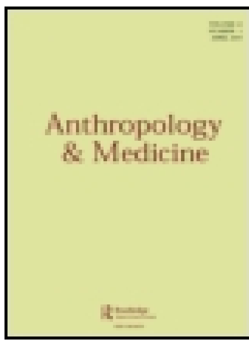

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Are migration routes disease transmission routes? Understanding Hepatitis and HIV transmission amongst undocumented Pakistani migrants and asylum seekers in a Parisian suburb

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ABSTRACT

Drawing on hospital-based interviews and fieldwork in a deprived Parisian suburb, this paper analyses the spatio-temporal dynamics of risk, exposure, and mobilities in individual stories of undocumented Pakistani male migrants, and asylum seekers—receiving treatment for single and combined diagnoses of HIV, and Hepatitis C and B. Inviting alignments with the 'sexual' turn in mobility studies, it prioritises the interface of all-male undocumented migration, mobility, sexuality, and homosociality in circumscribing disease transmission geneaologies. It questions the extent to which illegal migration routes are transmission routes, and risk environments assume different levels of intensity in everyday life in Pakistan, during the journey, and in France. It emphasises inadequately addressed epidemics of HIV and hepatitis in Pakistan, the significance of unequal routes to migrant healthcare in France, and the transnational adaptation of homosocial and sexual behaviours, including MSM. These factors interplay with intensified vulnerabilities relating to childhood sexual abuse, family traumas, sexual risks related to illegal migration and undocumented status in France, chronic stresses leading to depleted mental and physical health, and restrictions on heterosexual sex facing marginalised migrants. Further, temporal vulnerabilities relate to the colonial criminalisation of homosexuality in Pakistan, widespread sexual violence—and forms of contemporary exclusion and hostility regarding Muslim migrants in Europe. Particularly, we emphasise the paradox, and need to sensitively address, a complex confluence of hidden risks that are deeply embedded in ethnic communities of solidarity and support. The findings trouble the tendency to partition global hepatitis and HIV prevalence rates by 'developed' and 'developing' country variation.

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HIV; Hepatitis; MSM; undocumented Pakistani migrants; France

The paper draws on community and hospital based research conducted in 2018 in a hospital in Seine-Saint-Denis, a socio-economically deprived suburb of North-East Paris. It aims to investigate the reasons for a spike in cases of Hepatitis C (HCV) and, to a lesser extent

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HIV and Hepatitis B (HBV) amongst recent migrants from Pakistan, with the further aim to raise community awareness and prevent transmission. The Pakistani population in Seine-Saint-Denis is the region's second largest South Asian population, numbering over 6000 (Seine-Saint-Denis Le Department 2016). Unofficial numbers are likely higher, since the International Organization for Migration (IOM) and NGOs on the Eastern Mediterranean route report increasing numbers of Pakistanis (mostly men, from Punjab province) entering Europe via Turkey, then crossing into Greece and Italy (IOM 2017). In Greece in 2012, an official figure of 15,000 Pakistani migrants contrasted with 60,000 estimated unofficial migrants. In 2014, Pakistan was the fifth most represented country amongst asylum seekers in France, comparable with Syria (OFPRA 2014). Pakistani migrants receiving healthcare in NGOs such as Médecins du Monde are primarily without health coverage (being mostly undocumented) (Médecins du Monde 2015).

Correspondingly, this hospital saw a spike in chronic hepatitis C referrals in 2016 and 2017. Johann Cailhol, a consultant practitioner at the infectious diseases clinic, estimates Pakistanis comprise c.90% new outpatients with hepatitis C; and a small percentage of HIV patients. Most participants were undocumented when diagnosed. Some applied for asylum, were successful, or failed then become undocumented. Some overstayed their tourist visas and became undocumented. The rest entered France illegally via the Eastern Mediterranean route and, like many migrants, remained undocumented until they needed residency papers for medical treatment, or work (Vignier 2018).

The patients all came from rural Punjab: Gujranwala and Gujrat districts; Rawat, Ranewal, Mandi Bahauddin, Sialkot, Karianwala, Makewal, Alla, Mandi Madiya, and Kotli Mohara villages; Rawalpindi and Faisalabad cities. They were from peasant families on large farms, small farm holders, or larger farm owners. They were all men aged 23–56, had all lived in France for an average of five years—with research showing migrants in France face greater hardships and vulnerability to risky behaviours for HIV during their first years (Desgrées-Du-Loû et al. 2016). Most left Pakistan with friends as young men, and paid smugglers between €3-7000, typically arriving in Paris three to five years later. Unlike many new migrants—Africans and Syrians—sleeping under the flyovers at Porte de la Chapelle, Porte d'Aubervilliers and along the canals, Pakistanis use transnational social and kinship networks for work and accommodation. Their families typically borrowed money for their passage with expectations of remittances. While these men's lives are precarious, they differ from Pakistanis trafficked by organised criminals from Punjab for begging and forced domestic labour in Europe (Butt 2016). Of our sample of thirteen, nine men had HCV, two HIV, one HBV, and one was co-infected with HCV and HIV (i.e. ten hepatitis patients, three HIV). All were receiving treatment.

This study concerns risk and vulnerabilities shaped by migration routes, and differentiated routes into healthcare. In France, healthcare is decoupled from rights to stay; many undocumented migrants are referred to hospital by local doctors or NGOs, or if a GP discovers a serious condition—(for a detailed discussion of healthcare and migrants in urban France see Hoyez, Gasquet-Blanchard, and Bergeon 2019). In France, sexual health screening universally includes hepatitis C, B, and HIV, because transmission routes are similar. Migrants' access to healthcare is differentiated and unequal. Working residents receive social security health benefits, topped up with not-for-profit or private insurance. Legal, unemployed individuals not meeting these criteria (e.g. French citizens, temporary contracted foreigners) and asylum seekers, receive universal medical coverage (Couverture

Maladie Universelle-CMU). Those who have resided in France more than three months who cannot obtain social security or CMU, typically undocumented migrants or French citizens homeless or without papers, are entitled to state medical aid (Aide Médicale d'État-AME). Health professionals usually apply for the patient. The protracted application and state reimbursement process means many health professionals refuse legitimate AME and CMU cases, adversely affecting and dissuading precarious migrants with hepatitis or HIV from applying (Despres and Couralet 2011; Vignier et al 2018; Vignier 2018). Those outside these categories are entitled to a one to three months PASS voucher (Permanence d'Accès aux Soins de Santé). If an asylum seeker's case is refused by the *Office Français pour la Protection des Réfugiés et des Apatrides* (OFPRA), they may become undocumented. Entitled to AME, they rarely apply for fear of the authorities.

French healthcare is complicated, involving *shifting* categories of legality for migrants who may enter illegally, acquire permits for residence for healthcare, and again become undocumented. Hence the mobilities aspect of this study also applies to migrants' variegated status in the French healthcare system. Although everyone has rights to medical treatment, not all can exercise those rights in a labyrinthine bureaucracy which creates simultaneous access and barriers for migrants (Hoyez 2012; Vignier et al 2017; Vignier et al. 2018). The French urban healthcare system operates particularly inefficiently for newly-arrived immigrants who are highly-represented among economically deprived and precarious populations, disproportionately excluded from resources, over-represented in NGO healthcare centres, and constrained by residential precarity (Hoyez, Gasquet-Blanchard, and Bergeon 2019).

Most of our participants applied for temporary health visas ('cartes de séjour temporaires pour soins') granted for six to twelve months for all foreigners with a serious medical condition. Approvals decreased since 2017 when the process moved from Health to Immigration authorities. Nonetheless Johann Cailhol spends much time writing migrant healthcare applications. Fassin and D'Halluin (2005) emphasise dilemmas facing activist doctors in France whose time spent writing medical certificates evidencing trauma for asylum seekers leaves them little time left to treat patients. They locate the body seeking asylum as a site of political power and truth, and show how the authority of medical certificates in citizenship cases erases the personal experience of asylum seekers as political subjects.

Being undocumented, and rounds of asylum and residence permit for medical care applications produce considerable mental tension. These participants experienced anxiety, poor sleep quality, rumination, and multiple fears: concerning HIV status which could not be disclosed; around Hepatitis C hypothetical survival, reactivation, and re-infection; infertility due to HIV or hepatitis; risks to a future spouse; being unemployed; working extremely long hours; feeling disillusioned, isolated from their families; being sick and unable to work. There is a widespread lack of knowledge about HCV and HIV transmission among Pakistanis in Paris. Despite reassurances from physicians, these participants continued to believe in unsubstantiated causes of HCV e.g. food with chillies, dirty water, dirty environments. Several suffered traumatic reviviscences of their migration journey. They despaired about their unstable status in France, their health conditions, and hoped to receive effective treatment.

Migrant mobilties and Hepatitis and HIV transmission risks

Pakistan has the world's second highest global prevalence of HCV after Egypt, affecting 8 million people (5% population) (Moin, Huda and Qadir 2018). The focus on the endemic

prevalence of HCV in Pakistan has largely been displaced by a focus on HIV/AIDS which, after the 2000, the World Bank, despite initial government scepticism, established as urgent public health priority (Qureshi 2018). Both hepatitis and HIV prevalence rates have risen sharply in recent years (Moin et al. 2018; Qureshi 2018). Pakistan's HCV story is tragic: ignored by global health funds which targeted HIV, but epidemic, especially in Punjab province (Qureshi 2018, 157). HIV, HCV and HBV transmission modes are similar—including contaminated blood exposure, intravenous drug use (IDU), re-use of contaminated syringes, non-sterilized medical devices, mother-to-baby vertical transmission, and unprotected sexual intercourse. While unprotected heterosexual and MSM sex are a risk for HIV and HBV transmission, HCV is rarely transmitted via heterosexual intercourse. MSM constitutes a significant risk for HIV and HCV as it involves more blood contact via micro-traumatisms of mucosa. HCV and HBV B are more infectious than HIV, and survive longer outside body fluids; all bodily fluids containing blood are infectious.

Pakistan has one of the highest global frequencies of injection use; almost 50% patients receive unnecessary therapeutic injections (Mahmood and Raja 2017, 3). Our interviews also confirmed the looping effect between the widespread use of therapeutic injections in Pakistan with the belief that illnesses are most effectively treated with injections. The use of unqualified village doctors is common, even when illnesses are not cured, and half a village is infected with HCV (Safdar 2018). A government survey cites 72% therapeutic injections and 50% immunisation injections as a major HCV transmission risk in government and private sectors—with dentists, barbers, ear and nose piercing also common factors (Mahmood and Raja 2017, 29).

A systematic global review identified IDU as the major risk for HCV transmission in developed countries, and the reuse of syringes for unnecessary therapeutic purposes as the most important factor in Pakistan, followed by IDU—with MSM unmentioned (Shepard, Finelli and Alter 2005). The omission adumbrates a highly stigmatised scenario where homosexuality has been criminalised in Pakistani law since colonial times, and 'pathologically high levels of discrimination and contempt towards sex workers, injecting drug users and transgendered *hijrae*' exist (Qureshi 2018, 36). Notwithstanding, Pakistan has a high prevalence of hidden MSM, HIV, hepatitis, and co-infection amongst MSM (Khanani et al. 2010). High rates of HIV persist in cities amongst *hijras* (feminised males) and male sex workers (Reza et al. 2013). Prevalent unsafe healthcare practices such as the reuse of therapeutic syringes, shared syringes between injecting drug users, unprotected sex among men, criminalised and hidden MSM, and largely unaddressed HIV and hepatitis epidemics combine with the large-scale illegal migration of young men to Europe in the transnational mobility of risks. In France, migrants are stigmatised and negatively associated with the diffusion and 'import' of disease, and face situations of precarity and vulnerability wherein they must prioritise accommodation, papers, and work over health (Hoyez 2012).

Proposing an intersectional 'sexual' and 'emotional' turn in mobility studies, Mai and King (2009) argue that economic imperatives may result in losses of emotional expressiveness and sexual identity for migrants. Ahmad (2009) disrupts tendencies to reduce all migrants to asexual accumulators of capital and senders of remittances, and prioritises intimately connected sexual and economic spheres in Pakistani labour migration to Europe. This study adds to the nexus of migration, mobility and sexuality a view on HIV and hepatitis vulnerabilities related to unprotected MSM, childhood sexual abuse, sexual

exploitation by employers, transactional sex, abuses risk and exposure during migration, and restrictions on heterosexual relationships facing low-paid, cohabiting, marginalised migrants in France. Prioritising the interface of all-male migration, mobility, sexuality and homosociality in creating risk environments, it queries: to what extent are migration routes transmission routes? Do migrants carry HIV and hepatitis from Pakistan, acquire it *en route*, or in France? Are social networks of support for Pakistani migrants in Europe a transmission risk factor? How do unequal routes into health-care impact differentially for undocumented migrants and asylum seekers in France?

Prioritising three spatio-temporal fields—growing up in Pakistan, travel to Europe, and life in Paris—the paper implicates three interrelated areas of transmission risk: formal and informal healthcare in Pakistan and Paris; migrant homosociality and ethnic communities of support; risky sexual behaviours, including MSM, heightened in conditions of irregular migration.

Mobility and migration circumscribe risk environments for HIV and STIs in other contexts, being associated with sex trading, multiple partners, and unprotected sex (El-Bassel et al. 2016). Pakistan's majority HIV-positive patients comprise Gulf returnee migrants Qureshi (2013). Discourses of returning migrants as 'morally contaminable, disreputable and suspected of sexual transgression' combine with the state's neglect of HIV prevention and control (Qureshi 2013, 217).

We argue for considering the entire migration process in predominantly all-male Punjabi migration to Europe to understand ways particularities of risk intersect with geographical, political, sexual and developmental journeys and mobilities, and assume different levels of relative intensity during the journey and settlement process. Regarding prevention, it is important culturally to understand what can and cannot be spoken about openly, especially regarding stigmatised behaviours surrounding MSM. Concerning sexual transmission, we de-emphasise psychological traits such as impulsivity as a reason for risky behaviours, or framing 'homosexuality' as a distinct 'Pakistani' category (Cohen 2007). Rather, male migration from Punjabi villages, as elsewhere in South Asia, produces intense homosocialities—formed through friendships strengthened *en route*, diasporic living conditions, and cohabitation—in which MSM responds to harsh conditions, and the deprivation of heterosexual sex in migrant labour markets (Osella 2012; Kirpalani, Moliner, and Muhammad 2015). Further, given the whole process of smuggling oneself is terrifying, protracted, leads to a total deprivation of intimate life, and depleted physical and mental health—and that low-paid undocumented labour in Parisian suburbs is difficult and demoralising, the question of risky behaviour arguably becomes 'why not', rather than 'why'?

Methods

This study, entitled "Musafir",[1] was conducted between July-September 2018. It involved ethnographic observations in a large hospital and its neighbourhood in Seine-Saint-Denis, hospital-based interviews with 13 patients, some twice, a focus group comprised of six patients and were interviewed separately, and driving, walking, and sharing food with patients in the locality. We introduced our aim to build deep insights into the recently-arrived Pakistani community in Seine-Saint-Denis, to take opportunities to build community-level prevention work, and to add messages on STIs, as many recently-arrived migrants are single men. We solicited details about interlocutors' relationships with Pakistani and

non-Pakistani communities, friendships and intimacies, life in France, sexual and non-sexual routes of transmission including MSM, and ideas for prevention. While Nichola Khan has conducted long-term anthropological research in Pakistan, Johann Cailhol is an established HIV and Hepatitis medical consultant. Our position as educated European women created inevitable distances and differences with our interlocutors who were treated by Nichola Khan, and had low literacy. These differences, alongside the fact we were fully appraised of their diagnoses, also afforded a space 'outside' conventional Pakistani and gender norms which in most cases, not all, allowed the men to speak freely about their condition, lives, and sexuality. Likewise, our shared, mixed Asian background created types of commonality that aided familiarity, but did not belie underlying power relations which we were sensitive to.

Given there exists no site-profiling of HIV, hepatitis, and other infectious diseases in Pakistani areas across Paris, this localised study centred on one hospital clinic represents a snapshot rather than a wider picture.

Notes on Fieldsite

It is dusk and I wait for Aziz outside the tram-stop at the sprawling junction. Four policemen have pinned a young North African man to the ground. Another escapes into the traffic shouting obscenities; a swelling crowd watches. Men sit on the narrow pavement in the overclouded evening outside cafes, on walls, and at tram stops. Finally Aziz arrives. The evening streets are overwhelmingly male, and full. We walk past Sri Lankans standing around drinking, young Africans jostling one another, Roma children begging. The overcrowded tramway is full of North Africans, South Asians, and Africans, shoppers pushing trolleys of market merchandise. Beggars holding signs reading "Syrians" wait at traffic-lights. As night falls, lights signal that supermarkets, eateries, money-changers, Lycamobile shops, halal butchers, and cheap barbers remain open. The area expands outwards from the metro, with four main roads coming off a central roundabout—one lined with shops in two directions, another with shops leading to residential blocks, another with cheap eateries and supermarkets leading to the hospital. Alongside West African communities from Mali, Senegal, Cameroon, Côte d'Ivoire, and central Africa, mostly South Asian communities live here: Sri Lankans, South Indians, Pakistanis, Tamils, Bangladeshis, and Afghans. Waves of Sikh immigration since the early eighties, including refugees of India's secessionist Khalistan movement, has produced a strong local Sikh community (Moliner 2007). Older more established Pakistani communities reside in Gare du Nord and Gare de l'Est, and poorer neighbourhoods like this. Many newer migrants live further out in the suburbs of Bobigny, Sarcelle, Pierrefitte, Le Bourget and come here for Friday prayers, to meet friends or frequent Pakistani restaurants. Like many new migrants in Seine-Saint-Denis, their lives are characterised by clandestinity, precarious employment, and multiple geographical mobilities and migrations (Moliner 2007, 134). In their special issue, Goreau-Ponceaud and Gallo (2015) present a study by Moliner, Kirpalani, Hoyez, and d'Halluin on migrants in France, including ways 'clandestinity' has come to represent specific kinds of legal and social exclusion from traditional institutions and social services, being linked to mobility, and a loss of identity alongside new forms of racism.

Aziz was being treated for a recently-diagnosed HCV infection. His arm pullulated with sores, a symptom medication would alleviate. Over a *biryani* he described first visiting a

local Urdu-speaking doctor who failed to diagnose his condition, disparaging him as a 'businessman' who wished only to profit from seeing sixty-plus patients daily. He speculated he acquired HCV through a dog-bite in Pakistan. He refuted ever having injected drugs, having sex with a man, or a sex worker. He agreed sharing toothbrushes or razors might be an overlooked transmission mode in Paris, certainly in cramped one-room apartments where up to five migrants may contribute E200 each to the monthly rent. Walking around the small crowded streets afterwards, we observed several barbers using traditional steel blades—not renewable blades. Shaving practices and barber shops emerged in this study, as in Pakistan, as a risk factor (Mahmood and Raja 2017). Likewise potash alum stone, traditionally used by Pakistani barbers to sterilise shaving cuts, can preserve HCV for several weeks (Waheed, Safi and Qadri 2011).

The hospital itself suffers many deprivations relating to pressurised resources, and little interest in why the infectious diseases department overwhelmingly treats Pakistani patients with Hepatitis C. Patients include many asylum seekers and refugees. Infectious and tropical diseases rank low on the hierarchy of hospital departments. The department occupies a run-down prefabricated building; a plastic sack serving as a hook held the front door open. The interviews were conducted in Urdu in the only air-conditioned room. Many African migrants who have sufferend extreme traumas on the migration routes through Libya, including being sold, tortured, having their children taken, and imporisonment by traffickers, are patients at the hospital's ethnopsychiatry department. The stresses of irregular Pakistani migrants are typically less severe and related to their diagnoses and working and living conditions; these can usually be addressed by infectious diseases department's psychologist.

My first day was instructive. An oppressively hot day, between interviews I gazed inside an open door at Johann Cailhol and a translator engaged in conversation with a desperate patient wearing a worn *shalwar kameez* who shouted he hated the Prefecture, and swearing he would bomb them if not granted residence papers. He, like many patients, arrived without an appointment to demand Johann Cailhol do something. He had been in France for 18 years, paying tax and working. He had applied for residence papers previously, but was not highly literate, had no official support, dispatched this application incorrectly, and it was rejected. He had recently presented with a brain embolism, and been diagnosed with HIV, tuberculosis, and meningitis. He adamantly denied having HIV although was taking anti-retroviral treatment. He now presented with new STI symptoms, but denied any sexual contact. Johann Cailhol worried he would spread infection, and how to control it.

Healthcare

In understanding the complex interplay of sexuality, homosociality, transmission modes, and secrecy that underpins the predominance of Pakistani patients in this clinic, it is important to examine the genealogy of HIV and HCV healthcare in Pakistan, community health practices in rural and urban areas. The interviewees showed a high awareness of HCV, gleaned in Pakistan—"My eyes were yellow; in Pakistan yellow eyes is normal, because everybody has hepatitis". However they also demonstrated low knowledge of transmission. Almost unanimously they cited bad water (a transmission route for hepatitis A and E, not HCV or HBV). Other reasons included hot weather, 'hot' food, oil, alcohol, syringes, poor sanitation. Even after education and treatment, most retained the belief in dirty water; some

continued to have unprotected sex. They commonly used the terms *yerkaan* (jaundice), *kala yerkaan* (black jaundice), or *jigar ki gurmi* (hot liver) to describe HCV—symptomatic descriptions employed by Punjabi patients elsewhere (K. Qureshi, personal communications). Several have relatives also infected, for example Hakim's parents, sister, and brother-in-law in Karianwala all have HCV. Hamid's father died of HCV when he was eight after taking medicine 'for fifteen years', indicating Hamid possibly contracted the virus at home. Shahid travelled to France specifically to access treatment for HCV—although this case was unusual. Shehehyar speculated he contracted HIV in the army through sex workers.

While unsafe, unregulated medical practices are well-documented HIV and HCV transmission risks in Pakistan, informal healthcare practices and illegal drug use also pertain in impoverished Parisian suburbs. For example, one patient described a local low-cost hostel (*foyer*) for migrant male workers where a peripatetic South Asian dentist offered cheap, unregulated treatments. Another, recently diagnosed with HIV, baffled Johann Cailhol with an indetectable viral load, indicating he was taking anti-retroviral HIV medication despite his protestations. It transpired he was visiting a "sex shop" whereupon entry he could supposedly have sex with any number of women. For €5 he bought a pill to putatively enhance his libido and offer STI protection. His blood-test revealed not Viagra, as assumed, but an antiretroviral drug for treating HIV which, used irregularly, incorrectly, and combined with unprotected sex, heightens resistant strains' transmission risks. This scenario implicates new migrants as a factor in the rise of HCV and chemsex among all MSM groups in Paris.

Dedicated NGOs in North Paris assist new migrants—for example *Centre d'Accueil, de Santé et d'Orientation* (CASO) run by *Médecins du Monde*, *Comede*, and several community doctors we visited. Communications between services are informal and poor. Dr Malik's popular GP surgery caters mostly to South Asians. On visiting him he described his childhood in Pakistan, and struggles to qualify and settle in France. He treats many Pakistanis for diabetes; newer migrants for depression or insomnia. None had mentioned MSM or IDU. He held a daily drop-in session. This day the waiting room was packed, the queue stretching onto the pavement outside. While he viewed his Pakistani patients as hardworking vulnerable young men, as he had been, our sense was this view clouded his sensitivity to many risky behaviours. Patients may not have disclosed blameworthy activities to a fellow Pakistani doctor. Other doctors were less sympathetic, such as one South Asian GP who contentiously asserted Pakistani migrants 'all visit whores'. He derogated Pakistan's conservative society that prohibits sex outside heterosexual marriage. Although Islamic traditions may drive 'illicit' sexual practices and MSM underground, they also discourage high-risk behaviour; likewise, male circumcision contributes to Pakistan's 'substantially reduced proportion of urinary tract infections, penile cancer and sexually transmitted disease' compared with neighbouring India (Khan 2009, 204).

Musafir: homosocialities and sexualities

In France, these patients mostly worked as low-paid painters on building projects, or electricians. Like many Pakistani migrants in Europe they work long days, for months on end, without respite or holidays (Ahmad 2011). They lived with other Punjabi migrants, or their bosses; some in hostels for asylum-seekers, others alone. Those who worked together and cohabited formed stronger ties—cooking Punjabi food, and sharing bills and chores. Such living arrangements are common among South Asian migrants

in Europe (Khan, 2020). Friends likely share toothbrushes and razors to shave their face, armpits and genital areas, customary practices for Muslims. Sometimes they used rougher traditional *miswaq* toothbrushes (sold at the mosque) for *wuzu* (purification before prayer), which if shared, may transmit disease. If a housemate has HCV, transmission may occur at home. When Bilal informed his housemates of his HCV status, they were supportive, saying "just don't cook too much" and solicited his agreement he would henceforth use separate crockery (without mention of razors or hygiene practices).

Regarding sexuality, young Pakistani men cannot easily access heterosexual relations or relationships. Ahmad (2009) argues that the denial of normative heterosexual relations that Pakistani migrants in Europe must endure, or watch without participating in because of their lack of money, personal space, privacy, and long working hours—produce conditions in which 'bodies *do not materialise* according to heterosexual/heterosexist norms' (322). He views the migrant labour process as desexualised and de-feminised: a loss contrasting with migrants' unfulfilled desires. Several interlocutors watch pornography; Google data analysis identifies Pakistan as the world's top online pornography searching country (Express Tribune 2015). The restrictions on heterosexual sex facing unmarried men do not appear to be 'producing homosexuality', but rather shaping pan-sexual practices—outside relationships—between men, women, and children.

The interviews reveal MSM is common in villages, between boys at school, men and boys, and married and unmarried adult friends. While some disavowed engaging in MSM, even its existence in Pakistan, others discussed MSM in very normative ways that indicated neither perversion nor shame. Although they asserted MSM is hidden in village life, it may be more accepted than they describe. Parallels exist across South Asia, in Kerala for example where Muslim MSM is accepted as a 'men's secret' hidden from the public gaze through the assertion of normative heterosexuality (Osella 2012, 540). While Osella mostly emphasises men's exchanges with male sex workers, not sex between friends as we found, his argument that long-term all-male migration to the Gulf produces intense discreet forms of normative homosociality and 'homosex' that can be enjoyed unproblematically in women's absence, is germane (538). Certainly we concur that all-male intimacies and desires forged through life-long modes of homosociality are intensified in the political-economic conditions of long-term migration (Ahmad 2009). Our interlocutors' overwhelming rejection of a 'gay' identity also underscores ways MSM is intrinsically, normatively tied to heterosexual, hetero-normative contexts, rather than a distinct individual identity, and ways male sexualities resist hetero/homosexual distinctions (Boyce 2006, 94). Likewise does the finding that MSM relations continue in Pakistan after marriage, including sex with male and female sex workers (Qureshi 2018).

de Lind van Wijngaarden, Rani, and Iqbal (2010) describe MSM experiences in Pakistan in the extended family/household, at work, in institutional settings, schools, in exchange for money, in public spaces, between men and *hijrae*, and in fairly equal relationships. In cosmopolitan urban centres, smartphone apps mean 'gay sex' is readily available in a country where all extra-marital relationships are 'difficult' for men who inevitably marry women (Azhar 2013). If the consequence is 'double lives and dishonesty' (ibid), it also raises complexities around HIV/HCV prevention work onto stigmatised sexual behaviour amongst communities of illegal, already-marginalised, invisibilised Punjabi migrants in France (Kirpalani et al. 2015)—here from the Pakistani side of the India-Pakistan border.

If MSM and casual sex between male friends is acceptable despite societal taboos—writing anthropologically about Muslim MSM nonetheless requires caution given the persistence of colonial discourses on 'perverse' Muslims and the like in British India (Cohen (2007). Cohen (2007) explores the populist nexus between criminality and homosexuality, and many floating signifiers: Pakistan, terrorists, backwardness, feudalism, and colonial discourses of Pathan proclivities to pederasty that were resurrected in the post 9/11 context of anti-Muslim racism[3]. 'Feudalism' is not a recursive autochthonous condition, but a direct effect of the *longue durée* of highly oppressive colonial and postcolonial infrastructures around land tenure and taxation that led landowning groups to exact severe punishments on men and women, including rape (110). They emphasise Asian male sexuality as a fearful, deviant phenomenon, alongside a repulsion to migrants' sexual and emotional lives (Ahmad 2009, 310). This implicates the entanglement of nationalism and immunology in social imaginaries, with immunology an imperilled nation-state warring to defeat alien invaders (Martin 1990)—akin to the dangerous figure of the Muslim migrant in Europe with his uncontrollable sexual urges toward European women and children.

Ahmad (2009) argues that while the returnee migrant's displays of cash, expensive clothes and *accoutrements* drives desire to migrate, in women's absence it also displaces libidinal investments into an urge for commodities, a scopophilic fetishisation of bodies and material goods that return from abroad, and a powerful attraction to migrant men (312). These desires are not homo-erotic; they occur in contexts of intense male same-sex sociality comprised of deep, intense intimacies, tenderness, friendships and affection that is idealised in Pakistan and South Asia, and propels young migrant men to leave Pakistan together and undertake dangerous journeys to Europe (315). Ahmad primarily focuses on the 'currents of sexual and erotic energy' driving migration (2011, 5), and the suppression and displacement of sexual desires by labour conditions in Europe which lead friends to take sexual and erotic pleasures in each other's bodies outside the norms of marriage and heterosexuality. While homosocialities, MSM, and visiting sex workers shape risks for Pakistani migrants in France, we also highlight disease vulnerabilities related to sexual exploitations, and sex migrants exchange for goods, gifts, livelihoods, work, and sex work they inexorably drift into.

Exploitation and abuse

We highlight diverse abusive practices between men and boys, and associated forms of shame and stigma. These reveal an anachronistic linkage between homosexuality and 'backwardness' derived from colonial attitudes and caste divisions (Cohen 2007) internalised by patients, for example Hasan: '[child sexual abuse] happens a lot in villages because people are uneducated'. They reveal deep stigma around speaking about sex in non-private settings—for example in Aziz's denial of sexual relations despite presenting with fresh STI symptoms. They speak to the transnational adaptation of high HIV and STI transmission rates involving an array of stigmatised extramarital sex and sexual activities including with sex workers, child sex abuse, and abuses of street children, and child and adolescent labourers (de Lind van Wijngaarden, Rani, and Iqbal 2010). Such behaviours are silenced in a context of endemic structural, institutional and sexual violence against women, girls and non-heteronormative individuals, wherein victims of abuse and rape are shamed, ostracised, or sometimes killed.

The rape of young boys is prevalent in Pakistan, and shrouded in fears of family 'shame', perceived threats to masculinity, and taboos surrounding speaking about sex (de Lind van Wijngaarden and Schunter 2014). Also prevalent are sexual abuses of young boys by neighbours, teachers, the police, family members, relatives and employers. It also includes all-male working environments such as truck-driving, fisheries, mining and services industries—with sex not always considered rape, abusive or important, but a transactional 'part of the job' (de Lind van Wijngaarden, Rani, and Iqbal 2010). Aziz mused, older boys in school might rape younger, 'pretty' boys to gain sexual experience—'it's normal'—arguably too in all-male English boarding schools (a system that serviced the colonial administration). de Lind van Wijngaarden and Schunter (2014) found varied sexual subjectivities among Punjabi and Pashtun truck cleaners who were sexually interested in men only, women and men, older men only, young boys only, who bought and sold sex regularly, practised, coerced and had willing sex, and multiple partnerships with men and women. Women's unavailability legitimised MSM, which did *not* constitute a different sexual or gender identity, or intentions not to marry (571).

Among our interlocutors the word love only appeared once, when Aziz described his Greek employer in terms of paternal love. It was also implied in Asim's feelings of lost intimacy with a friend in Pakistan. Slight but tough looking, Asim grew up on a small farm-holding in Ranewal. At school, which he left at 13 to assist on the farm, many boys had mutual sex. Secluded from the scrutiny of village morality, they engaged in experimental sex—in fact reproducing normative behaviours in the village. Many friends continued secretly after leaving school. In France his friends have sex with other friends; he does not judge them. Male same-sex desire is openly joked about, as in other Muslim contexts (Osella 2012, 533), as when these friends admire each other's bodies or joke, 'I had sex with X last night'. All smoke *charas*, but none inject drugs, notable given the hospital site in Seine-Saint-Denis is a 'hot spot' for drug trafficking and consumption (Pfau and Francia 2017). Asim has no close friends, and lives alone. His friend in Pakistan is the only person he confides in about his hepatitis, worries, and depression. He willingly volunteered for a focus group on MSM: "It's normal, why should I not talk, it's not unusual."

Khalid grew up in Pindi Rawan farming cows, buffaloes, rice, and fruits. His father was a heroin addict; he left school at 16 and borrowed money to travel to Europe. Khalid concurred with Asim: 'In Pakistan, everywhere you feel many men looking for men. In Paris I took money for sex with Arab men". His interview intimated an earlier abusive experience: "When I was young I had horrible nightmares of the night. I wanted to sleep with my grandmother. In the fields I always felt followed; still now I fear the dark.'

The focus group revealed interesting tensions between older and younger members. Asim and Shahrukh sat closely, touched, laughed nervously—they were friends after meeting at the hospital. Mohan, older, dominated, closing down conversation by saying MSM is 'boring', forbidden in Islam and, directing his hostility toward Johann Cailhol and, readily described how his friends share information about inexpensive women (sex workers). When discussions turned to child abuse in Punjab, he left to smoke a cigarette. In his absence, the younger men concurred that MSM happens between friends, but they are not gay. Their silence likely deferred to Mohan's age and hostility; the older men were unwilling to elaborate about MSM, or experiences with sex workers (information they had shared individually).

Musafir: on the move

The stories raise questions evoking ways emigration is underpinned by sexual imaginaries and desires for Europe. Migrants' sexual disappointments and denials of heterosexual sex may be morally rationalized, as in Asmat's disparagement: "girls in Europe have bad sex lives". Aziz, who had a girlfriend, saw France as a place to 'live', and resented sending remittances and being poor.

Some patients experienced profound disappointments with European life, which combine vulnerabilities associated with the necessity of physical labour, cramped living conditions, having a stigmatised health condition—and illegal Punjabis' marginalisation in France (Kirpalani et al 2015). Rafiq, who left Pakistan after his father's legs were amputated in a land dispute in Karianwala, blamed Europe for his HCV, 'My problems started *here*, not Pakistan'. Combined with childhood traumas (sexual abuse, parental deaths, chronic poverty), long-term stresses of travelling, living in camps, the shock of a serious diagnosis, selling/exchanging sex, and being unable to confide about one's problems produce syndemic disease (multiple diagnoses), and multiple vulnerabilities to risky behaviours.

El-Bassel et al. (2016) highlight mobility in the context of migration in developing HIV and STI prevention strategies, and identify sex trading, unprotected sex and multiple partners as risks for migrants across Central Asia; these are exacerbated by low-income status, debt, homelessness, and limited access to medical care. Mobilities are significant in HIV/HCV transmission across Pakistan (heightened by mobile workers who have unprotected sex with multiple partners); for migrants on the move (as abuse, sex work, intimacy between friends); and *in* France (for and at work, between friends, to tempt danger, for self-esteem, or monetary gain). Journeys to Europe brought excitement alongside extreme dangers and fear: being crammed into trucks and containers, walking across borders, being shot at, numerous agents whose fees increased *en route*—alongside a lack of hygiene, sanitation, air, water; sleeping in forests, barns, animal pens, in snow and freezing weather, and being undocumented. Several stayed in Greece some years. Others worked within Pakistan before journeying to Europe. Some were raped *en route*; others had consensual same-sex relations. Others, Ali described, sold sex during free hours outside refugee camps, for example in Sicily. These life-threatening, illegal journeys and transits bear on migrant routes elsewhere. For example De Leon (2015) studies the U.S.-Mexico borderlands in remote desert zones. He analyses migrants' crossings through abandoned shoes, clothes, and make-shift graves. This is complemented by migrants' stories, which tell of women and children particularly—*not* men, as we found—who commonly experience rapes and sexual violence en route.

Sexual violence is prevalent in Pakistan, *en route*, and in Europe. Reshaping Martin's (1990) metaphoric link between nationalism and immunology, implicit in Aziz's words, told after he had received combined HIV and HCV diagnoses, is the idea that Europe, the dream of Europe, and immoral European market forces pollute/destroy (infect the bodies) of Pakistani migrants and children.

> 'In Istanbul, we were 80 Pakistani men in one house. After being in a container for 20 hours, some were unconscious. On the way agents raped women, young boys, some fellow travellers. In my group, when men had sex with each other, it was always forced. When you're a man and you see something, you take it. If a young boy looks nice, somebody will approach him sexually. Others take young kids, three or four years old. In Pakistan. They have sex with them,

make videos and put it on YouTube. For business. They sell it to *Europe*. In Punjab. Here in (this municipality), young girls must sleep with their bosses. Remember that Roma girl begging? What future does she have? Just sex.'

The stories reveal important ways that bodies and transmission risks are inscribed in ethnic communities of solidarity. Sexual exploitation also occurs within these communities. Shahrukh and Asim concurred that Pakistanis in Paris exchange sex for work, housing, favours etc., but stressed that sex lives are private, secret. Shahrukh lived with his Turkish boss, who employs him as a painter—a trade many Pakistani migrants work in. His boss attended all his hospital appointments, concerning the interpreter he wished to censor Shahrukh's words. Shahid also lived alone with his Pakistani boss in Franconville suburb—he did painting work, cooking, and cleaning in exchange for a room—and perhaps unwillingly provided sex until he moved out because he 'didn't like him'. More openly, Asim described a older unmarried Pakistani in Seine-Saint-Denis who spends 'all his earnings' on young boys. He is notorious, Asim asserted, for targeting the hostel/care-home (*foyer*) for minors (refugees, excluded, and neglected/abused children), for obtaining sex in exchange for gifts, dinners, mobile phones, and driving his luxury car around, unashamedly parading young boys[2]. Institutional, state, and social 'support' environments may be inherently exploitative, and thus risk factors for disease transmission.

Ali's story

Ali was the only patient who openly described sexual encounters with European men, and engaged in sex work. When I first interviewed Ali (Nichola Khan), he was severely upset about his HIV diagnosis, and had complex feelings regarding his sexuality. He had left Sialkot for Greece at 16 with friends. The journey was difficult; he saw death. Travelling with around 100 people near the Turkish border, the police caught them, broke people's legs and worse, and returned all to the Iranian border. He reached a forest near Istanbul where '5-600 *more* people were waiting to cross'. Finally in Greece, he rented space in a farmer's outbuilding, and moved onto Thessaloniki with a friend where they were placed in a camp and granted work permits. During the 2012 economic crisis he travelled to Sicily and another camp. Later he moved to Milan where, working to deliver pizzas he experienced his first sexual contact with a male customer, and subsequently the man's friends. Shocked at his behaviour, distressed at feeling pleasure, he left his job. He planned to flee Italy, but first submitted a housing application. The application required a blood test; he was recalled and informed he was HIV positive. His world collapsed: he would never marry, he would die, he considered suicide. He began treatment but wanted to escape those men and his suffering, so fled Milan to friends in Paris. There he was diagnosed again, and recommenced treatment—sleeping rough until being housed in a centre for asylum seekers. Meanwhile his fiancée's family in Pakistan ended his engagement due to the long delay. 'I'm like someone without a mother. I've lost everything.'

I re-interviewed Ali in September about his MSM experiences. Calmer, he elaborated: 'You have to dare this feeling, to make contact with somebody. I've been approached in the Place de Clichy by many men offering money. It just comes, I don't seek it. I see one married man regularly, he pays me, we have sex in the sauna. Another proposed me €100

for fellatio.' While Ali described sex with men fairly easily, his HIV and citizenship status cause him shame: 'I hide, lie, because I didn't get asylum, I got ill, I'm not a French citizen. I always feel tension. I cannot reconcile this (MSM), so I hide…those from the past, my old friends.'

The assortment of loss, alienation, excitement, shame and erotic desire, and a deep sense of difference in Ali's story bears on the sometimes unrecognized, transgressive, erotic appeal of dangerous journeys (Ahmad 2009). This is explicit for Ali in unknown sexual encounters in sex clubs and saunas, being solicited by unknown European men, being admired, singled out, *chosen* in full view, and paid for sexual pleasures he gave and received.

Conclusion

The problems of Hepatitis and HIV among recently-arrived Pakistanis are pressing for Europe's new migrant demographies; migrants contribute c.34% total chronic HCV cases in France, 35% in the UK (Falla et al. 2018). The patterns of MSM, homosocialities, and risky sexual behaviours are likely not limited to undocumented migrants from Pakistan. The mapping of HCV sequences (types) against individual mobilities and migration stories is one aspect to follow up—for example, the finding that Pakistani HCV sequences closely relate to those in Iran and Italy (Ghori et al. 2016, 10).

Mahmood and Raja (2017) highlight a decrease in the incidence and prevalence of HCV infection in developed countries—1.03% in Europe. This paper shows that vulnerabilities to infection are *not* necessarily lower in high-income countries, but points to conditions in France which approximate those of low and middle-income countries. They derive from Pakistan's HCV/HIV epidemics; and heightened by migrant precarity, migrant sociality, family and sexual traumas in Pakistan, *en route* and in Europe, by the distress of serious stigmatized diagnoses, and political hostilities which force migrants into camps long-term, selling and exchanging sex, and risky behaviours which assume different intensities throughout migration and settlement. Regarding prevention, questions regard the extent it is possible to deliver knowledge around MSM and sexual behaviours, given the secrecy involved; and to which people will reduce harmful behaviours even with knowledge. Secrecy, tied to colonial and post-colonial contexts of silencing and criminalization, reveal how moral economies index 'parallel and incommensurable temporalities' for Muslim migrants in Europe (Nguyen 2015, 328). If the global 'failure' to stop HIV is a theoretical and ideological construct, failure *can* be productive if research fully accounts for the moral economies and social complexities that shape realities and communities (ibid).

Community findings highlight a widespread lack of knowledge, and several areas for prevention: barbershops, shared razors and hygiene practices; general STI prevention, stigma reduction, culturally-appropriate condom messaging and risk reduction for MSM, quack doctors and dentists working in foyers etc., promoting greater connectivity between hospitals, GPs, HIV/HCV and migrant clinics, and municipalities. They point to migrants' high vulnerability to economic and sexual exploitation, and to child migrants targeted for sexual abuse. Finally, they point to the helix of an infection that draws unwitting, deadly power from those ethnic communities migrants seek support, dignity, and survival—and the need for ethical strategies to reach highly invisibilised, precarious migrants before they present as symptomatic.

Notes

1. Musafir means 'traveller', with connotations of pilgrim, migrant, and exile.
2. This prompted a report to the department authority for child protection.
3. As noted by Banerjee (2000, 39), traditional homosexual liasons with and between Pathan men and youth had a significant place in the burgeoning corpus of Victorian and late Edwardian erotica, and served as a displacement channel for British officers who faced sexual restrictions on homosexuality in England.

Ethical Approval

It was given full ethical approval by the INSERM ethics committee and Institutional Review Board, France.

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