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"Stigma Is Still There": Healthcare Providers' Accounts of Multilevel Stigma Affecting Transgender Women's HIV Service Access in Ghana. BSGH 019

Osman Wumpini Shamrock

OsmanWumpini_Shamrock@URMC.Rochester.edu

University of Rochester https://orcid.org/0000-0003-3127-9596

Samira Shirzaei Nichols

University of Central Arkansas

Adams Al-Mardhiyyah

University of Central Arkansas

Henry Delali Dakpui

University of Rochester

George Rudolph Kofi Agbemedu

University of Rochester

Kwasi Torpey

University of Ghana

Natalie M. Leblanc

University of Rochester

Gamji Rabiu Abu-Ba'are

University of Rochester

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Abstract

Background.

Transgender women experience substantial barriers to HIV prevention, testing, treatment, and other healthcare services, with stigma operating across healthcare and broader social contexts. Although previous research has documented transgender women's experiences of stigma in Ghana and other settings, less is known about how healthcare providers perceive and describe the forms, sources, and consequences of stigma affecting transgender women's HIV-related healthcare access. This study examines healthcare providers' accounts of stigma affecting transgender women in Ghana.

Methods.

A qualitative study was conducted among 20 healthcare providers working in healthcare facilities in the Greater Accra Metropolitan Area of Ghana. Participants included nurses, midwives, laboratory personnel, a counselor, and a physician working across HIV-focused and general clinical services. Semi-structured in-depth interviews were conducted between May and June 2023. Interviews were audio-recorded, transcribed verbatim, translated into English where applicable, and analyzed thematically using NVivo. The Ecological Systems Framework guided the organization and interpretation of providers' accounts across individual, healthcare facility, community, and structural levels.

Results.

Healthcare providers described stigma affecting transgender women across four interconnected levels: individual, healthcare facility, community, and structural. At the individual level, providers described anticipated stigma, self-stigma, fear of disclosure, identity concealment, and fear of recognition as barriers to healthcare-seeking. At the healthcare facility level, providers reported ridicule, derogatory language, gossip, neglect, refusal of care, and healthcare arrangements that could increase the visibility of patients seeking HIV-related services. At the community level, providers described social rejection, surveillance, fear of exposure, and concerns about being recognized by relatives or acquaintances. At the structural level, providers linked the persistence of stigma to broader religious beliefs, cultural expectations, and sociocultural norms. Across these levels, providers perceived stigma as contributing to nondisclosure, delayed or avoided healthcare-seeking, interrupted engagement with HIV services, and discontinuity of care.

Conclusions.

Healthcare providers described stigma affecting transgender women as a multilevel phenomenon extending across individual, healthcare facility, community, and structural contexts. Their accounts

suggest that anticipated judgment, discriminatory healthcare encounters, social exposure, and broader sociocultural conditions may interact to influence disclosure, healthcare-seeking, engagement with HIV-related services, and continuity of care. These findings provide a provider-centered perspective on how stigma is perceived to shape HIV-related healthcare access for transgender women in Ghana.

Introduction

Gender non-heteronormative individuals face a disproportionate burden globally when accessing health services[1,2], particularly in HIV prevention and care[3]. For transgender women (TGW), this burden is especially pronounced, as they encounter heightened stigma when seeking these HIV services[3–6]. In sub-Saharan Africa, intersecting social, structural, and legal factors create profound vulnerabilities for TGW[3–6]. Across the region, TGW experience extensive stigma, discrimination, and violence, all of which significantly hinder their access to vital HIV prevention and care services[4–8]. The criminalization and social rejection of TGW, coupled with healthcare system failures, further compound these barriers, contributing to significant gaps in the HIV care continuum and perpetuating health inequities [4–10].

Evidence from previous research indicates that stigma is an important contributor to the barriers experienced by TGW and may operate across interconnected individual, healthcare, community, and broader structural contexts [5]. For TGW, stigma manifests in various forms, including anticipated discrimination, self-stigma, fear of disclosure, and the need to conceal their identity[5,11,12]. Together, these experiences discourage them from seeking HIV prevention and care services, as well as other related health services [5,6,11,12]. Within healthcare facilities, TGW often report adverse treatment related to disrespect, misgendering, neglect, denial of care, confidentiality breaches, and other forms of mistreatment, which create hostile environments that erode trust and discourage ongoing service utilization[5,6,11,12]. Such reports of negative experiences are often accompanied by HIV-related stigma, particularly when service delivery structures increase patient visibility or inadvertently disclose HIV status[4–10]. At the community level, TGW face social rejection and surveillance, which fuel fears of exposure and deepen their marginalization. These experiences of stigma are frequently amplified by religious beliefs and broader sociocultural norms[5].

Studies in Ghana have shown that while TGW in Ghanaian slums can have positive testing experiences in welcoming environments, negative experiences are far more common at the health facilities[6]. These negative encounters are characterized by significant fear, anxiety, and judgmental attitudes from healthcare workers, especially in facilities that are not friendly to key populations [4–8].

These adverse experiences are shaped by broader social influences. Widespread societal stigma toward TGW is reinforced by deeply rooted cultural and religious norms that may contribute to social rejection, fear of exposure, and negative attitudes within healthcare and community settings [4–8].

Studies have shown the crucial role that healthcare providers play in shaping the healthcare experiences of TGW and their access to HIV services[13–16]. Healthcare provider attitudes, knowledge and behaviors can facilitate or obstruct care, and their perceptions of stigma influence how they interact with TGW patients and organize service delivery[17]. Previous studies suggest that many healthcare providers lack sufficient training in TGW health and may hold stigmatizing beliefs that manifest as discriminatory practices[18,19]. Studies in various settings have shown that healthcare providers often find it difficult to understand gender diversity, fail to use gender-inclusive frameworks and have gaps in their knowledge of TGW-specific medical needs [18,19]. These gaps are perpetuated by healthcare systems that reinforce gender binarism through electronic records, intake forms and physical clinic structures, creating environments that are inherently unwelcoming to TGW patients[19,20]. While some healthcare providers express supportive attitudes, their statements often reveal significant gaps in medical knowledge and cultural humility for TGW and other gender diverse people[19].

Despite the growing recognition of these challenges, there has been limited research into how healthcare providers in Ghana perceive and describe the stigma experienced by TGW and their understanding of its impact on access to HIV-related healthcare[4,6]. Although a growing body of research has documented TGW experiences of stigma, disclosure, and healthcare access in Ghana and other sub-Saharan African settings[4,5,7,21], comparatively less attention has been given to the perspectives of healthcare providers who interact with TGW within healthcare systems. Existing studies involving healthcare providers have also frequently examined TGW alongside broader key populations, limiting understanding of how providers specifically perceive stigma affecting TGW and its consequences for HIV-related healthcare access[22–26]. Understanding healthcare providers' accounts is important because providers occupy a distinctive position within healthcare systems. They may observe stigma occurring within clinical environments while also participating in institutional and interpersonal processes that shape patients' experiences of care. Examining their accounts therefore provides a complementary perspective on the forms, sources, and perceived healthcare consequences of stigma affecting TGW.

This study explores healthcare providers' accounts of stigma experienced by TGW in Ghana by examining how they perceive its impact on HIV-related healthcare access. Guided by the Ecological Systems Framework, we conceptualize stigma as occurring across multiple interconnected levels (individual, healthcare facility, community, and structural levels). The study investigates healthcare providers' observations of stigma affecting TGW in different social environments. By centering healthcare providers' narratives, this study examines how providers describe the forms and sources of stigma affecting TGW across healthcare and broader social contexts, and how they perceive this stigma as influencing HIV-related healthcare access. Attention is given to providers' accounts of anticipated stigma, identity concealment, discriminatory treatment within healthcare settings, community exposure, and broader religious and sociocultural influences. The study provides a complementary perspective to existing research documenting TGW experiences by examining how stigma and its consequences are understood from the perspective of healthcare providers in Ghana.

Study Methodology

Study Design

This qualitative study explored healthcare providers' perceptions of stigma experienced by TGW in Ghana and how such stigma influences access to HIV-related healthcare services. The study was guided by the Ecological Systems Framework[27], with findings organized across four interconnected levels relevant to providers' accounts in this study: individual, healthcare facility, community, and structural contexts. This framework informed the organization and interpretation of providers' accounts of how stigma was perceived to operate across these interconnected social and healthcare environments.

Study Setting and Participants

Twenty healthcare providers (HCPs) participated in this study. Participants were recruited from public and private healthcare facilities within the Greater Accra Metropolitan Area of Ghana, including government polyclinics, a teaching hospital, and private healthcare settings. Participants represented a range of professional roles, including nurses, midwives, laboratory personnel, counselors, and physicians. To capture diverse perspectives regarding TGW healthcare experiences, providers were recruited from both HIV-focused services, including antiretroviral therapy (ART), sexually transmitted infection (STI), and counseling units, as well as general clinical departments such as outpatient, maternity, and laboratory services.

Eligibility criteria required participants to be healthcare professionals with direct patient contact and a minimum of six months of employment at their current facility. Participants were selected because they provided health services to TGW. Recruitment was conducted using purposive and snowball sampling approaches. Purposive sampling was initially used to recruit participants across professional roles and facility types. Snowball sampling supplemented recruitment. Out of 23 healthcare providers approached, 20 consented to participate. Sampling and preliminary analysis occurred iteratively. After each set of interviews, the research team reviewed emerging codes and themes during debriefing meetings and assessed whether subsequent interviews contributed substantively new information. Thematic saturation was considered reached when three consecutive interviews produced no new codes, themes, or substantively different patterns relevant to the study objectives. Recruitment was then concluded after 20 complete interviews.

Data Collection

Data were collected through semi-structured in-depth interviews conducted between May 30 and June 30, 2023. Interviews were carried out by trained research assistants experienced in qualitative research and in working with key populations. Prior to participation, healthcare providers received information about the study and provided written informed consent.

Interviews were conducted in either English and took place in private locations within health facilities or other mutually agreed settings to ensure confidentiality. Interviews lasted approximately 30 to 45 minutes.

The interview guide explored healthcare providers' experiences and perceptions related to TGW and HIV service provision. Key domains included understanding of TGW identity, perceptions and attitudes toward TGW, experiences providing care to TGW, perceived barriers to healthcare access, experiences and observations of stigma and discrimination, organizational practices related to TGW-inclusive care, the influence of religion and sociocultural norms on healthcare delivery, and previous exposure to LGBTQ + or stigma-reduction training.

Because the study sought to understand healthcare providers' accounts of stigma experienced by TGW, interview questions encouraged participants to reflect on observations occurring across multiple social contexts, including interactions between TGW and healthcare workers, encounters within healthcare facilities, community attitudes, and broader social and institutional influences. All interviews were audio-recorded, transcribed verbatim, and de-identified using unique participant identification numbers. Field notes were maintained throughout the data collection process to document contextual observations and support interpretation of the interview data.

Data Analysis

Data were analyzed using a thematic analysis approach in NVivo. Analysis was informed by the Ecological Systems Framework while remaining open to emergent themes arising from the data. A multidisciplinary research team developed an initial codebook based on interview domains and early transcript review. The codebook was iteratively refined through repeated discussions and transcript comparisons.

The first five transcripts were coded collaboratively by multiple team members to establish consistency in code application and interpretation. The remaining transcripts were independently coded by two researchers, with coding comparisons conducted throughout the analysis process to enhance reliability and ensure consistency across coders. Discrepancies were resolved through consensus discussions involving the broader research team.

Following coding, related codes were grouped into higher-order categories and themes. Particular attention was given to identifying how providers described stigma operating across ecological levels. Themes were subsequently organized into individual-level, healthcare facility-level, community-level, and structural-level influences to capture the interconnected nature of stigma experienced by TGW. This analytical process facilitated examination of how multiple forms of stigma interact to shape TGW healthcare experiences and HIV service access. To enhance rigor and trustworthiness, the research team employed iterative coding, analyst triangulation, regular debriefing sessions, and continuous comparison across transcripts. Throughout the analytical process, participant identities were protected through systematic de-identification procedures.

Reflexivity Statement

The research team included investigators with diverse disciplinary backgrounds in public health and nursing, with varying levels of experience working with key populations in Ghana. While none of the researchers identified as TGW, several had prior experience conducting community-based research with sexual and gender minorities in West Africa. Researchers acknowledged that their training in global health and stigma reduction may have introduced assumptions about the pervasiveness and harms of stigma. However, to mitigate potential bias, the team engaged in regular debriefing sessions, maintained reflective field notes, and employed iterative coding with multiple coders to challenge interpretive assumptions and reduce the influence of individual researcher perspectives. Additionally, all interviewers received specialized training in conducting sensitive discussions with healthcare providers, including strategies for maintaining neutrality and avoiding leading questions. We recognize that providers' responses may have been influenced by social desirability, particularly since most participants had received prior stigma-reduction training. This possibility was considered during the analysis and interpretation stages.

Ethical Considerations

Ethical approval

for this study was obtained from the Research Subjects Review Board (RSRB) at the University of Rochester (STUDY00008151) and the Ghana Health Service Ethics Review Committee (GHS-ERC:002/03/23). Given the sensitivity of discussions surrounding TGW identities, stigma, discrimination, and HIV service provision, strict measures were implemented to protect participants.

Written informed consent was obtained from all participants before data collection. Interviews were conducted in private settings selected to maximize confidentiality and participant comfort. All identifying information was removed from transcripts and replaced with unique participant identification numbers. Audio recordings, transcripts, and associated study documents were stored in encrypted and password-protected files accessible only to authorized members of the research team.

Research assistants received specialized training in conducting interviews on sensitive topics, including stigma and healthcare experiences among marginalized populations. These procedures were implemented to ensure participant privacy, confidentiality, and psychological safety while facilitating candid discussion of healthcare providers’ observations and experiences regarding stigma experienced by TGW in Ghana.

Results

Demographic Characteristics of Healthcare Providers

Participant characteristics relevant to understanding healthcare providers' accounts of stigma experienced by TGW are presented in Table 1. A total of 20 healthcare providers participated in the study, representing a range of professional backgrounds and service areas. Nurses constituted the largest professional group (n = 14, 70.0%), followed by midwives (n = 2, 10.0%), laboratory personnel (n = 2, 10.0%), a counselor (n = 1, 5.0%), and a physician (n = 1, 5.0%). Participants were drawn from clinical departments that frequently interact with TGW and other key populations, including ART/HIV units (40.0%), STI and counseling services (15.0%), outpatient departments (10.0%), maternity services (5.0%), general medical units (5.0%), laboratory services (10.0%), and reception or entry points to care (5.0%).

Most participants worked in government or public healthcare facilities (60.0%), while others worked in private facilities (25.0%) or across both public and private settings (15.0%). Participants reported between 2 and 16 years of professional experience (mean = 7.8 years, SD = 4.2), providing perspectives from both relatively early-career and experienced healthcare providers involved in HIV prevention, treatment, counseling, and general healthcare delivery.

Religion emerged as an important contextual factor in providers' accounts of TGW experiences of stigma. All participants identified as Christian, although levels of religious involvement varied considerably. While some participants reported frequent participation in religious activities, others described lower levels of engagement. Participants often reflected on how religious beliefs within healthcare settings and the broader community could shape attitudes toward TGW and contribute to stigmatizing experiences.

Training exposure also represented a key characteristic relevant to the study findings. Most participants (n = 18, 90.0%) reported receiving LGBTQ + or stigma-reduction training, primarily through in-service workshops and facility-based programs rather than formal professional education. Only one participant reported receiving TGW-related content during formal schooling, while two participants reported no prior training. Several providers referenced previous stigma-reduction training when discussing their awareness of stigma and attitudes toward TGW.

Table 1
Characteristics of Healthcare Providers Relevant to Accounts of TGW Stigma (N = 20)

Characteristic	Category	n (%)
Professional Role	Nurse	14 (70.0)
	Midwife	2 (10.0)
	Laboratory Personnel	2 (10.0)
	Counselor	1 (5.0)
	Physician	1 (5.0)
Department	ART/HIV Unit	8 (40.0)
	STI/Counseling Unit	3 (15.0)
	Laboratory	2 (10.0)
	OPD	2 (10.0)
	Maternity	1 (5.0)
	General Medical	1 (5.0)
	Entry/Reception	1 (5.0)
	Not Specified	2 (10.0)
Healthcare Sector/Work Setting	Government/Public	12 (60.0)
	Private	5 (25.0)
	Both Public and Private	3 (15.0)
Years of Experience	Mean (SD)	7.8 (4.2)
	Range	2–16 years
Religious Affiliation	Christian	20 (100.0)
Religiosity	Very High (≥ 3 times/week)	4 (20.0)
	High (2 times/week)	3 (15.0)
	Moderate (1 time/week)	6 (30.0)
	Low/Rarely Attend	5 (25.0)
	Did not Specify	2 (10.0)
General TGW Stigma Reduction Training	Received Any Training	18 (90.0)
	Training During Formal Schooling	1 (5.0)
	In-Service/Workshop Training	17 (85.0)

Characteristic	Category	n (%)
	No Training Received	2 (10.0)

healthcare providers’ Accounts of Stigma Experienced by TGW in Ghana

Using the Ecological Systems Framework, healthcare providers described stigma affecting TGW across four interconnected levels (individual, healthcare facility, community, and structural). Providers' accounts described how stigma within these contexts could influence identity disclosure, healthcare-seeking, engagement with HIV-related services, and continuity of care. Across interviews, providers acknowledged that TGW in Ghana experience stigma both within and outside healthcare settings, and that this stigma shapes how they present themselves, disclose their identity, seek HIV services, and remain in care.

Individual-Level Stigma. At the individual level, healthcare providers described stigma as an internalized and anticipatory influence that they perceived as shaping TGW healthcare-seeking behaviors. Providers observed that many TGW enter healthcare settings expecting judgment, ridicule, or mistreatment, a phenomenon they attributed to "self-stigma" rooted in prior experiences of rejection and awareness of widespread societal prejudice. This anticipated stigma manifested in three interconnected ways, which are explored in the subsections below: Anticipated Stigma and Self-Stigma, where providers described how fear of discrimination discourages healthcare-seeking; Fear of Disclosure and Identity Concealment, which examines how TGW hide their gender identity to avoid negative reactions; and Fear of Recognition and Disengagement from Care, which addresses how concerns about being seen by acquaintances in healthcare settings lead to avoidance and interrupted care. Providers recognized that these individual-level processes often operated before any direct interaction with healthcare staff occurred, creating psychological barriers that could prevent TGW from accessing HIV prevention, testing, and treatment services. Collectively, providers' accounts suggest that they perceived stigma as operating not only through enacted discrimination but also through anticipation and internalization, with potential consequences for healthcare-seeking and service engagement.

Anticipated Stigma and Self-Stigma.

Healthcare providers described stigma as operating at the individual level through fear and anticipation of negative treatment. Several providers perceived that TGW may internalize societal prejudice and approach healthcare settings expecting discrimination, even before direct interaction with healthcare staff occurs. Providers frequently referred to this phenomenon as "self-stigma," whereby previous experiences of rejection or awareness of widespread societal stigma shape expectations about healthcare encounters. As one provider explained, "Sometimes also it is a self-stigma, thinking that when I go, I'll be treated this way" (HCW005). Similarly, another provider stated, "I will say self-stigma, they will be afraid to come all out for that" (HCW020).

Providers attributed what they perceived as fear and anticipation of stigma to previous or expected stigmatizing reactions within healthcare and community settings. Participants described situations in which TGW were subjected to ridicule, derogatory labels, and other forms of judgment. One provider noted that staff may "laugh at the person, say derogatory words" (HCW016), while another reported that TGW are sometimes referred to as "Kojo Besia" (HCW020), a derogatory term used to ridicule gender nonconformity. Providers also described non-verbal expressions of stigma, including staring, pointing, and gossiping. As one participant explained, people "will be looking at them, and then they will be pointing fingers" (HCW010), while another described instances of nurses "gossiping and murmuring words" (HCW019).

In providers' accounts, previous or anticipated experiences of judgment were perceived to contribute to self-stigma and reluctance to seek healthcare. Providers' accounts suggest that stigma may operate not only through direct discriminatory encounters but also through anticipation of such encounters, creating perceived psychological barriers to healthcare engagement.

Fear of Disclosure and Identity Concealment.

Providers further described how anticipated stigma influenced whether TGW disclosed their gender identity during healthcare encounters. According to participants, fear of judgment, discrimination, or negative reactions often led TGW to conceal aspects of their identity when seeking care. One provider noted that TGW "don't really come out clear, they're afraid of stigma" (HCW009). In such cases, concerns about social judgment appeared to outweigh the perceived benefits of disclosure.

Participants suggested that nondisclosure often reflected efforts to avoid negative reactions from healthcare workers and others present within healthcare settings. Providers described instances where TGW faced comments questioning their gender presentation. One participant recalled hearing remarks such as, "you are a man but see how you are dressed" (HCW013). Such comments illustrate how gender expression can become a focus of scrutiny and judgment, reinforcing fears surrounding disclosure.

Providers interpreted nondisclosure as a possible protective strategy through which TGW sought to reduce the risk of mistreatment, embarrassment, or social rejection. These accounts suggest that providers perceived stigma as influencing patient-provider interactions by affecting whether TGW felt safe disclosing personal information relevant to their healthcare.

Fear of Recognition and Disengagement from Care.

Beyond concerns about provider reactions, participants described fear of being recognized by relatives, acquaintances, or community members within healthcare settings. Providers explained that the possibility of being seen by someone familiar could discourage TGW from accessing services or cause them to leave facilities before receiving care. One provider recalled, "a person will come like, eeii I've met my relative, immediately they spot the person, the person is gone" (HCW013).

These accounts suggest that providers perceived concerns about exposure and unwanted disclosure as extending beyond interactions with healthcare providers. Providers perceived fear of recognition as contributing to healthcare avoidance, interrupted care-seeking, and disengagement from services. From the providers' perspective, concerns about visibility and the social consequences of recognition could undermine continuity of care.

Healthcare Facility-Level Stigma. Within healthcare facilities, providers identified stigma as operating through both overt discriminatory acts and subtle organizational practices that collectively undermine TGW trust, safety, and willingness to engage with care. Nearly all participants affirmed that stigma remains pervasive within clinical settings, manifesting in forms ranging from laughter, gossip, and derogatory language to more severe expressions such as neglect, refusal of care, and conditional acceptance. These dynamics are examined in two subsections: Stigmatizing Treatment, Neglect, and Refusal of Care, which documents providers' accounts of discriminatory treatment, conditional acceptance, and the tension between formal access and meaningful care; and HIV Service Visibility and HIV-Related Stigma, which explores how service delivery structures such as visibly labeled ART units and dedicated service days can inadvertently increase patient visibility and compound stigma.

Stigmatizing Treatment, Neglect, and Refusal of Care.

Providers consistently affirmed that stigma persists within their facilities, often using emphatic language to convey its ubiquity: "definitely stigmatization is everywhere" (HCW001), "Oh yes, stigma is there" (HCW006), "Yes, there is. Stigma is still there" (HCW007), and "Oh, definitely. Any day, there is" (HCW018). One provider emphasized that stigma affects many patients but is particularly severe for TGW: "Even the ordinary ones are stigmatized not to talk of these people. That is the truth. There is stigma" (HCW019).

Providers described stigma manifesting as neglect and refusal of care, revealing how prejudice can override professional obligations. One provider recalled a situation in which nurses refused to attend to a TGW client because of their identity: “the nurses said once he is into the community, they are not going to attend to him (TGW), even if they give all the money in the world, they are not going to do it” (HCW006). Another provider similarly noted, “Sometimes they have been neglected, some nurses don't want to attend to them because of their religious beliefs” (HCW014). These accounts illustrate providers' perceptions that stigmatizing attitudes may extend into clinical practices that can restrict or discourage access to healthcare services.

Providers also described forms of conditional acceptance, whereby TGW could access healthcare services but were expected to modify or conceal their gender expression to avoid negative reactions. One provider advised that dressing as a woman could create difficulties and suggested presenting as a man when visiting healthcare facilities: “Just because you see yourself as a woman doesn't mean you should dress like that to the hospital, you can dress up as a man, so it doesn't bring you problem when you go out” (HCW017).

This account illustrates how providers could simultaneously recognize TGW access to healthcare while reproducing expectations that gender expression should conform to socially normative expectations. Such conditional acceptance represents an important form of stigma within providers' accounts.

HIV Service Visibility and HIV-Related Stigma.

Providers also identified HIV service delivery structures as a source of stigma. Particular concern was raised about the visibility of HIV services when ART units or HIV-related services were physically separated or clearly labeled. One provider explained: “when it comes to HIV services, and HIV care. There's a big stigma in the healthcare system. they will mention this place as ART facility or ART corner, that one alone is a stigma” (HCW002).

Providers recognized that HIV-related stigma may compound existing stigma associated with TGW identity. Consequently, some facilities adopted strategies to reduce patient visibility and protect confidentiality. One provider described an integrated service model where HIV clients were not separated from other patients: “everybody passes through the same protocol” (HCW005). Similarly, another provider argued that creating dedicated service days for TGW individuals or people living with HIV could inadvertently reinforce stigma: “if let say we have a particular day for TGW or HIV people, it's still Stigma or discrimination. But when everybody comes together, we wouldn't know whether this one is HIV or whatever” (HCW020).

Other facilities implemented privacy-oriented approaches to reduce unintended disclosure. One provider described discreet medication collection procedures: “we schedule someone for today, so even if you walk in boldly, you just come and pick your medication well packaged. So no one knows what you have come for” (HCW007). Another explained that services were sometimes arranged on less busy days to minimize exposure: “they come here non-clinic days, especially Thursdays and Fridays” (HCW015).

Providers' accounts suggest that the organization and visibility of HIV-related services may create additional concerns about unwanted disclosure. From their perspective, TGW seeking HIV-related care may therefore encounter overlapping forms of stigma associated with both gender identity and perceived HIV status.

Community-Level Stigma. At the community level, providers situated stigma within the broader social environment, describing Ghanaian society as largely unaccepting of TGW and characterized by social rejection, surveillance, and public exposure. Providers explained that community stigma extends beyond individual interactions and permeates healthcare spaces through other patients, relatives, and acquaintances who may recognize or scrutinize TGW within clinical settings. This dynamic is explored in two subsections: Social Rejection, which describes how societal unacceptance and shunning create barriers to care; and Fear of Recognition, which examines how the presence of community members in healthcare settings and the fear of being identified leads to avoidance, interrupted care, and disengagement from services. Providers also noted that community stigma affects TGW's mobility and public presentation, with some avoiding public transport or limiting their visibility in public spaces to

reduce identification. These accounts demonstrate that healthcare facilities are not socially neutral environments but are embedded within communities where gender non-conformity and HIV are heavily stigmatized, and that community-level stigma can prevent TGW from seeking care even before they enter a healthcare facility.

Social Rejection.

At the community level, providers described Ghanaian society as generally unaccepting of TGW. One provider explained, “You know, society is not accepting them, it becomes difficult for them to relate” (HCW009). Another linked stigma to social shunning and lack of understanding: “because of the way we shun them, we don't know more about it” (HCW011). These statements show that providers saw stigma as rooted in broader social norms, not only in healthcare interactions.

Fear of Recognition.

Providers also described community members within healthcare spaces as potential sources of stigma. One provider said TGW could experience “friction” from consultation to the pharmacy area (HCW011). Another provider described public assumptions about HIV when people enter certain spaces: “As soon as you enter here, they say you have AIDS. Sometimes if they come here and meet people, they know they stop coming” (HCW019). This indicates that healthcare facilities are not isolated from community stigma. Other patients, relatives, and community members can reproduce stigma inside clinical spaces.

Providers also perceived community stigma as affecting TGW mobility and public presentation. Providers noted that TGW may avoid ordinary public transport or public exposure to reduce identification. These accounts suggest that, from providers' perspectives, stigma may influence healthcare access before a clinic visit begins by shaping concerns about travel, public visibility, gender presentation, and recognition.

Structural-Level Stigma. At the structural level, providers linked the persistence of stigma affecting TGW to broader religious beliefs, cultural expectations, and sociocultural norms. Participants described these influences as extending beyond individual attitudes and shaping how TGW are perceived and treated within both healthcare settings and the wider community. Providers particularly emphasized moral and religious interpretations of gender and sexuality as important social influences that could normalize negative attitudes and discriminatory responses toward TGW. These accounts illustrate how stigma was perceived as being embedded within broader belief systems that extend across healthcare and community contexts.

Religious and Cultural Foundations of Structural Stigma.

Providers frequently linked stigma toward TGW to broader religious beliefs and social norms operating within communities and healthcare settings. Participants explained that negative attitudes toward TGW were often rooted in moral and religious interpretations of gender and sexuality that extend beyond

individual interactions. According to providers, these beliefs shape how TGW are perceived and treated both within healthcare facilities and in society more broadly.

Several participants noted that healthcare workers sometimes bring personal religious beliefs into their professional roles, influencing how they interact with TGW. As one provider explained, “they are attaching their beliefs to the work which shouldn't be so” (HCW001). Similarly, another provider stated, “you know our religion in our community frowns on TGW r stuff so because of that there is definitely discrimination” (HCW014). These accounts suggest that stigma is reinforced through social and religious systems that define TGW identities as inconsistent with accepted cultural and moral norms.

Providers' narratives indicate that structural stigma extends beyond individual prejudice and is embedded within broader belief systems that influence attitudes, behaviors, and expectations. Providers' accounts therefore situated stigma not only within individual attitudes but also within broader religious and sociocultural norms that may normalize or reinforce exclusionary attitudes toward TGW.

Discussion

Using an ecological framework, this study examined healthcare providers' accounts of stigma affecting TGW and its perceived influence on HIV-related healthcare access in Ghana. Providers described stigma as operating across four interconnected levels: individual, healthcare facility, community, and structural. Their accounts linked anticipated stigma, fear of disclosure, visibility within HIV-related services, community recognition and surveillance, and broader religious and sociocultural norms with healthcare avoidance, nondisclosure, interrupted engagement, and concerns about continuity of care. These findings should be understood as healthcare providers' perceptions and observations rather than direct accounts of TGW lived experiences. Nevertheless, they provide an important complementary perspective on how stigma is understood within healthcare systems and how providers perceive its consequences for HIV-related healthcare access.

Providers described TGW as potentially entering healthcare spaces expecting judgment, ridicule, or mistreatment, which they attributed to previous experiences or awareness of broader societal prejudice. This finding aligns with studies that emphasize stigma affects health not only through enacted discrimination, but also through anticipation, concealment and psychological vigilance[5,28]. In the context of HIV care, such anticipation may be particularly significant because timely testing, disclosure, treatment initiation and retention require sustained trust in healthcare systems[21,29–33]. These provider accounts are consistent with previous studies in which TGW themselves reported delaying or avoiding healthcare because of fears of disrespect, involuntary disclosure, or discriminatory treatment [4,6,21,34–36]. However, this study builds on this body of work by demonstrating that Ghanaian healthcare providers recognize these anticipatory processes and acknowledge that stigma may prevent TGW from accessing services even before they (TGW) arrive at the facility.

The findings also highlight the critical point at which stigma disrupts care. Providers described how TGW may hide their gender identity to avoid judgment, ridicule or mistreatment [5,37,38]. From the providers' perspective, nondisclosure may function as a protective response to healthcare environments perceived as potentially stigmatizing or unsafe. Providers' accounts further suggest that concerns about disclosure may complicate communication during healthcare encounters and influence engagement with HIV-related services. This interpretation is consistent with previous studies directly involving TGW, in which participants described concerns about disclosure, confidentiality, and negative reactions from healthcare workers. This finding is consistent with prior qualitative work in Ghana which documented fears that nurses or other healthcare workers might disclose identities of non-heteronormative individuals to others[4,6,21,29,30,32]. This study also builds on this nondisclosure by showing that providers themselves identify fear of disclosure as a barrier to care for TGW.

Another key finding in this study was the emergence of healthcare facility-level stigma on TGW. Providers acknowledged that stigma is still present in healthcare facilities and can be seen in laughter, gossip, derogatory language, neglect, refusal of care and conditional acceptance. These accounts are important because they challenge the assumption that access to healthcare is simply a matter of making services physically available[39]. Having formal access does not guarantee meaningful access[40], especially when patients must deal with feelings of shame, the sense of being under surveillance, disrespect, and pressure to conceal their gender expression. The finding that some providers advised TGW to dress in ways that conform to the sex they were assigned at birth reveals how access to healthcare may be conditional on gender conformity[41–43]. Providers' accounts of conditional acceptance may reflect an institutionalized form of stigma in which access to socially acceptable care is implicitly linked to conformity with normative gender presentation [41–43], as it conveys the message that TGW can only receive care if they reduce their visibility and suppress their identity[44].

Providers' accounts also suggest that the organization of HIV-related services may unintentionally increase patient visibility and concerns about stigma. Providers identified clearly marked ART units, separate HIV service areas or dedicated service days as potential sources of unwanted visibility. This finding is consistent with research showing that HIV-related stigma can be reinforced through clinic structures that expose patients' HIV status or mark them as different[45,46]. For TGW, this visibility may compound gender identity stigma with HIV stigma, creating layered risks of exposure. Providers' concerns about visibly identifiable HIV services highlight how healthcare organization itself may contribute to anticipated or perceived disclosure. For TGW, providers perceived this visibility as potentially layering HIV-related stigma onto existing gender-related stigma.

At the community level, healthcare providers described Ghanaian society as being largely unaccepting of TGW [4–6]. This stigma extends into healthcare environments through other patients, relatives, acquaintances and community members. This finding highlights that healthcare facilities are not socially neutral spaces. They are embedded in communities where gender non-conformity, HIV and sexual diversity may be heavily stigmatized. Providers perceived fear of being recognized by community

members as a factor that could discourage TGW from seeking or remaining engaged in care [4–6,47]. This is particularly pertinent in healthcare settings, where patients may share waiting areas, queues, pharmacies and clinic corridors with individuals they know [4–6]. These findings contribute to existing research by demonstrating that community-level stigma can infiltrate clinical spaces and influence healthcare engagement through surveillance, gossip, and the fear of social exposure [4–6,48–50].

Structural-level stigma also featured prominently in providers' accounts. Participants frequently linked negative attitudes toward TGW to broader religious beliefs, cultural expectations, and sociocultural norms. Rather than describing these influences solely as individual beliefs, providers suggested that they form part of the wider social environment in which attitudes toward TGW are developed and reinforced. Some participants specifically described how healthcare workers may bring personal religious beliefs into clinical interactions, potentially contributing to judgment or discriminatory treatment. These accounts suggest that broader religious and sociocultural norms may become reflected in everyday healthcare encounters. Providers therefore situated stigma within social belief systems that extend beyond individual attitudes and influence both community perceptions and healthcare interactions.

A key strength in this study lies in its focus on healthcare providers as narrators of the experiences of TGW facing stigma. Much of the existing literature rightly focuses on the experiences of TGW themselves [4–6]. This study provides a complementary perspective by examining how providers understand stigma, where they locate its sources and how they perceive its impact on HIV care. Providers' accounts reveal both awareness and ambivalence. On the one hand, many recognized that TGW experience discrimination and that training could improve provider attitudes. However, some accounts reproduced stigmatizing assumptions, misgendered individuals, or expected TGW to modify their presentation to avoid problems. This duality suggests that healthcare providers may recognize stigma affecting TGW while simultaneously reproducing some of the assumptions and practices through which stigma persists.

Most participants reported previous exposure to LGBTQ + or stigma-reduction training. This context is important when interpreting their accounts because prior training may have influenced their awareness of stigma, their understanding of professional expectations, and the language they used when describing discriminatory practices within healthcare settings. Providers sometimes associated such training with greater awareness of the challenges TGW may encounter when seeking care. However, stigmatizing assumptions and practices remained evident in some participants' narratives, including misgendering, expectations that TGW modify their gender presentation, and descriptions of discriminatory treatment by healthcare workers. These accounts suggest that awareness of stigma may coexist with attitudes and practices that contribute to its persistence within healthcare environments. Accordingly, the findings highlight the complexity of providers' perspectives and the ways in which stigma may continue to be reproduced even among healthcare workers who have previously been exposed to stigma-related training.

This study makes several contributions to existing literature. First, it provides a TGW -specific analysis of healthcare providers' accounts in Ghana, where TGW have often been included within broader categories of sexual and gender minority populations. Second, the ecological framework illustrates how providers perceive stigma as operating across interconnected individual, healthcare facility, community, and structural contexts rather than within a single domain. Third, the study complements research directly involving TGW by examining how healthcare providers themselves understand the forms, sources, and healthcare consequences of stigma. Together, these perspectives provide a fuller understanding of how stigma is perceived within the healthcare and social environments surrounding HIV-related service access.

Previous studies in Ghana that directly examined TGW experiences reported fear, shame, concerns about disclosure, and heightened vigilance within healthcare settings[4,5,7,21]. Providers' accounts in the present study converged with some of these findings, particularly in their recognition of anticipated stigma, fear of exposure, and discriminatory treatment as barriers to healthcare engagement. However, the perspectives are not directly equivalent. The present study reflects providers' interpretations and observations, whereas studies involving TGW capture first-person lived experiences [4,5,7,21]. Considering these perspectives together highlights both convergence and differences in how stigma and its consequences are understood.

Limitations

Several limitations should be considered when interpreting these findings. First, this study examined healthcare providers' accounts rather than TGW direct reports of their healthcare experiences. Providers may not have fully captured the frequency, intensity, or emotional consequences of stigma experienced by TGW, and their interpretations should not be treated as substitutes for first-person accounts. Second, participants' responses may have been influenced by social desirability, particularly because most reported previous exposure to stigma-reduction or related training and may have been aware of expected professional norms. Third, participants were recruited within the Greater Accra Metropolitan Area, and the findings may not reflect healthcare providers' perspectives in other regions or healthcare contexts in Ghana. Fourth, nurses constituted most participants, while physicians and several other professional groups were minimally represented or absent. Finally, although participants were provided with a standardized explanation of TGW when clarification was needed, individual cultural, religious, and professional understandings of gender identity may have influenced how participants interpreted questions and described TGW. These limitations underscore that the findings represent providers' accounts of stigma and its perceived consequences rather than direct evidence of TGW lived experiences.

Conclusion

This study provides a healthcare provider-centered account of stigma affecting TGW and its perceived influence on HIV-related healthcare access in Ghana. Providers described stigma as operating across

interconnected individual, healthcare facility, community, and structural contexts. At the individual level, their accounts emphasized anticipated stigma, self-stigma, fear of disclosure, identity concealment, and concerns about recognition. Within healthcare facilities, providers described ridicule, derogatory language, gossip, neglect, refusal of care, conditional acceptance, and HIV service arrangements that could increase patient visibility. Community-level accounts emphasized social rejection, surveillance, and fear of exposure, while structural-level accounts situated stigma within broader religious beliefs and sociocultural norms. Across these contexts, providers perceived stigma as contributing to delayed or avoided healthcare-seeking, nondisclosure, interrupted engagement with HIV-related services, and challenges to continuity of care. These findings complement research directly involving TGW by illustrating how healthcare providers understand the forms, sources, and healthcare consequences of stigma within the Ghanaian context.

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