

# “Per my religion”: Religious beliefs and healthcare workers’ moral negotiation of HIV care for transgender women in Ghana BSGH056

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## Research Article

**Keywords:** religion, HIV care, transgender women, healthcare workers, stigma, Ghana

**Posted Date:** October 12th, 2026

**DOI:** <https://doi.org/10.21203/rs.3.rs-10961708/v1>

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**Additional Declarations:** No competing interests reported.

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# Abstract

## Background

Religion can shape healthcare workers' attitudes and practices toward sexual and gender minority patients, yet little is known about how healthcare workers in Ghana reconcile religious beliefs with professional responsibilities when providing HIV care to transgender women. This study aimed to examine how religious beliefs influence healthcare workers' moral reasoning and provision of HIV-related care to transgender women in Ghana.

## Methods

This qualitative descriptive study included 20 healthcare workers recruited from public and private health facilities in the Greater Accra Metropolitan Area. Semi-structured interviews conducted from May to June 2023 explored religious beliefs, perceptions of transgender women, and experiences of HIV-related care. Interviews were audio recorded, transcribed verbatim, and analyzed using codebook-based thematic analysis with deductive and inductive coding.

## Results

Three interrelated thematic categories were identified. First, Christian teachings supported compassion, dignity, and nondiscriminatory care. Second, religious beliefs and community narratives could frame transgender identities as sinful, spiritually deviant, or contrary to divine creation, and participants linked these beliefs to avoidance, neglect, moral judgment, and secondary stigma toward healthcare workers serving transgender women. Third, healthcare workers negotiated theological discomfort with professional duty. We conceptualize this pattern as conditional professional care, in which workers provide respectful HIV services and avoid overt refusal while retaining religious beliefs that do not affirm transgender identities.

## Conclusions

This study identifies moral negotiation as an important mechanism through which religion shapes transgender Human Immunodeficiency Virus care and introduces conditional professional care as a conceptual framework for understanding how respectful clinical practice can coexist with theological non-affirmation. The findings extend existing literature beyond binary models of discriminatory versus affirming care and highlight the need for interventions that address not only clinical knowledge and stigma, but also the moral reasoning processes through which healthcare workers reconcile faith, professional ethics, and transgender identity.

**Clinical trial number:** not applicable

## Background

Religion plays an important role in shaping social norms, moral values, and professional practices across sub-Saharan Africa [1–4]. This influence is particularly relevant to health and healthcare delivery [5]. In Ghana, Christianity plays a central role in everyday life and public discourse and significantly influences social expectations, political debates, and the conduct of professionals, including healthcare workers [3, 4, 6]. Religion is well documented as shaping understandings of identity, responsibility, acceptable behavior, gender, and sexuality. Within HIV care settings, these beliefs provide an important context for understanding how healthcare workers interact with and respond to transgender women and other key populations.

Globally, transgender women experience a disproportionately high prevalence of HIV and face pervasive barriers to HIV prevention, testing, treatment, and engagement in care [7, 8]. Research across diverse settings has documented reluctance to use healthcare services, fear of discrimination, breaches of confidentiality, and limited access to gender-affirming and culturally competent care [7]. Emerging evidence from sub-Saharan Africa demonstrates that transgender women and other sexual and gender minority populations encounter significant challenges within health systems, including healthcare worker knowledge gaps, discriminatory attitudes, and structural barriers to HIV services [8, 9]. In Ghana, recent studies have drawn attention to concerns regarding stigma, expression of gender identity, confidentiality, and HIV service access experienced by transgender women [8]. These findings highlight persistent barriers to HIV testing and treatment among transgender women. However, most research in this field has focused on the experiences of transgender women themselves, with less attention paid to how healthcare workers understand and navigate these issues in their routine clinical work.

Religion is frequently identified as a source of stigma toward sexual and gender minority populations and as a potential barrier to inclusive healthcare in African contexts [5, 6]. Research on sexuality and gender diversity in the region has demonstrated the significant influence of religious leaders and institutions on public discourse surrounding sexual and gender minority rights [6]. A recurrent theme in these discourses is the portrayal of non-heteronormative identities as being incompatible with religious doctrines and African cultural values [6]. In Ghana, religious discourses have been shown to influence public attitudes toward sexual and gender minorities, including transgender women, and to contribute to contested debates over morality, social order, and national identity [6, 10]. Within healthcare settings, these broader discourses can translate into healthcare worker discomfort, moral judgment, and reluctance to engage fully with transgender women patients, thus reinforcing barriers to HIV care [5].

However, understanding religion solely as a source of exclusion overlooks its more complex role in healthcare [5, 11, 12]. Many religious traditions emphasize compassion, service, hospitality, and care for people who are vulnerable or marginalized [13]. Research suggests that religious commitments can encourage healthcare workers to uphold ethical obligations, protect patient dignity, and extend care even in the face of social stigma [5, 11]. Consequently, religion can function as both a source of moral judgment and a foundation for compassionate care, creating ambivalence and tension in everyday clinical practice [14, 15]. Recent studies in the field of religion and health have highlighted that responses to sexual and gender diversity are frequently characterized by a process of negotiation rather than

definitive resolution [5, 6]. This negotiation may involve simultaneous commitments to inclusion and continuing theological reservations.

These dynamics are particularly salient in highly religious settings where healthcare workers provide HIV care to transgender women [16]. Healthcare workers operate within a complex ethical landscape shaped by religious beliefs, professional ethics, institutional norms, commitments to patient well-being, and the continuing influence of missionary-colonial understandings of gender and sexuality [5]. Contemporary religious beliefs about gender and sexuality in African settings may partly reflect missionary and colonial influences that promoted rigid heterosexual and binary gender norms as both Christian and culturally authentic [17]. When patients' identities or practices conflict with healthcare workers' religious worldviews, healthcare workers may experience tension between faith and professional responsibility [15, 18]. Rather than resolving these tensions, healthcare workers may develop pragmatic approaches that allow them to maintain both religious commitments and a minimum standard of professional care, producing forms of service that are neither fully affirming nor overtly exclusionary [16]. Understanding these processes is important for developing interventions that reduce stigma and strengthen inclusive HIV care for transgender women.

Despite the growing attention to sexual and gender minority health in sub-Saharan Africa, relatively little research has examined how healthcare workers themselves understand the relationship between religion and HIV care for transgender women, or how they navigate competing moral imperatives in everyday practice [8, 9]. Existing research has documented healthcare worker-level stigma and gaps in HIV care training [8, 9]. However, the way religious beliefs are interpreted and managed within clinical decision-making and patient interactions remains largely unexplored [15, 19]. In Ghana, where health systems and public discourse about gender and sexuality are profoundly influenced by religious values [20–24], the examination of these negotiations is of particular importance for public health policy and programming.

This study advances the existing literature in several important ways. First, it shifts the analytical focus from documenting transgender women's experiences of stigma to examining the moral reasoning processes through which healthcare workers interpret and respond to transgender identity within HIV care. Second, rather than treating religion as a uniformly stigmatizing or protective influence, the study conceptualizes religion as a dynamic moral framework that can simultaneously support compassion, legitimize exclusion, and generate tension between personal belief and professional responsibility. Third, the study introduces the concept of conditional professional care to describe a previously underarticulated form of clinical practice in which healthcare workers uphold professional obligations to provide respectful HIV-related services while retaining theological reservations about transgender identities. This concept extends existing scholarship beyond the binary distinction between affirming and discriminatory care by identifying an intermediate form of professional engagement that may preserve access to services while still allowing subtle forms of moral distancing, conditional acceptance, or non-affirmation to persist. Finally, by locating these processes within Ghana, the study contributes context-specific evidence from a highly religious sub-Saharan African setting where religious, cultural,

professional, and postcolonial understandings of gender intersect in the delivery of HIV care. Together, these contributions offer a new framework for understanding how religious belief is translated into everyday healthcare practice and identify moral negotiation as an important but insufficiently examined determinant of transgender-inclusive HIV care.

Accordingly, this study aimed to examine how religious beliefs influence healthcare workers' moral reasoning and provision of HIV-related care to transgender women in Ghana.

## **Methods**

### **Study design and setting**

This qualitative descriptive study used thematic analysis to organize findings into categories and subcategories and to interpret how religious beliefs shaped healthcare workers' moral negotiation of HIV care for transgender women. The study was conducted in the Greater Accra Metropolitan Area, an urban region with multiple public sector polyclinics, a teaching hospital, and private facilities providing HIV and sexually transmitted infection services. Facilities were purposively selected to include sites with high HIV patient volume and varying levels of exposure to stigma reduction and key population programming. This setting allowed exploration of religious influences on care within routine public and nongovernmental organization-affiliated HIV service delivery environments.

### **Participants and sampling**

A total of 20 healthcare workers participated in the study. Eligible participants were nurses, midwives, laboratory personnel, counselors, physicians, and front-desk staff who had direct patient contact and had been employed at their current facility for at least six months. Purposive sampling was used to recruit healthcare workers from both HIV-specialized units (for example, antiretroviral therapy clinics, sexually transmitted infection and counseling units) and general departments (for example, outpatient departments, maternity, laboratory services) to capture a range of perspectives on caring for transgender women. Recruitment began with key departments known to serve key populations and proceeded via snowball sampling, with enrolled healthcare workers referring colleagues who met eligibility criteria. Recruitment continued until the analytic team determined that consecutive interviews were no longer generating substantively new codes or themes relevant to the study objectives. Saturation was assessed through ongoing review of interview summaries, emerging codes, and team discussions during data collection.

### **Data collection**

Semi-structured, in-depth interviews were conducted between 30 May 2023 and 30 June 2023 by trained research assistants with experience in qualitative data collection and working with key populations. Prior to participation, healthcare workers received an information sheet describing the study aims, topics to

be discussed, and confidentiality protections, and provided written informed consent. All interviews were conducted in English in private spaces within health facilities or at other locations convenient and safe for participants. Interviews lasted approximately 30 to 45 minutes.

The interview guide explored domains including religious identity and practices; perceived influence of religion on professional duties; knowledge and perceptions of transgender women; identification of transgender women in clinical settings; experiences of stigma and discrimination; HIV and sexually transmitted infection service provision; and training history related to key population health and stigma reduction. All interviews were audio recorded with permission, transcribed verbatim into English, and deidentified using unique participant codes. Field notes were taken after interviews to document contextual details, nonverbal cues, and researchers' preliminary reflections. At the end of each interview, participants were invited to review their responses, but none chose to do so.

## **Reflexivity**

The research team comprised investigators with interdisciplinary training in public health, nursing, and related health research fields, with varying levels of experience working with individuals in the sexual and gender minority communities and HIV-related healthcare in Ghana. Given the study's focus on religion, transgender identity, stigma, and HIV care, the team recognized that their professional training, prior research experiences, and familiarity with stigma-related scholarship could influence how participants' accounts were understood and interpreted. To promote reflexivity, researchers maintained reflective field notes and engaged in regular discussions about emerging interpretations, assumptions, and potential sources of bias throughout data collection and analysis.

During analysis, multiple researchers contributed to developing and refining the codebook, and transcripts were independently coded by more than one team member. Differences in coding and interpretation were discussed during team meetings to challenge individual assumptions and ensure that findings remained grounded in participants' accounts. Interviewers also received training in conducting sensitive discussions about religion, stigma, and HIV-related healthcare, with particular emphasis on maintaining neutrality, using nonjudgmental language, and avoiding leading questions. The team further recognized the potential for social desirability bias because participants were healthcare professionals discussing sensitive attitudes and practices, and most had previously received sexual and gender minority stigma-reduction training. This possibility was considered throughout the analysis and interpretation of participants' accounts, particularly when examining the relationship between religious beliefs, professional responsibilities, and reported HIV care practices.

## **Data analysis**

Interview transcripts were analyzed using a codebook-based thematic analysis supported by NVivo qualitative data analysis software. Codes were organized into categories and subcategories, and relationships across these categories were interpreted to explain how religious beliefs shaped

healthcare workers' moral reasoning and HIV-related care practices. The analysis combined deductive and inductive approaches. Deductive codes were informed by the study objectives and sensitizing concepts from the literature, particularly those related to religion, stigma, professional responsibility, moral reasoning, and HIV-related care for transgender women, while inductive codes were developed through close reading of participants' accounts to capture additional meanings and experiences emerging from the data. The research team collaboratively developed an initial codebook after reviewing the transcripts. The first five transcripts were coded collectively to refine code definitions, clarify areas of overlap, and establish a shared understanding of the coding framework. Following refinement of the codebook, two members of the research team independently coded each transcript. Coding differences were reviewed during regular team meetings and resolved through discussion and consensus to strengthen coding consistency and ensure that alternative interpretations were considered.

After coding was completed, coded segments were compared within and across participants to identify recurring patterns in how religious beliefs shaped healthcare workers' perceptions of transgender women, moral reasoning, and provision of HIV-related care. Related codes were organized into categories and subcategories and iteratively reviewed against the coded extracts and broader dataset. Attention was given to accounts in which religion supported compassionate and nondiscriminatory care, contributed to stigma, judgment, avoidance, or discomfort, and created tensions between theological beliefs and professional responsibilities. This iterative analysis produced three interrelated thematic categories and informed the concept of conditional professional care, which describes situations in which healthcare workers maintained personal or theological reservations about transgender identities while emphasizing their professional responsibility to provide respectful HIV-related healthcare. Throughout the analytic process, potentially identifying information was removed or masked, and the research team engaged in ongoing discussion of emerging interpretations and the possible influence of researchers' perspectives on coding and theme development.

## **Ethical approval**

### **and informed consent**

## **Ethical approval**

was obtained from the Research Subjects Review Board at the University of Rochester (STUDY00008151) and the Ghana Health Service Ethics Review Committee (GHS-ERC:002/03/23). All procedures involving human participants were conducted in accordance with the ethical standards of these committees and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. Written informed consent was obtained from all participants before data collection. Transcripts were deidentified, and study data were stored in encrypted, password-protected folders accessible only to authorized study personnel.

# **Results**

# Participant characteristics

Participant characteristics are summarized in Table 1. Seventeen participants were female (85.0%), and nurses were the largest professional group (n = 14, 70.0%). Twelve participants (60.0%) worked in government or public facilities. Among the 18 participants with available experience data, professional experience ranged from 2 to 16 years, with a mean of 7.8 years (standard deviation = 4.2). All 20 participants identified as Christian, although one described being non-practicing. Eighteen participants (90.0%) reported receiving some form of key population stigma-reduction training, primarily through in-service workshops or facility-based programs.

Table 1  
Demographic characteristics of healthcare worker participants (N = 20)

| Characteristic                                                                                          | Category                                         | Number | Percent |
|---------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------|---------|
| <b>Sex</b>                                                                                              |                                                  |        |         |
|                                                                                                         | Female                                           | 17     | 85.0    |
|                                                                                                         | Male                                             | 3      | 15.0    |
| <b>Professional role</b>                                                                                |                                                  |        |         |
|                                                                                                         | Nurse                                            | 14     | 70.0    |
|                                                                                                         | Midwife                                          | 2      | 10.0    |
|                                                                                                         | Laboratory personnel                             | 2      | 10.0    |
|                                                                                                         | Counselor                                        | 1      | 5.0     |
|                                                                                                         | Physician                                        | 1      | 5.0     |
| <b>Department</b>                                                                                       |                                                  |        |         |
|                                                                                                         | Antiretroviral therapy / HIV unit                | 8      | 40.0    |
|                                                                                                         | Sexually transmitted infection / counseling unit | 3      | 15.0    |
|                                                                                                         | Laboratory                                       | 2      | 10.0    |
|                                                                                                         | Outpatient department                            | 2      | 10.0    |
|                                                                                                         | Maternity                                        | 1      | 5.0     |
|                                                                                                         | General medical                                  | 1      | 5.0     |
|                                                                                                         | Entry / reception                                | 1      | 5.0     |
|                                                                                                         | Not specified                                    | 2      | 10.0    |
| <b>Facility type</b>                                                                                    |                                                  |        |         |
|                                                                                                         | Government / public                              | 12     | 60.0    |
|                                                                                                         | Private                                          | 5      | 25.0    |
|                                                                                                         | Both public and private                          | 3      | 15.0    |
| <b>Facility location</b>                                                                                |                                                  |        |         |
|                                                                                                         | Ashaiman                                         | 10     | 50.0    |
|                                                                                                         | Korle-Bu Teaching Hospital                       | 6      | 30.0    |
| <i>Note.</i> Percentages are based on N = 20 unless data were unavailable for the characteristic shown. |                                                  |        |         |

| Characteristic                                                                                          | Category                                                               | Number       | Percent        |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------|----------------|
| <b>Sex</b>                                                                                              |                                                                        |              |                |
|                                                                                                         | Mamprobi                                                               | 4            | 20.0           |
| <b>Years of experience</b>                                                                              |                                                                        |              |                |
|                                                                                                         | Mean (standard deviation)                                              | 7.8<br>(4.2) | Not applicable |
|                                                                                                         | Range                                                                  | 2 to 16      | Not applicable |
| <b>Religious affiliation</b>                                                                            |                                                                        |              |                |
|                                                                                                         | Christian                                                              | 20           | 100.0          |
| <b>Religious service attendance frequency</b>                                                           |                                                                        |              |                |
|                                                                                                         | Very high (3 or more times per week, approximately 12 times per month) | 4            | 20.0           |
|                                                                                                         | High (2 times per week)                                                | 3            | 15.0           |
|                                                                                                         | Moderate (1 time per week)                                             | 6            | 30.0           |
|                                                                                                         | Low (not often or rarely)                                              | 5            | 25.0           |
|                                                                                                         | Not specified                                                          | 2            | 10.0           |
| <b>Key population stigma-reduction training</b>                                                         |                                                                        |              |                |
|                                                                                                         | Received training (any)                                                | 18           | 90.0           |
|                                                                                                         | Training in formal schooling                                           | 1            | 5.0            |
|                                                                                                         | Training through in-service workshop                                   | 17           | 85.0           |
| <b>Marital status</b>                                                                                   |                                                                        |              |                |
|                                                                                                         | Single                                                                 | 9            | 45.0           |
|                                                                                                         | Married                                                                | 8            | 40.0           |
|                                                                                                         | Not specified                                                          | 3            | 15.0           |
| <i>Note.</i> Percentages are based on N = 20 unless data were unavailable for the characteristic shown. |                                                                        |              |                |

## Overview of thematic findings

Thematic analysis identified three interrelated ways in which religious beliefs shaped healthcare workers' moral negotiation of HIV care for transgender women. First, religion functioned as a moral resource for compassionate and nondiscriminatory HIV care. Healthcare workers frequently drew on Christian teachings such as loving one's neighbor and the Golden Rule to justify empathy, dignity, and equal treatment for transgender women, even within a hostile sociocultural environment. Second, the same religious field also generated stigma, refusal, and secondary healthcare worker stigma. Religious beliefs and community discourses framed transgender identity as sinful, spiritually corrupted, or mentally unstable, contributing to avoidance or neglect of transgender patients and stigma toward healthcare workers who served transgender women and other key populations. Third, many healthcare workers described an ongoing process of moral negotiation between theological belief and professional duty, resulting in conditional professional care in which they maintained conservative religious views about gender while still feeling obligated, as health workers, to accept and treat transgender women respectfully. The three categories and corresponding subcategories are summarized in Table 2.

Table 2  
Summary of thematic categories and subcategories

| Thematic category                                                                                         | Subcategory                                                                        | Description summary                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Thematic category 1:<br/>Religion as a moral resource for compassionate and nondiscriminatory care</b> | 1.1 Loving one's neighbor as a basis for care                                      | Healthcare workers use Christian teachings such as "love your neighbor" to justify respectful, nonjudgmental care for transgender women, positioning faith as a reason to treat patients with dignity despite wider stigma.                         |
|                                                                                                           | 1.2 Religious teaching as a foundation for nondiscrimination                       | Religion is described as prohibiting discrimination and promoting empathy, fairness, and respect for all patients, including those whose identities healthcare workers may not fully understand.                                                    |
| <b>Thematic category 2:<br/>Religion as a source of stigma, refusal, and barriers to HIV care</b>         | 2.1 Religious beliefs as a basis for refusal and neglect                           | Some healthcare workers report that colleagues' religious beliefs can contribute to avoidance or neglect of transgender patients and create pressure to correct or confront behavior viewed as contrary to religious norms.                         |
|                                                                                                           | 2.2 Spiritualized and condemnatory religious narratives about transgender identity | Community religious discourses may frame transgender identity as an abomination, demonic possession, or mental instability, reinforcing moral and spiritual deviance and shaping how transgender women are viewed in and outside health facilities. |
|                                                                                                           | 2.3 Secondary stigma from religious institutions                                   | Healthcare workers who serve transgender women and other key populations sometimes experience rejection within their own churches because of their association with stigmatized groups.                                                             |
| <b>Thematic category 3:<br/>Moral negotiation between theological belief and professional duty</b>        | 3.1 Accepting patients despite personal religious discomfort                       | Healthcare workers describe not understanding or agreeing with transgender identity, yet choosing to accept and care for transgender women by separating personal discomfort from professional obligations.                                         |
|                                                                                                           | 3.2 Belief in divine creation as a barrier to full affirmation                     | A recurring belief that God created each person "as they should be" makes gender transition theologically problematic despite healthcare workers recognizing patients' lived experiences and feelings.                                              |

## Thematic category 1: Religion as a moral resource for compassionate and nondiscriminatory care

Although some healthcare workers initially reported that religion did not influence their professional practice, subsequent accounts demonstrated that several participants drew explicitly on Christian teachings to explain compassionate and nondiscriminatory care for transgender women. Within HIV-related service settings, these beliefs provided a religious rationale for maintaining patients' dignity and providing care despite broader social stigma. Rather than positioning religion solely as a source of moral condemnation, participants frequently framed faith as a moral resource that encouraged empathy, dignity, and humane treatment within healthcare settings.

## **Subcategory 1.1: Loving one's neighbor as a basis for care**

Many healthcare workers invoked Christian principles such as "love thy neighbor" to explain why transgender women deserved respectful treatment and access to care. These narratives reflected efforts to reconcile personal faith with professional obligations, particularly within a broader sociocultural context where transgender identities are heavily stigmatized.

One healthcare worker explained:

"Sometimes some scriptures tell us that we should love our neighbors as ourselves, so the patients I'm seeing is like a brother or a sister to me." (Midwife)

Similarly, another participant stated:

"I'm a Christian. I'm supposed to love my neighbors myself. And so, when you come to me and you need of anything, if only I can afford it, I'll give it to you." (antiretroviral therapy unit nurse)

## **Subcategory 1.2: Religious teaching as a foundation for nondiscrimination**

Participants also described religion as teaching fairness, respect, and empathy toward all patients. Rather than emphasizing judgment, these healthcare workers interpreted faith as requiring emotional sensitivity and nondiscriminatory practice.

One participant noted:

"My religious belief does not allow discrimination." (Antiretroviral therapy unit nurse)

Another healthcare worker described religion as promoting empathy rather than condemnation:

Even though you have your counseling skills, it shapes the way you go about it. It makes you unique, it makes you empathetic towards the person. towards the person. Not judgmental in the way, by putting yourself in the person's shoes and understanding how he or she's feeling. (Registered nurse)

Similarly, one healthcare worker emphasized respect for all individuals regardless of religious or social difference:

My religion has taught me to treat everybody as an individual, and give them the utmost respect like, treat everybody with humility. When people come to me, I try as much as possible, to give them the respect they need, and I don't judge people because they don't belong to my religion or not. (Registered nurse)

Others framed care through the “Golden Rule,” emphasizing reciprocal humanity in interactions between patients and healthcare workers:

“Per my religion, I believe that whatever you want other people to do to you, you first do to others. So, I treat my client as myself.” (Registered nurse)

This finding challenges the common assumption that religion functions only as a source of stigma. Among these healthcare workers, Christian faith also functioned as a moral vocabulary for nondiscrimination, dignity, and professional care, giving them religious language to legitimize welcoming and treating transgender women in a hostile sociocultural context.

## **Thematic category 2: Religion as a source of stigma, refusal, and barriers to HIV care**

While some healthcare workers used religion to support compassionate care, others described religion as contributing directly to stigma, exclusion, and barriers to healthcare access for transgender women. Participants reported that religious beliefs shaped not only personal attitudes, but also institutional practices, community perceptions, and broader social responses to transgender identity.

### **Subcategory 2.1: Religious beliefs as a basis for refusal and neglect**

Several participants acknowledged that healthcare workers' religious beliefs sometimes contributed to refusal of care, avoidance of certain services, or neglect of transgender women patients within healthcare facilities.

One healthcare worker explained how others linked religious beliefs to the neglect of transgender women patients:

“Sometimes they have been neglected, some nurses don't want to attend to them because of their religious beliefs.” (Registered nurse)

Another participant reflected on the difficulty some healthcare workers experience when encountering behaviors they perceive as conflicting with their religious worldview:

“When you meet people who you think are not doing according to what you believe in, the temptation that you would want to talk about it is there.” (Registered nurse)

## Subcategory 2.2: Spiritualized and condemnatory religious narratives about transgender identity

Participants further described how transgender identity is frequently interpreted within broader community religious discourse as sinful, demonic, mentally unstable, or spiritually corrupted. Such narratives appeared deeply embedded within social understandings of gender and morality.

One participant explained:

“Abomination, oh no, no, no it's not acceptable or (you've gone mad) these you hear a lot of them (are you a stupid man who made himself a woman)” (Antiretroviral therapy unit nurse)

Another reported hearing community members describe transgender women individuals as spiritually possessed:

“I heard one that these people they are being possessed by some spirits.” (Antiretroviral therapy unit nurse)

Similarly, healthcare workers described narratives linking transgender identity with mental instability or spiritual abnormality:

“I think they see them as inferior and having no use. Some also see them as spiritual.” (Antiretroviral therapy unit nurse)

“It's like they are out of their senses, lemme put it that way, they always say this is a mental condition.” (Registered nurse)

Another participant stated:

“Sometimes, we feel that these people are possessed by demonic spirit, but it's not so.” (Registered nurse)

These accounts illustrate how spiritualized and moral interpretations of transgender identity formed part of the social context within which healthcare workers understood and interacted with transgender women.

## Subcategory 2.3: Secondary stigma from religious institutions

A particularly striking finding was that healthcare workers working with transgender women and other key populations also experienced rejection from their own religious communities. In some cases, participants described being stigmatized because of their association with and care for marginalized patient groups.

One healthcare worker shared:

“Because they know the nature of the work I am doing, sometimes my offering will not be accepted. So I stopped going to the Wednesday class.” (Counselor)

In contrast to the first theme, which presents religion as a source of compassionate care, the same religious context also contributed to refusal of care, neglect of transgender patients, and secondary stigma toward healthcare workers who work with transgender women. In this sense, religion positioned some healthcare workers as moral gatekeepers whose beliefs could legitimize exclusionary practices within health facilities.

## **Thematic category 3: Moral negotiation between theological belief and professional duty**

Beyond describing religion as either supportive or stigmatizing, healthcare workers articulated an ongoing negotiation between personal theological convictions and professional obligations. Many participants neither fully affirmed nor rejected transgender identities. Instead, they occupied an intermediate position characterized by moral ambivalence and conditional acceptance, separating personal religious judgment from their professional responsibility to provide HIV-related care.

### **Subcategory 3.1: Accepting patients despite personal religious discomfort**

Despite endorsing compassionate care, some healthcare workers simultaneously expressed discomfort or confusion regarding transgender identity itself. These narratives revealed an ongoing process of moral negotiation in which healthcare workers separated personal theological beliefs from professional responsibility.

One participant acknowledged difficulty understanding transgender identity while still affirming the importance of acceptance:

“I personally do not understand them, but I accept them for who they are. I don't understand why somebody would want to change who they are to something else.” (Registered nurse)

Another healthcare worker similarly expressed theological discomfort while emphasizing inclusion:

My perception of TGW is like, why would you want to do a thing like this? But that is what they have chosen to do, and they have done it, it doesn't mean that they're not part of us again. So, for me, I accept them. (Registered nurse)

Likewise, one healthcare worker initially framed transgender identity as “abnormal,” but later described how professional education altered their perspective:

Being a male going to transform yourself to a female, I feel it's not a normal thing, and it sounds a bit weird. I see them like, God has given you this, and you saying you want this, but after the education and all that, I've realized that is how they feel. Who are we to judge? (Registered nurse).

One healthcare worker summarized this position by stating:

"I accept them, and provide care as it is required, but I won't encourage somebody to do that."  
(Registered nurse)

Similarly, another participant described adopting a neutral stance despite personal disagreement:

I'm neutral. If that's what they say they are, I accept it. For them. It may not be good. I may not see it as a good thing but that's how the person identifies him or herself, I basically have to accept it. (Registered nurse).

## **Subcategory 3.2: Belief in divine creation as a barrier to full affirmation**

A recurring belief among participants was that gender is divinely assigned and should not be altered. Many healthcare workers framed transgender identity as conflicting with religious understandings of how God created human beings.

One healthcare worker explained:

Biblically, I think the way God wants you is how he created you, if you believe in the creation at all. That is how He created you, and so, for you to change it; I know a lot of things might have influenced somebody's decision to change his or her gender or something, but no matter what it is, I believe that there's no need for you to change it, but once the person has decided, and has done it, I will not throw that person away. (counselor)

Another participant similarly struggled to reconcile religious beliefs with transgender identity:

"I see them like, God has given you this, and you are saying you want this, but after training, I've realized that is how they feel. Who are we to judge?" (Registered nurse)

These narratives illustrate the persistent tension between creationist religious beliefs and emerging professional understandings of gender diversity.

Across these accounts, the central mechanism is not simple acceptance or outright rejection, but conditional professional care. Healthcare workers frequently separated their theological views about transgender identity from their professional obligation to provide HIV testing, counseling, treatment, and other HIV-related services respectfully.

## **Discussion**

In this study, we examined how healthcare workers in Ghana negotiated religious beliefs, professional obligations, and HIV-related care duties when providing services to transgender women. The findings show that religion does not operate in a single or predictable direction but rather functions as a moral field through which healthcare workers interpreted transgender identity, defined their professional responsibilities, and managed tensions between religious conviction and clinical duty. The study revealed three interrelated findings. The first showed that many healthcare workers drew on Christian teachings of love, compassion, and humility to justify respectful and nondiscriminatory care. The second revealed that healthcare workers' religious beliefs and community discourses contributed to stigma, refusal, neglect, and spiritualized interpretations of transgender identity. The third showed that healthcare workers often managed these tensions through conditional professional care, offering treatment and respect while withholding full theological or identity affirmation.

The principal conceptual contribution of this study is the identification of conditional professional care as a distinct form of healthcare practice. Existing scholarship frequently positions healthcare workers' responses to transgender patients along a continuum from discrimination to acceptance or affirmation. Our findings suggest that this framing may be incomplete. Healthcare workers may provide technically appropriate and outwardly respectful care while simultaneously withholding personal or theological affirmation of transgender identity. Conditional professional care therefore reveals an important distinction among access to care, respectful professional conduct, personal acceptance, and identity affirmation. These dimensions should not be assumed to occur together. Our findings demonstrate that the opposite of discriminatory care is not necessarily affirming care. Between these positions lies conditional professional care, where professional obligation secures access and respectful treatment while unresolved theological reservations continue to shape how transgender patients are understood.

Our findings complicate accounts that emphasize religion primarily as a source of exclusion for sexual and gender minority populations [4, 25, 26]. Previous research has demonstrated that religious institutions and leaders have frequently influenced public opposition to sexual and gender minority rights by portraying gender and sexual diversity as immoral, foreign or incompatible with African values [27–29]. Our findings support this body of work by demonstrating that religious discourse can portray transgender identities as sinful, demonic, abnormal, or indicative of mental instability [30, 31]. Such narratives are not merely abstract beliefs. They can enter clinical spaces, shaping healthcare worker discomfort, avoidance, neglect, and reluctance to engage fully with transgender women seeking HIV testing, counseling, treatment, or related services [21, 32–35]. Even when overt refusal does not occur, subtle moral judgment or emotional distance within HIV services may affect trust, disclosure, willingness to return for care, and continuity of engagement [36]. The religious discomfort described by some healthcare workers may also be understood within the broader historical influence of missionary-colonial teachings on gender and sexuality. These teachings often reinforced rigid understandings of gender, marriage, and acceptable sexuality while marginalizing more diverse African understandings of gender and social identity [17].

At the same time, the study demonstrates that religion can provide the basis for ethical care. Several healthcare workers used explicitly Christian language to advocate compassion, nonjudgment, and equal treatment. For these participants, having faith did not mean rejecting transgender women. Instead, it demanded humility, empathy, and service to all patients. This finding is important because it challenges overly simplistic views that religion is inherently stigmatizing [37]. It suggests that religious frameworks can be used in different ways within healthcare settings. The same religious tradition that can authorize moral condemnation can also provide the language through which healthcare professionals justify dignity, restraint, and professional responsibility toward marginalized patients. This finding extends existing religion-and-health scholarship by suggesting that religion should not be understood only as a predictor of positive or negative attitudes. Rather, religion may function as a moral interpretive framework through which healthcare workers define professional obligation, compassion, judgment, acceptable identity, and the boundaries of care.

One of the study's most significant contributions is its identification of moral negotiation as a central mechanism through which religion influences HIV care for transgender women. Healthcare workers in this study did not simply accept or reject transgender women. Instead, many occupied an intermediate position, maintaining conservative theological beliefs about gender while also affirming their duty to provide care. This form of conditional professional care enabled healthcare workers to distinguish between personal beliefs and clinical actions. However, it also highlights the limitations of nondiscrimination when care is not accompanied by complete acceptance. A healthcare worker may treat a transgender woman respectfully while still viewing her identity as incorrect, abnormal, or incompatible with divine creation. While this form of care may reduce overt refusal, it may not fully protect patients from subtle stigma, emotional distance, misrecognition, or conditional acceptance. This distinction contributes to the literature by showing that the absence of overt discrimination should not automatically be interpreted as the absence of stigma. Moral distancing and theological non-affirmation may persist within healthcare interactions that appear professionally respectful. Consequently, assessments of transgender-inclusive care should examine not only whether services are provided, but also how transgender identities are recognized, respected, and understood within the clinical encounter. A decolonial perspective also suggests that separating professional care from identity affirmation may leave unexamined some missionary-colonial assumptions through which gender diversity is interpreted as foreign, immoral, or inconsistent with African identity [38, 39].

The study's findings expand upon the existing research on HIV care for transgender women by shifting the focus of analysis from patients' experiences alone [32, 40] to the moral perspectives of healthcare workers. Previous studies in Ghana and sub-Saharan Africa have documented the fears of transgender women regarding disclosure, breaches of confidentiality, discriminatory treatment and avoidance of healthcare settings [32–34]. Our study helps to explain how such experiences may arise from the perspectives of healthcare workers. The study also demonstrates that stigma can arise not only from a lack of knowledge or training [41], but also from unresolved moral conflicts between faith, social norms and professional ethics. This finding is particularly important in highly religious societies, where healthcare workers may view their clinical roles through biomedical and spiritual moral frameworks. By

examining provider meaning-making, this study therefore moves beyond documenting the consequences of healthcare stigma toward identifying a moral mechanism through which discriminatory, accommodating, and respectful practices may be produced within clinical settings. This provider-level explanation complements patient-centered accounts and helps connect reported experiences of stigma to the belief systems and professional negotiations that may generate them.

Our findings also revealed that some healthcare workers experienced secondary stigma from religious institutions. Healthcare workers who serve transgender women and other key populations may become targets of suspicion or rejection within their own churches and communities [42–45]. This suggests that stigma operates relationally. It attaches not only to transgender women but may also extend to those who care for them. Such secondary stigma may discourage healthcare workers from openly supporting programs that promote the health of key populations, limit advocacy within facilities and reinforce silence around transgender women's health needs. Therefore, interventions must address not only healthcare worker attitudes toward patients, but also the broader moral and institutional environments in which healthcare workers work. This finding extends transgender stigma scholarship by demonstrating its relational reach. Stigma may attach not only to transgender individuals but also to healthcare workers associated with their care. Healthcare workers therefore operate within, rather than outside, the moral environments that generate transgender stigma, and they may themselves face social or religious sanctions when professional obligations conflict with community expectations.

A high proportion of participants reported receiving some form of sexual and gender minority stigma-reduction training. Although training alone may not eliminate conservative religious beliefs, participants' accounts suggest that prior key population stigma-reduction training may have helped some healthcare workers distinguish personal beliefs from professional responsibilities. However, because this study was not designed to evaluate training effectiveness, the findings should not be interpreted as demonstrating a causal effect of training. The persistence of theological reservations despite substantial prior training adds an important dimension to existing intervention literature. It suggests that improving knowledge or professional competency may influence behavior without necessarily resolving the moral frameworks through which transgender identity is interpreted. Provider interventions may therefore need to address ethical reflection, moral reasoning, professional boundaries, and the management of value conflicts alongside conventional stigma-reduction and clinical competency training. Therefore, future interventions should move beyond information-based training alone. They should incorporate guided reflection on professional ethics, confidentiality, patient dignity, stigma, and the practical implications of moral judgment in HIV care. In Ghana, where Christian moral language carries significant social influence, interventions could also incorporate faith-compatible ethics of compassion, service, and nondiscrimination. Provider training may additionally benefit from brief engagement with decolonial perspectives that challenge the assumption that gender diversity is foreign to African societies while recognizing the diversity of precolonial African social and spiritual understandings [17].

## Limitations

Because all participants identified as Christian, the findings primarily reflect Christian perspectives and do not capture how healthcare workers from other religious traditions, including Islam and African Traditional Religions, may negotiate the relationship between personal faith and professional responsibility.

The small, purposively recruited urban sample limits the transferability of the findings to healthcare workers working in rural areas and other regions of Ghana. The use of snowball recruitment may have further introduced selection bias, as participants may have referred others with similar perspectives or experiences, potentially reducing the diversity of viewpoints represented.

Because the study relied on healthcare workers' self-reported attitudes and experiences rather than observation of HIV care encounters, the analysis cannot determine whether reported commitments to nondiscrimination consistently translated into clinical behavior. Social desirability pressures may have been particularly important given the sensitivity of discussing religion, professional conduct, and healthcare for transgender women.

## Conclusions

This study demonstrates that religious beliefs can function simultaneously as sources of compassion and sources of moral tension in the provision of HIV-related care for transgender women in Ghana. Healthcare workers described drawing on religious teachings about love, dignity, service, and nondiscrimination to justify respectful care, while some also expressed theological beliefs that framed transgender identities as inconsistent with divine creation or religious expectations. Rather than resolving these tensions completely, many healthcare workers described separating their personal religious convictions from their professional responsibilities. This pattern, conceptualized in this study as conditional professional care, reflects a form of moral negotiation in which healthcare workers may retain theological reservations about transgender identities while still emphasizing their obligation to provide respectful and nondiscriminatory HIV-related healthcare.

These findings suggest that the relationship between religion and HIV care for transgender women should not be understood solely in terms of either stigma or support. Instead, religious beliefs may influence healthcare practice in complex and sometimes contradictory ways depending on how healthcare workers interpret and reconcile faith with professional ethics. Efforts to strengthen transgender-inclusive HIV services should therefore address not only clinical knowledge and stigma, but also the moral and religious tensions that may shape interactions between healthcare workers and patients. Brief engagement with decolonial perspectives may also help challenge assumptions that gender diversity is foreign to African societies and support more empathetic and respectful HIV-related care. Approaches that reinforce confidentiality, dignity, nondiscrimination, and professional responsibility, while recognizing the religious frameworks through which some healthcare workers understand their work, may be especially relevant in highly religious healthcare settings. Conceptually, the study contributes to the field by identifying conditional professional care as an intermediate form of

clinical engagement between overt discrimination and full identity affirmation, and by positioning moral negotiation as a mechanism through which religious belief is translated into healthcare practice. Further research should examine whether similar patterns of moral negotiation occur among healthcare workers from other religious traditions, in different regions of Ghana, and across other HIV care settings.

## Abbreviations

HIV  
human immunodeficiency virus

TGW  
transgender women

AA: Al-Mardhiyyah Adams

OWS: Osman Wumpini Shamrock

SSN: Samira Shirzaei Nichols

HDD: Henry Delali Dakpui

GRKA: George Rudolph Kofi Agbemedu

CGN: Charles Gagbe Nukunu

NML: Natalie M. Leblanc

LN: LaRon Nelson

GRA: Gamji Rabi Abu-Ba'are

## Declarations

Ethics approval and consent to participate

All procedures performed in this study involving human participants were in accordance with the ethical standards of the University of Rochester Research Subjects Review Board (STUDY00008151), the Ghana Health Service Ethics Review Committee (GHS-ERC:002/03/23), and the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. Written informed consent was obtained from all participants before data collection.

### Consent for publication

Not applicable.

### Availability of data and materials

Data are not publicly available because of participant confidentiality and restrictions under the study's ethical approval.

### **Competing interests**

The authors declare that they have no competing interests.

### **Funding**

This work was supported by the University of Rochester Research Support Group. Funding was awarded to Osman Wumpini Shamrock.

### **Authors' contributions**

AA and OWS contributed to the development of the study, preparation of the manuscript, interpretation of the findings, and critical review and revision of the manuscript. OWS served as the Principal Investigator of the grant that supported the study and was responsible for funding acquisition and overall oversight of the funded project. GRA served as Co-Principal Investigator and contributed to the scientific oversight and implementation of the study. SSN, HDD, GRKA, CGN, NML, LN, and GRA contributed to the development of the study, interpretation of the findings, and critical review and revision of the manuscript. All authors reviewed and approved the final manuscript and agree to be accountable for the integrity of the work.

### **Acknowledgements**

The authors thank the healthcare workers who participated in this study.

## **References**

1. Bompani B. Religion and development in sub-Saharan Africa: An overview. In: Tomalin E, editor. *The Routledge handbook of religions and global development*. Routledge; 2015. pp. 101–113. <http://www.routledge.com/books/details/9780415836364/>. Accessed 7 Sep 2026.
2. Onsarigo TG. Role of religion in shaping social norms in contemporary society. *J Res Innov Implications Educ*. 2025;9(4):700–11. 10.59765/pg84kt.
3. Shamrock OW, Ginn HG. Disability and sexuality: Toward a focus on sexuality education in Ghana. *Sex Disabil*. 2021;39(4):629–45. 10.1007/s11195-021-09699-8.
4. Shamrock O. Disability, religion and work among vulnerable populations: An inquiry of women experiences and perspectives [doctoral dissertation]. State University of New York at Binghamton; 2022.
5. Abate Bekele B, Kachouh C, Byiringiro C, Degefu Gashu A, Cherri B, Mshaymesh S, et al. Ethical considerations in surgical care: Cultural and religious perspectives in Africa. *Annals Med Surg*. 2025;87(11):7177–85. 10.1097/MS9.0000000000003695.

6. Osisanwo A, Alugbin M. Pentecostal voices and discourse perspectives to LGBTQ+ narratives in Nigeria. *Afr Identities*. 2025;23(4):1099–115. 10.1080/14725843.2024.2427177.
7. Kloek M, Bulstra CA, van Noord L, Al-Hassany L, Cowan FM, Hontelez JAC. HIV prevalence among men who have sex with men, transgender women and cisgender male sex workers in sub-Saharan Africa: A systematic review and meta-analysis. *J Int AIDS Soc*. 2022;25(11):e26022. 10.1002/jia2.26022.
8. Thapa S, Ogunleye TT, Shrestha R, Joshi R, Hannes K. Increased stigma, and physical and sexual violence against men who have sex with men and transgender women in sub-Saharan Africa: A qualitative evidence synthesis analyzing social and structural barriers to HIV testing and coping behaviors. *J Homosex*. 2025;72(2):245–71. 10.1080/00918369.2024.2320237.
9. Dada D, Abu-Ba'are GR, Turner D, Mashoud IW, Owusu-Dampare F, Apreku A, et al. Scoping review of HIV-related intersectional stigma among sexual and gender minorities in sub-Saharan Africa. *BMJ Open*. 2024;14(2):e078794. 10.1136/bmjopen-2023-078794.
10. Tweneboah S. Religion, international human rights standards, and the politicisation of homosexuality in Ghana. *Afr J Gend Relig*. 2018;24(2):25–48. 10.14426/ajgr.v24i2.
11. Dombo EA. The profound influence of belief systems. *J Relig Spiritual Social Work: Social Thought*. 2025;44(1):1–2. 10.1080/15426432.2025.2462351.
12. Onyishi CN, Eseadi C, Ilechukwu LC, Okoro KN, Okolie CN, Egbule E, et al. Potential influences of religiosity and religious coping strategies on people with diabetes. *World J Clin Cases*. 2022;10(25):8816–26. 10.12998/wjcc.v10.i25.8816.
13. Daniel O, Harris H. Intersections of compassion, science, and spiritual care in global health for public health benefits. *J Relig Health*. 2024;63(6):4257–75. 10.1007/s10943-024-02145-x.
14. Kubitz J, Große G, Schütte-Nütgen K, Frick E. Influence of spirituality on moral distress and resilience in critical care staff: A scoping review. *Intensive Crit Care Nurs*. 2023;76:103377. 10.1016/j.iccn.2022.103377.
15. Swihart DL, Yarrarapu SNS, Martin RL. Cultural religious competence in clinical practice. In: *StatPearls*. StatPearls Publishing; 2023. <https://www.ncbi.nlm.nih.gov/books/NBK493216/>. Accessed 7 Sep 2026.
16. Scott D, Pereira NM, Harrison SE, Zarwell M, Sanasi-Bhola K, Poteat T. In the Bible Belt: The role of religion in HIV care and prevention for transgender people in the United States South. *Health Place*. 2021;70:102613. 10.1016/j.healthplace.2021.102613.
17. Shingange T. The missionary-colonial forms of marriages and sexualities within African Pentecostalism: A Sankofa-decolonial perspective. *Religions*. 2025;16(1):74. 10.3390/rel16010074.
18. Williams MR. Navigating conflicts between religious and professional values: Psychologists' experiences [doctoral dissertation]. Brigham Young University; 2018. <https://scholarsarchive.byu.edu/etd/6933/>. Accessed 7 Sep 2026.
19. Lawrence RE, Curlin FA. Autonomy, religion and clinical decisions: Findings from a national physician survey. *J Med Ethics*. 2009;35(4):214–8. 10.1136/jme.2008.027565.

20. Abu-Ba'are GR, Shamrock OW, Agbemedu GRK, Dakpui HD. How will I know the results if I self-test at home? At-home HIV self-testing versus at-clinic HIV testing preference among trans women in Ghana's slums [preprint]. Res Square. 2024. 10.21203/rs.3.rs-4659823/v1.
21. Dakpui HD, Shamrock OW, Aidoo-Frimpong G, Zigah EY, Agbemedu GRK, Ahmed A, et al. A qualitative description of HIV testing and healthcare experiences among trans women in Ghanaian urban slums. PLOS Glob Public Health. 2024;4(12):e0003980. 10.1371/journal.pgph.0003980.
22. Shamrock OW, Abu-Ba'are GR, Zigah EY, Dakpui HD, Adjaka G, LeBlanc NM, et al. Community stigma, victimization, and coping strategies among gay, bisexual, and other cisgender men who have sex with men in slum communities in Ghana. BMC Public Health. 2024;24(1):966. 10.1186/s12889-024-18242-1.
23. Shamrock OW, Abu-Ba'are GR, Zigah EY, Apreku A, Agbemedu GRK, Boyd DT, et al. Family rejection of non-hetero sexuality: Sexual orientation and behavior anonymity among sexual minority men in slum communities. PLOS Global Public Health. 2023;3:e0001659. 10.1371/journal.pgph.0001659.
24. Zigah EY, Abu-Ba'are GR, Shamrock OW, Dakpui HD, Apreku A, Boyd DT, et al. For my safety and wellbeing, I always travel to seek health care in a distant facility: The role of place and stigma in HIV testing decisions among gay, bisexual, and other men who have sex with men. Health Place. 2023;83:103076. 10.1016/j.healthplace.2023.103076.
25. Mavhandu-Mudzusi AH, Sandy PT. Religion-related stigma and discrimination experienced by lesbian, gay, bisexual and transgender students at a South African rural-based university. Cult Health Sex. 2015;17(8):1049–56. 10.1080/13691058.2015.1015614.
26. Mukherjee S, VanHeuvelen JS, Thomas CD. Professional in practice: Stigma management strategies of workers with concealed mental health conditions. Work Occup. 2025;52(2):245–77. 10.1177/07308884241250349.
27. van Klinken A, Chitando E. Introduction: Public religion, homophobia and the politics of homosexuality in Africa. In: van Klinken A, Chitando E, editors. Public religion and the politics of homosexuality in Africa. Routledge; 2016. pp. 1–16.
28. Williams BA, Kenyan. Christian, queer: Religion, LGBT activism, and arts of resistance in Africa, written by A. van Klinken [Book review]. Journal of Religion in Africa. 2021;50(1–2):189–190. 10.1163/15700666-12340187
29. Yekple M, Mitkov Z. Can trusted authorities change minds on anti-LGBTQ norms: Evidence from an experiment in Ghana. PLoS ONE. 2024;19(8):e0304698. 10.1371/journal.pone.0304698.
30. Alstott A, Olgun M, Robinson H, McNamara M. Demons and imps: Misinformation and religious pseudoscience in state anti-transgender laws. Yale J Law Feminism. 2024;35(1):223–87.
31. Meyer PT. The lived experience of religious trauma among transgender and gender diverse people: An interpretative phenomenological analysis [master's thesis]. University of Nebraska-Lincoln; 2025.
32. Shamrock OW, Abu-Ba'are GR, Hosseini FS, Dakpui HD, Zigah EY, Boakye F, et al. Characterization of HIV peer support based on the Dennis peer support model: Accounts from trans women in Ghana [preprint]. Res Square. 2024. 10.21203/rs.3.rs-5730804/v1.

33. Shamrock OW, Dakpui HD, Agbemedu GRK, Boyd DT, Islam K, Mashoud IW, et al. I'm scared of the nurses telling other people I am a transwoman: Disclosure and nondisclosure of gender identity among trans women in Ghana's urban slums [preprint]. Res Square. 2024. 10.21203/rs.3.rs-4243840/v1.
34. Shamrock OW, Guure C, Reeves JM, Ni Z, Turner D, Haruna A, et al. A qualitative study of the ecology of stigma experiences: An application of the ecological model to stigma experiences of trans women from Ghana. PLOS Global Public Health. 2026;6(4):e0006336. 10.1371/journal.pgph.0006336.
35. Westwood S. Religious-based negative attitudes toward LGBTQ people among healthcare, social care and social work students and professionals: A review of the international literature. Health Soc Care Commun. 2022;30(5):e1449–70. 10.1111/hsc.13812.
36. Eaton LA, Driffin DD, Kegler C, Smith H, Conway-Washington C, White D, et al. The role of stigma and medical mistrust in the routine health care engagement of Black men who have sex with men. Am J Public Health. 2015;105(2):e75–82. 10.2105/AJPH.2014.302322.
37. Delaney DG. Secular but not superficial: An overlooked nonreligious/nonspiritual identity [master's thesis]. University of Louisville; 2016. 10.18297/etd/2578
38. Kasa L. Queer affirmative practice in Africa: A social work practice model for working with LGBTQIA+ people. Res Social Sci Technol. 2024;9(1):279–90. 10.46303/ressat.2024.16.
39. Shingange T, Mavhandu-Mudzusi AH. A decolonial analysis of religious medicalisation of same-sex practices in South African Pentecostalism. HTS Teologiese Stud / Theological Stud. 2024;80(1):a9014. 10.4102/hts.v80i1.9014.
40. Kilty JM. I just wanted them to see me: Intersectional stigma and the health consequences of segregating Black, HIV-positive trans women in prison in the US state of Georgia. Gender. Place Cult. 2021;28(7):1019–39. 10.1080/0966369X.2020.1781795.
41. Ritterbusch AE, Correa Salazar C, Correa A. Stigma-related access barriers and violence against trans women in the Colombian healthcare system. Glob Public Health. 2018;13(12):1831–45. 10.1080/17441692.2018.1455887.
42. Ben Natan M, Drori T, Hochman O. Associative stigma related to psychiatric nursing within the nursing profession. Arch Psychiatr Nurs. 2015;29(6):388–92. 10.1016/j.apnu.2015.06.010.
43. Mizumoto J, Kono E, Yoshida E. Healthcare professionals' experiences related LGBTQ+ patients and colleagues at their workplace: Descriptive research in Japan. J Gen Family Med. 2025;26(4):312–25. 10.1002/jgf2.70012.
44. Njaka S, Ogbodo BA, Okpua NC, Uwa AN. A systematic review on prevalence and perceived impacts of associative stigma on mental health professionals. Int J Afr Nurs Sci. 2023;18:100533. 10.1016/j.ijans.2023.100533.
45. Waddell C, Graham JM, Pachkowski K, Friesen H. Battling associative stigma in psychiatric nursing. Issues Ment Health Nurs. 2020;41(8):684–90. 10.1080/01612840.2019.1710009.

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