Eurasian Coalition
on Male Health

ECOM

Desk review on LGBT migrants and refugees in CEECA in the context of HIV

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CONTENTS

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CEECA	Central, Eastern Europe and Central Asia
CIS	Commonwealth of Independent States
CJEU	Court of Justice of the European Union
CGRS	Commissioner-General for Refugees and Stateless persons
COI	Country of Origin Information
CSO	Civil Society Organization
EASO	European Union's Asylum Support Office
ECOM	Eurasian Coalition of Male Health
EEA	European Economic Area
EECA	Eastern Europe and Central Asia
EMIS	European MSM Internet Survey
EU	European Union
FMR	Forced Migration Review
FRA	European Union Agency for Fundamental Rights
GDP	Gross Domestic Income
HIAS	Hebrew Immigrant Aid Society
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced People
ILGA	International Lesbian and Gay Association
IOM	International Organization for Migration
LGBT	Lesbian, Gay, Bisexual and Trans
MSM	Men Having Sex with Men
NGO	Non-Governmental Organization
OECD	Organization for Economic Cooperation and Development
OHCHR	Office of the High Commissioner for Human Rights (UN)
ORAM	Organization for Refugee Asylum and Migration
RF	Russian Federation
SOGI	Sexual Orientation and/or Gender Identity
STI	Sexually Transmittable Disease
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization

PREFACE

Issues related to immigration, as part of ordinary demographical statistics, generally fall under the spotlight of the media, the public, and politicians during times of serious geopolitical upheaval, such as armed conflicts, wars, and ethnic cleansing. These events cause mass migration, as well the exacerbation of related, existing problems and the emergence of new ones that must be addressed in a short period of time. 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, the effects of which were felt even in Armenia. 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.

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.

In the region of Central and Eastern Europe and Central Asia (CEECA), all possible causes of migration exist: domestic 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.), 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.

The Eurasian Coalition on Male Health (ECOM) presents the findings of a literature review on the situation of lesbian, gay, bisexual and trans (LGBT) migrants and refugees in the CEECA region in the context of the Human Immunodeficiency Virus (HIV) epidemics.

This study attempts to explore patterns of LGBT migration related to root causes and geography, assesses what data is available and what research gaps exist in this broad and complex area, and explores some connections between the migration of LGBT people, the vulnerabilities of these groups, and public health problems.

The failure to protect the human rights of LGBT people is a well-recognized global problem. Evidence confirms that LGBT communities are disproportionally affected by HIV, and have a much higher risk of developing other medical conditions no matter where they are born, or to where they migrate. Emphasizing their risk behaviors takes attention away from widespread anti-LGBT and anti-migrant social and structural stigma that lead to alarming health disparities for these people and limit their access to healthcare services.

The findings of this study illustrate that, beyond the dry figures of public health and migration statistics, there is a long chain of unresolved problems that result in LGBT communities exacerbating HIV epidemics and migrant crises. ECOM believes that generating knowledge about the complexities of the problems faced by LGBT will help to improve programs that specifically target them.

CONCLUSIONS

1. The data about human rights, health and migration of LGBT people are mostly discussed without illustrating interconnections between these three areas. Data on migration of LGBT people is scarce, as majority of countries worldwide do not even keep statistics on asylum claims that are based on SOGI. There is no unified methodology to measure migration in/out flows of general population globally, and this context can explain, why no quantitative data exists on which countries have the highest levels of inflow and outflow of LGBT migrants. Another reason why it is difficult to ascertain the real level of LGBT-migration caused by SOGI is that many migrants do not disclose their SOGI when migrating, or claiming asylum.

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 RF. There are also significant migrant flows to the RF 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 USSR.

3. There is quite limited data on specific reasons of why LGBT people are migrating. It can be assumed that LGBT persons migrate for the same reasons, as all people globally, i.e. people could be either pushed or pulled by safety, economic, environmental and social factors. In addition, it can also be assumed that LGBT people may prefer to migrate to more friendly countries, i. e. where LGBT people are less stigmatized and where policy environments are more liberal in comparison with their countries of origin.

4. Anti-LGBT and anti-migrant stigma exists to a certain extent in all countries around the world, and leads to significant disparities between the levels of access of LGBT people and of heterosexual people to a number of services, even in host countries. European asylum policy has no unified approach. With the exception of the Netherlands, Sweden, and the United Kingdom, most European countries do not have explicit and publicly available guidelines on how they handle the asylum applications of LGBT people. This situation explains, why additional action is needed to improve legal protections for LGBT asylum-seekers during displacement and resettlement, evidence says that LGBT people often face threats, harassment, and discrimination from border officials. Central and Eastern European countries in particular struggle to handle SOGI-based asylum claims. They are bound by international standards concerning refugees and asylum-seekers. Nevertheless, the practices and policies of their national asylum authorities in relation to LGBT people often fall below these standards.

5. LGBT migrants belong to intersectional population and therefore they face two forms of stigma: stigma against LGBT people and stigma against migrants and both forms lead to increased vulnerability to health-related problems, such as HIV, other infections, and mental health disorders. Additional factors causing stress for migrant are adapting to the new cultures, structures and systems of host countries, which may negatively influence their physical and psychosocial well-being. Migrants are not always welcome in host countries, and such attitudes can have a negative impact on health outcomes at the individual, community, and public health levels. The research shows that LGBT people have lower access to healthcare in comparison

with heterosexual population in all countries regardless of income level; Furthermore, HIV epidemics among MSM are expanding in countries of all income levels; Mobile populations are often overlooked by the health and HIV-related policies of host countries.

6. The research and data on trans group of the LGBT population is limited. There is no disaggregated data on HIV or STI prevalence among this group. Medical professionals in most countries lack the specific knowledge and skills to properly handle health problems specific to trans people. Trans people who are claiming asylum and who have already started hormonal treatment before migrating, may not receive timely treatment in host countries, as each country has different policies related to this. Even if treatment is provided, procedural requirements may result in significant delays before the person has access to treatment.

1. INTRODUCTION

Problems related to growing HIV epidemics, refugee crises, and the rights of LGBT people are among predominant global issues widely discussed by United Nations agencies, and other international organizations and societies. In recent decades, a substantial amount of money has been pledged by governments and international donors to address problems related to three key areas: migration, public health and human rights.

Generally, these problems cannot be considered in complete isolation from each other, since issues related to migration, health, and human rights are often linked or overlap for certain groups of people. Any refugee or asylum-seeker may face problems related to health, human rights, or both, for example, LGBT migrants have an increased risk of engaging in sex work. Gay and bisexual men and other MSM are among the populations most affected by HIV or other sexually transmitted infections (STIs). Public health bodies often state that the risky behavior of this population is the reason for their vulnerability to HIV and STIs. Key priorities for LGBT groups often include reducing stigma and discrimination, and protecting their rights. Evidence also suggests that gay, bisexual, and other MSM may be more likely to migrate in order to gain the social and sexual freedom not available in their countries where homophobic attitudes may be prevalent. The number of LGBT refugees and asylum-seekers has significantly risen in recent decades. Although human rights, health, and migration issues are often causally linked for LGBT people, almost no research has been carried out to explore the synergies between these three issues for this particular population.

This study attempts to understand the interconnection between the main rights-, health-, and migration-related problems experienced by LGBT people, and to describe the causal links between these issues. Before examining the problem from a regional perspective, the first step was to determine what is known at the global level about the migration of LGBT people.

The main finding of this study is that most problems related to the rights, health and migration of LGBT people are discussed in isolation. The issues most commonly examined include the human rights of LGBT people, and health issues specific to gay, bisexual and other MSM, especially ones related to HIV. Various issues related to the health of migrants have also been widely researched, but very little is known about the health issues of lesbian and trans people. Significant gaps exists in national health information systems worldwide in the collection of data about both migrants and LGBT people. There are significant limitations in data about global migration in general. Data on the migration of LGBT people is very scarce; even the number of asylum claims on the basis of sexual orientation and/or gender identity (SOGI) is not tracked by the vast majority of host countries.

It is relatively easy to document violations of the rights of LGBT people and SOGI-based stigma and discrimination. However, it can be quite difficult to highlight the specific health- and migration-related problems faced by LGBT people, and to show how these problems are connected to SOGI-based discrimination. It is obvious that, in developing countries, inequality is a general problem, and that all migrants face difficulties due to displacement. Therefore, this document would like to go beyond such general claims and explain the nature of the specific problems faced by LGBT communities with respect to human rights, migration and health. It will also show how these problems affect LGBT individuals differently than heterosexual people, and what causal links exist between these group-specific problems.

Based on the resources reviewed, we argue that the high incidence of certain diseases (primarily HIV and mental health problems) and a high level of LGBT migration can be considered to be negative

consequences of social and structural stigma against LGBT populations. Anti-LGBT and anti-migrant stigma exists to a certain extent in all countries and leads to significant disparities for LGBT people in accessing a variety of quality services. In order to better explain all causal links, the following sub-chapter describes how international organizations view LGBT rights, what core documents govern LGBT rights, and which bodies deal with issues related to LGBT rights. The second sub-chapter provides key information about migration, describes the main migration flows using the assumption (in the absence of any quantitative data) that LGBT migrants are following the same flows. The final sub-chapter presents the issue of SOGI-based asylum claims in European Union (EU) member states. Chapter 3 explains what data exists on LGBT migration, and what data is not available and why? Chapter 4 discusses the health problems of LGBT people, migrants and LGBT migrants, and focuses on various aspects of the right to health and group-specific disparities.

LGBT Rights: Position of the International Community

In the last two decades, and especially since 2011, statements of the United Nations (UN), and reports released by the European Union and other international agencies demonstrate increased concern about the human rights of LGBT people and confirm the urgent need to address violations of the rights of LGBT communities worldwide (1). Despite the fact that significant international attention has been given to protecting these communities, there are still many problems to address and resolve (2, 3, 4). These problems are largely determined by the laws and policies that perpetuate unequal treatment, as well as by the social stigma that continues to exist even in those societies, where democratic legislation exists. In other words, globally, LGBT people continue to face a high level of social stigma, exclusion and violence (3, 51). According to ILGA's world report on state sponsored homophobia (2017), 78 countries in the world criminalize people based on their sexual orientation with penalties ranging from imprisonment to the death penalty, which is applied in five countries [(1)].

The first-ever UN report on the human rights of LGBT people was released on December 15, 2011 by the UN Office of the High Commissioner for Human Rights (OHCHR). The report entitled "Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity" raised concerns about human rights violations against LGBT people, described patterns of violations based on homophobic and transphobic attitudes, and presented an overview of discriminatory laws including detention and the death penalty. The report emphasized that "governments have too often overlooked violence and discrimination based on sexual orientation and gender identity. Violent incidents or acts of discrimination frequently go unreported because victims do not trust police, are afraid of reprisals or are unwilling to identify themselves as LGBT". Possible solutions highlighted in the report included reporting and documenting such violations, and introducing public awareness campaigns to promote fair treatment and to end bullying or other forms of persecution of LGBT people [(1)].

UN publications published after the first report was developed in 2011, as well as other sources specializing on LGBT issues including international and local NGOs, think tanks, academic institutions and online media, confirm that the problem is far from resolved and that progress has been slow [(2,5,6,)]. However, UN agencies repeatedly express the political will to address and resolve the problem of LGBT rights violations worldwide. For example, in September 2015, the UN issued a statement entitled "Ending violence and discrimination against lesbian, gay, bisexual, trans and intersex people", in which the need to protect the rights of LGBT people is strongly linked to the achievement of the Sustainable Development Goals by 2030: "Failure to uphold the human rights of LGBT people and protect them against abuses such as violence and discriminatory laws and practices, constitute serious violations of international human rights law and have a far-reaching impact on society – contributing to increased vulnerability to ill health including HIV infection, social and economic exclusion, putting strain on families and communities, and impacting negatively on economic growth, decent work and progress towards achievement of the future Sustainable Development Goals" [(5)].

The UN statements and calls for action are echoed by the European Commission. A list of actions to advance LGBT equality was developed in December 2015. The list covers the period 2016-2019 and provides detailed guidance to EU member countries on guaranteeing the rights of LGBT people to equality and non-discrimination. Recommendations are primarily focused on repealing discriminatory laws, policies and practices, and on promoting appropriate legislation, policies and action [(2)].

A report on fundamental rights published in 2018 emphasized that, despite important advancements in addressing problems related to LGBT equality in the EU, there are still significant problems, as "unequal treatment and discrimination remain a reality in European Societies" [2]. In September 2016, the UN appointed its first Independent Expert on violence and discrimination based on sexual orientation and gender identity in order to respond to the challenges of LGBT rights worldwide [3]. Community groups or NGOs focusing on LGBT rights are operating in most CEECA countries. They monitor the overall legislative climate of the respective countries and are documenting incidents of SOGI-based crimes and hate speech [6, 7, 8].

ECOM is a leader among organizations in the region in assessing cases of LGBT rights violations in the CEECA region, and highlighting the link between such violations and the right to health of individuals and public health problems. Since 2017, the organization has been documenting cases of LGBT discrimination in CEECA countries. Two analytical reports (developed in 2018 and 2019) have been published in order to support CSOs and national governments in effectively addressing the issues faced by LGBT communities [7, 8].

2. LGBT MIGRATION

Global data on migration, which is routinely collected and publicly available through international organizations, such as the IOM and UNHCR, does not allow researchers to track the specific migration flows of LGBT people, i.e. data on LGBT people is not disaggregated from data on other groups. Our review demonstrates that the vast majority of countries worldwide do not even track asylum applications based on SOGI [6]. Therefore, there is no quantitative evidence on which countries have the highest levels of inflow and outflow of LGBT migrants. It can be assumed that LGBT migrants are primarily following the same migration outflows common to other groups in their countries of origin In addition, they most likely prefer to migrate to more favorable countries, i.e. where LGBT people are less stigmatized and where the policy environment is more liberal in comparison to their countries of origin [9, 10].

It was not possible to find research examining and explaining the main reasons motivating LGBT individuals to migrate. Relatively informative quantitative data exists on the forced migration of these communities. However, these sources are not always clear about what factors forced people to migrate: was it structural and social stigma, or were they forced to migrate for the same reasons as other populations (for example, political conflicts, war, natural disasters, economic difficulties, etc., or a combination of these factors?). After reviewing basic information about the root causes of migration (Table 2), it became obvious that the only cause that would be specific only to LGBT communities is anti-LGBT social and structural stigma. However, it is clear that motivations for migration are usually quite complex and can be determined by multiple factors.

Existing literature suggests that LGBT individuals are more likely to migrate for security reasons and to seek safety and freedom. While migrating within a country, LGBT people tend to move towards bigger cities and capitals, while international migration flows tend to be towards those countries with lower levels of structural and social stigma towards LGBT people. At the same time, LGBT people face greater difficulties compared to heterosexual people during any form of forced displacement, whether international or domestic (due to war, political conflicts, natural disasters, etc.) [3, 6, 12, 13, 14, 15].

In recent years, a growing body of knowledge has been compiled on LGBT refugees and asylum-seekers. International organizations, such as the UNHCR and IOM, have paid more attention to the specific problems experienced by LGBT asylum-seekers in general, and by those who claim asylum based on SOGI. The problems specific to LGBT refugees and asylum-seekers are examined in the following chapter, after clarification of general issues related to migration.

In the following sub-sections, we define the key terms and concepts related to migration. In order to better understand LGBT migration, we first briefly examined root causes of migration in general and global migration trends. We also examined what data is routinely collected, and by which agencies. All this information helped to better analyze issues related to LGBT migration in the regional context of CEECA. The basic information laid out below also serves to explain the reasons why certain information is not available (especially information related to either LGBT groups, to the region, or to both), and discusses what must be changed in order to fill existing information gaps related to LGBT migration.

Migration: Key Terms & Concepts

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 as a result of external forces.

The International Organization for Migration (IOM), an intergovernmental organization working on global migration issues under the UN 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 [16].

The term "forced migration" is not clearly defined in existing literature and has different meanings covering a wide range of situations. While the IOM suggests that forced migration is a migratory movement which involves an element of force, compulsion or coercion[1], arising from both natural and man-made causes, the UNHCR suggests avoiding use of the term, as it is not a legal concept. The term does not clearly indicate which factor (or which combination of factors) has forced a person to migrate.

For example, when LGBT people flee a country looking for security and freedom, this could be considered forced migration regardless of the legal ground for the displacement, or the legal status of the LGBT migrant. Definitions for the terms "migrant", "refugee", "asylum-seeker", and "IDP" are provided in Table 1. It is important to understand that "migrant" is an umbrella term for any person crossing a border for the purpose of resettlement (regardless of the reason for movement, duration or status), whereas "refugee" and "asylum-seeker" are international migrants with different legal statuses, and are closely linked with the reason for a person's migration. The term "IDP" cannot be applied to international migration, as it denotes a person displaced within the same country.

Table 1. Migration: Key Terms[2]

KEY TERMS	DEFINITION
Migrant	any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status, causes for the movement, length of the stay and whether the movement is voluntary or involuntary
Immigrant	foreign-born migrants residing in the country
Emigrant	people born in the country who were residing outside their country of birth
Refugee	a person who flees their country due to well-founded fear of persecution due to reasons of race, religion, nationality, membership in a particular social group or political opinion, and who are outside of their country of nationality or permanent residence and due to this fear are unable or unwilling to return to it
Asylum-seeker [3]	a person who has sought international protection and whose claims for refugee status have not yet been determined
Internally displaced person (IDP)	a person or group of people, who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.

1 https://www.iom.int/key-migration-terms
2 Sources: https://www.iom.int/who-is-a-migrant and IOM Glossary on Migration, 3rd edition, 2018
3 The 1951 UN Convention Relating to the Status of Refugees is an international document that defines who is a refugee, and sets out the rights of individuals who are granted asylum, and the responsibilities of nations that grant asylum

Root Causes of Migration

Different factors may drive people to leave their country. These motivations can be classified by their nature in several different ways. For example, they can include so called "push factors" i.e. "why the person wants to leave the country?" and "pull factors", i.e. "why the person wants to move to another country?". The push/pull factors can be further divided by safety, economic, environmental and social factors. Table 2 illustrates most of these factors.

Table 2. Driving Factors for Migration[4]

ROOT CAUSES	PUSH FACTORS	PULL FACTORS
Safety Factors	Persecution Violence War	Safety Stability Freedom
Economic Factors	Poor Wages Lack of Jobs	Higher Wages Job Opportunities
Environment Factors	Crop Failure Pollution Natural Disasters	Food Availability Better Environment
Social Factors	Limited Opportunities Lack of Services (i.e. health) Family Separation	Better Quality of Life Available Services Family Reunification

Table 2 shows that the driving factors for migration can be any combination of the root cause factors listed in the vertical columns with a predominance of either push or pull factors. Any situation where push factors are the predominant motivation in a decision to migrate can be considered as forced migration. In the case of LGBT migrants, all factors that apply to migrants in general can be true for LGBT migrants as well. If an LGBT person migrates to escape from either social or structural stigma or from both, this can also be considered as forced migration. However, given that "forced migration" is not a legally accepted term, no official statistical information is available on whether migration is forced or voluntary for any group of population including LGBT people. Unfortunately, there are no statistics on SOGI-based asylum applications [43]. However, even if migration offices worldwide did accurately track statistics on SOGI- based claims, it would not be possible to determine the real volume of LGBT migration driven by SOGI-based discrimination, since many of these migrants prefer not to disclose their SOGI even when they are migrating and even when claiming asylum abroad [2, 3, 6]. Other LGBT-specific reasons for migration can include the separation of a couple/family or the lack of relevant services, for example, gender reassignment surgery.

Data on Global Migration: What is Available and Where Can It Be Obtained?

Global data on all types of international migration is available on the Migration Data Portal managed by the IOM[5]. The portal is divided into different themes about migration. It provides data sources for each particular topic, and explains the main indicators and limitations in the data. There are no specific sub-topics or sub-groups related to LGBT migration, reasons for migration, or the status of migrants. The main indicators illustrating international migration movements are migration flows and migration stocks.

4 Modified by author, source
5 https://migrationdataportal.org

Migration flows (inflow and outflow) are the number of migrants entering or leaving a country during a given period of time, which is usually one calendar year.

Data on migration flows provides an understanding of global migration patterns and trends, and of how different factors and policies influence migration processes. However, the available data on migration flows does not fully describe global migration trends for the following reasons: estimates on inflow and outflow by country of origin and destination are not available at the global level; only 45 countries[6] worldwide report migration flows to the UN; and each country has a different definition of "international migrant" and different methodologies for collecting data about migration flows, which makes it difficult to compare some data.

Migrant stocks are the total numbers of international migrants in a given country at a particular moment of time. Data on migrant stocks is collected at both the national and international level. National statistical offices collect data on migrant stocks through censuses, population registries and other administrative sources.

Comparable annual data on migration flows and migration stocks is limited to the countries in the Organization for Economic Cooperation and development (OECD). Some countries report the data to the Statistical Office of the European Union (Eurostat)[7], while some countries report data on annual flows to the UN Statistics Division, which has a mandate to collect migration statistics, including data on migration flows and migration stocks, from countries through the Demographic Yearbook data collection system[8]. However, the number of countries reporting data to each source is limited.

It is important to emphasize that countries worldwide and even within the EU use different concepts and methodologies to collect migration-related data. Furthermore, global data is not harmonized.

Refugees, Asylum-Seekers, IDPs and Other Populations of Concern: Since 1951, the UNHCR has maintained statistics on the numbers of refugees, asylum-seekers, IDPs and other groups of concern (which includes SOGI-based asylum claims as they are not tracked separately). This database allows users to track statistics based on the group, country of residence and origin, and time period[9]. As mentioned earlier, the database does not contain data disaggregated by SOGI.

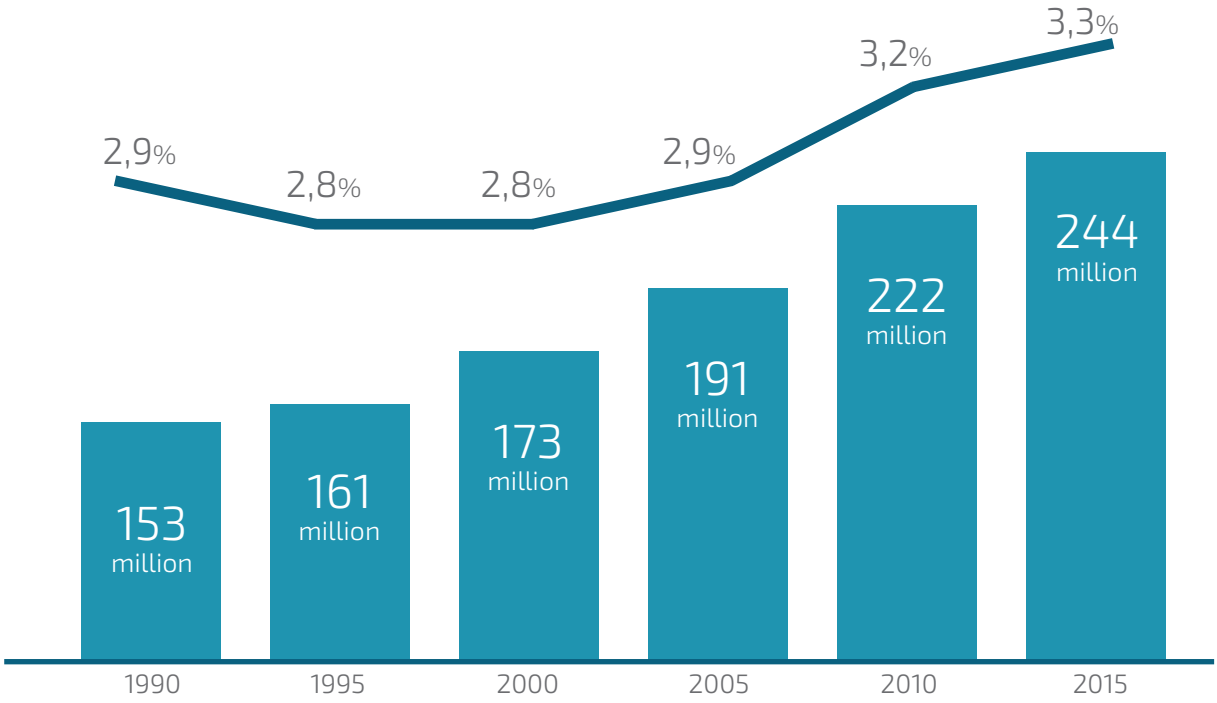
This brief overview explains why there is no consistent and comparable data on migration (or on the migration of specific groups, such as LGBT people) from/to and within CEECA.

Global Migration: Trends & Figures

Global movement of populations has significantly increased in the last few decades. Between 1990 and 2015 the absolute number of international migrants has nearly doubled, increasing from 153 to 244 million. However, while the world population has also grown, the proportion of migrants out of the overall population is relatively stable (Figure 1), having increased from 2.9% to just 3.3% [(16)]. The issues related to collecting data on migration explained in the previous sub-section indicate that these figures are simply rough estimates illustrating general trends.

6 https://www.un.org/en/development/desa/population/migration/data/empirical2/docs/migflows2015documentation.pdf Out of the 45 countries, 19 are in EECA, including 12 post-Soviet countries (except Georgia, Tajikistan, Turkmenistan, Uzbekistan) and 7 others, Poland, Bulgaria, Czech Republic, Slovakia, Croatia, Slovenia and Hungary.
7 https://ec.europa.eu/eurostat/data/database
8 https://unstats.un.org/unsd/demographic-social/products/dyb/index.cshtml
9 http://popstats.unhcr.org/en/time_series

Figure 1. Number of International Migrants Globally



Source: IOM: Global Migration report 2018

Unfortunately, many people migrate due to political reasons, wars and disasters, or to seek security or freedom by escaping different types of rights violations. Between 2007 and 2017, the number of forced migrants worldwide increased from 42.7 to 68.5 million. This figure includes 40 million internally displaced people (IDPs), 25.4 million refugees and 3.1 million asylum-seekers [17].

In 2017, UNHCR published a list of the top ten source and host countries for refugees worldwide [17]. The majority of source countries are the least developed states located in Asia and Africa. Germany is the only host country on the list located in Europe, and ranks sixth out of the top ten host countries worldwide, with Turkey and Pakistan ranking as the top two.

Ukraine is the only European country included in the UNHCR's 2017 list of countries with the largest IDP populations worldwide. The country is tenth on the list, while Colombia and Syria are the top two. Ukraine and Albania are the two European countries that were listed by the UNHCR in 2017 as major countries of origin for new asylum-seekers. Currently, Ukraine has the largest number of IDPs on its territory of all the CEECA countries, and is also among the top source countries of asylum-seekers worldwide [17].

Migration in Europe: Main Corridors & Other Features

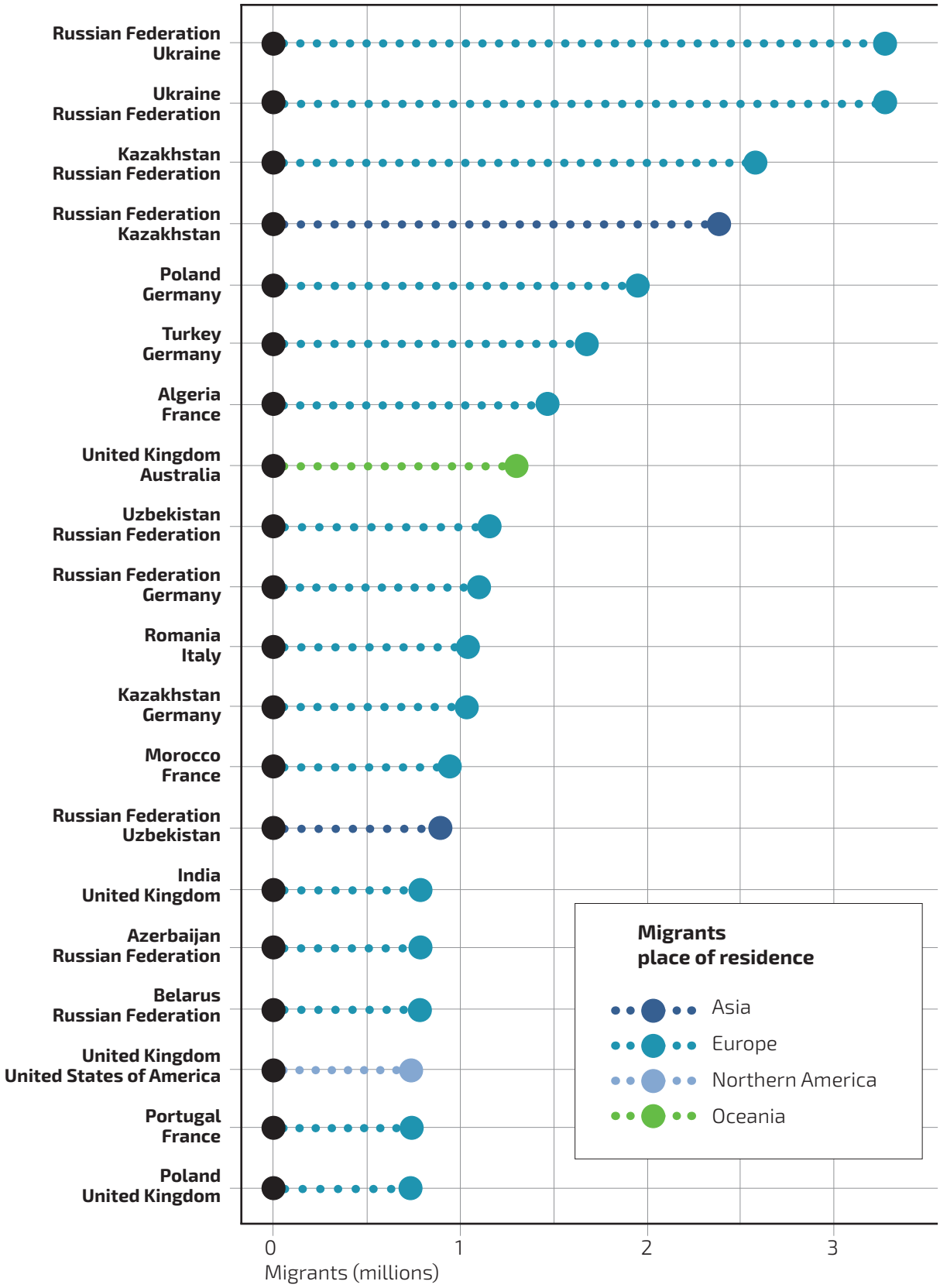
According to the IOM, there were 75 million migrants in Europe[10] (the continent) in 2015, which accounted for nearly 30% of the world's international migrants at the time. More than half of those migrants (40 million) were Europeans, while the others were born in Asia, Africa, Latin America and the Caribbean. Migration within Europe (Europe to Europe migration) was the second largest regional migration corridor worldwide, after Latin America and the Caribbean to Northern America [16]. This means that most European countries are both hosts and sources for migrant populations (Figure 2).

10 Hereinafter the term "Europe" refers to the continent of Europe. In other cases, we refer to certain groups of countries such as EEA, Eastern Europe, EU, etc.

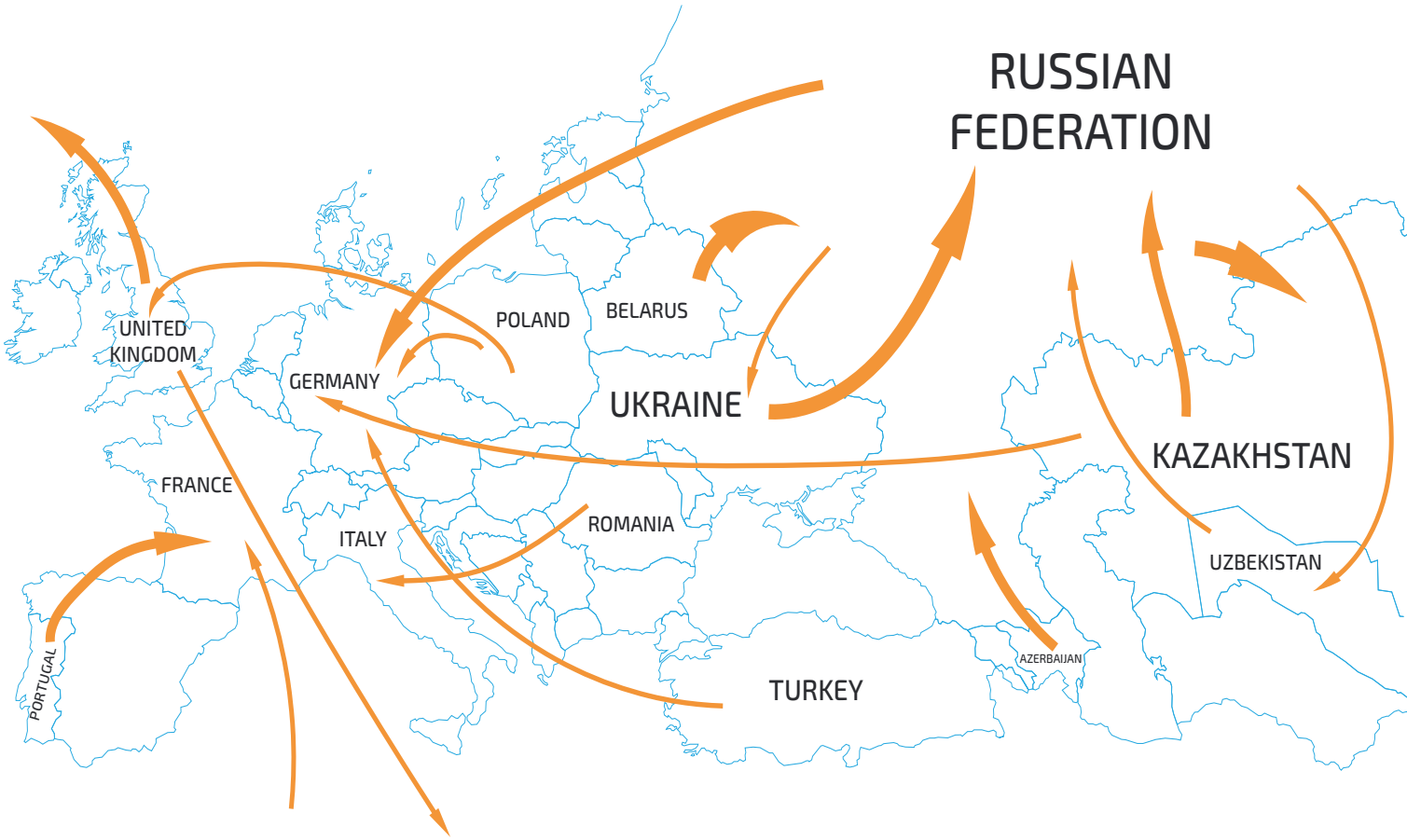
Figure 2. Top 20 European Migrant Countries in 2015

Source: IOM: Global Migration report 2018

Figure 3. Top 20 Migration Corridors within Europe



Source: IOM: Global Migration Report 2018, Chapter 3, p. 28



The dynamics of intraregional migration is largely determined by the border-free Schengen Area, which allows individuals within 22 EU member states and 4 non-EU countries to move freely across borders. Migration issues were of high priority on the European agenda in 2016 and 2017 [16].

Migrants and refugees generally enter Europe through one of three routes: the Eastern, Western, or Central Mediterranean . The IOM reported that in 2015 more than 900,000 migrants, refugees and asylum-seekers entered the EU through the Eastern and Central Mediterranean[11] routes to Greece and Italy. Between 2015 and 2017, migrants flows decreased (18). According to the EU Fundamental Rights Agency (FRA), each year approximately 250,000-300,000 people apply for asylum in the EU. Although the number of applications has fallen, in 2018, there were still 150,000 asylum applicants coming from different parts of the world [6, 32].

The largest source countries of migrants in Europe are Eastern European countries, such as the Russian Federation (RF), Ukraine, Poland and Romania. In 2015, more than 10 million citizens of the RF were living abroad. The number of migrants from certain Eastern European countries is not very high in terms of absolute figures, but is quite high as a percentage of the country's population. For example, 18% of the population of Belarus has emigrated from the country; 15% – from Serbia; and nearly 45% from Bosnia and Herzegovina. Many of the migrants from Southeastern Europe emigrated following the break-up of Yugoslavia [16] (Figure 2).

Figure 3 illustrates the largest migration corridors within Europe. The top two are migration flows between countries of the former USSR: from Ukraine and Kazakhstan to the RF. Other migrant flows to the RF include from Uzbekistan, Azerbaijan, and Belarus. In total, eight of the top twenty migrant corridors within the Europe are interregional and are between countries of the former USSR [16, 63] (see Figure 3).

11 The Central Mediterranean Route refers to the sea journey from North Africa (mainly Libya) to Italy. The Eastern Mediterranean Route refers to the sea crossing from Turkey to Greece, and the Western Mediterranean Route refers to the sea crossing from Morocco to mainland Spain.

Germany was the host country with the largest immigrant population in 2015. Migrants from Poland, Turkey, the RF, and Kazakhstan were the largest groups with more than one million people from each community residing in Germany as of 2015 [16].

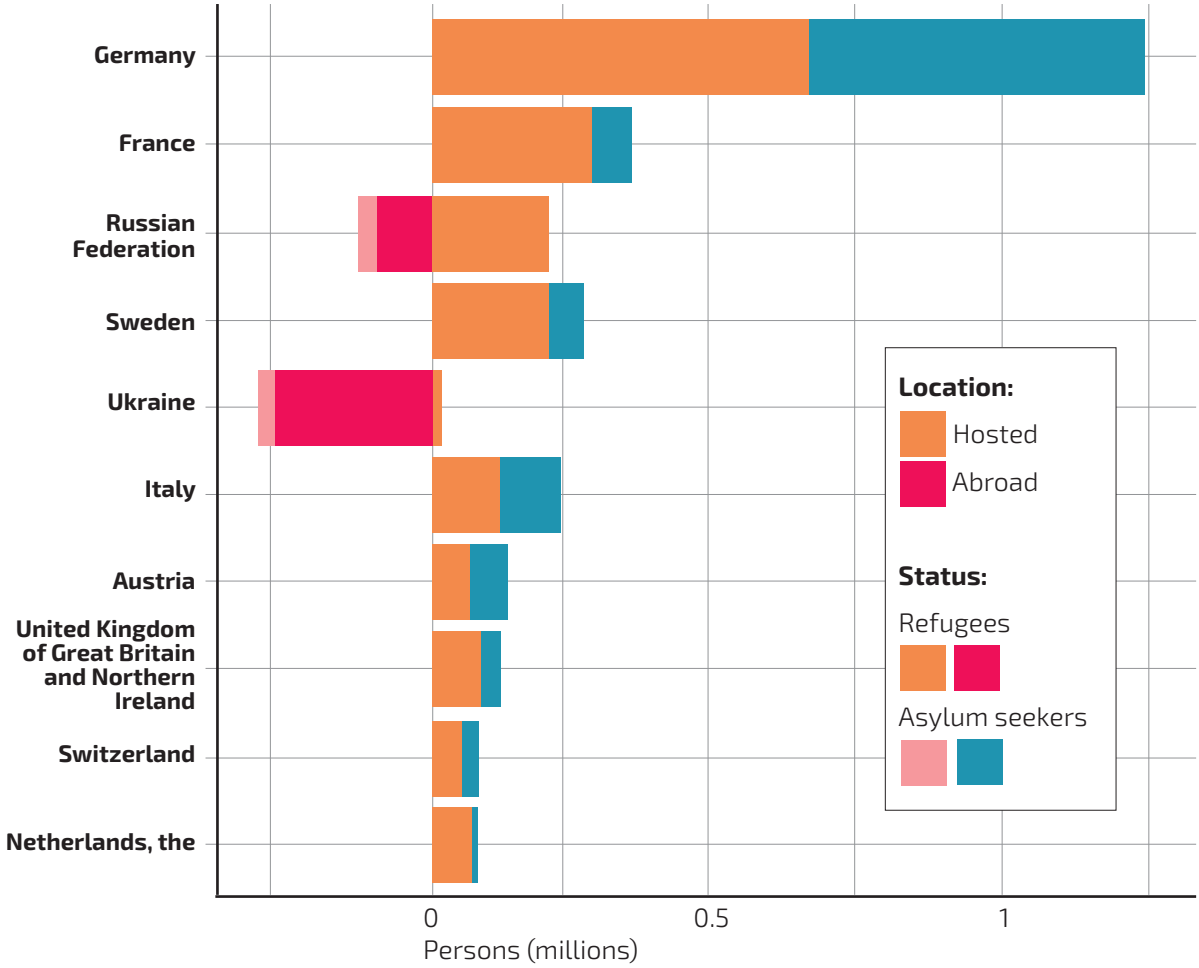
In 2016, the RF had the second largest population of migrants in Europe after Germany, which hosted the largest population of refugees and asylum-seekers in Europe, nearly half of whom were asylum-seekers. In 2016, over 220,000 Ukrainian refugees were resident in the RF, many of whom immigrated after the Ukrainian conflict began in 2013-2014 [16] (see also Figure 4).

In Europe, Germany, Italy and France had the highest number of asylum applications. Since 2015, asylum applications in Germany have sharply declined: 198,300 new applications were received in 2017, which is 73% lower than the 772,400 received in 2016. In 2017, Italy received the second most new asylum applications after Germany [16, 17] (see also Figure 4).

For most Southeastern and Eastern European countries, emigration rather than immigration has been the key feature over recent years and decades. Bosnia and Herzegovina, Bulgaria, Romania, Moldova, and Ukraine are projected to experience very significant population declines by 2050 [16].

Emigration from Eastern to Western Europe has been a growing trend, particularly since the expansion of the European Union in 2004 and 2007 to include new Eastern European member states [16].

Figure 4. Top 10 European Migrant Countries by Total Refugees and Asylum-Seekers, 2016



Source: IOM: Global Migration Report 2018, Chapter 3, p. 29

Ukraine: In Ukraine, displacement within and from the country has increased in recent years, mainly as a direct result of the protracted war against Russian aggression in Ukraine (including the occupation of Crimea and the Donbass region). It remains one the countries in the region most affected by migration and has a large IDP population. At the same time, Ukraine hosts immigrants and refugees from many different countries, and is the main source of immigrants/asylum-seekers in other European countries.

Since the conflict with the RF began in 2014, 1.4 million Ukrainians have applied for asylum or other forms of legal protection in neighboring countries. The ongoing conflict continues to cause large-scale displacement, and has resulted in an IDP population of more than 1.6 million people, according to government registration figures from 2018 [18]. Since 2014, over 400,000 Ukrainians immigrated to the RF. As of 1 July, 2018, 102,000 Ukrainians have received refugee status or temporary asylum. As of 1 July, 2018, there were also 2,650 non-Ukrainian refugees and temporary asylum holders who have received international protection in the RF[12]. According to UNHCR estimates, as of 2019, there are at least 1,700,000 IDPs in Ukraine, approximately 35,000 stateless persons, more than 6,000 asylum-seekers, and over 3,000 recognized refugees. A majority of the refugees and asylum-seekers in Ukraine are from Afghanistan, with others originating from thirty other countries including Syria, Iraq, Armenia, Azerbaijan, Uzbekistan and Somalia. According to HIAS-Ukraine[13], an increasing number of refugees and asylum-seekers in Ukraine originate from other countries of the former USSR.

Central Asia: Migratory flows in Central Asia are primarily out of the region, and mainly to the RF. In 2015, 5 million migrants in Central Asia were living in the RF. Today, the migration flow has slowed since the RF introduced several policy changes, such as re-entry bans on migrants. EU economic sanctions on the RF also make it less attractive to migrants from Central Asia. This has affected income generated through remittances[14], and some Central Asian migrants have either returned to their country of origin, remained illegally, or have migrated to Kazakhstan. Other popular destinations for people from Central Asia include other European countries and China. For example, in 2015, there were 1 million migrants from Kazakhstan residing in Germany. Migrant workers from Central Asia are often vulnerable to exploitation and abuse, particularly when engaged in informal employment such as construction, agricultural and domestic work [16, 63].

At the same time, Central Asia is home to millions of international migrants, mainly from the countries of the former USSR, some of which are current member states of the Commonwealth of Independent States (CIS). In 2015, Kazakhstan had a foreign-born population of 3.55 million, out of which 2.35 million were born in the RF [16].

Kazakhstan attracts skilled workers from various countries, as well as migrant workers from Kyrgyzstan, Tajikistan, and Uzbekistan. Such migration has been stimulated by recent policy changes, such as revised bilateral agreements on entry and readmission, and the establishment of the Eurasian Economic Union in 2015, which allows people from its member states, including Kazakhstan and Kyrgyzstan, to freely live, work and study in other member states [16].

Kyrgyzstan and Tajikistan are among the top 10 remittance-receiving countries worldwide relative to their GDP[15]. Remittance flows into Central Asian countries from the RF, for example, largely reflect migration patterns within and from the region, which are closely linked to labor and income generation. Between 2014 and 2015, remittance levels to Kyrgyzstan decreased by nearly 50 percent, and by nearly 60 percent to Uzbekistan, while personal money transfers from the RF to Tajikistan dropped by nearly 70 percent [16].

12 http://reporting.unhcr.org/node/41
13 HIAS-Ukraine Website
14 A remittance is a transfer of money by a foreign worker to their family and relatives in their home country. Money sent home by migrants is one of the largest financial inflows to developing countries.
15 Gross Domestic Product is a monetary measure of the market value of all the final goods and services produced in a period of time.

Migration Policies in Europe Are Criticized

One of the reasons for the decreasing flow of migrants to Europe may be border and migration regulations. The migration policies of EU countries are often criticized for their restrictive approach. Most EU countries are struggling between attempts to meet the survival needs of migrants and protecting their own labor markets. Some experts suggest that immigration restrictions are exacerbating existing problems rather than resolving them. Some experts believe that addressing underground labor markets that lead to illegal migration would be more effective than pursuing illegal migrants or refusing asylum-seekers. Other recognized shortcomings in EU migration policy is the lack of uniformity across countries, the absence of a common European Asylum system, and the subsequent lack of a coherent approach to dealing with asylum claims. Some believe that the refugee crisis in the EU is more of a result of failures of the political leadership of the EU rather than of its capacity to manage the situation [19, 20, 21].

Although some EU countries have shared standards on migration, the official treatment of refugees and migrants, as well as the understanding of the concept of solidarity largely vary across European countries. The UNHCR has noted that the standards and practices of some EU member states are not in agreement with international law [18]. Eastern European countries that serve as entry points or corridors for migrants are often criticized for their lack of capacity and their unwillingness to welcome refugees, asylum-seekers and LGBT migrants [21]. Such criticisms have been raised in relation to Bulgaria, Serbia, Albania, Czech Republic, and Poland and their rigid approaches to migration, and low capacity and inexperience in dealing with ethnic, cultural, and other minorities [18, 21, 22, 23, 24, 25].

This recognized lack of a standardized approach in dealing with asylum-seekers [19, 20] specifically affects LGBT people, and those who make SOGI-based asylum claims. The fragmentation and other shortcomings of European asylum policies affect LGBT migrants in many different ways. The following section describes specific issues related to SOGI-based asylum applications in EU countries.

LGBT Migration & Asylum Claims

In many countries worldwide, homosexuality is stigmatized and may even be a criminal offense. Under EU law, persecution based on SOGI is a ground for international protection. LGBT individuals persecuted in their countries of origin are eligible to receive refugee status under the Refugee Convention and EU asylum law. The first-ever refugee claim based on SOGI was approved in 1980 [26].

The United Nations Convention Relating to the Status of Refugees is grounded on Article 14 of the Universal Declaration of Human Rights (1948), which recognizes the right of a person to seek asylum from discrimination, oppression or maltreatment in another country. The Convention protects those who have escaped situations, in which their identity, dignity or freedom was violated [27]. Recently, the UNHCR has published new guidelines on asylum claims based on SOGI, which represents a progressive step in acknowledging the problems faced by LGBT, and is an expression of the political will of the international community to strengthen protections of the rights of LGBT communities worldwide [6, 62].

Over the past decade, international organizations specializing in LGBT rights, migration, and specifically in SOGI-based asylum claims have expressed increased awareness about the reality of people who must flee their countries based on SOGI, and work to provide guidance to relevant institutions [6].

Since 2007, growing attention has been paid to the rights of LGBT individuals. The 2007 Yogyakarta Principles explained how human rights norms should be interpreted in relation to SOGI. International organizations have published a number of key documents/excerpts that highlight the issue of LGBT rights:

- United Nations Human Rights Council's July 2011 Resolution 17/19 expressed "grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity";

- Resolution 1728 adopted by the Parliamentary Assembly of the Council of Europe in April 2010 calls on member states to "recognize persecution of LGBT persons as a ground for granting asylum";

- European Parliament resolutions from September 2011 and February 2014 recall, respectively, the "obligation to protect or grant asylum to third country nationals escaping or risking persecution in their country of origin on the basis of their sexual orientation" and the need to "include specific issues linked to sexual orientation and gender identity in the implementation and monitoring of asylum legislation."

- A European Parliament resolution of 4 February, 2014 outlined an EU roadmap against homophobia and discrimination on the grounds of sexual orientation and gender identity, and called for the systematic documentation of the legal and social situations of LGBT persons in their countries of origin and for this information to be made available to asylum decision-makers as part of country of origin information (COI).

In December 2015, the UNHCR launched «Protecting Persons with Diverse Sexual Orientations and Gender Identities», the first global overview of the progress it has made in protecting LGBT asylum-seekers and refugees. The report recognizes that LGBT individuals have more issues than other forced migrants/asylum-seekers due to their SOGI. It also identifies gaps, and notes that the criminalization of homosexuality is a serious barrier to protecting the rights of LGBT people worldwide [3].

ILGA-Europe and its partner organizations across Europe are working to protect LGBT asylum-seekers, and to raise awareness about the additional difficulties LGBT asylum-seekers face because of their SOGI. For example, having escaped from persecution because of their SOGI, LGBT asylum-seekers are often at risk of additional dangers during their journey, and upon arrival in the country where they seek asylum, including harassment, exclusion, sexual violence, or other forms of violence [6].

The European Union Agency for Fundamental Rights (FRA) regularly reports on migration-related fundamental rights concerns in those member countries that are affected by large migration movements. The European Commission asked the FRA to collect data about LGBT asylum-seekers arriving to EU countries, in particular to those affected by large migration flows (Austria, Bulgaria, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Netherlands, Poland, Slovakia, Spain and Sweden). In 2017 in response to this request, the FRA developed a special report on how SOGI-based asylum applications are assessed and analyzed, and examined the specific problems related to this type of asylum application. The report shows that LGBT asylum-seekers face multiple forms of discrimination, asylum officers are often ill-equipped to deal with these types of applications, and that existing policies are not always supportive [6].

Specific Problems of LGBT Asylum-Seekers

A strong body of evidence suggests that, during displacement and resettlement, LGBT people face increased threats and are often discriminated against by border officials, and that additional action is needed to improve the legal environment for the protection of LGBT asylum-seekers [26, 28, 29, 30].

LGBT asylum-seekers usually conceal their SOGI in order to avoid discrimination and violence from other refugees, the local community, or from state authorities. As HIAS' study found, a significant number of asylum-seekers may be unaware that their experience of persecution is a legitimate ground for seeking international protection [12].

As mentioned earlier, the EU does not have a unified system for reviewing asylum applications, which also affects the handling of SOGI-based claims. Differences in national policies and approaches lead to various challenges for LGBT people. ILGA notes that such challenges may include the credibility of asylum-seekers, late disclosure of SOGI during the asylum process, incomplete or incorrect COI, low capacity and lack of expertise of immigration officers and translators, and poor conditions in reception facilities [42]. With the exception of the Netherlands, Sweden, and the United Kingdom, most European countries do not have explicit and publicly available guidelines about how they handle the asylum applications of LGBT people. There are different challenges faced by EU countries when reviewing claims based on SOGI, for example, questions and credibility assessment [6].

The FRA report examines some contradictions and challenges related to asylum decisions for LGBT people. For example, asylum officers in some countries (Denmark, Hungary, Italy) do not ask questions related to sexual orientation unless the applicant mentions this as a ground for the asylum application. The idea underpinning such an approach is that questions related to the details of an applicant's sexual practices violate the fundamental right to respect for private and family life. Moreover, the Court of Justice of the European Union (CJEU) instructs that assessments of SOGI-based asylum claims should be consistent with other rights guaranteed by the Charter (the rights to human dignity, respect for private and family life). Therefore, "the assessment of claims for international protection must examine the applicant's individual situation and not be based only on stereotyped notions". However, NGOs argue that there are significant shortcomings in the way that eligibility interviews are conducted, [6] which is confirmed by the need to train officials and translators on how to sensitively handle interviews for SOGI-based asylum claims [2, 3, 6].

According to the FRA report, one of most challenging aspects of assessing SOGI-based asylum claims is proving the sexual orientation of the applicant. Most EU member states do not have specific national guidelines for interviewing LGBT persons. NGOs protecting the rights of LGBT people in different European countries express concerns about how eligibility interviews are conducted, and about how SOGI-based applications are handled. Asylum officers often have stereotypical views on SOGI. In most EU member states, there are no special accommodation facilities for LGBT people. In cases of abuse or harassment, they can be transferred to single rooms, but no preventive measures are taken. There is an obvious need to provide special sensitivity training to asylum officers on the vulnerabilities of LGBT people. Informational leaflets provided by NGOs to LGBT asylum-seekers are usually available, but are not translated into all relevant languages. Guidelines on the provision of specific medical interventions (e.g. hormonal treatment) to trans people who have already begun treatment in their countries of origin are insufficient. The interruption of treatment in such cases can have severe consequences [6].

Central and Eastern European countries are bound by international standards concerning refugees and asylum-seekers, but continue to struggle in handling SOGI-based asylum claims. The practices of national asylum authorities in this region related to SOGI-based claims fall below international standards. Research published in 2011 found that authorities in Central and Eastern Europe only occasionally have to deal with LGBT asylum claims. Given the low number of LGBT asylum-seekers in the region, the relevant national authorities lack expertise in dealing with such claims, and may easily err in assessing the individual circumstances of applicants and the objective situation in countries of origin. In addition to low levels of awareness and a lack of guidance, authorities in these countries may have some "cultural hostility" towards LGBT people. Authorities in these countries have been criticized for abusive credibility assessments and discretion requirements, and for inconsistent approaches to assessing asylum claims. Articles published on the Forced Migration Portal in 2013 criticize Kosovo, Albania, Poland, and Bulgaria for the inappropriate handling of SOGI-based asylum claims. EU immigration requirements may clash with local, conservative cultures, which may result in slow changes in practice despite existing legal developments [14, 21, 23, 25, 33].

3. WELL-RECOGNIZED GAP: STATISTICS ON LGBT MIGRATION

According to the report published by European Union Agency for Fundamental Rights (FRA) in March 2017, there are no official statistics on the number of SOGI-based asylum claims. The report covered 14 European countries[16] (with high migration flows), none of which keep statistics on SOGI-based asylum claims and decisions. The FRA explained that data on the grounds on which asylum claims are based is generally not collected [6]. Currently, Belgium has the most comprehensive and reliable data on asylum-seekers that is publicly available [42]. The Commissioner-General for Refugees and Stateless Persons (CGRS) publishes statistical reports on a monthly basis, and provides information on the number of asylum applications and first-instance decisions[17]. The data is disaggregated by countries, however, LGBT-related data is grouped with other data under the category "members of a particular social group", meaning that it is not possible to track the number of SOGI-based asylum claims. The FRA report states that Belgium and Norway are the only countries that track decisions based on SOGI-based asylum claims [6]. However, we assumed that this information is not publicly available, as we were unable to find such information online.

The lack of comprehensive data on LGBT migration has been already recognized. Opinion 3.5 of the 2018 FRA report states that "EU institutions and EU Member States are encouraged to continue supporting and funding the collection of reliable and robust equality data by EU agencies and bodies, national statistical authorities, national equality bodies, other public authorities and academic institutions. In addition, EU Member States are encouraged to provide the Statistical Office of the European Union (Eurostat) with robust and reliable equality data, so as to enable the EU to develop targeted programmes and measures through which to foster equal treatment and promote non-discrimination. Where possible and relevant, the collected data should not only be disaggregated by sex and by age, but also by ethnic origin, disability and religion" [2].

The paucity of available statistics remains a significant challenge. The number of LGBT asylum-seekers and refugees is not known since many LGBT people do not reveal their true circumstances and do not claim asylum on the ground of SOGI due to fear and discrimination [12].

The 2017 FRA report notes that virtually no information exists on intersex asylum-seekers, and that there are no official statistics on the number of SOGI-based asylum claims [6].

However, it is clearly recognized that reliable information on the number of people, age, geographical location, etc. is vital for planning relevant activities, and that the lack of data is a barrier to developing targeted programs and services for LGBT people [6, 17, 62].

16 Austria, Bulgaria, Denmark, Finland, France, Germany, Greece, Hungary, Italy, The Netherlands, Poland, Slovakia, Spain, Sweden.
17 https://www.asylumineurope.org/reports/country/belgium/statistics; https://www.cgra.be/en/figures

4. LGBT MIGRANTS AND HEALTH DISPARITIES

LGBT People and Health

Social and structural stigma against LGBT communities greatly influences their increased vulnerability to health-related problems. A review of grey and academic literature demonstrates that gay, bisexual and other MSM are especially vulnerable to HIV and other STIs, and to developing mental health disorders. The health issues of lesbian and trans people are less explored, and examinations of the health-related concerns of these groups is rarely found in grey and medical literature.

This review demonstrates that, in general, LGBT health is viewed from two different perspectives: one is a human rights-based approach, which emphasizes the disparities between LGBT people and the general population. These disparities are caused by unfair treatment (stigma, discrimination), and the resulting limited access to healthcare, which leads to the increased individual vulnerability of LGBT people. The other approach views LGBT health from a public health perspective, considers SOGI as social determinants of health, and focuses on the higher prevalence of HIV and other STIs, and mental disorders among LGBT sub-groups.

In order to address the health problems specific to the LGBT population and to find the most effective solutions at the individual and public health levels, it is important to understand the synergies between these two approaches. In particular, key issues include: how social and structural stigma can contribute to the increased vulnerability of LGBT people to certain diseases; how low access to targeted services can act as a barrier to the realization of the right to health; how human rights restrictions can increase people's vulnerability to diseases; and finally, how and why these vulnerabilities affect public health indicators, i.e. HIV epidemics.

SOGI are social determinants of health and there is a strong correlation between SOGI and health disparities between individuals. Sexual orientation is an important predictor of access to health care and the health status of a person. Several studies have demonstrated that LGBT people have lower access to healthcare than heterosexual people [34-39]. For example, women who identify as lesbian have lower rates of cervical cancer screening than those who identify as heterosexual [19]. Meanwhile, gay, bisexual and other MSM are disproportionally affected by HIV [34, 37].

A study of the global epidemiology of HIV infection among MSM published in Lancet in 2012 argues that HIV epidemics among MSM are expanding in countries of all income levels, and that these epidemics are characterized by high HIV burdens among this specific population [37]. Another study carried out among native-born Swedes confirmed that LGBT people have lower levels of access to healthcare than the general population, even in high income countries like Sweden. The study concluded that disparities related to sexual orientation are determined by an unequal distribution of resources, such as knowledge, prestige, power, and other supportive social connections. The sampling approach used in this study helped to exclude general challenges, which affect LGBT people residing in developing countries and are difficult to separate from LGBT-specific challenges. These factors include social, financial and legal insecurities, lack of awareness, and the absence of specific services or information, all of which affect the entire population to a certain extent [34].

The study therefore provides evidence of substantial health disparities between LGBT people and heterosexual individuals that affect multiple health outcomes, and exist in countries of all income-levels. However, disparities between so-called 'advantaged' and 'disadvantaged' groups are greater for preventable diseases than for non-preventable diseases. The study also confirmed that most diseases or conditions developed by LGBT people due to health inequalities are preventable [34].

When the level of access to services for LGBT populations is significantly lower for communicable diseases (i.e. preventable diseases), it can be assumed that the problem may be their unwillingness to disclose their SOGI. A number of studies has confirmed that nondisclosure of SOGI is one of the negative factors that affects healthcare for LGBT individuals. A study conducted in both countries where homosexuality is legal and ones where it is illegal confirmed that possible barriers to disclosing SOGI at healthcare institutions can include an unsupportive community, fear of discrimination, breaches in patient confidentiality, refusals by healthcare professionals to provide treatment, informing police about a patient's SOGI, as well as fears of being abandoned by the community. The WHO confirms that it is a widespread phenomenon in many countries worldwide that healthcare professionals are insensitive to the needs of LGBT people and lack necessary professional training, in particular expertise in dealing with the conditions of trans people [35, 41].

Although the literature review demonstrates that LGBT people experience similar health disparities worldwide, the extent of such disparities and vulnerabilities is still strongly connected to the level of the social and structural stigma that exists in a country. It is important to emphasize that social and structural stigma are interconnected: social stigma and prejudices towards homosexuality can be seen as a reflection of discriminatory laws in the country, i.e. social stigma can illustrate the extent to which countries promote the unequal treatment of MSM through discriminatory laws [40].

In highly homophobic contexts, targeted services for LGBT people are generally unavailable, or are inadequate or unfriendly to LGBT patients [1, 8, 41]. Homophobic, sexist and transphobic attitudes expressed by society, governments, or healthcare institutions may deter LGBT people from seeking services. For example, in many countries, trans people face particular difficulties in accessing healthcare services (1, 8). MSM living in countries with high levels of stigma have lower detection rates for HIV, high levels of risky sexual behavior, unmet prevention needs, lower rates of testing, and often do not disclose their sexuality during testing out of fear of discrimination or violence. This is confirmed by a rigorous study that explored the impact of country-level stigma on HIV detection rate, sexual opportunities, and access to HIV prevention services on 174,209 MSM migrants across 38 European countries [40].

Although the majority of the countries of Eastern European and Central Asia do not criminalize same-sex sexual conduct, and have adopted antidiscrimination laws, there remains acute anti-LGBT attitudes among most segments of society. Widespread homophobia among government officials and healthcare workers makes it extremely difficult to advocate for financing and developing targeted services for LGBT people, and to advocate for relevant policy changes [8].

Empirical evidence (cases) collected through direct observation or experience by members of the Eurasian Coalition on Male Health (ECOM) representing five countries[18] illustrated how violations of the right to health of gay men, other MSM and trans people actually affects these communities. An analysis of the data showed that high levels of stigma towards LGBT communities in all five countries result in various mental health conditions and increased levels of internalized homonegativity [8, 61]. Most LGBT people tend to hide their medical and psychological problems, and prefer not to seek support and health services [8]. These conclusions are in line with academic research finding that assert that higher levels of structural and social stigma in a country is associated with lower access to HIV prevention services. In other words, restricting the public visibility of MSM makes them more vulnerable to HIV infection [40].

Anti-LGBT stigma makes individuals more vulnerable to other non-LGBT-specific factors, such as risky sexual behavior and substance abuse. There is a growing body of research on internalized homophobia that demonstrates the interrelation between the factors discussed above and self-stigmatization [11, 61].

18 Armenia, Belarus, Georgia, Kyrgyzstan and North Macedonia.

The literature review showed that in countries with high levels of homophobia the freedoms and entitlements related to the right to health are not ensured for LGBT populations. The criminalization of homosexuality and homophobic attitudes in society can significantly limit the realization of the right to health of LGBT people in two main ways: 1. fear of discrimination or violence and of breaches in confidentiality may discourage individuals from seeking existing health services; 2. national health systems and policies do not address the specific needs of LGBT people, which results in either the absence or the inadequacy of targeted services for these populations [1, 8].

Realization of the right to health of LGBT people in EECA countries is limited by a number of interconnected factors, including: widespread SOGI-based discrimination, negative attitudes or aggression expressed by society, medical personnel, and state officials, as well as the low quality or absence of targeted health services. ECOM's study confirmed that, in most EECA countries, these problems are largely determined by gaps in antidiscrimination legislation and in legal recognition of gender identity. Health disparities affecting LGBT people in the EECA region are further exacerbated by the general problems of national healthcare systems, the criminalization of HIV transmission, and negative attitudes towards LGBT patients [8].

KEY DEFINITIONS & CONCEPTS

Health
The Constitution of the World Health Organization (WHO) [31], defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The document assigns to governments the responsibility for the health of their populations.

Right to Health
The International Covenant on Civil and Political Rights defines the right to health as "the highest attainable standard of physical and psychological well-being".

Freedoms and Entitlements to be ensured by Governments
The right to health [43] is an integral component of international human rights law and establishes norms for governments in two main directions: 1. Freedoms: freedom to control one's health and body, for example, sexual and reproductive rights, or to be free from torture and non-consensual medical treatment and experimentation; 2. Entitlements: the right to a system of health protection that provides everyone with adequate health and social measures, the equal opportunity to enjoy the highest attainable level of health" (WHO) [31, 43].

The WHO has recognized the vulnerability of LGBT people, and has stated that key populations are disproportionally affected by HIV in most countries and settings. According to the WHO, these populations are vulnerable to HIV due to legal and social factors, and because of the inadequacy of services. In such settings, even when the overall HIV incidence declines, it can remain high or even increase among key populations [41]. ECOM's research has confirmed that LGBT people in EECA have similar problems, and are highly vulnerable to HIV for the same reasons described by the WHO [7, 8, 41].

Pushing LGBT communities underground contributes to the increased vulnerability of LGBT people to HIV and other STIs [1]. Unfortunately, HIV incidence is increasing in most countries of the EECA region with HIV prevalence among MSM at than 5%, which can be considered a concentrated epidemic [44]. The vulnerability of trans people in the region can only be estimated, as data on HIV prevalence among this community is not available [8].

Among the suggested solutions to address the health disparities faced by LGBT communities is improving the awareness of healthcare professionals of their patients' sexual orientation. Healthcare professionals should be aware of the multiple factors that influence disclosure of sexual orientation, and the potential negative impact of non-disclosure on providing care. A welcoming environment, healthcare professionals' communication skills, both verbal and non-verbal, are considered important factors [8, 35].

Another solution to address disparities is improving data collection methods. Although it is recognized that sexual orientation and gender identity are predictors of health outcomes and can affect access to healthcare services, in many countries, relevant data is rarely collected by healthcare organizations. Evidence suggests that questions related to SOGI include a variety of response options with definitions. In addition to defined responses, "Identity not listed (please specify)" could also be included as a response. The patients should be asked about the sex they were assigned at birth (male or female), and about their current gender identity. Several sources also noted that providing relevant training to increase the awareness of staff about SOGI-related issues is important [6, 36, 42].

Migration and Health

People migrate for different reasons: displacement can occur due to armed conflict in a country, or as a result of natural disaster; some people may migrate to search for jobs and better economic opportunities. There are significant disparities between different groups of migrants in terms of their status, living conditions, and economic opportunities. For example, asylum-seekers, refugees and IDPs are often limited by their legal status; some of them may live in camps or collective settlements, often in extremely poor conditions. A migrant's status determines their access to healthcare. For example, illegal migrants are often denied even basic services. However, regardless of the reasons for migration, the conditions under which someone migrates, or any status-related problems, the issues migrant populations face make them especially vulnerable to health-related problems [40, 45, 46, 47].

The stress connected to any form of displacement is exacerbated by structural stigma against migrants, which exists to a certain extent in most host countries (15). Adapting to a new culture, structures and systems in host countries takes time and can be a stressful process, especially if the migrant does not speak the local language, which is proven to be an important factor in allowing migrants to better utilize support services. These factors can all influence the physical health and psychosocial well-being of migrants, and can increase their risks of HIV, TB, and mental and other diseases in many different ways [45].

Mobile populations are often overlooked by host countries. This may be due to assumptions that these groups will not stay long, or to a failure to understand how the needs of migrants are different than those of the local population. UNAIDS states that forced migrants are often overlooked in the HIV policies of host countries, even though such policies are aimed at ensuring universal access to HIV services for vulnerable groups [45, 47].

Macro-social, economic and political determinants greatly influence people's vulnerability to HIV infection, and include factors, such as poverty, gender inequality, population mobility and conflict [49]. Migrants are not always welcomed in host countries. Refugees, asylum-seekers and other migrants, legal or illegal, are treated as "others". The study shows that such attitudes towards migrants have a negative impact on health outcomes at all levels, and on individuals, communities, and the public health of the country in general [46].

The WHO devotes significant attention to the health of migrants and closely cooperates with the IOM and local ministries of health to develop and implement relevant strategies, as well as to overcome existing problems that are exacerbated by increased migration related to globalization, war and conflict, economic opportunities, etc. In 2010, the WHO called for greater collaboration in monitoring the health of migrants, developing migrant-sensitive health policies, and in promoting the inclusion of migrants in national health and social programs [47].

There is a large number of different sources claiming that migrants are at high risk of HIV infection. For example, a study that analyzed 156,817 HIV cases reported to the European Surveillance System between 2007-2012 revealed that 38% were migrants from different regions, more than half of whom were from Sub-Saharan Africa, 12% from Latin America, 9% from Western Europe, 7% from Central Europe, 4% from Eastern Europe, and the rest from Asia, the Caribbean, and the Middle East [55]. A systematic review of the studies carried out between 1997 and 2014 showed that migrants from

low- and middle-income countries are at a heightened risk of HIV infection. The vulnerability of these migrants can be decreased by providing HIV testing services, however, migrants face significant barriers to receiving testing and counseling services at the individual, social, and structural levels [51].

It is generally believed that if a person with HIV migrates from a country with high HIV incidence, then they were infected in their home country. However, a systematic review of 27 studies has demonstrated that the post-migration acquisition rate of HIV is quite high in the EU and EEA, and is significantly underestimated. Therefore, migrants have a high risk of HIV infection in host countries, regardless of whether they come from a country with generalized HIV epidemics. A systematic review demonstrated that post-migration acquisition of HIV ranges between 2-62% among different European countries, and that MSM have the highest risk of HIV infection in host countries [52]. Another review confirms these results. A systematic review and meta-analyses of the sexual behavior of international migrants examined global literature on the relationship between acculturation and HIV-related sexual behaviors, and concluded that acculturation can increase the risk of HIV infection for migrants after migration [53].

The most recent event organized in the EECA region on the crosscutting theme of migration and health, was held in the RF. Civil society called upon the government to reconsider its policy on HIV-positive migrants in the RF. According to this policy, the country does not allow HIV-positive migrants to enter the country. If HIV infection is confirmed while a migrant is in the country, they then face deportation. According to CSOs, such an approach forces HIV-positive migrants to hide their status, which has negative effects on the epidemiological situation. To resolve this issue, CSOs suggest that the HIV-related migration policies are liberalized, and that investments are made in prevention programs for the migrant populations[19]. These recommendations are in line with the approach of international organizations. Existing evidence demonstrates that restrictive legislation forces key populations underground and exacerbates the epidemiological situation [3, 54, 62].

LGBT Migrants and Health

Migrants who are sexual minorities are potentially affected by social and structural stigma in their native countries, and by two forms of stigma in their host countries – stigma directed towards sexual minorities and stigma directed towards immigrants [54]. In previous sections, we separately reviewed the health vulnerabilities and risks specific to both LGBT people and to migrants. The majority of health studies examine the effects of anti-LGBT and anti-migrant stigma separately, and demonstrate that homophobic structural stigma[20] negatively affects the health of LGBT people, and that anti-immigrant stigma adversely affects the health of immigrants (54). However, there are very few studies that examine the influence of both types of stigma on LGBT migrants. Very few of the studies that do attempt to examine these issues use a rigorous methodology and use a large population sample [9, 40, 54].

LGBT asylum-seekers, refugees or migrants are part of so called "intersectional" groups. There is limited research on the health issues of the intersectional group of LGBT-migrants that examines how double stigma affects LGBT people who are migrating to another country. No studies on the health of LGBT-migrants were conducted in the EECA region, however, some studies do examine how this intersectionality affects the health of LGBT migrants in general. These studies mainly deal with two major health issues faced by LGBT migrants: HIV and a wide range of mental health disorders, which may lead to further issues, such as drug use and difficulties related to social integration and obtaining legal status in host countries [54-57, 60].

When discussing health disparities related to LGBT people, it is important to distinguish between different determinants of health disparities, including individual factors, such as SOGI, migration status (asylum-seeker, refugee, or other type of migrant), level of personal education, and knowledge of the language of the host country, and other contextual factors, including the social attitudes and level of structural stigma[21] towards sexual minorities in the country of origin and in the host country, and the

19 Resolution of the first meeting of CSOs in EECA on migration and health issues, Moscow, 27-29 April, 2019
20 Structural stigma is defined as a set of law and policies promoting the unequal treatment of an oppressed population.
21 Measured by discriminatory laws

level of development[22] of the country of origin and host country [54, 58]. Each individual may be affected by a different combination of multiple factors. Therefore, the health risks of LGBT migrants can vary depending on the situation, but in general, are quite high.

Public health studies that examine multiple factors suggest that health risks are higher for groups that are marginalized for two or more reasons (for example, SOGI and ethnicity, or SOGI and migrant status). As part of this review, we came across two different theories to explain the increased risks of intersectional populations: syndemic impact [55] and intersectionality [58]. Evidence confirms that people who belong to two marginalized groups experience double social and structural stigma, which puts them at higher risks for health problems specific to each particular group. Therefore, the prognosis and burden of any disease is exacerbated for intersectional populations [55, 58]. The study of intersectionality has the potential to enrich public health research by improving data quality, and by providing increased attention to the heterogeneity of influences and causality of health disparities [58].

Public health research suggests distinguishing between the causes of one specific medical condition (i.e. HIV, mental health disorders, etc.) for individuals and the causes of the same condition for populations. Even in cases where the causes of an individual disease are the same (e. g. the same virus, the same individual genetic or environmental susceptibilities), the incidence or prevalence of the disease among population groups is influenced by various socio-demographic factors, such as social inequalities and social policies and practices, which are determinants of incidence rates for the population. In most studies, disparities are generally documented based on one specific factor, such as SOGI, ethnicity, or migration status. Researching inequalities related to intersectional populations improves understanding of their situation and measures aimed at addressing their needs [58].

Evidence shows that health disparities are observed among both internal and international migrants. For example, a study conducted among young gay and bisexual men in New York City showed that individuals who move to urban settlements in order to escape social stigma and achieve greater sexual and social freedom have increased risk of HIV infection, substance abuse, and depression compared to heterosexual individuals of the same background. The study described these disparities as a "syndemic"[23] effect that is determined by two factors: marginalization due to SOGI and migrant status [57].

Recent large-scale research has concluded that structural stigma toward migrant sexual minorities (MSM) (in countries of origin and in host countries towards MSM, and in host countries towards migrant-MSM) is a modifiable determinant of the global HIV epidemic [54]. LGBT migrants who belong to ethnic minorities, who do not speak the language of host countries, and who come from countries with higher levels of structural and social homophobic stigma, are at higher risk in comparison to those who migrate from less restrictive countries and who speak local languages [54, 56, 57].

A study on the impact of structural stigma on a large and geographically-diverse sample of MSM migrants from 181 countries who migrated to 38 host countries confirmed that structural stigma in host countries and countries of origin is a potential barrier to effective HIV prevention for MSM-migrants (i.e. an intersectional population). The study examined linguistic status, time since migrating, and five HIV-outcomes: coverage by HIV prevention services, knowledge about HIV transmission, and use of prevention measures, including condom use[24]. The study used a rigorous methodology, and is based on the European MSM Internet Survey (EMIS)[25], which is the largest dataset on MSM [9, 54].

22 Measured by GINI-index

23 A syndemic or synergistic epidemic is the aggregation of two or more concurrent or sequential epidemics or disease clusters in a population with biological interactions, which exacerbate the prognosis and burden of disease

24 These outcomes are based on recommendations of the United Nations' General Assembly Special Session (UNGASS) on HIV/AIDS (Joint United Nations Programme on HIV/AIDS, 2009) and the European Centre for Disease Control (ECDC, 2009).

25 The dataset covers over 23,000 MSM migrants from 181 countries. The majority (56.5%) of respondents were born in Europe; 13.8% were born in Asia; and 10.8% were born in South America. The most common countries of origin were Germany (8.9%), Brazil (5.1%), and the United States (5.0%). The most common host countries were the United Kingdom (20.4%), Germany (18.9%), and Spain (12.3%).

What makes both the dataset and the study unique is that no other dataset previously developed covers such a large number of MSM migrants, examines a wide range of contextual variations related to structural stigma in the countries of origin and host countries of respondents, or combines the effects of both types of structural stigma (related to sexual orientation and immigration). Thus, this dataset provided an unprecedented opportunity to researchers to examine the links between various health determinants, overcoming a problem of previous similar studies that relied only on self-reporting by MSM to assess levels of structural stigma [54].

The rigorous methodology of the study allowed researchers to separate the effects of general structural inequality, which is more country specific, from the effects of inequality that specifically affect sexual minorities or immigrants. Therefore, the links between structural stigma and HIV-related outcomes were controlled for by taking into account the Gini coefficient, an income inequality index, of each host country and country of origin. The study also controlled for whether respondents migrated from Europe versus from another continent [54].

Structural stigma towards sexual minorities and immigrants is linked with low access to HIV-prevention services, lack of knowledge about HIV transmission, and higher levels of risky behavior [54]. The social isolation of sexual minorities is associated with lower rates of drug use, but with higher levels of mental health problems. Higher income levels lower HIV and mental health risks, but increase levels of alcohol consumption. Interpersonal stigma and discrimination in hometowns increase all health risks, however structural stigma in hometowns lower the risk of drug use [57].

Anti-LGBT structural stigma in countries of origin may affect HIV prevention among LGBT migrants upon arrival in a new country. Knowledge of the language of the host country can affect outcomes for LGBT migrants. For instance, anti-immigrant structural stigma is associated with greater coverage by HIV prevention services and HIV testing, and with higher rates of disclosure of sexual orientation only for those migrants who the language of the host country [54, 56]. Newly-arrived MSM migrants have higher levels of knowledge about HIV prevention and about risky sexual behavior than those who have lived in the country longer, especially in anti-gay and anti-immigrant host countries [54].

LGBT asylum-seekers who migrate from countries with high levels of homophobia and structural stigma, have probably experienced persecution from family members and society during childhood. This group of asylum-seekers has generally faced higher levels of sexual violence or other negative experiences, which negatively impacts their mental health outcomes. Data on the links between the negative experiences of asylum-seekers in the past and their mental health outcomes is quite limited. Understanding these connections is an important step in addressing the problems of this population [59].

LGBT forced migrants who flee their countries due to prosecution or fear of prosecution, cannot receive the same level of support in the host country as heterosexual individuals from the same country. The past negative psychological experiences and trauma of LGBT forced migrants have a serious impact on their ability to secure refugee status, and to integrate within diaspora communities in host countries. For example, LGBT migrants generally do not integrate within diaspora communities in host countries due to fear of experiencing the stigma that they faced in their country of origin. If they do integrate in diaspora communities, they often continue to hide their sexual orientation due to fear of negative attitudes. Therefore, LGBT migrants are often forced to hide their SOGI and suffer from related stress, or they are deprived of the support networks usually provided to migrants by others from their country of origin. The majority of LGBT forced migrants around the world report a history of traumatic experiences. Often, they do not feel comfortable sharing this information, and are ashamed of their past. This is one reason why LGBT migrants find it difficult to participate in local LGBT groups and societies [60].

Health Challenges of Trans Migrants

The findings of this review demonstrate that MSM is the most studied group of the LGBT community. Generally, the LGBT community is referred to as a single entity, so readers may assume that the problems and challenges described above affect all LGBT sub-groups equally. Issues such as social and structural stigma may affect all LGBT people in a relatively similar way. Nevertheless, there are certain health-related problems that are specific to different sub-group of LGBT people, for example trans people and access to hormonal treatment and related procedures. In general, the findings of this review reveal that information about trans people in relation to migration and health is quite limited.

Trans people often undergo specific hormonal treatment. Due to the nature of such treatment, patients face high risks when their treatment is stopped or interrupted. Therefore, access to such treatment is highly important when migrating from one country to another, especially if the individual has already begun treatment. According to the 2017 FRA report, asylum-seekers have access to essential and emergency healthcare in most EU states. However, trans people often have difficulty accessing hormonal treatment. There are no standardized approaches to providing such treatment to individuals who have already begun hormonal treatment in their country of origin. Even if the host country (for example, Sweden) has policies on providing hormonal treatment to asylum-seekers who have already begun such treatment in their country of origin, procedures for applying for treatment can take a significant amount of time, which can result in negative health consequences [6].

5. KEY FINDINGS

Data on LGBT migration

Issues related to LGBT human rights, health, and migration are causally linked. However, there has been almost no research on these crosscutting issues and how they affect LGBT people. Most issues related to LGBT human rights, health and migration are discussed in isolation. Human rights and health issues, in relation to gay, bisexual and other MSM, are relatively well explored. The migration of LGBT people is an area that is less well-researched. Data on this issue is very scarce, and the majority of countries worldwide do not even keep statistics on asylum claims that are based on SOGI.

It is important to emphasize that countries worldwide, and even within the EU, use different concepts and methodologies to collect data on migration, including on migration flows and migration stocks. As a result, global data on migration is not harmonized. Each international source that collects consolidated data on migration, such as the Statistical Office of the European Union, the UN Statistics Division, and the Demographic Yearbook data collection system, only tracks a limited number of countries.

No quantitative data exists on which countries have the highest levels of inflow and outflow of LGBT migrants. However, it can be assumed that LGBT migrants primarily follow the same migration outflows as other migrants from their countries of origin. In addition, they may prefer to migrate to more friendly countries, i. e. where LGBT people are less stigmatized and where policy environments are more liberal in comparison with their countries of origin.

Belgium and Norway are the only countries that track decisions on asylum applications based on SOGI claims.

Even if migration offices worldwide kept accurate statistics on SOGI-based asylum claims, it would be very difficult to ascertain the real level of LGBT-migration caused by SOGI-based discrimination, since many migrants do not disclose their SOGI when migrating, or even when claiming asylum.

Patterns and trends

European countries are both sources and hosts of migrant populations. The dynamics of intraregional migration in Europe is largely determined by the border-free Schengen Area, which allows people in 22 EU member states and 4 non-EU countries to move freely across borders.

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 numbers of migrants from certain Eastern European countries (Belarus, Bosnia and Hertzogovina) are not high in terms of absolute numbers, but often do represent large percentages of the countries' populations.

The top two largest migration corridors within Europe are migration flows from Ukraine and from Kazakhstan to the RF. There are also significant migrant flows to the RF 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 USSR.

Specific challenges at border and in host countries

Anti-LGBT and anti-migrant stigma exists to a certain extent in all countries around the world, and leads to significant disparities between the levels of access of LGBT people and of heterosexual people to a number of services.

Migrants who are also sexual minorities are potentially affected by social and structural stigma in their native countries and two forms of stigma in their host countries: stigma towards sexual minorities and stigma towards immigrants. In most studies, disparities are documented according to one specific factor, such as SOGI, ethnicity, or migration status. Researching the inequalities faced by intersectional populations provides a better understand of their needs and of the measures needed to address them.

A strong body of evidence suggests that during displacement and resettlement, LGBT people often face threats, harassment, and discrimination from border officials, and that additional action is needed to improve legal protections for LGBT asylum-seekers.

The European Union does not have a unified approach to deciding asylum claims, including ones based on SOGI. The fragmentation and other shortcomings of European asylum policies are well recognized. Differences in national policies and approaches lead to various challenges for LGBT people. With the exception of the Netherlands, Sweden, and the United Kingdom, most European countries do not have explicit and publicly available guidelines on how they handle the asylum applications of LGBT people.

The following problems are specific to LGBT people in the context of migration: Most EU member states do not have specific national guidelines on interviewing LGBT people. Moreover, NGOs protecting the rights of LGBT people in different European countries express concern on how eligibility interviews are conducted, and how SOGI-based asylum applications are handled. Asylum officers often have stereotypical views on SOGI. In most EU member states, there are no special accommodation facilities for LGBT people. In cases of abuse or harassment, LGBT people can be transferred to single rooms, but no preventive measures are taken. There is an obvious need to provide special sensitivity training to asylum officers about the vulnerabilities of LGBT people.

EU countries have been criticized for the restrictive approaches of their migration strategies. Many EU countries are struggling between attempts to address the survival needs of migrants while protecting their own labor markets. Although there are shared standards across a few EU countries, official treatment of refugees and migrants, as well as understandings of the concept of solidarity largely vary across European countries.

Eastern European countries that serve as entry points or corridors for migrants often lack the capacity to welcome refugees, asylum-seekers and LGBT migrants, and may even show an unwillingness to host the migrants. Criticisms have been raised in relation to some Eastern European countries and their rigid approaches to migration, and low capacity and inexperience in dealing with ethnic, cultural, and other minorities. EU immigration requirements may clash with local, conservative cultures, which may result in slow changes in practice despite existing legal developments.

Central and Eastern European countries in particular struggle to handle SOGI-based asylum claims. They are bound by international standards concerning refugees and asylum-seekers. Nevertheless, the practices and policies of their national asylum authorities in relation to LGBT people often fall below these standards.

Health disparities associated with anti-LGBT and anti-migrant stigma

LGBT health is usually viewed from either a human rights or a public health perspective. One considers disparities and the vulnerabilities of LGBT people at the individual level, while the other focuses on the population level. It is important to understand the logic of each perspective, as well as the similarities and the differences between the two perspectives.

Social and structural stigma towards LGBT communities lead to their increased vulnerability to health-related problems, such as HIV, other infections, and mental health disorders.

Adapting to the new cultures, structures and systems of host countries takes time and can be a stressful process, which may negatively influence the physical and psychosocial well-being of migrants. Nevertheless, mobile populations are often overlooked by the health and HIV-related policies of host countries. Migrants are not always welcome in host countries, and such attitudes can have a negative impact on health outcomes at the individual, community, and public health levels.

LGBT people have lower access to healthcare in comparison with heterosexual population in all countries regardless of income level. Furthermore, HIV epidemics among MSM are expanding in countries of all income levels.

It is generally believed that if a person with HIV migrates from a country with high HIV incidence, then they were infected in their home country. However, studies have demonstrated that the post-migration acquisition rate of HIV is quite high in the EU and EEA, and is significantly underestimated, varying between 2-62% among different European countries. MSM have the highest risk of HIV infection in host countries, as acculturation can increase the risk of HIV infection for migrants after migration.

LGBT migrants who belong to ethnic minorities, who do not speak the language of the host country, and who come from countries with high levels of structural and social stigma towards LGBT people, are at higher risk to acquire an HIV in comparison with those who migrate from less restrictive countries and who speak local languages.

Anti-LGBT structural stigma in both host countries and countries of origin is a potential barrier to conducting HIV prevention work among MSM-migrants. Structural stigma towards sexual minorities and immigrants is connected to low access to HIV prevention services, lack of knowledge about HIV transmission, and high levels of risky behavior.

Structural stigma towards LGBT people in countries of origin may continue to have an effect on HIV prevention among LGBT migrants upon their arrival in host countries. However, knowledge of the language of the host country may positively affect the situation of LGBT migrants. For example, anti-immigrant structural stigma is associated with greater coverage by HIV prevention and testing services, and higher rate of disclosure of one's sexuality only for those migrants who speak the language of the host country.

Newly-arrived MSM migrants demonstrate greater knowledge about HIV prevention and HIV related behaviors than those who have lived in the country longer, especially in anti-gay and anti-immigrant host countries.

LGBT migrants generally do not integrate within diaspora communities in host countries in order to avoid the same stigma that they experienced in their country of origin. Therefore, they either continue to experience the stress of concealing their SOGI, or are deprived of the support that is usually provided to other migrants from their country of origin.

Trans people related

The research on trans group of the LGBT population is limited. There is no disaggregated data on HIV or STI prevalence among this group.

Medical professionals in most countries lack the specific knowledge and skills to properly handle health problems specific to trans people.

Trans people who are claiming asylum and who have already started hormonal treatment before migrating to another country, may not receive timely treatment in host countries, as each country has different policies related to this. Even if treatment is provided, procedural requirements may result in significant delays before the person has access to treatment.

6. METHODOLOGY

Project Description

The main purpose of this literature review was to assess and analyze the situation of LGBT migrants and refugees in the CEECA region in the context of HIV.

The goal of the review was to collect and analyze published data (qualitative and quantitative) about voluntary and forced migration of LGBT people in the CEECA region in order to develop a report that can support ECOM programming in the future. The final output of the project (deliverable) was a report on LGBT migration in the CEECA region with an emphasis on related public health/HIV issues, and on gaps in existing research.

Research Questions

The literature review addressed the six research questions listed below:

1. What data is available about various types of LGBT migration within/from CEECA?
2. What are the patterns of LGBT migration in terms of geography (from and to which countries)?
3. What are the reasons for the migration of LGBT people in the region?
4. How are the reasons for migration linked with violations of the rights of the LGBT community?
5. How is LGBT migration linked to public health problems, and to HIV epidemics specifically?
6. What gaps in the study and in published literature exist in relation to the topic being researched, and how do such gaps affect the quality of programs/services targeting LGBT communities?

Description of the Research Process

The research began with a scoping review using "Google Scholar" to identify what type of information was available in general about the migration of LGBT people in Europe and about the health/HIV-related aspects of LGBT migration. During the scoping review, we used different combinations of search terms covering the three main areas of the review: LGBT people, migration, and health/HIV.

A quick search and review of article titles and, in some cases, abstracts was performed during the scoping review. The scoping review helped us to refine search terms within each focus area of the research. We used the following search terms:

1. LGBT: LGBT, gay men, MSM, lesbian, trans, trans people, sexual orientation, sexual minority(ies), homosexuality, marginalization, marginalized groups
2. Migration: migrant, migration, refugee, asylum-seekers, IDP, forced migration, forced migrants
3. Health/HIV: health, HIV, health disparities, HIV vulnerability, HIV epidemics

The scoping review also helped to identify what the main sources of required information are. It became clear that best source of information related to LGBT migration was grey literature, i.e. reports developed by organizations focusing on the specific issues of migration and LGBT populations.

These organizations include: UNHCR, Human Rights Watch, IOM, International Lesbian and Gay Association (ILGA), Organization for Refugee Asylum and Migration (ORAM), and the European Union Agency for Fundamental Rights.

The scoping review also identified several websites and online journals focusing specifically on issues related to LGBT migration. Some of these websites are part of research projects run by academic institutions and universities.

The scoping review also demonstrated that sources focused on a combination of the three research areas of LGBT people, migration, and health, are extremely limited. The scoping review revealed that the scientific portal, "PubMed", had a fair amount of articles covering the topics of LGBT people, homosexuality, sexual orientation, and migrants' health, so this resource was used to search for sources on these issues (using the search terms "health of LGBT people", "health of LGBT migrants", or "health of migrants").

During the scoping review using "Google Scholar", we came across a rigorous and very interesting research project conducted using an unprecedentedly large sample of MSM migrating to/within Europe (EMIS-Survey Database), as well as two academic articles on other research carried out using the data of the EMIS Survey [9, 40, 54]. The study covered all three thematic areas of our review (LGBT people, migration, and health). LGBT migrants are considered to be an intersectional population, and the study concluded that LGBT migrants experience both anti-LGBT and anti-migrant stigma [54]. Once we discovered that LGBT migrants experience health issues specific to both groups (LGBT people and migrants), we decided to continue our research on health/HIV issues in two main directions: LGBT people and health/HIV, and LGBT people and migration.

Thus, the research process was refocused on two main areas following the scoping review:

1. Health/HIV with two sub-topics: LGBT people and health/HIV, and LGBT people and Migration (to answer research question 5)
2. LGBT migration (to answer research questions 1-4 and 6)

Research Focus No. 1: Health/HIV

The research demonstrated that significant academic work has been devoted to researching the health disparities of LGBT people and to various other issues affecting LGBT people. Several studies were selected based on the following factors: recent publication, published in reputable sources, used large samples or systematic reviews, or highlighted route causes, results and solutions of existing problems (such as increased HIV risk, or disparities, inequalities, and vulnerabilities). Research question No. 5, "How is LGBT migration linked to public health problems, and to HIV epidemics specifically?", was actually divided into two qualitative questions: a. "How is migration linked to public health problems, and to HIV epidemics specifically?", and b. "How is LGBT-status/SOGI linked to public health problems, and to HIV epidemics specifically?". Given that the findings of the review will inform ECOM's activities and programs, it was considered important to identify the reasons for the health- and HIV-related disparities and vulnerabilities of LGBT migrants, which lead to unfavorable health outcomes for these communities, as recognized by public health organizations (i.e. recognizing MSM as one of the main drivers of the global HIV epidemic).

Research was primarily carried out by using PubMed and the websites of journals focusing specifically on LGBT health or on the health of migrants. Information obtained through academic medical sources was complemented by information collected from grey literature (such as the parts of reports that are devoted to the health-related problems of LGBT migrants) and from online journals focusing on the health of LGBT people and/or migrants, for example, the Journal of Homosexuality.

Research Focus No. 2: Migration of LGBT people

As stated above, research on this sub-topic was carried out using grey literature and specific websites. The research was also complemented by using websites suggested by ECOM experts or other experts in the field (for example, the websites of the Moscow Conference on Health and Migration, the Border Agency of the Russian Federation, etc.).

The main criterion for selecting documents and citations for the review was their potential to respond to research questions 1-4 and 6, and to explain existing research/information gaps or why some questions cannot be fully answered. The research also identified a number of fundamental documents related to the rights of refugees and LGBT refugees, as well as important documents demonstrating the relevance of the rights of LGBT migrants (asylum-seekers). It became clear that, since 2011, greater attention has been given to the health rights and HIV risks of LGBT people. Between 2011 and 2015, the UN and other international organizations focusing on migration published a number of reports, and issued important resolutions and statements focusing on LGBT issues. Therefore, this review references these documents in order to provide background information on the issues, as well as to demonstrate that issues related to LGBT people, migration, and health have been recognized and that there are strategies to follow. Such information is valuable for conducting advocacy work with local and national governments.

Below are the preliminary findings of the research carried out to answer research questions 1-4 and 6 (i.e. what information is available, what is not, and why). These findings informed the structure and content of this report.

1. What data is available about various types of LGBT migration within/from CEECA?

2. What are the patterns of LGBT migration in terms of geography (from and to which countries)?

Data about the migration of LGBT people is very scarce. All information, in particular quantitative data, which is available about migration is not group-specific.

Another important finding was that migration-related statistics are not disaggregated by groups of people (for example, LGBT people), or by the grounds for international protection (for example, SOGI). Therefore, it is very difficult to identify patterns in relation to LGBT migration. Thus, we came to the conclusion that general migration flows can be used to illustrate LGBT migration flows, assuming that they follow the same patterns.

If the migration of LGBT people occurs due to SOGI-based discrimination in countries of origin, such information should be found among information related to asylum-seekers. However, a review of relevant documents shows that most countries do not gather statistics related to the grounds for asylum applications.

Specific information about the EECA region is very limited. We were able to find a few articles about Eastern European and the Balkan countries in the Forced Migration Review. We selected these articles by searching for country names in article titles, and selected relevant information that could help us answer the research questions.

3. What are the reasons for the migration of LGBT people in the region?

No specific research was found explaining the reasons for the migration of LGBT people within CEECA. Literature related to LGBT asylum claims (which is not region-specific) indirectly allows us to assume that the main reasons for LGBT migration include stigma, discrimination, restriction of freedom, fear of persecution, desire for freedom of expression, and conflicts/forced migration.

4. How are the reasons for migration linked with violations of the rights of the LGBT community?

No information is available to answer this question. Based on existing information, we can only assume that these two issues are linked, because there is an increasing number of reports covering the problems of LGBT asylum-seekers. No data was found to link the migration trends of LGBT people to medical treatment, education, or other motivations. Moreover, the number of LGBT asylum-seekers and the number of SOGI-based asylum claims are not known, as such statistics are not collected.

5. What gaps in the study and in published literature exist in relation to the topic being researched, and how do such gaps affect the quality of programs/services targeting LGBT communities?

The primary gap is the lack of statistics (quantitative data) on LGBT migration. This gap determines and explains the absence of other information, such as on geographical flows, reasons for LGBT migration, and the links between LGBT migration and SOGI-based discrimination. This gap has already been recognized by international organizations, which have made strong calls to begin gathering relevant data and statistics.

Another problem is the lack of consolidated information in host countries about asylum policies for LGBT people. Each European country deals with asylum claims in a different way. A few countries have specific regulations on handling SOGI-based asylum claims, however, there are remain many problems related to the handling of such applications. There are no consolidated documents on migration policies or regulations concerning LGBT migrants.

There is also a well-recognized gap in COI, which is necessary for host countries to make sound decisions on SOGI-based asylum claims.

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