Emerging Perspectives on Society and Health in Sub-Saharan Africa

Edited by

Mathew Nyashanu, Mandu Stephen Ekpenyong, and Efrider Maramwidze

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Foreword

The health of communities in sub-Saharan Africa is affected by numerous challenges, including limited resources, hunger, poverty, and conflict. Efforts to address these issues have often been hindered by inadequate funding, sparse research, and insufficient collaboration. Many health systems in sub-Saharan Africa operate with heavy reliance on aid agencies and minimal government funding, which is constrained by weak economies. However, the influence of aid agencies often brings a colonial legacy that shapes health interventions, driven by the financial power of these organizations. In post-colonial Africa, the focus on political power struggles has left health and social infrastructure under-resourced, as much-needed funds are diverted to political agendas rather than public welfare.

Inadequate health infrastructure across the continent leaves many communities vulnerable to preventable diseases. Health interventions often rely on Eurocentric approaches, which may not suit local needs. There has been limited integration of African indigenous knowledge into health solutions, partly due to the perceived superiority of Western models. The marginalization of African perspectives hampers the development of context-specific solutions and is compounded by the lack of adequate funding for local health research. Without the resources to create a robust, indigenous knowledge base, African nations are left dependent on external systems that often fail to address their specific challenges.

Africa also faces destabilizing effects from civil wars and governance issues fuelled by corruption and the pursuit of personal wealth by some leaders. These factors contribute to failing economies and deteriorating health infrastructure while widespread diseases strain an already fragile system. Addressing these health challenges will require a multifaceted approach involving good governance, community-driven research, and respect for African knowledge systems.

There is an urgent need to rethink the role of aid in rebuilding Africa's health systems. Aid agencies must adopt decolonized strategies that respond to Afrocentric needs rather than impose external models. Funding should be directed according to the priorities of African communities, those who bear the impact of inadequate health infrastructure. African scholars, health practitioners, and communities must lead this transformation through inclusive research that reflects their experiences and aspirations.

Decolonizing research funding from the Global North to the Global South is essential, as is respecting African researchers as authorities on their health challenges. Funding and aid should be free from political conditions that reinforce the dominance of Western knowledge and foreign strategies. Though Africa's health challenges are complex, with united and sustained efforts, meaningful restructuring is possible.

Editors and Contributors

About the Editors

Dr Mathew Nyashanu is a senior lecturer at Nottingham Trent University in the Institute of Health and Allied Professions (IHAP). Mathew contributes on a number of modules on the MA in Public Health including supervising PhD students in the IHAP Some of the modules that Mathew contributes to include Concepts of Health and Healing, Research Methods and Dissertations. Mathew also engages in research which include Community engagement, Sexual Health and HIV including Health strengthening systems in Low and Middle income countries (LOMICs). Mathew also collaborates with diaspora community groups working in health and development nationally and internationally. Some of his notable international collaborations are in Uganda, South Africa, Zimbabwe, Zambia, Jamaica and Guyana. Mathew has published widely in peer reviewed journals and books on the subject of Public health. Mathew is a Fellow of the Higher Education Academy (FHEA) and Fellow of the Royal Society of Public Health (RSPH).

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About the Contributors

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Dr. Elizabeth Revai Mudzimu is a social scientist graduate from the University of Groningen in the Netherlands. Her research focuses on Women' Sexual and Reproductive Health and Rights and transformative and sustainable strategies. Her passion for women's development has led her to venture into Public Health where she has researched culturally tailored interventions for Physical activities with minority ethnic groups in the United Kingdom. Elizabeth brings a unique interdisciplinary approach to health and social issues, combining academic rigor with a deep commitment to community engagement and social issues. She has vast experience working with women in development and empowerment programs. Her research and practical work have centred on women's health, social well-being, and empowerment, particularly focusing on underserved populations in Zimbabwe. Elizabeth is currently teaching Religious Education and Philosophy in the United Kingdom.

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Chapter One

The Social Construction of HIV Stigma Among Black Sub-Saharan African Communities and its Impact on Sexual Health-Seeking Behaviour in the United Kingdom

Mathew Nyashanu, Mandu Stephen Ekpenyong, Rumbidzai Chireshe, Laura Serrant, and Elizabeth Revai Mudzimu

Abstract

HIV stigma has hampered positive sexual health-seeking behaviour among Black and Minority Ethnic (BME) communities in the UK, leading to late presentation at treatment centers and premature death. Despite many health initiatives to reduce risk and promote engagement with services, there remains a dearth of empirical sexual health information related to newly established BME communities in England, such as Black Sub-Saharan African (BSSA) communities. This chapter explores the social construction of HIV stigma and its impact on sexual health-seeking behaviour among BSSA communities in England. In doing so, it considers the seven pillars of HIV stigma, namely marriage institution, Religion, Sexual health professionals' cultural competency, Reported HIV statistical data, cultural sensitivity of sexual health, gender stereotyping, and social media. The chapter is mainly drawn from qualitative PhD research utilizing The Silences Framework (TSF) to explore beliefs and perceptions in the construction of HIV stigma and sexual health-seeking behaviour among BSSA communities in one English region. The experiences emanating from the research have potentially wider application, demonstrating through the pillars of HIV stigma how social, political, and personal contexts associated with specific sexual scripts among the BSSA communities impact sexual health-seeking behaviours.

Introduction

For decades, sexual health service provision in England has been generic and designed for all communities, except for temporary initiatives for asylum seekers and refugee communities. It was not until 2011 that The National Institute for Health and Care Excellence (NICE) produced guidelines that encouraged the establishment of specific sexual health services targeting at-risk communities and social groups (NICE 2011). Although this came into effect, there remain no statutory obligations for health authorities to ensure that sexual health services are provided to specific, diverse communities in their areas (Wang et al., 2012). This is against the backdrop of increased numbers of migrant communities, with some being disproportionately affected by HIV (Public Health England, 2014). Furthermore, there is evidence of the restricted uptake of HIV and sexual health services within communities in the UK due to HIV stigma and discrimination (Chinouya and Muza 2007).

In this context, sexual health services have often found it challenging to engage with the gatekeepers of some migrant communities, such as the BSSA communities, sometimes leading to late presentation at treatment centers and an upsurge in new HIV infections (Nyashanu and Serrant 2016). In addition, the latest epidemiological data on HIV infection in the UK continue to show an increase in new infections (Public Health, England, 2015). This indicates the need for Public Health Departments to address the sexual health of BME and migrant communities at risk of contracting HIV (National AIDS Trust, 2016). Therefore, it is important that diverse communities are engaged at the earliest convenience to reduce the impact on their communities and wider population. Case studies and qualitative community research indicate that social and cultural factors such as HIV stigma and community expectations may affect health behaviours, calling for a need to identify the environmental and structural sources that support the social construction of these factors and the ways in which they are manifested (Nyashanu et al., 2017). This will add value to existing HIV prevention strategies among communities in the UK and worldwide, considering new emerging communities.

Fear of stigma associated with HIV infection has deterred individuals and communities from taking up STI and HIV tests, and from disclosing their seropositive status to their sexual partners, family, and the community at large (Reif, Golin, and Smith 2007). Furthermore, high levels of perceived stigma may be linked to more depressive and HIV-associated symptoms, including lower adherence to antiretroviral therapy (Smedley 2002). On a positive note, while many studies have focused on public and personal HIV stigmatisation, there has been a marked improvement in HIV prevention for mother-to-child transmission and between sexual partners (WHO 2011; UNAIDS 2014). However, ample evidence highlights the serious challenges to health improvement in this area, such as the low uptake of HIV testing and poor treatment adherence, leading to poor health outcomes for affected individuals (Lehmann and Zulu 2005; Kuznetsova et al. 2016). Therefore, while there continue to be compelling cases to expand the supply of HIV services, mounting evidence demonstrates an urgent need to respond to demand-side barriers that prevent people from using sexual health services, such as HIV stigma and discrimination (Ekouevi et al. 2012).

One of the key factors limiting the sustained, successful prevention and treatment of HIV is the persistent HIV stigma and discrimination that has engulfed the BSSA communities over the years. Many BSSA individuals have opted out of testing and treatment programs for fear of facing disclosure difficulties among their friends and communities (Turan et al., 2008). There is evidence that many people with BME living with HIV have experienced different types of stigma (Earnshaw and Chaudoir, 2008; Earnshaw and Chaudoir, 2009). Furthermore, it has been suggested that stigma and discrimination perpetrated by close friends or relatives have a greater impact than first thought, compared with stigma arising from responses in the wider community (Brickley et al., 2009; Turan et al., 2008; Nyashanu et al., 2017).

HIV-related fears and extreme experiences of stigma have been shown to lead to loss of confidence and other psychosocial effects on the affected individual, which in turn can lead to behavioural consequences, such as lack of disclosure and low uptake of sexual health services (Turan et al., 2008; Nyashanu et al., 2017). This increases the chances of poorer sexual health outcomes in communities and in affected individuals. The effects of

HIV stigma are wide, varied, and complex when considered in the context of BME community dynamics, particularly when considering both affected and infected individuals.

The Context and Definition of HIV Stigma

Much of the literature on HIV stigma acknowledges its discriminatory and prejudicial nature of HIV stigma and its impact on sexual health-seeking behaviour. However, there is very little discussion on what HIV stigma involves (i.e., actions, reactions, and experiences) in the context in which it is used. Researchers have highlighted that the nature of HIV stigma should be clearly understood in context, including how it has evolved among different social groups over time (Janni et al., 2008). Stigma as a concept, manifests itself in different forms and at different levels depending on the complexities and dynamics of a given community (Malcolm 1998). This assertion, therefore, supports the notion that the nature of HIV stigma experienced by BSSA communities can only be understood in the context of research, having taken place within a defined environment, as opposed to the generalized nature of HIV stigma cutting across various communities (Eaton et al., 2009). It is therefore important to note that identifying the nature of stigma in these communities can go a long way towards aiding efforts to reduce HIV stigma. In revealing the different ways in which the nature of HIV stigma is manifested within BSSA communities, some dilemmas and contradictions inherent in the HIV stigma itself are evident. The 'inter' and 'intra' nature of HIV stigma raises some pertinent issues regarding the significance of HIV stigma in the affected communities. Central to this is the fact that BSSA communities have their own views and understanding of the term HIV stigma as experienced in their daily lives.

Nature of HIV stigma among BSSA communities

A Silent Derogatory Term (SDT)

In a research carried out in 2018 most of the BSSA participants referred to HIV stigma as something negative and hateful, which they felt was commonly played out within their communities by different social groups towards people affected or infected by HIV (Nyashanu 2018). This reflects both the impact on those affected and the ways in which it remains hidden and difficult for those affected to prove. This illustrates the issue of HIV stigma in the BSSA communities 'evolved' over time to be housed in actions that community members identified as existing in three subtle forms of ‘screaming silence' - where screaming silences denotes marginalized experiences that are under-researched, little understood, or simply ‘missing’ from discourses around sensitive issues such as HIV stigma in society (Serrant-Green, 2011).

Subtle Prejudice

'Subtle prejudice' is the term used to describe 'inter-community' HIV stigma which was applied from the outside to the whole community and not directly related to the actions of a specific individual. As identified through the study referred to above, this form of HIV stigma often includes prejudiced behaviours or negative attitudes from wider society, including maltreatment, aimed at people living with HIV or those perceived to be living with and spreading HIV. This type of HIV stigma is underpinned by a feeling among the BSSA people interviewed that their communities were stereotyped in many circumstances, based on the established and constructed beliefs about BSSA communities, sexual behaviour, and HIV.

Silent Discrediting

This form of stigma describes the feeling among BSSA communities that they are sometimes silently discredited in many social setups because of their association with a community that has been linked to epitomizing HIV-positive individuals from the outset of the HIV/AIDS Pandemic (Nyashanu, 2018). It was believed that the often-cited disproportionate statistics of HIV cases within BSSA communities, both in the UK and overseas, made them vulnerable to silent discrediting. Moreover, they highlighted that this discrediting, unlike the subtle discrediting described above was not confined to the reactions of those external to the BSSA communities - this could be both 'intra-community (from within the BSSA community itself) or 'inter-community' (from wider society).

Subtle Blaming

Research into sexual health and HIV has previously reported covert blaming of those infected with HIV for their condition, usually arising from outside the communities involved (Serrant-Green, 2011). The BSSA communities and sexual health professionals interviewed in the study also acknowledged the existence of what they termed subtle blaming because an individual is HIV-positive or is associated with an HIV-positive person. Furthermore, similar to the subtle discrimination described earlier, subtle blaming has been reported to arise mainly from 'intra-community' sources. In most cases, the participants reported that the affected individuals were blamed by others in the community for their HIV status or the status of their close associates (Nyashanu, 2018).

Overview of the Pillars of HIV Stigma

The specific issues identified as influencing the construction of HIV stigma and sexual health-seeking behaviour within BSSA communities are referred to as the ‘pillars of HIV stigma’. These include marriage institutions, religion, cultural competency of sexual health professionals, Reported HIV statistical data, cultural sensitivity of sexual health, gender stereotyping, and social media. A brief overview of each of the pillars, in relation to what its role is within either BSSA communities or sexual health/HIV services, is given here so that perceptions can be read in context.

Marriage institution

In many BSSA communities, getting married and retaining marriage are regarded as important achievements in one’s life (Chigwedere & Essex, 2010). BSSA men and women project viewpoints that sharply contrast with marriage as a pillar of the HIV stigma. BSSA men were opposed to the inclusion of marriage institutions as pillars of HIV stigma. Instead, they chose to hail the marriage institution as an important pillar of the social fabric of the BSSA communities and warned that any attempt to label it as a pillar of HIV stigma threatened the core values of the BSSA communities, including their ethos, beliefs, and culture (Nyashanu, 2018). This position projected by BSSA men is not new in the communities, as evidenced by the literature describing many BME communities as patriarchal (Cloete et al., 2009). The argument pushed by the BSSA men was in direct response to the sentiments advanced by the BSSA women that there is an acute imbalance of power in marriage between men and women, where women had no say in transacting HIV-related behaviours and sexual health issues, although it directly impacted them (Nyashanu 2018). The women are aware of the use of the marriage institution as a trump card by BSSA men to silence them on any issues that brought HIV and sexual health to the center of discussion. This assertion is closely supported by the literature viewing most BSSA men as scriptwriters of their communities with little tolerance for women's rights as compared to men's (Mbonu, 2009). Further studies have identified that African men often regard themselves as custodians of the communities they live in, with very little space given concerning decisions that are equally exclusive to women.

Marriage institutions are highly respected in BSSA communities and are used as fundamental achievements in life that a man or woman should endeavour to realize. At the same time, this value accorded to marriage can be seen as limiting the negotiating power of women on issues of HIV and sexual health. In general, discussing HIV or related issues is considered sensitive in BSSA communities, far removed from the marriage institution, and only fit to be discussed by those perceived as not suitable for marriage, thus labelling anyone bringing these issues into marriage as disrespectful and sometimes labelling women as 'prostitutes. This assertion is well documented and supported by the literature, where discussing issues around HIV and sexual health can be viewed as 'promiscuous' and 'uncultured' (Gagnon et al., 2010). This view not only stifles the discussion of important contemporary issues affecting BSSA communities but also potentially takes away opportunities to address the sexual health of BSSA women and men. In light of this assertion, many women have suffered in silence at the hands of their spouses to retain their marriage and fulfil the expected obligations of the community, irrespective of the specific situation of the marriage. Against this background, some women have suffered domestic violence and have become vulnerable to HIV infection (Parker, 2001).

Religion

Religion, like marriage, is viewed as an important institution within most BSSA communities (Kuipers et al., 2014). Religious leaders are among the strongest gatekeepers in most BSSA communities and may determine access to communities through services or willingness to engage with services by community members (Nyashanu and Serrant, 2016). In view of the above, religion has a strong impact on how members of a community conduct themselves. At times, some strong views projected by religious leaders have been taken by community members to set the standard for living one's life.

Religion can be identified in BSSA communities as a pillar through which HIV stigma is scripted (Nyashanu & Serrant, 2016). Sexual health professionals and some members of BSSA communities have expressed concern about the contribution of religion to the construction of HIV stigma and sexual health-seeking behaviour (Nyashanu, 2018). Although both men and women from BSSA communities expressed concerns about this, their views and perceptions of the impact and role of religion differ. Different viewpoints were expressed regarding the place of religion, the power distribution between men and women in the BSSA communities, and the subsequent effects that this may have on sexual health transactions between the two groups. At this point, it is important to acknowledge that although religion is identified as a pillar of HIV stigma, it is within the broader context of the acknowledgment of the importance of religion in shaping the lives of African communities (Link and Phelan 2014).

Moreover, studies have indicated that the projections (values, beliefs, and comments) advanced by religious leaders have a lasting effect on community behaviours and responses to HIV. For example, researchers have described how some religious leaders uphold a negative perception of people living with HIV, which, in some circumstances, such rigidity in religious norms and perceptions has directly associated HIV transmission with immorality and sinful behaviour (Chitando and Gunda, 2007; Parker and Birdsall, 2005). Furthermore, there is evidence in the literature linking the teachings of some Lutheran and Pentecostal churches, interpreting HIV infection as a punishment from God (Dalmida et al. 2012). Such views have ultimately been filtered down to believers following that particular religion, resulting in some of the stigmatizing responses reported by community members.

Literature suggests that some religious leaders have gone further, indirectly discouraging their members from taking antiretroviral medication by continually linking 'recovery' with holiness and freedom from sexually transmitted infections rather than undertaking prescribed treatment regimens (Koenig 2008). This was borne out by the participants in the research study conducted by one of the authors (Nyashanu 2018), but the reasons for this stance were believed to go beyond a lack of health information on the part of religious leaders, believing that some religions discouraged their followers from taking HIV medication to conceal their effectiveness from them for fear of losing followers to the secular world. The combination of the importance of religion and the influence of religious leaders on their everyday lives can affect the behaviours of some members of BSSA communities on these important issues of HIV stigma. This was reported as having created divisions in BSSA communities, leading to an adverse effect on access to sexual health services by BSSA communities and their response to suspected infection.

The urgent need to reduce HIV stigma among religious communities and their leaders has been indicated in literature (UNAIDS, 2014). Negative religious beliefs about people affected and infected by HIV can easily multiply while fostering hate when it comes from religious leaders and congregations. Religion on sex as the cause of HIV is also cited as exacerbating HIV stigma. Sexual activity - a taboo subject not suitable for discussion within some religious groups and BSSA communities and something that should be practiced only within the confines of marriage– is often central to the stigmatization of individuals. As a result, these views have impacted the health and well-being of members who make decisions on their own health and well-being based on the stance taken by their religious leaders, as they feel that they have no right to question religious authority (Ivy III et al., 2017).

Sexual Health Professionals' cultural competency

Health professionals and service users have different contested positions on accessing and delivering services (Social Care Institute for Excellence, 2014), and in some cases, health professionals have been viewed by service users as being judgmental or lacking the skill to provide quality culturally sensitive care to service users informed by cultural practice (South, Raine and White, 2010). Furthermore, as cultural competency among healthcare professionals is central to delivering health services to service users (Mikkonen et al., 2016), a lack of cultural competency among professionals can be a barrier to accessing health for patients.

Both men and women acknowledge that sexual health professionals play a part in social scripts of stigma (Nyashanu 2018). The issues at the center with sexual health professionals included cultural competence and the type of questions asked to patients or service users at the sexual health clinic. In BSSA communities, sexual health is a sensitive subject that is normally discussed only by people of the same sex when necessary (Drummond 2008). BSSA men struggle to entrust their sexual health to female sexual health practitioners (Nyashanu, 2018). This raises the question of why BSSA men do not request a male sexual health practitioner during appointments. Although this issue has not been explored in depth, there are some possible explanations for their embarrassment and reluctance to make such requests. First, in most BSSA communities, requesting an alternative practitioner is likely to be perceived as requesting additional services. While this is acceptable in the UK society, where service users' experiences are highlighted as one of the most important aspects of high-quality care (NHS England 2014), in BSSA communities, as a result of historical/colonial structures and cultural values, this is viewed as inappropriate (Nyashanu, 2018). Therefore, BSSA men may be reluctant to make a request as this may be perceived as not appreciating the initial service offered. In addition, the lack of awareness about sexual health services and processes in sexual health clinics among BSSA men may mean that they were not aware that they *could* ask for extra services or that an alternative practitioner should they need them.

The BSSA men who participated in the aforementioned study had already indicated their preconceived ideas about how sexual health professionals and their own women viewed them as risk-takers (Nyashanu, 2018). This raised their anxiety as soon as they walked into the sexual health clinic, perceiving that sexual health professionals were already judging them. This made some men defensive about their actual sexual health behaviour to manage the stigma that they were experiencing (Nyashanu 2018). In the literature, men are generally seen as finding it difficult to seek sexual health services (Addis & Mahlik, 2003; Serrant-Green, 2004). Health outcomes for men are reported to be adversely affected by unwillingness to seek sexual health services (Vaswani, 2012). In light of the patriarchal BSSA communities, where men regard themselves as custodians of their communities, it is unsurprising that direct sexual history questions to BSSA men made them feel embarrassed and belittled, especially when it came from a woman (Nyashanu 2018). Furthermore, many sexual health professionals professed ignorance about the culture of African communities, although in most cases they made up most of the individuals attending clinics who were living with HIV (Nyashanu 2018). Interestingly, some sexual health professionals also acknowledged that it was a setback that they did not have sufficient knowledge of the culture of the BSSA communities. Against this background, unresolved contested positions between health professionals and service users have created barriers in accessing services. The available literature asserts that the cultural competence of staff working in sexual health is critical for reducing disparities and achieving positive sexual outcomes for patients and communities (Diaz, 2006).

Reported HIV Statistical Data

It is important for population health service planning that statistics of HIV cases be recorded to enable professionals to monitor and measure service demands and overall progress (WHO, 2011). According to recent HIV epidemiological statistics, approximately two-thirds of people living with HIV worldwide today are from the BSSA communities (UNAIDS, 2014). However, these clinical reports of stigmatized conditions are sometimes misinterpreted by lay members of society and the media, contributing to the further stigmatization of certain groups because of their high prevalence. Misinterpretation of reported statistics can be a challenge for affected communities when accessing services.

Misinterpretation in this case does not necessarily relate to the interrogation of the reported figures themselves but to the reaction to the reported data. Such a scenario is often described as a source of stigma arising from other communities with a low HIV prevalence.

In the United Kingdom, approximately 30 percent of HIV-positive individuals are from BSSA communities; however, they constitute less than 1% of the total population (PHE 2015). This does not imply that all BSSA individuals are sources of HIV risk. However, participants in studies on HIV and sexual risk (Nyashanu, 2018; Serrant-Green, 2011) reported experiencing reactions from others, which made them feel as if they were perceived as such. While BSSA communities acknowledge the importance of HIV statistics to public health, they also expressed reservations about how these were interpreted by wider society and at times used by politicians to stigmatize other communities (Nyashanu, 2018). This raises an interesting question as to how official statistics arising from public health bodies and research may be perceived by marginalized groups as not providing a full picture of a phenomenon. This questioning of data by minority communities cited in the reports highlights the potential challenge of the trend in which epidemiological statistics are commonly used to compare disease prevalence in public health in different geographical areas with very little qualitative data to contextualize what is presented as the status quo (Serrant-Green, 2004). BSSA communities and other marginalized groups have challenged a range of issues concerning what they see as the negative use and abuse of HIV statistics to further stigmatize their communities. This highlights the need to introduce community perspectives and the social and political aspects of sexual health into such debates. The inclusion of minority ethnic groups that may be the subjects of such data is essential for gaining a fully contextualized picture of the quantified information generated.

While these HIV statistics have meaning and purpose for professionals working in public health and delivering sexual health services, some laypeople from BSSA communities may not fully understand why it was like that and why it should be a subject of public discussion. This feeling of being unsure generated a feeling of wariness about the statistics and actively engaged with them. They also felt that it gave people from other communities an opportunity to judge HIV and BSSA communities. In an atmosphere of competition for support between communities with high levels of deprivation and marginalization, such conclusions sometimes fuelled friction between communities competing for restricted resources such as jobs and other social amenities.

The Cultural sensitivity of sexual health

Discussions of any issues related to sexual health and HIV may be deemed sensitive and inappropriate among BSSA communities, leading to discouragement of members from discussing such subjects within the communities (Nyashanu and Serrant, 2017). In this context, it can be difficult for members to openly share information on the awareness of the subject, leading to reinforcement of HIV stigma within the community.

Cultural sensitivity to sexual issues in BSSA communities has emerged as a wide and complex pillar of HIV stigma (Nyashanu 2018). Gender stereotyping of black men as risk-takers revealed a key aspect of BSSA communities (Serrant-Green, 2004). This view has been previously reported in literature. BSSA men expressed concern about the negative stereotypes surrounding their sexual behaviour in ways that suggested self-stigmatization (Nyashanu, 2018). The preconceived belief that BSSA men are risk-takers is, to some extent, associated with the aforementioned pillar, which identifies them as belonging to communities with high rates of contracting HIV. Studies including both women with BME and sexual health professionals reinforced the existence of this view, which is widely held across the social divide (Nyashanu, 2018; Serrant-Green, 2004; Vaswani, 2012). Nyashanu's (2018) study found that when this belief is coupled with the perceived bias towards stigmatizing BSSA communities, BSSA men are likely to view the 'routine' screening questions at sexual health clinics with suspicion and mistrust. This, in turn, acted as a 'double stigmatization' effect for men with BSSA, resulting in late presentation and delayed diagnosis at HIV treatment centers or clinics.

The BSSA participants in Nyashanu’s (2018) study felt that sexual orientation was an area of silence within their communities. They discussed the existence of a 'phobia' against all sexual orientations other than heterosexuality by some people from the BSSA communities, and in turn participants reported shared silences of psychological persecution of the gay and lesbian communities from some in their social circles who blamed them for the spread of HIV. Interestingly, while they did not openly agree with these actions, they made great efforts to distance HIV from discussions of the marriage institution and notion of community identity. This denial and shift of blame to other ‘vilified’ sections of the community is a clear indication of the degree of stigmatization associated with HIV.

There is ample evidence in the literature suggesting that gay communities in BSSA communities are exposed to stigma, discrimination, and blame for stigmatizing conditions (Cloete et al., 2008; UNAIDS, 2013). This has ultimately affected the sexual health-seeking behaviour of people within the communities themselves and increased HIV stigma within the BSSA communities. This was further evidenced by the clear disenfranchisement of the gay community within the BSSA communities, as described by the participants. Interestingly, the same discussions revealed a ‘silent’ tension – in that, that the research participants were also mindful of the persecution that the gay communities experienced, which they did not necessarily condone. This leaves many unanswered questions about the plight of gays and lesbians, including their sexual health-seeking behaviour among BSSA communities.

The cultural sensitivities surrounding HIV and Sexual Health, as subjects that cannot be discussed openly within a family setup in BSSA communities, underpin difficulties in addressing concerns and allaying fear. Feelings that the subjects themselves not only bring embarrassment when discussed but are also associated with the BSSA communities’ perspective with individuals having loose morals are at the very least unhelpful. Such an association has increased the stigmatization of HIV within BSSA communities, as members try to live within the expected community standards. Conversely, it must also be considered that if the subject is not frequently discussed, communities’ knowledge about HIV and its impacts may also be limited, leaving them exposed and vulnerable to infection, transmission, and poorer outcomes.

Gender Stereotyping

One clear finding in the literature on men and sexual health is that outcomes for men are adversely affected by unwillingness to seek sexual health services and help (Vaswani, 2012). Furthermore, there is an intersectional aspect of stereotyping along gender lines that intersects with ethnicity in relation to sexual behaviours and risk. For example, there is a long-held perception in Western society that black men are sexual risk-takers and repositories of infection (Serrant-Green, 2011). This notion shared in the literature and media platforms further fuels the judgemental conclusions on the sexual risk of BME men in particular.

Studies have also revealed that men rarely ask for help from their social networks, even though they may experience sexual health problems (Visser, 2011). Men are less likely to seek help from anyone regarding health issues, especially concerning highly stigmatized or sensitive issues such as sexual and mental health, compared with women who are viewed as receptive to health promotion messages, leading to a higher utilization of such services (Adelekan et al., Omoregie and Edoni 2014). Interestingly, these behaviours are even more likely to be reinforced in BSSA men as a result of the patriarchal system operating within BSSA communities, where BSSA men are viewed as custodians of the communities in which they live. In this context, fear of being stigmatized by those both within and outside the BSSA communities appears to have created a reluctance to engage in HIV testing, disclose HIV status, and receive treatment. This has worked to continue the perpetuation of secrecy, silence, and denial within the BSSA communities studied, and may have further fuelled HIV stigma and the risk of transmission.

Social Media

Bullying, in both the physical and cyber worlds (the latter known as cyber bullying), has been recognized as a serious national health issue among adolescents in the twenty-first century. However, previous social studies of bullying have been hampered by data scarcity, while few computational studies have narrowly restricted themselves to cyberbullying, which accounts for only a small fraction of all bullying episodes (Office of National Statistics, 2015). The use of cyberbullying has also taken its toll on people affected by HIV in some BSSA communities, as illustrated in this study, where people report having been subjected to ridicule because of their HIV status or simply being associated with people who are HIV-positive.

One of the most surprising aspects revealed during discussions with BSSA research participants about HIV stigma was that Facebook (social networking) was a contributing factor to this pillar of HIV stigma. They reported that through this medium, many negative things associated with HIV and people living with HIV have been posted with little or no restraint. They revealed a range of strategies used to post prejudicial and discriminatory messages against people living with HIV, with attacks coming from both within and outside the BSSA communities and the social groups targeted. Media reports from other areas have shown that those who have been victims of bullying or persecution from online sources often withdraw from social networks, isolating themselves from friends and relatives, which has been cited as possibly increasing the chances of depression and mental health problems (The Guardian, July 6, 2015). Some of the BSSA participants who took part in the study acknowledged that young people from their communities had gone on to require counselling services after their HIV status was divulged on Facebook. One of the difficulties with attacks on social media is the 'facelessness' of the perpetrators which leaves the victim unable to defend themselves on such a platform, leading to more stress and possible development of negative feelings towards the utilization of sexual health services in order to avoid confirmation (or suspicion) that they are HIV positive.

Fears of disclosure have also led some individuals to discontinue medication as a way of distancing themselves from anything that has to do with HIV, especially among people who are negative about their HIV status. Such actions are derived from the fear of being posted in the public domain and becoming a subject of discussion in the community regarding HIV status. The effect of Facebook as a pillar of HIV stigma has not only affected HIV-positive individuals but also HIV-negative individuals, causing them to develop negative attitudes towards anything to do with HIV, leading to negative sexual health-seeking behaviours. Although relatively new in the literature, some people are known to use social media to bully or blackmail others. The UK Home Office (2008) identified a series of risks to individuals' safety associated with social networking such as Facebook, including bullying, harassment, exposure to harmful content, sexual grooming, and racist attacks. While the problem may be viewed as overstated, there are grounds for genuine concern and the possibility of severe implications for current sexual health issues, such as HIV stigma and sexual health-seeking behaviour.

Implications for education and training

Considering the above discussion, there is a need to increase the awareness of sexual health professionals regarding the construction of HIV stigma and sexual health-seeking behaviours among BSSA communities and other ethnic minority groups. However, it is critical that awareness be accompanied by an increase in the skills and knowledge levels of professionals and communities to enhance their effectiveness in terms of HIV and sexual health. The issues discussed in this chapter from the findings of the study have demonstrated the need for a three-pronged education and training endeavour for professionals, BSSA communities, and the mainstream community to combat HIV stigma and improve the outcomes of the sexual health-seeking behaviour among BSSA communities.

What emerges is the evidence of gaps in service delivery and contested viewpoints in key social institutions within BSSA communities, leading to the construction of HIV stigma and limiting the number of people accessing sexual health services in a timely manner. Some sexual health approaches and treatment services are not suitable for some communities as they may not be culturally friendly (Ume-Nwagbo, 2012). The Framework for Sexual Health Improvement in England (2013) aims to build a sexual health culture that prioritizes HIV prevention and supports behavioural change, signifying the need to educate and train professionals and communities. Sexual health promotion and prevention should endeavor to assist people in making informed and responsible choices, with a strong emphasis on making healthy decisions.

To improve sexual health outcomes in BSSA communities, more intervention programs targeting priority populations and social groups are needed. Basic sexual health training should be made available to all professionals who meet community needs to address them. This basic training should equip each professional with the underpinning sexual health knowledge that can be provided to their clients while accessing different services. Sexual health training for professionals should raise awareness of the needs and cultures of specific ethnic minority groups. Clear links between awareness raising, social contexts, and personal experiences are key to maintaining effective HIV prevention and sexual health-seeking behaviours among BSSA communities. More detailed training covering key social determinants of sexual health behaviour, including HIV stigma, should be rolled out to sexual health professionals to ensure that they become conversant with the cultural practices of minority communities, such as BSSA, or those proven to be at higher risk. Often, as illustrated in the study, sexual health education and training received by sexual health professionals had more to do with the medicalization of sexual health than culture and behaviour. This missing link has made it difficult for sexual health practitioners to engage with diverse community groups, such as the BSSA communities, among other ethnic minority groups. As a result, sexual health professionals often lack the social and cultural competence to deal with the non-medical issues brought by BSSA communities. This leaves sexual health professionals to rely on stereotypes and ad hoc means when dealing with BSSA communities regarding HIV stigma and sexual health-seeking behaviour.

Inadequate training is identified as a barrier to providing effective HIV and sexual health services among the BSSA communities. There is also a need to train sexual health professionals from BSSA communities to fill the gaps in service provision. This may also help BSSA communities to have a sense of ownership in the provision of sexual HIV and sexual health work. In some instances, nursing has tried to encompass cultural awareness to cater to the cultural needs of various social groups when accessing sexual health services, but most courses have not paid attention to specific cultural