Exploring the Impact of Religion, Superstition, and Professional Cultural Competence on Access to HIV and Mental Health Treatment among Black Sub-Sahara African Communities in the English City of Birmingham

Authors Mathew Nyashanu, Griffin Ganga and Tiffany Chenneville

Abstract

HIV and mental health are sensitive subjects among Black Sub-Saharan African (BSSA) communities despite the disproportionate impact of HIV among this population and high comorbidity between HIV and mental disorders. This study explored the impact of religion, superstition, and professional cultural competence on access to HIV and mental health services among BSSA communities in the English city of Birmingham. Researchers utilised explorative qualitative methods. Specifically, 12 focus groups were conducted followed by a semi-structured interview with a member from each focus group. Data were analysed using a thematic approach guided by the four phases of the silences framework. Results suggest that religion, superstition and professional cultural competence affect access to HIV and mental health services among BSSA communities. Findings indicate a need to educate religious leaders on the impact of HIV and mental health stigma as well as a need for cultural competence training among health professionals.

Keywords: HIV, mental health, Black sub-Sahara African, religion cultural competence.

Introduction

Sub-Saharan Africa is comprised of 36 countries (Gershman & Rivera, 2018). Among the 398 regions within these countries, there are 750 unique ethnolinguistic groups (Gershman & Rivera, 2018). Christianity and Islam are the dominant religions in Sub-Saharan Africa. As a result of political and economic disruptions in Africa (Public Health England, 2015), Black Sub-Saharan African (BSSA) communities have now permanently established themselves in many UK cities. Among other cities, there are large BSSA communities in Birmingham, England.

HIV and mental health are sensitive issues among BSSA communities, which has a direct impact on community members' access to treatment (Nyashanu & Serrant, 2016). This is despite the disproportionate impact of mental illness and HIV among Black communities in the United Kingdom (UK; Public Health England, 2017). Worldwide, epidemiological statistics suggest that BSSA communities account for two thirds of people living with HIV (PLWH; World Health Organization [WHO], 2018; Department of Health [DH], 2013). This has resulted in suspicion among African communities and conspiracy theories linking the HIV epidemic to sabotage directed toward the Black African race (Snowden, 2019). The impact is further marginalised views and silences within African communities that are counterproductive to efforts designed to tackle the HIV epidemic (WHO, 2018; UNAIDS, 2013). Furthermore, Black communities are disproportionately represented in mental health institutions (Williams, 2017).

In the sections to follow, we explore the existing literature on religion, superstitious beliefs, and cultural competence within the context of HIV and mental health stigma and access to care. We then present the purpose of the current study.

Religion

Religion and professional attitudes contribute to HIV and mental health stigma (Nyashanu, 2018; Braun & Clarke, 2012). It is in these realms that stigma is socially scripted during different forms of interaction. For example, when faith groups blame PLWH and mental illness as pay back for their past sins (Hickman, Glass, Arnkoff, & Fallot, 2012; Aranda, 2008), they perpetuate stigma. Furthermore, to cope with stigma, superstitions have been used as a substitute for HIV and mental health diagnoses among BSSA communities, thereby affecting access to uptake of treatment services.

Religion heavily influences attitudes about sex and sexual orientation although the impact of religion on actual sexual behavior varies. Based on findings from a systematic review, Shaw and El-Bassel (2014) found lower levels of sexual HIV risk behaviors with increased religiosity; however, the relationship was weaker when condom use was the outcome variable. Christianity is prevalent in Sub-Saharan Africa (Manala, 2013), but the impact of Christianity on the HIV epidemic is variable (Cage & Rueda, 2020). Cage and Rueda (2020) found higher HIV prevalence among regions close to historical missionary settlements and lower HIV prevalence in regions near missionary settlements with health facilities and an investment in health. Given that community-level poverty may affect sexual risk taking (Tenkorang, Maticka-Tyndale& Rajulton, 2011), it stands to reason that socioeconomic factors may also affect the impact of religious discourse on sexual behaviors. Political and cultural factors also contribute to stigma and perceptions about sexual health within BSSA communities (Nyashanu, Serrant & Paniaqua, 2017). The need to better understand stigma related to HIV and mental health stigma is gaining urgency within communities and among public health practitioners, policy makers, and researchers. Indeed, the intersectionality framework highlights how co-occurring stigmas (e.g, HIV stigma, mental health stigma, physical disability stigma) combined with stigmatized identities based on gender, race, and sexuality may intensify the experiences of stigma among PLWH

(Jackson-Best & Edwards, 2018). Religion may further foster HIV stigma, even among the healthcare providers responsible for caring for PLWH (Reyes-Estrada et al., 2015). Indeed, many religions classify homosexual behavior, sex work, and drug use as immoral, which are behaviors often associated with HIV and mental health. As a result, church members may promote HIV and mental health stigma through moralistic attitudes and conservative ideologies (Malwela, 2019; Campbell et al., 2011). In many BSSA communities, religious leaders are seen as powerful gatekeepers who control what happens within their communities (Nyashanu & Serrant, 2016). These power dynamics and sanctions have a direct impact on the health seeking behaviour of community members, including access to HIV and mental health services.

HIV and mental health stigma can manifest through stereotyping and may result in separation from others, loss of social status, and discriminatory behaviors and also may affect health seeking behavior (Bharadwaj et al., 2017; Earnshaw et all, 2013). In some instances, PLWH have been perceived as promiscuous despite the various ways in which the virus can be transmitted (Nyashanu, 2018). Living with HIV often is associated with a degradation of respect. Furthermore, religious beliefs may perpetuate negative perceptions of PLWH (Bass, 2019; Campbell et al., 2011) as religious norms may link HIV and mental illness with sinful behavior and immorality, thus exacerbating stigma across different religions. Some faiths interpret HIV and mental illness as punishment from God, resulting in a rift between those affected and those not affected (Pantelic et al., 2018; Crabb et al., 2012). This has resulted in further division within communities and, subsequently, adverse consequences related to accessing HIV and mental health services among those in need. Because some negative religious beliefs foster hate for PLWH and other stigmatized illnesses, it is important to reduce HIV and mental illness stigma within religious communities (Reyes-Estrada et al.,

2015). However, reducing HIV stigma is only possible when there is a better understanding

of the underlying factors contributing to stigma.

Superstitious Beliefs

Belief in superstition and witchcraft is prevalent in BSSA communities and is

significant in the conception of HIV as well as associated mental illness (Kroesbergen, 2019;

Tenkorang, Gyimah, et al., 2011; Kyei et al., 2014). In such a context, evil spirits are

considered wicked forces that cause disease and death to the extent that witches or evil spirits

can be blamed for any misfortune (Anderson, 2018). PLWH and associated mental illness

suffer double stigma within a biomedical paradigm, which focuses on the biological aspects

of diagnosis and treatment. Viewed through a biomedical lens, superstitions do not seem to

make much sense. However, superstitious beliefs serve a powerful purpose as they provide an

alternative explanation for natural events that are deemed unexplainable (Tenkorang,

Gyimah, et al., 2011).

Superstitious beliefs about HIV and associated mental illness form a significant factor

in understanding access, or lack thereof, to treatment within BSSA communities. The

biomedical model forms the bedrock of health promotion and treatment for HIV and mental

health (Deacon 2013). However, failure to accommodate cultural interpretations may present

barriers to effective treatment of HIV and mental health. Traditional healers just like religious

leaders are powerful and influential in BSSA communities (Nyashanu & Serrant, 2016).

Within the biomedical paradigm, the diagnosis of HIV is most often the function of

behaviour (e.g., sexual behaviour), whereas diagnosis from a traditional healer places the

blame on witches and evil spirits (Tenkorang, Gyimah, et al., 2011). This shift of blame from

the individual to the supernatural realm as a cause for the ailment may free the individual

from blame and the associated stigma, but also may result in increased risky sexual behavior,

especially among men (Tenkorang, Gyimah, et al., 2011). Remedies may include traditional

herbs and rituals to appease the offended spirits. Virgin cleansing also may be prescribed based on the myth that having sex with a virgin cures HIV (Charlier et al., 2017).

Cultural Competence

Despite efforts to enforce practices that take into account culture and diversity, health disparities persist across the world. Racial and ethnic minorities as well as people from lower socio-educational and socio-economic groups are at greater risk for poor HIV and mental health outcomes, which may be attributed, in part, to healthcare professionals' lack of cultural awareness (Penn et al., 2011), which can lead to stereotyping and, in some cases, apathy. To foster relationships of trust and to improve sexual health outcomes, professionals must understand the basic cultures of the various groups they serve. When healthcare professionals are knowledgeable about the cultural issues that affect treatment, it is easier to establish trust within the therapeutic relationship (Penn et al., 2011; Campinha-Bacote, 2010; Anderson et al., 2010).

Cultural competence refers to a professional's ability to effectively work in a variety of cultural contexts and with people from different cultures (Betancourt, Green, & Carrillo, 2012). As noted above, cultural competence is particularly important for professionals providing HIV and mental health services in order to reduce the health disparities related to poor outcomes for individuals and within communities (Diaz, Clarke, & Gatua, 2015). Cultural incompetence can fuel antagonism between professionals and the people they serve, resulting in anticipated, perceived, or enacted stigma. HIV and mental health are very sensitive subjects. It is, therefore, particularly important for professionals working in the area of sexual health to have strong communication skills and knowledge of the impact of cultural factors on sexual health. Cultural diversity within the HIV and mental health workforce may affect the provision of culturally competent care. Unfortunately, few organisations truly

invest in ensuring that staff are culturally aware. Instead, many organisations invest primarily

in clinical care, overlooking the importance of social factors in disease management.

While many health care courses, for the most part, incorporate cultural awareness into their

training in order to help professionals cater to the needs of the people accessing HIV and

mental health services, specific details about various cultures often are lacking (e.g., how

different cultures perceive nonverbal behavior) (Ume-Nwagbo, 2012). This lack of cultural

knowledge on the part of the professional may affect how people perceive their experiences

with a healthcare provider. Therefore, developing cultural competence should require

knowledge seeking and experiencing different cultures (Penn et al., 2011; Campinha-Bacote,

2010). In other words, cultural encounters are a necessary aspect of gaining cultural

competence. Providing culturally competent HIV and mental health services to diverse

populations requires more than a recognition of race and ethnicity and must include an

acknowledgement of the various values, beliefs, and experiences that contribute to the

individual experience (Penn et al., 2011; Anderson et al., 2010). When these factors are taken

into consideration, people from diverse communities are more likely to engage in healthcare

services with confidence. Differences related to gender identity, sexual orientation,

socioeconomic status, and religious affiliation also should be taken into consideration.

Training programmes need to promote self-awareness among healthcare professionals in

order to build cultural competence with the goal of improving health outcomes for the people

they serve (Saha et al., 2013).

Cultural competence is particularly important when healthcare professionals from a

dominant or empowered group provide services to people from a minority or marginalized

group, which may be common in treatment centres for HIV and mental health. Although

cultural incompetence may manifest differently among sexual health and mental health

professionals, the common result may be frustration or anger resulting from an inability to

communicate or a failure to acknowledge important cultural beliefs or principles. Affected communities may interpret such actions as stigma.

Purpose of Study

Guided by The Silences Framework (TSF; Serrant-Green, 2011), the purpose of this exploratory study was to understand the impact of religion, superstition and professional cultural competence on access to HIV and mental health treatment among BSSA communities living in the English city of Birmingham in the UK, which has a large BSSA population. Specifically, this study sought to answer the following research questions: (1) How do religion, superstitious beliefs, and health professional's cultural competence affect access to HIV and mental health services in BSSA communities? and (2) What are the implications for sexual health and mental health professionals working in BSSA communities?

An interpretivist paradigm asserts that no single reality exists but, rather, that the world is understood through the underlying meanings people attribute to their personal experiences (Clarke & Braun, 2013). Consistent with this paradigm, TSF assumes that reality is not fixed or objective. Rather, people are the authors of the social world they find themselves in at any given time within a particular society (Serrant-Green, 2011). TSF emphasises the importance of "screaming silences" in individuals and group interpretation of lived experiences or events that may be perceived as "truth". Screaming silences are regarded as marginalised discourses within societies (Serrant-Green, 2011). In this study, discourses were explored in relation to the power of religious leaders, superstitions, and health professionals in accessing HIV and mental health services among BSSA communities in Birmingham.

Methods

Study Design

This study employed an exploratory qualitative study (EQS) approach, which is designed to examine research questions for the purpose of better understanding an issue or issues as opposed to offering conclusive solutions to the existing problem(s) under investigation (Saunders, Lewis, & Thornhill, 2012). With increased understanding of the nature of a problem, findings from an EQS may be used to identify areas in need of further investigation. As such, an EQS is useful for offering new perspectives on existing problems and can be a source for the development of future interventions (Creswell, 2009).

Participants and Procedures

Ethical approval was obtained from the Heart of England Foundation Trust United Kingdom and the University of Wolverhampton Research Ethics Committee. To be included, participants had to be from a Sub-Saharan African country and living in a BSSA community in Birmingham, UK. HIV status was not a criteria for participation, and participants were not asked to report their HIV status due to privacy concerns. Participation was voluntary, and all participants provided written consent.

Participants were divided across 12 focus groups comprised of 8 people each. An attempt was made to balance gender across focus groups although this was not always possible. At the conclusion of the focus group, participants were asked to indicate if they would be willing to engage in a follow up interview. Among those who agreed, one participant from each focus group was randomly chosen to take part in an individual semi-structured interview. Focus groups and interviews were conducted by an assistant moderator, and questions were designed to gather data about the lived experiences of research participants around the impact of religion, superstition and professional cultural competence on access to HIV and mental health treatment. An interview schedule was used to guide the focus group discussions. Following the focus group discussions, an interview schedule was developed to further explore issues raised in the focus groups. The focus group discussions

lasted for one hour and the individual interviews each lasted 30 minutes. Both the focus

group discussions and individual interviews were audio recorded and transcribed verbatim.

Data Analysis

Data was analysed using a thematic approach guided by the four phases of TSF (See

Figure 1). During Phase 1, the data from interviews were analysed by three researchers, and

recurrent themes were identified. During Phase 2, the findings from Phase 1 were reviewed

by the research participants. Feedback from participants was used to refute or confirm the

findings from Phase 1. During Phase 3, further examination of Phase 2 findings was done

through the social networks of research participants which, in this case, included members of

BSSA communities who had not participated in the study. During Phase 4, the findings from

Phase 3 were reviewed by the researchers and developed into the final themes.

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Results

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Participant Demographics

Participants included 96 men and women from BSSA communities living in

Birmingham, which is located in the West Midlands county of the UK. Participants ranged in

age from 18 to 60 years. The sample consisted of BSSA community members as well as

community leaders, including religious leaders and academics. All participants were from

Sub-Saharan African countries. Among participants who reported their religion, most

identified as Christian or African tradition, which are the dominant religions within BSSA

communities. See Table 1 for more detailed information about the demographic

characteristics of participants.

Religion and Access to HIV and Mental Health Services

Participants reported high levels of stigmatisation toward PLWH and/or experiencing

mental health issues, asserting that they live in fear of being discriminated and/or blamed for

their conditions. In addition, they reported that there was reluctance to use HIV and mental

health services owing to this stigma, which is entrenched in religious views. For example,

one participant said:

"*The pastors seem to blame people with HIV and mental health as though it's their*

fault. They seem to say it's payback time for the bad things they have done in the past.

Honestly they treat them like outcasts. This really need to change" (African man

aged 40).

Another commented:

"*Even though there is treatment readily available at the hospital for both HIV and*

mental health you have to think twice before you can go to the hospital as it only

confirms that you are suffering from these stigmatised conditions" (African

woman aged 35)

Participants also suggested that religious leaders viewed PLWH and/or experiencing mental

health problems as different from the rest of the congregation unless they recover from their

conditions. For example, one participant said:

"*We all know that HIV cannot be cured but our church leaders always ask for those*

affected to come for prayers so that they will be cured of their HIV and mental health.

It distresses the affected people as they are vulnerable to all sorts of ridicule" (African

woman aged 37)

Another participant noted:

"*You hear other people within the church criticizing people who are taking HIV and*

mental health medication. Honestly how are these people going to feel? Some begin

to think twice whether to continue taking the medication or just pack it in." (African man

aged 40)

Furthermore, participants expressed discomfort about the competition for dominance between

religious leaders and health professionals. Some believed religious leaders were worried that,

by encouraging congregants to take hospital treatment, their influence was at stake. For

example, one participant said:

"I am worried about how people who are taking mental health and HIV treatment

are viewed. You hear people talking ill about them because they are on treatment

while very little is said about those who prefer spiritual treatment from the pastor.

It seems to me the church is competing with the hospital for influence" (African women aged

29)

Another participant said:

"I feel that the church has an obligation to inform the congregants about the

beauty of accessing treatment for HIV and mental health but there seems to be

a silent voice from the powers that be to discourage people from taking treatments

(African man aged 37)

Participants acknowledged the importance of religion in their everyday lives and the

perceived protection it offered them against HIV and mental health stigma. For example, one

participant explained:

"Religion is very important to our life; it gives us protection and confidence against

forces of evil. It is because of this reason that no one would want to be seen on the

*wrong side of religion." (*African woman aged 38)

Superstitions and Access to HIV and Mental Health Services

Participants explained that many people feel comfortable when prophets and

traditional healers interpret their HIV and/or mental health diagnosis as evil spirits from

enemies given that it is less stigmatizing to be "cursed" than to contract HIV or to suffer from

mental illness. For example, one participant said:

"*Even after being told that one is HIV positive you see them going to seek diagnosis*

from traditional healers where their diagnosis is substituted as evil spirits. Many people

at that point will give up medication" (African woman aged 23)

Another participant explained:

"I don't blame people who visit traditional healers and prophets when they have HIV

or mental health issues. There is too much stigma in our community, people seem to

feel sorry for you if the diagnosis is said to have been caused by evil spirits" (African man

aged 28)

Participants also explained that fear of HIV and mental health stigma was driving some

people to engage in unscrupulous rituals such as sexually abusing children and, in some

cases, infecting them with HIV. For example, one participant said:

"The desperation to evade HIV and mental health stigma in communities sometimes

 drive people to rape and abuse children hoping to be cured. This is very sad for our

community" (African man aged 46)

Another participant said:

"These silly interventions are caused by traditional healers and prophets trying to

maintain their relevancy in the modern world. They just need to be reported to the

 police to stop this type of behaviour and abuse" (African woman aged 28)

Professionals' Cultural Competence and Access to HIV and Mental Health Treatment

Male participants explained that it was embarrassing to be asked personal sexual

information by female health professionals. They said they were inclined to give "acceptable"

answers in order to avoid embarrassment. In the same way, female participants were

embarrassed to be asked personal and intimate information by male health workers, causing

them to avoid services altogether or to provide "acceptable", but inaccurate, information. For

example, one male participant said:

"It is so embarrassing to be asked intimate personal information by a female

health professional. This is not common in my culture. I normally give an answer

which I know does not impact on me or my family" (African man age 39)

A female participant explained:

"I find it difficult when you get to the clinic and find it's manned by a male clinician.

It makes it difficult for me to answer intimate questions like how many times have I

had sex in the last two weeks. Honestly I will say none, because it's embarrassing in

my culture" (African woman aged 48)

Participants also expressed feeling stigmatized simply by walking into an HIV or mental

health clinic because of the disproportionate epidemiological statistics in the public domain.

The majority of PLWH today are from Sub Sahara Africa yet they do not constitute a

significant proportion of the world population (WHO, 2018). For example, one participant

said:

"As soon as you walk into the clinic you just feel like the professionals are stigmatising

you as being HIV positive or having mental health problems just because you are Black.

Sometimes you see them whispering as soon as you walk in. I just wish these statistics

are not made public" (African man aged 27).

Another participant explained:

"Once you walk into the clinic you feel like everyone is saying here she comes again.

You just feel stereotyped" (African woman aged 29).

Discussion

Findings from this exploratory qualitative study provide important information about

the interacting impact of religion, superstitious beliefs, and health care professionals on

access to HIV and mental health services in BSSA communities in the UK. These impacts are

discussed within the context of the existing literature in the section to follow. This is followed

by a description of the current study's strengths and limitations. Conclusions and future

directions also are discussed.

Interaction Impact of Religion, Superstitious Beliefs, and Health Professionals on

Access to HIV and Mental Health Treatment

While religion was identified as a barrier to HIV and mental health treatment among

BSSA communities, participants also acknowledged the importance of religion as a source of

comfort and protection, which is consistent with findings from the existing literature (Ayvaci,

2017; Arzah, Ketchum, & LeMoon, 2018). Findings further revealed the lasting impact that

religious leaders have on BSSA community members' behaviour and response to HIV and

mental health treatment. Some religious leaders promote negative perceptions of PLWH and

mental health problems (Bass, 2019). Consistent with other available research, participants in

this study revealed that rigid religious norms and perceptions result in linking HIV and

mental illness with immorality and sinful behaviour (Hickman, Glass, Arnkoff, & Fallot,

2012; Aranda, 2008) or as punishment from God for sins committed in the past (Pantelic et

al., 2018), which is common in Lutheran and Pentecostal churches. In some cases, religions

have described HIV and mental illness as the inevitable consequence of breaking divine

moral laws (Varas-Diaz et al., 2017). In this study, participants indicated the religious

community views negatively those living with HIV or with mental health issues. The

negative association between HIV, mental illness, and morality extends from religious

leaders to religious followers, leading to resentment towards PLWH and/or mental illness

within the congregation.

Beyond promoting negative stereotypes, previous research suggests that some

religious leaders indirectly discourage members from receiving medical treatment for HIV or

mental illness by continually linking being holy with being free from stigmatised conditions

like HIV and mental illness (Nyashanu & Marenga, 2010). To make sure they are in control

of the congregants, they lead to remain relevant. Similar findings were revealed in this study, with some participants reporting that some religious leaders discouraged their followers from taking medication for HIV and mental illness due to a fear of losing congregants to the secular world if they found medication to be effective. These issues have created divisions within BSSA communities resulting in adverse consequences with regard to members' willingness to access HIV and mental health services. Further, there appears to be a relationship between religion and superstitious beliefs with congregants preferring to believe prophets or religious leaders who attribute HIV and mental illness to be a function of evil spirits given that being cursed is less stigmatizing than HIV contracted through what is perceived to be immoral behaviour or mental illness, which is otherwise difficult to explain.

Findings from this study confirm the impact of health professionals on social scripts that promote HIV and mental health stigma. Specifically, the type of questions patients are asked reflect a lack of cultural competence. For example, asking a patient if they have travelled to Africa within the last two months may send the message that healthcare professionals believe all PLWH contracted the disease in Africa. This may be particularly stigmatizing to BSSAs who are already sensitive to HIV stigma. Some participants acknowledged that such questions may trigger negative experiences with colonialism in Africa, thereby resulting in the perception of sexual health professionals as racist. Indeed, research suggests that most BSSA communities in the UK today have either personally experienced, or witnessed a close relative experience, racism back in their home countries (Chigwedere & Essex, 2010). Such experiences may further alienate BSSA community members from seeking services from sexual health clinics or other treatment centres and/or might result in negative reactions to certain inquiries.

In BSSA communities, sexual health involves sensitive discussions, which normally are held only between people of the same gender (Drummond, 2008). In this study, BSSA

men struggled to discuss their sexual health with a female sexual health practitioner and, conversely, BSSA women struggled to discuss their sexual health with a male sexual health practitioner. Most experienced embarrassment or perceived stigma and, as a result, contemplated not returning for additional services. There are several possible explanations for the reluctance of BSSA men and women to request a same-gender practitioner. First, in many BSSA communities, requesting an alternative practitioner may be perceived as requesting additional services. While this is generally acceptable in the UK, where the opinion of service users' experiences is highly valued as a part of quality care (NHS England, 2014), doing so is viewed as inappropriate in BSSA communities as a result of cultural values and historical experiences related to colonial structures. Therefore, BSSA men and women may be reluctant to make a request for fear of being perceived as unappreciative of the initial service offered. In addition, men and women in BSSA communities may not be aware that they *can* ask for additional services or a different practitioner due to a lack of knowledge or misinformation about sexual health services and processes in sexual health clinics.

BSSA men, specifically, perceived being viewed as risk takers by sexual health professionals and women in their own communities. The perception of being judged by sexual health professionals, real or perceived, resulted in feelings of anxiety upon entering a sexual health clinic. As a result and in order to manage perceived stigma, some BSSA men feel defensive about their sexual health behaviour. These findings are consistent with earlier research, which suggests that men find it difficult to seek sexual health services (Addis & Mahalik, 2003). Men's health outcomes are thought to be adversely affected by their reluctance to seek sexual health services (Vaswani, 2011). In light of the patriarchal nature of BSSA communities, where men are regarded as the custodians of their communities, it is not surprising that men feel embarrassed and belittled when question by a woman about their sexual history.

Findings suggest that the challenges BSSA communities face when interacting with health professionals encourages them to seek alternative and unorthodox means of avoiding HIV and mental stigma, preferring to seek spiritual guidance from religious leaders and alternative diagnoses from spiritual healers in order to create distance from being HIV positive or having mental health issues. In seeking acceptance within their own communities, many BSSA community members tend to favour a spiritual diagnosis to a medical diagnosis. In some extreme cases, PLWH or mental illness have engaged in unorthodox cleansing rituals involving sexual abuse of minors with the hope of being cured of their condition. This superstitious phenomenon is not new among BSSA communities and is driven by socially constructed myths on the treatment of stigmatised conditions. The power of socially constructed beliefs is supported by the landmark work of Fanon (1952) who asserted that individuals who hold strong core beliefs are reluctant to accept evidence that refutes those beliefs. This makes it difficult for some people to abandon superstitious interventions for new medical interventions.

Providing sexual health services to diverse populations goes beyond recognising race and ethnicity and acknowledges the values, beliefs, values and experiences that shape the unique identities of individuals (Anderson et al., 2010). Recognising diversity along with the political, social and migration factors that affect health can foster the trust needed between healthcare providers and community members. There is therefore a need to ensure that the ' cultural competence training programmes that healthcare professionals receive improve self-awareness and impart the knowledge and skills needed to provide services to people from different cultures (Saha et al., 2013).

The challenge with BSSA communities living in the UK is that Sub-Sahara Africa is a big region with different nations. It would be nearly impossible for a healthcare professional to fully understand the different cultures that exist within BSSA communities. However,

given that many similarities exist between cultures within BSSA communities, it is possible for healthcare professionals to understand some of the basic cultural factors that influence sexual behavior and other behaviors related to sexual health. Of utmost importance is healthcare professionals' acknowledgement that sexual health is a sensitive subject and that sociopolitical and other factors may further exacerbate HIV stigma.

Strengths and Limitations

The use of The Silences Framework (TSF) to guide this study is a strength. Also, this is one of few studies that has examined the impact of religion, superstition and professional cultural competence on access to HIV and mental health treatment among BSSA communities living in the English city of Birmingham in the UK. Given the large BSSA population in Birmingham, current findings have practical significance in addition to contributing to the existing literature. Limitations surround the challenges of qualitative research. For example, current findings do not speak to causality and it may be difficult to verify results. Further, current findings may not represent the views of all important stakeholders.

Conclusions and Future Directions

Current findings support efforts to reduce HIV and mental health stigma among religious leaders and their communities (UNAIDS, 2010). In addition to the need to educate religious leaders on the impact of HIV and mental health on members of BSSA communities, participants in this study described the importance of confidentiality and support for those living with or affected by HIV and mental health issues. Nyashanu and Serrant (2016) described the importance of HIV and mental health service providers working with, and not against, religious communities by acknowledging the benefits of religion to congregants, thus providing a vehicle to access BSSA communities directly.

Consistent with the existing literature in other communities (Diaz, Clarke and Gatua, 2015), current findings also confirm the need for improved cultural competence among staff providing HIV and mental health services to BSSA communities in order to reduce health disparities and achieve positive outcomes. This will require education, training, and policy changes.

Future research is needed to expand this line of research using larger and more representative samples. Cross-cultural comparisons of BSSA communities living in the UK and BSSA communities living in Africa or other parts of the world is needed to better understand the similarities and differences based on contextual factors. While EQS was appropriate for this initial study, future studies may want to employ quantitative and/or experimental designs to further understand the constructs of religion, superstitious beliefs, and health professionals' cultural competence on the access to HIV and mental health services within BSSA communities.

Compliance with Ethical Standard

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Conflict of Interest

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