AFRICA QUEER NETWORK

AQNET | AFRICA QUEER NETWORK

Beyond Fear, Towards Care

Strengthening SRHR Access & Advocacy for LBTQ Womxn in Uganda

ABOUT AQNET

Africa Queer Network (AQNET) is a feminist, community-based organization founded in 2021 to address the systemic exclusion, discrimination, and violence faced by Lesbian, Bisexual, Transgender, and Queer (LBTQ) persons in Uganda. Established by LBTQ leaders and grassroots organizers, AQNET emerged as a collective response to the urgent need for protection, visibility, and empowerment of gender-diverse individuals, particularly those in rural, low-resource, and criminalized settings.

AQNET's work is grounded in participatory approaches, feminist organizing, and movement building. The organization works to amplify LBTQ voices, create safe spaces, strengthen capacity, and drive meaningful social change through six core thematic areas: research and knowledge generation, documentation and queer storytelling, capacity building, advocacy and movement building, linkages and referrals to essential services, and strategic partnerships. The organization's vision is a just and inclusive society where LBTQ persons live with dignity, equality, and freedom from violence and discrimination. Its mission centers on advancing the rights, safety, and well-being of LBTQ persons in Uganda through community-driven research, capacity building, inclusive advocacy, service linkages, and strategic partnerships.

AQNET has implemented several key initiatives including strengthening SRHR access for LBTQ womxn in rural Uganda, organizing workshops on gender-based violence, documenting queer history through storytelling and oral interviews, providing digital and physical security training for activists, advocating for legislative reforms, and building economic resilience among LBTQ youth and womxn. The organization operates with core values of feminist liberation, equity, solidarity, dignity, accountability, and intersectionality.

This research study on SRHR access for LBTQ womxn was conducted by AQNET as part of its commitment to generating evidence that informs advocacy, policy reform, and inclusive community-based interventions.

Contact Information:

- Location: Wakiso District, Uganda
- Email: info@aqnet.org
- Phone: +256 705 568129 / +256 786 252933
- Website: www.aqnet.org
- Social Media: Twitter/X @Afriqnetwork | Facebook @Afriqnetwork | Instagram @afri_caqueernetwork

Acknowledgements

This research would not have been possible without the courage, trust, and participation of the 50 LBTQ womxn who shared their lived experiences, struggles, and hopes with us. Your voices are at the heart of this report. We honour your resilience and your commitment to creating a future where all LBTQ persons can access healthcare with dignity and without fear. This work is for you, by you, and with you.

Our Community

We extend our deepest gratitude to the LBTQ community across Uganda—particularly in the Central, Northern, Eastern, and Western regions—for opening your hearts and homes to this research. To the peer educators, community mobilizers, and grassroots leaders who facilitated access to participants, ensured safety protocols, and created trusted spaces for dialogue: your work is the foundation upon which this study stands.

Special thanks to the entire LBQ community , Drop-In Centers (DICs), and safe houses that provided secure venues for focus group discussions and interviews. Your commitment to protecting our community while advancing our collective rights is invaluable.

To the survivors of violence, discrimination, and exclusion who chose to share your stories despite the risks: we see you, we believe you, and we stand with you. Your courage fuels our advocacy and our determination to change the systems that harm us.

Our Partners

This research was strengthened through collaboration with dedicated partners who share our vision of health equity and human rights for all.

Our Donors and Supporters
We are profoundly grateful to the donors and funding partners whose financial and technical support made this research possible. Your commitment to supporting community-led research and LBTQ rights in challenging contexts demonstrates a deep understanding that true change comes from within communities themselves.
Thank you for:

- Providing flexible, responsive funding that allowed us to prioritize participant safety and ethical research practices
- Trusting LBTQ-led organizations to define our own research questions and methodologies
- Supporting work that centers marginalized voices, even in politically sensitive environments
- Investing in evidence generation that drives policy reform and program innovation

Your solidarity goes beyond financial support—it affirms our humanity and our right to exist, to organize, and to demand justice.

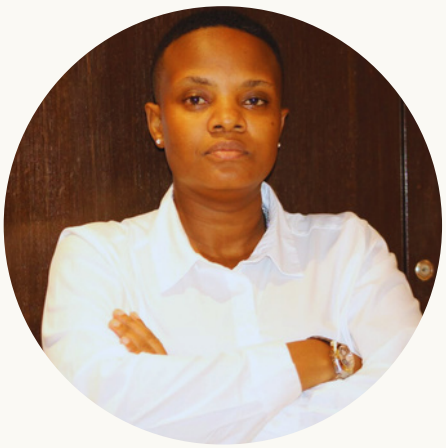
Our Team and Staff
This research was led and conducted by AQNET's dedicated team of researchers, program staff, and volunteers, many of whom are themselves members of the LBTQ community:

- Research Team – Thank you for your meticulous attention to ethics, safety, and participant wellbeing. Your skills in community engagement, data collection, and qualitative analysis brought rigor and compassion to every stage of this study.
- Field Coordinators and Data Collectors – Your commitment to traveling long distances, often at personal risk, to reach isolated community members in rural areas was extraordinary. You ensured that voices from all four regions were heard.
- Peer Interviewers – As LBTQ community members yourselves, you brought cultural competence, empathy, and trust to the interview process. Participants felt safe with you, and that safety was essential to gathering honest, nuanced data.
- Program and Administrative Staff – Thank you for managing logistics, ensuring participant reimbursements, maintaining data security, and supporting the research team throughout this intensive process.
- Mental Health and Psychosocial Support Team – For providing care and debriefing to participants and researchers who experienced retraumatization during this emotionally demanding work.

Special Recognition
We acknowledge the following individuals and groups whose contributions were instrumental to this study:

- Community Advisory Committee – Thank you for guiding research design, reviewing tools, and ensuring that our methodology was community-centered and trauma-informed.
- Legal and Security Advisors – For helping us navigate the complex legal landscape post-AHA 2023 and ensuring that our research protocols protected participants from harm.
- Transcribers and Translators – For sensitively handling participant narratives in multiple languages and ensuring accuracy in translation.
- Data Analysis Support – To those who assisted with coding, thematic analysis, and data visualization, bringing clarity to complex findings.

Table of Contents



Foreword

It is with profound emotion and unwavering conviction that I present this groundbreaking research report on the Sexual and Reproductive Health and Rights (SRHR) of Lesbian, Bisexual, Transgender, and Queer (LBTQ) womxn in Uganda. This work represents far more than data and analysis—it is a testament to the courage, resilience, and humanity of a community that refuses to be erased.

When we embarked on this research journey, we knew the path would be difficult. The passage of the Anti-Homosexuality Act in 2023 created an environment of fear and hostility that many believed would silence us forever. Health facilities that once quietly served our community withdrew. Safe spaces closed. Activists went underground. Yet, in the midst of this darkness, 50 brave LBTQ womxn across Uganda's four regions stepped forward to share their stories. They trusted us with their pain, their struggles, their hopes, and their dreams. This report is their legacy—a permanent record that we exist, that we matter, and that our health and dignity are non-negotiable.

Why This Work Matters

Healthcare is a human right, not a privilege determined by who we love or how we identify. Yet, for LBTQ womxn in Uganda, accessing basic health services—contraception, cancer screening, mental health support, safe abortion care, gender-affirming treatment—remains a daily battle against stigma, discrimination, and criminalization. We are turned away from clinics, humiliated by providers, denied life-saving care, and forced into dangerous coping strategies that threaten our very survival.

This research lays bare these realities with unflinching honesty. It documents the barriers we face, the resilience we embody, and the community-led solutions we create when formal systems fail us. But more importantly, it provides the evidence needed to demand change. For too long, LBTQ womxn have been invisible in Uganda's health policies and programs. We have been mentioned in passing, if at all, while our specific needs—hormones for trans womxn, female condoms for lesbian and bisexual womxn, inclusive adoption services—remain unmet. This report says: We are here. We have needs. And we will not be ignored.

The findings are sobering. Over 90% of our participants reported experiencing stigma and discrimination in healthcare settings. Eighty percent live in fear of arrest or violence when seeking care. Many resort to selling their ARVs to survive, or accessing hormones through unsafe underground networks. These are not isolated incidents—they are systemic failures that cost lives. Yet, amidst this pain, we also document extraordinary resilience: peer networks that save lives, community DICs that provide sanctuary, and grassroots organizing that keeps hope alive.

The Community That Made This Possible

This research would not exist without the LBTQ community itself. To the 50 womxn who participated in surveys and focus groups, often at great personal risk: you are the heart of this work. Your voices echo through every page, challenging systems of oppression and demanding a future where no one has to choose between their identity and their health.

To the peer educators, community mobilizers, and grassroots organizers who facilitated this research: you walked long distances, risked your safety, and held space for difficult conversations. Your commitment to our collective liberation is the foundation of this movement.

To the Drop-In Centers and safe houses that hosted our research activities: you are lifelines in a hostile landscape, and we honour your courage in keeping your doors open when others shut theirs.

Gratitude to Our Partners, Allies, and Donors

No movement succeeds in isolation. I extend my deepest gratitude to the donors and funding partners who believed in this work and provided the resources necessary to conduct ethical, community-centered research. In a context where many funders shy away from "controversial" issues, your willingness to stand with LBTQ communities demonstrates true solidarity. Thank you for flexible funding that prioritized participant safety, for trusting LBTQ-led organizations to define our own research agendas, and for understanding that evidence generation is itself an act of resistance.

To our partners

- Freedom and Roam Uganda (FARUG)
- Human Rights Awareness and Promotion Forum (HRAPF)
- Women Probono Initiatives (WPI)
- Centre for Women Justice Uganda (CWJU)
- Uganda Key Populations Consortium (UKPC)
- Uganda Minority Shelters Consortium (UMSC)
- Sexual Minorities Uganda (SMUG)
- HER Internet
- Women Of Faith in Action (WOFA)
- Akina Mama wa Afrika (AMwA)
- LBQ Loose Network
- KuchuTimes Media Group (KTMG)
- Mend Initiative

Your advocacy and work creates space for us to breathe, to organize, and to dream of a better future.

To progressive faith leaders, sympathetic policymakers, and healthcare workers who treat us with dignity: you remind us that humanity can prevail over prejudice. Your allyship, especially in these dark times, is a beacon of hope.

A Personal Reflection

As the founder of Africa Queer Network and a lesbian woman who has navigated Uganda's healthcare system myself, this research is deeply personal. I have felt the sting of rejection in a clinic waiting room. I have watched friends deteriorate because they could not access hormones. I have held survivors of violence who had nowhere to turn for help. These are not abstract policy issues—they are our lives.

But I have also witnessed the power of community. I have seen trans womxn mentor each other through hormone transitions. I have watched peer educators save lives with timely referrals. I have celebrated with couples who finally found adoption agencies willing to consider them. This resilience, this refusal to give up even when the world tells us we don't matter—this is what sustains me. And this is why I remain hopeful.

This report is a gift to future generations of LBTQ persons in Uganda. It says: we were here. We fought. We documented. We refused to be erased. And we laid the groundwork for the liberation you will inherit.

In solidarity, struggle, and hope,

Agnes Nshemeirwe
Founder and Executive Director
Africa Queer Network (AQNET)
Wakiso District, Uganda
October 2025

Introduction

Sexual and Reproductive Health and Rights (SRHR) are globally recognized as fundamental human rights. However, SRHR services in Uganda have historically focused on maternal health and family planning for heterosexual women and adolescents, often leaving lesbian, bisexual, transgender, and queer (LBTQ) women invisible in health programming. Consensual same-sex relations remain criminalized under Penal Code Act §145, and the Anti-Homosexuality Act (AHA) of 2023 has further intensified fear, stigma, and discrimination within healthcare settings. This hostile legal climate not only deters LBTQ women from seeking care but also makes many providers reluctant to offer inclusive services.

Access to safe abortion and post-abortion care, a key component of SRHR, is particularly restricted. While Article 22(2) of the Constitution allows abortion "as may be authorized by law," the Penal Code Act criminalizes most abortions under Section 141 (attempts to procure abortion), Section 142 (supply of instruments or drugs to procure abortion), Section 143 (self-induced abortion), and Section 212 (child destruction). These provisions create widespread fear among patients and health workers, leading to denial of care even when abortion is legally permissible — for example, to save a woman's life. For LBTQ women, whose access is already limited by stigma and criminalization under the AHA, these barriers are even more severe, pushing many to unsafe methods and increasing preventable health risks.
Consequently, LBTQ women in Uganda face intersectional barriers stemming from gender inequality, restrictive laws, and anti-LGBTQ bias that severely limit their access to SRHR information, commodities, and services — from contraception and cancer screening to safe abortion, GBV response, and mental health support.

This study documents the lived realities of 50 respondents across Uganda's four regions, mapping the barriers, coping strategies, and community-led solutions that shape LBTQ women's SRHR access in the current socio-legal environment. The findings aim to generate evidence for advocacy, policy reform, and inclusive community-based interventions that ensure SRHR for all.

Abbreviations

AHA – Anti-Homosexuality Act (2023)
ARV – Antiretroviral (medication used to treat HIV)
CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women
DIC – Drop-In Center
FARUG – Freedom and Roam Uganda
FGD – Focus Group Discussion
GBV – Gender-Based Violence
HIV – Human Immunodeficiency Virus
HRAPF – Human Rights Awareness and Promotion Forum
LBQ – Lesbian, Bisexual, and Queer (women)
LBTQ – Lesbian, Bisexual, Transgender, and Queer (women)
LGBTI – Lesbian, Gay, Bisexual, Transgender, and Intersex
MSM – Men Who Have Sex with Men
NGO – Non-Governmental Organization
PEPFAR – President's Emergency Plan for AIDS Relief
SDG – Sustainable Development Goal
SOGIE – Sexual Orientation, Gender Identity, and Expression
SRHR – Sexual and Reproductive Health and Rights
STI – Sexually Transmitted Infection
UNAIDS – Joint United Nations Programme on HIV/AIDS
UN – United Nations

Glossary of Terms

Anti-Homosexuality Act (AHA) 2023 – Ugandan legislation that criminalizes consensual same-sex conduct and the "promotion" of LGBT rights, creating significant barriers to healthcare access and human rights for LGBTI persons.

Antiretroviral (ARV) Therapy – Medication used to treat HIV infection by suppressing viral replication and allowing the immune system to recover.

Cervical Cancer Screening – A preventive health service that tests for precancerous or cancerous cells in the cervix, particularly important for all women including those who have sex with women.

Community-Based Distribution – The provision of health services and commodities through community networks rather than formal healthcare facilities, often used to reach marginalized populations.

Drop-In Center (DIC) – Safe spaces operated by NGOs or community organizations where LBTQ individuals can access health information, services, and peer support.

Female Condom – A barrier contraceptive method worn internally that provides protection against pregnancy and STIs, relevant for women who have sex with women.

Gender-Affirming Care – Medical and psychological services that support individuals in aligning their physical characteristics with their gender identity, including hormone therapy and surgical interventions.

Gender-Based Violence (GBV) – Violence directed against a person based on their gender, sex, or gender identity, including physical, sexual, psychological, and economic harm.

Key Populations – Groups who are at increased risk of HIV and other health vulnerabilities due to social, legal, or structural factors; often includes men who have sex with men, sex workers, transgender persons, and people who inject drugs.

Sexual Orientation – A person's emotional, romantic, and/or sexual attraction to others, which may be toward people of the same gender, different gender, or multiple genders.

Stigma – Negative attitudes, beliefs, and behaviors directed toward individuals based on perceived characteristics, such as sexual orientation or gender identity, leading to discrimination and marginalization.

LBQ Women – Lesbian, Bisexual, and Queer women; sometimes written as "LBQ womxn" using gender-inclusive spelling.

LBTQ Women/Womxn – Lesbian, Bisexual, Transgender, and Queer women; the term "womxn" is used as a gender-inclusive alternative spelling.

Maputo Protocol – The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which guarantees comprehensive rights to women including health and reproductive rights.

Misgendering – The act of referring to someone using language (such as pronouns or titles) that does not correctly reflect their gender identity.

Mobile Clinics – Healthcare services delivered via vehicles or temporary setups that travel to underserved areas to increase access to care.

Pap Smear – A screening test for cervical cancer that collects cells from the cervix for laboratory examination.

Penal Code Act – Uganda's criminal law that includes provisions criminalizing same-sex conduct (Section 145) and most forms of abortion (Sections 141-143, 212).

Post-Abortion Care – Medical treatment provided after an abortion (whether spontaneous or induced) to address complications and ensure reproductive health.

Safe Abortion – Abortion services provided in accordance with medical standards and legal frameworks to protect women's health and rights.

Self-Medication – The practice of obtaining and using medications without medical supervision, often resorted to when formal healthcare is inaccessible or unsafe.

Sexual and Reproductive Health and Rights (SRHR) – A comprehensive approach to health that includes access to contraception, safe abortion, STI prevention and treatment, maternal health, cancer screening, fertility services, mental health support, and freedom from gender-based violence.

Transgender – A term for people whose gender identity differs from the sex they were assigned at birth.

Queer – An umbrella term for sexual and gender minorities; also used by individuals whose sexual orientation or gender identity does not conform to conventional categories.

Background

Uganda has made notable progress in improving public health outcomes through national programs on maternal health, family planning, and HIV prevention. However, sexual and reproductive health and rights (SRHR) remain unevenly realized, particularly for lesbian, bisexual, and queer (LBQ) women. SRHR goes beyond HIV—it includes access to contraception, safe abortion, fertility services, respectful maternal care, prevention and treatment of sexually transmitted infections, cervical cancer screening, mental health support, and protection from gender-based violence.

Despite Uganda's international and regional commitments — including SDG 3 (Good Health & Well-Being), SDG 5 (Gender Equality), the Maputo Protocol, and CEDAW — many LBQ women continue to face systematic exclusion from SRHR services. The Anti-Homosexuality Act (AHA) 2023 has compounded these challenges by criminalizing consensual same-sex conduct and "promotion" of LGBT rights, creating an atmosphere of fear for both healthcare providers and patients. This has led to:

- Denial of services or hostile treatment in public facilities.
- Self-censorship by health workers worried about legal repercussions.
- Reduced availability of inclusive programs, as NGOs withdraw or scale back outreach to avoid criminal liability.

These barriers have deepened existing health disparities. Findings from the policy review show that while Uganda has progressive frameworks — such as the HIV Testing Policy and Guidelines and the National HIV and AIDS Strategic Plan — they rarely include explicit provisions for LBQ women's SRHR needs. Key populations are often mentioned broadly, but the focus tends to center on men who have sex with men and female sex workers. As a result, LBQ women lack tailored care packages for services like:

- Access to female condoms and lubricants.
- Cervical cancer screening for women who have sex with women.
- Safe abortion and post-abortion care in line with constitutional provisions.
- Mental health and GBV support responsive to queer women's realities.
- Inclusive fertility options for those seeking to start families.

This policy gap forces service providers to rely on general provisions that often fail to meet LBQ women's needs, resulting in low health-seeking behavior and poor SRHR outcomes. The situation is especially severe in rural Uganda, where cultural and religious norms strongly influence law enforcement, amplify stigma, and heighten risks of violence and forced outing when LBQ women attempt to access care.

These legal, social, and health system gaps translate into a serious public health and human rights challenge. Without deliberate, inclusive policies and service packages, Uganda risks leaving behind a significant population of women — undermining its own health targets and international obligations. Bridging this gap will require explicit inclusion of LBQ women in SRHR policies, culturally sensitive provider training, and protection of safe spaces for community-led advocacy and service delivery.

Problem Statement

LBTQ women in Uganda face systemic and persistent barriers to accessing comprehensive sexual and reproductive health and rights (SRHR) services. Stigma and discrimination in health facilities — including denial of services, harassment, and misgendering — are compounded by punitive laws such as the **Anti-Homosexuality Act (AHA) 2023**, which has heightened fear and reduced safe access to care. These barriers result in:

- Limited or no access to essential SRHR commodities such as contraceptives, lubricants, and cervical cancer screening.
- Denial of gender-affirming care and safe abortion services.
- Increased exposure to gender-based violence with limited access to psychosocial or legal support.
- Avoidance of health facilities altogether due to fear of arrest, forced outing, or humiliation.

Some LBTQ women adopt dangerous coping strategies, including self-medicating or purchasing antiretroviral drugs informally, underscoring how poverty and exclusion intersect with health vulnerabilities. Despite Uganda's commitments to equity and non-discrimination under the Constitution, **SDGs 3 & 5**, the **Maputo Protocol**, and **CEDAW**, the SRHR of LBTQ women remain largely unaddressed in policy and service delivery. The lack of documented evidence on these gaps contributes to continued invisibility in national health planning.

Purpose of the Study

This study seeks to **document and analyze the lived experiences, barriers, and coping mechanisms of LBTQ women across Uganda** in relation to SRHR. Its goal is to generate evidence that:

- Maps how the current socio-legal environment — particularly post–AHA 2023 — affects LBTQ women's access to SRHR services.
- Identifies service gaps and unmet needs to inform the development of tailored, inclusive care packages.
- Provides a foundation for community-led advocacy and stakeholder engagement to advance SRHR equity for LBTQ women.

Research Objectives

- Identify the SRHR needs of lesbian, bisexual, transgender, and queer (LBTQ) womxn in Uganda, including contraception, safe abortion, STI prevention and treatment, mental health care, and gender-affirming services.
- Examine the barriers — social, legal, economic, and health-system — that hinder LBTQ womxn from accessing SRHR information and services.
- Analyze the impact of the 2023 Anti-Homosexuality Act (AHA) on LBTQ womxn's health-seeking behavior and utilization of SRHR services.
- Document coping mechanisms and community-based strategies LBTQ womxn use to address their SRHR needs in restrictive environments.
- Develop evidence-based recommendations for policymakers, healthcare providers, and donors to strengthen inclusive SRHR programming and service delivery for LBTQ womxn at facility, community, and national levels.

Research Questions

- What are the main sexual and reproductive health service needs of LBTQ womxn in Uganda?
- What barriers (social, legal, economic, health-system) do LBTQ womxn face when trying to access SRHR information and services?
- How has the 2023 Anti-Homosexuality Act (AHA) affected LBTQ womxn's health-seeking behavior and access to care?
- What coping strategies or community support mechanisms do LBTQ womxn employ to meet their SRHR needs?
- Based on findings, what policy/programmatic recommendations can strengthen SRHR access for LBTQ womxn (at health facility, community, and donor levels)?

Review of Available Literature

Previous studies and reports by local rights groups document the obstacles LBTQ womxn face in Uganda. FARUG (Freedom and Roam Uganda) and the LBQ Loose Network have highlighted that LBQ womxn are "largely underrepresented and underserved" in health and legal services. They emphasize that cultural and legal discrimination forces LBQ womxn out of care. A 2025 FARUG study found that many SRHR needs specific to LBTQ womxn (e.g. female condoms, lubricants, cancer screenings, safe abortion) are neglected. This literature notes that interventions remain maternal-health–centric, often ignoring lesbian or bisexual women who may not fit the typical demographics of reproductive services. Similarly, HRAPF's Human Rights Violations Reports (2019–2021) , most recent report **here** document cases of clinic staff violating privacy and denying services to suspected LGBTI clients, suggesting systemic discrimination.

On a global/regional level, organizations like UNAIDS, Human Rights Watch, and Amnesty International have repeatedly warned that criminalization of homosexuality undermines public health. The UNAIDS/Global Fund/PEPFAR joint statement on AHA 2023 stresses that the law will "obstruct health education and outreach" and already led to reduced access to prevention as well as treatment services. UNAIDS data show that HIV prevalence among key populations remains far above the general population, and that punitive laws directly contribute to these disparities by driving people away from clinics. Human Rights Watch reports that AHA and similar measures have created a "permissive environment" for violence and allowed health services to retreat: health providers have "cut back on essential services for LGBTI people, who also fear harassment or arrest if they seek health care. UNAIDS has also condemned Uganda's 2021 Sexual Offences Act for mandating HIV testing and criminalizing key populations, noting that "increases stigma and discrimination and undermines the HIV response.

In summary, the literature consistently frames this issue as both a human rights emergency and a public health concern. It underscores the need for a rights-based, intersectional approach that addresses legal reform, stigma reduction, and health system capacity to serve LBTQ womxn. However, most existing sources are high-level or focus on MSM and sex workers; few have gathered primary data on LBQ/trans women's own experiences in rural Uganda. This gap justifies the present research.

Methodology

This was a mixed-methods descriptive study. We conducted **structured surveys** with 50 participants who self-identify as lesbian, bisexual, transgender, or queer women, recruited purposively across four regions of Uganda (Central=20, Northern=10, Eastern=10, Western=10) to ensure regional representation and capture diversity of contexts. The questionnaire covered demographic data, health behaviors, service use, and perceived barriers to SRHR. In addition, we held 4 focus group discussions (FGDs) and several in-depth interviews with key informants (e.g. health workers, community leaders, NGO staff) to contextualize and triangulate the survey findings. Secondary data sources (desk review) included policy documents, NGO reports, and media on LGBTI health.

Surveys were administered in a manner sensitive to anonymity. Interviewers from the LBQ community were trained to ask questions in a respectful, non-judgmental way. Most survey items were multiple choice or Likert scales (e.g. "Have you ever been denied a health service because of your identity? – Yes/No/Not sure; If yes, where and why? (open answer)"). Survey responses were anonymized. FGDs used a semi-structured guide to explore themes that emerged in the surveys (e.g. experiences with health facilities, effects of recent laws, community support). All qualitative data were coded thematically.

Ethical Considerations

Given the sensitivity of LGBTI issues in Uganda, this study followed strict ethical protocols. Participation was voluntary and confidential,we did not collect names or identifiers. Informed consent was obtained verbally and in writing with an option to withdraw at any time. We ensured that no question required disclosure beyond what participants were comfortable with. Data were stored securely.To protect participants, we avoided any collection of GPS or precise location data, and interviews were conducted in safe, private settings. Data were reported in aggregate to avoid identification of individuals or small groups. Data was coded thematically and supplemented by desk review of documents.

Limitation

This study has several limitations. The sample (n=50) is relatively small and was reached through community networks and NGOs, so it may not capture all sub-groups of LBTQ womxn (e.g. very isolated individuals). It is predominantly qualitative and exploratory. Self-report data may be affected by recall or social desirability bias, especially given the legal context. The cross-sectional design cannot prove causality (e.g. linking AHA directly to health outcomes), but it captures participants' perceptions and experiences. Also, as the climate is rapidly evolving (e.g. legal changes), findings represent a snapshot at one point in time. Finally, urban bias may be present if more connected individuals are over-represented, though we specifically sought rural participants. Despite these limitations, the data provide valuable insights into trends, obstacles, and coping strategies that are currently under-documented.

Discussion of Findings

Service Utilization

Participants reported widely varying engagement with SRHR services. Nearly all respondents (close to 80%) had accessed HIV testing at some point, reflecting Uganda's strong national testing campaigns. Access to ARVs was also relatively high among both LBQ and trans respondents (around 60%), largely due to community-based distribution and targeted HIV programs.

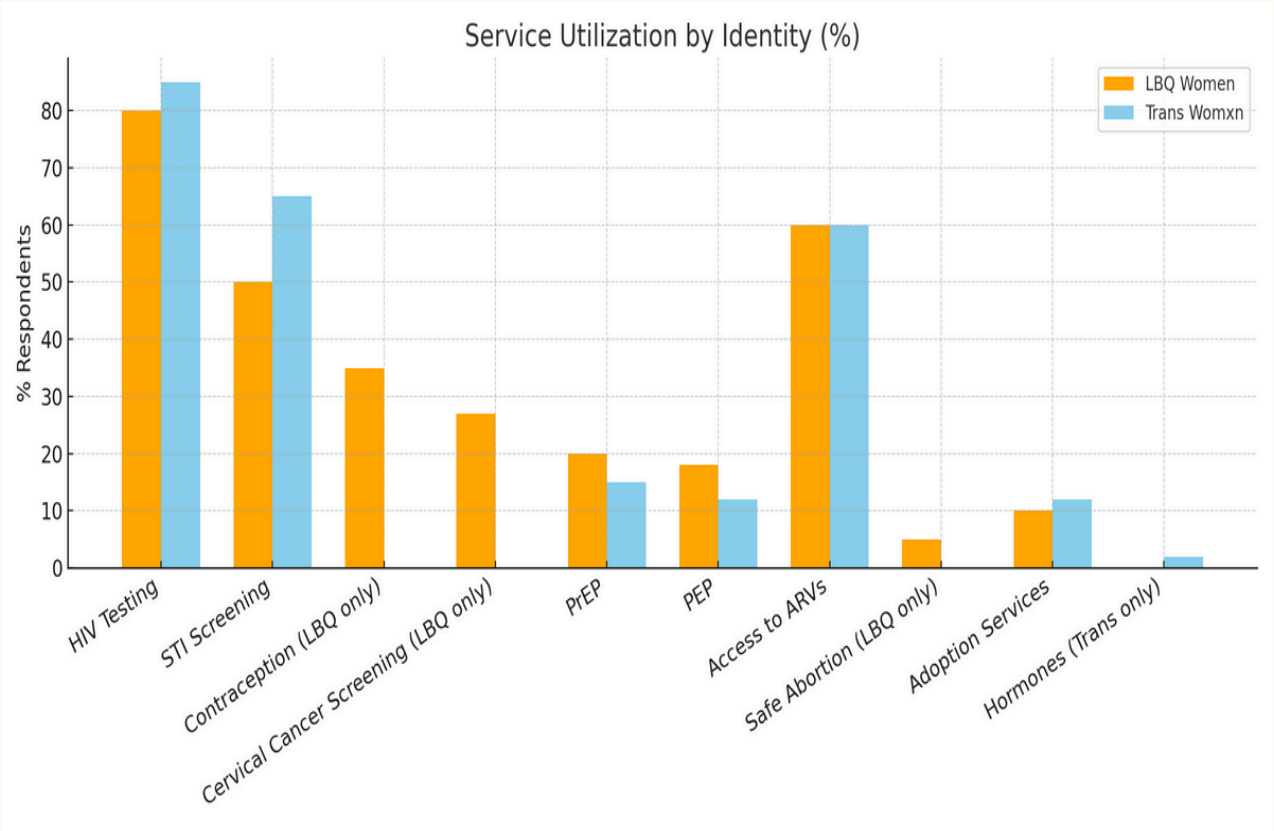
However, fewer participants reported accessing other essential services. About half (50%) had sought STI screening or treatment, while only 30–35% had ever used modern contraceptives, often noting that these were framed as irrelevant to them or not freely offered. A very small minority around 5% had attended antenatal or maternal health clinics, as most were not planning pregnancies and reported facing hostility when attempting to access such services. Cervical cancer screening (pap smears) and preventive check-ups were extremely rare, with less than 27% of respondents ever having accessed them. Safe abortion services were reported by only 5% of participants, despite many acknowledging the need. Legal restrictions, stigma, and lack of accurate information made abortion almost inaccessible particularly for LBQ women, who often faced invisibility within mainstream reproductive services.

For trans women, access to hormone therapy and gender-affirming care remained a critical but unmet need. While demand was very high, fewer than 2% reported ever accessing hormones through safe or formal medical channels, forcing many to rely on unsafe or underground networks. In contrast, LBQ women did not report hormone use as a service need but instead highlighted adoption services as a major area of exclusion. Only about 10% had attempted to pursue adoption, and most faced rejection on the basis of sexual orientation.

Overall, these utilization patterns reveal a stark imbalance,while HIV-related services (testing and ARVs) are relatively accessible due to targeted campaigns, most other SRHR services ,contraception, safe abortion, cervical cancer screening, adoption, and gender-affirming care remain out of reach. For many LBQ and trans womxn, SRHR continues to be perceived as "for straight married women," reinforcing systemic exclusion.

> "The nurse looked at me and said, 'You don't need family planning because you are a lesbian.' I felt so ashamed, I just left without getting any help."
>
> LBQ woman, Central Region

The chart below illustrates respondents' access to different SRHR services:



> When I went to the clinic with my partner, the health worker refused to attend to us. She called other staff and they all stared at us like we were criminals. We ran away."
>
> Bisexual woman, Eastern Region

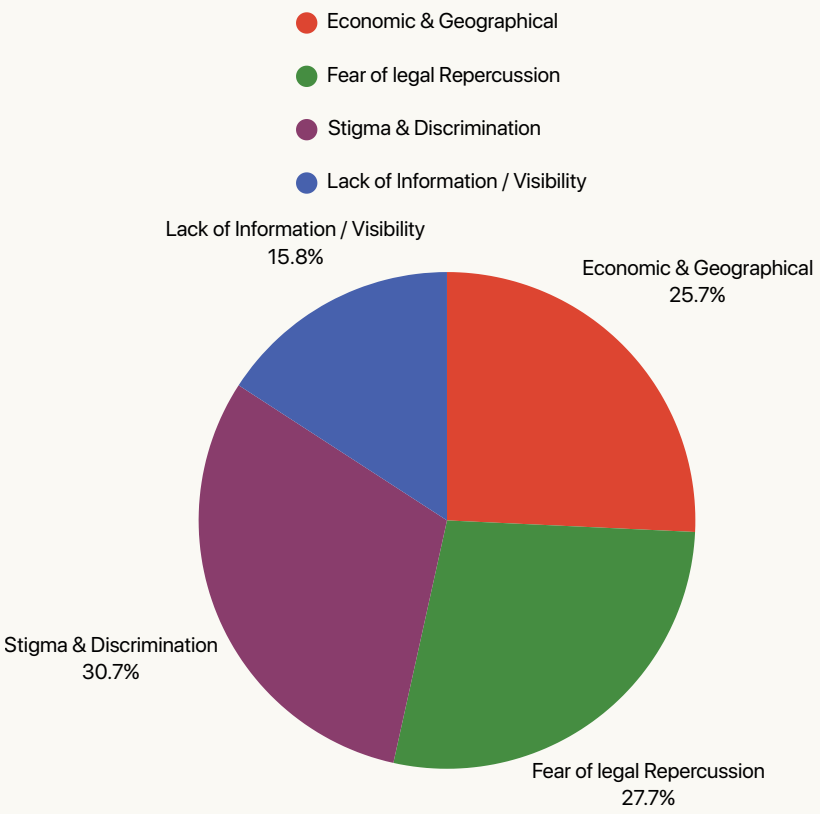
> They told me to dress like a 'proper woman' if I wanted to be seen by the doctor. I was wearing jeans and a t-shirt. What does that have to do with my health?"
>
> LBQ woman, Western Region

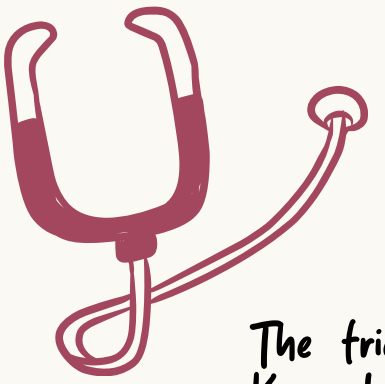
Barriers to Access

The primary findings concern barriers encountered (Figure 2). We identified five major categories:

- **Stigma and Discrimination:** Over 90% reported being treated poorly ,ignored, lectured, insulted by health workers once their sexual identity became known. Many respondents recounted being told by nurses "you don't need family planning because you are a lesbian," or being forced to dress in more "conservative" female attire to be seen.
- **Fear of Legal Repercussion:** About 80% cited fear of being arrested or reported under AHA as a deterrent. Even before 2023, participants knew of police "entrapment" operations targeting key populations; under AHA, this fear has grown. Some avoided clinics altogether, worrying that staff might call authorities.
- **Economic and Geographic Barriers:** Roughly 75% mentioned cost and distance. Most participants are poor and live in rural areas. Unlike mainstream SRH programs which provide free clinics for mothers, LBTQ services are informal when available and often far away. Travel expenses and time off work were prohibitive.
- **Lack of Information/Visibility:** About 45% of all respondents noted that even general SRHR information on contraception, HIV, GBV is never tailored to or advertised for LBQ women, so there is little awareness of specialized services like lesbian-friendly clinics or support line until connected by NGOs. One commented, "We only know about services from community DICs which is insuffient ,otherwise we don't see ourselves in health posters."

Key Barriers to SRHR Access for LBQ Women





"The friendly clinic is three hours away in Kampala. I can't afford the transport every time I need care, so I just use google to find the nearest pharmacy ."

LBQ woman, rural Western Region

"The public clinic is free but they treat us like trash The private clinic is easier but costs money we don't have. Either way, we lose."

Queer woman, Eastern Region

"I've been trying to access hormones for two years. Every hospital I go to asks for a doctor's letter, which costs money I don't have. Meanwhile, my mental health is suffering.

Trans woman, Central Region

"My HIV support group moved to WhatsApp after the AHA. It's the only place I feel safe asking health questions without fear.

LBQ woman living with HIV, Central Region

AHA Impacts and Copying Strategies

Over 80% of respondents said the Anti-Homosexuality Act (2023) has had a negative impact on their lives. Many described a dramatic shift after May 2023 where support organizations were raided, some community safe spaces closed, and health outreach virtually halted in Uganda. Several respondents noted that anonymous referrals and peer networks became essential for even basic health advice. For example, HIV support groups had moved into secure WhatsApp chats. One trans woman shared: "Before AHA, I could discreetly get hormones at a hospital I trust. Now, I am afraid to go - I order them secretly online." In this sense, the AHA has driven many services underground.

A critical coping mechanism emerging is the informal diversion of ARVs. About 15% of HIV-positive respondents admitted to selling or trading part of their antiretroviral medication to raise cash for necessities like food. For example, one participant said she had sold some of their ARVs to raise funds for essentials like food for the family. This dangerous coping strategy mirrors that corruption and extortion have increased,It highlights a tragic irony about lifesaving HIV medicine intended for patients' benefit is being repurposed as a last-resort cash resource because of poverty and criminalization.

Another case pattern was denial of gender-affirming care. Trans respondents unanimously reported that public facilities require burdensome documentation (e.g. psychiatric letters), which effectively blocks access. Some described side-effects of interrupted treatment ,physical and mental health deteriorations.This matches global findings that anti-trans stigma in healthcare leads to dire health outcomes and Self Medication.

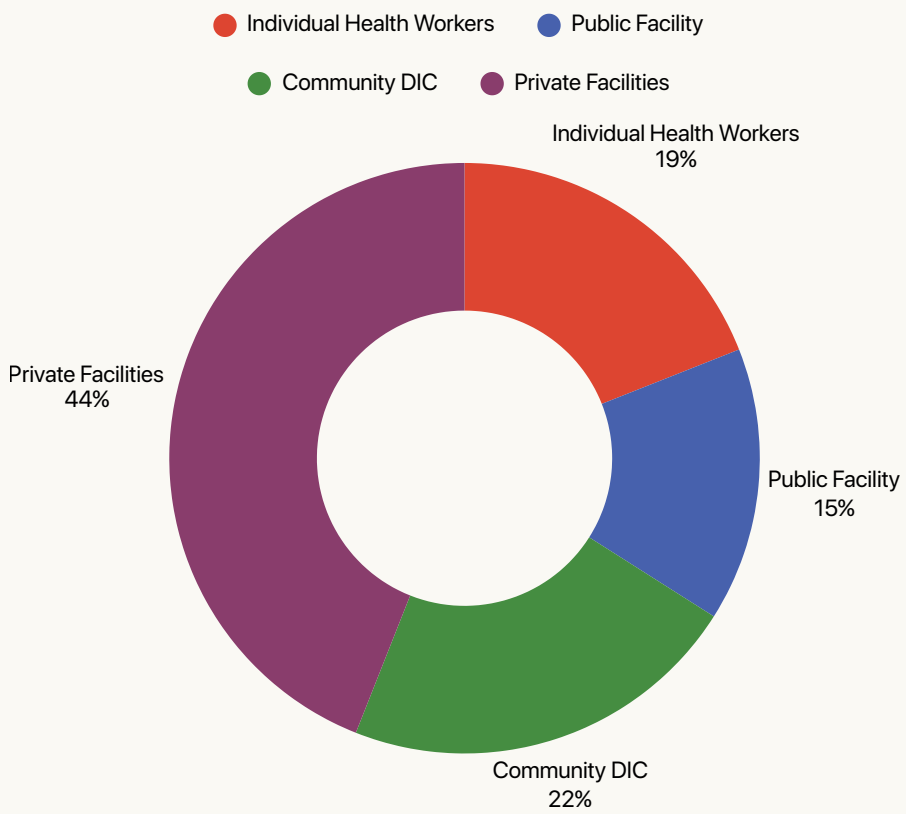
Finally, reproductive rights for LBQ womn were impeded. Several lesbian and bisexual women who sought prenatal care or tried to adopt children reported subtle or overt discrimination. Some said adoption agencies refused them outright, assuming "two mothers" were unfit by law or custom. While our sample had no recent pregnancy successes among LBQ women, interviews revealed that women do give birth but then fear parenting without any legal protections. These qualitative findings underscore the invisibility and exclusion of LBQ womxn from legal parenthood frameworks.

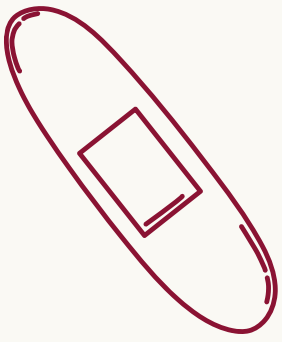
> I believe things will change. Our community is strong, and there are good people who want to help us. We just need the system to catch up.
>
> **Lesbian woman, Western Region**

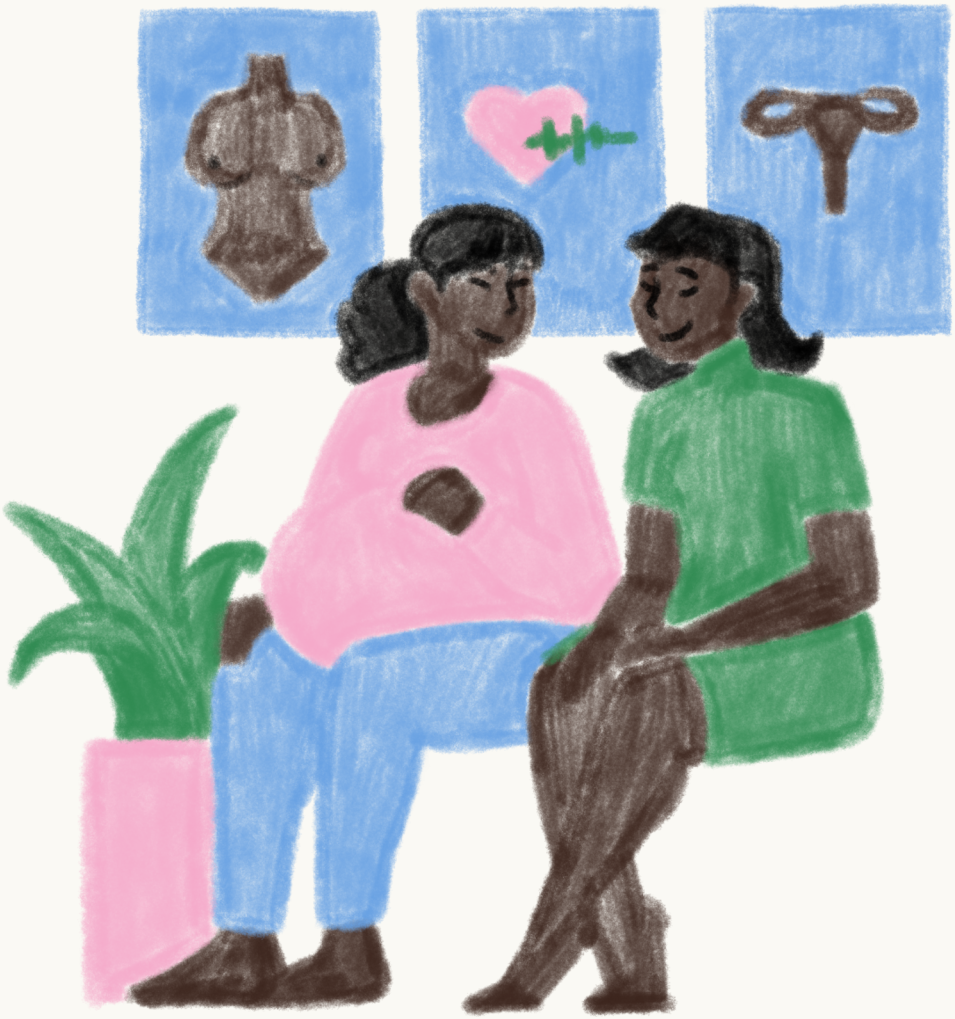
Facility Use and Service Preferences

When LBTQ womn did seek SRHR services, choice of facility was telling. Public facilities were often avoided unless absolutely necessary, due to fear of stigma. Many preferred anonymous Private facilities, NGO-run drop-in centers or peer-led clinics (where available), even if farther away. Some reported traveling to Kampala or Masaka solely for "gay-friendly" health camps. Others relied on community health workers known to be allies. Notably, none reported trusting routine general hospitals. This indicates that improving SRHR access will require both de-stigmatizing public services and bolstering civil society outreach.

Facility Use and Service Preferences for LBQ Women







Summary of Key Findings

In sum, the data show that LBTQ womxn in Uganda:

- Have significant SRHR needs (HIV prevention/treatment, GBV support, reproductive health) but low utilization of mainstream services.
- Face pervasive stigma and legal fear at healthcare sites, intensified by AHA, leading many to avoid formal systems.
- Lack crucial supplies (hormones, female condoms, safe abortion) due to both policy (criminalizing "promotion) and market scarcity.
- Sometimes resort to dangerous coping (selling ARVs, underground medicine networks/Self Medication) in the absence of supportive care.
- Rely heavily on community networks and key-population clinics when seeking care, underscoring the importance of community-led solutions.

Risk Matrix

The following risk matrix uses color coding to indicate severity:
Red = Severe Risk, **Orange** = High Risk, **Yellow** = Medium Risk, **Green** = Low Risk.

Risk	Likelihood	Impact	Risk Rating	Mitigation Strategy
Legal restrictions under AHA limiting access to SRHR services	High	High	Severe	Engage international partners and use discreet community-led service delivery.
Stigma and discrimination by healthcare providers	High	Medium	High	Train friendly health workers, develop safe referral pathways.
Lack of funding for inclusive SRHR programs	Medium	High	High	Diversify funding sources and leverage regional/international commitments.
Safety concerns for LBTQ womxn in rural communities	Medium	High	High	Create safe spaces, integrate digital platforms for SRHR education.
Limited availability of hormones and gender-affirming care	High	Medium	High	Advocate for policy reform and establish safe underground supply networks.
Community backlash from anti-gender movements	Medium	High	High	Strengthen community sensitization and allyship with progressive local leaders.

Conclusion & Recommendations

Recommendations

Based on the findings, we offer the following recommendations at various levels:

Policy/Legal:

- *Repeal AHA Provisions:* Advocate for removal of provisions criminalizing consensual same-sex behavior and "promotion" of LGBT identity.
- *Enact Anti-Discrimination Protections:* Introduce legislation (or Cabinet directives) explicitly prohibiting discrimination by health providers on grounds of sexual orientation or gender identity.
- *Incorporate LBTQ Needs in National Health Policy:* Update Uganda's SRHR policy to recognize LBTQ womxn as a vulnerable group with tailored provisions (e.g. priority access to female condoms and safe abortion care).
- *Ratify/Implement International Commitments:* Fully align national law with Maputo Protocol and CEDAW by issuing clear guidelines that SRHR services must be non-discriminatory for all women, including LBQ and trans women.

Health Programs and Facilities:

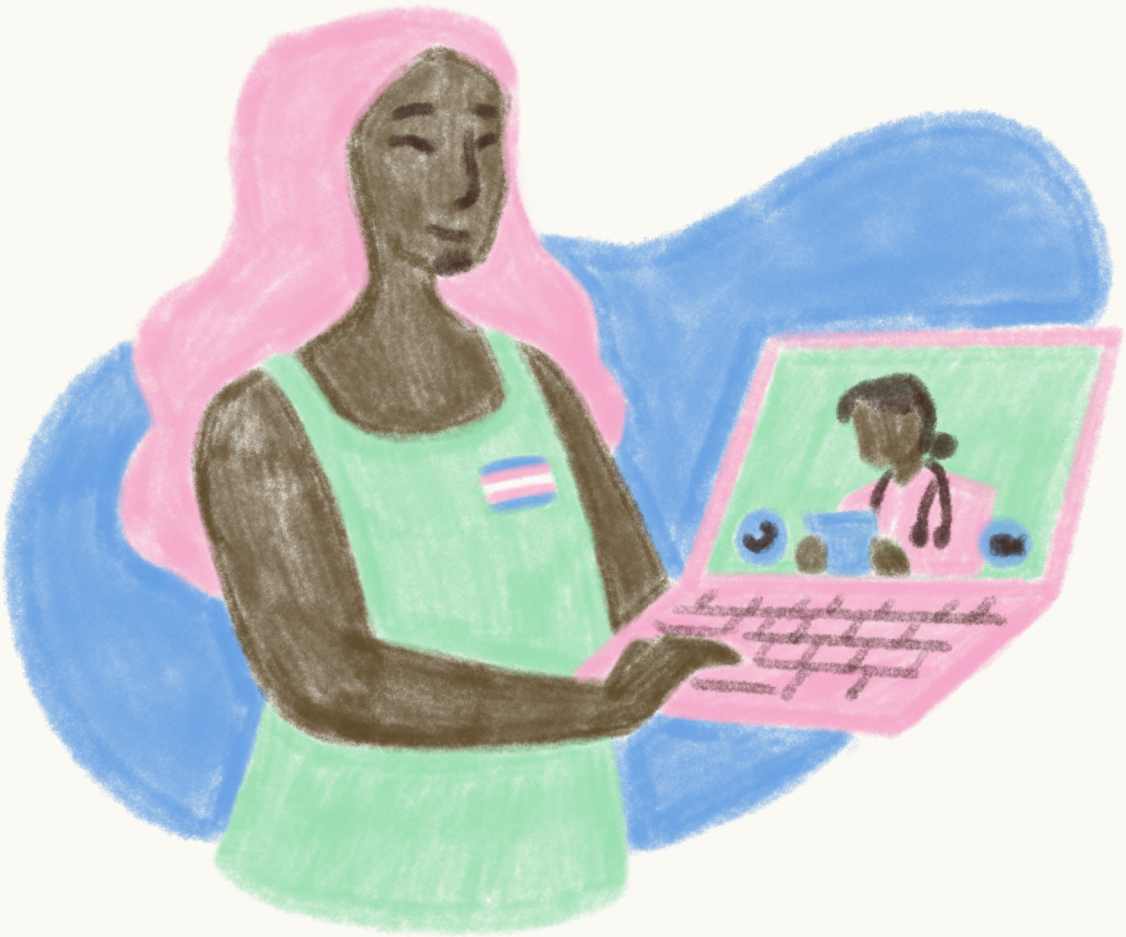
- *Training for Providers:* Develop and mandate sensitization training for all healthcare workers on LBTQ issues and respectful care.
- *Key Population Services:* Fund and scale up community-based clinics (DICs) that provide integrated SRHR (HIV, STI, mental health, gender-affirming care) for LBTQ womxn. Ensure these clinics are widely known (e.g. via discreet networks) and supported to operate safely.
- *Mobile/Outreach Services:* Use mobile clinics and outreach teams to reach rural areas. Teams should include trained peers who can communicate confidentially and refer clients. Focus services on hormone provision for trans women and cervical cancer screening and other SRH services for LBTQ womn.
- *Supply of Commodities:* Ensure SRHR commodity planning includes needs of LBTQ womxn e.g. stock of female condoms, lubricants, and gender-neutral menstrual products. Abortion care (post-abortion and safe abortion) must be available without bias.

Community/Advocacy:

- *Empower LBTQ Organizations:* Support groups to document cases, conduct peer education, and hold governments accountable. Build their capacity for legal aid to challenge discrimination and health outreach.
- *Public Awareness Campaigns:* Engage media and faith leaders where possible to counter myths about LBTQ persons. Highlight messages of health rights and solidarity. Community dialogues can reduce stigma at the local level.
- *Psychosocial Support:* Fund programs addressing mental health and GBV for LBTQ womxn, since social ostracism and violence have increased. Peer support lines and survivor networks are urgently needed.

Donor/International:

- *Enforce Non-Discrimination Clauses:* Donors (Global Fund, PEPFAR, UN agencies) should insist on conditionality that SRHR funding be inclusive. For example, grant agreements can require services to key populations without interruption, even if laws change.
- *Flexible Funding Mechanisms:* Given the hostile environment, donors should allow funds to flow through trusted local NGOs and civil society rather than government channels alone. This ensures continuity of care if formal systems become restricted.
- *Support Strategic Litigation and Research:* Allocate resources for legal challenges to rights-violating laws and for ongoing data collection on LBTQ health. High-quality research (like this study) must continue to inform policy, and should be indexed and disseminated widely.
- *Regional Collaboration:* Work with East African community health initiatives to promote a unified stance on inclusivity in SRHR. Share best practices from other countries where possible.

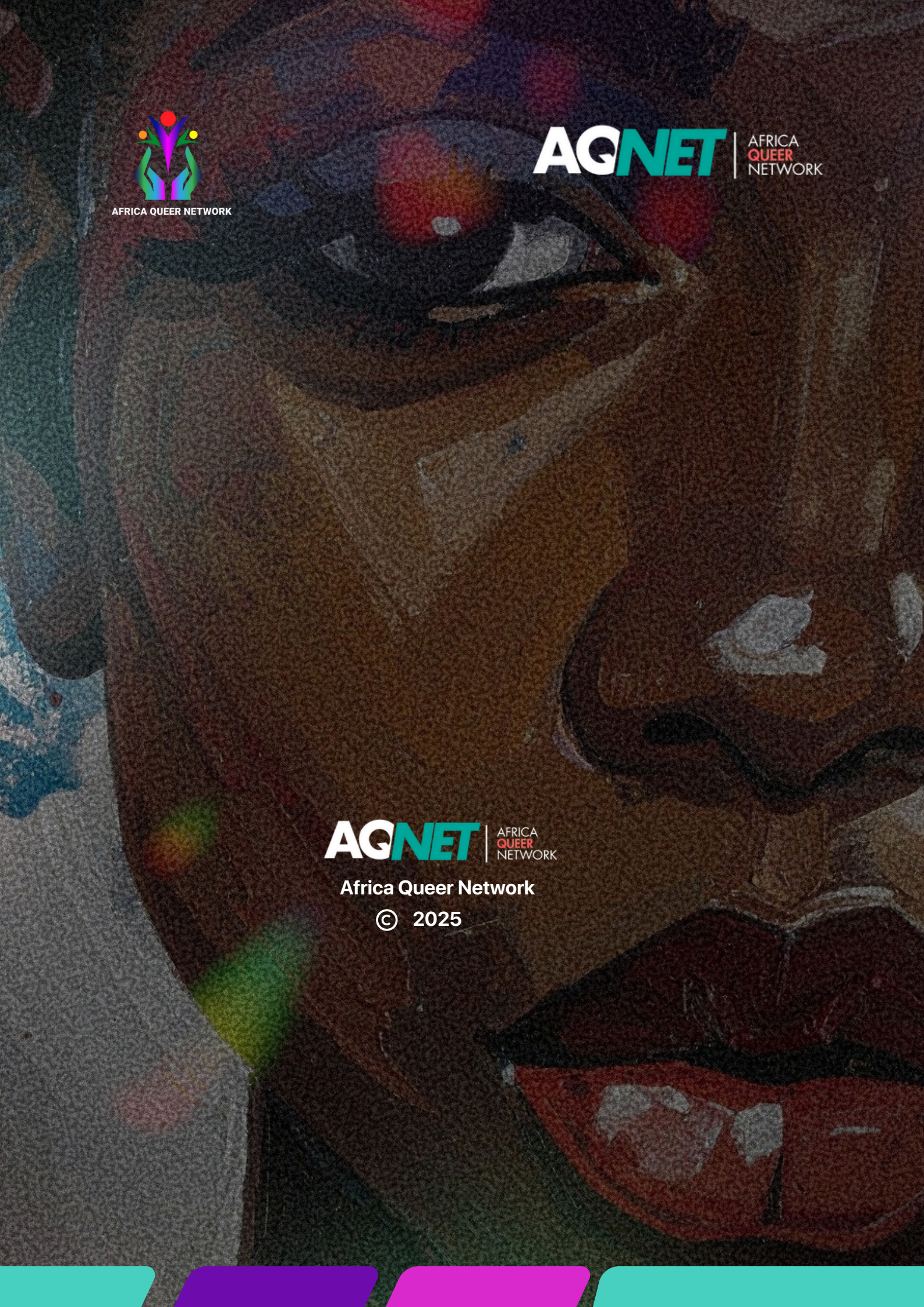


Conclusion

This research corroborates and extends the emerging consensus that LBTQ womxn in Uganda are systematically denied their sexual and reproductive health rights. Despite Uganda's commitments to health equity, LBTQ womn experience multi-layered discrimination from legal barriers and violent rhetoric at the top, to individual bias from providers at the clinic level. The 2023 AHA has exacerbated an already dire situation, driving services underground and increasing isolation. Key conclusions include:

- SRHR Services Reach Very Few LBTQ Womxn**:** Except for HIV testing, most routine services like contraceptive counselling, maternal care, GBV support,Safe Abortion are not reaching LBQ women in rural areas.
- Stigma and Criminalization Are the Overriding Obstacles: Fear of being reported under AHA and facing provider hostility are top reasons LBTQ womxn avoid or delay care. Even where services exist, they are often physically or culturally inaccessible.
- Community Networks Are Lifelines**:** In the absence of inclusive public care, LBTQ womxn depend on peer groups, informal referrals, and Drop In Centers. These networks are fragile and underfunded, making the community itself vulnerable.
- Human Rights Frameworks Are Unmet: Uganda's own laws and international agreements obligate it to protect SRHR for all. This duty bears against a backdrop of violations (see risk of violence, eviction, extortion) that threaten LBTQ womxn's dignity and health.

Overall, the study underscores the urgent need for rights-based, inclusive policy and program responses. Health is a human right, and LBTQ womxn just like all Ugandans must be able to seek care without fear of arrest or abuse. Ignoring the community undermines the whole health system and humanity's shared commitment to ending HIV and ensuring gender equality.



Africa Queer Network