Intersectional identities and dilemmas in interactions with health care professionals: An interpretative phenomenological analysis of British gay Muslim men

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Abstract

Individual interviews were conducted with six self-identified Muslim gay men living in London focusing on their experience of health service use. Transcripts were analysed using Interpretative Phenomenological Analysis. Analysis identified two major themes: namely, the close(d) community and self-management with health care professionals, detailing participants' concerns regarding the risks of disclosing sexuality; and the authentic identity: "you're either a Muslim or you're gay, you can't be both", which delineated notions of incommensurate identity. Analysis highlights the need for health practitioners to have insight into the complexity of intersectional identities, identity disclosure dynamics, and the negative consequences of assumptions made, be these heteronormative or faith-related.

Keywords: Health inequalities, gay men, Muslim, identity London, interpretative phenomenological analysis.

Introduction

Despite improvements in overall health in the United Kingdom in recent years (Murray et al. 2013), health disparities still exist across different socioeconomic, cultural, religious and sexual orientation groups (Scott et al. 2013; Westwood et al. 2015). Inequalities are visible in both religious (Laird et al. 2007; Hussain and Choudhury 2007, Rassool 2014) and sexual minority groups (Clarke et al. 2010; Elliott et al. 2015). However, little research to date has focused upon questions of intersectionality (Cole 2009; Cho, Crenshaw and McCall 2013; Crenshaw 1989) in relation to health inequalities.

In part, this absence of intersectional work is understandable given the reliance upon epidemiological logic and quantitative research methods to identify and demarcate health inequalities. These approaches can be characterised by their tendency to deracinate the subject from their social context and analytic methods which struggle to engage with identities in more than the simplest unidimensional ways. In contrast, qualitative methods are more useful for exploring subjectivity within social context and the intersectionality of social categories and coterminous subjectivities. In this article, we examine the experiential accounts of a small group of participants to understand these wider social processes.

To date, research that focuses upon intersectionality has tended to focus upon ontology and social theorising around identity (Minwalla et al. 2005; Rahman 2010; 2014; Midoun et al. 2016; Barnett 2017). Research which connects intersectionality to more applied questions in relation to its implications for health, for example, is arguably still within its infancy (Ghabrial 2017). Recently approaches to understanding health inequalities have begun to engage with increasing this complexity, for example, with the intersections between mental, physical and sexual health through the lens of syndemics (Adam et al. 2017). However, research is also needed that can connect social theory to an examination of the lived experience of intersectionality in order to flesh out *how* intersectionality can lead to health inequalities. Here, we aim to address this connection through an interrogation of the lived experience of one small purposive sample of British Muslim gay men living in London.

Lesbian, gay and bisexual health inequality

Research has shown lesbians, gay men and bisexual individuals show poorer physical and mental health outcomes when compared to heterosexuals (Conron, Mimiaga and Landers 2010; Hagger-Johnson et al. 2013; Semlyen et al. 2016), and tend to be less satisfied with the health care services they receive (Clift and Kirby 2012). Compelling evidence suggests that lesbians are less likely to uptake preventative health practices such as mammography, screening and cervical smear tests than their heterosexual counterparts (e.g. Fredriksen-Goldsen et al. 2013). Similarly, gay men are less likely than heterosexual men to take part in preventive health practices, other than sexual health (e.g. Knight and Jarrett 2015) as they fear a homophobic response to disclosing their sexuality in a health care setting (Conron, Mimiaga and Landers 2010). Studies

frequently highlight the need for developing alternative, more socially inclusive health promotion strategies in primary care (Cant and Taket 2006). Such reasoning has been shown to be well placed with several studies indicating both that doctors acknowledge that they would feel uncomfortable treating sexual minority patients (Stein and Bonuck 2001) and that lesbian, gay and bisexual patients receive substandard care (e.g. Kelley et al. 2008) while it has been reported that in training, for a range of healthcare professionals, lesbian, gay and bisexual content is significantly limited (Obedin-Maliver et al. 2011; Semlyen 2015).

Muslim health inequalities

Islam is currently the fastest growing religion in the UK, due to high levels of in-migration and above average birth rates (Johnson and Zurlo 2015). Epidemiological literature, which tends to homogenise the considerable heterogeneity of Muslim cultures, suggests that Muslim individuals tend to experience a range of serious health problems. In particular when compared to the white British population, those of Pakistani origin have been found to exhibit higher rates of mortality and morbidity such as coronary health disease (CHD), hypertension, Type 2 diabetes and obesity (Rassool 2014).

Previous research has shown that Muslim people in the UK tend to rationalise these statistics showing an inferior quality of health by offering explanations of lower socioeconomic status and lack of trust of western medicine (e.g. Platt 2005). In addition, a recent study by (Mir and Sheikh 2010), exploring attitudes towards health and illness within a sample drawn from the UK Pakistani Muslim community concluded that religious identity tends to play a role in participant's perceptions regarding illness and health. For example, participants often referred to Islamic teaching as a therapeutic resource for coping with long-term health issues. However, participants reported that they were unsure about the appropriateness of raising religious influences when discussing illness and treatment plans with health care professionals, and thus were sometimes reticent to do so.

There is considerable diversity of religious beliefs, teachings and practices in Muslim majority countries, and it is important to note that dominant attitudes within specific cultures are not universally shared. However, non-heterosexual sexuality has widely and strongly been considered a taboo subject within Islam, with all sexual relations other than those between a married man and woman being forbidden (Shafiq and Ali 2006). In the UK, those of a Muslim background who self-identify as lesbian, gay and bisexual, or display what would be considered as overtly homosexual behaviour, are often discriminated against and/or ostracised by their family, friends and community (Kugle 2013). Although other interpretations of homosexuality within Muslim scripture exist, (Kugle 2003; Dialmy 2010), the dominant heteronormative discourse of Islam constructs homosexuality as problematic (Siraj 2009). Thus, for many Muslims, but certainly not all, the idea of homosexuality exists in tension with the teachings of Islam (Jaspal and Siraj 2011; Kugle 2010), which besides a religious identity also constitutes an ethno-cultural identity (Jaspal and Coyle 2010). These factors discourage 'coming out'

for many sexual minority Muslims (Breakwell 2001; Yip 2004), as they see it as an threat to their community belonging and their self-esteem (Jaspal and Siraj 2011). Moreover, in many Muslim majority countries, both civil law and *shari'a* (the rules governing the practice of Islam) criminalise homosexual activity and lesbian, gay and bisexual individuals are liable to abuse, torture, imprisonment and sometimes state-sponsored execution (Cviklová 2012). In these ways non-heterosexuality is broadly rejected as a viable way of life by the majority of Muslims (Siraj 2006; Kligerman 2007).

Given the evidence of health inequalities along lines of sexual and religious identity, lesbian, gay and bisexual Muslim patients face multiple challenges in accessing effective and high quality healthcare. Critically, these challenges may include overcoming Islamophobia and/or homophobia within their health care journeys, but they may also include the potential loss of support and community buffering because of Islamophobia within lesbian, gay and bisexual communities and homophobia within particular Muslim communities. In this study, we explore participants' experiences of how their sexuality and religious beliefs affect their healthcare use, and the meanings they derive from such experiences.

To do so, we focus upon three inter-related topics; i) the lived experience of health service use amongst a small purposive sample of British Muslim men who are gay; ii) the literature on intersectionality with an empirical focus upon how it is realised within the provision of health care and iii) research and implications for health care training and interventions that connect intersectionality with health inequalities. The study uses Interpretative Phenomenological Analysis (Smith, Flowers and Larkin 2009) to capture and explore qualitative data collected using in-depth interviews with Muslim gay men investigating the intersection of their sexual identity, their Muslim identity and the gender identity in health care experiences. The IPA approach utilises an inductive approach to both data collection and analysis. IPA attempts to describe the lived experience of a typically small number of participants. Its phenomenological focus enables analysts to explore participants' experiential data first and foremost, but also enables the exploration of resonance within wider theoretical or conceptual frameworks such as intersectionality and health inequalities.

Methods

Six self-identified Muslim gay men living in London agreed to take part in this study. All participants described themselves as being of Pakistani or South Asian descent and identified as Muslim and were aged between 18 and 45 years. Ethical approval for the research was granted by London Metropolitan University Ethics Committee. Participants were invited to take part through advertisements placed on an online forum for a London support group for gay Muslims, as well through an East London charity that also works primarily with this group of men. Face to face, semi-structured interviews were devised to capture the experiences of each participant and open ended questions were used throughout ensuring participant-led interviews (Smith, Flowers and Larkin 2009).

It is acknowledged that the sample included a diverse group of men not representative of the gay Muslim population as a whole.

The interviewer was himself a gay Muslim man. The topic guide explored issues of gay identity and Muslim identity along healthcare experiences and expectations from their health care provider. Throughout data collection, participants were encouraged to elaborate on their experiences within the interview and additional questions were used to encourage natural conversational flow. Narratives were collected using voice recording equipment and transcribed verbatim immediately after each interview. The pseudonyms used throughout this paper were those chosen by participants themselves.

The data were analysed using Interpretative Phenomenological Analysis, a qualitative approach with its foundations within phenomenology that emphasises the importance of subjective experience in individual sense making (Larkin, Watts and Clifton 2006). Such an approach enables the researcher to consider variability and diversity within human experience (Willig 2008). Analysis followed the stages outlined by Smith and Osborn (2003).

Findings

Through analysis, two superordinates, inter-related themes were identified which illustrate the lived experience of health service use amongst a small purposive sample of British Muslim gay men: (i) the close(d) community and self-management with health care professionals and (ii) the authentic identity: "you're either a Muslim or you're gay, you can't be both".

The close(d) community and self-management with health care professionals

Without eliciting it, participants' discussion centred on encounters with practitioners from the same cultural and religious background as themselves (i.e., Islam). The Muslim community was constructed as a tight network in which divisions between Muslim and non-Muslim are central. Participants raised concern relating to breaches of confidentiality, and uninvited disclosure of their sexual identity to family and other members of the community. The following extract from Fahd illustrates some of these concerns:

> … If the doctor is Muslim… as in, if they look Muslim to me… I would be very reluctant to mention my sexuality, and would probably try to 'act straighter' than with someone of a different culture type thing… it's just how I've always been. I guess I'm a little paranoid that he or she will judge me, or not give me the same standard of care, in all honesty, even if they stayed completely professional or whatever, I would feel hugely uncomfortable sitting there… face to face, with someone who is Muslim, who probably most likely despises gay people, knowing that I'm gay, wondering what's going through his or her head.

Fahd's extract depicts a complex intrasubjective world in which he demonstrates something of the intricate strategies adopted to manage multiple identities and associated subjectivities. For Fahd, the clinical encounter represents a multifaceted task in which, in order to secure the best quality care, he must attempt to assess the health care professional's own religious identity and their professionalism, and pitch his own intersectional self-presentation and disclosures accordingly.

Whilst telling in terms of the demands it places upon Fahd himself, the account is also interesting in its reliance upon relatively homogenous and essentialist constructions of both homosexuality and Islam. Equally, in the extract below, Barak reiterates many of Fahd's concerns and introduces the relevance of individual biography and global movement in that his experiences are shaped by earlier experiences growing up within a different cultural milieu:

> Yes, I think that would definitely be an issue I would definitely not be comfortable to disclose my sexuality to somebody, who is a Muslim… or somebody who is from the same cultural background… I don't know what their reaction will be, maybe it's to do with the fact that… being grown up in a country where you have, erm, where sexual-homosexuality is, is erm, erm like hateable, and, and you've been ostracised for being gay, so… maybe that is within myself. Like, that, image come back to me, if I see somebody and I feel that I have to tell my sexuality.

Barak describes reasons for being unwilling to disclose, placing inability to predict the practitioner's reaction as the main reason. He constructs the idea that disclosing his sexuality to people from his own culture serves as a reminder for past negative experiences. In stark contrast to the participants highlighted above, Emran below mentioned that he felt having a practitioner from the same background could yield positive experiences:

> Emran: Erm… if they were like the same, religious… I'd ask like, Muslim to Muslim, like my therapist, erm we're clo, clo, kind of close to him because we're the same, he's Pakistani and we clicked basically
>
> Interviewer: If a doctor was the same skin colour or religion as you, would you find it easier to come out to him?
>
> Emran: …easier to talk to, because they know how we… what, where I'm coming from basically. They'll know… I just feel that someone else who is… is... a Muslim themselves… will better understand what I have to go through

Emran describes how, for him, perceptions of similarity and shared experiences were positive for establishing rapport and a sense of perceived empathy within the clinical interaction. Tellingly however, even these positive interactions are marked by deliberation concerning intersectional disclosure.

Similarly, Deen, below, describes talking to a doctor about his sexuality. He communicates that his doctor believed his homosexuality would be 'cured' after meeting a woman. Here, the health care professional draws upon essentialist and incompatible identities endorsing traditional heteronormative assumptions within Islamic doctrine and considering a dual identity impossible.

> … One of the things that he said was don't worry, as soon as you find another woman your homosexuality will be cured… he honestly just couldn't believe I was gay… he said that I was a Muslim, I couldn't be gay.

This theme has shown the importance of perceptions of the Muslim community in shaping the participants experiences with health care professionals. These interactions are experienced as complex; they require a considered and deliberate approach to health care professional appraisal, the disclosure of sexual identity and an assessment of the concomitant risks that this may bring. Whilst much of the psychological effort described in navigating such interactions is intrasubjective, it is also intersubjective, with participants reporting experiencing homophobia and negative reactions when disclosing their sexuality.

The authentic identity: '*… you're either a Muslim or you're gay, you can't be both*'

The second theme addresses participants' feelings of inauthentic identities. Identities figure as essentialist and incommensurate. Often being Muslim was understood as a dominant identity, and was largely considered by the health care professional that if a person is gay they cannot simultaneously be practising Islam. Therefore, being gay and Muslim are often seen as mutually exclusive identities. Participants reported feeling the need to challenge practitioners' assumptions about their identities. Azim, for example, describes an encounter in which the health care professional appeared unable to accept Azim's dual identity at face value:

> …one GP who spoke to me like… asked me specific questions, it was almost like he repeated them because he like kind of thought that I mustn't of understood the questions he was asking because I was a Muslim, so there was no way I could have had a gay relationship… He repeated the questions because I didn't think he thought it would be possible for me to be like gay and a Muslim…

Azim describes how this dynamic has deep significance as it questions the legitimacy of his subjectivity. The everyday affirmation of self-identity from the other is absent. In contrast, Azim must persuade others of his legitimacy as a gay Muslim, 'a proper Muslim' and he must constantly assert his sense of intersectional self within interactions, which systematically elide his multiple identities.

> … when you combine them both people just seem to be really like confused by the concept of someone being a gay Muslim, like especially other Muslims, they don't think that it should be, they just don't think that you can be Muslim and gay. Erm, they and for people who are non- Muslim they've just never met a gay Muslim before so erm they seem to get kind of, really confused by it and they don't think I can be a proper Muslim I don't think that I can be like properly gay they think. Everyone just seems to think you have to be one or the other which isn't really the case.

Further challenges arise from this need to actively construct identities. In the extract below for example, Fahd describes how for him, his assertions relating to being a gay Muslim also require an articulation of the apparent aetiology of homosexuality. It is almost as if he has to compensate for, or differentiate between, the agentic articulation of his identities with a disavowal of his choice or agency in being gay in the first place.

> Basically, many Muslims don't believe that being gay is even an actual thing, they sort of see it as something that is a feature of the perversions of the West… So, I think the very first issue I feel that… I feel is that I need to sort of prove that I haven't chosen to be the way I am… Even with doctors and professionals who should know better, that it is something that you're born with, and that it is something that is most likely genetic, and I'm not doing it because I'm being rebellious, or I've spent too much time with people outside of my culture.

These complex dynamics shape many interactions; however, they can be compounded by questions which specifically address sexual behaviour:

> The person come out thinking that I was straight, purely because they've asked me whether I've had sex with a man in the last six months, when I haven't. So, what happens then is I get the feeling that I'm only gay if I've actually had sex with men recently, otherwise I'm straight…Why assume I'm hetero just because I haven't got laid in a while. If someone who was straight hadn't slept with a woman in a while, you wouldn't automatically assume they're gay would you?

Here Azim describes how he thinks the practitioner has deduced sexual preference through knowledge about sexual contact. He uses rhetorical questions to challenge the validity of such actions and constructs the feeling that his sexuality is not seen as a salient part of him, but only relevant when he engages in sexual activity. His questioning explores the idea that gay and straight identities are not treated equally, and his feeling that a straight Muslim man in the same position as himself would not have the same assumptions made surrounding sexual identity.

Heteronormativity was a key part of Fahd's clinical encounter:

> …especially someone who's a psychiatrist, you know a trained doctor, I think it's really unprofessional... what if I'd then lost confidence to correct her… what then? She probably looked at me, saw that I was Asian, you know with a Muslim name, and the thought that I might be gay probably never even entered her head.

Equally, in circumstances in which disclosure has taken place, there were concerns relating to its perceived salience in relation to health issues in which participants described being worried about the health care professionals' misattribution of their health problem:

> I think you tell people you've got like piles or whatever and you're bleeding, they, they always assume it's to do with your sexuality, but it's nothing to do with that, really. I, I, I've had them, I have suffered from stuff that I wouldn't go to the doctors with because knowing my luck I'd probably have an Asian doctor.

This theme has explored participants' struggle to articulate their identities within interactions that seem to delegitimise their subjectivities. It has shown how heteronormativity seems to be amplified within interactions in which multiple identities are intersecting. It suggests that health care professional (especially those with a Muslim background) struggle to consider the plausibility of gay and Muslim identities co-existing. It has described how a focus upon any one identity in isolation may lead to poor quality health care interactions.

Discussion

Within this paper, we have focussed on two inter-related research questions; i) we have explored the lived experience of health service use amongst a small purposive sample of British Muslim men who are gay; and ii) we have added to the literature on intersectionality with an empirical focus on how it is realised and experienced within and through the provision of health care. We then suggest future research and implications for health care training and interventions which connect intersectionality with health inequalities.

In relation to both the exploration of the lived experience of health service use and how links between intersectionality and health inequalities are realised within health care interactions, our analysis highlights the complexity of identity work within intrasubjective health care interactions. Our study explored the intersection of religious, ethnicity, gender and sexual identities amongst a single sample of gay Muslim men in relation to their interactions with health care professionals. It identified two major theme: the first which described how participants managed their self-presentation and multiple identities in relation to interaction with health care professionals; and the second theme, which described how participants' multiple identities were often seen as

incommensurate within health service interactions. Health care professionals' responses often echoed their viewing the 'impossibility' of their patient's presented identity, in relation to their own Muslim beliefs (Abraham 2009) thus challenging the men's 'authentic' identity.

Disclosure of sexuality in the health care setting is important for the provision of appropriate, sensitive and individualised care. In contrast, poor communication may provoke reduced levels of adherence to physician advice and treatment plans, and decreased rates of satisfaction (Clift and Kirby 2012). Practitioners who are unaware of their patients' sexual orientation may fail accurately to diagnose, treat or recommend appropriate preventive measures for a range of conditions (Petroll and Mosack 2011).

For most participants, the prospect of disclosing one's sexuality through coming out, especially to a Muslim health care professional, was viewed as a potential threat to either the person's religious-ethno-cultural identity or their sexual identity. Even though sexuality represents a vital component of individuality, endorsing a gay identity is difficult for gay Muslim men because Islam constitutes both a meaning system and a religious identity for many Muslims (Silberman 2005). Prevailing Muslim tradition overtly promotes compulsory heterosexuality (Kligerman 2007) and portrays gay identity as radically incompatible with Islamic beliefs and analogous to a *Western* disease of moral decline (Yip 2004). Hence, by revealing their sexuality, gay Muslim men who reside in, for example, many countries in South Asia, risk their physical integrity or even their lives *per se* (Cviklová 2012). It seems likely that in such cases, individuals are more reluctant to disclose their sexuality putting them at greater vulnerability for poor mental and physical health (Ponce et al. 2010; Rucker et al. 2017). Indeed lower disclosure has been shown to be linked to poorer health care access and under-use of health prevention services (Clift and Kirby 2012; Austin 2013).

Similarly, health disparities exist with regard to Muslim identity (Rassool 2014) yet, the intersections of these inequities are rarely examined simultaneously. This study has offered an opportunity to study the 'impossible' gay Muslim man's experience (Abraham 2009), a dual identity that by its existence challenges the dominant narratives of both traditional Muslim and lesbian, gay and bisexual identities (Rahman 2014). Moreover, the experience of the heath care professional unable to reconcile the dual identities becomes a place in which the framework of 'queer as intersectionality' (Rahman 2010) can be seen played out in a yet unstudied healthcare context. Here, we offer an albeit 'partial' understanding of this processe gained through the lived experience of the gay Muslim men in our study (Collins 2002; Hartsock 1983).

The study themes show how these intersecting identities can combine to amplify health inequalities. Muslim gay men not only face the inequalities associated with other members of the Muslim communities but in addition they face the inequalities experienced by other gay men. However, on a fundamental level they *also* experience the amplification, or additive aspects of both of these aspects of health inequality. From the accounts presented here it is clear that health care professionals do not accept them as either 'proper' gay men or 'proper' Muslims. The unspoken aspects of their precarious subjectivities are reflected within the experiential world of challenging interactions with

health care professionals in which a preoccupation with identity work delimits access to good quality health care. Interactions with health care professionals are understood as risky. Risks relate to potential breaches of confidentiality and consequent stigmatisation within family and the broader Muslim community; the necessity of justifying the co-existence of their sexual identity alongside their Muslim religious and Islamic cultural identity, and concerns relating to inability to predict potential homophobic and/or neglectful reactions from health care professionals. This could then lead to delayed presentation to primary care or lack of provision of culturally competent care.

Extant literature further suggests that Muslim men who have sex with other men find it hard to manage and reconcile their sexual and religious identities (Minwalla et al. 2005). One way that is adopted is that of compartmentalisation' whereby specific identities are foregrounded and backgrounded where needed or felt 'safe' to do so (Yip 2015). Kugle (2010), in his critical exploration of reconciling faith and sexuality in Islam also talks about the inward struggles or *ijtihad* of those attempting reconciliation as interpretive work. Yip (2005) goes on to show that his individual interpretation can be seen as repositioning the interpretive authority from the religion to the personal.

As part of this process of reconciliation, presenting outwardly as gay represents a viable coping strategy for embracing one's sexuality and thus enhancing one's identity (Jaspal and Siraj 2011). Sexuality disclosure to a Muslim Health Care Professional was repeatedly perceived by participants as synonymous with a direct thwart of their psychological and emotional well-being. Employing compartmentalisation of their dual identities as a coping strategy, Muslim gay men are thereby rendered vulnerable to conforming, avoidance and/or self-defeating behaviours (Zimmer-Gembeck and Nesdale 2013).

Further research

Our focus within this paper has been to explore, in detail, with a small number of participants how intersectionality is realised within health care interactions. We have examined how intersectionality in action can compromise health care quality and provide a mechanism by which the health inequalities associated with both being Muslim and non-heterosexual can be amplified or seen as additive.

Our work is limited, however, in that it only explores the experiences of six self-identified Muslim gay men and in particular those of Pakistani descent, all living within one city and within one country. Future research would benefit by being more inclusive towards other Muslim sexual minorities and Muslim cultures by considering the embodied experiences of lesbian, bisexual and transgender individuals who resident in the UK and beyond. By excluding from the study's sample men of Middle Eastern, Arabic, African and East Asian descent, this study is limited in its transferability to other Muslim gay men.

A programmatic approach of mixed methods research examining the perspectives of both those receiving and delivering care would yield a robust theoretical

contribution to the literature. Ethnographic approaches and action research also offer fruitful ways of exploring these issues at scale.

Implications

Medical education is a key route through which culturally competent healthcare practice might be developed (Obedin-Maliver et al. 2011) and this study clearly indicates the need for health care professionals' improved understanding of intersecting identities. Moreover, participants expressed the need for a healthcare practitioner to be able to be non-judgemental and to empathise with and understand them. Participants also highlighted the need for education for health care professionals on issues around Muslim religion and homosexuality as parallel identities.

> There should be some like training program… whereby all the health care professionals are exposed to… these issues that the gay people do exist and they could be from… same culture and how, you… have you… treat with them and how sensitive this topic is, if your patient was gay and from the same culture coming to you for, for …to be seen then how do you, you have to react to that. People like me are desperate to be understood…. in the same way that everyone else is.

Tailored health care for gay Muslim patients is an emerging priority, pointing to the need to establish a more concrete and inclusive knowledge of the issues affecting this group of patients (Calle et al. 2003). Improvements in the quality of care may be addressed through curriculum change, continued professional development for qualified health personnel, and by a principled and collaborative 'anti-religionist' stance (on the harms of religious beliefs) in the UK health care system (Laird et al. 2007). Respectively, the introduction of topics around sexuality and diversity can represent an exceptionally valid addition during the interview process of applicants in medical and health care services.

The role of the wider community

Our study's findings have wider implications for Muslim religious and community leaders, who should be mindful of the feelings of isolation, depression, loneliness and disconnection to the community that gay Muslim men may feel (Semlyen et al. 2016). Greater social and peer support may help members of this group better deal with issues arising from their sexual orientation, as well as enable them to manage their religious and sexual identities. Working in conjunction with Islamic lesbian, gay and bisexual organisations may provide great opportunity for culturally competent educational material to be developed but also an opportunity for identity coherence (Jaspal 2015)

Conclusion

Continued health disparities continue to be present in gay men and the wider lesbian, gay and bisexual community. Multiple identities, both sexuality and faith-related, intersect to create further barriers to the participants in their study and their access to primary health care. The paper sought to examine intersectional identities in a primary care settings focusing on the experiences of a small group of British Muslim men. Improvements to health care access for these men can be achieved through the adoption of culturally competent health care practice. Improvements in medical curricula for trainees and continuing professional development for qualified health care professionals would go some way to addressing gaps in knowledge and create raised awareness about this population. Further research to examine experiences of other sexual minorities and in a wider Muslim community would extend our knowledge base and offer opportunities for greater understanding to address any heath disparities within this group.

Funding details: This work received no funding.

Disclosure statement: There are no conflicts of interest pertaining to this study.

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