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IMMIGRANTS IN ESTONIA: WHETHER THE DIFFERENT CULTURAL BACKGROUND IS A BASIS OF EXISTING KEY BARRIERS TO MEDICAL AND SOCIAL SERVICES

The article is devoted to the migrants' barriers to accessing and adhering to care, including stigma, and fear of discrimination at health services. The article specifically states that existed barriers should be considered in the provision of services. The authors' purpose was to show the existing problems in the unequal access of migrants (especially Ukrainian) to services, as well as their possible connection with cultural and linguistic differences with the local population. The article presents results of the analysis of data obtained using twenty-two in-depth semi-structured interviews with representatives of different subgroups of migrants and three interviews with specialists working with migrants. 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 targeted for recruitment, including vulnerable populations (illegally working people, men having sex with men (MSM), people living with HIV). It has been also demonstrated that other migrants, non-governmental diaspora organizations and family members both in Estonia and abroad were mentioned to be the most important sources of support. Also, we show that regarding access to health services, several misconceptions and lack of information about what was available and who could access the services emerged as problematic issues. The article states, that main barriers for accessing health care was related to the status – illegal migrants 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 general Estonian population – long waiting lists, high prices (especially dental care), not attentive medical personnel. Language and cultural issues were mentioned several times – even in capital, Tallinn, had been difficult to find a doctor who was used to communicate with people with other cultural backgrounds. In conclusion, newcomers to Estonia highlighted the gaps in the Estonian health care system with which also local population is not satisfied with. But they also experienced unique issues related to their status. 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 to meet the needs of people. From public health perspective, it is necessary to provide basic health services to illegal undocumented migrants, including ensuring that they receive care for communicable diseases as early as possible.

Keywords: *Estonia, access to care, migrants, refugees.*

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ІММІГРАНТИ В ЕСТОНІЇ: ЧИ Є КУЛЬТУРАЛЬНА ВІДМІННІСТЬ ОСНОВОЮ НАЯВНИХ КЛЮЧОВИХ БАР'ЄРІВ У ДОСТУПІ ДО МЕДИЧНИХ І СОЦІАЛЬНИХ СЕРВІСІВ

Стаття присвячена бар'єрам, з якими мігранти стикаються в доступі до медичної допомоги та інших соціальних сервісів, зокрема через побоювання стигматизації та страх перед дискримінацією в медичних і соціальних службах. Особливо у статті зазначається, що це слід враховувати при наданні послуг. Показано наявні проблеми у неоднаковому доступі мігрантів (зокрема українських) до сервісів, а також можливий їхній зв'язок з культурними та мовними відмінностями з місцевим населенням. Презентовано результати аналізу даних, отриманих з використанням 22 глибинних напівструктурованих інтерв'ю з представниками різних підгруп мігрантів та 3 інтерв'ю зі спеціалістами, які працюють з мігрантами. Основна увага зосереджується на новоприбулих мігрантах (протягом останніх трьох років) з метою вивчення того, як люди адаптуються в Естонії в контексті громадського здоров'я. Опитування проводилося серед різних груп мігрантів, зокрема вразливих груп населення (нелегально працюючих, чоловіків, які мають секс з чоловіками (ЧСЧ), людей, які живуть з ВІЛ). Продемонстровано, що інші мігранти, неурядові організації діаспори та члени родин як в Естонії, так і за кордоном були згадані як найважливіші джерела підтримки. Показано, що деякі помилкові уявлення та брак інформації про те, що доступно і хто може отримати доступ до послуг, виявилися проблемними питаннями. У статі стверджується, що основною перешкодою в доступі до медичної допомоги виявився статус, тобто нелегали та люди без посвідки на проживання не мали доступу до неї; що нелегальні мігранти побоювалися наслідків і втрати конфіденційності у разі звернення за будь-якою медичною допомогою; проблеми з медичними послугами, подібні до проблем загального населення Естонії: довгі черги, високі ціни (особливо на стоматологічну допомогу), неуважний медичний персонал, а також часто згадувані мовні та культурні проблеми. Показано, що люди, які нещодавно прибули до Естонії, зіткнулися зі специфічними проблемами, пов'язаними з їхнім статусом. Для подолання виявлених проблем треба забезпечити освіту та інформацію для спеціалістів, які працюють з мігрантами та шукачами притулку в різних організаціях. Інформаційні та освітні програми для мігрантів повинні відповідати культурі та потребам цільових груп. Зменшення стигматизації та дотримання прав людини є важливими, зокрема з точки зору громадського здоров'я необхідно надавати базові медичні послуги нелегальним мігрантам без документів, в тому числі забезпечувати їм якомога більш раннє лікування інфекційних захворювань.

Ключові слова*: Естонія, доступ до допомоги, мігранти, біженці.*

Estonia is a small country in the north of Eastern Europe and Central Asia (EECA), whose economy is the most successful compared to other post-Soviet states [1]. Estonia is characterized by low level of corruption, high public trust in the legislative, executive and judicial authorities [2]. All these factors contribute to the attractiveness of Estonia as a

destination country for migrants from the former Soviet Union territories, where all possible causes of migration exist: wars (Armenia / Azerbaijan, Georgia / Russia, Moldova, Russia / Ukraine), labour 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.) [3], 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).

The population of Estonia is 1,3 million. According to WHO (2018) up to 15% of the total population in Estonia were international migrants [4]. 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[1]. 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[2]. There is a growing tendency to use illegal migrant labour in Estonia[3]. 'Quiet migration', such as cross-border tourism, migration for temporary or permanent work or study, family reunification, etc., is continuous, and influences the social situation in the field of public health [5].

In Europe, migrants face barriers to access and adherence to care, including low self-perceived risk of TB, stigma, and fear of discrimination in health services, which should be considered in the provision of services. The risk of getting worsed migrants' health (e.g. blood-borne and sexually transmitted infections (STI) among migrants) is associated with political and sociocultural factors [6]. Migrants without residency status may avoid care for fear of detention or deportation. Migrants may have lower levels of awareness of infections and their risk factors, which may lead to lower levels of screening [7].

The migration situation has significantly changed with the beginning of the Russian Federation's full-scale invasion of Ukraine (Figyre 1) – Estonia, like other Baltic countries, provided Ukrainians with international protection. According to the data of the Statistics Estonia, until February 24, 2022, 11,717 people with Ukrainian passports lived in Estonia. After the start of the war, as of January 1, 2024, 37,003 people from Ukraine have arrived and remained in Estonia, which is 3,6% of the country's pre-war population.

Such radical demographic changes were interpreted by a part of Estonian society as the biggest threat to the national identity of the Estonian people since the russification efforts of the occupying power of the USSR (1970–1980s) [8]. There is a limited literature on so-called 'eastern Ukrainian diaspora', especially in the Baltic countries [9; 10]. Although after the start of the Russian full-scale invasion of Ukraine the number of publications on the

[1] Statistics Estonia. (n.d.). Statistics by theme > Population > Migration. URL: https://www.stat.ee/en/find-statistics/statistics-theme/population/migration

[2] Sisseränne aitas suurendada rahvaarvu. (2020). URL: https://www.stat.ee/et/uudised/pressiteade-2020-059

[3] Police: Use of unregistered labor in Estonia has grown severalfold. (2017). Estonian national broadcasting company. URL: https://news.err.ee/651309/police-use-of-unregistered-labor-in-estonia-has-grown-severalfold

situation of war refugees began to grow, publications dedicated to Estonia remain few in number and concern, for example, changes in Estonian domestic policy [11], adaptation of Ukrainian children [12], changes in the identity of Russian minority [13]. Issues of migrants' access to health and social services are addressed primarily in "grey" literature, such as reports by the International Organisation for Migration (e.g. [14; 15]). Thus, it is stated that among refugees from Ukraine only 28% felt completely healthy and 58% partially [16]. Data from 2024 indicate that 26% had problems with their own health (two-thirds of them had chronic diseases), with 19% not having a family doctor (in particular due to denial of service) [14].

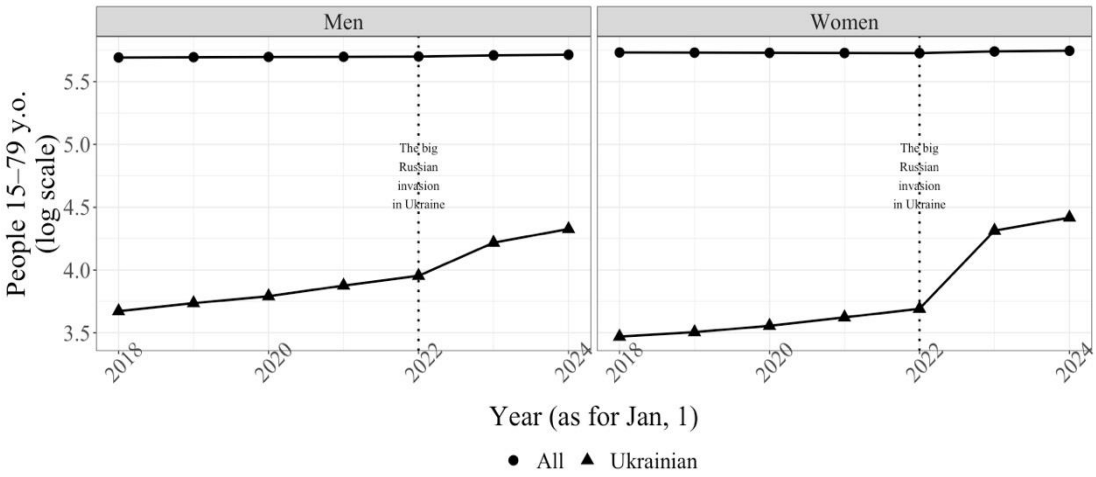

Figure 1. The dynamics of the number of citizens of Ukraine in Estonia compared to the number of all citizens (data taken from the website of the Statistics Estonia)
Source: indicator RV069U. URL: https://andmed.stat.ee/

The proposed article is based on the materials of the pre-war study on barriers in the existing Estonian social and health care for migrants (both legal and illegal workers, refugees, asylum seekers), especially visibility and accessibility of social and medical services.

The purpose of the article was to show the existing problems in the unequal access of migrants (in particular Ukrainians) to services, as well as their possible connection with cultural and linguistic differences with the local population. We'll show that despite the imagined historical and cultural commonality between the local population and 'new' migrants, the existed in Estonia milieu may be the basis for the ambivalent attitude towards immigrants and issues of access to social and health services.

This was the first qualitative study on the subject in Estonia to identify practical approaches to involving this key group into services. The focus was on rather newly arrived

migrants (in the last three years) to study how people are adapting in Estonia. ECOM grant "Immigrants in Estonia: a risk assessment to involve the key group into HIV and co-infections services" [17] supported by the Western-Eastern European Partnership Initiative on HIV, Viral Hepatitis and TB (WEEPI). The study was approved by the Research Ethics Committee of the National Institute for Health Development (approval number 607, 14.01.2021).

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 verbal 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.

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

Eligibility criteria for migrants or asylum seekers or refugees: is not an Estonian citizen or does not have an alien passport, came to Estonia during last three years (legally or illegally), is 18 years old or older, speaks Russian or English or Estonian.

Eligibility criteria for people, working with migrants or asylum seekers or refugees: is an Estonian citizen or has an alien passport, lives in Estonia on legal basis at least last 10 years, 18 years old or older, speaks Russian or English or Estonian, involved in direct service provision to migrants or asylum seekers (in NGO or municipal institution).

As the focus of the study was on HIV (because of its highly stigmatizing social image), it was specifically aimed at recruiting also a few people from vulnerable populations (e.g. people living with HIV, MSM).

The qualitative method was iterative in nature [18]. The interviewer worked to achieve a rapport with the interviewee, assuming the role of a listener guiding the conversation to cover the main themes. The duration of the interviews varied between 40 and 60 min.

The first migrant participants were identified by the Association of Ukrainian organisations 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 or situation. In order to recruit participants for this study, professionals working with migrants, asylum seekers and refugees were approached directly.

The interviews were conducted between January and May 2021. Due to the COVID-19 pandemic and respective risks and restrictions, all interviews were conducted online.

Based on the audio recording of the interview, the interviewers prepared verbatim transcripts and coded them with MAXQDA software. The study coordinator verified the accuracy of the transcripts. Transcripts did not contain any personal information, such as names, date or place of birth, home address.

All data were examined line-by-line, and the main categories and themes were identified and coded using thematic analysis. The transcripts were analysed qualitatively, with a

summary of the main topics and issues raised during the interviews being written. Direct quotes are provided here 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, 4 months in Estonia'. These data include country of origin, age, gender, migration status (the abbreviations from the abbreviation list), length of stay in Estonia.

General characteristics of the sample. *Demographics.* The final sample size was 25, among them 3 specialists and 22 migrants or refugees.

One specialist was from state agency dealing with adaptation of migrants, and two were from NGOs working with refugees. Their work experience with migrants was more than seven years in both state and non-state organisations. All interviewed specialists had experience of interacting with the Estonian health care system.

Migrants: 6 migrants were from Ukraine, 6 from Russian Federation, 3 from Central Asia (Tajikistan and Kazakhstan), 3 from Africa, 2 from South America, 2 from Western Europe (Norway and Germany). The average age of the interviewed migrants was 31 years. Among participants 15 were men and 7 women. Most of the people interviewed (19 from 22) lived in the capital, Tallinn. 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 8 legal low-paid workers, 8 middle and high-paid legal workers, 3 illegal low-paid workers, 3 asylum seekers or refugees. There were 4 migrants, who had been diagnosed with HIV in Estonia in within the previous three years.

Areas of employment. The participating migrants were engaged in different types of activities in Estonia – from casual jobs (cleaning, chef assistant, etc.) to highly paid IT jobs. Economic factors force migrants to look for legal options to remain in Estonia, although at less prestigious positions, compared to the one that was before moving from their homeland.

Reasons to remain. In addition to economic reasons, respondents also mentioned family circumstances (relocation to a spouse or sexual partner, reuniting with parents), relocation for employment or educational purposes, seeking asylum, etc. There were no sex workers or victims of human trafficking among the participants. It should be mentioned that respondents from the former Soviet Union emphasized the apparent cultural closeness of Estonia, in particular the ability to get by in everyday life using only Russian: "*At 30, life already seemed settled. But the moment I had to leave, well, I was invited. Friends were abroad, in Poland, and asked: 'Would you like to go to Poland?' But in Poland, salaries are a little less than in Estonia, and I know the Russian language, which is important in Estonia, because my English is primitive. I hoped that in Estonia they would understand me, so I decided to go*" (Ukraine, 33 y. o., woman, 33 months in Estonia); "*We came here to visit, saw with our own eyes, when the same grandmas on a bench discuss prices in euros. Hard to imagine. There is some kind of tent with vegetables, fruits. Everything is as I am used to, only the prices in euros. And everybody speak Russian*" (Russian Federation, 35 y. o., man, 45 months in Estonia).

Sources of informal support are migrants' relatives abroad, friends and colleagues (incl. other migrants) in Estonia, and the help of other people of migrant's nationality in the

country. For example, some of the respondents communicate with relatives abroad, including 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, 6 months in Estonia). Local diaspora (Brazil, Ukraine, etc.) NGOs or communities were often mentioned in contexts of integrational support during very first months in the country: "*I have already made new acquaintances in Estonia... I found a Ukrainian organisation here. These people are certainly not my family. Just nice friends*" (Ukraine, 46 y. o., woman, 6 months in Estonia). In some cases, contacts established in a migrant milieu continue and serve as support after the departure of these acquaintances from Estonia.

Family doctor. Of the 22 migrants interviewed, six did not have a family doctor.

Gaps in medical and social services for migrants. Two main areas where migrants face obstacles to contact with healthcare providers are differences in cultural background (especially language) and the legal status.

Cultural background. According to both the interviewed migrants and specialists, one of the key obstacles is related to the language – on 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 interviewed migrants cited as an example the websites of Estonian police or Estonian Unemployment Insurance Fund where information in English and Russian does not coincide in essential details with information in Estonian. The point of view of specialists who work with migrants is similar: if it is not so 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: "*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 keep their role. But for men it's difficult, because in the first 6 month you are not 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. It's stressful for sure*" (Specialist, NGO). Indirect refusals in medical help 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, 24 months in Estonia).

Those who did use the help of a family doctor complained about a rather formal approach to the patient: "*They barely checked the symptoms. If I went to a doctor in my country, they'd do an X-ray and look what is wrong and maybe, I don't know, be stricter about fixing it. But here they just give you advice and let you be*" (Africa, 30 y. o., woman, 24 months in Estonia). Complaints about the formal attitude towards patients, about the doctor's unwillingness to delve into the problem, were also voiced by other participants. Cultural differences affect the ability of healthcare providers to be individualized about the

situation of each patient: "*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 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, but 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 centres 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 must 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*" (Specialist, NGO).

Respondents from the countries of the former Soviet Union also find that first impressions of similar cultures and lifestyles are false, and differences can manifest themselves in the organisation of, for example, school life (a significantly more individualised approach to child development), relations between employers and employees, or the greater role of local communities: "*We didn't have that kind of nationalism. We all lived in the same building, several nationalities lived there, and everyone was friends. It was weird for me that people would come to my house and say, how can you listen to Russian music?*" (Ukraine, 48 y. o., woman, 18 months in Estonia); "*Well, if you compare it with Ukraine, the attitude of the people, the owners. It's better here. I really like Estonians. The behaviour itself, the human attitude here is better, like on another planet. That is, you feel that even if you are like a janitor there, you don't feel this attitude as a janitor. Everything is smooth, clear, good*" (Ukraine, 53 y. o., man, 10 months in Estonia).

Several migrants' problems may be related to the xenophobia towards non-Estonians in the form of racist statements by officials and politicians: "*I have not had a feeling that the officials here 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 stigmatises when someone is from Africa, for example. The same is true for sexual orientation*" (Specialist, state agency). In two interviews the respondents indicated that belonging to sexual minority group is associated with stigmatisation, 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 is for people to give up*" (South America, 32 y. o., man, 6 months in Estonia).

Lack of official status. Significant part of the problems was related to the legal status. However, even if a person was in Estonia formally on a legal basis (e.g. on a short-stay visa), problems could arise: "*Every year I go to 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, 33 months in Estonia, Tallinn). The lack of a residence permit affects not only the availability of medical services, but also the ability to register for free Estonian language courses.

Some respondents associated the refusal in medical help with the lack of insurance: "*During the time I was looking for a free clinic I tried to contact 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, 10 months in Estonia). The migrant workers interviewed were generally 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: "*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, 24 months in Estonia).

Considering the generally low incomes of migrants and the lack of legal status in some cases, the need to pay can be a significant factor limiting the availability of medical services.

The interviewed experts confirm that residence permit is a key to a wide range of 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 with visa is problematic.*" (Specialist, state agency). Six respondents did not have a family doctor, which was partly due to the lack of official status (no residence permit or health insurance).

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. However, in my situation, I try not to contact any organisations, 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, 24 months in Estonia).

Education and experience of specialists. The organisation of healthcare is not part of the professional education of specialists counselling migrants, asylum seekers and refugees. If such questions arise, then specialists rely only on the knowledge gained at school. Professionals, who are working with migrants, as a rule, undergo psychological training and subsequently receive supervision, they are taught to value linguistic and cultural diversity. In addition to specialists, organizations that assist to migrants, asylum seekers and refugees have volunteers who are also trained: "*In our system support people get regular supervision. It goes to all our employees who work in this support service part in Refugee Council. 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. Peak of traumas*

emerging of what they have 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).

Discussion and conclusions. This article describes the results of 22 in-depth interviews with migrants and 3 interviews with specialist working with migrants and refugees in Estonia. This study is the first in Estonia to take a deeper look into the sphere of accessibility of medical and social services for this population group due to the existing differences in cultural characteristics between the country's indigenous inhabitants and newcomers.

We interviewed different types of migrants, both legal and illegal, with the average age of 31 years. Among them, there were people from vulnerable populations – three participants were HIV-infected and nine identified as non-heterosexual men. Two thirds of the participants were men, and more than half originated from either Ukraine or Russia. All of them had migrated to Estonia less than three years ago. 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.

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

Participants reported similar problems with healthcare services as Estonian general population (e. g. see [19]) – long waiting lists, high prices (especially dental care), not attentive medical personnel. 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 from the healthcare organisations, state or UN-affiliated intergovernmental structures, as well as other public organisations.

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 various topics, including prevention of unwanted pregnancy, access to maternal health services, availability of prevention measures (e. g. vaccination or condoms). The respondents of this study, as a rule, accessed healthcare, 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.

The collected data confirmed that before relocating to Estonia, people from the former Soviet Union perceived this country as close in linguistic and cultural terms – it was one of the main reasons for choosing Estonia as a target country, while respondents from other regions of the world (Africa, South America, Western Europe) ended up in Estonia due to work/study or for family reasons. Thus, for people from post-Soviet countries, discrepancies (both positive and negative) between expectations and reality became a source of additional tension. Language issues were mentioned several times (it has been difficult to find a doctor who speaks English or Russian even in the capital city) – they were common to all respondents.

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 colour of their skin. 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.

The legal status was main formal barrier for accessing healthcare – illegal migrants and people with no residency permit had no access. Illegal migrants were also afraid of the consequences and loss of confidentiality should they reveal their legal status to medical professionals. At the same time, Estonians themselves apparently perceive migrants differently depending on their country of origin, and this may *de facto* be reflected in the availability of legal status.

People from post-Soviet countries, who are united in the eyes of the local population by speaking Russian as their native language, may seem 'familiar', but evoke associations with the times of the Soviet occupation, the consequences of which in the form of the existence of a huge enclave of descendants of the labour force brought in in the 1970s and 1980s who do not speak Estonian have not yet been overcome.

People from other regions of the world, due to their smaller numbers, attract less attention, and the English that unites them may be associated with a higher material status, although external differences (for example, skin colour) may provoke the racist excesses mentioned.

Unfortunately, the data collected in the study do not allow us to unambiguously confirm the hypothesis of differences in the perception of migrants depending on the country or region of origin. However, indirect confirmation is the fact that problems with obtaining a residence permit were mentioned only by respondents from the former Soviet Union.

In conclusion, people newly arriving to Estonia highlight the gaps in Estonian health system; this concept is also voiced by local population, as well as experience unique issues related to their legal status. Migration issues are still an urgent problem in European Union in general (e. g. because of ongoing wars [20]) and especially in the Baltic countries (from 2021, Lithuania, Latvia and Poland are tackling a migrant influx from Belarus[4]). Baltic countries (except Poland) are very small and do not have sufficient resources to create a special system of medical and social services for migrants. This is what 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 have 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 healthcare 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.

[4] AP with Euronews. (n. d.). Lithuania takes a tougher line on the migrant influx from Belarus. URL: https://www.euronews.com/2021/08/03/eu-pledges-aid-to-lithuania-as-migrants-pour-in-from-belarus

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

It is necessary to start providing basic health services for illegal undocumented migrants (with no documents and no health insurance), including making sure they receive care for communicable diseases as early as possible. As WHO phrases it – there is no public health without refugee and migrant health [4].

It should mention that the results cannot be extrapolated to all migrants in Estonia – we used a convenience sample with a small number of people. 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 for 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.

A methodological limitation of the study is that we did not conduct interviews with native residents, except for three specialists who, due to their professional ethics and the requirements of political correctness, could not mention their personal attitude towards migrants. At the same time, the described material allows us not only to see the gap in healthcare and social services for migrants but also provides grounds for further work on studying the links between the features of intercultural communication and the existing inequality in access to social benefits – an area that becomes more and more relevant in times of great social instability.

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