from Uzbekistan. She practiced sex without a condom; she did not think about contraception. The payments for Nargiza's services taken personally by Ruslan and then by another man. The issue of Nargiza's migration status was settled. She started working as a cleaner in a shop owned by the brothel owner. Nargiza was constantly blackmailed: they promised to notify her relatives that she was selling sex, so she was afraid to return home. Nargiza got pregnant and had three children within three years. After the third birth Nargiza, could no longer do sex work. She felt ill and was exhausted, and her boss told her to leave the room. Nargiza had nowhere else to go, so she decided to return to her home village. With three small children, she travelled there with great difficulty for several days by land transport. She tried to live in her parents' house but was expelled along with her children and was left without a roof over her head and livelihood.

 Mahfuza, 30, a resident of the Bukhara region of Uzbekistan, is a single mother, raising her son alone. In 2019, she travelled to the city of Istanbul at the suggestion of her acquaintance named Dilorom, an Uzbek emigrant, who promised to employ Mahfuza as a shop assistant in a shop with wages much higher than in Uzbekistan, so that she could improve the financial situation of her family. Dilorom purchased a plane ticket for Mahfuza and helped place her three-year-old boy with a relative who agreed to babysit for a few months until Mahfuza returned home.

A man met Mahfuza at Istanbul airport, took her to a flat where he took her passport away, allegedly to register it with the police, and left. There were several other women and a man in the flat. After a while, Dilorom came and informed Mahfuza that her job would be offering sex services. Mahfuza tried to refuse and leave. The male guard would not let her out, moreover, Dilorom told her that Mahfuza's child's life was in her hands, that she would be killed if she disobeyed. Mahfuza complied. Dilorom accepted payment for sex. Two months later Dilorom handed Mahfuza over to another woman, allegedly to repay her debt to her. Mahfuza had to work off that debt too. A small house in a fenced compound, where she lived in one of the rooms, turned out to be a brothel where clients were offered drugs and alcohol.

The landlady did not care about access to condoms, Mahfuza and several other young women like her who lived there were not allowed outside the yard. From there, a few months later, Mahfuza was bought by a third owner of a brothel. The woman gained a regular customer there who eventually took her into his house as his maid and concubine. Mahfuza had no money, was forbidden to leave the house, had no access to contraception and, against her wish, became pregnant. Mahfuza tried to persuade the man to help her renew her passport and let her go to Uzbekistan, but he was relentless. One day, she chanced to use a home computer to send an email to her friend, asking for help. She, in turn, informed Mahfuza's mother about her daughter's situation. Mahfuza's mother called the hotline of the Republican Social Information Centre Istikbolly Avlod in Tashkent, which arranged the rescue of the enslaved woman a year after her departure.

3.2.2 Access to antenatal care

According to the experts, access to antenatal care for internal migrants varies from country to country. In fact, in all the reviewed countries, pregnant women, including migrant women, whether or not they have regular status, are eligible for free-of-charge emergency care in cases of life-threatening complications of pregnancy such as preeclampsia, placental disruption, and preterm labour. Pregnant women with such symptoms as bleeding from the vagina, sudden swelling of the hands or face, a pain in the abdomen, a fever, severe headaches, dizziness, persistent vomiting, and blurred vision can be referred to doctors/hospitals for diagnosis, and if the women are in a life-threatening condition, medical aid will be provided to them as long as a pregnancy-related condition persists.



In Kyrgyzstan, the right of pregnant women to receive a comprehensive package of antenatal care at any health facility is legally enshrined and generally respected. As one respondent indicated, *“pregnant women can go to an outpatient clinic for antenatal care, regardless of their residence registration, with no restrictions. This is very well established now. Pregnancy is the only condition that ensures access to health services. All doors are open.”*

The experts from Tajikistan pointed out that despite the formal permission for internal migrants to get a package of antenatal care at their place of residence in migration, provided they are duly registered, they are often sent for observation to the place, where they come from. Free scheduled antenatal care can be provided to internal migrants, who cannot register at the place of migration, only at the place of residence. At the same time, as one Tajik expert stated, *“...in any case, the standard package of mandatory tests that a pregnant woman has to take during pregnancy is fee-based and normally unaffordable for many women from rural areas who come to work in the cities”*.

In Turkmenistan, pregnant women receive free antenatal care at their place of residence or registration. The full package of services is only available to internal migrants who are registered at their place of residence in migration. Antenatal care, which is provided to internal migrants without registration, is limited to a general examination by an obstetrician-gynaecologist. Laboratory tests, ultrasound examinations and relevant specialists' consultations should be paid for.

In Uzbekistan, internal migrants, if they are registered at the place of migration, receive a free comprehensive package of antenatal care in the same way as local women. Internal migrants who are not registered at the place of migration and therefore are not assigned to local medical organizations can get scheduled antenatal care on a fee basis only. If they wish to receive these services for free, such internal migrants have to return to their 'permanent place of residence', often hundreds of kilometres away from the place of migration.

Experts from Kyrgyzstan, Tajikistan and Uzbekistan told interviewers that in all those countries, many pregnant women, internally migrated from rural areas, ignored antenatal care, including HIV and syphilis testing. Women continue to live and work at their place of migration until they go into labour, then they show up at maternity hospitals, where women in labour are normally admitted regardless of their permanent place of residence or identity papers.

There are no disaggregated data on the migrant status for either women first diagnosed with HIV at birth or pregnant women in any of these countries. However, experts from all countries estimate that internal migrants account for a significant proportion of both.

In general, the interviewed experts believe that access to antenatal care for all internal migrants in Central Asian countries, except Kyrgyzstan, at the place of migration, is very low or just low, or significantly less than for the rest of the present population.

In the Russian Federation, the comprehensive package of antenatal care is available to external migrants covered by OMS, which is accessible only for documented migrants from EAEU member states (only Kyrgyzstan among the four countries under consideration); in Kazakhstan only for migrants who enjoy guaranteed free medical care (i.e., only those who are registered as permanent residents and assigned to local medical organizations); in Turkey free scheduled antenatal care is accessible only for documented migrants covered by the universal health insurance.

Irregular international migrants can only receive paid scheduled antenatal care services in most of the cases, which many cannot afford. According to an expert from the Russian Federation (Moscow), most migrant women admitted to maternity wards are neither regularly observed in the antenatal clinics nor fully examined, and about one in five migrant women coming to give birth have not been previously examined at all, including testing for HIV. This view is consistent with the data from a study published in St. Petersburg. Year after year, approximately 14% of unregistered internal and external migrant women living with HIV start receiving ARV medicine for the first time only at the maternity clinic.⁷¹

3.2.3 Access to Perinatal Care

Regardless of their status, both international migrants from Central Asia and internal migrants in Central Asia are entitled to free intrapartum care. Formally, internal migrants in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan are provided with maternity services in their places of residence irrespective of their registration. There are no refusals to be admitted to

⁷¹ Мозарева А.Л., Самарина А.В. социально-демографические и эпидемиологические характеристики ВИЧ-инфицированных беременных женщин в Санкт-Петербурге, как фактор риска перинатальной передачи ВИЧ// ВИЧ-инфекция и иммуносупрессии. 2019б Том 11, Вып.3, С.7-15 (in Russian). <https://doi.org/10.22328/2077-9828-2019-11-3-7-15>

maternity hospitals, although in fact they are often referred to give birth at their place of residence.

However, as already mentioned, in the Russian Federation, migrant mothers without OMS are only entitled to free care until the third hour after the end of natural delivery and, in case of complications, as long as the mother's life is still in danger. In some regions of Russia, the local budget covers delivery assistance to international migrants. A representative of the Tajikistan migrant community, interviewed as an expert, reported: *"In Russia a relative's wife went into labour. She was admitted to a maternity without any problems, and she didn't pay for anything"*.

In Kazakhstan, as in Russia, childbirth assistance is free up to the end of delivery. As for postpartum care, once the mother's life and health are no longer in danger, she shall pay for all services. One of the experts explains: *"In my experience I had a woman in labour, a former Kazakhstan national, who emigrated, changed her citizenship, but then returned and worked under contract in the North Kazakhstan region, i.e., she was a temporary regular labour migrant. I brought her in labour to the maternity hospital; she was admitted; the delivery was physiological, and she gave birth to a baby girl. However, the day after delivery, the woman was told that she could not leave the hospital until she had paid 72,000 tenge (at that time, about US\$300) for the services she had received. It was a lot of money for a new mother. She was frightened, saying she would have been better off giving birth at home. The situation was resolved a week later when the owner of the firm where the woman worked paid the amount"*. Apart from the limited access to obstetric care for migrant workers, this case demonstrates migrants' low awareness of health services available for them in Kazakhstan.

In Turkey, free maternity services for irregular international migrants are also available, but only to the extent of emergency care.

3.2.4 Access to family planning


Free family planning services are available in places of permanent residence of officially working migrants in all Central Asian countries, and in places of migration only if the migrants are registered there. At the same time, an unmarried rural woman cannot apply for family planning services at her place of permanent residence or registration due to the conservative rural culture, which is intolerant of extramarital sex. In the village, many residents, including health workers, know each other and often have close interpersonal relationships, so that information about extramarital affairs is disclosed and shared. For young female unmarried internal migrants coming from rural areas (and these are the majority) and who are sexually active, the family planning services are acceptable only in big cities.

An expert from Bishkek (Kyrgyzstan), where family planning service is covered by OMS, notes: *"There are several categories of internal migrants. A*

small part of them (10–15%) has an official job, an OMS insurance policy; their employers make social payments for them. These migrants have unimpeded access to family planning services. Those employed in the "black" labour market make up the majority of internal migrants. They have no employment contracts, they do not pay into social security funds, they do not have OMS policies, sometimes they do not even have proper ID papers. They do not know how to buy an OMS policy (which is possible in Kyrgyzstan), or how to get assigned to a health clinic if they are registered at a place of residence in migration. Before 2015, UNFPA distributed contraceptives. People were getting informed and it created demand. However, the prices of oral contraceptives have recently doubled; due to the high cost (about 10 USD per month), hormonal contraceptives are not affordable to migrants who are rather poor. Implants, injectable contraceptives are not even on sale. IUDs are available in the country, and they are free, but there is a fee for their insertion and the fee is very costly for the poor".

The experts from Uzbekistan, Tajikistan and Turkmenistan also point out that of all the family planning services available in their countries, the insertion of IUDs was mostly accessible. All experts from Central Asian countries consider the access of internal and international migrants to family planning services during the stage of preparation for migration as insufficient.

In the Russian Federation, Kazakhstan and Turkey, family planning services are available to migrants on the same basis as antenatal care, i.e., for both regular and irregular migrants, they are paid services and are often unaffordable for many.

 *Anvar, 31, and Altynkul, 27, are a married couple from the Ferghana region of Uzbekistan, who have decided to travel to different Russian cities, rent low-cost housing there, and engage in flat and houses finishing and renovating business to earn some money. The couple is convinced that this occupation is a kind of personal service for money and concerns only them and their employer (which of course they are mistaken about, author's note). The couple arrived in St. Petersburg. They believed they would be better off if they came to Russia twice a year for three months (90 days is the maximum period of stay during which a migrant from Uzbekistan without an official employment contract can reside in the country). According to them, many people from their village and nearby communities did so. They began to work without a formal employment contract with the owner of the housing in a new building, committing themselves to do the finishing work on a turnkey basis. The employer was found through an intermediary (an acquaintance who registered them in his flat).*

Anvar and Altynkul's two young children stayed at home with their older relatives. The couple did not plan to have any more children. Shortly before the migration, Altynkul inserted an IUD. However, after a few days of work in St. Petersburg the IUD fell out. Altynkul blamed it on physical exertion: she had to lift heavy weights. Initially, when the IUD was inserted, she was not warned about the risk of the IUD getting out of place. Altynkul went to an outpatient clinic in St. Petersburg for contraceptive advice, but was refused to get the service for free. As she and Anvar were short of money, the couple decided to practice the withdrawal method remaining sexually active.

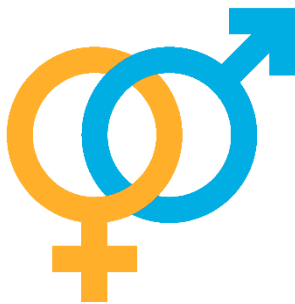
Two months later, Altynkul suddenly developed acute abdominal pain and uterine bleeding. The ambulance team took her to the hospital where she was operated on for an ectopic pregnancy. A week later Altynkul was discharged from the hospital for outpatient treatment. She did not feel well and could not continue working as a plasterer and painter. Anvar, in Altynkul's absence, was unable to complete the work in time and their employer refused to pay. The couple ran out of money. They had to move into a cubicle where another migrant couple was living behind a curtain. Previously the couple had rented a small room in a former dormitory on the edge of the city, but those days they could no longer afford it.

Their roommate has been staying in bed for two days. She has a high fever, a sore throat and continuous coughing. Altynkul thinks she has contracted COVID-19.

Meanwhile, the couple's temporary stay in Russia is expiring. They need to leave the country, but are unable even to purchase their return air tickets. The couple who decided to migrate for work took on the associated burden of health risks ignorant of limited access to family planning services for migrants in Russia. In addition, she was not prepared for migration, having scarce information regarding Russian legislation on foreign nationals.

3.2.5 Access to condoms and lubricants

Male latex condoms, along with other contraceptives, are available and sold unhampered in pharmacies and not only across Central Asia, as well as in Russia, Kazakhstan and Turkey. However, they are too expensive for most migrants. Social marketing sales of condoms and lubricants are not available in any of the countries.



Access to free condoms and lubricants is mainly available to migrants from key populations, in both migrant-sending and -receiving countries, if these people are involved in HIV transmission prevention programmes, largely funded by donors, e.g., through grants from the GFATM. Condoms and lubricants are distributed anonymously through donor-supported drop-in centres, friendly clinics, outreach centres, where people from key populations are not required to identify themselves as migrants.

However, according to respondents from Kyrgyzstan and Tajikistan, such programmes are not sustainable, and not all migrants from the target groups are aware of them. In Turkmenistan, according to the experts, there are no such programmes and there have never been any. According to respondents, in Tajikistan, male latex condoms are occasionally distributed through donor-funded programmes and reproductive health centres.

A respondent from Bishkek, Kyrgyzstan, laid out the issue of condom availability as follows: "The government hasn't responded to the population's need for cheap quality condoms, while business focuses on supplying and selling expensive brands and doesn't address the people's needs". The experts assessed migrants' access to condoms and lubricants as 'low to moderate' in all countries.

Female condoms are practically unavailable in Central Asia. They are not on sale in pharmacies, appearing only occasionally in Kyrgyzstan and Tajikistan

when purchased by international donors and distributed to members of key populations, especially SW who participate in donor-funded HIV transmission prevention programmes. In Russia and Turkey (Moscow, St. Petersburg, Istanbul) female condoms can be purchased in large cities' pharmacies, but they are not affordable to the vast majority of international labour migrants as their price is \$3–7 US per unit at the national exchange rates.

3.2.6 Access to safe abortion

As already mentioned, induced termination of pregnancy up to 12 weeks at a woman's request is legal in all Central Asian migrant-sending countries. Internal migrants can receive abortion services free of charge at their place of residence. Migrants shall be registered to receive abortion services at their place of residence. For internal unregistered migrants, medical abortion services at the place of stay in migration are provided for a fee in all Central Asian countries.

Elected safe abortions before 12 weeks of pregnancy are legal in Kazakhstan and Russia and before 10 weeks of pregnancy in the Republic of Turkey. In Turkey, however, not all gynaecological service providers accept public health insurance, some do not provide abortion services, therefore a regular migrant who has such insurance but does not speak fluent Turkish can find it challenging to receive the service. OMS and OSMS cover abortions in Russia and Kazakhstan respectively. However, as indicated, OMS in Russia is only available to regular migrants from EAEU countries, while in Kazakhstan, OSMS does not cover migrants.

Respondents in Kyrgyzstan, Tajikistan, Russia and Kazakhstan stated that migrants quite often resort to medical (drug-induced) abortions without a doctor's prescription. In Kyrgyzstan, there has been a significant decrease in registered abortions, while spontaneous abortions account for almost half of the abortions (42.7%).⁷² As stated by an expert in Bishkek (Kyrgyzstan), *"desperate poor pregnant women who come from rural areas buy smuggled abortion pills at bazaars, where many of these women work. The sellers instruct them on how to take the pills. In case of complications like prolonged heavy bleeding, severe pain and fever, women call an ambulance, which takes them to the hospital with supposedly spontaneous abortion. In this case, emergency intervention is required, but it will be carried out for free, regardless of whether they have OMS policy or registration. The abortion pills available in the market are believed to contain mifepristone or misoprostol. The sellers have no certificates of formulation, no name of the manufacturer, no track of storage conditions before the sale, the expiry dates are unknown... But in the market these pills are four times cheaper than the prescription drugs in pharmacies, which again the migrant woman has to pay for, so women choose the market"...*

An expert from Moscow expressed the same opinion: *"There is a big problem with abortions, because many migrant women are not able to pay for*

⁷² Женщины и мужчины Кыргызской Республики 2015–2019, Бишкек, Национальный статистический комитет, 2020, с. 123 (in Russian) <http://www.stat.kg/ru/publications/sbornik-zhenshiny-i-muzhchiny-kyrgyzskoj-respubliki/>

pregnancy termination in the official clinics, so they look for other ways. They buy pills from their acquaintances at their own risk, and then, if they develop bleeding and fever, they call an ambulance to take them to the hospital, and emergency care in Russia is free for everyone."

The inadequate access of migrants to termination of pregnancy is further illustrated by a case described by an expert from St. Petersburg "A migrant woman from Uzbekistan, who failed to terminate her pregnancy in time, decided to have a late abortion on her own. For this purpose, she used some improvised means in trying to puncture the amniotic fluid sac, but instead she perforated her uterus. Massive bleeding developed. The ambulance arrived on time and the woman's life was saved, but the uterus had to be removed."

The respondents from Uzbekistan unanimously agreed that vacuum aspiration and surgical abortion dominate among abortion techniques, considering a large proportion of migrant women use medical abortion to control childbirth. However, since health workers are paid informally to perform abortions, they do not keep medical records and do not register abortions.

An expert from Turkmenistan, cited examples she knew of internal migrant women who failed to have timely abortions at their place of migration would give birth and commit infanticide.

The experts noted that in all countries, when accessing medical abortion services, clients have to make informal payments to health-care providers in addition to formal payments to avoid having their cases registered in medical records.

If a woman went out alone without a husband, had sex while in migration and became pregnant, she had to have an abortion and this fact should be kept secret," said a respondent from Tajikistan. In Central Asian countries, especially in rural areas, unmarried women who give birth are severely stigmatized by the local community, all the way to ostracism. If a woman becomes pregnant, according to respondents, in most cases she has no choice but to have an abortion.

All experts agree that abortions are common among migrants, mainly because migrants often cannot afford contraceptives.

3.2.7 Access to STI treatment

STI treatment is available to female and male migrants, mostly at their own expense. Internal migrants in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan can have a free medical check-up provided they have registered "at their place of residence in migration" and are assigned to a local clinic. However, they have to pay for laboratory tests and medicines. Internal migrants without registration are not eligible for free STI treatment in places of migration. The friendly clinics, which operate in Kyrgyzstan and Tajikistan with funding from the GFATM grant, provide STI treatment services to key populations (men who have sex with men, sex workers and people who inject drugs), including migrants, using a syndromic approach to STI case management. (That approach involves making clinical decisions based on a patient's symptoms and signs. In

settings with limited or no molecular tests or laboratory capacity, WHO recommends syndromic management to ensure treatment on the same day of the visit, which is a priority. In such cases, WHO advises strengthening the syndromic approach by using quality-assured rapid tests with a minimum sensitivity of 80% and a specificity of 90%, if available⁷³). According to experts, as of late, patients at friendly clinics have to purchase medication, which not everyone can afford.

The experts rate access to STI treatment for internal migrants in Kyrgyzstan on average as 2 out of 5 (on a five-point scale where 1 is 'none' and 5 is 'excellent').

"There are no inexpensive antibiotics, diagnostics are paid for. The outpatient clinics do some tests, but not all that is necessary. You have to go to private laboratories, for example, to diagnose chlamydia infection using polymerase chain reaction or culture diagnosis of gonorrhoea, so you still have to pay for treatment. That's why people self-medicate," concluded an expert from Bishkek, Kyrgyzstan. Similar assessments refer to Tajikistan.

In Uzbekistan, anonymous STI treatment is only available for a fee. Apart from examinations, it also involves expensive tests. According to experts, most internal migrants cannot afford such treatment. Free STI treatment is available at the place of permanent residence. Moreover, it is not anonymous and requires registration, which makes it unacceptable for many migrants. Therefore, internal migrants, in case of symptoms suspected of STI, seek advice from health workers they know or even from pharmacies and peer migrants.

Based on a sentinel surveillance survey conducted in Tajikistan in 2020, 7% of men and 15% of women said they had experienced symptoms of STIs while in migration. However, only 57% of men and 26% of women with such symptoms sought medical attention while in migration. Before migration, 60% of men and 59% of women in Tajikistan reported seeking treatment from health care providers when experiencing STI symptoms, which illustrates low access to STI treatment in the country and particularly for women in migration outside of Tajikistan.⁷⁴

In the Russian Federation, STI treatment is a paid service for migrants. Statutory health insurance, which is available to migrants from EAEU countries, does not cover STI treatment. Treatment of these infections for Russian citizens is financed from the state budget and is considered to be planned medical care. In Kazakhstan, OSMS covers the costs of STI treatment except for medicines. However, as already noted, only international migrants with the status of permanent residents of Kazakhstan can obtain such insurance. Therefore, STI treatment services for migrants are chargeable. The international migrants from key populations participating in HIV prevention programmes in Kazakhstan are

⁷³ Guidelines for the management of symptomatic sexually transmitted infections, World Health Organization, 2021
<https://www.who.int/publications/i/item/9789240024168>

⁷⁴ Service data of the Republican Centre for AIDS Prevention and Control of the Ministry of Health and Social Development of the Republic of Tajikistan

eligible for STI treatment in friendly clinics, but the number of such clinics is limited.

According to the experts, in migrant receiving countries, also, most international migrant workers, if they have STI symptoms, rely on advice from medical professionals they know or pharmacists and fellow workers. Until recently, antibiotics were categorized as non-prescription drugs in the Russian Federation and Kazakhstan were sold over-the-counter. Even now, however, they are not considered 'strictly controlled medicines', so arrangements can be made with pharmacy staff who are interested in selling them, according to experts. A smaller share of migrants uses paid STI treatment services, making both formal and informal payments to doctors to avoid having their illnesses reflected in medical records.

Untreated STIs pose a high risk to others and frequently have serious consequences, such as infertility, miscarriage, ectopic pregnancy, and damage to internal organs and the nervous system. STIs are very widespread throughout the world, and the most common bacterial STIs: syphilis, gonorrhea, urogenital chlamydia, infection caused by *Mycoplasma genitalis*, and trichomoniasis are completely curable if diagnosed and treated properly. Paradoxically, STIs are not on the list of infections for which medical care is provided free of charge to the entire present population including migrants in any of the three reviewed migrant-receiving countries.

3.2.8 Access to voluntary HIV testing

HIV testing sites are available in all countries. Immunoassay (ELISA) testing for HIV 1 and HIV 2 antibodies is anonymous and free. However, according to the experts, voluntary HIV testing among internal and international migrants is not in high demand. Migrants underestimate the severity of the problem. Experts emphasize that the highest priority for both internal and international migrants is to earn money and thereby survive. A sentinel surveillance among international Tajik migrants showed that only 42% of them were tested for HIV infection in their home country and 59%, while in migration.⁷⁵ This number includes those who had mandatory HIV testing required to acquire a patent to be legally employed in Russia. Moreover, the certificates of HIV status issued by Russia's accredited medical organisations only are recognised in the Russian Federation. According to an expert from Turkmenistan, HIV testing makes no sense at all for migrants, as the results in most cases are not communicated to clients.

The Russian Federation receives the largest number of migrants from Central Asia. The country's officially registered HIV rates are rather high: In 2020, HIV prevalence among the general population was 0.75% and HIV incidence (the number of new HIV cases per 100,000 population) was 49.1, of which 65% were

⁷⁵ Service data of the Republican Centre for AIDS Prevention and Control under the Ministry of Health and Social Development of the Republic of Tajikistan

attributed to sexual transmission.⁷⁶ The migrants, many of whom are away from their families, find sexual partners among the local population and become exposed to HIV transmission.⁷⁷ As follows from the reports of the respondents during this source, migrants also use the sexual services of other migrants originated from the same country, many of whom are forced for sex (in fact, being in slavery). This limits their ability to protect themselves from HIV / STI infection, as well as from HIV transmission to their partners.

Rapid HIV antibody tests are available both in Kyrgyzstan and in Tajikistan, from donors to nongovernmental organisations. However, these tests are only occasionally available when donor agencies procure test kits for the programmes they support. HIV rapid tests for self-testing are available in pharmacies in major cities in the Russian Federation and Kazakhstan. According to experts, there is little overall demand for HIV testing among migrants – the cost of rapid HIV-1/HIV-2 antibody test that uses whole blood is US\$3–4, or saliva US\$12–14 (based on the national currency exchange rate).

As already mentioned, in Russia, international migrants with HIV are subject to deportation; they are not provided with HIV treatment. Planning their life, it is important for people who have tested positive for HIV antibodies to ascertain whether they are actually living with HIV. Previously, an immunoblot technique based on mixing natural HIV proteins with antibodies from blood serum obtained for investigation was available anonymously in Russia. That assay is used to validate a positive ELISA result, which is based on the ability of synthetic HIV proteins to interact with antibodies in blood serum and thus, to make a diagnosis of HIV infection. From September 2021, however, confirmation tests are no longer anonymous, as the health authorities have been collecting personal data of people with confirmed HIV infection. The relevant information is forwarded to the Federal Service for Consumer Rights Protection and Human Welfare, which issues orders prohibiting HIV-positive migrants from further staying in the Russian Federation. The instructions are communicated with the immigration authorities, who are in charge of deporting and barring migrants with HIV from entering the country.

Free counseling and ELISA-based HIV testing are available in Turkey and Kazakhstan without the need to disclose personal information. Migrants who get a positive ELISA test can decide what they want to do next. They are not deported, and they are not prohibited from traveling to those countries. The vast majority of them, however, are not eligible either for the free confirmative immunoblotting or free HIV medication (please see below).

Thus, the main challenges in migrants' access to HIV testing boil down to underestimating the risk of HIV transmission and the migrants' rejection of

⁷⁶ Data from the Federal Research and Methodological Centre for AIDS Prevention and Control of the Central Research Institute of Epidemiology of Data from the Federal Research and Methodological Centre for AIDS Prevention and Control of the Central Research Institute of Epidemiology of Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing of Russia.

⁷⁷ The Gap Report, UNAIDS, Geneva, 2014

https://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report

testing, which, if positive, can lead to adverse consequences such as deportation (and loss of livelihood), but not getting treatment.

3.2.9 Pregnant women's access to HIV testing

Access to HIV testing of pregnant women is closely linked to access to antenatal care, as two-time HIV testing is part of its clinical protocol in both Central Asian migrant-sending countries and Russia and Kazakhstan. Testing for HIV antibodies is initiated on a mandatory basis by the antenatal care provider. At the same time, an expert from Tajikistan noted that due to a shortage of tests for all pregnant women, only those women at high risk of HIV exposure are tested twice during pregnancy. Internal migrants are not considered as such.

In the Russian Federation, where one in every 110 pregnant women was HIV positive in 2020⁷⁸, access to antenatal care for pregnant migrant women is very low. As a result, many of these women are not properly screened. In Russia, pregnant international migrant women are not sufficiently motivated to be tested for HIV. If a woman is HIV positive, she is offered immediate deportation. According to the expert, an obstetrician-gynaecologist, in Moscow, if a pregnant migrant woman is found to be HIV positive in the late stages of pregnancy, she is prescribed antiretroviral therapy before delivery and ARV prophylaxis during delivery at the expense of the city. However, this is an exception to the rule. After giving birth in Moscow, treatment stops, the mother, and her newborn baby shall be deported by law.

3.2.10 Access to ARV therapy

In Turkmenistan, people living with HIV, regardless of whether they are migrants or nationals, do not have access to antiretroviral therapy. As it was stated above, although such people do evidently live in Turkmenistan and the local experts have interviewed some of them personally, the government denies their existence.

Antiretroviral therapy is available in Kyrgyzstan, Tajikistan and Uzbekistan, in part thanks to GFATM grants. Migrants can receive ART free of charge for up to three months in Uzbekistan, up to six months in Tajikistan and up to twelve months in Kyrgyzstan. A further provision of antiretroviral medicines depends on screening results, including viral load laboratory tests, and the CD4 cell count of a person living with HIV.

Internal migrants who do not have registration at their place of residence while in migration shall receive ARV drugs at HIV treatment centres, which provide HIV services at their original place of residence, while internal migrants who have registration at the place of migration can receive ARV drugs at their place of actual residence. An expert from the community of internal migrants living with HIV in Dushanbe, Tajikistan said: *"I have been in Dushanbe for over*

⁷⁸ Data from the Federal Research and Methodological Centre for AIDS Prevention and Control of the Central Research Institute of Epidemiology of Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing of Russia

2 years, I rent a flat with my sister, and we do not have registration. I sell things in the bazaar. I have always received ARV drugs in Dushanbe from the AIDS Centre without any problems. Now they say I have to get the drugs in the district where I live. At the beginning of the COVID-19 pandemic, we were all given pills for six months. After the pills ran out, I had to go to the city of Khorog, the Gorno-Badakhshan Autonomous Oblast, by a mountain road 600 km away from Dushanbe to get pills for another six months. The fare is expensive, and it is very inconvenient."

In Russia, migrants from Central Asian countries have virtually no access to free HIV treatment (except migrants in penitentiary institutions). An expert from Osh, Kyrgyzstan, a doctor from the regional AIDS Centre, said: *"Migrants with HIV are returning to Kyrgyzstan to die. There have been three such cases in recent months alone, and they have been guys under 30 years old. International migrants working in Russia and Kazakhstan account for the majority of AIDS-related deaths. They return to the country in the terminal stage of disease with tuberculosis and other opportunistic infections and with a very low CD4 cell count. There is nothing we can do despite all the medicines we have. Because of the COVID-19 pandemic and closed borders, one of the patients was unable to leave Kazakhstan for several months. And when he arrived, it was too late."*

In Kazakhstan, access to free HIV treatment for migrants is limited to permanent residents and the migrant population in penitentiary institutions. An expert from Almaty, Kazakhstan is reflecting the sentiments in some circles regarding migrant workers' access to HIV treatment, even though they pay all due taxes as local nationals do: *"Society is not willing to be complacent about those spreading HIV; migrants with HIV should be treated at the expense of their countries of citizenship or, if available, with the support of international organizations"*.

To overcome the lack of access to ARV treatment for migrants living with HIV in Moscow, there are community-based organisations of Tajik and Kyrgyz nationals that facilitate the supply of ARV drugs from their countries of origin to their compatriots living in Russia. The capacity of these organisations, however, is low.

Kyrgyzstan partially provides ARV drugs to migrants living with HIV who, although subject to deportation, remain in Russia. From a legal perspective such people are not deprived of the right to receive proper medical care. AIDS Centres transfer ARV drugs by proxy to individuals, including representatives of non-governmental organisations, who are authorised by people living with HIV who are registered at the centres and are in migration to receive the drugs for them. According to the national clinical protocol, ARVs can be dispensed for up to one year. Medicines in volumes for individual use are sent to Russia by parcel using courier delivery services or through intermediaries. Courier services are paid for by donors.

A person living with HIV in Russia regularly has his/her blood tested for viral load, gets the CD4 cells count and other indicators in private laboratories and then communicates with the doctor from an AIDS centre in Kyrgyzstan

through a mobile app to share test results and other relevant information, and receive further advice from the physician.

Naturally, access to HIV treatment for migrants using this option is limited, including their financial capacity to take laboratory tests and pay for additional consultations at commercial medical centres in the places of migration, which may be required by the specific course of HIV infection. Besides, private laboratories whose technical capacity allows monitoring of viral load and immune status of people with HIV, as well as private health centres providing treatment services for people with HIV, are available only in some Russian cities where migrants work. Finally, nobody provides adherence support for migrants living with HIV, which is crucial for many migrants, particularly those who inject drugs.

An alternative option for migrants living with HIV in Russia is to pay for treatment in full, including the purchase of antiretroviral drugs from pharmacies. However, the vast majority of HIV patients cannot afford it, especially in Moscow.

In Kazakhstan, the duly registered international migrants living with HIV have equal access to the ARV drugs as all other people living with HIV thanks to the GFATM grant, which covers the cost of ARV drugs and laboratory testing. There are no government budget allocations for the treatment of migrants in Kazakhstan, as it is in Russia. Antiretroviral drugs are not available to international migrants who do not register at the place of migration.

In Turkey, HIV treatment for international migrants from Central Asian countries is expensive and therefore not widely available.

3.2.11 Access to pre- and post-exposure prophylaxis of HIV

Pre-exposure prophylaxis (PrEP) is primarily topical for key populations and, in particular, men who have sex with men.⁷⁹ Access to post-exposure prophylaxis (PEP) used to reduce the risk of HIV infection after an exposure to HIV, is equally essential for other populations, including those not related to their occupation (e.g., unprotected sex with a stranger or an episode of injecting drugs using somebody else's injecting equipment). The level of access to ARVs, in fact, reflects the level of access to ARV prophylaxis. In all countries except Turkmenistan, where ARVs are not available, such access is formally provided, although unregistered internal migrants can usually get ARVs in facilities serving the population at their place of residence. In Kyrgyzstan, PEP is provided to everyone at the Republican AIDS Centre and ambulance stations regardless of their permanent residence, mainly at the expense of the GFATM grant.

However, access to PEP is actually very low because of the limited population awareness of that option and unacceptable conditions of its provision due to hostile attitudes faced by key populations in all countries. Furthermore, receiving these services requires applicants to provide documented personal

⁷⁹ What's the 2+1+1 event-driven oral pre-exposure prophylaxis to prevent HIV for men who have sex with men: Update on WHO's recommendations on oral PreP – Technical Brief, 2019 EVENT-DRIVEN ORAL PRE-
<https://apps.who.int/iris/bitstream/handle/10665/325955/WHO-CDS-HIV-19.8-eng.pdf?sequence=1&isAllowed=y>

information. Many people from key populations prefer not to disclose their personal information. Access to PrEP and PEP in the case of homosexual contact is particularly denied to MSM in Uzbekistan, where consensual sex between two adult males is a criminal offence.

In Russia, PrEP and PEP are not offered free of charge to migrants. In Kazakhstan, PrEP and PEP are only available at AIDS centres for registered international migrants (as ARV procurement for migrants in Kazakhstan is funded by international donors), but these services are not available to irregular migrants.

The experts believe that in the Russian Federation and Kazakhstan, key populations, including migrant MSM, who know about PrEP and PEP and can afford it, buy ARVs from pharmacies after getting prescriptions from doctors they know or from private clinics. The experts underscore that very few international migrants are aware of PrEP and PEP and their availability.

3.2.12 Access to services of preventing and overcoming the impact of violence against women


The constitutions of Central Asian countries, Kazakhstan, Russia and Turkey guarantee equal rights of women and men. Physical violence against both sexes, by and against whomever it is committed, is a criminal or an administrative offence, depending on the severity of the injuries inflicted, while sexual violence is a criminal offence. Depending on the nature and gravity of the crime committed, the laws of all countries provide for public, private-public and private prosecution. The health sector provides health care services for women subjected to violence, including emergency medical care for migrant women where necessary, informs law enforcement bodies about cases of physical violence, and refers women to other support services they may need. The related organisations, including governmental, non-governmental and religious organisations, set up crisis centres, which can be funded by governments, donor organisations and communities. In these centres, victims can find refuge from their abusers and receive both psychological and legal assistance. However, according to experts, these crisis centres are generally meager and under-funded.

The main issue with supporting victims of gender-based violence is women's lack of awareness of their rights and cultural barriers that make seeking help unacceptable for women subjected to domestic violence. In Tajikistan, for example, 97% of men and 72% of women believe that a woman must endure violence to keep her family together, and over 60% of women, aged 15–49 condone acts of violence by their husbands.⁸⁰ In Turkmenistan, 44% of urban dwellers and 69% of rural dwellers believe that a husband has the right to

⁸⁰ Таджикистан, Медико-Демографическое Исследование, 2017, Основные результаты, Душанбе Агентство по статистике при Президенте Республики Таджикистан – <https://www.stat.tj/ru/news/publications/new-survey-shows-improvement-in-maternal-and-child-health-in-tajikistan>

physically abuse his wife.⁸¹ In Kyrgyzstan, the figures are 22% and 35% respectively.⁸²

The gender role of women in patriarchal societies is limited to domestic work; at the same time, a woman has to be obedient to her husband, on whom she depends financially. The tradition of female subordination maintained in patriarchal societies makes migrants' wives particularly vulnerable. In Tajikistan, migrant wives account for about half of women living with HIV.⁸³ Female migrant workers are employed in industries and help their families financially, contrary to the established beliefs. However, they also remain committed to traditional gender roles. Central Asian migrants bring these traditions to migrant receiving countries as well. An expert from St. Petersburg (Russia) gave the following example to illustrate this point (all names are changed).

 *Niso, 34, came to St. Petersburg, Russia, to earn money and lived there for two years. Initially, she sold sex services. Two children were left at home in the care of relatives; Niso's husband died. In St. Petersburg, she met a migrant from her country of origin, named Toshmat, who had also come to Russia to earn money. The two people moved in together. Toshmat worked at a construction site, while Niso took over the household. Toshmat had a wife and three children in Tajikistan, but he had promised to marry Niso (she saw no problem in becoming another Toshmat's wife). Niso had unprotected sex with her partner, as Toshmat was unwilling to use a condom, and Niso, as his wife, did not dare contradict him. The woman became pregnant and went to a fee-based clinic for testing, where she found out that she was HIV-positive. The cohabitant was also tested and diagnosed with HIV. Toshmat blamed the HIV transmission entirely on Niso; he refused to get treatment in St. Petersburg for money or to go to Tajikistan to get treatment there free. He started beating up Niso regularly. Niso lived through her entire pregnancy in a situation of physical violence; she had no money for HIV treatment as her partner refused to give her money for any health services. Niso, who was pregnant, did not seek help to deal with her partner's abuse, believing that he had the right to it as her husband. After another beating, Niso went into premature labour at the 36th week of pregnancy and gave birth to a baby boy. It was only after the birth that she decided to return to Tajikistan. In June 2021, thanks to the support of "Malta Help Service" in St. Petersburg, Niso was able to buy a plane ticket and leave with her baby. Toshmat, on the other hand, continues to work in St. Petersburg; he has another concubine. He does not receive ARV therapy and does not consider using condoms.*

3.2.13 Specifics of access to sexual and reproductive health and HIV services for migrants from key populations

The experts from Central Asian countries rated the internal migration of individuals from key populations, who move from rural to urban areas, as well as

⁸¹ Turkmenistan Multiple Indicator Cluster Survey, 2018 Snapshots of Key Findings, 2019
<https://mics.unicef.org/surveys>

⁸² Kyrgyz Republic Multiple Indicator Cluster Survey, 2018 Snapshots of Key Findings, 2019
<https://mics.unicef.org/surveys>

⁸³ Болтаева М.Р. Гендерные аспекты ВИЧ-инфекции в Восточной Европе и Центральной Азии. 2017 (in Russian)
<http://congress-ph.ru/common/htdocs/upload/fm/vich/17/prez/5-A3-4.pdf>

international migration to Russia, Kazakhstan and Turkey, as very intensive. Besides economic factors, stigmatisation and discrimination are the drivers of key populations' migration.

The conservative rural population in Central Asia is hostile to men who have sex with men and sex workers. In rural communities, where privacy is hard to maintain, men who have sex with men can hardly exercise their sexuality and tend to move to big cities, where they can get away from the public eye. Sex workers are also facing particularly hostile attitudes in remote areas and find it more difficult to attract clients there and so sex work is mainly concentrated in urban areas. People who inject drugs also predictably migrate to cities, where they have better access to drugs.⁸⁴

When HIV infection in Central Asia has become predominantly sexually transmitted, the health needs of migrant MSM and SW are largely centred on the availability of SRH services, in particular, STI and HIV prevention, testing and treatment. As the pattern of new HIV cases throughout Central Asia and Eastern Europe is largely dominated by heterosexual transmission, HIV is now found in almost a quarter of MSM in several cities of the Russian Federation.⁸⁵ The seeming discrepancy can be explained by the relatively small size of the MSM population (its median in different regions of the world range between 1% and 3% of adult males aged 15–49 years⁸⁶). The sexual transmission of HIV beyond the MSM population into the general population occurs as a result of linkages between sexual networks. A significant proportion of MSM, particularly in countries where they feel forced to marry or have partnerships with women, according to traditional culture, also reports having sex with women⁸⁷. Hence, prioritizing interventions addressing sexual risks among MSM is obviously critical to controlling HIV epidemic.

The key populations are stigmatised at the individual, interpersonal and structural levels, which reflect negative stereotypes in public perception; additional stigma affects migrant key populations due to xenophobia, resulting in expulsion of 'outsiders' from the local community. As a result, migrants from key populations are subject to double discrimination at different levels.

Punitive legal systems reinforce stigma against key. For example, consensual sex between adult males is criminalised in Turkmenistan and Uzbekistan; selling sex to adults in these countries is also considered socially

⁸⁴ World Drug Report, Executive Summary United Nations, 2020
https://wdr.unodc.org/wdr2020/field/WDR20_BOOKLET_1.pdf

⁸⁵ Data from the Federal Research and Methodological Centre for AIDS Prevention and Control of the Central Research Institute of Epidemiology of Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing of Russia

⁸⁶ Key populations strategic information: recommended population size estimates of men who have sex with men – Technical Brief, World Health Organization, UNAIDS, 2020
https://www.unaids.org/sites/default/files/media_asset/2020-recommended-population-size-estimates-of-men-who-have-sex-with-men_en.pdf

⁸⁷ Xiufang L, Beichuan Z., Juan Wang et al. Sexual health status of women who have regular sexual relations with men who have sex with men in mainland China// BMC Public Health, 2017 Vol. 17, P. 168
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5294694/>

disparate, although to a lesser extent: sex workers detained for the first offence face an administrative fine or arrest.

Sex work is also considered an administrative offence in Russia and Tajikistan. In the latter two countries, consensual sexual relations between adult males are not considered an offence by law. In Kazakhstan, Kyrgyzstan, and Turkey, neither consensual sex between men nor sex work as such is an offence. Differences in the legal environment constitute one of the factors determining the migration patterns of MSM and SW, although in all the countries surveyed, sex between men and selling sex are heavily stigmatised by large segments of society.

PWID are also vulnerable to punishment by law. Although drug use is not formally criminalised, in some countries, such as Turkmenistan, the mere discovery of drugs in the possession of a drug-dependent person, even in minimal quantities, provides grounds for legal action against the individual.

People from key populations are afraid of data sharing between health care providers and law enforcement agencies, they believe that their personal information can be misused, including information on their HIV status. They are also in fear of disdainful treatment by health personnel. If members of these groups are internal or external migrants, they feel even less protected.

There are almost no information resources on SRH and HIV services for key population migrants in national languages of Central Asian countries. In Turkmenistan and Uzbekistan information resources that are essential for MSM and SW, preparing to migrate, including information on less risky sexual practices, condom and lubricant choices, is also not available in Russian, as specialised Internet resources are blocked.

The research conducted by the Qurium Media Foundation, a Swedish non-governmental organization, showed that all popular social networks, including Facebook, Twitter, YouTube, Odnoklassniki and VKontakte are also blocked in Turkmenistan, besides using VPN services is prohibited⁸⁸. According to one of the experts from an HIV service organisation that works among MSM in Moscow, it results in *"very poor awareness of HIV infection and its prevention among migrants from Central Asian countries. They often take psychotropic and dissociative drugs, such as ketamine, and lose control over the situation while not using condoms. For example, one MSM migrant fell ill with syphilis six times in four years. It is hard to "reach out" to Central Asian migrants; they do not know the fundamentals; they have to be shown everything in pictures."*

An expert from Osh, Kyrgyzstan, drew attention to the fact that urban MSM communities increasingly practiced chemsex – sexual activity while under the influence of stimulant drugs including mephedrone, amphetamine, methamphetamine, etc. However, migrants from rural areas, joining these communities, had no specific information about HIV prevention. In fact, intentional sex under the influence of psychoactive drugs (chemsex), mostly

⁸⁸ <https://www.qurium.org/alerts/turkmenistan/turkmenistan-and-their-golden-dpi/>

among MSM, has been practiced in many countries for at least a decade⁸⁹. It looks like it is now reaching urban settlements in Central Asian countries, where MSM populations that are intensively moving from remote rural areas both within their countries to big cities and externally to other countries, may not be aware of how to cope with that challenge, and their vulnerability to HIV acquisition increases.

Sex workers

An interviewed expert from a sex worker NGO in the city of Nur-Sultan (Kazakhstan) noted: *"Internal migrants who sell sex often have neither registration, nor OSMS; therefore, they are not assigned to any primary health care clinics. This is why they cannot see a gynaecologist for free. Since condoms are not always used, some of these women get pregnant and perform medication abortions at home using contraband pills made in China, which they buy from strangers in the market. They don't do post-abortion examination". In the six months of 2021, 19 sex workers approached our NGO for anonymous, gynaecologist-friendly services to get abortion medications, STI and HIV testing, and STI treatment. Although sex work is not illegal, the police conduct raids against women who sell sex, and then coerce them to be tested for HIV during these raids. If a sex worker is found to be HIV-positive, they can be accused of knowingly exposing other people at risk of HIV acquisition and face a criminal charge. It interferes with the sex workers' intention to continue sex work. So, knowing their HIV status is disadvantageous for sex workers from a legal standpoint. "*

"The internal migrants who sell sex have no passport, no OMS policy, no money, and no residence permit. If they need SRH services, they can only go to private clinics. They can still go to the AIDS centre to get HIV services, thanks to the GFATM grant, but any issues related to pregnancy are chargeable for them," said an expert from Osh (Kyrgyzstan).

Experts from Ashgabat (Turkmenistan) highlighted the low access to SRH services for migrants who sell sex. Sex worker who come from rural to urban areas, as a rule, do not have social ties, means or knowledge on how to protect themselves from STIs, including HIV infection, and unwanted pregnancy. They do not get tested for HIV, ignore possible STI symptoms, and agree to sex without a condom. They are afraid to seek medical attention from public health institutions because they believe that if they do, law enforcement agencies would find out their occupation and subject these people to administrative or even criminal penalties.



Sex worker Bahar (not her real name), 38, single, 9 years of school education, has a 20-year-old son living with her mother in her brother's family in the countryside, where she is formally registered. In fact, Bahar lives in Ashkhabad, where she is not registered, rents accommodation together with her friend and formally earns her living by helping to sell food at the market. This income is not enough to

⁸⁹ McCall H., Adams N., Mason D., Willis J. What is chemsex and why does it matter? BMJ 2015;351:h5790 <https://www.bmj.com/content/351/bmj.h5790>

support her brother's family and pay the rent. She provides sex services at a price of 50–100 manats (equivalent to US\$12–25 according to the official exchange rate). She finds clients in Ashgabat by calling people involved in the clandestine organisation of the illegal sex business; she has two or three clients a day. Occasionally, she travels with her friends to other localities in the country for sex work. She says the pay is lower there but the clients are more. She is addicted to alcohol. She dreams of finding a male partner to help her around and leave for Turkey with her.

Bahar does not use condoms. She believes that condoms are expensive and meant only for the sick, whereas she feels well and her clients are also healthy, "because they are married". She does not know how to properly use a male latex condom. She has never seen a female condom. She does not practice regular testing for STIs. She had her last induced abortion two years ago at 10 weeks of pregnancy "using her personal connections" for a fee at a medical institution without getting registered. She was detained by the police for engaging in sex work and held administratively liable. At the time, she had a blood test for HIV infection, but she does not know the results of the test.


According to experts, many Central Asian sex workers perceive the physical, sexual and moral abuse to which they are subjected by their clients as part of their job. As it happens, they suffer physical injuries. Fearing that the circumstances of their injuries, and therefore their occupation, will become known to third parties and information will be passed on to their relatives, sex workers, particularly those from rural areas, do not seek, as a rule, legal or even medical assistance. In addition, not being registered at the place of migration, they cannot receive health care services for free unless for life-threatening conditions and many cannot afford to pay for medical services. Migrants who sell sex coming from Central Asian countries to work in Russia feel deprived of civil rights: *"Humiliated, insulted, beaten up, raped... Nothing can be done in response, except to spit in the back..."* from an interview with a community representative in St. Petersburg.

Men who have sex with men

An expert from Khujand, Tajikistan reported that it has become more closed, as discrimination against them has increased over the last 2–3 years. In his opinion, this is linked to the ongoing de-secularisation of society. MSM migrate internally and externally; in areas of their migration where they are not known, they have casual relationships and do not form stable couples as this might arouse suspicion. MSM fear ridicule, humiliation and insults from health staff, so if they seek SRH services, they usually see the physicians they know well and pay them. There is little information in the Tajik language about SRH, including HIV, which MSM need. Another expert from Dushanbe, Tajikistan, reported, that a number of MSM migrating to Russia, particularly to Moscow, engage in sex work and have unprotected sexual contacts. *"Health is not a priority for MSM migrants. MSM with HIV who migrate to Russia have no desire to return home: there is a great fear of reintroduction into the environment of hatred and discrimination, although for many of them, ARV treatment is not available (it is only available for a fee), while in Tajikistan they could get treatment for HIV infection free of charge. Among migrant MSM, a sense of hopelessness and despair is very widespread, they say, "If I die, I die".*

In Uzbekistan, access to SRH and HIV services for men who have sex with men remains low. The topic of homosexuality is out of bounds and practically not discussed in society. Internal MSM migrants often lack social ties at the place of migration, and for them seeking SRH and HIV services from government-funded health institutions means admitting to the criminal offence of sodomy, which in Uzbekistan is punishable by up to three years in prison. Some internal migrant MSM resort to medical tourism to neighbouring Kazakhstan or Kyrgyzstan as a solution to their situation, while others self-treat their health problems or go untreated. In the case of HIV infection, MSM often decide to turn to AIDS centres for treatment only when they develop symptoms. There are no non-governmental organizations of MSM in the country, and this population is reluctant to contact non-governmental AIDS service organizations.

The topic of homosexuality is closed and practically never discussed in Turkmenistan too. Co-operation between health institutions and MSM is out of the question. The police actively identify, detain and prosecute men who have sex with men. For instance, a raid to round up men who have sex with men in Turkmenabad, Turkmenistan, was reported in the Russian press, when about 30 men were taken into custody on charges of sodomy.⁹⁰

 *Artur, 30, comes from the countryside. He migrated to Ashgabat. He works and lives in the capital city, where he is registered and renting accommodation. He has sexual partners with whom he meets in strict confidentiality. In order to avoid suspicion, he shares rented accommodation with an alcohol-dependent woman who occasionally engages in sex work; he does not have any sexual or family relations with her. Living together as a different-sex couple serves as a 'cover' for both of them. He claims that if the police find out about his sexual orientation he will be persecuted, as he has repeatedly witnessed regarding MSM he knows. One of his friends committed suicide for this reason.*

According to Arthur, information on safe sex for MSM is almost inaccessible, male latex condoms with thicker walls and lubricants are not commonly available, and even asking for them in pharmacies is risky, as both pharmacy staff and customers can guess of sexual orientation of the curious customer, humiliate the person, or even report to the police. He occasionally practices anal sex without a condom. He has had urethral discharge for which he has received medical attention from a health care professional he knows, who is MSM too.

He believes that MSM, particularly those with rectal lesions, who do not know a health worker among their friends, will not seek medical care in Turkmenistan and will resort to medical tourism to other countries if they can afford it. Arthur is aware that some MSM in the country are living with HIV and have sought to emigrate in order to receive ART. He notes that the AIDS service does not work with MSM. There are no rapid tests for HIV self-testing or community-based testing in the country. Free, anonymous HIV testing is available, but there is no point in testing due to a lack of access to ARV treatment and widespread disbelief in medical institutions.

Another case of an MSM migrant from Kazakhstan:

⁹⁰ https://lenta.ru/news/2021/09/28/turk_lgbt/



Bekzat, 28, a resident of Uralsk, the centre of West Kazakhstan Region, until recently was a private entrepreneur, married, an MSM who had previously concealed his sexual orientation, learned recently that he was living with HIV.

He decided to change his life and met a man called Arman over the internet. After several face-to-face meetings, the men decided to form a couple. Bekzat disclosed his sexual orientation and HIV status to his family. However, his parents, who were of conservative views, did not accept their son's homosexuality, despite Bekzat's psychological affinity to them. Under pressure from his parents and close relatives, the young man renounced his property in their favour. He was subjected to moral and physical abuse, sustained injuries and was kept in the flat against his will. The parents insisted that Bekzat return to his wife so that he and his wife can use in vitro fertilisation, which includes purification of sperm from HIV, so that they can have a child and live 'like everybody else'. Bekzat contacted the police. However, the law enforcement authorities took no action against the perpetrators, remaining on their side. Eventually Bekzat ran from home. Because of fear of being caught by his relatives, Bekzat, together with Arman, kept moving from place to place across Kazakhstan (Aktau, Aksai, Nur-Sultan, Almaty) and Russia. They lived in rented accommodation using savings and money that he managed to earn avoiding formal employment. Bekzat does not have registration at his place of residence in migration or OMS insurance, as he does not formally work anywhere and is not registered with the employment centre. Bekzat has not received any services from AIDS prevention and control centres in Kazakhstan regions where he was on the move, let alone Russia. In order to receive ARV drugs and have a check-up and laboratory tests, he has to travel every now and then, sometimes hundreds of kilometres away from his place of migration, to the AIDS Prevention and Control Centre in Uralsk, for fear of being found and abused again by his relatives.

Deprived of adequate access to SRH and HIV services, some international migrant Central Asian MSM come in groups to major Russian cities, primarily Moscow and St. Petersburg, for sex work. According to the expert interviewed "Upon arrival, such a group initially rents a flat, where 15 plus people live together for two to four months, until they have enough money to rent more private dwelling. In one of those groups, an NGO arranged for rapid HIV testing: out of 12 people, four tested positives for HIV. The migrants were unaware of their HIV status".

People who inject drugs

Migrants who inject drugs often remain unregistered at the place of migration. A threat of punishment drives them into hiding. Many people who inject drugs have served sentences for trafficking or possessing drugs.



Shokhrat (not his real name), 46, moved to Ashgabat from a small town 200 km off the capital city, where he has permanent residence registration.

Shokhrat served 24 years in correctional facilities and was released three years ago. He admits to injecting heroin. He claims he is not currently injecting drugs. He refuses to discuss any issues relating to drug-seeking, their price or use practices. Shokhrat says he is working. He lives in a private house, which belongs to his partner Maral (not her real name), 39, who has four children. He is not registered in the room he occupies. Shokhrat is not faithful to his cohabitant and occasionally has sex with other women. He does not use a condom, considering that they are expensive and that he only has relations with "clean" women from whom he cannot get infected, and that

it is up to them to make sure they do not get pregnant. Shokhrat and Maral do not plan to have children but do not use modern or traditional methods of contraception. While in detention, Shokhrat had a blood test for HIV, but he did not know the results. He had not been tested for STIs. He does not consider either contraception or protection against HIV and other STIs transmission as problems worthy of his attention. Among his friends the issues of HIV infection and SRH are not discussed, and in his opinion, these issues are not relevant for people who inject drugs who "die early anyway from overdoses on street drugs".

In Kyrgyzstan, Tajikistan, Uzbekistan, Kazakhstan, and some cities of Russia, notably Moscow and St. Petersburg, low-threshold HIV prevention centres for key populations have been opened to provide their services to PWID. The centres are staffed by nurses, psychologists and peer counsellors. The centres provide information on HIV prevention, refer clients for anonymous testing for HIV antibodies by ELISA assay or use rapid tests, offer psychological support, provide personalised counselling and accompany clients if necessary. These centres are open to migrants too.

Opioid substitution therapy (OST), which promotes PWID socialization, treatment-seeking behaviour and adherence to treatment, including ART for HIV infection, is not available in Turkmenistan, Uzbekistan and Russia at all. In Kyrgyzstan, where it is widely applied, PWID can be assigned to a methadone dispensing clinic at their place of residence while in migration. In Tajikistan, internal migrants who inject drugs, when temporarily relocating to another area, can get methadone at the place of their temporary stay or in the nearest district, provided one of the total of 15 methadone treatment sites, operates there. In Kazakhstan, OST is not available to internal migrants who inject drugs. In this country, OST is virtually inaccessible to other PWID as well; only a few hundred people are covered. Methadone is neither approved as a medicine nor included in the National Formulary. Its supply is prone to disruptions. In Turkey, tourists can legally bring in up to 15 daily methadone doses for personal use, provided they carry the appropriate prescriptions. Only regular migrants are eligible to OST.

Lack of OST significantly affects PWID's access to any kind of health services, including SRH and HIV services. The need to prevent or manage withdrawal syndrome in this population comes to the fore.

3.2.14 Impact of the COVID-19 pandemic on migrants' access to SRH and HIV services

The crisis triggered by COVID-19 led to serious disruptions in migrants' access to SRH and HIV services throughout Central Asia. In these countries, antenatal care, family planning and STI treatment services have become even less accessible to internal migrants, as well as international migrants who have lost their income.

According to the experts, SRH issues for migrants have been relegated to the background: The priority is to earn money and solve the problems of sending money to unsupported families under restrictions on movement as part of the

epidemic response. Quarantine measures led to the closure of some SRH and maternity care providers.

Border closures prevented migrants living with HIV in Russia from returning to their home countries and receiving needed ARV treatment there. The experts believe that access to antenatal care, contraception, condoms and lubricants, safe termination of unwanted pregnancies, STI treatment, ARV therapy, PrEP and PEP for internal and international migrants has decreased from 'moderate' to 'low' extent in all countries.

At the beginning of the pandemic in Kazakhstan, pregnant women were required to undergo PCR testing for SARS-CoV-2 every five days from the 37th week of pregnancy until delivery. If a pregnant woman had registration and was properly assigned to the relevant clinic, the tests were free, while for most migrants these services were chargeable. In several Russian cities, all pregnant women were also required to do PCR tests for SARS-CoV-2.

The Advance Market Commitment Summit of the Global Alliance on Vaccines and Immunization (GAVI) adopted the COVID-19 Vaccines Global Access (COVAX) initiative, identifying 92 low- and lower-middle-income countries worldwide to be provided with vaccines against COVID-19. These countries include Kyrgyzstan, Tajikistan and Uzbekistan. Immunisation is available there to all internal migrants who only need to present passport. According to experts, there is no difference in access to vaccination between migrants and the rest of the population in all the three countries indicated.

Turkmenistan denies the existence of confirmed cases of COVID-19 among its population. However, the country is undertaking extensive preventive measures against the spread of the pandemic, including compulsory mass vaccination. There is no need to have permanent or temporary residence registration in order to be vaccinated.

In Russia and Kazakhstan, international regular migrants are vaccinated free of charge. Regular migrants in Kazakhstan are eligible for free vaccination, provided they have stayed in the country for longer than three months. Irregular migrants are not eligible for free vaccination. In Russia, irregular migrants can be vaccinated for a fee but only with the one-component Sputnik-Light vaccine, which has not been approved by WHO at the moment.

Internal migrant women, including pregnant women, can be vaccinated at their place of residence on a general basis.

It is necessary to mention that COVID-19 pandemic harmed the activity of civil society organizations implementing HIV prevention and control programmes, particularly NGOs serving key populations with a high proportion of migrants who are hard to reach among them. Due to quarantine-related restrictions, the number of community-based HIV tests has been significantly reduced; opportunities to accompany beneficiaries to healthcare and social support institutions and law enforcement bodies have diminished; many drop-in centres have closed; and funding for relevant civil society organizations has decreased.

NGOs, whose main strength is conducting outreach activities, are working mostly online.⁹¹

One of the consequences of the COVID-19 pandemic for SRH service is the increased level of domestic violence and gender-based violence in all countries. Respondents reported a rise in violence against women in migrant families, triggered by unemployment and increased alcohol abuse by men who had lost their earnings and returned from migration or who continued to stay in migration with their wives or cohabiting partners. Unemployed female migrants have become more economically dependent on their husbands.

Experts also believe that one of the consequences of COVID-19 is an increase in bride abduction in Turkmenistan and Uzbekistan, as migrant men cannot earn money to pay a bride price (a traditional form of wealth paid by a groom to the bride's family or her relatives). Issues of bride abduction are usually resolved between relatives, although kidnapping is a criminal offence in all Central Asian jurisdictions. Experts also believe that in all countries the number of informal marriages of young women to wealthy men has increased. Young women become second and subsequent wives, without gaining legal rights as spouses, but nevertheless helping their families to survive once they have lost their sources of income from labour migration.

Several experts told stories of increased sexual harassment and coercion towards migrant women. The prospect of job loss due to dropped turnover or closure of food markets, consumer goods markets, small shops, cafés, saunas, car washes, hotels and other businesses where female migrants work, as well as a surplus of migrant labour in the labour market, compel female migrants to tolerate sexual advances and abuse by their business owners and managers. Some migrant women are told to perceive keeping their jobs during the crisis as a reward from business managers and owners for sexual favours and services.

3.3 Key specific barriers to accessing sexual and reproductive health and HIV services for migrants

Migrants within and from Central Asian countries coming to Russia, Turkey, and Kazakhstan face a number of barriers to accessing quality SRH and HIV services and achieving proper health coverage. Such barriers as poverty, insufficient funding of healthcare, inappropriate health systems, their outdated physical structures, ineffective policies of supply with medicines and health commodities, improperly trained health staff, inadequate health-seeking behaviours of the populations, and others are among them. However, these barriers equally concern the general population. This section focuses on specific barriers that make migrants underserved in comparison with the resident population.

⁹¹ <https://afew.org/wp-content/uploads/2020/10/COVID-impact-survey-report-AFEW-International-3.pdf>

3.3.1 International migrants have low-level entitlements to access free SRH and HIV services and reproductive health commodities in the three reviewed countries of destination

All the reviewed countries are committed to achieving uhc within the framework of sdg-3. Who defines uhc as a state where all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care⁹². By definition, universal access to srh must be an essential component of uhc. The right of women and men to decide freely and responsibly the number and spacing of their children, as outlined in the convention on the elimination of all forms of discrimination against women, cannot be exercised without access to srh. However, currently, most international migrants from central asian countries, particularly irregular migrants, do not receive the services they need. In the russian federation, turkey, and kazakhstan, the main sources of health system funding include taxes (government budget) and premiums for mandatory health insurance, while most international migrants are not eligible to participate in the mandatory health insurance system. Their right to free healthcare is practically limited to emergency healthcare and treatment of certain acute infectious diseases, which, however, do not include hiv and other stis. There are no cost recovery mechanisms for srh services for migrants and their family members in the system of social health insurance, tax revenues, or social assistance. International migrants have to purchase srh services out of pocket or get voluntary health insurance to cover srh services, which is unaffordable for the vast majority of them. Many migrant workers are pushed into poverty because of out-of-pocket spending on health, and that push has become strikingly high in the era of the covid-19 pandemic. Access to the srh service depends upon the paying capacity of migrant clients.

3.3.2 Linking access to SRH and HIV services to registration at the place of migration

Access to SRH and HIV services for internal migrants in all Central Asian countries is linked to migration laws, while the right to the highest attainable standard of health in line with achieving the SDGs should be egalitarian. However, the need for formal registration at the place of migration prevents many internal migrants from receiving SRH and HIV services. The experts consider the registration requirement to be one of the main obstacles faced by internal migrants in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

According to the current legislation, every person residing in a certain locality must have a legal address in that place. Registration of internal migrants with the state migration authorities is formalised either if an internal migrant rents a dwelling or part of it (including a hostel, a furnished room) by concluding a formal contract or if the owner of the dwelling, registered in the place of

⁹² https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

migration, applies to register the migrant for a certain period at his/her dwelling, where the migrant can actually settle or remain only formally registered, in fact living in another place. Even in the latter case, the migrant has the right to reside in the premises owned by the owner, at least for the period specified by him or her on paper at the time of registration.

Expert interviews showed that various reasons are preventing the majority of internal migrants from registering:

- In some countries, registration is a permissive rather than notifying procedure; registration is a lengthy and complicated bureaucratic exercise that may lead to the migration authorities' refusal to register an internal migrant and following expulsion from the place of residence, such as the capital city, to the place of permanent residence.
- The authorities can revoke decisions on residence registration of internal migrants in such countries for various reasons; the police can easily find a registered migrant and force him (or her) to return to the place of permanent residence.
- In some cases, internal migrants live on non-residential premises (e.g., construction trailers, utility rooms at the place of work, semi-basements, shacks on garden plots, etc.), where registration is not permitted under the law.

Migrants often live in overcrowded, but affordable to them, dwellings, violating sanitary norms (based on the ratio of living spaces to the number of dwellers); both migrants and owners of overcrowded accommodation are interested in concealing these facts from the authorities.

- Owners who rent accommodation to migrants under formal contracts charge a higher rent price to cover their risks because, firstly, registration entitles the migrant to occupy the premises legally, and this makes it more difficult to evict them if they fail to pay rent or utilities and, secondly because the formal contract discloses the rent price and the owners are liable to pay tax on their income.

In Turkmenistan and Uzbekistan, the government budget covers healthcare services, therefore migrants need to register at the current place of residence as a prerequisite for being assigned to a local primary health care institution and getting medical services. A similar procedure is in place in Tajikistan, where a significant part of SRH and HIV services is covered by donor organizations. In Kyrgyzstan, the Programme of State Safeguards of Healthcare is funded mostly by the government budget and the OMS. Furthermore, international funders, particularly the GFATM, contribute significantly to the HIV prevention, diagnosis, and treatment programme. The government-supported maternity care programme, which includes antenatal and perinatal care, as well as the HIV prevention, diagnosis, and treatment programme, which is mostly sponsored by international donors, are available to all Kyrgyz citizens in any locality, regardless of registration. Other SRH programs, such as family planning and STI treatment, are only available for free to OMS holders and only at medical organizations with which they are enrolled. The prerequisite for enrolment with the medical

organization is the presence of registration in the area that the medical organization covers.

In Russia, registration at the place of migration is a condition for international migrants from EAEU countries covered by OMS to be assigned to a local polyclinic and receive health services, including SRH services. In Kazakhstan, registration at the place of migration is an essential prerequisite for migrants from any country permanently residing in Kazakhstan to get access to health care services on an equal footing with Kazakh citizens.

3.3.3 The funding and established rules to spend government budget allocated for SRH and HIV services are not matched with the needs of migrants

Budget discipline regulates spending budgetary resources, which is mandatory for all organizations receiving them. In all the reviewed migrant-sending countries, as well as in Russia and Kazakhstan, government budget funds allocated for healthcare can be spent only for specific purposes, in strict observance of the established rules and regulations concerning procurement and distribution of healthcare commodities and products. Shortages in public healthcare governmental funds and budget discipline requirements make the procurement of a range of reproductive health commodities by public healthcare organizations in sufficient quantities to meet the needs of underserved populations or, moreover, the distribution of health commodities and products procured at the expense of the government budget among anonymous consumers unaffordable and ineligible.

Internal migrants who are not assigned to medical organizations at the place of migration, as well as irregular external migrants in the two above-mentioned migrant receiving countries who make up a significant part of their present population, have limited opportunities to obtain reproductive health commodities, including condoms, lubricants, contraceptives, and medicines, with ARV medications for PEP and PreP among them, at the expense of the government budget. In Kyrgyzstan and Tajikistan, which both receive significant donor support from the GFATM, the issue of supply for underserved migrants with reproductive health commodities is somehow resolved, as the relevant rules established by donors are rather flexible. The governments of Russia and Kazakhstan allocate some resources just to procure certain amounts of condoms to distribute anonymously among the key populations. However, in general, the issue of the free supply of irregular migrants with reproductive health commodities and products is still impossible to solve.

Kazakhstan and Russia's governments, as well as Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan's, approve drug lists that can be procured for and distributed to specific populations at the expense of the government budget. However, in any case, these products are available only to people assigned to medical organizations, while such an assignment requires registration in the inhabitant settlement. Commonly, neither antimicrobial medicines for STI treatment nor a range of contraceptives are on the lists, and even those people

who are assigned to medical institutions must pay the full cost. In Turkey, public health insurance covers 99 percent of the usual residence population. However, this is not about the de facto population, which includes irregular external migrants. Public health insurance coverage is considered only for foreigners who have an official residence permit⁹³. Medicines in Turkey are not totally free and imported medicines cannot be covered by the Social Security Institution. In such cases, people have to pay 20% of the total cost of medicine as a contribution fee.

3.3.4 Xenophobia, stigma and discrimination against migrants, including key populations

Xenophobia is a significant barrier to access to SRH services for migrants in migrant-receiving countries. According to the experts, migrants from Central Asia often experience humiliating and insulting treatment, even in health institutions and pharmacies, owing to their different appearance, manner of communication, lack of understanding of the official language, accent, and occupation, as migrants from Uzbekistan, Tajikistan, and Kyrgyzstan as mostly guest workers occupy lowly niches in the labour market.

In host countries, many migrants, especially irregular migrants, feel disempowered, fearful of asserting their interests, including health issues, to avoid sanctions of detention and deportation. Labour migrants from Central Asia report much more frequent experiences of discrimination than migrants from Eastern Europe, and have significantly higher levels of depression, as measured by the Self-Assessment Scale.⁹⁴

According to 2020 survey data, which included personal interviews with 1601 people aged 18 and older in 137 municipalities across 50 regions of the Russian Federation, 59 percent of respondents said they would not allow Uzbek and Tajik people into Russia at all or would only allow them temporarily, while only 37 percent would accept Uzbek and Tajik people as relatives, close friends, neighbours, colleagues at work or Russian residents.⁹⁵

There are regular publications in the Russian media about the so-called ethnic crime against individuals that are sweeping the country and which is associated with migrants from Central Asia. Ideologies are crafted to explain the danger allegedly posed by Central Asian migrants, thus trying to justify the hostile attitudes towards them by a certain part of the population. In the State Duma, Russia's lower house of parliament, deputies of some political parties even demanded to introduce a separate, tougher criminal code for international migrants⁹⁶ placing them on an unequal footing with Russian citizens. The economic crisis caused by the COVID-19 pandemic and dramatic rise in unemployment exacerbated the cautious attitude of some Russians towards

⁹³ http://www.sgk.gov.tr/wps/portal/sgk/en/detail/universal_health_ins

⁹⁴ Amirkhanian, Y.A., Kuznetsova, A.V., Kelly, J.A. et al. Male Labor Migrants in Russia: HIV Risk Behavior Levels, Contextual Factors, and Prevention Needs//J Immigrant Minority Health, 2011, Vol. 13, P 919–928
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4476384>

⁹⁵ <https://www.levada.ru/en/2020/09/30/xenophobia>

⁹⁶ <https://regnum.ru/news/society/3228340.html>

migrants. This sentiment is based on the persistent myth that migrants are driving the Russian workforce out of the labour market.

Internal migrants from rural areas to large cities are also socially stigmatized due to cultural differences and the migrants' lower position in the social hierarchy. Migrants are often called names, discriminated against, and treated with obvious disrespect in health care settings. All this has a negative impact on migrants' access to health care.

Key migrant populations experience double discrimination. They may also face enmity from health providers who do not value the diversity of people. Many health care workers stigmatise members of key populations, treat them with contempt, make derogatory statements degrading human dignity of MSM, SW, PWID, make comments to patients that are irrelevant to their motivation for seeking medical assistance.

A typical example was shared by a sex worker who came to Dushanbe, Tajikistan, from the countryside. *"I got pains in my lower abdomen and went to a medical clinic. The gynaecologist, recognising me as an out-of-province visitor, grumbled unhappily about why everyone was coming to Dushanbe. However, she examined me on a gynaecological chair, took swabs and, during the examination, asked me whom I had sex with. I confessed that I was engaged in sex work. In response, the doctor rudely slapped me on the thigh, called me names, cursed me, told me in a harsh tone to get dressed, threw me a blood test referral and told me to come back the day after tomorrow for the test results and a prescription, promising to report me to the relevant authorities. There was nothing I could do about it. It was useless to complain. If you complain to her supervisor, I will be blamed for everything; you will not go to the police to report sex work and living in Dushanbe without registration: they will punish me for both. And if you answer, the doctor will get angry, call the police, tell them everything, and I will be punished again. I just left and never came back."* The expert from Russia also confirmed that sex workers from Central Asia, in need of SRH services, go only to a doctor they trust. Many people who sell sex are convinced that medical staff collaborates with the police, as health staff is involved in police raids, and take blood for HIV and syphilis tests from detainees. The discriminative attitudes make SRH services unacceptable to many sex workers.

Homophobia significantly reduces access to health care for MSM.⁹⁷ As mentioned above, stigmatization and discrimination against men who have sex with men render SRH and HIV services unacceptable for them, especially in Turkmenistan and Uzbekistan, where reporting sexual contacts of men who have sex with men with STI and HIV infection is virtually admitting to a crime subject to criminal penalties involving imprisonment. Migrant men who have sex with men are particularly vulnerable due to the lack of social ties in the place of migration. Another barrier to accessing SRH and HIV services and facilities for

⁹⁷ Albuquerque, G.A., Garcia, C., Quirino G.S. et al. Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review. BMC Int. Health Hum Rights, 2016, Vol. 16, Article 2. <https://doi.org/10.1186/s12914-015-0072-> .

MSM are policies of ignoring their needs for information and education on less harmful practices, given the subculture prevalent among gay men.

PWID remain the population with the highest HIV prevalence in Central Asia. The fact is ignored that existing methods of opioid dependence treatment, based on abstinence, are insufficiently effective, while the absence of OST alternatives in this setting of punitive measures for buying drugs illegally, constitute a major impediment to providing HIV prevention and treatment services. For drug-dependent people, the priority is to prevent and manage withdrawal syndrome rather than get SRH services.⁹⁸ Migrants who inject drugs previously having access to OST in their home countries are losing this access when in Russia and Kazakhstan.

UN human rights experts consider it unacceptable to sanction drug-dependent people who, in the absence of effective treatment for drug dependence, use drugs; adults who practice homosexual orientation, although such orientation may not be a matter of their free choice; and people who provide sexual services to adults.⁹⁹ A comparative analysis of the effectiveness of HIV responses shows that sanctions on key populations at high risk of HIV infection lead to a further increase in the epidemic.¹⁰⁰ Adequate access to SRH and HIV services for migrants could be addressed through the adoption and implementation of specific laws and regulations that protect migrants from xenophobia and all types of discrimination, concurrently removing sanctions against key populations and ensuring the full enjoyment of their rights and interests.

3.3.5 Deportation of people living with HIV

Migrants living with HIV are subject to deportation from the Russian Federation, even if they have become infected in the country and regardless of the time they have worked and paid direct and indirect taxes, as Russian citizens do. Indeed, when HIV infection is detected, many migrants do not leave the country and proceed to work illegally, living without registration and hiding from law enforcement. According to the experts, deportation is rarely practiced, as it involves costs and efforts to find the migrant. However, migrants living with HIV are listed as banned from entering the Russian Federation. If a migrant living with HIV whose status is known to the authorities leaves Russia, he or she will not be able to re-enter the country. Faced with the dilemma of losing their earnings in Russia, often the only means of family survival, and the access to antiretroviral therapy in their home country, a significant share of migrants chooses earnings giving up HIV treatment. Likewise, such migrants avoid

⁹⁸ Deryabina A.P., Wafaa M. El-Sadr Optimizing HIV prevention and treatment outcomes for persons with substance use in Central Asia: what will it take? // Current Opinion in HIV and AIDS, 2019,14(5) pp. 374–380

[https://journals.lww.com/co-](https://journals.lww.com/co-hivandaids/Fulltext/2019/09000/Optimizing_HIV_prevention_and_treatment_outcomes.6.aspx)

[hivandaids/Fulltext/2019/09000/Optimizing_HIV_prevention_and_treatment_outcomes.6.aspx](https://journals.lww.com/co-hivandaids/Fulltext/2019/09000/Optimizing_HIV_prevention_and_treatment_outcomes.6.aspx)


⁹⁹ Joint Statement by UN human rights experts on the occasion of the High-Level Meeting on ending AIDS by 2030

<https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20053&LangID=E>

¹⁰⁰ Kavanagh M.M., Schadrac S.A., Marissa J. et al. Law, criminalization and HIV in the world: have countries that criminalize achieved more or less successful pandemic response?//BMJ Global Health, 2021, Vol.6, Issue 8, P. 8
<https://gh.bmj.com/content/6/8/e006315>

contacting SRH services for fear of provider-initiated HIV testing, as such testing may increase their chance of being deported.

For fear of being deprived of their rights, many migrants, who intrinsically are vulnerable to HIV infection, refuse to test. A sentinel surveillance study conducted in Tashkent showed that 41% of migrants avoided HIV testing while in external migration.¹⁰¹ The following typical case, where an HIV positive status detected in Russia turned into a de facto employment ban in Kyrgyzstan, was given in the interview of an expert from that country.

 *Eric (not his real name), 59, a resident of Bishkek, Kyrgyzstan, had previously worked as a migrant worker in Russia, where he was asked to test for HIV in order to obtain a temporary residence permit. His test turned out to be positive, and the authorities demanded that he leave the country. Upon his return to Kyrgyzstan, Eric went to the AIDS Centre, his diagnosis was confirmed, and he was prescribed antiretroviral therapy. He took out a bank loan, bought a pre-owned heavy goods vehicle, and started a delivery business. He soon undertook to deliver expensive goods to the city of Astrakhan, Russia. He crossed the border into Kazakhstan and travelled over 2,500 kilometres across its territory, reaching the border with the Russian Federation. However, the border guards stopped him from going any further. Erik ended up in a database of foreign nationals banned from entering Russia. Erik had no option but to return to Kyrgyzstan, thousands of kilometres away, carrying the cargo and then pay the shipper a forfeit for non-delivery. He had to go to the town of Atyrau in Kazakhstan, closest to Astrakhan, stay there, urgently pleading for help from a driver he knew, asking him to get from Bishkek to Almaty and arrive on the next flight. He explained the situation, had to disclose his HIV status, entrust his colleague with his truck and cargo to deliver it to Astrakhan, and wait for his friend to return from Russia. Eric lost offers of relatively high-paying jobs (travelling to Russia became impossible for him) and started doing low-cost short-distance trucking. It took him three years to lift the ban on entering Russia as a result of three court hearings and at the cost of high legal fees.*

Since the Russian authorities only issue work permits, including patents for the right to work (which migrant workers originating from countries outside the EAEU must purchase) and residence permits in Russia to those migrants who can prove their HIV-negative status, some Central Asian migrants living with HIV enter the country for up to three months without indicating work as the purpose of migration, and keep on working on a rotating basis together with other irregular migrants.

An analytical review by leading Russian specialists has shown that deportation of HIV-positive migrants is inconsequential to the HIV response measures.¹⁰² At the same time, the abolition of this provision would make HIV testing acceptable for migrants and thus contribute to their motivation to know their HIV status and hence to seek HIV treatment as well as not be afraid to seek SRH services.

¹⁰¹ Service data of the Republican Centre for AIDS Prevention and Control of the Ministry of Health and Social Development of the Republic of Tajikistan

¹⁰² Покровская А. В., Юмагузин В.В. Киреев Д.Е. и др. Влияние миграционных процессов на ситуацию по ВИЧ-инфекции (аналитический обзор)// Вестник Российской Академии медицинских наук, 2019, том 74, №2, С. 88–97

3.3.6 Limited information resources

All experts from Central Asia, Kazakhstan, and Russia noted poor knowledge among internal and international migrants about SRH and HIV infection. In Tajikistan, where this level was measured, only 28% of migrants knew how HIV is transmitted.¹⁰³ This lack of knowledge is largely explained by the lack of necessary information in migrants' languages, insufficient command of the Russian language among migrants, and the purposeful withholding of information, first and foremost, needed for key population groups with a high risk of exposure to and transmission of HIV.

There are very few sources of information on migrants' health care rights concerning SRH disorders, HIV infection, and health issues related to gender-based violence. Migrants often do not know where to find health care providers at the places of migration. Some countries, such as Tajikistan, recommend migrants to use special mobile apps, which address only general legal issues in migration, not covering any legal aspects of relations between health care providers and migrants in need of SRH and HIV services. Nevertheless, such apps, along with other resources in national languages, could help educate and inform migrants.

3.3.7 Insufficient capacity and involvement of migrant communities and non-governmental organisations

Migrants, including migrant MSM, migrants who sell sex and inject drugs often mistrust reproductive health and HIV service providers. According to the experts, in this context, NGOs, including community-based organisation of key populations, act as "safe havens". Among such organizations in Russia, they mentioned Humanitarian Action, a charity in St. Petersburg, Silver Rose, an NGO set up by sex workers in St. Petersburg, and the Steps Foundation in Moscow, which mobilized resources from international donors and in particular facilitated access to free antiretroviral therapy for migrants living with HIV during quarantine and border closure caused by the COVID-19 pandemic. At the same time in countries where key populations are criminalized their communities are playing limited or no roles in the relevant education and information of their members, delivery of SRH and HIV services including distribution of condoms and other reproductive health commodities, and community-based testing for HIV.

3.3.8 Overpriced SRH and HIV services and commodities

As previously stated, the prices of STI drugs, condoms and lubricants, hormonal contraception, and antiretroviral drugs are frequently unacceptably high. Affordable reproductive health commodities and products, including drugs that are consistently produced and controlled in accordance with WHO-confirmed quality standards, are not always available in the reviewed countries. The health

¹⁰³ Service data of the Republican Centre for AIDS Prevention and Control of the Ministry of Health and Social Development of the Republic of Tajikistan

authorities take accountability for the effectiveness and safety of reproductive health commodities and products in the internal market, but rarely for their range. The issue of reproductive health commodities and products availability in the pharmaceutical market is almost entirely at the mercy of private entrepreneurs who are selling drugs and other medical supplies provided that the imported a consignment of goods corresponds to quality and composition of the registered samples.

In Russia and Kazakhstan, international migrants commonly pay for reproductive health commodities such as ARV drugs, antimicrobial drugs to treat STIs, condoms, other contraceptives, and HIV self-testing kits out of pocket. However, many migrants cannot afford these commodities and products. Most internal migrants, including those who are registered at migration residences in Kyrgyzstan, Tajikistan, and Uzbekistan, should also pay for reproductive health commodities out of pocket. Internal migrants frequently have access to free ARV drugs in some form or another. However, condoms obtained through HIV prevention and control programs implemented in those countries are distributed for free, primarily to key populations, and SRH service organizations have no contraceptives and anti-microbial medicines for STIs treatment to distribute them for free, while they are too expensive for many internal migrants.

The reproductive health commodities could be made more accessible to migrants through the procurement of WHO-qualified HIV and STI medicines, female contraceptives, condoms, lubricants, etc., using UNFPA and UNICEF mechanisms on condition that the financial resources spent are recovered through non-profit sales. The governments could consider automatic approvals of essential reproductive health commodities and products qualified by WHO, purchase them centrally at low prices, and sell them through pharmacies of public health organizations.

As indicated, it is virtually impossible for migrants living with HIV to receive antiretroviral therapy in Russia. The Regional Expert Group on Migrant Health in Eastern Europe and Central Asia, set up by civil society activists and researchers to develop an expert position to improve the quality of life of migrants in the countries of the region, has assessed the cost of HIV treatment applying two scenarios. The cost of an outpatient treatment with the cheapest ARV drugs once HIV infection remains under control, adjusted for the cost of doctors' appointments, was estimated to be around 83,000 roubles per year or less than \$100 US per month at the current exchange rate. According to information received from the expert, outpatient management of patients receiving ART at a private infectious disease clinic in St. Petersburg could cost only 3,000 roubles per month (less than \$50 US). Such prices may still be affordable for migrants with HIV. At the same time, according to the same expert, the management of people living with HIV in private infectious diseases clinics in Moscow is several times more expensive. Contrary to this, the cost of 21-day hospital care for complications in a patient with HIV infection is estimated to be around 229,000 roubles (or \$3,500 US at the current exchange rate) ¹⁰⁴. That amount includes

¹⁰⁴ <http://migrationhealth.group/en/how-much-does-it-cost-to-treat-hiv-positive-migrants-in-russia>

the cost of all laboratory tests, doctors' fees, medicines, accommodation, food and services.

4

4. CONCLUSION AND RECOMMENDATIONS

The main message of the 2030 Agenda for Sustainable Development, adopted in September 2015 by all UN member states "Leaving no one behind" is fully aligned with achieving SDG 3 "Good Health and Well-being" and meeting the challenges of UNC, universal access to SRH of ending the HIV epidemic as we move towards this goal.

Although populations on the move are part of the present population in countries and their administrative regions, migrants in many places find themselves excluded from adequate health care. Yet, without adequate health services for migrants in general and HIV services in particular, it is impossible to achieve universal access to SRH and universal health coverage.

Meanwhile, SDG goals and targets are framed as human rights entitlements applicable to all members of the population, enabling those left behind to seek universal access to SRH and UHC in a broader perspective that meets the core requirements of the right to health: availability, accessibility, and good quality. The first of the core rights to health obligations listed in General Comment 14 of the Committee on Economic, Social, and Cultural Rights (2000), which all state parties having joined the International Covenant on Economic, Social, and Cultural Rights, including all the reviewed countries, are required to fulfil immediately, is "to ensure non-discriminatory access to health facilities, goods, and services, especially for vulnerable or marginalized groups".¹⁰⁵ Thus, access to essential health services, including SRH services, which are particularly emphasized in the Convention on the Elimination of All Forms of Discrimination against Women, as well as safe, effective, high quality, and affordable medications and vaccines, is framed as a legal obligation. All the reviewed countries joined both of the mentioned international treaties.

The COVID-19 pandemic has been overshadowing all other pressing health issues. The global crisis brought about by the pandemic has shifted public health resources to respond strategically and rapidly to the epochal challenge everywhere. Priority has to be given to quarantine, providing health workers and the public with protective equipment, reassigning hospitals, setting up extra beds for patients with severe COVID-19 infection, procurement, installation and maintenance of diagnostic and treatment equipment, mass vaccination campaigns, etc.

¹⁰⁵ https://www.who.int/hhr/Economic_social_cultural.pdf

The COVID-19 pandemic prevented implementing the recommendations of the Technical Meeting on HIV and Migration in Central Asia and the Russian Federation held in Astana (now Nur-Sultan, Kazakhstan) a year before the pandemic began. Neither a regional working group was set up on political and public advocacy for the meeting's recommendations, nor an appropriate programme and monitoring framework were designed for implementation of this strategy. Data collected in countries on the early HIV diagnosis, coverage of PLHIV treatment, coverage of pregnant women for HIV antibody testing and prevention of mother-to-child transmission of HIV, AIDS deaths, etc., were not disaggregated by migration status. All sanctions against key populations that existed prior to 2018 are still in place. The challenges of providing HIV treatment to patients during the whole migration cycle have not been resolved. The capacity, including financial, of NGOs of key populations has not improved. Their mandate has not been expanded. The discrepancy between the declared absence of HIV infection in Turkmenistan (and therefore no need in antiretroviral therapy) and the detection of HIV among countries receiving migrants from Turkmenistan in countries of destination, has not been resolved.

In-depth interviews with experts from each of the reviewed countries showed that internal migrants in the four migrant-sending Central Asian countries, particularly in Tajikistan, Turkmenistan, and Uzbekistan, as well as international migrants from these countries in Russia, Turkey, and Kazakhstan have no or too limited access to antenatal and perinatal care, family planning, STI treatment, safe abortion, HIV counselling, testing, prevention, and treatment. Internal migrants have guaranteed access to maternity care as well as HIV prevention and treatment. Kyrgyzstan provides access to maternity care as well as certain aspects of HIV prevention and treatment including ARV treatment for internal migrants at their destinations; however internal migrants have limited access to family planning including condoms and other contraceptives and STI treatment.

Internal and external migrants from among key populations have limited access to maternity and SRH services due to dual or even triple stigma and discrimination, which they face as migrants, representatives of key populations, and, not rarely, as people with HIV. The unacceptability of conditions for receiving SRH services, including fear of legal prosecution of certain key populations, which is practiced in several countries, public hostility, and judgmental attitude towards them by health staff that share the data with law enforcement bodies, along with the low awareness of essential issues of SRH and HIV as well as the unaffordability of reproductive health commodities and services, is a critical element that precludes reaching these populations with SRH services.

It is necessary to bring attention of key stakeholders back to the HIV epidemic and migration by broadening the subject of addressing access to SRH services and commodities for migrants in terms of acceptability, affordability and accessibility.

There is a need to address the problem of migrants' limited entitlements to SRH and HIV services in all the three reviewed countries of destination. In order to meet the SDG 3 targets, a significant increase in healthcare funding is required, as well as a possible revision of the healthcare funding model to make

family planning, STI treatment, safe abortions, antenatal care, ART, including PreP, PEP, and prevention of HIV transmission from mother to child, along with perinatal care and treatment of life-threatening reproductive health conditions, affordable and acceptable for migrants and their families.

The disliking of people's registration at their residence places and their enrolment in healthcare organizations covering the places of their registration, on the one hand, with the population's access to essential health services, on the other hand, is one of the preconditions for ensuring access to essential SRH and HIV services for many migrants. The establishment of appropriate databases and the revision of funding modalities could expand the pool of migrants with access to at least basic health services, including maternal health, SRH and HIV services among others. It is imperative to design a funding modality in such a way that "money allocated for health services from any source of funding follow the client" who is entitled to get the above services, no matter where the person lives in the country. It should be recognised that universal access to SRH and universal health coverage cannot be achieved without embracing the entire present population, including the irregular migrants, with SRH services.

There is a need to revise funding policies so that all poor and underserved internal and international migrants can receive essential reproductive health commodities and products, such as condoms, other contraceptives, STI treatment medicines, ARV drugs for PEP, vaccines, and other means in outpatient clinics, at the expense of the government, provided that the migrant has medical indications to use those means, whether the migrant is regular or irregular, has ID or not. The mobilization of resources from alternative sources, such as charitable foundations and private businesses, in conjunction with the adjustment of the funding strategy, could have helped to address the SRH needs of migrants in the short term.

Further policy and public advocacy is needed to reinforce fighting xenophobia and abolish stigma and discrimination against the key populations, which are inconsistent with SDG 3 and stipulate leaving behind these populations, and in particular, migrants from among these populations. Paradoxical situations should be resolved when countries adopt legislation specifically protecting the rights of people with HIV while prosecuting adult men who have voluntary sex with other adult men, people who sell sex, and drug-dependent people who have no access to legal drugs and therefore purchase illicit drugs and keep them, despite the fact that such people make up a large proportion of PLHIV. There is a need to consider the enhancement of legislation and law enforcement practice to counteract xenophobia. Politicians, public health opinion leaders, and celebrities should be encouraged to speak out against this phenomenon and its connection to the SDGs.

Further policy and public advocacy are required to achieve the abolishment of the deportation of international migrants with HIV from the Russian Federation, which actually triggers the spread of HIV and other STIs by pushing the migrants to reject HIV testing and hence treatment of HIV infection, as well as SRH services (because of fear of being tested for HIV at the service provider initiative). The threat of deportation is a contributing factor in the

deprivation of migrants' rights to the highest attainable level of sexual and reproductive health.

It is critical to address the problem of migrants' access to accurate SRH and HIV information in their native languages, including information on internal and external migrants' legal rights to SRH and HIV services and opportunities to receive them at places of their departures and destinations. Mobile applications can be useful in this regard. Migrant key populations should also have access to the precise knowledge they need to avoid unintended pregnancies, STIs, and HIV transmission and acquisition via internet resources and maybe printed materials provided specifically to key populations members. To accomplish such access, more legislative advocacy is needed, particularly in countries where, selling sex, having voluntary sex between adult men, purchasing, and keeping illicit drugs are criminalized.

Experience in responding to HIV infection in several Central Asian countries, notably Kyrgyzstan, Tajikistan and Kazakhstan, demonstrates the need to empower formal and informal migrant communities, including key populations where migrants originate from and are involved, in host countries that best understand what services migrants need and under what conditions they can receive them. Community empowerment, including social marketing of contraceptives and condoms, rapid HIV testing, social support for antenatal care, PrEP, PEP, treatment of HIV and other STIs, etc., is a way to make services more efficient and cost-effective. However, in none of the countries stable financial support is currently ensured to key population communities or non-governmental HIV service organisations that would allow them planning long-term SRH and HIV programmes for migrants.

The issue of providing outpatient treatment of HIV infection for migrants could apparently be solved at least partly, with political will, by creating conditions when migrants cover the costs of medical services and clinic expenses on a not-for-profit basis. Migrants could be treated with ARV medicines, which shipment to migrant-receiving countries should be arranged from their home countries for migrants' personal use as these medicines in the lower-middle incomes countries are available at low prices and their governments ensure the ARV medicines supply to their nationals for free. Inter-state transfers should be considered to cover hospital costs, or, if the burden on the budgets of migrant-sending countries proves prohibitive, migrants should be offered the opportunity to receive in-patient treatment in their home countries, where costs are likely significantly less, possibly with partial or full coverage of transportation by using donor resources mobilized for such a purpose in migrants' home countries. Migrants with HIV should be permitted to return to the Russian Federation.

Coordinated national programmes based on situation analysis, unique country pledges with outlined milestones for fulfilling government commitments could be valuable tools for improving access to SRH and HIV services for internal and external migrants. Intergovernmental agreements should be reached on a range of topics relating to ensuring proper international migrants' access to treatments for HIV infection, other STIs, and reproductive health disorders, as well as family planning. Migrant-receiving countries could have considered

abolishing any obstacles to importing medicines and other reproductive health commodities prequalified by WHO and approved in migrant-sending countries for migrants' personal use regardless of whether these medications are registered. The countries could also have found ways to increase the amount of healthcare to ensure continuity and succession of HIV treatment in migrants with HIV. The programmes should include a results matrix with relevant indicators, allowing experts to monitor and evaluate their implementation. International organizations can engage in relevant advocacy efforts and provide necessary technical assistance.

Annex 1. Expert interview questionnaire (set of questions for informal face-to-face interview)

Below is a sample list of questions for individual interviews with experts. First, a closed-ended question is asked, including multiple-choice questions and then specifics are requested with an open-ended question. Open-ended questions allow respondents to give answers based on their full knowledge, feelings and understanding and thus produce non-numerical qualitative (categorical) data that could be systematized based on respondents' attitudes to the phenomenon and its features.

The expert may skip answering some questions due to insufficient knowledge. Before conducting expert interviews, the interviewer should know likely answers in order to apply a deductive approach to qualitative data (the testing of original hypotheses made in advance by reviewing materials on the topic).

A transcript should be written for each interview.

Legislation regulating SRH and HIV services for migrants	1	Does your country have legislation and/or regulations on sexual and reproductive health and HIV prevention and treatment services that specifically mentions appropriate provisions for migrants? (If yes, please provide a link)	
	2	Does your country implement SRH and HIV prevention programmes at the stages of the migration process: (a) pre-departure, (b) en route, (c) upon arrival, (d) during the stay and (e) upon return?	If so, please tell us what exactly these programmes are, what interventions they involve, who supports them and at what stages they are implemented

Access to family planning services	3	Rate the access to family planning services for internal labour migrants in your country on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	4	Rate the access to family planning services for regular international labour migrants (and their spouses) on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	5	Rate the access to family planning services for irregular international labour migrants (and their spouses) on a 5-point scale (where 1 is very limited, 5 is very broad).	
	6	Rate the change in access to contraception for migrant women during the COVID-19 pandemic on a scale from -5 to +5 (-1 is slightly worse, -5 is drastically worse; 0 is no change; 1 is slightly improved, 5 is drastically improved).	Allow the expert to explicate the issue of access to family planning for different groups of migrants and how the situation can be improved.
Access to safe abortion	7	Do migrant women practise medical abortion (with mifepristone and misoprostol medication) outside healthcare facilities without the involvement of a healthcare professional? (Yes, no)	If you answer in the affirmative, ask the expert why and how often this happens in the migrant group they know.
	8	Are you aware of any problems with pregnancy termination among migrants?	If you answer in the affirmative, ask the expert to tell you the stories they know.

Access to STI treatment	9	Rate the access to STI diagnosis and treatment services for internal labour migrants in your country on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	10	Rate the access to STI diagnosis and treatment services for international regular labour migrants in your country on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	11	Rate the access to STI diagnosis and treatment services for international irregular migrant workers in your country on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	12	Rate the change in access to STI diagnosis and treatment for migrants during the COVID-19 pandemic on a scale from -5 to +5 (where 0 means no change, 1 is slightly improved, 5 is drastically improved; -1 is slightly worse, -5 is drastically worse).	Let the expert explicate the issue of access to STI diagnosis and treatment for migrants from familiar groups and how this situation can be improved.
Access to antenatal care	13	Rate the access to antenatal care for internal labour migrants in your country on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	14	Rate the access to antenatal care for international regular labour migrants in your country on a 5-point scale from 1 to 5 (where 1 is very limited, 5 is very broad).	
	15	Rate the access to antenatal care for international irregular labour migrants in your country on a 5-point scale (where 1 is very limited, 5 is very broad).	
	16	Rate the change in migrants' access to antenatal care during the COVID-19 pandemic on a scale from -5 to +5 (where 0 means no change, 1 is slightly improved, 5 is drastically improved; -1 is slightly worse, -5 is drastically worse).	Let the expert explicate the issue of access to antenatal care for migrant groups and how it can be improved

Access to intrapartum and postpartum care	17	Tell us if you are aware of any changes that would make it more difficult for migrants to access childbirth care.	Allow the expert to express his or her thoughts on the matter at will
Rights of migrants living with HIV	18	Assess the likelihood of an international migrant being deported from Russia if he/she is known to be HIV-positive and has no close relatives who are citizens of the host country, on a 5-point scale (where 1 is a very low probability, 5 is a very high probability).	
	19	Are international migrants living with HIV provided with ART? (Yes, No). If such provision is administered by the migrant sending country, indicate the period for which the medication is provided to the migrant.	Allow the expert to explicate the issue of HIV treatment for migrants living with and how the situation could be improved.
The rights of people who inject drugs	20	Is methadone registered in the country as a medicine for opioid substitution therapy (Yes, no)?	
	20 a	If methadone-based OST is an officially recognised treatment option? Please, rate access to it for internal migrants on a 5-point scale (where 1 is very limited, 5 is very broad)	
	20 b	Will an internal migrant who injects drugs in one area continue to receive OST if he or she moves temporarily to another area? (Yes, no)	
	21	Has there been a shift in the provision of OST to people who inject drugs in the country compared to 2018? If so, which ones specifically?	Ask the expert to share the typical stories about migrants who inject drugs with a focus on access to SRH and HIV prevention and treatment.

Rights of men who have sex with men	22	Assess the probability of any form of harassment of an adult male having sex with an adult male, if the fact is reported to law enforcement agencies, on a 5-point scale (where 1 is very low, 5 is very high).	
	22 a		Ask an expert to share typical stories of migrant men who have sex with men with a focus on access to SRH and HIV prevention and treatment.
Rights of sex workers	23	Assess the likelihood of any form of harassment of people who sell sex, if this fact comes to the attention of law enforcement agencies, on a 5-point scale (where 1 is very low, 5 is very high).	
	23 a		Ask an expert to share the typical stories of migrants who sell sex with a focus on their access to SRH and HIV prevention and treatment.
Engagement with communities	24		If your country's laws and/or regulations provide for collaborative activities involving migrant communities and/or key populations in ensuring equal access to SRH and HIV services for these groups, ask the expert to share an example of good practices.

Access to HIV testing for migrants	25	Is HIV testing offered to ALL women seeking care for pregnancy and childbirth? Please, rate on a 5-point scale (where 1 is far from universal, 5 is definitely universal).	
	26	Please, rate access to HIV self-testing for migrants in your country on a 5-point scale (where 1 is very limited, 5 is very broad).	
	27	Rate access to rapid HIV tests for migrants provided by their communities in your country on a 5-point scale (where 1 is very limited, 5 is very broad).	
	28	Has access to HIV testing of migrants changed over the three years, including during the COVID-19 pandemic? Please, rate on a scale from -5 to +5 (where 0 is no change; -1 is slightly worse, -5 is drastically worse; 1 is slightly better, 5 is drastically better).	Invite an expert to share their thoughts on how to improve access to HIV testing for migrants.
Access to HIV prevention for migrants	29		Are male and female condoms and lubricants available, acceptable and affordable to migrants from different population groups in your country? Ask the expert to share their views on migrant awareness of condom use, including their choice of size, material, and thickness.
	30		Ask an expert to share their views on the availability, acceptability and affordability of HIV pre- and post-exposure prophylaxis for

				international and internal migrants, including 2-1-1 pre-exposure prophylaxis for MSM.
Implementation of some recommendations of the Astana Technical Meeting in 2018	Recognising the problem of the epidemic in Turkmenistan	31	Have the recommendations from the 2018 Astana regional meeting on HIV and migration influenced the revision of HIV prevalence data in Turkmenistan, judging by the frequency of HIV detection rates among migrants in the receiving countries? If yes, please indicate how.	
	SRH, HIV and migration databases	32	Have any databases on migration and sexual and reproductive health issues been developed in the country?	
Impact of the COVID-19 pandemic on migration		33	To which extent has international migration in your country decreased due to the COVID-19 pandemic? Assess on a 5-point scale (where 1 is very little, 5 is very much) by population groups: labour migrants in general, sex workers, MSM, PWID, and PLHIV.	Ask the expert to substantiate his or her opinion on the matter.

	34	How much has internal migration decreased in your country due to the COVID-19 pandemic? Assess on a 5-point scale (where 1 is very little, 5 is very much) by population groups: labour migrants in general, sex workers, MSM, PWID, and PLHIV.	Ask the expert to substantiate his or her opinion on the matter.
	35	Rate the extent to which migrants' earnings from work abroad have decreased due to the COVID-19 pandemic on a 5-point scale (where 1 is very little, 5 is very much).	
	36	Rate the extent to which the earnings of internal migrants have decreased due to the COVID-19 pandemic on a 5-point scale (where 1 is very little, 5 is very much).	
Impact of the COVID-19 pandemic on gender-based violence	37	Please, assess whether the COVID-19 pandemic has caused a change in the frequency of gender-based violence in migrant families, using a scale from -5 to +5 (where 0 is no change; -1 is slightly worse, -5 is drastically worse; 1 is slightly better, 5 is drastically better).	Ask an expert to share stories on the subject, perhaps of their own experience.
	38	During the COVID-19 pandemic, job loss and difficulties in leaving receiving countries, has the sexual exploitation of international migrant women increased?	
	39	Has the sexual exploitation of female internal migrants increased due to the COVID-19 pandemic and fewer employment opportunities?	
Exposure to COVID-19 of migrants and access to vaccination for migrants, including pregnant women	40	Which vaccines against COVID-19 are used in your country? (specify)	Ask the expert to express their thoughts and feelings on the issue of exposure of pregnant migrant women and people living with HIV to COVID-19 and ensuring their access to vaccination
	41	Rate the availability of vaccination against COVID-19 for pregnant and young international migrant women who are married or in partnership with a migrant or their family member on a 5-point scale (where 1 is very low, 5 is very high).	
	42	Rate the availability of vaccination against COVID-19 for pregnant and young internal migrant women who are married or in partnership with a migrant or their family member on a 5-point scale (where 1 is very low, 5 is very high).	

	43	Rate how aware do you think migrant women are of the importance of COVID-19 vaccination for safe motherhood on a 5-point scale (where 1 is unaware, 5 is very well).	as part of health programmes.
	44	Migrants are considered to be at high risk of COVID-19 infection. Do you think that migrants are more likely to get COVID-19 than the general population? Are there data on the incidence of COVID-19 among migrants in the country? If yes, please share the data.	
Raising awareness of SRH, HIV and COVID-19	45	Rate the availability of information for migrants on SRH and HIV infection and COVID-19 in their own language on a 5-point scale (where 1 is barely available, 5 is fully available).	Ask the expert to express their thoughts and feelings on how to improve education, information, and communication on SRH, HIV and COVID-19 interrelationships for migrants and their access to appropriate prevention, treatment and care, including vaccination against COVID-19.
	46	Are there websites and/or mobile applications for migrants in your country that have made it easier for migrants to get information and access health care? If yes, please provide the address of the website and the name of the app.	
Stigma and discrimination	47		Ask the expert for an opinion on how tolerant society, including health workers, is towards migrants of different groups; how widespread xenophobia and homophobia are and how this affects the demand for SRH and HIV services.

Step-by-step guide for analysing the qualitative data of each expert interview

1. Read the transcript. Take notes on first impressions. Read the transcript again carefully.
2. Mark relevant words, phrases, paragraphs. Give them appropriate titles (coding), e.g.: "Differences", "Progress", "Complaints", "Expressions of frustration", "Solutions", "Human rights violations", "Good practices", etc. Write these codes in the margins of the text, indicating to which places they refer. A reason to consider a particular statement relevant, along with the researcher's conclusions from the desk study, may be its repetition, surprise at hearing it, stressing the significance of what the expert has said, relating it to international standards and human rights upheld by the international community, etc. You should try to be impartial and assign more codes to various phenomena.
3. You need to decide which codes are the most important and generalise the different codes into categories. For example, a very important code might be "violation of reproductive rights", and the codes "complaints" and "expressing frustration" in relation to some phenomena can be integrated under the code. The category can be new or some codes can be integrated under the umbrella of another code. Secondary codes should be omitted. Group the categories into themes. They may characterise, for example, an object or process, or a difference. This is how the conceptualisation of data is carried out.
4. Give titles to the topics, e.g. "Unresolved problems", "New problems", "Practical solutions". Describe the relationship between the topics.

Define a hierarchy of topics, make drawings to illustrate the findings. You can use computer software for qualitative data analysis that supports content analysis of open data in qualitative research, e.g. Auad 7