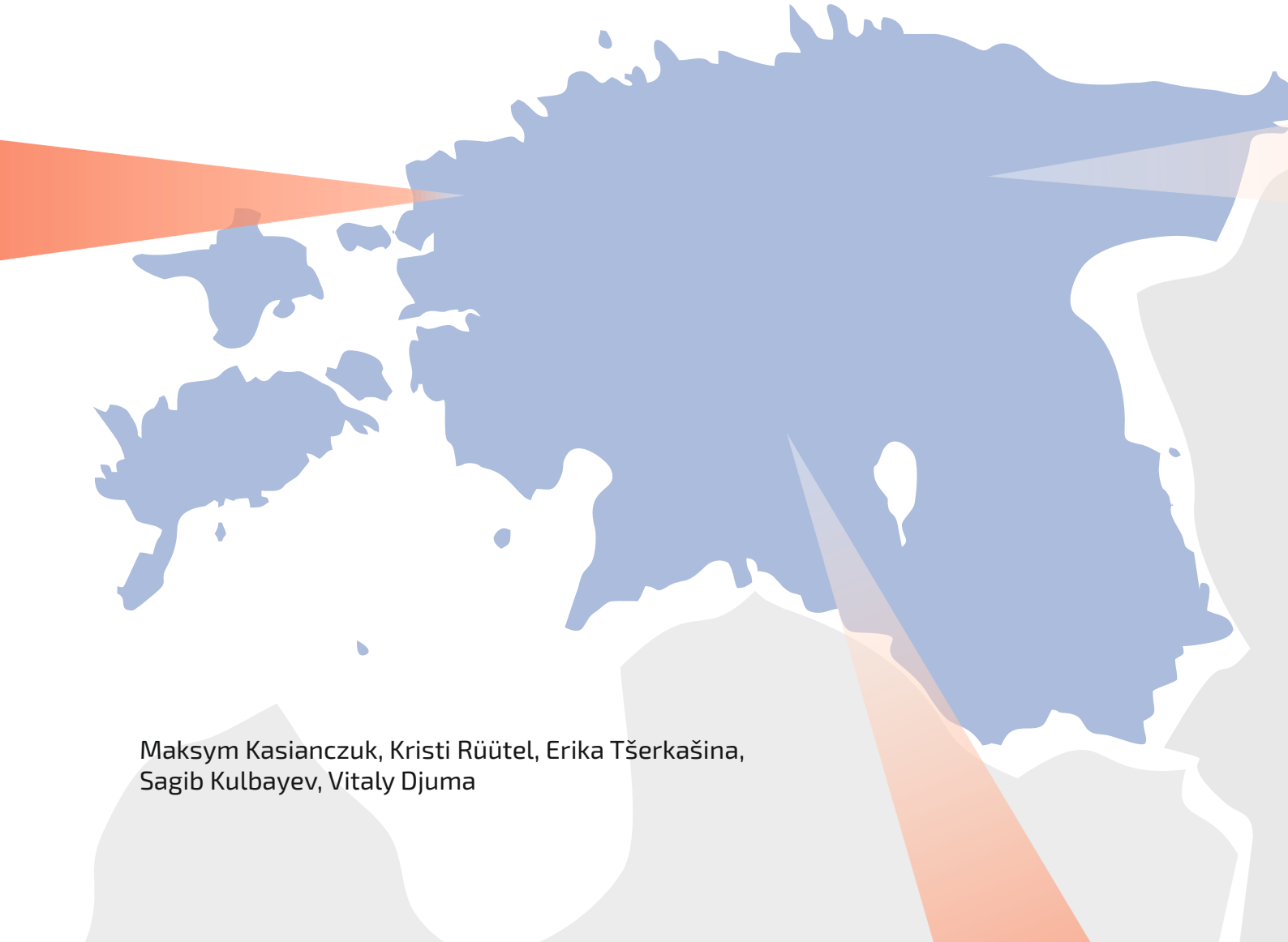
ECOM

National Institute for Health Development

STUDY REPORT

Immigrants in Estonia: a risk assessment to involve the key group into HIV and co-infections services



Maksym Kasianczuk, Kristi Rüütel, Erika Tšerkašina,
Sagib Kulbayev, Vitaly Djuma

ECOM grant “Immigrants in Estonia: a risk assessment to involve the key group into HIV and co-infections services” (https://weepi.org/projects/stage-1/improving-migrant-access-to-hiv-and-co-infections-services-in-estonia) supported by Western-Eastern European Partnership Initiative on HIV, Viral Hepatitis and TB (WEEPI).

ECOM — Eurasian Coalition on Health, Rights, Gender and Sexual Diversity is an international non-governmental association based in Tallinn, Estonia. We are a membership organization open to non-profit organizations and activists working in the response to the epidemic of human immunodeficiency virus among men who have sex with men and transgender people in the Eastern Europe and Central Asia region. The network currently has 76 members from 19 countries, stretching from Estonia to Tajikistan.

The authors would like to thank all the participants and organizations involved in the study — the Integration Foundation, Estonian Refugee Council, Estonian Network of People Living with HIV, Association of Ukrainian organizations in Estonia, as well as all our reviewers from different countries.

Suggested citation to this publication: Kasianczuk M, Rüütel K, Tšerkašina E, Kulbayev S, Djuma V. Immigrants in Estonia: a risk assessment to involve the key group into HIV and co-infections services. Study Report. Tallinn: ECOM; 2021.

ISBN 978-9916-4-0771-4 (pdf)

Contents

Abbreviations

AR	asylum seeker or refugee
ART	antiretroviral therapy
ARV	antiretroviral
CEECA	Central and Eastern Europe and Central Asia
ECDC	European Centre for Disease Prevention and Control
ECOM	Eurasian Coalition on Health, Rights, Gender and Sexual Diversity
EEA	European Economic Area
EU	European Union
HIV	human immunodeficiency virus
ID	identifier
ILPW	illegal low paid workers
LGBT	lesbian, gay, bisexual and trans
LLPW	legal low paid workers
MHPLW	middle and high paid legal workers
MSM	men who have sex with men
NA	not applied/not available
NGO	non-governmental organization
NIHD	National Institute of Health Development (Estonia)
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
STI	sexually transmitted infections
TB	tuberculosis
WEEPI	Western-Eastern European Partnership Initiative on HIV, Viral Hepatitis and TB (Switzerland)
WHO	World Health Organization

Executive Summary

Introduction

Migration affects the epidemiology of infectious diseases, including HIV, tuberculosis (TB) and viral hepatitis. For example, 44% of those diagnosed with HIV in the European Union/European Economic Area in 2019 were migrants. Migrants face barriers to accessing and adhering to care, including low self-perceived risk of TB, stigma, and fear of discrimination at health services. This should be considered in the provision of services. In 2020, more than 16,000 people immigrated to Estonia. So far, migrants have played almost no role in Estonian HIV epidemic as well as in the burden of co-infections. The aim of the study was to assess the risk-behaviors related to HIV and co-infections among different sub-populations of migrants in Estonia as well as map their needs and identify the gaps in existing prevention, social and health care services.

Methodology

Twenty-two in-depth semi-structured interviews with representatives of different subgroups of migrants and three interviews with specialists working with migrants were conducted. The focus was on newly arrived migrants (in the last three years) to study how people are adapting in Estonia in the context of public health. Different groups of migrants were aimed to recruit, including vulnerable populations (illegally working people, men having sex with men (MSM), people living with HIV).

Results

Other migrants, non-governmental diaspora organizations and family members both in Estonia and abroad were mentioned to be the most important sources of support. Regarding access to health services, several misconceptions and lack of information about what is available and who could access the services emerged as problematic issues. The main hindrance for accessing health care was related to the status — illegal immigrants and people with no residency permit had no access. Illegal migrants were also afraid of the consequences and loss of confidentiality in case of asking any medical help. Participants also reported similar problems with health care services as Estonian general population — long waiting lists, high prices (especially dental care), not attentive medical personnel. Language and cultural issues were mentioned several times — even it Tallinn had been difficult to find a doctor who spoke English or Russian and medical personnel was not used to communicate with people with other cultural backgrounds. Participants also reported difficulties in accessing birth control measures as well as condoms.

Most of the participants were aware of HIV and tuberculosis and had been tested during their lifetime. Testing during their stay in Estonia was limited, especially tuberculosis screening. All four HIV-positive participants received free ARV therapy and had no complaints about the system. Most MSM migrants (n = 9) had not heard about pre-exposure prophylaxis of HIV and only a few had used it in Estonia. The system for providing pre-exposure prophylaxis was considered complicated.

In the context of vaccination, influenza was the most frequently mentioned (at the time of data collection, vaccination against COVID-19 was not widely available). Two thirds of the respondents said that no one in Estonia had ever offered them to be vaccinated.

Conclusions

In conclusion, people newly arriving to Estonia highlighted the gaps in Estonian health system which also local people are not satisfied with. But they also experienced unique issues related to their status. In the near future, education and information for the specialists working with migrants and asylum seekers in a variety of organizations should be provided. Information and educational programs for the migrants should be culturally appropriate and tailored to their needs. Reduction of stigma and enforcing human rights is essential in order to meet the needs of people. From public health point of view, it is necessary to provide basic health services for illegal undocumented migrants, including making sure they receive care for communicable diseases as early as possible. This is especially important in the light of COVID-pandemic. Migrants

themselves can serve as a significant human resource for HIV service organizations, and their involvement as volunteers would contribute to a more successful prevention of HIV and co-infections.

РЕЗЮМЕ

Введение

Миграция влияет на эпидемиологию инфекционных заболеваний, включая ВИЧ, туберкулез (ТБ) и вирусный гепатит. Например, 44% людей, у которых был диагностирован ВИЧ в Европейском союзе / Европейской экономической зоне в 2019 году, были мигрантами. Мигранты сталкиваются с трудностями во время получения медицинской помощи в полном объёме, в том числе из-за недооценки риска туберкулёза, стигмы и страха дискриминации в медицинских учреждениях. Это следует учитывать при предоставлении услуг. В 2020 году в Эстонию иммигрировало более 16000 человек. До сих пор мигранты практически не играли роли в эстонской эпидемии ВИЧ, а также в распространении сопутствующих инфекций. Целью исследования было изучить рискованное поведение, связанное с ВИЧ и сопутствующими инфекциями, среди различных подгрупп мигрантов в Эстонии, а также составить карту их потребностей и выявить пробелы в существующих профилактических, социальных и медицинских услугах.

Методология

Было проведено 22 полуструктурированных интервью с представителями разных подгрупп мигрантов и 3 интервью со специалистами, работающими с мигрантами. Основное внимание уделялось вновь прибывшим мигрантам (за последние три года) для изучения того, как люди адаптируются в Эстонии в контексте общественного здравоохранения. Были выбраны различные группы мигрантов, в том числе уязвимые группы населения (нелегально работающие люди, мужчины, практикующие секс с мужчинами (МСМ), люди, живущие с ВИЧ).

Результаты

Другие мигранты, неправительственные организации диаспор и члены семей как в Эстонии, так и за рубежом были упомянуты респондентами как наиболее важные источники поддержки. Что касается доступа к медицинским услугам, то наблюдался недостаток информации о том, что именно доступно и кто может получать услуги. Основное препятствие для доступа к медицинской помощи было связано со статусом нелегальных иммигрантов и людей без вида на жительство. Нелегальные мигранты также опасались последствий потери конфиденциальности в случае обращения за медицинской помощью. Участники также сообщили о проблемах с медицинскими услугами, схожими с проблемами населения Эстонии — длинные очереди, высокие цены (особенно стоматологические услуги), невнимательный медицинский персонал. Языковые и культурные вопросы упоминались несколько раз — даже в Таллинне было трудно найти врача, говорящего по-английски или по-русски, а медицинский персонал не владел навыками взаимодействия с людьми другой культуры. Участники также сообщили о трудностях с доступом к средствам контроля рождаемости, а также к презервативам.

Большинство участников знали о ВИЧ и туберкулёзе и прошли тестирование при жизни. Тестирование во время их пребывания в Эстонии было ограниченным, особенно скрининг на туберкулёз. Все четверо ВИЧ-положительных участника получали бесплатную АРВ терапию и не жаловались на систему. Большинство мигрантов-МСМ (n = 9) не слышали о доконтактной профилактике ВИЧ, и лишь немногие использовали ее в Эстонии. Систему доконтактной профилактики опрошенные сочли сложной.

В контексте вакцинации чаще всего упоминался грипп (на момент сбора данных вакцинация против COVID-19 не была широко доступна). Две трети респондентов заявили, что никто в Эстонии никогда не предлагал им вакцинацию.

Заключение

Вновь прибывшие в Эстонию отметили ряд пробелов в системе здравоохранения, которые не устраивают и местных жителей. Но они также столкнулись со специфическими проблемами, связанными со правовым статусом. В ближайшем будущем необходимо

обеспечить обучение и информацию для специалистов, работающих с мигрантами и лицами, ищущими убежища, в различных организациях. Информационные и образовательные программы для мигрантов должны соответствовать их культурным традициям и соответствовать их потребностям. Снижение стигмы и обеспечение прав человека необходимы для удовлетворения потребностей людей. С точки зрения общественного здравоохранения необходимо предоставить базовые медицинские услуги нелегальным мигрантам, не имеющим документов, включая помощь при инфекционных заболеваниях, как можно раньше. Это особенно важно в свете пандемии COVID. Сами мигранты могут служить значительным кадровым ресурсом для организаций, предоставляющих услуги в связи с ВИЧ, и их участие в качестве волонтеров будет способствовать более успешной профилактике ВИЧ и сопутствующих инфекций.

1. Introduction and background

Migration has always shaped the history of humankind. Human migration is the movement of people from one place to another for the purpose of settling either temporarily or permanently. Therefore, the term migration covers a wide range of individuals who are displaced for various voluntary reasons, or because of external forces. The International Organization for Migration, an intergovernmental organization working on global migration issues under the United Nations mandate, outlines the following types of migration: labor migration and remittances, interregional migration, irregular migration, migrant smuggling and human trafficking, and internal and international displacements (1).

Migration trends change and every now and then there is a new wave of migration. Political or economic situation as well as climate change may drive migration trends. While writing this report, Lithuania, one of the three Baltic countries with a population of 3 million people, is tackling a migrant influx from Belarus. Lithuanian officials estimate that more than 10,000 more migrants might try to arrive in 2020 (2).

European countries are both sources and hosts of migrant populations. Emigration from Eastern European countries to Western Europe has been a growing trend, particularly since the expansion of the European Union in 2004 and 2007 to include more Eastern European member states. The largest sources of migrants in Europe are Eastern European countries such as the Russian Federation, Ukraine, Poland and Romania. The top two largest migration corridors within Europe are migration flows from Ukraine and from Kazakhstan to the Russian Federation. There are also significant migrant flows to the Russian Federation from Uzbekistan, Azerbaijan, and Belarus. In total, eight of the top twenty migration corridors within Europe are interregional and are between countries of the former Union of Soviet Socialist Republics (3).

In the last five years, one of the most significant conflicts that caused a surge in the number of refugees in European countries was the civil war in Syria. Thus, in 2015–2016 Europe faced the largest migration crisis since the Second World War. That year, more than million people crossed the Mediterranean to find new life in European countries. This wave of migration has vaned, with approximately 120,000 people coming in 2019 (4).

Such a concentration of displaced persons and the urgency of their problems related to being in a new place (such as the insufficient efforts of host countries to encourage integration, the prevalence of discrimination and prejudice, and large barriers to healthcare, education, and other necessities) led to the mobilization of the refugee community and the participation of its representatives in the European Parliament elections (3).

The influx of refugees and migrants into the WHO European Region since 2015 has come in a series of repeated waves encompassing from tens to several hundreds of refugees and migrants, often simultaneously in different areas, and increasing significantly in frequency during the summer months (5). As of January 1st, 2019, 21.8 million people lived in EU who did not have EU citizenship. This comprised 5% of the total population. At the same time, 13.3 EU citizens lived in some other EU country than their country of origin (4).

Against the background of the Syrian crisis, people rarely note “quiet migration”, such as cross-border tourism, migration for temporary or permanent work or study, family reunification, etc. However, such processes are continuous, and have no less of an effect on the social situation, in particular, in the field of public health (3).

Among other issues, migration affects the epidemiology of infectious diseases, including HIV, tuberculosis (TB) and hepatitis B/C. It is also the case in European Union/European Economic Area (EU/EEA) countries. Some sub-populations of migrants are also considered to be an under-immunized group and thus at risk of vaccine-preventable diseases (6). Migrants are a key population affected by HIV across Europe. While most migrants are HIV negative, a minority of migrant communities may be more vulnerable to HIV due to a higher prevalence in their countries of origin and to sexual mixing within communities of higher prevalence following migration (7). Forty-four per cent of those diagnosed in the EU/EEA in 2019 were migrants, defined as

originating from outside of the country in which they were diagnosed, with 18% originating from countries in sub-Saharan Africa, 9% from countries in Latin America and the Caribbean, 8% from other countries in central and Eastern Europe, and 3% from other countries in western Europe (8).

Many barriers and gaps have been identified in this field in Europe. Migrants face barriers to accessing and adhering to care, including low self-perceived risk of TB, stigma, and fear of discrimination at health services, which should be considered in the provision of services. The risk of blood borne and sexually transmitted infections (STI) among migrants is associated with political and sociocultural factors (9). Migrants without residency status may avoid care due to fear of immigration enforcement. Migrants may have lower levels of awareness of infections and their risk factors, which may lead to lower levels of screening (6). This all contributes to their vulnerability to HIV and co-infections.

In the region of Central and Eastern Europe and Central Asia (CEECA), all possible causes of migration exist: wars (Armenia/Azerbaijan, Georgia/Russia, Moldova, Russia/Ukraine), labor migration (Tajikistan/Russia, Tajikistan/Iran, Uzbekistan/Russia, Kyrgyzstan/Kazakhstan, Ukraine/Poland, Belarus/Lithuania, etc.), seeking international protection due to systematic human rights violations (Belarus, Russia, Uzbekistan, Turkmenistan, etc.) (10), and migration in order to receive vital medical care (for example, the migration of trans people to Russia, Iran, or Turkey to undergo gender reassignment procedures). In addition, the region is experiencing an extremely unfavorable situation related to HIV and hepatitis epidemics.

1.1. Immigration in Estonia

According to WHO (2018) up to 15% of the total population in Estonia were international migrants (5). In 2011–2014, 2000–4000 people immigrated to Estonia each year. Since 2015, these numbers have increased more than four times. In 2020, more than 16,000 people immigrated to Estonia (11). Thus, immigration to Estonia has contributed to population growth for past six years. Large proportion of migrants include EU and Estonian citizens, but in 2020, almost 1400 Russian and 1600 Ukrainian citizens migrated to Estonia. The number of other countries' citizens was close to 2200 (12). There is a growing tendency of using illegal immigrant work in Estonia (13). More than half of the migrants are men and most are working age people aged 20–49 years (12).

So far, migrants have played almost no role in Estonian HIV epidemic as well as in the burden of co-infections. According to unpublished data from Health Board, in 2015–2019 4% new acute hepatitis B cases, 0.5% new acute and chronic hepatitis C cases, and 1% new HIV cases were reported among migrants. In 2020 a new trend was noticed — 8% of new HIV cases diagnosed in Estonia were people who had previously been diagnosed with HIV in some other country. Some of them were Estonians returning to Estonia, some were migrants (Unpublished data, Health Board of Estonia).

So far, no specific study or data collection about HIV and related issues among migrants has been performed in Estonia.

1.2. Description of the existing system of services that are provided in the context of HIV and co-infections

This short description is based mostly on state report of Estonian Republic to UNAIDS (14).

HIV testing and screening

HIV testing is voluntary and it may be performed only upon the person's informed consent (as in case of all health care services). Any doctor in Estonia (either a general practitioner or a specialist) can recommend HIV testing based on clinical indications, risk assessment or the patient's request. HIV testing is provided only in health care institutions (including family medicine centers and prison health services). In case of an indication for testing, a general practitioner or a specialist provides HIV testing to patients with health insurance without a fee. People who are not insured

can take advantage of other free testing options, for example anonymous and free HIV testing sites across the country. In syringe exchange programs also home-test are provided free of charge.

HIV prevention among people who inject drugs

Needle and syringe exchange programs in Estonia were launched in 1997. Services are mostly provided in Tallinn and its surrounding areas and in North-Eastern Estonia (nine organizations). Altogether there are 14 stationary and 22 out-reach needle and syringe exchange points. In addition, opioid substitution therapy is provided to PWID, mostly in capital city Tallinn and North-Eastern Estonia.

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) is officially available since early 2020. It has to be prescribed by an infectious diseases specialist. No referral is needed. PrEP drugs are available in pharmacies and compensated by 50% in case the person has national health insurance.

Health care and social support for people living with HIV

Patients who test positive for HIV are referred to an infectious disease doctor for health monitoring, treatment, counselling and contact tracing. No official referral is required (as opposed to appointments with other specialists, for which a general practitioner's referral is necessary). HIV-related health care services including antiretroviral therapy (ART) are free of charge for all patients. Patients on ART usually have to visit the hospital once a month to get a month's supply of antiretroviral (ARV) medication. Patients who are not receiving ART yet usually visit the hospital once or twice a year for regular medical check-ups. Several non-governmental organizations (NGO) provide counselling for people living with HIV and their close ones (social, psychological and legal issues, adherence to treatment, HIV prevention, etc).

Prevention of mother to child transmission of HIV

All pregnant women in Estonia are covered by health insurance once their pregnancy is confirmed by health care specialists and thus are guaranteed all health services free of charge (including prophylactic ART for women and newborns). Besides that, HIV-positive women receive free of charge breast milk substitute until the child is one year old.

Sexual health and STI services

There are 18 youth counselling centers all across the country. These centers provide STI and HIV counselling, diagnostics, and treatment, also counselling on safe sex, family planning issues for young people up to 26 years of age. Services are free of charge for all clients.

General population can access STI services at their family doctors (which is not often covered by health insurance), gynecologists (for women), or urologists/andrologists (men). Contraceptive pills are mostly prescribed by family doctors and gynecologists.

Condoms are sold everywhere. In the framework of National HIV Prevention Plan, free of charge condoms are distributed in many places and organizations — youth counselling centers, anonymous HIV testing centers, syringe exchange programs, infectious diseases out-patients departments, drop-in centers for different risk groups, etc.

For men having sex with men (MSM), there are three clinics that provide free of charge STI counselling and testing. In most cases, treatment is also free or charge.

One NGO in Tallinn provides counselling and social support for sex workers and there are three sexual health clinics in different regions of the country that provide free of charge STI and HIV counselling and testing as well as treatment.

Prevention and treatment of tuberculosis

Health services related to TB diagnostics and treatment are free of charge for all patients, including those who do not have health insurance. All TB patients are routinely offered HIV testing (opt-out approach, recommendations from the professional society of pulmonologists).

Prevention and treatment of viral hepatitis

Hepatitis B vaccination for the babies and teenagers is in the national vaccination plan since early 2000ies. People born earlier must cover the costs of vaccination themselves, unless they have occupation where vaccination is considered necessary. Hepatitis B and C are diagnosed and treated by infectious diseases specialists or gastroenterologists, referral by family doctor is needed. Services are free of charge for those who have national health insurance.

2. Methods

2.1. Aim of the study

The main aim of the study was to contribute to the prevention of HIV and co-infections (viral hepatitis, STIs, TB) among different sub-populations of migrants in Estonia. The specific aims were:

- To study the risk-behaviors related to HIV and co-infections among different sub-populations of migrants in Estonia.
- To map the needs and identify the gaps in existing social and health care as well as prevention services related to HIV and co-infections for migrants.
- To propose changes in the system of existing services that would make it possible to reach migrants with HIV and co-infections prevention and treatment.

To our knowledge, this was the first qualitative study on the issue in Estonia to find practical approaches to involve this key group into services, so at this stage, no clear hypotheses were formulated. The main themes to discuss during interviews were the following:

- Visibility and accessibility of social and medical services to people who came to Estonia (both legal and illegal workers, refugees, asylum seekers);
- Risk behaviors among migrants, contacts with the public social system;
- Migrants' (including illegal) needs around which it is possible to build a more effective system of providing HIV and co-infections services.

The focus was on rather newly arrived migrants (in the last three years) to study how people are adapting in Estonia.

2.2. Methodology

To answer the study questions, 25 semi-structured interviews with representatives of different subgroups of migrants and specialists were conducted. Participation in the study was voluntary and participants could cancel participation at any time without providing explanations. Each participant provided oral informed consent for participation. No personal identification data were collected. Each respondent was offered an incentive of a €30 voucher for participating in the study. Approval for the study was sought from the Research Ethics Committee of National Institute for Health Development (approval number 607, 14.01.2021).

The study participants were divided in two main groups: migrants who arrived in Estonia no earlier than three years prior to the interview (n = 22); and specialists involved in direct provision of services to migrants or asylum seekers in NGOs (n = 3).

Eligibility criteria for participation were:

1) Migrants or asylum seekers/refugees:
    - is not an Estonian citizen or does not have an alien passport
    - came to Estonia during last three years (legally or illegally)
    - 18 years old or elder
    - speaks Russian or English or Estonian
2) People, working with migrants or asylum seekers/refugees
    - is an Estonian citizen or has an alien passport
    - lives in Estonia on legal base at least last 10 years
    - 18 years old or elder
    - speaks Russian or English or Estonian

- involved in direct provision of services to migrants or asylum seekers (in NGO or municipal institution)

As the focus of the study was HIV and associated infections, it was specifically aimed to recruit also a few people from vulnerable populations (e.g. people living with HIV, MSM).

The first migrant participants were identified by the Association of Ukrainian organizations in Estonia, the Estonian Network of People Living with HIV and the Integration Foundation. Another group of participants was recruited by means of dating apps, such as Tinder and Grindr. The recruitment process also relied on the snowball method, i.e. all respondents were asked to provide at least one contact of a friend or acquaintance with a similar status/situation. Professionals working with migrants or asylum seekers of refugees we recruited by directly contacting relevant organisations.

Interviews were conducted by one interviewer, Erika Tšerkašina, between January and May 2021. Due to the COVID-19 pandemic and respective risks and restrictions, all interviews were conducted online. All interviewers gave their consent to record the interviews and thus all interviews were recorded (audio only). The interviews were conducted in either English, Russian, or Estonian language. In the end of each interview the participants were informed about HIV and health services in Estonia and could ask questions specific to their situation and get directions to resolve their health-related issues.

There were several challenges faced with recruitment. It was problematic to find respondents that could meet the recruitment criteria. For example, many of the refugees had lived In Estonia more than three years. Secondly, many of them refused to give an interview due to religious reasons (some Muslim people refused from being interviewed because of questions about sexuality). Thirdly, some people who were interested to participate, could not speak either Estonian, Russian or English. Thus, 20 potential respondents refused participation after being introduced the study.

2.3. Data management and analysis

Based on the audio recording of the interview, the interviewers prepared verbatim transcripts and coded them with MAXQDA software. The accuracy of the transcripts was verified by the study coordinator. After checking the accuracy and completeness of the transcripts, the audio recordings were deleted. Transcripts did not contain any personal information, such as names, date or place of birth, home address. Other names, addresses, and cities that were discussed during the interview were abbreviated to the first letter. For example, „person T“ or „city L“.

Transcripts were analyzed qualitatively, writing a summary of main topics and issues which were raised during the interviews. In the report direct quotations are also used. Direct quotes are provided in italics, with authors comments in square brackets "[]". In case some text has been left out, it has been marked as "/…/".

Every citation is followed by information about the participant, e. g." Russian Federation, 28 y. o., man, LLPW, 4 months in Estonia, Tallinn". These data include country of origin, age, gender, type of migrant (the abbreviations from the abbreviation list), length of stay in Estonia, and region of living in Estonia, and in some cases HIV status.

3. Results

3.1. Demographics of the sample

The final sample size was 25 — three specialist and 22 immigrants/refugees (detailed data are presented in table 1).

One specialist was from state agency Integration Foundation (*Integratsiooni Sihtasutus*), and two were from NGOs working with refugees. Their work experience with migrants was more than seven years in both state and non-state organizations. All interviewed specialists had experience of interacting with the Estonian health care system.

Migrants:

- Six migrants were from Ukraine, six from Russian Federation, three from Central Asia (Tajikistan and Kazakhstan), three from Africa, two from South America, two from Western Europe (Norway and Germany)
- average age of the interviewed migrants was 31 years
- among participants 15 were men and seven were women
- 13 respondents were interviewed in Russian and nine in English
- most of the people interviewed (19 from 22) lived in Tallinn, three lived in North-East Estonia
- the average length of migrant's stay in Estonia before the interview was 20 months (just over one and a half years)
- among all interviewed migrants, there were eight legal low paid workers (LLPW), eight middle and high paid legal workers (MHPLW), three illegal low paid workers (ILPW), three asylum seekers/refugees
- among all respondents there were four migrants, who had been diagnosed with HIV in Estonia in less than three years ago

3.2. Areas of employment

The participating migrants were engaged in different types of activities in Estonia — from casual jobs (cleaning, chef assistant, etc.) to prestigious and highly paid IT jobs. Naturally, this was related to both skills and legal status. One of the respondents noted that „*It's hard to look for a job abroad without knowing the language, without any rights. So I had to work as a cleaner. I worked legally for about a year*" (Ukraine, 30 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

Economic reasons force migrants to look for more or less legal options to stay in Estonia, although at less prestigious positions, compared to the one that was before moving from their homeland. „*I had to work with them directly with the sector related to Russian-speaking countries /.../ But from the very beginning, things did not go very well, and I did not work officially, I received money /.../ they know my situation, I continue to work unofficially. So I don't pay taxes*" (Kazakhstan, 33 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

One might get the impression that low-paid work is the only option for immigrants from post-Soviet countries who do not know English, but the following example describes the experience of an English-speaking person who lived in Belgium before moving to: „*I am 28 years old and I moved to Tallinn just a couple of months ago. Before that, I lived in Belgium for about 5 years. I came to study, at the moment I am working. /.../ Now I work as a security guard in a shop and in a warehouse*" (Russian Federation, 28 y. o., man, LLPW, 4 months in Estonia, Tallinn).

Table 1. Background characteristics of the participants (as for specialists in the table, we omitted their age and gender to be them not identifiable)

№	Country of origin	Age	Gender	Language of interview	Social status	Place of residence in Estonia	Months in Estonia	HIV status
1	Ukraine	46	Female	Russian	LLPW	Tallinn	6	Neg
2	Ukraine	30	Female	Russian	MHPLW	Tallinn	18	Neg
3	Ukraine	31	Male	Russian	MHPLW	Tallinn	1	Neg
4	Ukraine	33	Male	Russian	LLPW	Tallinn	33	Neg
5	Ukraine	30	Female	Russian	ILPW	Tallinn	24	Neg
6	Russia	28	Male	Russian	LLPW	Tallinn	4	Neg
7	Russia	28	Male	Russian	LLPW	Narva	30	Neg
8	Russia	27	Male	Russian	MHPLW	Tallinn	25	Neg
9	Russia	36	Male	Russian	LLPW	Narva	30	Pos
10	Russia	35	Female	Russian	AR	Tallinn	30	Neg
11	Russia	35	Male	Russian	LLPW	Sillamäe	5	Pos
12	Kazakhstan	24	Male	Russian	ILPW	Tallinn	10	Neg
13	South America	32	Male	English	LLPW	Tallinn	6	Neg
14	Norway	27	Male	English	MHPLW	Tallinn	8	Pos
15	South America	26	Male	English	MHPLW	Tallinn	4	Neg
16	Germany	37	Male	English	MHPLW	Tallinn	30	Neg
17	Kazakhstan	33	Female	Russian	ILPW	Tallinn	24	Neg
18	Tajikistan	29	Male	Russian	AR	Tallinn	34	Pos
19	Africa	33	Female	English	AR	Tallinn	24	Neg
20	Africa	30	Female	English	MHPLW	Tallinn	24	Neg
21	Africa	30	Male	English	MHPLW	Tallinn	34	Neg
22	Ukraine	30	Male	Russian	LLPW	Tallinn	24	Neg
23	Estonia	NA	NA	Estonian	specialist, state	Tallinn	NA	NA
24	Estonia	NA	NA	English	specialist, NGO	Tallinn	NA	NA

25	Estonia	NA	NA	English	specialist, NGO	Tallinn	NA	NA

3.3. Reasons for coming in Estonia

In some cases, the decision to move was made for **economic reasons**: „*By education I am an engineer-surveyor. In Ukraine, I did this work for 10 years, but then my salary collapsed and if converted to dollars, it turned out to be 280 USD. It felt bad to work for that kind of money, so I began to think about how to earn my living. Honest work, of course. Although I work in the land sector and there are opportunities to earn in a dishonest way, I am not that kind of person*" (Ukraine, 33 y. o., man, LLPW, 33 months in Estonia, Tallinn).

In addition to economic reasons, respondents also mentioned **family circumstances** (moving to a spouse or sexual partner, reuniting with parents), moving in connection with **work** or **study**, seeking **asylum**, etc.: „*I arrived about a month ago /.../ My girlfriend lives in Estonia, and I decided to move here, as it is very difficult to maintain a relationship at a distance now*" [with closed borders] (Ukraine, 31 y. o., man, MHPLW, 1 month in Estonia, Tallinn).

First time I came as a tourist and I am planning to stay here with my children /…/ my ex-husband has political problem in Egypt and he lives in Germany, but in this time, we can't go to Germany. So, we came to Estonia in Tallinn Airport. I had Estonian Schengen visa, but the airport did not accept it and cancelled my visa and my children's visas also /…/ So, in the airport I asked the police that I am a refugee. And we make this like ID to stay for 3 years here. And after that police will see what they must do with me (Africa, 33 y. o., woman, AR, 24 months in Estonia, Tallinn).

It is important to note that some of the respondents noted police officials were prejudiced when considering applications for a residence permit.

3.4. Sex work and human trafficking

There were no sex workers or people human trafficked among the participants themselves. The interviewed specialists had not met such migrants or at least the migrants had not talk about it, but this is partly due to the specifics of counseling: „*I don't know that* [if they have clients who are involved with sex work]. *I don't think so. I have never had this feeling about anyone. For some reason I think that these people often do not come to public offices. The Integration Foundation is still a state institution, although we are a foundation. And the International House... I don't think they* [immigrant sex workers] *will get there either. They hardly come to an Estonian language course for their work. I have a feeling that they are exactly in the grey and they wouldn't turn to anyone for help or advice, because this activity is illegal here. Usually, they would not reach out. /…/ I don't know* [if they had clients who were victims of human trafficking]. *Once I was providing language counseling for a young woman who arrived from Ukraine to work in Estonia. And her company manager was exactly* [like a person who would be in charge of human trafficking]... *It is very subjective how I felt about this meeting. All her things were run by this man who was the head of this company. It really felt like she was a doll in this man's hand. He kept all her papers, he had a whole folder about this woman. Our meeting was still a physical one and took place at the Estonian language house. I asked the man to stay behind the door so I could communicate with the woman alone. We do one-on-one counselling; we don't usually use peers. Everything seemed very good, but I was disturbed that all her affairs were in the hands of this man and he even wanted to answer for her. This man said she was coming here for the language course and asked me to arrange it. The woman didn't seem to have any wishes of her own. At the same time, I can't prove or claim that there was anything like this* [human trafficking], *but my alarm went slightly on. What I greatly emphasized in communication with this woman was that "here are my contacts, please reach out to me in case of any questions". I couldn't complain about it, because it*

wasn't the content of our meeting — we talked about how to learn Estonian, what are the different possibilities. But it was the only case. I don't know how these schemes work here, I haven't come across it" (Specialist, state agency).

At the same time, another specialist noted that some migrants can use the opportunities of people who are engaged in the slave trade in order to get into the European Union: „*When you want to know more about sex trafficking than there is an NGO in Estonia, Eluliin, who have this particular sideline working with this kind of people. We really do not know. We are not directly dealing with human trafficking, we just know that some of our clients used the help of human traffickers to get away from Syria or Turkey or so on, but not in a sexual context. They paid huge amount of money to had a place on a boat or something like that*" (Specialist, NGO).

3.5. Sources of informal support

Relatives to whom the respondents could turn for help, if necessary, were usually located outside Estonia. The exception was those migrants who either moved to the country with their wife/husband or other relatives, or changed their country of residence due to marriage, or came to a sexual partner. Despite the fact that some of the respondents had no family ties in Estonia, they noted that they maintained **communication with relatives abroad**, including consultations in case of illnesses: "*And from my family I think my biggest contact is my mum. I lost my father five years ago, so she lives alone with my brother and my two sisters and nephews. I mostly talk to my mum and my sister, but they are in Brazil. So I'm alone, physically alone*" (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

If there are **relatives or friends in Estonia**, their help is realized in several ways. First, friends and relatives can help a migrant with essential information when they come to Estonia for the first time, how to do something (find a family doctor, where is supermarket, how to use reflector, etc): "*Of course, I take her advice on how to organize my life in Estonia — I know almost no one and nothing here* [You said that you came to Estonia to visit your girlfriend. Does she help you make decisions about your health and to solve problems associated with it?]. *I've only been here for a month... So there have been no health problems yet, so we haven't discussed it in detail. Not so long ago, she went to get tested for HIV and STIs and suggested that I do this too. I refused... We have been in a relationship for a long time and, moreover, her analyzes confirmed that everything is fine*" (Ukraine, 31 y. o., man, MHPLW, 1 month in Estonia, Tallinn).

Secondly, if the wife or husband of a migrant is officially employed, then at the expense of their taxes, an unemployed or unofficially employed migrant can receive medical help from their family or friends: "*Yes, he [*husband*] does* [have health insurance]. *He is paying taxes. We found out that if later there will be a quota for residence permit and he will make these documents, we will be able to register our child here. As he has Haigekassa* [national health insurance], *it will be possible to receive medical services for our child*" (Ukraine, 30 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

Thirdly, the respondents noted that both other migrants and colleagues in Estonia can be a source of support for them: "*In Estonia I can contact my work colleagues and I also have met a couple of persons, but I cannot rely on them in case if I have a problem*" (Norway, 27 y. o., man, MHPLW, 8 months in Estonia, Tallinn, HIV+).

About other sources of support, then in addition to colleagues, the **help of diaspora**[1] (Armenia, Azerbaijan, Brazil, Georgia, Ukraine, etc.) organizations or communities was often mentioned: „*I have already made new acquaintances in Estonia... I found a Ukrainian organization here. These people are certainly not my family. Just nice friends*" (Ukraine, 46 y. o., woman, LLPW, 6 months in Estonia, Tallinn).

In some cases, contacts established in a migrant milieu continue and serve as support after the departure of these acquaintances from Estonia: „*I really have this situation happening, so I turned*

[1] A diaspora is a scattered population whose origin lies in a separate geographic locale

to my neighbor and my boyfriend. And also, to this friend I have from Finland. She was at my house, so she is the oldest contact I have and the closest here. I have bigger connection to her even though she is in Finland" (South America, 26 y. o., man, MHPLW, 4 months in Estonia, Tallinn).

And finally, new acquaintances among the **citizens of Estonia** can serve as a source of support: "*Yes, there are* [friends in Estonia]. *These are the people with whom I study and work together. They are all Estonians, and since they live here they help me with language difficulties and when I need to translate something*" (Tajikistan, 29 y. o., man, AR, 34 months in Estonia, Tallinn, HIV+).

3.6. Free time

Among migrant participants of the study, two groups can be distinguished. Some noted that they had to devote their free time to another job or to studies, which are necessary for work, while others indicated that due to stricter labor legislation compared to how it was in their homeland, they have more free time.

"In my free time, I take up extra work and teach English. I go for walks and to cafes. I don't go to cafes so much during the quarantine, but Estonia has beautiful nature: parks, forests, sea" (Ukraine, 30 y. o., woman, MHPLW, 18 months in Estonia, Tallinn).

"There is a lot of free time, since you cannot overwork at work. I love to travel. I sometimes have three days off in a row, sometimes even 4–5 days in a row, when I swap shifts. And then I fly away to travel. I have been to Norway, Sweden, Finland. I love mountains, so I went to the mountains in Norway. I traveled around Estonia — this year that is the only option available. I make music, write my own music and play the guitar" (Ukraine, 33 y. o., man, LLPW, 33 months in Estonia, Tallinn).

At the same time, it should be noted that the need for additional income and, accordingly, less free time, apparently, is not determined by the respondent's belonging to a group with medium-high or low paid work — for example, in the two examples given, a young woman from Ukraine working as a logistics manager, seeks and finds additional work, while a young man with low income uses his free time to travel.

As for the **hobbies**, the list of those mentioned was very long: reading, cooking, traveling, walking, playing computer games, surfing the Internet, music, visiting museums, cinemas, etc. In a number of cases, the respondents noted that it was after the move that they had the opportunity to return to their old hobby or do what they wanted to do at home for a long time.

Habits are a broader concept than hobbies, but since, by definition, they are something routine for each of the respondents, they can remain unspoken. Therefore, each participant was asked by the interviewer to describe behavior in certain situations that are important for the research objectives, for example: „What do you usually do when …? — When do you want to rest, relax?, When do you feel happy? Unhappy? When you are sick?, When you want to meet new people? When you want to find a partner or a date?".

As it was already mentioned, some of the respondents had to work much more than at home: "*You don't have to rest here for a long time. I work seven days a week for two or three weeks. The weekend is a big holiday, I say. I came home, cooked the food, cleaned it up, and that's the whole weekend*" (Ukraine, 30 y. o., man, LLPW, 24 months in Estonia, Tallinn). However, rest is carried out in the usual ways: walking, sleeping, reading, online social networks.

In situations when respondents feel happiness, they mentioned the desire to share this feeling with others was very common: „*Usually when I'm happy I invite people over and we listen to music, drink wine and we eat and cook something. I still trying to get acquainted to not having outdoor space available*" (South America, 26 y. o., man, MHPLW, 4 months in Estonia, Tallinn).

In some cases, such situations were associated with behavior that could be called destructive. For example, the following quote indicates the habit of seizing stress (whether positive or negative) by increasing eating sweets and communication with other people: „*I think when I'm happy and unhappy I do the same thing — I have chocolate. When I'm happy, I like to meet new people. When*

I can't meet with my friends, I try to be outside, go to a bar or whatever. I like to go to parties, but we don't have them anymore" (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

In situations of emotional decline, feeling unhappy, the respondents either try to „get away from the world", try to reduce activities and contacts to a minimum, or seize stress. In the context of this study, we did not assess the prevalence of symptoms of emotional instability among the respondents, however, given the frequent mention of a higher workload, and in some cases illegal status, it can be assumed that migrants are more likely to experience stress and, thus, are more likely to use compensators of stress — food, alcohol or other psychoactive substances, as well as social and/or sexual contacts. The next section provides information for this assumption.

3.7. Sexual relationships and behaviors

Steady and occasional sexual partners

Of the 22 migrants, eight had permanent partners (men or women). In five cases the partner was a permanent resident or an Estonian citizen (some respondents mentioned that their move to the country was due to the fact that their partner lives here). The duration of a marriage or permanent relationship varied from several months to nine years.

A **steady partner** was often described as the only sexual partner, even if the relationship was now separated by distance: „*I am married for the second time. We met on social networks. We quickly found a common language, came together after almost a month of communication. This year it will be 9 years since we live together /.../ My wife should come to visit me next month. I don't know how it will be with flights and lockdowns, now it's very difficult with moving. In the past period, as I worked here, my wife and children came to me four times. It was much easier. They waited at home, food was prepared. There was someone to hug ... Warmer somehow /.../ When I divorced my first wife, I lived alone for about a year. There was a relationship, but somehow it wasn't right. And then a wife appeared. After that we have a common page* [on Facebook], *everything is common. I removed my acquaintances so that there were no temptations and jealousy or something like that. After that we are all right*" (Ukraine, 30 y. o., man, LLPW, 24 months in Estonia, Tallinn).

It is important to note that in the described case the respondent considers his stay in Estonia as temporary — his wife and children „come to visit" from time to time, then leave again, just like the young Ukrainian man himself.

The situation when a migrant and his/her steady partner are in a foreign country together is less common among labor migrants, whose stay in the country is limited by the availability of work. However, as shown in the previous section, there are other cases where respondents immigrated to Estonia to reunite with a partner who could be either a citizen of the country or someone who came to the country earlier.

Occasional partners. Some of the respondents who did not have a steady romantic partner indicated that they did not have casual partners either, while others described their relationship as a series of contacts with different people: „*No, I don't have a permanent partner. Here I have dates, people I see regularly with whom I hang out regularly, but I don't have a permanent partner*" (Norway, 27 y. o., man, MHPLW, 8 months in Estonia, Tallinn, HIV+).

In some cases, the presence of a steady partner was not a reason to refuse other acquaintances: „*We were texting yesterday and discussed that we can just be friends. It's not necessary to have sex. I am not against friendship, I could have another relationship and stay in touch*" (Russian Federation, 28 y. o., man, LLPW, 4 months in Estonia, Tallinn).

In some cases (4 out of 22), the respondents described sex as a form of recreation: „*Usually I dive into my thoughts about my past* [when they want to rest, relax]. *I would like to rest by being with some new people, to relax somehow, but now with the quarantine measures I have to get by myself. For example, by watching films /.../ It's more related to all sorts of sexual fantasies. Thoughts of this kind eat me alive somehow... I get carried away when I am on my own and*

something drags me in this direction… Something like 50 shades of gray. This is my challenge — thoughts and fantasies. — So you mean some kind of sexual thoughts? Why 50 shades of grey? — It's not exactly like there (in the film). But I feel an urge to look for something like this. I am more open in this sense. And when I am on my own, I quickly start imagining something like this and get carried away. Sometimes these thoughts even scare me. But to relax after work, I need to splash some energy out… to put it mildly" (Russian Federation, 28 y. o., man, LLPW, 4 months in Estonia, Tallinn).

Some people use dating apps to find partners. „*I'll use Grindr and invite young men, whom I like, and in case they agree, I'll invite them*" [What do you do when you want to relax?] (Tajikistan, 29 y. o., man, AR, 34 months in Estonia, Tallinn, HIV+).

The presence or absence of casual partners (in some cases in addition to an existing steady partner), apparently, is also not related to economic status — for example, in the examples given, there were young men with both medium-high and low incomes. However, it should be emphasized that communication (sometimes realized as sexual interactions) is viewed by respondents as a way to relax and relieve stress (for example, a 26-year-old Brazilian man mentioned this in the example from the previous section).

3.8. Ways to find new acquaintances

As described above, the search for new acquaintances (including for sex) is partly associated with an emotional background. Migrants, being in a foreign country, have limited opportunities to establish new relationships, since they are not only excluded from communication networks, but as a rule they do not know the language of the host country: „*Well, in Estonia it's hard. For me I found it hard to make a friend, and especially in Corona-time. It's almost impossible. I think we hang out with our university friends, a few friends. And that's pretty much it. I know someone from work, but not much*" (Kazakhstan, 24 y. o., man, ILPW, 10 months in Estonia, Tallinn).

Thus, social contacts of a migrant, especially one working illegally, are often limited and one of the few available opportunities is the Internet: "*It depends on the situation and on the country* [What do you usually do when you want to meet new people?]. *If we are talking about Estonia and about the present moment, I use the Internet. Because now no one really goes anywhere, and I'm not fond of going to a bar or clubs, so I get to know people on the Internet*" (Ukraine, 30 y. o., woman, MHPLW, 18 months in Estonia, Tallinn).

In addition to the virtual environment, new acquaintances, including romantic ones, are found in night clubs or private parties (access to such parties is possible if there is a developed network of personal contacts): „*If I want to just talk to someone, I can go to some event. Mostly I meet up with friends I made in Narva. We get together and play table games. Or I can organize something for friends, or go visit friends whom I haven't seen in a long time*" (Russian Federation, 28 y. o., man, LLPW, 30 months in Estonia, Narva).

The life situations of the respondents sometimes differ and the following example demonstrates that being in work is associated with the absence of the need to make any additional efforts to expand their social networks: „*Usually I have a lot of contact with people during the day, so I don't want to make new contacts. I have 12 subordinates and everyone wants something from me. There is no lack of communication in my life. I am not making any effort to expand my circle of friends*" (Ukraine, 33 y. o., man, LLPW, 33 months in Estonia, Tallinn).

In general, however, the respondents did not describe any intense sexual life. On the contrary, the lack of free time and the limited range of social connections, most likely, do not enhance the search for new partners.

3.9. Migrant men who have sex with men

Of the 22 migrants interviewed, nine men indicated homo- or bisexual experiences. Few of them talked about the practice of casual relationships: „*I date just men. I'm divorced, I had a relationship*

of 10 years. I got divorced last year. I don't have a relationship, just random hook ups and partners. Actually, I'm getting to know someone know, but I don't know how it's going to be" (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

Another part of the gay participants pointed out the existence of permanent relationships in Estonia: „*I have my husband in Estonia, we live together. Otherwise, I don't have close people here. Actually, this is the reason why I live here. I have acquaintances from my Estonian language courses. I made contacts in 4 months. But it's early to speak about closeness*" (Russian Federation, 35 y. o., man, LLPW, 5 months in Estonia, Sillamäe, HIV+).

In two interviews the respondents indicated that belonging to sexual minority group is associated with stigmatization, which can increase stress in the country of origin, and in the country where the migrant arrived: "*Specifically, here in Estonia the gay community is still very repressed in some ways, internally. I think the more things you have between you and the medication, the easier people give up"* (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

When I was little I always dressed like a girl. But around the age of 5–6 before school, I started to feel like a guy. But when I went to school at the age of 7, I always cried to my parents and made a condition that I would go to school if only they would buy me a woman's dress, not like all boys dress. They didn't buy it for me, and I didn't go to school, I missed a lot. And when I went, after returning home I dressed in a woman's dress — my sisters dressed me. This desire of mine was killed by our tradition, our culture. I lived in a village close to the Afghan border. Uncivilized places. It is very difficult to live with such desires in Tajikistan. That is, I had such a desire before, but it has already disappeared, since 22–23 years have passed (Tajikistan, 29 y. o., man, AR, 34 months in Estonia, Tallinn, HIV+).

From the point of view of specialists involved in working with migrants, LGBT people in Estonia face such problems as weak interaction between LGBT organizations and the public sector. All interviewed experts mentioned the Estonian HIV Positive Network and Estonian LGBT Network[2], but did not know about many other LGBT initiatives in Estonia.

At the same time, a number of problems may not be related to the sexual orientation or gender identity of migrants, for example, such as racist statements by officials and politicians, xenophobia towards non-Estonians, especially those with a different skin color: „*Agencies don't seem ready to deal with this issue formally. I had a single case at EKA where a gay student was harassed by a teacher. And that was a complete precedent. Many countries already regulate how this is handled and by whom. I have not had a feeling that the officials here have discriminated against anyone because of their orientation, I have not heard that. Knowing myself or even being in different collectives, I've heard how for people this is an alienating issue /…/ I have heard, very surprisingly, how a person stigmatizes when someone is from Africa, for example. The same is true for sexual orientation*" (Specialist, state agency).

3.10.Alcohol and other psychoactive substances

Most of the respondents either did not use it at all, or irregularly and in the context of special social situations: "*During my first year in Europe, I lived in a new city, with new people… I had a depression. And even then I did not start drinking. Usually people start drinking and smoking when they are stressed. My maximum was drinking energy drinks. So I relate to weed and alcohol negatively. Sometimes I "sin"* [drink], *after a long day or when I am stressed. To dive in a different world, the world of pleasures or something like that*" (Russian Federation, 28 y. o., man, LLPW, 4 months in Estonia, Tallinn).

The above quote confirms the link between alcohol and stress mentioned in the section on habits. Thus, the environment in which the migrant finds himself can contribute to an increase in alcohol consumption, and in some cases, the habit of alcoholic beverages may be born before moving to

[2] In Estonia, there is not such NGO like Estonian LGBT Network, we suppose that this respondent meant Eesti LGBT Ühing or Estonian HIV Positive Network

Estonia: „*I like alcohol and I think in the cold weather I feel that I can drink more than I usually do. In Brazil, for example, I drink less than here. I think this is like a combination of a very different country, super cold to my parameter of cold and the pandemic. It makes me feel that I drink more than usually. I'm not drinking like every day, but when I drink I drink a bit more /…/ I can use the last time as an example* [to describe what and how much they drink]*. On a date we had half of a bottle of port wine and a bottle of an Estonian hot drink gloggie. Generally, I used to have vodka or cocktails with vodka and wine*" (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

As for other psychoactive substances, respondents generally said that they would not even want to try. The exception is „socially acceptable" habits (coffee, tobacco or ecstasy). In some cases, substance use is possible in the context of sexual activity: "*I never used any drugs, it was never interesting for me. I can have a drink, but I never smoke. Neither did I take other drugs. I had a conservative family, everything was prohibited. And I stuck with this, I think it's useful. I considered trying poppers. I think it doesn't lead to an addiction. But I think it's better to work with yourself, so that you can relax during sex. I believe in anonymity and if I took drugs, I would say it. I am quite an open person and I wouldn't hide anything" (*Russian Federation, 28 y. o., man, LLPW, 30 months in Estonia, Narva).

As the reasons for avoiding drugs, the respondents named mainly the fear of consequences (for example, the emergence of addiction), which in some cases is associated with negative previous experience*: „I think it's something in you…* [why they fear using alcohol or drugs] *If you want to try you are a little bit scared of it… Like, first time I tried alcohol in Estonia, in Egypt I never tried it, I was scared what will happened to me when I try*" (Africa, 33 y. o., woman, AR, 24 months in Estonia, Tallinn).

Thus, the interviewed migrants generally did not mention cases of serious alcohol and drug addiction, although they recognized the role of alcohol and socially acceptable psychoactive substances as a way of recreation and stress relief.

The interviewed experts argued that although individual complex cases of alcohol or drug addiction exist among migrants, their small number does not allow to assert that this problem is serious. At the same time, the possibilities to provide assistance are very limited and come down mainly to redirecting to other programs.

With regard to possible changes in the existing assistance system, it was noted that the current system of interaction with asylum seekers and refugees could be less stressful, and the assistance itself (especially in the case of addictions) should be more durable, including a clients' transfer system from one program to another: „*What I'd change, of course… Positive way of supporting work better, that's what I believe. So, if you support a migrant in a holistic way then you already support them in not doing drugs or using alcohol too much. Because there has to be, at least how I see it, when people start to abuse alcohol or narcotics there is like a deeper problem there. They are unhappy and they try to find a way out. So, we have to give another way out from there. They actually lack the support they need /…/ When we speak about refugees then I think the support person system is very good but should be longer, for a longer period of time /…/ So, like for two-year one organization is doing a project and then the next two year it is a different organization. And as the organizations are competing with each other they don't give the information and actually they are not even allowed to give the information about the refugees to another organization. So, it is really difficult to work like that, but this is how it is now in Estonia*" (Specialist, NGO).

3.11.Prevention of unwanted pregnancy and condom use

A number of respondents indicated that a condom for them is a means of contraception, and not prevention of HIV and STIs, accordingly, if a woman intends to become pregnant, then she refuses a condom. A case of using the calendar method of contraception and the absence, in connection with this, of a constant need for a condom, was also described: "*If it* [sex] *takes place during the*

days in the middle of the [menstrual] *cycle* [they would use a condom]. *Any sensible woman knows her cycle*" (Ukraine, 46 y. o., woman, LLPW, 6 months in Estonia, Tallinn).

The surveyed women, in addition to the calendar method, also used intrauterine devices for the prevention of pregnancy, interrupted sexual intercourse, and hormonal pills. It is important to note that according to one respondent, access to hormonal contraceptives in Estonia was difficult — there must be a prescription from a doctor, and the opportunity to visit a doctor appears only if you have a legal status and medical insurance: „*I used birth control pills, it was in Kazakhstan. I know that it is very difficult to buy such pills in Estonia and you need to get permission from a doctor. I don't know the medical details, but I don't think such pills should necessarily be sold with prescription. I know that I need to get tested and get results to find out which pills can be taken. It seems to me that in this situation there should be some indulgences so that people would not buy the first pills they come across*" (Kazakhstan, 33 y. o., woman, LLPW, 24 months in Estonia, Tallinn).

Other reasons for occasional non-use condom were: sex is so rare that the respondent is afraid of losing this opportunity due to the need to put on a condom, an illusion of trust in casual contacts, with oral sex, because of youth and absence of risk awareness, because of emotions or alcohol, and when a partner takes PrEP.

We can also note the case when the respondent began to use after receiving the HIV diagnosis, but this practice did not become systematic: "*… I could have sex without a condom* [before HIV diagnosis]. *Some even suspected that I wanted to infect them, and I said: I don't have it!*" (Tajikistan, 29 y. o., man, AR, 34 months in Estonia, Tallinn, HIV+).

Almost everyone noted that condoms are quite available in a store or pharmacy, at the same time, prices for immigrants from EECA countries seem to be lower than, for example, in Ukraine, since with the same cost in euros, salaries in Estonia are higher. In some cases, respondents have the opportunity to receive free condoms, e. g. at the Narva Linda Clinic or in the Sex-Max. Only in three cases respondents complained about high prices: „*Sold in the store, but expensive!* [Are condoms easy to get in Estonia?] *…I do not know* [where to get free condoms]. *In the sauna I saw condoms and took a couple of them so as not to waste money on condoms in the store. Another friend gave the packaging somehow, I don't know where he got them*" (Tajikistan, 29 y. o., man, AR, 34 months in Estonia, Tallinn, HIV+).

In two cases, gay respondents indicated that they discontinued to use a condom while using PrEP: „*Usually I use condoms, even though I cannot contaminate my partner. I always use, there might be a few exceptions, for example, when a partner says he is on PrEP, but I'd say that 90% of time I use condoms*" (Norway, 27 y. o., man, MHPLW, 8 months in Estonia, Tallinn, HIV+).

The interviewed MSM in most cases constantly used condoms (sometimes in combination with PrEP) — out of nine only three mentioned situations when they have had unprotected sex, for example, condom was not used with a regular partner or under the influence of alcohol.

3.12.HIV related health care services

HIV testing

Eighteen out of 22 migrant respondents had been tested for HIV, with the majority having done the test before arriving in Estonia, and only three indicated that they had been tested in Estonia. The tests had been done at the X-baar (in Tallinn) and Linda clinic (in Narva). Two of those who were tested before coming to Estonia said that they did not know where in Estonia they could get an HIV test. Most of the interviewed migrants had been tested irregularly, only three mentioned regular testing. Two regular testers were MSM and one was a woman who had worked in Emirates where they had been tested every two months.

Four people had never tested: „*Actually, I've never really paid attention to HIV. I don't know about it a lot. Also, because it didn't happen to anything around me. That's the main reason. We don't have a lot of it in my home country*" (Kazakhstan, 24 y. o., man, ILPW, 10 months in Estonia, Tallinn).

The motivation of the respondents to take the test was associated with past unprotected sex or with the intention to refuse protected sex with a regular partner: „*Usually I got tested after unprotected sex. The first time I tested when I just came to Estonia and the second time was after unprotected sex. I tested two times in my life. I know that they give medication to those who have some disease and they have psychological counseling. I think they do a good job* [Linda Clinic]*…. I think it's very easy* [to get tested for HIV in Estonia]. *I'd like it to be popular because a lot of people cannot know about this free opportunity. I learned about Linda clinic from my friend and then I went there. I didn't see anything like this on Facebook or elsewhere*" (Russian Federation, 36 y. o., man, LLPW, 30 months in Estonia, Narva, HIV+). In the cited quotation, it is also noteworthy that the information about the opportunity to take the test reached the respondent not through „official" channels (although there were attempts to find it), but through friends.

In several cases, the test was done in the context of regular check-ups. Almost all respondents who were tested for HIV did it voluntarily, only two mentioned mandatory tests (not in Estonia): „*I had to do it in Dubai, but not forced — you need to do it if you want to live in Dubai. Even here my employer kind of is forcing me to take general checkup to start with them. So that is the same, I don't see any difference. If you are not healthy enough for work they will fire you. In Dubai they are not going to fire you, they are trying to control the HIV spread by not welcoming people who have it. That's really sad, but it is what it is*" (Africa, 30 y. o., woman, MHPLW, 24 months in Estonia, Tallinn).

Testing for HIV co-infections

Most of the interviewed migrants (13 out of 22) knew about **tuberculosis** and had regularly underwent fluoroscopic examination of the lungs in their country of origin, but during their stay in Estonia they had not had such an examination. Only in two cases did the respondents mention that they had been prescribed an X-ray of the lungs in Estonia when they asked for medical help. At the same time, the respondents noted that in Estonia no one demanded this from them, while in Ukraine, Russia, Kazakhstan, the United Arab Emirates, tuberculosis examination is an obligatory part of regular medical checkup. About a third of the respondents have never been tested for tuberculosis, in two cases the reason for the non-examination was the vaccination.

As for **STIs**, most of the migrants interviewed denied having any suspicions of STIs during their stay in Estonia, in some cases they indicated that either they have only one partner, or do not have sexual contacts at all: „*No, I haven't had such suspicions [STIs] because I didn't have any intercourse before I got married*" (Algeria, 30 y. o., woman, MHPLW, 24 months in Estonia, Tallinn). In three cases, the respondents indicated that there were certain suspicions, but they were either not confirmed during a medical examination, or were associated with other diseases: „*I had a suspicion. I went to the Linda clinic, saw a doctor and got a referral to see a proctologist. Then I attended the proctologist. They tested me and nothing was found. At some point I was concerned about it*" (Russian Federation, 28 y. o., man, LLPW, 30 months in Estonia, Narva).

According to the migrants interviewed, they did not have **hepatitis B or C**. At the same time, many also referred to the fact that they were tested, both before coming to Estonia and here, as well as being vaccinated: "*No* [I have not been tested for hepatitis B or C]*, because I have my hepatitis vaccination for A and B. Just before I left Germany, actually. They tested my blood for antibodies or something like that before. So, I didn't do it here*" (Germany, 37 y. o., man, MHPLW, 30 months in Estonia, Tallinn). Some migrants only assume that they were tested for hepatitis in connection with a medical examination or blood donation, and a number of respondents did not really know. Several people were also vaccinated against one of the viral hepatitis.

Antiretroviral therapy for people living with HIV

Those who were not HIV-infected, as a rule, did not know anything about the possibility of receiving ARV therapy. Only one of the HIV-negative people knew that such therapy was available, but did not know whether it was paid or free. All four HIV-positive participants received free ARV therapy.

„*My friend said that he has a finger HIV test. I suspected I had HIV because my body was weak and I had a very bad cough. I did this test at home and it showed two stripes. Then I realized that I had HIV. But before doing it, I went to see a doctor for an examination, they did a tomography and other tests. A day later, they called and said that the tests were positive and that I needed to come urgently. At first I did not believe it, and after leaving the doctor I called a friend and asked him to bring me another test. This test also confirmed the diagnosis. Then I went to the doctor to get everything I needed. Yes, therapy* [ARV therapy?] *Yes* [get it for free] (Tajikistan, 29 y. o., male, AR, 34 months in Estonia, Tallinn, HIV+).

Pre-Exposrue Prophylaxis and Post-Exposure Prophylaxis

Most of the migrants surveyed had not heard anything about PrEP and PEP. However, among those who knew about this method of prevention, majority did not use it — some did not know if it exists in Estonia, others would not like to „experiment with themselves" and were afraid of side effects: „*I thought about, when it also was available in Germany from the health insurance, I thought about this PrEP situation and also heard that it has side effects that some people have problems with taking it regularly. And I decided against it and thought that I'd rather have a more conscious decision of having sex than being super random about sex choices and like popping a pill*" (Germany, 37 y. o., man, MHPLW, 30 months in Estonia, Tallinn).

Finally, there were those who thought that using PrEP in Estonia was too complicated: „ *I never tried it* [PrEP] … *Yes, yes* [I would like to try]. *Not in Estonia* [I have not tried to get it]. *My friend went to a doctor and he told me that you need to pay for it and maybe you need a prescription. And then I thought "Oh my god, first a doctor, then a prescription, then I have to buy it". Because in Brazil it is so easy, you go to the center then they test you then you say "I want it" and then they give it to you. Of course, you go to a psychologist before and have a conversation, talk about everything, the medication, like the full protocol. But I think it's easier to get. I don't know, maybe it's because I'm a foreigner. But yes, look less good I'd say*" (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

The interviewed specialists found it difficult to say anything about PrEP, since they discuss HIV-related issues rarely with their clients from among refugees or asylum seekers. They thought that considering the generally small number of asylum seekers, it makes no sense to build a separate HIV service system for them: „*Since 1997 until 2020 little bit more than 500 people have been granted international protection in Estonia, so it's very few. It's such a small amount so usually it doesn't even make sense to design specific services for them, they have to fit in. Which means when there is refugee with a very particular problem then officials are rather open to do some tailor-made solutions for them*" (Specialist, NGO).

3.13.Sources of information about HIV

First of all, respondents trust information about HIV, the source of which is medical structures (8 out of 22), state or UN-affiliated intergovernmental structures (seven out of 22), as well as those public organizations that professionally deal with HIV issues (6 of 22). From the media, trusted sources mentioned were ERR (local Estonian television), NTV +, Meduza, Ekho Moskvy (Russian TV channels, used by respondents from Russian Federation).

3.14.Needs and the gaps in existing social and health care system as well as prevention services related to HIV and co-infections for migrants

Medical needs and existing barriers

Of the 22 migrants interviewed, six did not have a family doctor, which was partly due to the lack of official status (no residence permit or health insurance), partly due to the lack of health problems.

Those who had a family doctor, in general, rarely used doctor's services, and in some cases (this applies to people with high income) preferred to use the services of private clinics: „*I have a huge luxury of having a private insurance that I have from Germany and Haigekassa* [Estonian national health insurance] *as well. So, I have both. And I have a family doctor which funnily enough I have only acquired recently and I have never seen her. But I now have a doctor. But before because I could claim it off my German health insurance I went for example to see these private clinics and paid. And I got it reimbursed from my German health insurance*" (Germany, 37 y. o., man, MHPLW, 30 months in Estonia, Tallinn).

Those who did use the help of a family doctor complained about a rather formal approach to the patient: „*It was okay* [the appointment with a family doctor in English]. *I feel like the doctors here, it's different cultures maybe, in my county I feel like doctors care more. Here I feel like they go by the book and they kind of don't care at all. They barely checked the symptoms. If I went to a doctor in my country they'd do an X-ray and look what us actually wrong and maybe, I don't know, be more strict about fixing it. But here they just give you advice and let you be*" (Africa, 30 y. o., woman, MHPLW, 24 months in Estonia, Tallinn). Complaints about the formal attitude towards patients, about the doctor's unwillingness to delve into the problem, were also voiced by some other participants.

Some of the respondents, described their negative experience of interacting with the healthcare system when they were in a need of medical services: *"I trust doctors here — not in Narva, but in other parts of Estonia. …At first I had appointments with doctors in Narva. I know the problem with my ear well and in addition I have education in biology, so I understand more or less what is happening. When I was given prescriptions of some ethnoscience or something like that, I knew something is not right. I had a prescription like "to put on a hat in summer, so that the ear would be warm". But if the ear is in the warm for a long time, it starts to become moist. I had a lot of such recommendations and I realised I won't go to these doctors. When I went to see doctors in Tartu, I liked it. They actually cured it. They looked at it for a long time, made an operation"* (Russian Federation, 28 y. o., man, LLPW, 30 months in Estonia, Narva).

If respondents feel unwell, they (regardless of whether they have a family doctor or not) try not to visit a doctor and only serious problems or special conditions (such as pregnancy) force them to seek medical help: „*I google the symptoms and what they mean* [when sick]. *Usually it shows some serious disease and then I start thinking of what I should do. I don't know… It's a difficult question. …Recently, when I found out that I was pregnant, I was happy. After some time problems started, I had excretions. First of all I called my husband and he left his workplace immediately. Then I googled what I should do and it was written that I should go to the hospital immediately. My husband came, dressed me and took me to the hospital at night. We were accepted there, I told about it already* [she was tested and convinced that everything was fine]. *When I get a cold, I open the box with medication that my mother gave me and take some medication. My mother has an algorithm for curing any disease. Although medication is the last resort for me, at first I try to understand what's going on with me*" (Ukraine, 30 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

The respondents mentioned several times that it is difficult to get to the doctor because of the need to wait for several months: „*It may be to the dentist, but practice shows that this case is bad in Estonia. It is difficult to make an appointment with a doctor, because everyone is busy for a long time. And to the dentist, and to another specialist too. I've heard a lot from colleagues who have come across this. They said that their back hurts and went to the doctor, and the doctor says that there is only time after 2 months. But my back hurts now, not later*" (Ukraine, 30 y. o., man, LLPW, 24 months in Estonia, Tallinn).

From the point of view of specialists who work with migrants, one of the most noticeable is the language barrier both in the service delivery system and in a broader social context: if it is not difficult for a Russian-speaking speaker to find a doctor or at least an unskilled job in general (although this depends on region), then already for an English-speaking and even more so for a person with a different language, this task is already much more difficult: „*For the women, when*

the women come here in Estonia, they still can take care of the children as they did. I'm speaking, of course, about refugees' families. And they still have their place, they can still keep their role. But for men it's really difficult, because in the first 6 month you are not able to work. And when you are able to work, it's hard to find the same work as you had, for example, in Syria. Because of the language barrier or people just don't trust giving you the work. Or it can be also that the work needs to be done in the local language. It's stressful for sure" (Specialist, NGO).

Professionals working with migrants may find that neither the client nor the community is aware of the Estonian health care system: „*There has been a case where I had a language consultation with a person from Bangladesh or India, and then it turned out that his wife had just given birth and in the hospital it turned out that she had cancer and she was forced to stay in the hospital immediately. And this man knew nothing about the social system, let alone the baby — what support is available. I don't know the feedback, but I gave him all the possible information, emphasizing the support of the municipality, if necessary, so that he would not be left alone with this newborn without any preparation. And then it was actually a big surprise for me that he has lived here in Estonia for some time — I think he worked as a taxi driver for Bolt, — the woman had also done some work, but he knew nothing about this system. And there are a lot of these people. They probably don't reach me often and they exchange information through the word of mouth, in communities*" (Specialist, state agency).

Cultural differences and the ability of healthcare providers to be individualized about the situation of each patient are the next issues requiring attention: „*We need to help the health workers to be more open. Because, when your first encounter with a family doctor then you start to trust this field. But when it's negative: the doctor doesn't speak your language or is angry or doesn't believe you then it's difficult for them to go back later on or even to go the other doctor when they didn't get help from the previous one. Because the family doctor usually helps with this kind of "easier" problems, buy when you have, for example, a post-traumatic stress, then you need to find a therapist or a psychiatrist*" (Specialist, state agency).

Experts also noted that at the beginning of their stay in Estonia, asylum seekers and refugees often face problems due to unusual and unbalanced food, the lack of opportunities in migration centers to choose more familiar food: „*When I was working in Harku Detention Centre. It was the first point where they live in Estonia. And in Harku they have to eat what is offered to them and it was Estonian food, of course, and it was very different for them and it was hard for their digesting system. They had many problems with their stomachs. And this they mentioned to me several times. Even though, of course, I sent them to the doctor, and they said we have spoken to the doctor about this, but the doctor cannot change the food here. But there were problems, especially the men — they were speaking about this more often. They had problems of bad mouth breath and they said it's because of the food and it makes them feel really bad and they are not used to this food. And it's only not about the taste, it's about that they are not used to the food*" (Specialist, NGO).

Lack of physical activity as a result of cultural differences is also a notable problem: „*the refugees tend to eat a lot of fried food and a lot of flour in their food. And they don't do so much exercise. So obesity is an issue. The women have this issue as well. In Estonia women are going to the gym, for example. They can go alone to the gym. But when you are speaking about a refugee family who is coming from the Middle East, for example, then they would like to go together with like a women group and there should be only women there, not women-men mix. And this makes it more difficult to find a place like this for physical activities or exercise*" (Specialist, NGO).

Medical examinations

The respondents usually carry out preventive medical examinations outside Estonia: „*I never did this in Estonia. In Ukraine I do them regularly. My mother insisted I go to the dentist, do the fluorography, go to the gynecologist. But this was back home. Here my husband and I don't do it, because it's expensive. We try to do it when we go home*" (Ukraine, 30 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

In Estonia, medical examinations are related to special circumstances, such as obtaining a driver's license or the requirement of an employer: „*I passed a medical examination when I arrived at work. They measured blood pressure, made a cardiogram. They said that you can fly into space. I'd like to donate blood, because in Ukraine I was a donor. But in connection with the work it does not work. I know that they go around the factory and take blood. But I never got to such a visit. And I don't have enough time to go myself*" (Ukraine, 30 y. o., man, LLPW, 24 months in Estonia, Tallinn).

With regard to medical examinations, the interviewed specialists found it difficult to give a definite answer, since this topic very rarely arises in the practice of communicating with migrants.

Vaccination

In the context of vaccination, influenza was the most frequently mentioned (at the time of data collection, vaccination against COVID-19 was not widely available). Some of the respondents did it on their own, some by referral: „*I got this flu shot — vaccination for flu. I was offered to get a vaccine and I received this vaccination in December or November. Also, I have all my vaccinations updated. I have this yellow book. I have everything except for COVID-19. … It was during work checkup*" (Norway, 27 y. o., man, MHPLW, 8 months in Estonia, Tallinn, HIV+). But most often (15 out of 22) respondents said that no one in Estonia had ever offered them to be vaccinated.

A number of respondents both noted the need to pay for vaccination and believed that these procedures were „unnecessary": „*Every year my employer insists I do a flu vaccination. But since I am Ukrainian, I can only do this at my own expense. Locals are compensated from the unemployment fund. Those who have a residence permit are also compensated. But I wouldn't want to do them even for free. I mean, even if I had a residence permit, I would not like to be vaccinated, that's for sure. I would only do it if I was forced to. But if there is an opportunity to refuse, I would rather refuse. … Never* [vaccinate in Estonia]*. Either for the flu nor for anything else. My illnesses go easy, I never had any complications. I don't see why I need it. My body is still young and strong, it does not need anything like that. It will fight by itself, only because of this. I believe that the fewer interventions in the body, the better*" (Ukraine, 33 y. o., man, LLPW, 33 months in Estonia, Tallinn).

Interviewed specialists considered vaccination to be less accessible to migrants due to their lack of a residence permit, widespread prejudices against vaccination, as well as difficulties in communicating with family doctors: „*Speaking to people I encountered that many people in general — not just migrants — don't always know whether they are vaccinated for a certain disease. /…/ Most of them don't have their documents, especially medical records. You don't have it with you when you are fleeing your country, you don't think about that*" (Specialist, NGO).

Payment for medical services

Although specialists working with refugees and asylum seekers believed their clients' awareness of the healthcare system in Estonia to be low, the interviewed worker migrants were generally well aware of the existing system: payment for a visit to a specialist (excluding a dentist) 5 euros in the presence of insurance and significantly higher prices in the absence of it: „*But to be in Tallinn longer than 3 months with a tourist visa, I got registered with my husband's company. So I am now registered with him and I work unofficially. It turned out this way that I got pregnant. Most likely I will go home soon. I can't give birth here, because I am not registered with Haigekassa* [state medical insurance in Estonia]*. So it* [giving birth in Estonia] *would be too expensive for us, so I will have to go home. I would like to give birth here, to stay working and living here. Compared to the fees in Ukraine, in Estonia it's much more expensive. But as it concerns our health and our child — it's not a pity for us to pay. In general, of course, it is a bit expensive. Every time I pay 45 euro for the appointment, 20 euro for the ultrasound, 10 euro for tests and so on. And it's like this every month*" (Ukraine, 30 y. o., woman, ILPW, 24 months in Estonia, Tallinn). However, for respondents from „wealthier" countries, these prices seemed quite attractive: „*Compared to where I was living before* [Belgium]*, I see a lot of positive things here. Dentist services are cheaper*

here, I think other services are cheaper too. I am glad" (Russian Federation, 28 y. o., man, LLPW, 4 months in Estonia, Tallinn).

Taking into account the generally low incomes of migrants and the lack of legal status in some cases, we can say that the need to pay can be a significant factor limiting the availability of medical services: „*I would like the tests to be available, because they are very expensive here. It is very expensive to pass a detailed analysis to see the composition of one's blood. I like the idea that there is a family doctor and it is easy enough to get a referral to a specialist. The only question is whether it is easy for migrants to get a family doctor... As far as I know, it is difficult for people who just moved to Estonia*" (Ukraine, 30 y. o., woman, MHPLW, 18 months in Estonia, Tallinn).

Concerns about confidentiality of medical services

Some respondents indicated that they were afraid to seek medical services, not only because they could not pay for them, but also because they were afraid of sanctions: „*I'd also like to be examined by a gynecologist. But in my situation, I try not to contact any organizations, because in any case I will be forced to give my data. I'm afraid the police will be interested in what reasons I'm here and what I'm doing*" (Kazakhstan, 33 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

Refusal to provide medical services

Although it was mentioned by a few respondents, the refusal was often related either to a very long wait or to the situation of the COVID epidemic, when planned treatment was cancelled in Estonia: „*Actually, there are problems with getting an appointment with a specialist in Estonia. When I wanted to see an ophthalmologist to check my vision, I waited 3 months. That's a lot! And I made an appointment with the gynecologist with a 3 months notice. And when the time came, the appointment was postponed by 1 month. Then I was offered a consultation by phone, I refused and had to postpone it for another month. I had to wait a long time, it's frustrating*" (Ukraine, 30 y. o., woman, MHPLW, 18 months in Estonia, Tallinn).

At the same time, some respondents associated such a refusal with the lack of insurance: „*During the time I was looking for a free clinic I tried to reach out to a family doctor and I remember she told me that I am not a taxpayer so they could not provide me with that service. It happened*" (Kazakhstan, 24 y. o., man, ILPW, 10 months in Estonia, Tallinn).

Indirect refusals were also due to the respondent's language: „*Someday I was trying to help some friend who didn't speak Estonian or good English and the doctor was very rude, she was shouting and got very emotional. She didn't say "Go away", but she was rude and pushing it that way. That was really weird*" (Africa, 30 y. o., woman, MHPLW, 24 months in Estonia, Tallinn).

Residency

Significant part of the problems were related to the legal status. However, even if a person was in Estonia formally on a legal basis (for example, on a short-stay visa), problems could arise: „*My salary is small and does not allow me to apply for a residence permit — you now need a salary of 1407 euro for this — I only have a visa of category D and the visa-free three months. So every year I leave for Ukraine for 3 months. When I get sick I stay at home and cure myself. I know which pills work for me. In Estonia, I cannot buy antibiotics without a doctor's prescription, so I have local friends who get medical prescriptions for themselves and give me what is left and not needed*" (Ukraine, 33 y. o., man, LLPW, 33 months in Estonia, Tallinn).

The lack of a residence permit affects not only the availability of medical services, but also ability to register for free Estonian language courses: „*I wanted to go to courses, like "Welcoming program" from police to migrants. Where there is basic Estonian language education and information about some daily situations. I couldn't get it, because I didn't have a residence permit and I came with a visa. Then I didn't yet know that many services are not available to those who live here with a visa and don't have an ID card. For example, you can't register and can't get free transport. You can't get discounts without this ID card. And you can't study with this program*" (Russian Federation, 27 y. o., man, MHPLW, 25 months in Estonia, Tallinn).

The interviewed experts confirm that residence permit is a key to pretty much all services and its absence means the inability to legally obtain many services (including medical ones) in the public or private sector: „*All benefits apply to people with a residence permit. But I know, my colleagues in Ida-Virumaa and this Tallinn Olga get a lot of clients who have come here to work from Ukraine, for example, and do not have a residence permit, they have a visa. This work visa is problematic. I haven't been exposed to it that much and because of that I don't know the details. I know that you do not have these rights unless the employer pays social security tax and registers the employees*" (Specialist, state agency).

Language barrier

According to both the interviewed migrants and specialists, one of the key obstacles is related to the language — in the one hand, it is difficult to demand knowledge of the Estonian language from people who have recently arrived in the country, on the other hand, not all services, even in Tallinn, can provide services in English and Russian:

The most important thing is to have people who work in these spheres to speak the language. They need to speak English. This is the most important thing and also the biggest problem here. If you go to a doctor — and they don't speak English. I spend some time looking for an English-speaking family doctor, actually. So, this is the first thing that comes to my mind when you ask this question. Other than that, there's nothing that I feel needs to be tailored specifically for migrants. From my experience" (Africa, 30 y. o., man, MHPLW, 34 months in Estonia, Tallinn).

At the moment what I see is the language barrier. It's one of the problems because it's expensive to have a translator to come with you. Of course, some projects have written the translator inside it, but It's just not a big amount as well. And when you don't have the support person anymore then you are on your own. So, basically what can be done is educating health personnel as well to be sure that there people speak English, for example" (Specialist, NGO).

The interviewed migrants cited as an example the website politsei.ee where in the section on visas and residence permits information in English and Russian does not coincide in essential details with information in Estonian: „*Even on the police web-page there in no synchronized information in different languages: in Estonian this web-page was in one state, in Russian — not so well updated, and in English in some other state"* (Russian Federation, 27 y. o., man, MHPLW, 25 months in Estonia, Tallinn).

About the social ones — I'm still not very aware of where they are and what they are doing. For example, when I learned about this situation with Töötukassa [Estonian Unemployment Insurance Fund] *and I searched for information, the explanation was inconclusive. So, I feel that things changed recently in Estonia regarding social institutions, especially for foreigners. And people are not very aware of how it is working not, not even the workers, I think"* (South America, 26 y. o., man, MHPLW, 4 months in Estonia, Tallinn).

Education and experience of specialists

HIV issues and, in a broader sense, the organization of health care are not part of the professional education of specialists counseling migrants, asylum seekers and refugees. If such questions arise, then specialists rely only on the knowledge gained at school: „*When I was back at school that was part of the school program* [HIV, co infections, illegal drugs use]… [*Since then*] *I read different articles and visited different websites related to sex-health and so on, but systematically I think the last time was back in school and it was quite a long time ago*" (Specialist, NGO).

Professionals, as a rule, undergo psychological training and subsequently receive supervision, they are taught to value linguistic cultural diversity: „*We have had coaching sessions and supervisions last spring. It was three times. It was about how to deal with human behavior. In our organization, when this counseling center was set up, there were several stages. And there have certainly been more of these trainings for counselors. They are done when there is a need. We have now created a map of services called LINDA. This is just about to be introduced to*

municipalities, essentially it is a search program: you write down a person's problem and then it gives you the links where you should turn" (Specialist, state agency).

In addition to specialists, organizations that provide assistance to migrants, asylum seekers and refugees have volunteers who are also trained: „*In our system support people get regular supervision. It's usually group supervision, but if necessary it is possible to do individual one. It actually goes to all our employees who work in this support service part in Refugee Council. We do different trainings when different issues emerge. For example, we just yesterday finished mental health first-aid course for the support people because we saw that mental health issues grow bigger and bigger. Because of the CORONA, but also because in 2015–2016 lots of refugees came to Estonia for the resettlement programs and now we see that those people having lives in Estonia for a while, having been settling in, having the jobs now, start to have bigger issues. Peak of traumas emerging of what they've been living through, of what they have put on hold until they feel secure. So we tried to support each other as much as possible*" (Specialist, NGO).

As for the quality of this training, the interviewed specialists were generally satisfied with it, although they pointed out certain gaps in the training program: „*I have been satisfied, but no doubt it has not been thematic. It was more about dealing with difficult customer behavior. There we learned how to solve a crisis situation and how to deal with such a person in a crisis situation. There can always be more training on different topics. As for healthcare issues, we just had a meeting with Andrei Petukhov. In fact, there are many complex issues for which we have not been trained. These are also so rare cases that it does not always make sense to provide general training*" (Specialist, state agency).

What migrants can offer to organizations working with HIV Issues

The interviewed migrants can serve as a significant human resource for HIV service or other organizations, and their involvement as volunteers will strengthen their sense of importance, self-confidence and will contribute to a more successful integration of migrants into Estonian society. More than half (13 out of 22) offered options for their participation in the activities of the HIV service, including: assistance in maintaining the organization's page on social networks, assistance to newly arrived migrants in adaptation, assistance in working with youth, creating a safe space, volunteering for those who do not speak Estonian, preparing information about HIV for countries from which migrants come to Estonia, etc.:

"I know some things that help my friends. Therefore, when it comes to helping Estonians to maintain their health, I can suggest herbs, fruits and vegetables, combinations. We eat it all together, but with the right approach, each product will show itself in a different way. I can give advice to my friends or relatives when there is a request, but I do not think that I can advise a wider community" (Ukraine, 46 y. o., woman, LLPW, 6 months in Estonia, Tallinn).

"Maybe, if I was in touch with someone, I could give advice based on my experience. But I don't think it would help to change anything, as these [healthcare] *systems have been in place for years and I doubt anything would change"* (Ukraine, 30 y. o., woman, ILPW, 24 months in Estonia, Tallinn).

"Of course, I could be doing something since I am not working; only studying. I have time; I could like just talk with people, other foreigners perhaps. They have similar background with so I could do this easily. It would be cool indeed. Also, spreading some information" (South America, 32 y. o., man, LLPW, 6 months in Estonia, Tallinn).

4. Discussion and conclusions

This report describes the results of 22 in-depth interviews with migrants and three interviews with specialist working with migrants and refugees in Estonia. It is the first study in Estonia to take a deeper look into the area of HIV and co-infections among this population group. The interviews were conducted in the first quarter of 2021. While reading this report, it must be kept in mind that the results cannot be extrapolated to all migrants in Estonia — the study was convenience sample study among small number of people.

The aim was to interview different subtypes of migrants, both legal and illegal. A total of 22 migrants were interview, with the average age of 31 years. It was also aimed to interview vulnerable populations — people living with HIV and MSM (as the latter are at greater risk of HIV infection). Three participants were HIV infected and nine identified as MSM. Two thirds of the participants were men and more than half originated either from Ukraine or Russia. All of them had migrated to Estonia less than three years ago. This was purposeful; in order to identify the issues people face during the migration and while settling in Estonia. Unfortunately, we did not manage to recruit anybody who would have identified as a victim of human trafficking or a person involved in prostitution. This may be partly due to the very sensitive and illegal nature of this topic. Also, none of the participants had injected drugs (another high-risk factor for HIV infection).

The number of interviewed specialists working with migrants was three, all of them had work experience of more than seven years.

The results of this study reveal that migrants do not engage in **high risk behaviors** very often. They did not report excessive alcohol or illegal drug use or engagement in casual sex and thus rather resembled Estonian general population.

Other migrants, non-governmental diaspora organizations and family members both in Estonia and abroad were mentioned to be the most important **sources of informal support**. Participants generally trusted **information about HIV** from the health care organizations, state or UN-affiliated intergovernmental structures, as well as those public organizations that professionally deal with HIV issues. From the media, trusted sources mentioned were ERR (local Estonian television) and a few Russian TV channels (by respondents originating from Russian Federation).

Regarding access to health services, several **misconceptions and lack of information** emerged about what is available and who could access the services. Misconceptions and lack of information were observed about other topics, too, including prevention of unwanted pregnancy, access to maternal health services, availability of prevention measures (e. g. condoms). The respondents of this study, as a rule, accessed health care when necessary, that is, if they are worried about something or if a doctor referred them for testing. Regular preventive check-ups were not common. People also missed psychological counselling.

Stigma was also echoed in many interviews with people feeling that they were not treated well or refused services because of their migrant status, language, culture differences or color of their skin. This study did not set itself a separate task to find out what special problems MSM have, but in two interviews the respondents indicated that belonging to sexual minority group is associated with stigmatization, which can increase stress in the country of origin and in the country where the migrant arrived.

The **main hindrance for accessing health care was related to the status** — illegal immigrants and people with no residency permit had no access. Illegal immigrants were also afraid of the consequences and loss of confidentiality should they reveal their status to medical professionals.

Participants also reported similar problems with health care services as Estonian general population — long waiting lists, high prices (especially dental care), not attentive medical personnel (15). **Language issues** were mention several times — it has been difficult to find a doctor who speaks English or Russian even in Tallinn.

Most of the participants were aware of HIV and tuberculosis and had been tested during their lifetime. **Testing** during their stay in Estonia was limited, especially tuberculosis screening. Only MSM participants realized the need for regular HIV testing.

All three HIV-positive participants received free **ARV therapy** and had no complaints about the system. Most MSM migrants (n = 9) had not heard about **pre-exposure prophylaxis** and only a few had used it in Estonia. The system for providing pre-exposure prophylaxis was considered complicated.

In the context of **vaccination**, influenza was the most frequently mentioned (at the time of data collection, vaccination against COVID-19 was not widely available). Two thirds of the respondents said that no one in Estonia had ever offered them to be vaccinated.

More than half of the respondents offered options for their participation in the activities of the HIV service, including: assistance in maintaining the organization's page on social networks, assistance to newly arrived migrants in adaptation, assistance in working with youth, creating a safe space, volunteering for those who do not speak Estonian, preparing information about HIV for countries from which migrants come to Estonia, etc.

In conclusion, people newly arriving to Estonia highlight the gaps in Estonian health system also locals complain about, as well as experience unique issues related to their status. In the near future, education and information for the specialists working with migrants and asylum seekers in local municipalities, governmental and non-governmental organizations, health care and other types of organizations should be provided. All institutions should be provided with up-to-date information about availability of services. Information and educational programs for the migrants should be culturally appropriate and tailored to their needs.

Reduction of stigma is critical, especially among social and health care specialists. There is a need to reduce cultural barriers, prejudices among providers of social and medical services against people of a different culture and language.

Enforcing human rights is critical. In theory legal immigrants in Estonia are entitled to the same level of health care as Estonian citizens. The system and services must be adapted and implemented in such a way that immigrants would also have real access to health care. Increasing the availability of psychological services for refugees and asylum seekers is needed, for example in the context of post-traumatic stress disorder issues.

From public health point of view, it is necessary to start planning basic health services for illegal undocumented immigrants (with no documents and no health insurance), including making sure they receive care for communicable diseases as early as possible. This is especially important in the light of COVID-pandemic. As WHO phrases it — there is no public health without refugee and migrant health (5).

According to ECDC offering active TB screening using X-ray (CXR) soon after arrival for migrant populations from high-TB-incidence countries should be established in Estonia. Those with an abnormal CXR should be referred for assessment of active TB and have a sputum culture for Mycobacterium tuberculosis. Many low TB-incidence countries practice pre-entry screening for visa applicants for work or studies for intended duration of stay of ≥ 6 months and for extended visitor (parents, grandparents) visas for those coming from a high TB-risk country (TB incidence of 40/100 000 cases of TB) so Estonia should consider this put into practice (16).

Migrants themselves can serve as a significant human resource for HIV service organizations, and their involvement as volunteers would strengthen their sense of importance, self-confidence and will contribute to a more successful prevention of communicable diseases as well as integration of migrants into Estonian society.

5. References

1. World Migration Report 2018 [Internet]. 2018. Available from: https://www.iom.int/wmr/world-migration-report-2018
2. AP with Euronews. Lithuania takes a tougher line on the migrant influx from Belarus [Internet]. Available from: https://www.euronews.com/2021/08/03/eu-pledges-aid-to-lithuania-as-migrants-pour-in-from-belarus
3. Zardiashvili T, Kasianczuk M. Desk review on LGBT migrants and refugees in CEECA in the context of HIV. Tallinn; 2019.
4. Europe's migration crisis [Internet]. Available from: https://www.europarl.europa.eu/news/en/headlines/society/20170629STO78631/europe-s-migration-crisis
5. Report on the health of refugees and migrants in the WHO European Region. 2018.
6. Noori T, Hargreaves S, Greenaway C, van der Werf M, Driedger M, Morton RL, et al. Strengthening screening for infectious diseases and vaccination among migrants in Europe: What is needed to close the implementation gaps? Travel Med Infect Dis [Internet]. 2021 Jan;39:101715. Available from: https://linkinghub.elsevier.com/retrieve/pii/S1477893920301836
7. HIV and migrants. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2018 progress report [Internet]. Stockholm; 2019. Available from: https://www.ecdc.europa.eu/sites/default/files/documents/HIV-migrants-Monitoring implementation of the Dublin Declaration on partnership to fight HIV-AIDS in Europe and Central Asia 2018 progress report.pdf
8. HIV/AIDS surveillance in Europe 2019 – 2018 data. Stockholm; 2019.
9. Weine SM, Kashuba AB. Labor Migration and HIV Risk: A Systematic Review of the Literature. AIDS Behav [Internet]. 2012 Aug 6;16(6):1605–21. Available from: http://link.springer.com/10.1007/s10461-012-0183-4
10. Fedorovych I, Yoursky Y. Legislative Analysis related to LGBTQ rights and HIV in 11 CEECA countries [Internet]. Tallinn; 2018. Available from: https://ecom.ngo/library/legal-environment-assessment-2018-en
11. Statistics Estonia. Statistics by theme > Population > Migration [Internet]. Available from: https://www.stat.ee/en/find-statistics/statistics-theme/population/migration
12. Sisseränne aitas suurendada rahvaarvu [Internet]. 2020 [cited 2020 Dec 29]. Available from: https://www.stat.ee/et/uudised/pressiteade-2020-059
13. Estonian national broadcasting company. Police: Use of unregistered labor in Estonia has grown severalfold [Internet]. 2017. Available from: https://news.err.ee/651309/police-use-of-unregistered-labor-in-estonia-has-grown-severalfold
14. HIV in Estonia : Situation, prevention, treatment, and care : Narrative report for GARPR 2015. Tallinn; 2015.
15. Eesti elanike hinnangud tervisele ja arstiabile. Aruanne / Kantar Emor, Eesti Haigekassa [Internet]. 2020. Available from: https://www.haigekassa.ee/sites/default/files/2021-07/Arstiabi uuringu aruanne 2020_Q4_KantarEmor.pdf
16. Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA [Internet]. Stockholm: ECDC; 2018. Available from: https://www.ecdc.europa.eu/en/publications-data/public-health-guidance-screening-and-vaccination-infectious-diseases-newly