ASSESSING ACCESS TO SRHR SERVICES FOR LBQ WOMXN ACROSS MULTIPLE DISTRICT CONTEXTS IN UGANDA

Community Voices.
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Executive Summary

Lesbian, bisexual, and queer (LBQ) womxn in Uganda continue to face persistent structural, social, and institutional barriers in accessing sexual and reproductive health and rights (SRHR) services. Despite the formal availability of essential health services in many facilities, discrimination, stigma, confidentiality concerns, and fear of legal and social repercussions frequently prevent LBQ womxn from safely utilising care. The current legal and sociopolitical environment, including the 2023 Anti-Homosexuality Act, further compounds these barriers by reinforcing fear of exposure, harassment, and arrest. As a result, many LBQ womxn delay or avoid seeking services even when those services are technically available.

This report presents findings from an LBQ-inclusive SRHR assessment conducted across nine districts in Uganda. The study employed a cross-sectional survey design and triangulated two complementary datasets: health facility assessments from 89 service providers and community-based surveys from 90 LBQ womxn, drawn from four regions across the country from 9 districts namely; Kampala, Wakiso, Jinja, Mbale, Lira, Gulu, Masaka, Mbarara, and Kasese.

The dual-perspective approach enabled comparison between reported service availability and lived experiences, allowing the assessment to move beyond infrastructure indicators to examine service quality, inclusivity, safety, and trust.

Findings show that core SRH services including STI screening, HIV testing and treatment, contraception, and GBV and mental health support are widely available across facilities, with most providers reporting readiness to deliver comprehensive care. Access to SRHR information and education was also relatively strong, with the majority of LBQ respondents reporting access to clear and accurate information. However, substantial gaps remain in inclusive service delivery. Over half of LBQ womxn reported experiencing stigma or discrimination from health providers, and many expressed concerns about confidentiality and unsafe disclosure. Financial and logistical barriers further constrained access, with nearly half reporting affordability challenges. Notably, more than two-thirds indicated they had avoided seeking care due to fear of outing, harassment, or legal risks.These findings reveal a critical disconnect between service availability and service utilisation. While structural readiness exists in many facilities, interpersonal discrimination, weak accountability mechanisms, and broader legal and community-level stigma undermine trust in the health system. Psychosocial and GBV services, though widely reported as available, are underutilised due to concerns about safety and confidentiality. Similarly, limited collaboration between facilities and LBQ-led organisations constrains outreach, referrals, and accountability.

The assessment highlights the need to move beyond counting services toward improving how services are delivered. Strengthening provider training, enforcing confidentiality safeguards, ensuring consistent commodity availability, creating safe and affirming environments, and deepening partnerships with community organisations are essential to making SRHR services truly accessible for LBQ womxn.

Ultimately, equitable access to SRHR for LBQ womxn requires not only functional health systems but also inclusive, respectful, and rights-affirming care environments. Cantering community voices in monitoring and accountability processes is critical to ensuring that services translate into meaningful health outcomes.

This report not only intended to document gaps in SRHR service delivery but also to advance community led monitoring, advocacy and service improvement for LBQ womxn in Uganda. First, it grounds assessment in lived experiences of LBQ womxn alongside facility level experience ensuring that accountability is informed by community realities rather than provider reporting alone. Second, it generates practical evidence for advocacy with health facilities, district actors, and national stakeholders on the changes needed to make services safe, inclusive, and rights affirming. Third, it provides a baseline and a structured monitoring tool; a score card that can be used over time to track progress, identify barriers and support continuous service improvement. In this way this report serves as both an evidence document and a community accountability tool for strengthening equitable SRHR services for LBQ womxn in Uganda.

Acknowledgement

This assessment was made possible through the collaboration, trust, and commitment of various individuals and organisations.

We extend our deepest gratitude to the LBQ womxn who courageously shared their experiences, insights, and recommendations. Your voices are central to this report and to the ongoing work of improving SRHR services. In a context where visibility and participation can carry personal risk, your willingness to contribute reflects both resilience and leadership within the community.

We sincerely thank the health service providers and facility staff across the participating districts for their openness, time, and engagement throughout the assessment process. Your reflections and cooperation have helped identify both strengths and areas for improvement within the health system.

We acknowledge the dedicated community data collectors, peer educators, and facilitators whose careful, ethical, and compassionate work ensured safe data collection and protected participant confidentiality. Your role was essential in reaching community members and generating reliable, meaningful data.

We also appreciate the contributions of partner organisations, networks, and advocates who supported mobilisation, coordination, and technical guidance throughout the study. Your continued commitment to advancing inclusive SRHR services strengthens accountability and drives sustainable change.

Finally, we recognise our partner AmplifyChange whose support enabled this work and reaffirmed the shared commitment to promoting equitable, dignified, and non-discriminatory healthcare for LBQ womxn.

Acronyms and Abbreviations

AIDS:	Acquired Immune Deficiency Syndrome
CME:	Continuous Medical Education
FARUG:	Freedom and Roam Uganda
GBV:	Gender Based Violence
HIV:	Human Immunodeficiency Virus
HPV:	Human papillomavirus
HRAPF:	Human Rights Awareness and Promotion Forum
IEC:	Information Education and Communication
LBQ:	Lesbian Bisexual Queer
LGBTQ:	Lesbian Gay Bisexual Transgender Queer
MCH:	Maternal Child Health
PEP:	Post Exposure Prophylaxis
PMTCT:	Prevention of Mother to Child Transmission
PreP:	Pre Exposure Prophylaxis
SOGIE:	Sexual Orientation and Gender Identity and Expression.
SRHR:	Sexual Reproductive Health Rights
STI:	Sexually Transmitted Infections

1.0 Background

Lesbian, bisexual and queer (LBQ) womxn in Uganda continue to face persistent and overlapping barriers in accessing sexual and reproductive health rights services. Within health facilities discrimination and stigma frequently manifest through verbal harassment, dismissive treatment and differential care once providers suspect or learn of a client's sexual orientation (FARUG, 2025). Health workers consistently insult, neglect and extend hostile attitudes toward LBQ womxn clients seeking SRHR services. Concerns about confidentiality further undermine trust in the healthcare system as breaches of privacy, including discussing cases of LBQ clients publicly, or exposing their personal information have been reported. These have discouraged disclosure and open communication with health service providers (FARUG, 2025).

Uganda's restrictive legal environment, particularly the Anti-Homosexuality Act 2023, has heightened fear of surveillance, arrest and violence reinforcing discrimination and directly deterring LBQ womxn from seeking healthcare services (Human Rights Watch, 2024). Evidence from broader key population health research in Uganda also shows that stigma and discrimination are strongly associated with avoidance of healthcare services with many LBQ womxn delaying or foregoing care altogether (Frontline AIDS, 2020). Provider related barriers including lack of competence in addressing diverse LBQ sexual health needs, discomfort in discussing same sex practices, fear of judgement further inhibit timely SRHR service utilization with studies documenting reluctance among sexual minorities to report symptoms or seek treatment due to fear of health workers (Ssekamatte, et.al,2020).

Legal and policy frameworks affecting LBQ womxn similarly contribute to health services exclusion by legitimising discrimination and limiting equitable access to healthcare (HRAPF, 2017).

Together these interpersonal, institutional, and structural barriers create a climate in which LBQ womxn may technically have services available but remain unable or unwilling to access them safely, underscoring the need for targeted, inclusive and accountability driven approaches to SRHR service delivery.

2.0 Introduction

Ensuring equitable access to SRHR services requires more than the physical presence of health facilities or the nominal availability of clinical services. For LBQ womxn, meaningful access depends on whether services are safe, respectful, confidential, affordable and responsive to their lived realities. Conventional health system assessments often measure infrastructure, staffing and commodities but fail to capture client experience, dignity, safety; factors that strongly determine whether services are actually utilized.

To address this gap, this study applied a dual perspective approach that combines health service provider data with LBQ womxn community experience data. By triangulating data collected from health facilities with lived experiences of LBQ womxn community members, the assessment moved beyond availability to examine quality, inclusivity and trust. This approach recognizes that community voices are essential in validating or challenging institutional claims about service provision.

This report presents findings from a comprehensive LBQ SRHR assessment conducted across selected health facilities and surrounding LBQ communities. It analyses both structural readiness and client experiences, identifies gaps between policy and practice and provides actionable recommendations to strengthen inclusive SRHR service delivery. The ultimate aim is to support evidence-based advocacy service delivery, inform service improvements and promote accountability within health systems so that LBQ womxn can access healthcare without fear, stigma or discrimination.

3.0 Methodology

3.1 Study Design

The assessment employed a cross-sectional survey design. The approach combined surveys from the health facility providers and LBQ womxn to provide a comprehensive understanding of both service availability and quality, and utilization as well. This triangulation of sources of data enabled validation of findings and strengthened the reliability of conclusions.

3.2 Data Sources and Sample

Two complementary datasets were collected. The first consisted of responses from 89 health service providers from 9 health facilities namely Kampala, Wakiso, Lira, Gulu, Masaka, Mbarara, Kasese, Jinja and Mbale. The health facilities included both public and privately owned health facilities. The survey assessed the availability of SRHR services including STI screening, HIV services, contraception, mental health, gender-based violence response, maternal healthcare, provider training and facility systems related to confidentiality, inclusivity and referrals.

The second dataset consisted of community members responses that were collected from 90 LBQ womxn across 9 districts. The responses gathered were about their lived experiences including affordability, flexible hours, respectful treatment, confidentiality, disclosure safety, stigma and discrimination, access to information and avoidance of care due to fear or avoidance of legal risks.

Together these two datasets enabled a direct comparison between what facilities reported providing and what community members experienced when seeking SRHR care.

3.3 Data Collection

Data was collected through structured questionnaires administered by community data collectors to health service providers and LBQ womxn. Data collectors received training on the project, ethical considerations including informed consent, confidentiality, and do no harm, particularly given the sensitive nature of sexual orientation and health information. No personally identifying information was recorded so as to protect participant safety.

LBQ womxn who participated in the research as respondents were selected from trusted LGBTQ+ networks and community organisations to ensure safety and minimize risk of exposure.

3.4 Data Analysis

Data that was gathered from surveys was analysed descriptively, to produce percentages and frequencies that were used to summarize patterns of service availability, accessibility, and client experiences across health facilities and communities. Results were synthesised across both datasets to identify convergences and divergences between facility reports and community reported experiences allowing for triangulation of findings and a more comprehensive understanding of quality, inclusivity and effectiveness of services.

3.5 Ethical considerations

Given the restrictive legal and social context affecting LBQ womxn in Uganda, ethical safeguards focused on minimizing risk of exposure, distress and unintended harm to both participants and data collectors. The study prioritized anonymity, confidentiality, and voluntary participation throughout the research process. Interviews were conducted in safe and discreet settings and audio recording was not permitted in order to limit the risk of identification or data misuse. Informed consent was obtained prior to participation and participants were informed of the purpose of the study, the voluntary basis of involvement. Data collectors who were LBQ womxn received training on research objectives, tools and informed consent procedures, confidentiality, ethical conduct and risk sensitive data collection. These measures were intended to ensure that fieldwork was carried out in a manner that was context aware, respectful and protective of all those involved.

3.7 Study Limitations

While this assessment provides important insights into the accessibility, quality and inclusivity of SRHR services for LBQ womxn in Uganda, several limitations should be considered when interpreting results.

First, health facility data that was gathered reflects what providers reported rather than independently verifying services provided. As a result, there is potential for reporting bias, overestimation of service availability or compliance with inclusive practices. Similarly, community experiences were based on personal experiences and perceptions which may be influenced by individual encounters, recall bias or expectations. Although triangulation between the two datasets helps mitigate this limitation, discrepancies between reported availability and lived experiences may persist.

Second, this cross-sectional assessment provides a picture of service readiness and community experiences at the time of data collection. As with most snapshot surveys, it does not capture how service availability or quality may shift over time due to staff turnover, stock-outs, funding cycles, or evolving sociopolitical conditions. The findings should therefore be interpreted as a baseline for monitoring and quality improvement, rather than as evidence of long-term trends.

Third, community respondents were selected and invited through trusted LBQ networks and community-based approaches to minimise risk and protect confidentiality in a context where disclosure can carry serious consequences. While this strategy strengthened ethical practice and facilitated participation from a hard-to-reach population, it may have preferentially reached individuals who are more connected to support structures. As a result, the experiences of more isolated LBQ womxn who may face equal or greater barriers may be underrepresented. To mitigate this, the assessment included respondents across multiple districts and triangulated community findings with facility-reported data to strengthen interpretive confidence.

Fourth, fear, stigma and legal risks in the Uganda context may have influenced participation and disclosure. Some individuals may have declined to participate or withheld information because of confidentiality or safety concerns. This could result in under-reporting of experiences such as discrimination, violence or avoidance of care. Similarly, health facility staff may have moderated their responses to present services more positively.

Finally, because the assessment focuses primarily on selected facilities and districts, findings may not be generalisable to all regions or health systems in Uganda. Variations in local governance, resources, and community engagement may produce different outcomes elsewhere.

Despite these limitations, the combined use of facility assessments, community experiences, and triangulation strengthens the credibility of the findings. The community-led monitoring approach, in particular, ensures that the voices of LBQ womxn remain central to evaluating service quality, offering a more grounded and actionable understanding of barriers and opportunities for improvement.

4.0 Findings

These findings were analysed from surveys conducted with 89 health providers from 9 health facilities and 90 LBQ womxn. Respondents were drawn from four regions across the country from 9 districts namely; Kampala, Wakiso, Jinja, Mbale, Lira, Gulu, Masaka, Mbarara, and Kasese.

The findings also informed the development of a score card conceived as a strategic tool to generate actionable data for advocacy and service improvement for inclusive and affirming SRHR services for LBQ womxn.

4.1 Core SRH Service Availability

Findings from health facility surveys indicate that core SRHR services are widely available across assessed health facilities. Nearly all health facilities 99.2% reported offering SRHR services and 100% indicated that they provide screening, prevention and treatment for sexually transmitted infections (STIs). HIV related services were similarly strong with 97.5% offering HIV counselling and testing, 94.2% providing antiretroviral therapy, 99.2% offering PreP, and 95.0% offering PEP. In addition, 94.1% reported offering services of distributing condoms and lubricants, and 72.9% reported availability of information on HIV/AIDS customized for LBQ womxn.

4.1.1 Availability of Birth Control and Contraceptive Services

Health providers also reported relatively high availability of birth control and contraceptive services across health facilities. Approximately 94% indicated that their facilities offer some form of contraception including (73%) providing Long-acting reversible contraceptives, (89.8%) offering short-acting hormonal methods, and (95%) providing barrier methods such as condoms, diaphragms, sponge, cervical cap. In addition, 68%% reported having information on birth control and contraceptive use customised for LBQ womxn and this varied across districts. Jinja recorded the highest reported availability, with 100.0% of facilities indicating that such information was available. High levels were also reported in Lira, Masaka, and Mbale, with 80.0% of facilities, and in Kasese where 72.7% reported availability. Kampala also showed a majority positive response, with 67.4% of facilities indicating availability. Lower levels were observed in Mbarara and Wakiso, where only 50.0% of facilities reported availability. Gulu had the lowest reported availability, with only 20.0% of facilities indicating that customised information on birth control and contraceptive use for LBQ womxn was available, compared to 80.0% reporting that it was not. These findings suggest that contraception is largely integrated into routine SRHR service packages and benefits from longstanding national prioritisation, commodity supply chains and donor supported family planning programs which most likely explains the relatively high coverage. The only birth control method with notably low availability was permanent contraception with female and male sterilization reported by about 36.4% health service providers.

In contrast, substantially lower availability was reported for Maternal child health (MCH) services specifically tailored for LBQ womxn. Only 52% reported providing antenatal services for LBQ womxn, 69% reported PMTCT (Prevention of Mother to Child Transmission) services, 46% reported delivery services, 55% reported Post natal services,50% reported Post Abortion care services for LBQ womxn. Availability of information on maternal health customised for LBQ womxn varied considerably across districts. The highest reported availability was recorded in Masaka and Mbale, where 80.0% of facilities indicated that such information was available. Jinja also reported relatively high availability at 77.8%, followed by Lira at 63.6%. In Mbarara and Wakiso, responses were evenly split, with 50.0% of facilities reporting availability. Kampala showed slightly lower availability, with 47.8% of facilities reporting that customized maternal health information for LBQ womxn was available, compared to 52.2% reporting that it was not. The lowest levels were observed in Kasese, where only 30.0% of facilities reported availability, and in Gulu, where just 20.0% reported that such information was available, compared to 80.0% reporting that it was not.

These lower rates may stem from structural and social factors. MCH services are often designed within heteronormative frameworks that assume heterosexual relationships and traditional family structures resulting in limited provider preparedness to address the needs of LBQ womxn who may be pregnant or parenting (Mkhize, Sthembiso Pollen, 2023). In addition, stigma, lack of provider training on inclusive maternal care and assumptions that LBQ womxn are unlikely to require pregnancy related services may reduce intentional service tailoring (Bushe S, Romero, 2017). Therefore, maternal health services for LBQ womxn remain less visible and less systematically addressed reflecting persistent gaps in inclusivity, provider awareness and service design.

4.1.2 Availability of Cancer- Related Services

Regarding cancer services including prevention, vaccination and treatment, findings indicate generally strong availability across health facilities. Approximately 90.7% of health providers reported their health facilities offer some of the cancer related services. Specific services included breast cancer examination (82.2%), Human papillomavirus (HPV) screening (93.2%), HPV vaccination (67.8%). In addition, (67.8%) of health providers reported availability of cancer related information tailored for LBQ clients.

However, availability of this information varied across districts. The highest reported availability was recorded in Jinja, where 88.9% of facilities indicated that such information was available. Relatively high levels were also reported in Masaka at 81.8% and Lira at 80.0%. In Kasese and Mbale, 70.0% of facilities reported that customised cancer related information for LBQ people was available. Kampala also recorded a majority positive response, with 67.4% of facilities reporting availability, although 30.4% reported that such information was not available. Lower levels were observed in Mbarara and Wakiso, where only 50.0% of facilities reported availability. Gulu had the lowest reported availability, with only 30.0% of facilities indicating that cancer related information customised for LBQ people was available, compared to 70.0% reporting that it was not.

These figures suggest that most health facilities are technically equipped to deliver core cancer prevention and early detection services as part of comprehensive SRH care. However notable gaps remain in specialised and less routinely prioritised services. Over half of the providers (54.2%) reported not offering anal cancer screening (54.2%), and an even larger proportion (72%) reported that lung cancer screening was unavailable. These lower proportions may reflect several factors, such as limited diagnostic equipment, resource constraints, gaps in provider awareness or training, prioritization of more common cancers such as breast cancer and cervical cancer within national SRH programming. In addition, anal cancer screening is not often integrated into standard SRH service packages and may be overlooked despite its relevance to sexual minority populations, while lung cancer screening requires more advanced technologies and equipment that may not be accessible in primary or lower-level healthcare facilities (Newman, Peter A et al, 2008).

4.1.3 Availability and Access to SRH Information and Education

Access to SRH information and education emerged as a relative area of strength compared to the aforementioned domains. A large majority of LBQ respondents (89.2%) reported access to clear and accurate information on SRHR services, particularly regarding STIs, contraception, mental health, and reproductive health, and 78.6% felt that available information was not LBQ affirming. In Uganda, general SRH information is commonly available at health facilities specifically focussing on the areas reflected in the Ministry of Health guidelines and standards on SRHR services not information specifically designed to be affirming, inclusive, and relevant for LBQ womxn. However, LBQ affirming SRH information appears to be far more limited, uneven and often not formally institutionalised as available evidence points to gaps in inclusive and affirming language, the absence of materials that explicitly reflect lesbian, bisexual, queer, diverse experiences(FARUG,2025). Where LBQ affirming SRH information and education was mentioned to be available these were private health facilities and DICs, and it included provider counselling delivered in a respectful way, informal guidance from sensitised providers, or materials introduced through community based organisations and peer networks rather than standard government health education materials.

Additionally, where SRH information and education may be available, persistent barriers in other areas including stigma, confidentiality concerns, affordability challenges, and fear of discrimination continue to limit the translation of knowledge and information into actual service uptake for LBQ womxn as revealed by the findings. In other words, awareness alone does not guarantee utilisation. While many LBQ womxn know where and how to access services, concerns about safety, provider attitudes, and privacy often discourage them from acting on that knowledge. This highlights an important disconnect between information access and effective healthcare access, underscoring the need for health systems to pair education efforts with improvements in respectful, inclusive, and confidential service delivery.

4.2 Respectful and Non-discriminatory and Safe SRH Care Delivery

Community responses reveal mixed experiences regarding respectful and non-discriminatory healthcare. While a majority of respondents (77.6%) reported being treated with respect and dignity during visits, nearly one in three respondents did not consistently experience respectful care. Only 63.2% felt that providers asked questions relevant to their SRH needs without judgement and these were mostly health service providers from private health facilities and DICs for queer communities that participated in the research. More concerning, 56.4%, reported experiencing stigma, discrimination or harmful comments from health workers linked to their sexual orientation or gender expression.

Regarding inclusive communication and provider competence there was reported inconsistency as 58.1% LBQ womxn who responded to the survey reported that providers used LBQ-inclusive language and avoided heteronormative assumptions. Responses from the health facility survey suggested a degree of facility readiness to support the use of inclusive language and communication for LBQ womxn. A total of 87.5% of respondents reported that their health facilities have policies that protect clients from discrimination while 75.8% indicated that visible signs and materials promoting non-discrimination, confidentiality and inclusivity, were present. However these measures appeared to be framed for the general public and do not specifically target LBQ womxn needs.

Additionally, health facility reports may suggest readiness, however lived experiences of LBQ womxn indicate that inclusive practices are not yet standardized as some described encounters characterised by judgement, ridicule, or outright hostility from some health providers.
One respondent shared: *"Why don't you marry rather than being lesbian and you come here to waste my time"* Another explained: *"Why do you choose that kind of life, What do you enjoy about being a lesbian", while another recalled being asked "Why do you dress like that? Why are you still doing those homosexual things? That's why you are getting these diseases? Now your mum thinks she has a child, see what you are doing." Another masculine presenting LBQ womxn reported being questioned about her identity and eligibility for care with remarks such as "You say you want these services but are you even a woman; How can you be with a fellow woman? What do you gain from it and how do you satisfy yourself. ? " and another respondent also mentioned: "At one private health facility where I went to check for HIV and Pregnancy, there was this doctor who made a comment "You lesbian where did you get this pregnancy?"* Another respondent *described encountering outright denial of care: "Are you a lesbian, I hope you are not because they are the ones who dress like that and you would be cute but you look like one. Don't even give her medicine, this hospital is not for lesbians." while others noted health workers avoiding them and neglecting them "The health workers ask us to wait for our people (the peers) to handle us meaning they don't have the time to handle our cases".*
Together these accounts describe how discriminatory attitudes and behaviours within health facilities create fear, erode trust and discourage LBQ womxn from seeking essential SRH services even when those services are technically available. This inconsistency points to gaps in provider confidence, knowledge or sustained sensitization which likely contribute to the stigma and disclosure concerns noted above.

These findings indicate that discriminatory behaviours remain common within clinical interactions and undermine trust in health systems despite health facilities reporting service readiness and availability. A majority of health service providers (88.1%) reported that their health facilities have formal guidelines or protocols for delivering inclusive SRH services while 87.3% reported having policies intended to protect clients from discrimination based on sexual orientation.

A health provider working at a private health facility that participated in this survey described these safeguards noting that: *We have rules that guide us to follow if it happens, one is punished. There is a penalty, they can suspend you, be transferred or terminated. For example, One staff' was warned for insulting a Lesbian client and she was told her contract would be terminated if she did it again" and another health service provider working at a DIC mentioned "We are a team of LGBTQ members serving the community. That is the foremost requirement before hiring is done"* These responses suggest that some health facilities have established formal structures meant to promote accountability and inclusive health practices.

Despite these reported safeguards, breaches of confidentiality remain a significant concern. Approximately 22.2% of providers acknowledged that confidentiality violations had occurred within their health facilities including the disclosure of clients' sexual orientation, gender identity or HIV status. Providers described several incidents and the actions taken in response. For example one noted: *"A doctor at our health facility exposed a queer client's health details in public and their gender identity which was not professional and the doctor had to be fired" while another stated: " We had staff that revealed a lesbian client's sexuality and their HIV status and these health workers were let go after investigations because the client's privacy is key" Others describe disciplinary or corrective measures including: "the people involved were cautioned about the consequences of disclosing client information without their consent and warned seriously" and another mentioned that: "through the health facility disciplinary committee, there was mediation between the health provider and the client, and the health provider subsequently apologised" Additional accounts included: "Management intervened and the health provider was taken to the disciplinary committee and later dismissed when the funding cuts came through" while another mentioned that:"we called back the affected client who was a lesbian and counselled them and cautioned the health provider who had leaked out the information"*

Taken together these findings reveal a gap between policy and practice. While many facilities report having formal non-discrimination and confidentiality guidelines, the continued occurrence of breaches suggest that enforcement, training, and everyday practice may lag behind institutional commitments, ultimately affecting clients' safety, trust and willingness to seek care. This aligns with the finding from LBQ womxn who responded to the survey, where 56.4% reported feeling unsafe disclosing their sexual orientation or relationship status to the provider. LBQ clients may still fear exposure or judgment. The low level of disclosure safety limits providers 'ability to provide tailored, risk appropriate care and reflects persistent mistrust within service environments.

4.3 Access and Affordability of SRHR Services

Financial and logistical barriers remain significant constraints on effective access. Just 54.7% of LBQ womxn considered SRH services affordable while 41.9% reported having been denied services due to inability to pay. General poverty in Uganda among marginalized groups including LBQ individuals is compounded by targeted discrimination, making it difficult for them to afford healthcare services. Economic barriers such as direct costs (fees, transport), indirect costs (lost wages), poverty, lack of income, and underfunded health systems, disproportionately affect vulnerable groups like LBQ womxn. This is exacerbated by stigma and discrimination, hindering access to contraception, maternal care, STI treatment, and education, despite efforts to address these. These results demonstrate that cost and convenience continue to exclude a substantial portion of LBQ womxn even when services are readily available. Availability challenges intersect with stigma and fear to further reduce utilization.

Additionally, 59% indicated that health facilities offer flexible hours to accommodate LBQ womxn. This contrasts with findings from a study conducted in Kampala, Wakiso, and Mbale districts in 2020 examining access to SRH services among sexual minority groups, that found that none of the health facilities assessed had separate working days, specific operating hours, or dedicated spaces for serving LGBT persons (Jiwe,2021). This lack of tailored or confidential service arrangements limited privacy and increased the risk of exposure to stigma, discrimination, or uncomfortable encounters in waiting areas, making many LGBT clients feel unsafe and unwelcome when seeking care (Kivumbi, 2019). As a result, they avoided or delayed seeking healthcare altogether due to fear of negative treatment or being identified by others consequently, never wishing to return to such facilities for health care services. (Jiwe,2021).

Health facilities offer flexible service hours for LBQ womxn to address longstanding structural barriers and promote equitable access to SRHR services. Many LBQ individuals experience or fear discrimination, stigma, or refusal of care, and attending at quieter times or when affirming staff are available reduces exposure and the need to conceal their identity (Relief Web, 2025). Flexible options such as evening clinics or telemedicine also accommodate work and caregiving schedules while protecting the privacy of those who have not disclosed their sexual orientation to family or employers (Seretlo, Raikane J. et al., 2024). By making services more accessible, confidential, and safe, these arrangements encourage timely care-seeking, improve uptake of preventive services, and ultimately support better health outcomes.

Coupled with all the above is the fact that a big proportion of LBQ womxn (71%), reported avoiding seeking healthcare due to fear of outing, arrest, partner violence, or community harassment. Previous research is in agreement with this finding. Additionally, a substantial proportion of LBQ womxn interviewed in this survey (61.1%) reported that they do not feel safe accessing SRH services within the communities where they live despite the presence of health facilities offering these services.

A 2019 Stigma Index Survey established that 12.1% of the Ugandan participants felt afraid to seek health services because they were worried someone might learn they were gay/lesbian. Additionally, the survey revealed that some individuals from sexual minority groups were subjected to insults, stares, and uncomfortable glances from other patients who tend to look at them as different (Jiwe, 2021). Such experiences were commonly reported by individuals from sexual minority groups who have attempted to access services from public health facilities that serve the general population.

Participants cited multiple and overlapping reasons for this lack of safety, including fear of discrimination, stigma, breaches of confidentiality, forced outing, hostile community attitudes, and the broader legal environment.

Several respondents spoke directly about experiences of exclusion and mistreatment, noting, *“I don’t feel safe, because of discrimination that comes with people like us,”* while another explained that she fears her sexuality will be revealed to others. Others described previous experiences of being exposed without consent, stating, *“we were once outed by one of the community members who told people when she got drunk that we are lesbians,”* and another one added: *“I was outed by a boda boda rider who had also come to the health facility for services. I had gone to receive PrEP, and when he saw me, he said he had seen me on the street wearing a short skirt and approaching other women for sex. He made these comments while I was still in the queue, making it difficult for me to stay and receive the service. The incident also made me fearful of returning to that facility or seeking services from health facilities near my home”.*

Fear of stigma and judgment within both communities and health facilities also featured prominently as participants described scenarios that made them avoid health seeking health services. *One participant shared, ““I am in constant fear of being discriminated against and stigmatised by the community I live in because I am masculine presenting. The way I dress and express myself often exposes me to judgement, suspicion, and rejection, making it difficult for me to feel safe, access services freely, or live openly within my community” Another stated, “I rarely go to health facilities because of fear and stigma from the community and health service providers. It’s not completely safe, because I even fear disclosing my health information and sexuality to the health service providers. I can’t even go to a nearby health facility, because of this I fear that I may be outed”.*

Some participants described how community surveillance and harassment extend beyond clinical settings, and being visibly queer or known in the community further limits their mobility and safety, subsequently hindering their access to SRH services. One explained, *“Because I am sex worker, I always come late in the night and I was told by my neighbour that I am likely to bring thieves. But also because everyone around knows I am queer, I was taken to the LC because of my sexuality and they tried to evict me but I refused and I insisted on staying. I am afraid and I fear that I can be arrested any time.”.*

Legal and institutional contexts were also cited as major sources of fear. Participants referred to the Anti-Homosexuality Act 2023 and broader criminalisation, and environments that feel openly hostile noting: *"I can't go to any health facility, the AHA stresses me a lot, the laws are not supportive of our existence and people are always speculating on my sexuality because I have no kids and am-not married. The community I live in is hostile, even yesterday someone called me a lesbian, so it's not safe" And another added: "After the AHA, I cannot go to the nearby health facilities in my area, especially public hospitals. I feel safer in private hospitals. I also would not go to the nearby hospital alone unless I am accompanied by a fellow peer. I may feel safer with peer support, but being alone with a clinician does not feel safe to me."*

Taken together, these findings illustrate that feelings of unsafety are shaped not only by individual experiences within health facilities but also by broader social, community, and legal pressures that create a constant risk of exposure and discrimination. This climate of fear significantly limits health-seeking behaviour and contributes to delayed or avoided SRH care among LBQ womxn, even where services are technically available.

4.4 Availability and Accessibility of GBV -Related Services

Facility level data indicate that support for gender-based violence and mental health needs is relatively widespread with 85.0% of health providers reporting availability of GBV services and 88.3% offering mental health or substance abuse services. These services are critical given the high levels of stigma and social vulnerability experienced by LBQ womxn. These figures further suggest that most facilities have integrated GBV response and psychosocial support into their broader SRHR service packages. The widespread availability of these services likely reflects national prioritisation of GBV prevention and mental health within primary healthcare systems, as well as growing recognition of the links between violence, mental wellbeing, and reproductive health outcomes.

Despite the availability of GBV and mental health services, availability of shelter or safe spaces for GBV survivors was generally limited across districts. The highest reported availability was observed in Wakiso, where

50.0% of facilities indicated that such spaces were available, although this was based on only two facilities. Among districts with larger numbers of facilities, Kampala recorded the highest proportion, with 43.5% reporting availability, followed by Kasese at 40.0%. In Lira, 33.3% of facilities reported having shelter or safe spaces, while Gulu and Mbale each recorded 30.0%. Masaka reported lower availability at 25.0%, and Jinja reported only 11.1%. Mbarara had the lowest reported availability, with none of the facilities assessed indicating that shelter or safe spaces for GBV survivors were available. These findings suggest that dedicated safe spaces for survivors remain scarce across most districts. It is also important to note as established by this research, the shelters identified are general GBV survivor shelters and are not specifically designed for LBQ womxn.

Moreover, documentation of GBV cases against LBQ womxn was more widely reported than the availability of shelter or safe spaces, although district variations remained evident. The highest reported levels of documentation were observed in Masaka, where 91.7% of facilities indicated that such cases are documented, followed by Mbale at 90.0% and Jinja at 88.9%. Kampala also recorded a high level of documentation, with 82.6% of facilities reporting that they document GBV cases against LBQ womxn, although 15.2% reported that they do not. Documentation was also relatively high in Mbarara at 80.0%, Lira at 77.8%, and Kasese at 70.0%. The lowest reported level was in Gulu, where only 30.0% of facilities indicated that such cases are documented, compared to 70.0% reporting that they are not. In Wakiso, responses were split, with 50.0% reporting documentation and 50.0% giving a mixed response, though this was based on only two facilities.

The reported low levels of documentation in districts such as Masaka, Mbale, Jinja, and Kampala may also reflect uneven exposure to training, mentorship, and partner supported GBV programming.The marked district variation in these findings is therefore consistent with literature showing that GBV service performance in Uganda often depends on local implementation capacity rather than uniform national functionality (UBOS 2020; MGLSD, 2023). GBV programming and case documentation is strongly dependent on strong development partner presence and active supervision or better functioning local data systems are therefore more likely to document cases more consistently than districts with weaker support structures.

A further point, specific to LBQ womxn, is that documentation of GBV cases does not necessarily mean that systems are fully inclusive, safe, or tailored to sexual minority survivors. Research on LGBTQ+ health access in Uganda shows persistent gaps in capturing LGBTQ+ specific data, alongside longstanding stigma, discrimination, and fear of disclosure in health settings (VOICE Partners, 2022).. More recent evidence indicates that the Anti Homosexuality Act environment has intensified discrimination, fear, and reluctance to seek services, with community led monitoring showing stigma, rude communication, harsh language, and fear of exposure in public health facilities. Under such conditions, some facilities may record cases when survivors do present, but actual reporting and help seeking are still likely to be suppressed, selective, or inconsistently classified. The lower reporting in districts such as Gulu may therefore reflect not only weaker systems, but also under disclosure linked to hostile social and legal environments (VOICE Partners, 2022; Nsubuga et al., 2025).

Despite the reportedly low levels of GBV case documentation, the findings of this study show that fear of being outed, harassed, or subjected to further violence remains a major barrier to seeking GBV services at health facilities, with 70.9% of LBQ womxn reporting that they had avoided seeking care for safety related reasons. This suggests that available GBV services may not be perceived as safe or accessible in practice, limiting their effectiveness. Additionally, this indicates that although services exist on paper, many potential LBQ users do not perceive health facilities as safe or confidential enough to disclose sensitive experiences such as intimate partner violence, sexual assault, or mental health concerns. Fear of secondary victimisation, breaches of confidentiality, and judgmental provider attitudes may discourage LBQ survivors from reporting violence or seeking psychosocial support (Buckley, C., et.al, 2025). As a result, the practical effectiveness of GBV and mental health services is likely lower than availability statistics alone suggest.

The data therefore point to an important quality gap: psychosocial and protection services may be physically present but not fully accessible or trusted by LBQ clients. For populations that already experience stigma and criminalisation, the decision to seek help for violence or trauma requires a high degree of confidence in provider confidentiality and respect (Human Dignity Trust, 2024). Where this trust is lacking, individuals may delay or avoid care altogether, increasing the risk of untreated trauma, chronic stress, poor mental health outcomes, and continued exposure to unsafe environments.

4.5 Social Support, Collaboration, Referral Linkages and Specialized Care

Only 71.0% of health providers reported collaborating with LBQ or gender diverse organisations or networks on SRHR service provision, leaving 29.0% without such partnerships. Facilities that were not collaborating cited fear of being associated with LBQ communities, concerns about victimisation, the reluctance of community groups to operate openly, and the restrictive legal and political context in Uganda. These findings are consistent with the wider Ugandan context, where same sex relations remain criminalised and the Anti Homosexuality Act has intensified fear, surveillance, and institutional caution, even after the Constitutional Court struck down some provisions affecting health access and mandatory reporting in April 2024 (Human Dignity Trust, 2024). This helps explain why collaboration appears incomplete even where services may technically exist. In practice, formal links with community organisations are often essential because peer networks and community led structures can support accompanied referrals, build trust, document abuse, and improve accountability in service delivery (UNAIDS, 2025). Where these linkages are absent, facilities are less able to reach hidden populations and clients may have fewer safe channels for referral, complaint, or follow up.

Housing support or shelters for homeless LBQ womxn were among the least available services across all districts. Overall, only 23.7% of facilities reported that such support was available, compared to 76.3% that reported it was not. Reported availability was highest in Wakiso at 50.0%, though this was based on only two facilities, followed by Kampala at 39.1% and Kasese at 30.0%. Lower levels were reported in Gulu at 20.0%, Masaka at 16.7%, Lira at 11.1%, and Mbarara at 10.0%. No facilities in Jinja or Mbale reported having this form of support.

The very low availability of shelter support is likely explained by the fact that housing assistance requires cross sectoral investment, institutional protection, and public visibility, all of which are difficult to sustain in a hostile legal and social environment (Outright International, 2022).In contexts where LBQ womxn face eviction, family rejection, or violence, establishing and operating shelters may be particularly difficult because such services can be wrongly portrayed as supporting identities or relationships that are socially and legally contested in a context where the law itself undermines their recognition, safety, and legitimate existence(UNHCR,2021). Kampala's comparatively higher reporting may reflect the concentration of NGOs, referral actors, and urban services in the capital, rather than a broadly supportive environment.

Gender affirming care or referral was also very limited. Overall, 23.7% of facilities reported that this service or referral was available, 75.4% reported that it was not, and 0.8% gave a mixed response. Mbarara recorded the highest reported availability at 40.0%, followed by Kampala at 37.0% and Mbale at 30.0%. Lower levels were reported in Masaka at 16.7%, and in Jinja and Lira at 11.1% each. No facilities in Gulu, Kasese, or Wakiso reported the availability of gender affirming care or related referral. This uneven pattern is plausible given the specialised clinical knowledge, referral pathways, medicines, and institutional readiness required for gender affirming services. Research consistently shows that gender diverse people face barriers linked to stigma, limited provider knowledge, administrative obstacles, and lack of service availability, with these barriers particularly acute in African settings (Jessani et.al,2024). The higher reporting in a few urban or regional centres may therefore reflect the presence of specialised providers or referral knowledge rather than comprehensive district capacity (Zambezi & Viljoen, 2024).

In contrast, 74.6% of facilities reported that they had healthcare providers specially trained regarding the needs of LGBTQ individuals, 24.6% reported that they did not, and 0.8% gave a mixed response. Jinja recorded the highest proportion at 100.0%, followed by Mbale at

90.0%, Masaka at 83.3%, and Kampala at 82.6%. Lira also reported a relatively high level at 66.7%, and Mbarara reported 60.0%. Gulu and Wakiso were evenly split at 50.0%, and Kasese recorded the lowest proportion at 40.0%. The relatively higher reporting of trained providers, compared with the much lower reporting of shelters and gender affirming care, may be attributed to the fact that training is easier to deliver than establishing specialised services. Training can be introduced through short courses, NGO supported programmes, or project-based interventions without major infrastructural change. Evidence from recent studies shows that provider training improves respectful care and reduces discriminatory practices, but training on its own does not remove structural barriers such as criminalisation, fear of exposure, weak referral systems, or shortages of specialised services (GATE,2023).

Taken together, these findings indicate that district health systems appear to have greater capacity in basic provider sensitisation than in specialised referral and social protection services. This may explain why psychosocial and SRHR related services can appear available on paper, yet still remain difficult to access in practice. Service use depends not only on formal availability but also on whether clients perceive services as safe, confidential, trusted, and linked to community support. In the Ugandan context, incomplete collaboration with LBQ led organisations, very limited shelter provision, and weak access to gender affirming care suggest that the enabling environment remains fragile. Strengthening formal partnerships with LBQ-led organisations, reinforcing confidentiality and survivor centred practice, and investing in referral networks and specialised support services will be necessary if reported availability is to translate into meaningful and equitable access.

5.0 Discussion

This assessment examined not only whether SRHR related services for LBQ womxn are reported to exist, but whether they are experienced as accessible, safe, confidential, and responsive. The central contribution of this assessment lies in the triangulation of facility self reporting with community lived experience. That comparison reveals a persistent gap between what facilities say they provide and what LBQ womxn are actually able and willing to use. This matters because conventional health system assessments often privilege infrastructure, commodities, staffing, and administrative compliance, yet these indicators alone do not capture whether services are socially accessible in contexts marked by stigma, fear, and criminalisation. Community led evidence is therefore not an optional supplement to routine service assessment. It is essential for identifying hidden barriers that standard facility reporting can miss or obscure.

The findings show that structural availability is generally stronger than meaningful access. On the supply side, many facilities report providing core SRHR, STI, HIV, contraception, GBV, and mental health related services. Many also report having non discrimination measures, referral pathways, and trained personnel. At face value, this suggests substantial readiness within the health system. This broad picture is not inconsistent with Uganda's formal policy framework. The Ministry of Health Patient Rights and Responsibilities Charter requires non discriminatory care, respect for dignity, confidentiality, and appropriate referral. Uganda's SRHR policy guidelines and broader health sector standards also emphasise quality, equity, and access to essential reproductive health services (MOH,2019). In HIV programming, Ministry of Health guidance and the wider national response recognise key populations as requiring tailored, stigma free, confidential, and linked services across prevention, treatment, and support (MOH, 2022).

Yet the community data show that these commitments are not being realized consistently in practice. LBQ womxn continue to report fear, stigma, judgement, hostile provider attitudes, breaches of confidentiality, and care avoidance. This divergence between policy and practice is one of the most important findings of the assessment. It suggests that formal facility claims of compliance should not be treated as evidence of actual inclusion. A facility may report that services are available, that staff are trained, or that non discrimination principles are in place, yet clients may still avoid those services because they do not trust the environment, fear exposure, or anticipate mistreatment (Frontline AIDS, 2020). Community voices are therefore critical because they reveal dimensions of service quality that are often invisible in routine monitoring, especially respect, relational safety, privacy, and the ability to seek care without social harm (UNAIDS, 2020).

This assessment also functions as a community led accountability tool rather than a conventional facility performance audit. Its value lies not simply in documenting service presence, but in testing whether health system claims hold true when viewed from the standpoint of those most affected. This approach is consistent with wider evidence on community led monitoring, which shows that communities directly affected by health inequities are often best placed to identify failures in service accessibility, responsiveness, and rights protection, and to generate reform demands grounded in lived experience (UNAIDS,2025). Community led accountability is particularly important where marginalised groups are unlikely to appear fully or accurately in routine datasets.

The policy gap is especially visible in relation to confidentiality, non discrimination, and referral. Uganda's ministry of health standards on quality of care and service delivery emphasize respectful care, prohibits discrimination, and requires referral where appropriate services are not available (MOH,2016). HIV testing guidance also explicitly emphasises non discriminatory provision of care and treatment while observing confidentiality (MOH,2022). These standards should, in principle, create a minimum threshold of safety for all patients, including LBQ womxn. However, the findings indicate that confidentiality breaches, judgemental treatment, and fear of being recognised or outed remain major deterrents to service use. This demonstrates that the challenge is not the absence of policy language alone. The challenge is weak implementation, weak accountability, and the absence of reliable mechanisms through which affected communities can contest poor practice and demand corrective action.

Criminalisation is central to understanding this implementation gap and should be treated not only as a rights issue but also as a health systems issue. Uganda's Anti Homosexuality Act and the broader environment of criminalisation and public hostility distort health system data, service uptake, and provider behaviour. They do so in several ways. First, criminalisation suppresses demand because people avoid facilities, delay care, conceal information, or seek informal alternatives to reduce the risk of exposure (Ssekamatte,2020; HRAPF, 2017). Secondly, it distorts supply side reporting because facilities may under-report targeted outreach, deny collaboration with LBQ or gender diverse organisations, or avoid documenting the specific needs of sexual and gender minorities for fear of political scrutiny, reputational harm, or legal consequences (Human Rights Watch, 2025). Thirdly, it makes it harder for records to show the weakens the SRHR unmet need of LBQ womxn in routine records reporting. Low uptake of SRHR services in such a context cannot be interpreted as low need. It may instead reflect fear, forced invisibility, and strategic silence among LBQ womxn for their own safety. The Anti Homosexuality Act has thus affected health reporting and privacy. Human Rights Watch has since documented how the law has intensified discrimination, violence, and exclusion, including impacts on access to services and the operations of LGBTQ organisations (Human Rights Watch, 2024).

The paradox identified in psychosocial support, GBV response, and mental health services illustrates this clearly. Many facilities report that such services are available, yet many LBQ womxn still avoid them. This should not be read simply as an awareness problem or an individual level reluctance to seek care. It is more accurately understood as a trust and safety problem. Survivors of violence and trauma are unlikely to disclose abuse in environments where confidentiality is uncertain, where provider attitudes are hostile, or where the legal context itself heightens vulnerability. In this sense, service effectiveness depends not only on technical provision but also on whether services are experienced as credible, protective, and survivor centred. Key population programming frameworks have long recognised that stigma free, community linked, confidential service delivery is necessary for uptake (UNAIDS, 2025). The present findings show that this principle remains only partially realised in practice.

The findings on collaboration with LBQ and other gender diverse organisations further strengthen this interpretation. Facilities with stronger community linkages are better positioned to build trust, facilitate referral, support follow up, and respond to abuse (UNAIDS,2025; Ogwe, G. et.al, 2023). Such organisations often act as intermediaries, navigators, advocates, and informal accountability actors. Their importance is amplified in hostile settings because they help clients interpret risk, identify safer facilities, and seek redress when mistreatment occurs (Center for Reproductive Rights, 2024). The fact that a notable proportion of facilities reported limited or no collaboration, often linked to fear of association and the restrictive political environment, is therefore significant. It suggests that one of the most important bridges between formal health services and marginalised communities' remains fragile. This is not a marginal issue. It is central to whether policy commitments can be translated into usable care.

The comparatively stronger reporting of health provider training than of specialised social support services such as shelter, referral protection, or tailored community partnerships also warrants attention. Training is easier to report and easier to introduce than deeper institutional reform (Kruk M.E, et.al,2018). A facility may host a sensitisation session or count selected staff as trained, yet still lack the supervisory systems, complaint pathways, leadership incentives, and community oversight needed to change everyday behaviour. This helps explain why facilities can report trained staff alongside continued community experiences of stigma and privacy violations. The issue is therefore not training alone, but whether training is embedded in enforceable standards, monitored practice, safe reporting channels, and sanctions for breaches.

Overall, the primary challenge is not simply expanding the list of services. The challenge is transforming the conditions under which care is delivered and measured. Respect, confidentiality, affordability, safety, and trust are not secondary dimensions of service quality. They are central determinants of access. National policy commitments already recognise many of these principles. The gap lies in implementation, accountability, and political context. This assessment shows that reform requires more than service availability. It requires the health system to take seriously the evidence produced by LBQ womxn themselves, especially where that evidence contradicts reassuring institutional narratives.

5.1 How FARUG Will Use These Findings

FARUG will use these findings as a community led accountability and advocacy tool at facility, district, and national levels. At facility level, the evidence can support structured dialogue with health service providers on confidentiality, respectful care, referral quality, and the need for formal collaboration with LBQ led organisations. At district level, the findings can inform engagement with District Health Teams on gaps between reported service readiness and community experience, helping to prioritise supervision, targeted provider support, and stronger complaint and redress mechanisms. At national level, FARUG can use the assessment to advocate for fuller implementation of Ministry of Health standards on non discrimination, confidentiality, referral, and quality of care, and to press for key population programming that responds to LBQ realities rather than treating them as invisible within generic service categories. The findings also provide a baseline for repeated community monitoring over time, allowing FARUG and partners to track whether reforms improve not only what facilities report, but what LBQ womxn actually experience.

6.0 Conclusion

This study demonstrates that most assessed health facilities possess the structural capacity to provide a broad range of SRHR services, including HIV prevention and treatment, contraception, cancer screening, GBV response, and mental health support. However, the lived experiences of LBQ womxn reveal that availability does not automatically translate into safe or equitable access. Persistent discrimination, confidentiality concerns, financial barriers, and fear of outing or legal repercussions continue to discourage many from seeking care.

The gap between policy commitments and everyday practice remains a defining feature of the current service landscape. While facilities report inclusive guidelines and protocols, inconsistent implementation undermines trust and limits utilisation. As a result, many LBQ womxn rely on peer networks and community organisations rather than formal health systems for support, highlighting the need for stronger institutional accountability and community collaboration.

Improving SRHR outcomes for LBQ womxn will therefore require more than expanding services. It will require creating environments where care is consistently respectful, confidential, affordable, and affirming. Strengthening provider competence, enforcing non-discrimination policies, enhancing confidentiality safeguards, and formalising partnerships with LBQ-led organisations are critical steps toward bridging the gap between availability and access. Community-led monitoring approaches, such as the scorecard developed from this assessment, offer practical mechanisms for ensuring that health systems remain responsive to those they serve.

Ultimately, equitable SRHR access for LBQ womxn depends on transforming both health facilities and the broader systems that shape safety and dignity. When services are not only present but trusted and inclusive, health systems can better fulfil their responsibility to deliver care without fear or discrimination.

7.0 Recommendations

The findings suggest that improving SRHR access for LBQ womxn requires action at several levels. Some reforms can be implemented immediately within facilities, others require coordinated district and programme level investment, and some depend on broader policy and health system change. The recommendations below are therefore grouped into short term, medium term, and system level actions.

Short Term Actions

The first priority is to strengthen health worker capacity, attitudes, and accountability. Health worker competence and behaviour emerged as one of the strongest determinants of whether services are perceived as safe and usable. The Ministry of Health, district health leadership, and facility managers should therefore institutionalise mandatory induction and refresher training for all cadres of staff, including clinicians, reception staff, security personnel, counsellors, and peer educators. Training should include SOGIE concepts, inclusive communication, confidentiality, seeking informed consent to perform medical assessments and examinations, non discrimination, trauma informed care, and the specific SRHR needs of LBQ womxn. This should be embedded into continuous medical education, mentorship, and supportive supervision rather than delivered as one off training. Facilities should also introduce practical accountability measures such as codes of conduct, confidential complaint channels, and routine review of staff behaviour linked to respectful care standards. Values clarification sessions should be used to address prejudice and improve provider attitudes.

A second immediate priority is to make service environments safer and more confidential. Facilities should establish private consultation spaces, discreet entry or service points where possible, and simple procedural safeguards that reduce the risk of unwanted disclosure.

Dedicated focal persons, peer educators, or counsellors should be available to support LBQ clients confidentially across the care pathway. Flexible clinic hours, special appointment arrangements, and telehealth or phone based follow up where feasible can also improve privacy and reduce fear of exposure. Visible anti discrimination messaging within facilities can help communicate commitment to respectful care, although this should be accompanied by real practice change.

Facilities should also improve information and communication. LBQ specific information, education, and communication materials should be made available in clear, affirming language and, where possible, in local languages. Health education should cover relevant SRHR topics, available services, referral options, and rights within care settings. Information should be shared not only within facilities but also through community outreach and trusted communication channels, including social media, to improve awareness and reduce misinformation.

A further short-term action is to address basic commodity security. Stock outs directly undermine confidence in services and contribute to delayed care. Facilities should strengthen routine monitoring of essential commodities including condoms, lubricants, PrEP, PEP, contraceptives, STI medicines, menstrual products, and related consumables.

Medium Term Actions

The next priority is to ensure more consistent availability of comprehensive and tailored SRHR services. Facilities should move beyond generic service provision and ensure that LBQ relevant SRHR services are intentionally integrated into service packages. This includes STI screening and treatment, HIV prevention, contraception, post abortion care, maternal health where relevant, mental health support, GBV response, HPV and Cancer screening, and gender affirming care or referral where applicable. The aim should be to reduce avoidable referrals and make essential care available within reachable service points. Monitoring should assess not only whether services are listed as available but whether they are actually being used.

Community partnerships and referral pathways also need to be strengthened.

Facilities should formalise collaboration with LBQ led organisations and other trusted community-based groups to improve outreach, accompanied referral, follow up, psychosocial support, and accountability. Written referral systems, agreed feedback loops, and named contact points can improve continuity of care. Expanding referral points and reviving drop-in centres across districts would also reduce travel burdens and improve access for those who cannot safely seek care near their homes. This is particularly important in a context where community trust is often built outside formal institutions.

Affordability should be treated as a medium-term service access issue. Facilities, district authorities, and implementing partners should explore practical mechanisms to reduce user fees and other indirect costs associated with SRHR care. Free or subsidised screening, prevention, treatment, and referral support would improve access substantially. Transport support and linkage to broader livelihood or economic strengthening initiatives may also help address the financial vulnerability that limits service uptake.

Data systems, monitoring, and score card implementation should be strengthened as part of continuous quality improvement. Facilities should establish regular feedback mechanisms, client experience reviews, and periodic community consultations to assess whether services are experienced as safe and responsive. Scorecard assessments should be repeated over time to track progress. Any collection of sexual orientation or gender identity related information must be voluntary, privacy protected, and used with caution, particularly in a criminalised environment. In this context, community led monitoring remains especially important because routine facility data alone may not reflect actual need, service avoidance, or fear driven under utilisation.

System Level Actions

At the broader system level, policy and structural reform is required to close the gap between formal service availability and actual access. The Ministry of Health should integrate LBQ relevant indicators into national guidelines, quality assurance tools, supervisory systems, and service monitoring frameworks. Existing commitments on non discrimination, confidentiality, respectful care, and referral need to be implemented more consistently and linked to enforceable accountability mechanisms. District and national actors should ensure that LBQ inclusion is not treated as peripheral or absorbed invisibly into generic key population programming without attention to specific needs.

Greater resource allocation is also required. Sustainable government and donor investment is needed to support provider training, supervision, community partnerships, referral networks, staffing, safe spaces, and uninterrupted commodities. Without dedicated funding, facilities are unlikely to sustain the changes required to make services genuinely accessible.

Legal and structural barriers must also be addressed. Criminalisation and hostile social environments distort service uptake, suppress disclosure, weaken community partnerships, and produce misleading impressions of service coverage. Advocacy is therefore needed not only for inclusive health policy implementation but also for broader structural reform that protects dignity, privacy, and access to care. In this regard, community led accountability should remain central. LBQ womxn and LBQ led organisations are not merely service users or referral partners. They are critical accountability actors whose evidence can expose gaps between facility self reporting and lived reality, and whose participation is essential for meaningful reform.

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