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Experiences of violence and abuse among transgender women in healthcare settings in Uganda: a community-engaged qualitative study

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Abstract

Background People who identify as transgender have a gender identity or expression that differs from the sex they were assigned at birth. Because of this, transgender people may encounter widespread stigma, discrimination, and violence, including in medical facilities. Understanding how these phenomena manifest during healthcare interactions is crucial for enhancing health equity for transgender individuals. Therefore, this study explored the experiences of transgender-related stigma and violence among transgender individuals in Uganda.

Methods The study used a community-based qualitative participatory approach, with transgender women actively co-generating the data. Six focus groups were held with 33 transgender women in southwestern and central Uganda. Data were thematically analysed using OpenCode software.

Results Four key themes emerged for the lived experiences of violence and abuse among transgender women in Uganda. These included: (i) Institutionalized physical violence and violation of bodily autonomy, (ii) Religious impositions and moral policing, (iii) Dehumanising treatment and objectification and (iv) Systemic discrimination and denial of care.

Conclusions In conclusion, this study highlights the pervasive violence, abuse, sexual assault and discrimination reported by transgender women in healthcare settings in Uganda. These experiences not only compromise access to quality healthcare but also perpetuate stigma and exacerbate health disparities. Addressing these issues requires comprehensive, trauma-informed care, alongside structural reforms and training for healthcare providers. Ensuring respectful, affirming, and inclusive healthcare environments is essential to safeguarding the rights and well-being of transgender individuals. Additionally, more studies should evaluate the effectiveness of interventions like healthcare provider training and addressing social determinants of health to determine the most impactful strategies for reducing violence.

Keywords Abuse, Healthcare, Sub-Saharan Africa, Qualitative study, Transgender, Violence

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Introduction

People who identify as transgender are those whose gender identity does not match the sex with which they were born [1]. Research from the United States and South Africa shows that transgender women face unique challenges and experience multiple forms of violence, including physical, verbal, and sexual assault, which can occur within healthcare environments [2–4]. These experiences of violence, can lead to the avoidance of healthcare facilities, denial of services, delays in receiving care, and low utilisation of essential services such as HIV testing and post-exposure prophylaxis [5]. This often occurs within environments that criminalise sexual and gender minority (SGM) individuals. Studies have shown that SGM patients encounter marginalisation in healthcare settings due to a lack of cultural competence among healthcare providers [6, 7].

The intersectionality and intersectional stigma faced by transgender women in healthcare settings is a multifaceted issue that significantly impacts their access to and quality of care. For instance, Naume et al. highlight that emotional abuse and discrimination in healthcare settings can ignite self-stigma among transgender women, adversely affecting their self-confidence and willingness to access necessary services, particularly in the context of HIV prevention and treatment [8]. Similarly, Smart et al. emphasize that negative healthcare experiences can lead transgender women to seek nonmedical, sometimes predatory, care sources, further exacerbating their health vulnerabilities [9]. These findings are corroborated by Logie et al., who discuss how the marginalization experienced by transgender women, particularly those living with HIV, is intricately linked to their healthcare access and outcomes [10]. Moreover, the intersection of various forms of stigma—such as racism, sexism, and transphobia—creates compounded barriers for transgender women, particularly those of color. Raghuram notes that in India, the intersectionality of gender, caste, and class creates unique healthcare access challenges for transgender individuals [11]. This is echoed in the work of Ogunbajo et al., who identify medical mistrust and negative healthcare experiences as significant barriers to HIV prevention and treatment among Black and Hispanic/Latinx transgender women in the U.S [12]. Discrimination against SGM individuals in healthcare is a well-documented issue, leading to disparities in access to care and health outcomes [13, 14]. The criminalisation of same-sex practices can further exacerbate the stigma and exclusion of SGM persons in various societal systems, including healthcare [15]. Studies have highlighted biased behaviours and discrimination by healthcare providers towards SGM individuals, ranging from subtle microaggressions to overt discrimination [16].

Despite global progress in addressing discrimination and violence based on gender identity and sexual orientation, transgender women continue to encounter pervasive stigma, discrimination, and violence, particularly in their interactions with healthcare providers and institutions [17]. Transgender women in Uganda often face barriers to healthcare access due to discriminatory attitudes among healthcare providers and inadequate institutional policies [18]. This marginalisation not only limits their access to essential healthcare but also exposes them to increased risks of violence and abuse within healthcare settings [19]. The intersection of transgender identity with other marginalised identities, such as education-level, socio-economic background, and HIV status, further compounds the vulnerabilities faced by transgender women in Uganda [20]. These intersecting forms of discrimination not only impede their access to healthcare but also perpetuate a cycle of violence and abuse that undermines their overall well-being [21]. The experiences of transgender women in Uganda reflect broader global trends where discrimination, stigma, and violence hinder their access to quality healthcare [22]. Additionally, the legal and cultural context in Uganda presents specific challenges, as being transgender is illegal and criminalized under the new Anti-Homosexuality Act of 2023 [23].

Considering these challenges, there is an urgent need for research that critically examines transgender women's experiences of violence and abuse while accessing healthcare in Uganda. By shedding light on the multifaceted barriers they encounter, we aim to inform evidence-based interventions and policy reforms that promote equitable healthcare access and address the systemic inequalities faced by transgender communities in Uganda. Therefore, this study seeks to answer the following research questions: *How do Ugandan transgender women experience violence and abuse in healthcare settings, and how does this affect their access to and utilization of health services?*

Methods

Research team and reflexivity

PAM, RN, LM, and SM work in the medical field as health equity researchers seeking to reach underserved populations with HIV prevention and testing services. From 2017 to 2019, PAM worked in an HIV clinic and observed how some health professionals handled transgender women who sought HIV care and prevention services. She also observed a decline in transgender women's clinic attendance following very unfavourable medical experiences. Building on that, and together with some transgender women, they conceptualized this study to comprehend and describe the stigmatising experiences through the lens of transgender people. The study's findings will serve as a foundation for developing and implementing anti-transgender stigma reduction interventions

among Ugandan health professionals. PAM and RN have qualitative research experience and received training in gender diversity and sensitivity. They have both received training in the protection of human subjects and ethics. They have collaborated with transgender communities and organizations since 2020. The team shared their personal goals and reasons for conducting the research to build trust and rapport. They also discussed their interests in the research topic and the potential usefulness of the study findings. Using bracketing, the researchers mitigated potential biases and presumptions regarding the central phenomenon [24]. None of the co-authors identifies as transgender.

Our experience working with transgender communities indicates they feel more comfortable being interviewed by trusted peers. To support this, we collaborated with four transgender women identified by community-based organizations as peer research assistants. The peer research assistants received two weeks of hands-on training in interviewing techniques, data collection, and analysis. The training also covered ethical topics, including human subjects' protection, confidentiality, informed consent, respect, and safety. In respect of their privacy, they have requested anonymity for this publication.

Study design and setting

This qualitative study used community-based participatory methods with transgender women from central and southwestern Uganda. These regions were selected because they have a high HIV prevalence, at 6.2% and 6.3%, respectively, compared to the national average of 5.5% [25]. This qualitative study is part of a larger project on reducing gender-identity stigma among transgender women at risk of HIV. However, HIV status was not a criterion for enrolment, as this paper focuses specifically on experiences of violence and abuse in healthcare settings.

Recruitment and study participants

We collaborated with leaders of transgender-led organizations in the two districts, which provide safe spaces for community members to access medical care, shelter, and peer support. These leaders helped identify peer researchers who, in turn, recruited participants based on the study's inclusion criteria. The community-based peer researchers actively sought and informed transgender women about the study and arranged suitable times for focus group discussions. Participants were recruited from their homes, shelters, social environments, and drop-in centers. The discussions took place in safe spaces, including transgender-led organizations, a hotel commonly used for community meetings, and a health facility offering tailored healthcare services for transgender people. To protect study participants' privacy and uphold the values of transgender-led organizations, we adhered to a policy of anonymity and confidentiality.

Anyone who self-identified as transgender was older than 14 years and had experienced violence and abuse in medical settings was eligible to participate in this study. Participants were enrolled if they self-identified as having experienced violence or abuse in healthcare settings, with the definition of violence or abuse left to their interpretation.

Transgender individuals face significant stigma and physical danger due to the criminalization of their identity in Uganda. To prevent potential harm to participants in the study, we developed and implemented a comprehensive risk mitigation plan, guided by existing literature, to ensure their safety throughout the study [26]. Some of these plans include providing access to legal representation, anonymizing data, storing data on servers outside Uganda, holding meetings in safe spaces, and collaborating with organizations already working closely with the Ugandan Ministry of Health. Participants were selected using purposive sampling. About eight (08) people refused to participate due to concerns about their safety.

Data collection

The peer researchers contacted their community members and explained the study's aims and data collection procedure. Those willing to participate could choose between a virtual or an in-person focus group at a designated "safe space" at their convenience. The peers were crucial in assigning participants to groups, prioritizing comfort and privacy. One group consisted of transgender women living in a shelter, another included those living with HIV, and a third group comprised transgender women who had not publicly disclosed their gender identity. Additionally, there was a group of transgender women engaged in sex work, while the remaining two groups were categorized by age. The age groups were divided into 18–29 years and ≥30 years, based on recommendations from transgender women. They believed younger participants might feel uncomfortable speaking openly in the presence of older ones, and vice versa.

Transgender women who had experienced violence and abuse and agreed to share their lived experiences participated in six focus group discussions (FGDs) [27]. Two trained peers and PAM moderated the six focus groups. RN attended all sessions as a notetaker and logistics coordinator while observing nonverbal cues. Each FGD lasted about three hours and was conducted in the local dialects commonly spoken in the study locations. Our initial goal was to recruit ten transgender women per group; however, we ultimately secured 5 to 6 participants per group. This smaller number proved more suitable for addressing emotionally charged topics, as it allowed for deeper participant engagement and involvement [28].

Data was collected using an open-ended FGD guide developed by the research team (Supplementary file 1). This guide included questions and prompts about participants' experiences of violence and abuse and how these experiences affect their trust in healthcare providers and the health system overall. It also included questions soliciting suggestions for improvement. The guide underwent pilot testing with 5 transgender women from a different region in Uganda. Based on feedback from the pilot testing, several adjustments were made, such as adjusting the length, adding more prompts, reorganizing the questions, and modifying some questions to use more inclusive language.

Both PAM and RN were fluent in these dialects and could understand formal and informal language. The participants agreed to have the discussions audio recorded. Data collection stopped when no new information emerged from the interviews.

Some participants may have been deterred from sharing their personal experiences during the focus group discussions. This hesitancy could stem from various reasons, such as feeling uncomfortable discussing personal matters in a group setting or speaking up among strangers. To address this issue, the moderators established rapport and trust with the participants beforehand to make them feel more comfortable. Additionally, the peers played a crucial role in this endeavor.

Data analysis

Immediately following the conclusion of each FGD, verbatim transcripts, and field notes were typed up and translated into English. OpenCode software was used to analyse the data employing thematic analysis using Braun and Clarke's method [29]. The inductive data analysis process was flexible and followed six key stages: familiarization with the data, generation of initial codes, identification of themes, refinement of themes, definition and naming of themes, and report writing.

To generate codes and themes, PAM and RN partnered with a peer to ensure that the findings' meaning emerged from the data and was corroborated by a community member, not just the researchers. Both groups then met to compare their mostly similar findings. In cases of slight disagreement, consensus was reached, with SM serving as the liaison. This method emphasized a comprehensive, reflective, and systematic approach to analysis, ensuring that the identified themes captured the richness of the data while maintaining a strong alignment with the research questions.

Five transgender women who participated in the study were consulted to review the categories, themes, and interpretations. This step aimed to verify whether the findings accurately reflected their perceptions and aligned with the discussions held during the focus groups. The team then collaboratively revised any themes that appeared to misrepresent the participants' experiences of violence and abuse. Additionally, the transgender women involved in the member-checking process felt that some categories were worded "insensitively" and assisted in revising them to use more inclusive language. Once the participants approved, the researchers created a textural description of their experiences. Finally, the team condensed the lengthy description into a few brief, dense sentences that captured the essential elements of the participants' experiences of violence and abuse [30]. Participant quotations are presented to illustrate the themes.

To ensure the process rigor, the study was guided by the four trustworthiness criteria: credibility, dependability, transferability, and confirmability [31]. The results were made credible by methods like openness and saturation [32]. Additionally, the research team developed rapport with the transgender community. The team leveraged their prior experience and commitment to health equity, particularly in underserved populations. Recognizing the importance of peer-led interactions, the team collaborated with four transgender women, identified through community-based organizations, as peer research assistants. This approach ensured participants felt comfortable and empowered, strengthening trust within the research process.

Recordings, transcripts, and field notes created an audit trail that transparently presented the procedures and methods, ensuring dependability. Thick descriptions will enable readers to assess transferability to their contexts. The researchers' field notes and written reflections helped confirm the study's credibility.

This paper was written following the COREQ guidelines [33].

Results

Thirty-three (33) transgender women participated in the study, with five to six participants in each focus group. Four themes emerged for transgender women's experiences of violence and abuse in healthcare settings (Fig. 1). The themes include: (i) Institutionalized physical violence and violation of bodily autonomy, (ii) Religious impositions and moral policing, (iii) Dehumanising treatment and objectification, and vi) Systemic discrimination and denial of care. Please be prepared, as some of the narrative quotes regarding violence and abuse may be difficult to read.

This section highlights the four key themes that emerged from participants' experiences of violence and abuse within healthcare settings. A nuanced thread of intersectionality underpins all the themes, which will be further explored in the discussion section.

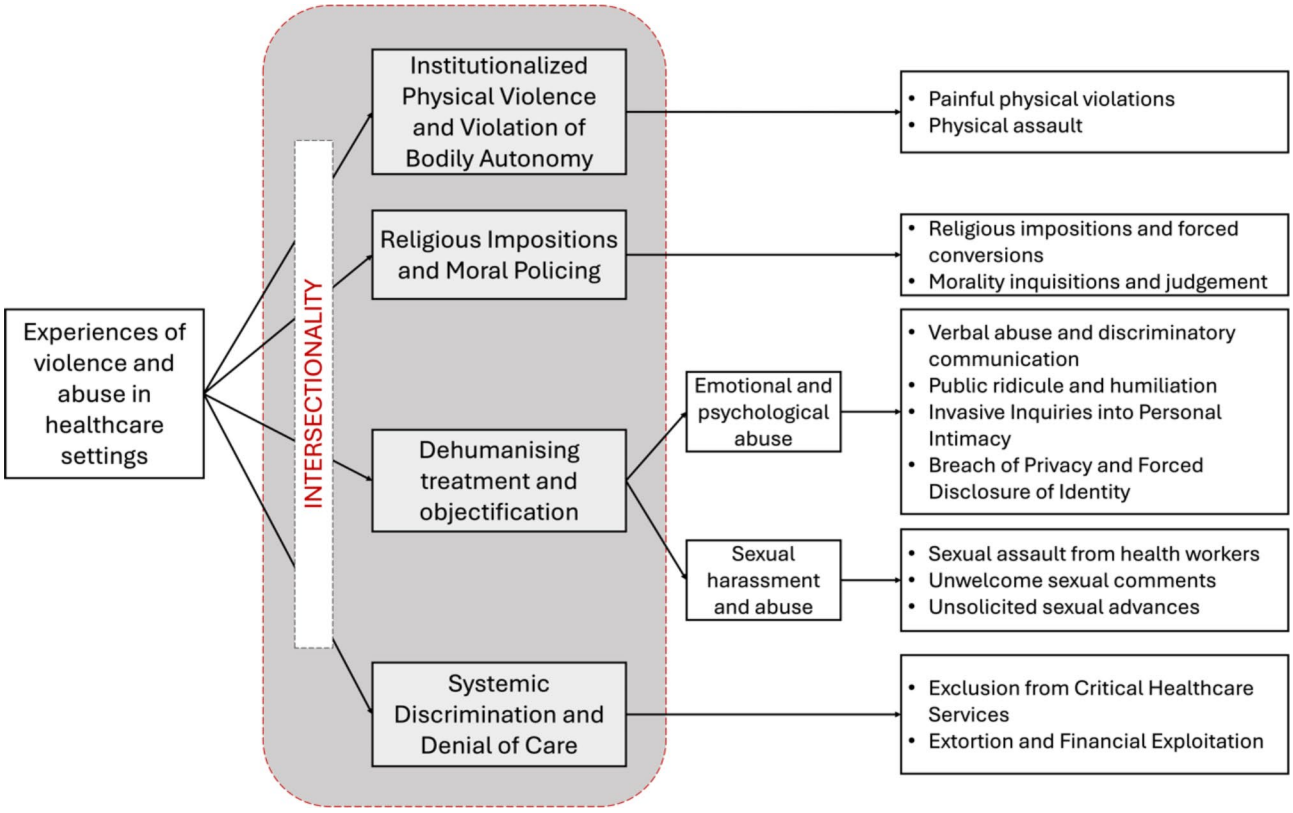

Fig. 1 Transgender women's experiences of violence and abuse in healthcare settings in Uganda

Institutionalized physical violence and violation of bodily autonomy

This theme highlights the systemic nature of violence, its profound physical and emotional impact, and the institutional tolerance that perpetuates such abusive practices. Participants described experiencing physical assault during medical encounters, including being beaten. This abuse was often rooted in assumptions about their gender identity or sexual orientation, reinforcing barriers to accessing care and exacerbating their vulnerabilities.

One transgender woman shared:

> *We were once imprisoned and badly beaten by other inmates. When we sought treatment at the prison's health facility, my friend, who had been assaulted so severely she became disoriented, was further harassed by health workers. They slapped her and called her a homosexual in front of guards, who did nothing. The incident was neither documented nor reported, yet when other inmates are severely assaulted, investigations are conducted.* (Participant 7, FGD 03)

Another participant reported that healthcare providers inflict pain and intentionally harm transgender people, particularly through anal examinations.

> *I went to a government hospital for a severe urinary tract infection. The health worker insisted on an anal exam, which I didn't think was necessary, claiming it could be the cause of the infection for 'people like me.' When I refused, she called two men who beat me. I didn't receive any treatment for the infection, I just bought medication from a pharmacy.* (Participant 4, FGD 04)

Another transgender woman described feeling traumatized and violated when the health worker conducted examinations without using any lubricant.

> *…. they brought in a female health worker to perform an anal examination, but instead, she inserted her two dry fingers roughly into the area. The experience was traumatizing, and I couldn't walk properly for a week afterward.* (Participant 6, FGD 01)

Religious impositions and moral policing

This theme captures the imposition of religious beliefs, and moral judgments by healthcare providers as forms of abuse that stigmatize, distress, and alienate transgender women in healthcare settings.

Religious imposition and forced conversion

Participants highlighted instances where healthcare workers imposed religious beliefs on them, often attempting to "convert" or "correct" their gender identity. These actions included preaching, praying, and attempting to "cast out demons," which were perceived as deeply stigmatizing and discriminatory. These practices compounded the participants' experiences of marginalization and had significant implications for their mental health and access to care.

One participant shared how presenting as her preferred gender often led to denial of care:

> *"Many times, health workers refuse to provide care when we go to the health facility, presenting as our preferred gender. This feels stigmatising and violates my rights. It's like nurses are telling me to revert to my former self. I don't want to go back to that. This situation affects my mental well-being and puts me in a bad state of mind."* (Participant 6, FGD 01).

Many participants indicated that they avoid certain public health facilities because healthcare workers engage in preaching and praying during medical encounters. These actions were perceived as an infringement on their liberties.

> *"Hey man, let me tell you, Jesus loves you. He came to die for people like you." I asked her, "Are you a medical worker or a pastor?" She replied, "I will do both." I left the facility speechless. As I exited, she stood atop the stairs, preaching very loudly, and everyone turned to look at me as if I were a sinner.* (Participant 2, FGD 05)

One participant reported that the health worker went so far as to try to cast out demons from her. They likened this persistent questioning to a form of unwarranted conversion therapy, further compounding their distress.

> *I'm concerned about unfriendly healthcare workers because they are unprofessional. They often seemed clueless when I approached them for help and started lecturing me instead. One time, a nurse began casting out demons when I went to her station for a blood pressure check. I thought they were there to help the sick, not to preach.* (Participant 3, FGD 04)

Moral inquisitions and judgements

The participants reported that during every healthcare encounter, health workers consistently questioned why they were transgender and why they could not revert to their assigned sex. The participants felt that these judgmental questions reflected a fundamental misunderstanding by the health workers about the nature of gender identity, which cannot simply be altered.

Participants recounted instances of health workers exhibiting stigmatizing behavior, including intrusive questioning, unnecessary exposure of injuries, and derogatory comments about their lifestyle.

> *"She asked me to explain how I got the injury and called two more nurses. She had me repeat the story when they arrived and kept lifting the sheet to show them the injuries. Then, she made comments about sin and sexual immorality while treating me."* (Participant 1, FGD 04).

Such actions violated their dignity and reinforced feelings of judgment and discrimination within healthcare settings.

Dehumanising treatment and objectification

This theme highlights the multifaceted nature of the abuse experienced by the study participants. The findings are organized into two sub-themes: psychological and emotional abuse, and sexual harassment and abuse.

Psychological and emotional abuse

Participants recounted incidents where healthcare workers subjected them to public ridicule, drawing unnecessary attention to their identities. For instance, healthcare staff often called colleagues to "see" them, turning their presence into a spectacle. Such encounters not only violated participants' dignity but also instilled fear and exacerbated feelings of alienation within healthcare environments. One transgender woman shared her distressing experience.

> *I've struggled for a long time to feel comfortable with who I am. Whenever I go to the hospital, the first person I see always calls others to come and see me. When I exit the doctor's examination room, I find many other staff and patients have gathered and are waiting to see me. Sometimes, I'm scared they will gang up on me.* (Participant 5, FGD 02)

This theme also encompassed instances where healthcare workers forced patients to disclose their gender identity or sexual orientation, effectively "outing" them in front of others without their explicit permission or consent.

> *Once at a health facility, I overheard one of the nurses telling her friends, "Can you imagine this cute lady is a man? These are the homosexuals." They all turned to look, not realising I was right behind her. It was awkward when she saw me. Being outed like*

that to people who aren't informed can be tough. Imagine if it happened to my neighbours, who don't know I'm transgender because I keep that part of myself private. These situations can have a big impact on us. (Participant 6, FGD 02)

Participants expressed dissatisfaction with healthcare providers' intrusive questions about their sex lives and inappropriate comments on their gender identity and sexuality. They felt that cisgender individuals are not subjected to similar inquiries and found these questions embarrassing and traumatizing. As a result, they were discouraged from returning to these facilities, knowing they would face further interrogation.

They ask questions like: Does it hurt? How do you manage it? Why did you choose this path? "What did you do to become like this?" or "Don't you want children in the future?" You might find yourself wondering why they're so interested in these aspects. I didn't come here to discuss children, so why are you so curious about that? (Participant 01, FGD 05)

They ask irrelevant questions, like how you have sex, how you could get HIV, or how your body parts became sick. It's frustrating to return to the facility when they ask such intrusive questions, like whether you're the one having sex or being involved in it, as if it's any of their business! (Participant 01, FGD 03)

Participants shared experiences of verbal abuse and discriminatory communication by healthcare workers, including shouting, demeaning language, and public disclosure of their health status. They felt targeted, as such treatment was not directed toward cisgender individuals.

One participant recounted:

"When you visit a health worker, they often rudely refer you to someone else who also can't help. Your file is brought out, and your name is read aloud, revealing you're there for HIV medication. At times, you're treated differently from other clients." (Participant 2, FGD 05).

Others described being addressed with derogatory language, causing significant humiliation:

"When I was leaving, the nurse shouted, 'Let those homos get out' in front of everyone. We were so embarrassed. They refused to give us medication even though we were sick and in pain." (Participant 3, FGD 04).

These experiences underscore the pervasive verbal hostility and discriminatory behaviour that marginalized groups face in healthcare settings, contributing to feelings of exclusion and mistrust.

Sexual harassment and non-consensual sexual acts

Transgender women in this study frequently reported incidents of sexual harassment by healthcare providers, ranging from invasive questions about sexual practices to non-consensual sexual acts during medical procedures. Participants reported experiencing harassment through unsolicited sexual advances from health workers and violations during bodily assessments conducted without their consent, which they perceived as forms of sexual violence.

Several participants shared experiences of non-consensual sexual acts with the health workers at the health facilities. One participant recounted.

I once suffered from a certain condition, and I went to the health worker for proctology. So, when I went and disclosed, the doctor examined me, and during the examination, he inserted something cold and hard in my anal region and started asking me if that's how I have sex and if it felt good. That was sexual abuse from a health worker, and I did not have anyone to report it to. (Participant 4, FGD 05)

Some of the participants reported that male healthcare workers made unsolicited sexual advances. One transgender woman narrated.

The man examining me said that because I wanted to become a woman, he'd teach me 'how to be a woman'. I felt upset because my identity isn't about my sexuality—it's just who I am. I felt so powerless, this was a person who was supposed to help me. (Participant 3, FGD 06)

Systemic discrimination and denial of care

This theme underscores the structural barriers and explicit biases that undermine access to quality healthcare for transgender individuals. Participants consistently reported discriminatory practices, including healthcare providers refusing treatment or delivering substandard care. Healthcare workers were frequently dismissive or hostile, making unfounded assumptions about patients' sexual orientation and, in some cases, blatantly refusing care.

One commonly recurring issue was the denial of essential health services, including emergency care and HIV treatment and prevention. Many described being denied emergency services or essential medications, such as HIV prevention or antiretroviral therapy (ART), solely because of their gender identity.

I had an accident on [.....] and went to the nearest treatment facility, [.....], but it was closed when I arrived. I was directed to the public hospital's emergency section. When I got there, I was bleeding heavily. A nurse approached, asked for my name, and then called the doctor. She said to the doctor, "These are the ones." The doctor seemed confused and asked, "Which ones?" The nurse replied, "The homos." I felt embarrassed. They gave me a tetanus shot but never attended to my injuries. I lost a lot of blood and had to go to another facility for proper care. (Participant 3, FGD 05).

Another participant did not take antiretroviral therapy (ART) refills because of the way the health worker spoke to her.

"Even the homosexuals get HIV!! I won't work on them." After that incident, I never went back. I even lost the courage to return for my medication. I became so fed up that I stopped taking my ART because I was afraid to go pick it up. (Participant 1, FGD 04))

While yet another transgender woman was denied access to post-exposure prophylaxis (PEP), and another was discouraged from HIV testing.

I went to a health facility for PEP, but they refused to provide it, saying they don't serve KPs [key populations] like me. I did not go to another facility and did not take PEP. I have not yet taken another test to know if I am still negative (Participant 6, FGD 04).

Some participants also recounted instances where health workers demanded bribes before providing treatment, further compounding these systemic injustices.

I visited a health facility where a health worker asked me for money before doing any work on me and this was at a public facility. I'm not sure if they ask everyone or just transgender people like me, but I think this might be a common experience for transgender individuals because they know it is difficult for us to get healthcare. (Participant 2, FGD 01)

Discussion

Four key themes emerged for the lived experiences of violence and abuse among transgender women in Uganda. These included: (i) Institutionalized physical violence and violation of bodily autonomy, (ii) Religious impositions and moral policing, (iii) Dehumanising treatment and objectification and (iv) Systemic discrimination and denial of care. Intersectionality emerges as a critical lens underpinning the findings of this study, highlighting the complex interplay of multiple forms of oppression experienced by transgender women in healthcare settings. Intersectionality theory explains that different forms of oppression are interconnected and work together to create and uphold a system of power maintained by social structures and institutions [34].

Physical violence, as reported by participants, illustrates how gender identity intersects with societal and institutional biases, creating environments where abuse and discrimination are not only pervasive but often normalized. These experiences are further exacerbated by structural factors such as legal criminalization and social stigmatization, which deepen barriers to justice and perpetuate cycles of violence. This aligns with findings from other healthcare settings [35–37]. Such violence ranged from overt aggression to subtle forms of mistreatment and discrimination. Participants described instances of assault, harassment, and even torture when accessing healthcare services [36]. These acts, perpetrated by healthcare providers, staff, or other patients, often led to fear, intimidation, and reluctance to seek care [35, 36]. A significant issue is the institutionalization of such violence, which is compounded by limited avenues for reporting abuse and systemic barriers, including legal criminalization and societal discrimination. Advocacy and structural reforms at policy levels are critical to addressing these foundational issues. Without systemic change, efforts like healthcare worker training or stigma-reduction interventions will have limited impact [38].

Instances of verbal abuse, service denial, and breaches of confidentiality underscore the compounded vulnerabilities faced by transgender women. The intersection of gender identity and societal norms fosters an environment where discriminatory behaviours, such as "outing" patients or gossiping about their gender identity, undermine their dignity and trust in healthcare systems. This multifaceted marginalization often forces individuals to avoid formal healthcare, highlighting the intersectional impact of social stigma, systemic discrimination, and institutional shortcomings [39]. This "outing" caused feelings of violation and discrimination [40, 41]. Studies from various countries, including Brazil, the US, Colombia, Korea, and Mozambique, highlight similar issues, such as denial of transgender-specific care, discriminatory behaviour, and confidentiality breaches [42–48]. The emotional toll of such treatment drives many transgender individuals to avoid formal healthcare systems, often turning to unsafe, nonmedical alternatives [9]. Research by Casey et al. revealed that one in six LGBTQ adults avoids healthcare due to anticipated discrimination [49]. This avoidance perpetuates health disparities,

emphasizing the need for trauma-informed, culturally competent, and stigma-free care.

Transgender individuals are disproportionately affected by sexual violence, including rape, unwelcome sexual comments, and unwanted advances [2, 50, 51]. Sexual violence and its aftermath further reveal how intersecting identities, including gender identity, socioeconomic status, and occupational vulnerabilities (e.g., sex work), amplify risks. Participants in this study shared how healthcare access was complicated by harassment, societal stigma, and fear of legal repercussions. These factors create barriers to seeking care and negotiating safe practices, particularly for those in contexts like sex work [52–54]. The resulting emotional distress often leads to maladaptive coping mechanisms, such as substance abuse, further impacting health outcomes [55]. Addressing these issues requires systemic healthcare reforms, including trauma-informed care and culturally competent provider training [56].

Additionally, the role of healthcare providers' personal beliefs highlights the intersection of individual biases with institutional practices, contributing to the denial of care and inequitable treatment. Such discrimination not only impacts physical health but also exacerbates mental health challenges such as anxiety and depression, reinforcing the importance of intersectionality in understanding and addressing these disparities [57]. Discrimination rooted in these beliefs manifested as refusal of care, biased treatment, and lack of understanding of transgender-specific health needs [58]. Comprehensive training programs emphasizing professional competency and affirming care are essential to counteract these barriers and foster inclusivity [59].

Finally, the denial of HIV care reflects how gender identity intersects with systemic healthcare inequities, resulting in delayed treatments and heightened health risks. In this study, some participants missed antiretroviral treatments (ART) or post-exposure prophylaxis (PEP), risking their health and increasing HIV transmission [60]. One participant avoided follow-up HIV testing after being denied PEP, highlighting the dangers of discrimination in healthcare. To mitigate these risks, healthcare providers must create supportive environments addressing the unique challenges faced by transgender women. Community-based initiatives, such as peer support and drop-in centers, have demonstrated effectiveness in providing stigma-free HIV care [61]. Furthermore, robust policies protecting patient confidentiality and preventing discrimination based on gender identity are critical to building trust and improving health outcomes.

By applying an intersectional lens, this study underscores the urgent need for inclusive policies, structural reforms, and community-based initiatives to address the multifaceted barriers transgender women face in accessing equitable healthcare. Through this lens, the findings advocate for a holistic approach to fostering health equity, grounded in an understanding of the interconnected forms of oppression that shape transgender women's experiences.

Strengths and limitations

The study's strength lies in its detailed documentation of transgender women's experiences of violence and abuse in healthcare settings in Uganda, initiating an important discussion through the lens of intersectionality. To increase transferability, we involved transgender women from both urban and rural areas. This approach allowed us to explore the experiences of transgender individuals in various settings and gain a more comprehensive understanding of their perspectives. Additionally, we identified common themes in their experiences by including participants from diverse geographic locations. One limitation of the study was the absence of a specific theoretical framework for data collection, particularly given the pervasive themes of intersectionality and intersectional stigma throughout the study. Future research could benefit from being guided by an intersectionality theoretical framework to explore and address these complexities better.

Conclusions

In conclusion, the experiences of transgender women in healthcare settings, as revealed in this study, highlight the pervasive and multifaceted nature of violence and abuse they face. These women endure a range of violations, from sexual assault and institutionalized abuse to dehumanizing treatment, religious impositions, and outright denial of care. The themes identified underscore the significant barriers transgender individuals encounter in seeking and receiving healthcare, often exacerbated by deeply ingrained societal and institutional biases. The findings call for urgent reform within healthcare systems to ensure the protection and dignity of transgender women, emphasizing the need for comprehensive training for healthcare providers on trauma-informed, affirming care. Additionally, addressing the structural and systemic issues that perpetuate discrimination, and violence is essential for improving the health outcomes and overall well-being of transgender individuals. Ultimately, fostering an inclusive and supportive healthcare environment is not only a matter of equity but also a fundamental human right.

Future qualitative studies should capture the nuanced experiences and coping mechanisms of transgender women who have encountered violence. Furthermore, additional research should evaluate the effectiveness of suggested interventions, such as healthcare provider

training and initiatives targeting social determinants of health, to ascertain which measures are most successful in reducing violence.

Abbreviations

ART	Antiretroviral therapy
DIC	Drop-in-center
DSD	Differentiated service delivery
FGD	Focus group discussion
HIV	Human immunodeficiency virus
IEC	Information education and communication
KP	Key population
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer +
MSM	Men who have sex with men
PEP	Post-exposure prophylaxis
SOGIE	Sexual orientation
STI	Sexually transmitted infection
TG	Transgender

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12591-2.

Supplementary Material 1.

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Authors' contributions
PAM Concept and design, acquisition, analysis, interpretation of the data, and manuscript drafting. RN Concept and design of the manuscript, supervision, data collection, analysis, and drafting of the manuscript. SM Manuscript design, qualitative expertise, and critical revision for important intellectual content. All the authors gave final approval for the work to be published. All authors agree to be accountable for all aspects of the work to ensure that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Data availability
The datasets used and/or analysed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
The Makerere University School of Health Sciences Research Ethics Committee approved the study (Ref. Number: MAKSHSREC-2022-257). Prior to participation, each participant was asked to provide written informed consent. This study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki and other applicable international and national ethical guidelines.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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