

REVIEW ARTICLE

Breaking barriers to health equity for sexual and gender minorities in South Africa: A systematic review of health services and governance interventions

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Abstract

Sexual and gender minorities (SGMs) in South Africa experience substantial health inequities despite a progressive constitutional framework. Stigma in healthcare settings, gaps in provider competence, and weak implementation of rights-based policies undermine progress toward sustainable development goals (SDGs) 3 (Good Health and Well-being) and 10 (Reduced Inequalities). This systematic review synthesized evidence on health system barriers, interventions, and governance approaches affecting SGM health and health equity for SGMs. Searches of bibliographic databases and grey literature (January 2000–December 2024) retrieved 978 records; 15 studies met the inclusion criteria. Findings were synthesized narratively using the social determinants of health framework, the availability-accessibility-acceptability-quality framework, and rights-based and participatory governance perspectives. Meta-analysis was not feasible due to heterogeneity in designs, populations, interventions, and outcomes. Across qualitative, mixed-methods, cross-sectional, and policy analyses, SGMs reported discrimination, moralizing attitudes, breaches of confidentiality, and consequent care avoidance, especially in rural and under-resourced settings. Structural barriers included the absence of sexual orientation and gender identity indicators in routine information systems, fragmented implementation of protective policies, and limited mechanisms for accountability and redress. Interventions clustered around healthcare worker training and sensitization; community- and peer-led psychosocial and HIV-prevention programs; and rights-based policy and participatory governance initiatives. Multi-level approaches integrating these domains appeared most promising for improving acceptability, trust, and uptake but were small-scale, unevenly evaluated, and rarely assessed long-term. Legal protections are necessary but insufficient; system-wide reforms in training, data systems, accountability, and meaningful SGM participation in health governance are required to translate constitutional commitments into inclusive, high-quality care and advance SDGs 3 and 10.

Keywords: Sexual and gender minorities; Health equity; Health services; South Africa; Social determinants of health; Participatory governance; HIV prevention and care

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1. Introduction

Health equity is a central concern in contemporary population studies and a core pillar of the sustainable development goals (SDGs), particularly SDG 3 (good health and well-being) and SDG 10 (reduced inequalities). These commitments recognize that all people, regardless of their social position or identity, should have equitable access to the social, economic, and political conditions that enable them to attain their full health potential. In South Africa, these global commitments are reinforced by a progressive Constitution and legal framework that prohibits discrimination on the basis of sexual orientation and increasingly recognizes gender diversity (United Nations, 2015; World Health Organization [WHO], 2021). Yet, for sexual and gender minorities (SGMs), the promise of equality is only partially realized in the health sector. Empirical evidence continues to show that SGMs face substantial barriers to safe, acceptable, and quality healthcare, with implications for morbidity, mortality, and population-level health indicators (Beyrer *et al.*, 2016; Müller, 2017).

Persistent inequities affecting SGMs in South Africa reflect the interaction of social determinants of health, institutional structures, and governance failures. The WHO's Commission on Social Determinants of Health has highlighted how structural conditions, such as unequal power relations, social exclusion, and discriminatory norms, shape the distribution of health outcomes across populations (Munn *et al.*, 2018; WHO, 2021). Müller's (2017) adaptation of the availability, accessibility, acceptability, and quality (AAAQ) framework to SGMs in South Africa shows that legal protections alone do not guarantee non-discriminatory, acceptable, and competent care when health systems remain embedded in heteronormative and cisnormative cultures. Within this conceptual framing, health equity is understood not simply as equal access to services but also as the outcome of rights-based governance arrangements, inclusive policies, and everyday practices that recognize SGMs as rights-bearing citizens rather than "risk groups."

Despite constitutional protections, SGMs in South Africa continue to encounter stigma, discrimination, and structural barriers within health facilities and communities. Qualitative and mixed-methods studies have documented instances of overt verbal abuse, moralizing attitudes, breaches of confidentiality, and denial or delay of services by healthcare workers, particularly in primary healthcare and sexual and reproductive health settings (Cele *et al.*, 2015; Human Rights Watch, 2011; Seretlo & Mokgatle, 2022). These experiences deter SGMs from seeking timely care, erode trust in providers, and

contribute to underutilization of preventive and curative services. From a population perspective, such exclusion undermines the ideal of universal health coverage and skews interpretations of national health statistics, as SGMs are often invisible in routine information systems and surveys (Müller, 2017; Joint United Nations Program on HIV/AIDS [UNAIDS], 2021).

The health consequences of this structural exclusion are well documented. Men who have sex with men (MSM), transgender women, and other gender-diverse individuals bear a disproportionate burden of HIV and other sexually transmitted infections and face elevated risks of depression, anxiety, substance use, and violence (Beyrer *et al.*, 2016; Poteat *et al.*, 2014). Studies from South African cities have described SGMs' reluctance to access facility-based HIV testing, pre-exposure prophylaxis (PrEP), and mental health services due to anticipated or experienced discrimination and have highlighted the importance of community-based and peer-led services in filling these gaps (Duby *et al.*, 2018; Luvuno *et al.*, 2019). Emerging works on queer people's sexual and reproductive health have further shown that nurses and other providers often lack the training, guidance, and institutional support required to deliver affirming, competent care, particularly in rural and peri-urban settings (Seretlo & Mokgatle, 2022; Seretlo *et al.*, 2024).

At the same time, SGMs are not passive recipients of services but active agents in struggles for recognition, resourcing, and accountability. Rights-based and participatory governance frameworks emphasize that health equity is sustained when affected communities are meaningfully involved in designing, implementing, and monitoring policies and programs (Scherf, 2024; UNAIDS, 2021). This review is informed by an integrated conceptual framework that draws on three streams: the social determinants of health, the AAAQ framework for health system responsiveness, and theories of rights-based and participatory governance. Together, these perspectives foreground how legal norms, policy instruments, institutional practices, and community mobilization interact to produce or mitigate inequities for SGMs. Health systems are viewed as governance arenas in which power, voice, and accountability determine whether constitutional rights are realized in everyday clinical encounters and public health programs (Müller, 2017; Scherf, 2024).

Although research on SGMs and health in South Africa has expanded over the past decade, it remains fragmented. Much of the literature has focused on documenting HIV burden, risk behaviors, and experiences of stigma and discrimination among MSM, transgender women, and sex workers (Beyrer *et al.*, 2016; Duby *et al.*, 2018; Ikhile,

2024). These studies are critical for demonstrating the scale and nature of inequities. However, they typically do not provide a systematic overview of interventions designed to transform health systems, provider practices, and governance arrangements in line with human rights standards. Evidence on bisexual people, intersex persons, non-binary individuals, and SGMs in rural or small-town contexts remains particularly sparse (Fish *et al.*, 2019; Seretlo *et al.*, 2024). Moreover, available reviews on key populations in the region tend to focus on epidemiology, service coverage, or individual-level behavioral interventions, with limited attention to how interventions align with rights-based and participatory governance frameworks (Luvuno *et al.*, 2019; UNAIDS, 2021).

These limitations constitute a critical research gap at the intersection of public health, governance, and population studies. There has been no comprehensive synthesis of how interventions and governance approaches targeting SGMs have been conceptualized, implemented, and evaluated within South Africa's health system. In particular, there is limited integrative evidence on healthcare worker sensitization and training programs, community- and peer-led psychosocial and HIV-prevention interventions, rights-based policy reforms and their implementation, and mechanisms for participatory governance that provide SGMs with structured roles in health planning and oversight. Without such a synthesis, policymakers and practitioners lack an evidence-informed map of which strategies show promise in reducing inequities, under what conditions they appear to work, and where critical gaps remain.

The present study addresses this gap by conducting a systematic review of empirical and policy-relevant evidence on health inequities and interventions affecting SGMs in South Africa. The review pursues three interlinked objectives. First, it synthesizes documented barriers to equitable health services for SGMs, with attention to how structural stigma, provider attitudes, and health system design intersect across urban and rural settings. Second, it identifies and critically appraises interventions and governance approaches, including provider training, community-led programs, rights-based policy reforms, and participatory governance mechanisms that seek to advance health equity for SGMs, and examines how they engage with the AAAQ dimensions and social determinants of health. Third, it assesses how these interventions and approaches contribute to, or fail to contribute to, the realization of SDGs 3 and 10 in the South African context.

Given the diversity of study designs, outcomes, and analytic perspectives in this field, the review adopts a narrative thematic synthesis, integrating qualitative,

quantitative, and policy analyses rather than attempting a meta-analysis of effect sizes (Braun & Clarke, 2006; Popay *et al.*, 2006). A meta-analysis was considered but deemed infeasible due to substantial heterogeneity in study designs and outcome measures. By drawing together multiple forms of evidence within an explicit conceptual framework, the study offers a novel, governance- and rights-oriented synthesis of interventions and health system responses for SGMs in South Africa. It aims to generate context-sensitive, actionable insights for policymakers, health practitioners, and civil society organizations and to contribute to broader debates on health equity, social justice, and population health in democratic but unequal societies.

2. Data and methods

This systematic review was designed to provide a rigorous, transparent synthesis of evidence on health inequities and interventions affecting SGMs in South Africa. The review followed the preferred reporting items for systematic reviews and meta-analyses (PRISMA) guidelines for reporting and drew on methodological recommendations for the narrative synthesis of diverse evidence (Dixon-Woods *et al.*, 2005; Page *et al.*, 2021; Popay *et al.*, 2006). The protocol was developed a priori, including the research questions, eligibility criteria, search strategy, and approach to data extraction and synthesis, to ensure consistency between the objectives and the evidence base.

2.1. Protocol registration

In line with best practice, the protocol was prospectively registered with the International prospective register of systematic reviews on January 13, 2025 (last updated January 30, 2026), under the title “*Breaking Barriers to Health Equity for SGMs in South Africa: A Systematic Review of Health Services and Governance Interventions*” (Registration No.: CRD420261286138).

2.2. Data sources

Data were obtained from a combination of bibliographic databases and targeted G-ray literature searches to capture both peer-reviewed and practice-oriented evidence relevant to SGMs in South Africa. We searched major international databases with strong coverage of public health, health services, and social science research, including PubMed/MEDLINE, Scopus, Web of Science Core Collection, and CINAHL. To ensure the inclusion of regionally published work, we also searched African-focused databases, including African Index Medicus and Sabinet African Journals.

Given the policy and governance focus of the review, we complemented database searches with a structured gray

literature search. This included Google Scholar, as well as the websites and online repositories of key organizations such as UNAIDS, the WHO, the South African National Department of Health, the Human Sciences Research Council, and selected human rights and SGM-led organizations. The reference lists of all included studies and relevant reviews were hand-searched to identify additional sources that were not retrieved in the primary searches. All data sources were searched for the period January 2000–December 2024 to align with the study's temporal eligibility criteria.

2.3. Study design

A systematic review method was employed to identify, appraise, and synthesize empirical and policy-relevant evidence on health system barriers, interventions, and governance approaches related to SGMs in South Africa. The review focused on studies that addressed health equity concerns, including differential access to and quality of services, experiences of stigma and discrimination in healthcare settings, and interventions or reforms aimed at improving responsiveness to SGMs. Given the heterogeneity of study designs, outcomes, and analytic approaches in this field, the review was planned from the outset as a narrative thematic synthesis rather than a quantitative meta-analysis. This design was deemed most appropriate for integrating qualitative, mixed-methods, and quantitative evidence, as well as policy and health systems analyses, within the conceptual framework of social determinants, the AAAQ framework, and rights-based and participatory governance perspectives (Homer *et al.*, 2018).

2.4. Eligibility criteria

Eligibility criteria were defined in advance to ensure alignment with the review's conceptual focus and objectives. Studies were eligible for inclusion if they (i) reported empirical data on SGMs in relation to health services or health systems in South Africa; (ii) presented regional or comparative analyses with a clearly identifiable South African component; or (iii) were contextual/transferability studies addressing comparable mechanisms relevant to South Africa. For this review, SGMs were understood to include, but not be limited to, lesbian, gay, bisexual, transgender, queer, intersex, and non-binary people, as well as MSM and other gender-diverse groups. Eligible studies examined phenomena directly relevant to health equity, such as access to and utilization of healthcare services, experiences of stigma and discrimination in health settings, quality and acceptability of care, mental health and psychosocial outcomes linked to health service interactions, and the design, implementation, or evaluation

of interventions and governance mechanisms aimed at improving health outcomes or reducing inequities for SGMs.

Interventions and approaches of interest encompassed healthcare worker training and sensitization initiatives, community-based and peer-led programs, rights-based policies and legal reforms with health implications, and participatory governance mechanisms or health system reforms that explicitly included SGMs. Outcomes of interest included the uptake of HIV prevention and treatment (for example, PrEP and antiretroviral therapy), mental health and psychosocial indicators, utilization of preventive and curative services, reports of perceived or experienced stigma and discrimination in healthcare, and governance or policy implementation outcomes linked to SDGs 3 and 10. Empirical study designs of any type were considered, including qualitative, cross-sectional, mixed-methods, cohort, and intervention studies, as well as rigorous policy or health systems analyses that reported methods in sufficient detail to allow appraisal. Publications needed to be available in English and to include data collected in South Africa or policy analyses grounded in the South African health system.

Studies were excluded if they did not focus on SGMs or did not provide clear relevance to the South African health context; if they were commentaries, editorials, or purely theoretical pieces without empirical data; or if they lacked sufficient methodological transparency or outcome reporting to inform the review questions. Duplicate analyses of the same dataset that did not add substantive empirical value were also excluded to prevent double-counting. These criteria were applied consistently to ensure that the included body of evidence was coherent and relevant to the review's aims.

2.5. Search strategy

A comprehensive search strategy was developed, guided by the conceptual framework and predefined eligibility criteria. All sources listed in Section 2.2 (Data sources) were searched for the period January 2000 to December 2024, corresponding to key phases in the consolidation of South Africa's constitutional protections for SGMs and subsequent HIV and health system responses.

In the bibliographic databases, we combined controlled vocabulary (e.g. medical subject headings terms) and free-text keywords relating to three main domains: (i) population (e.g., "sexual and gender minorities," "LGBT*," "MSM," "transgender," and "queer"), (ii) health and services (e.g., "health services," "healthcare access," and "health equity") and (iii) context and response (e.g., "South Africa," "intervention," "training," "policy," and "governance").

These terms were linked using Boolean operators (AND/OR) and adapted to the syntax of each database.

To address known gaps in the indexing of African and SGM-related work, we complemented database searches with a structured G-ray literature search using the organizational websites noted under Section 2.2 (Data sources) (e.g., multilateral agencies, national departments, and key civil society/human rights bodies), as well as targeted Google Scholar queries. Reference lists of all included studies and relevant reviews were hand-searched, and citation chaining (forward and backward) was used where necessary to identify additional influential or frequently cited publications not captured in the initial searches.

2.6. Study selection

All records identified through the database and G-ray literature searches were imported into reference management software (Mendeley Reference Manager v2.142.0, Elsevier, Netherlands) for de-duplication through automatic and manual checks (Bramer *et al.*, 2016; Liberati *et al.*, 2009; Moher *et al.*, 2008; Paez, 2017; Pieper *et al.*, 2019). Two reviewers then independently screened titles and abstracts against the eligibility criteria. Records judged potentially relevant by either reviewer proceeded to full-text screening. Full texts were obtained and assessed independently, with reasons for exclusion recorded systematically. Disagreements at any stage were resolved through discussion and, where needed, consultation with a two-reviewer panel until consensus was reached.

The search yielded 978 records. After removal of duplicates, 701 unique titles and abstracts were screened. Of these, 52 full-text articles or reports were assessed for eligibility. Fifteen studies met all inclusion criteria and were retained for detailed data extraction and synthesis (Ioannidis *et al.*, 2014; Polisena *et al.*, 2015).

The flow of studies through the screening and selection process is summarized in a PRISMA flow diagram presented in [Figure 1](#). Formal inter-rater reliability statistics, such as Cohen's kappa, were not calculated due to the relatively modest number of included studies and the primarily conceptual nature of decisions about relevance (Falagas *et al.*, 2008). Instead, inter-rater reliability was promoted through initial calibration of the eligibility criteria, joint piloting of the screening process, and regular consensus discussions.

2.7. Data extraction

Data extraction was conducted using a standardized form developed in line with the review objectives and conceptual framework. The form captured bibliographic information

(author, year, and journal or source), study design and methodological approach, and detailed information on the SGM population(s) considered (MSM, transgender women, lesbian, bisexual women, broader SGM communities, or mixed key population samples). It also recorded the geographical and service setting (urban, peri-urban, or rural; facility-based or community-based), sample characteristics (including population size where reported), and the type of intervention, program, policy, or governance mechanism examined. Outcomes were extracted in relation to health service utilization, HIV prevention and treatment uptake, mental health and psychosocial indicators, perceived or experienced stigma and discrimination, and indicators of governance or policy implementation relevant to SDGs 3 and 10. Where studies explicitly linked their analysis to SDG frameworks, human rights standards, or the AAAQ dimensions, this information was also recorded.

Two reviewers independently extracted data from each included study using the standardized form. The extraction tool was piloted on a small subset of studies and refined to improve clarity and alignment with the conceptual framework. Discrepancies in extracted data were resolved through discussion, with reference to the original texts, and, where necessary, input from two reviewers. When essential information, such as sample size and outcome measures, was not clearly reported, the reviewers noted these limitations and, where possible, inferred relevant contextual information from other sections of the report to inform the synthesis. This process ensured that data extraction was systematic, transparent, and closely tied to the review questions.

2.8. Risk of bias assessment

Risk of bias and methodological quality were assessed using tools appropriate to the design of each study. For any randomized controlled trials identified, the updated Cochrane Risk of Bias 2 (RoB 2) tool was applied, examining domains such as randomization processes, deviations from intended interventions, missing outcome data, measurement of outcomes, and selection of reported results (Higgins *et al.*, 2019). For non-randomized intervention studies and observational designs that evaluated exposures or programs, the risk of bias in non-randomized studies of interventions tool was used to assess potential biases due to confounders, participant selection, classification of interventions, deviations from intended interventions, missing data, outcome measurement, and selection of reported results (Sterne *et al.*, 2016).

Qualitative studies and policy or health systems analyses were not scored using these quantitative tools.

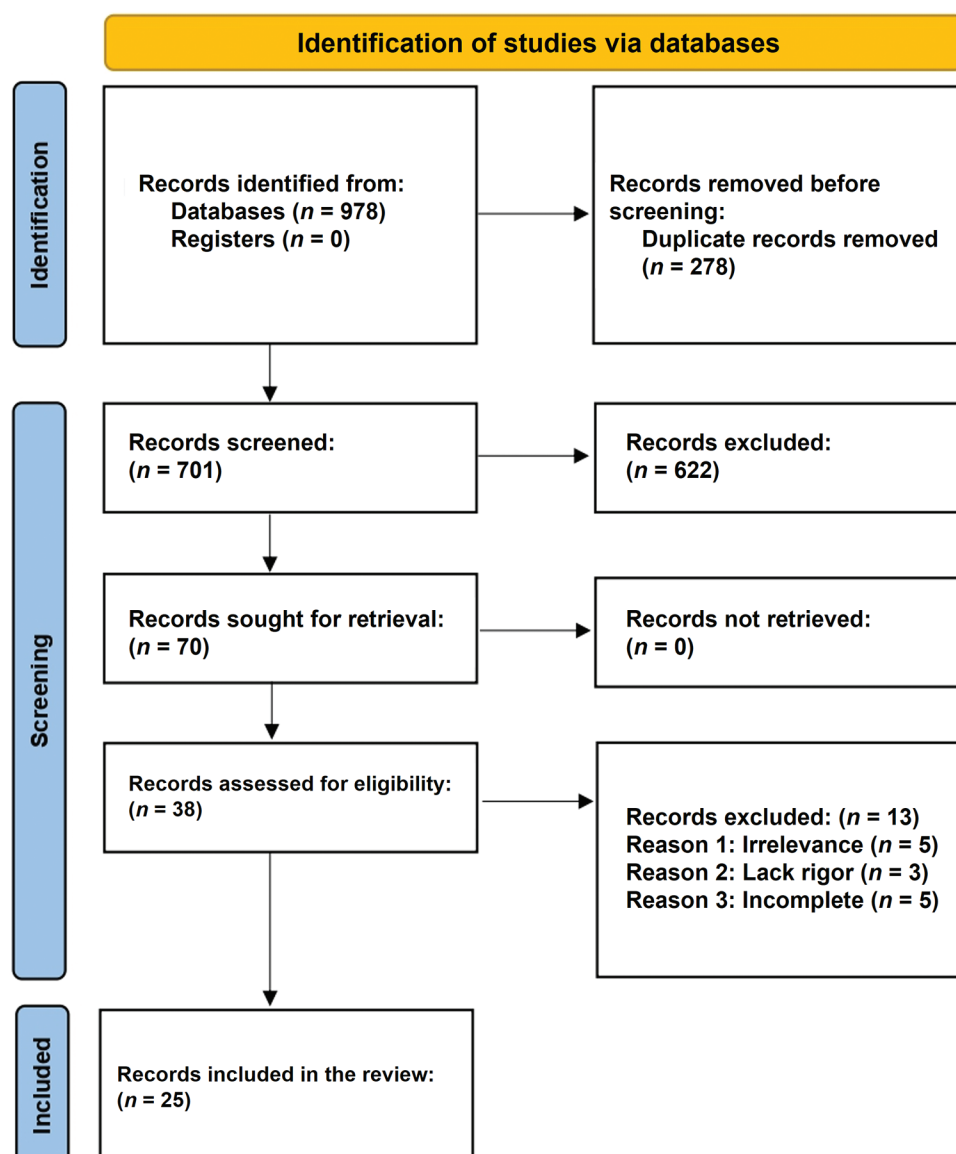


Figure 1. Preferred reporting items for systematic reviews and meta-analyses flow diagram

Their methodological rigor was appraised in terms of clarity of aims, appropriateness of design and sampling, transparency of data collection and analysis, reflexivity, and the credibility and transferability of findings. Two reviewers independently assessed the risk of bias or methodological rigor of each study and then compared judgments. Differences were resolved through discussion, with emphasis on consensus regarding the strengths and limitations of each study. Rather than excluding studies solely on the basis of risk of bias assessments, we used these appraisals to weight the contribution of each study to the synthesis and to inform the interpretation of findings in Section 4 (Discussion).

2.9. Data synthesis

Given the substantial heterogeneity in study designs, interventions, populations, and outcome measures, a formal meta-analysis was not feasible. Many included studies were qualitative or mixed-methods, and even among quantitative studies, outcomes were operationalized and reported in non-comparable ways. Although quantitative synthesis and calculation of pooled effect sizes (such as odds ratios and relative risks) were considered during protocol development, the diversity of the evidence base did not meet the assumptions required for a robust meta-analysis. We therefore adopted a narrative synthesis approach, guided by established frameworks for

integrating qualitative and quantitative evidence (Braun & Clarke, 2006; Dixon-Woods *et al.*, 2005; Popay *et al.*, 2006).

Thematic coding of study findings was conducted manually by the review team. Each included study was read multiple times, and relevant data were coded inductively and deductively with reference to the conceptual framework. The findings were then grouped into higher-order themes that captured recurring patterns and divergences across the studies. The synthesis focused on three interrelated domains: Systemic barriers to health equity for SGMs within the South African health system; interventions and governance strategies designed to address these inequities, including provider-focused, community-led, and policy or governance reforms; and gaps and limitations in the evidence base and in policy implementation. Throughout the synthesis, attention was paid to differences in context (e.g., urban versus rural settings), SGM subgroups, and the strength and type of evidence supporting particular claims.

This approach allowed the review to integrate rich contextual insights from qualitative and policy analyses with findings from quantitative and mixed-methods studies, while explicitly acknowledging the limitations of not providing aggregated numerical estimates of intervention effects. A narrative synthesis was employed to generate an interpretive account of how health systems, governance arrangements, and interventions currently influence health equity for SGMs in South Africa, and to identify implications for policy, practice, and future research. As the review drew exclusively on published and publicly available data, no ethical approval was required.

3. Results

The systematic search yielded a relatively small but heterogeneous body of evidence on how SGMs engage with the South African health system, the barriers they encounter, and the interventions and governance approaches that seek to advance health equity. As detailed in Section 2 and illustrated in the PRISMA flow diagram, 15 studies met the eligibility criteria and were included in the narrative synthesis. Together, they provide a multi-level picture that spans individual experiences of stigma in clinical settings, community-led responses, and policy and governance initiatives, collectively informing how far South Africa has progressed toward realizing SDGs 3 (Good Health and Well-being) and 10 (Reduced Inequalities) for SGMs.

3.1. Composition and characteristics of the included evidence

The 15 included studies encompassed a wide range of methodological approaches that mirror the complexity of

SGM health equity questions. Several qualitative studies employed in-depth interviews, focus group discussions, and ethnographic or case study methods to explore the lived experiences of SGMs in healthcare, capturing the nuances of stigma, coping strategies, and relationships with providers (Cele *et al.*, 2015; Human Rights Watch, 2011; Müller, 2017). Mixed-methods and cross-sectional designs combined structured surveys with qualitative components, enabling the quantification of selected outcomes, such as self-reported discrimination, service utilization, and HIV prevention uptake, while preserving contextual interpretation (Duby *et al.*, 2018; Fish *et al.*, 2019; Luvuno *et al.*, 2019). At least one study incorporated an explicit intervention or pre-post component to assess changes in knowledge and attitudes among healthcare workers following training, and several policy and health systems analyses examined how constitutional protections and policy commitments for SGMs are translated into, or blocked within, health sector governance (Scherf, 2024; UNAIDS, 2021).

The populations considered across the 15 studies were diverse but unevenly distributed. MSM and transgender women were most prominently represented, reflecting the historic concentration of HIV research and programming on these groups (Beyrer *et al.*, 2016; Duby *et al.*, 2018; Poteat *et al.*, 2014). A smaller subset of studies focused on lesbian, bisexual women, queer youth, and broader LGBT or SGM communities, often revealing distinct needs and vulnerabilities that are not visible in MSM-focused work (Cloete *et al.*, 2023; Fish *et al.*, 2019). Bisexual, intersex, and non-binary people were mentioned less frequently and rarely disaggregated analytically, pointing to significant evidence gaps for these subgroups. Sample sizes ranged from small qualitative studies with fewer than 30 participants, providing rich narrative data, to larger cross-sectional surveys involving several hundred respondents; policy and systems analyses drew on document review, stakeholder interviews, and secondary data to illuminate how power and accountability operate within the health system (Müller, 2017; Scherf, 2024).

Geographically, the evidence base was concentrated in urban and peri-urban areas, including major metropolitan centers where specialized HIV and key-population services are available and where SGM-led organizations are more likely to operate (Duby *et al.*, 2019; Fish *et al.*, 2019). However, several studies explicitly documented the experiences of SGMs in rural districts and small towns, showing how limited service availability, heightened community stigma, and the absence of visible SGM-affirming providers create a qualitatively different landscape of risk and exclusion (Luvuno *et al.*, 2019; Seretlo *et al.*, 2024). These rural-focused accounts suggest

that while urban SGMs can sometimes navigate toward niche or specialized services, rural SGMs often have no alternative to mainstream clinics where staff may lack training, institutional support, or even the willingness to engage respectfully.

In terms of substantive focus, the included studies cluster around three interrelated domains: healthcare worker training and sensitization initiatives; community- and peer-led psychosocial and HIV-prevention interventions; and rights-based policy and participatory governance strategies. These domains respond to documented health system barriers in everyday clinical encounters. Outcomes reported span multiple dimensions of the AAAQ framework, including availability, accessibility, acceptability, and quality, alongside psychosocial and behavioral outcomes, such as mental health, HIV prevention, and treatment uptake, as well as patterns of health service utilization (Müller, 2017; UNAIDS, 2021). Several policy and system analyses explicitly situated their findings within the language of human rights, social determinants of health, and SDGs 3 and 10, thereby linking individual and community experiences to broader questions of governance and structural inequality (Scherf, 2024; WHO, 2021). [Table 1](#) summarizes the 15 studies, highlighting for each the design, SGM population focus, setting, primary intervention or thematic emphasis, and key contribution to the review.

3.2. Barriers to equitable health services for SGMs

Thematic synthesis of the included studies revealed a consistent pattern of systemic barriers that constrain SGMs' access to safe, acceptable, and quality healthcare. At the interpersonal level, SGMs frequently describe health facilities as sites where social stigma and heteronormativity are reproduced. Participants in multiple qualitative and mixed-methods studies reported being subjected to derogatory comments, moralizing lectures, inappropriate curiosity about their bodies and relationships, and unsolicited attempts by providers to impose gender-conforming or heterosexual norms (Cele *et al.*, 2015; Human Rights Watch, 2011; Müller, 2017). For transgender and gender-diverse people, these experiences are often compounded by misgendering, refusal to use correct names or pronouns, and ignorance about basic aspects of gender-affirming care (Luvuno *et al.*, 2019; Poteat *et al.*, 2014). Anticipated stigma is pervasive: many SGMs delay or forego care because they fear humiliation, being "outed" to family or community members, or being denied treatment altogether.

These everyday encounters are embedded within structural and institutional arrangements that systematically disadvantage SGMs. Several studies have

highlighted the absence of routine data collection on sexual orientation and gender identity in public health information systems, rendering SGMs statistically invisible and undermining the ability of planners to identify and respond to inequities (Müller, 2017; UNAIDS, 2021). Policy and governance analyses revealed that, although South Africa's Constitution and key health policies prohibit discrimination, the mechanisms for enforcement and redress are weak, fragmented, or inaccessible. SGMs, particularly those who are poor, rural, or otherwise marginalized, often have limited knowledge of their formal rights and few realistic avenues to challenge discriminatory treatment or hold institutions accountable (Human Rights Watch, 2011; Scherf, 2024).

The spatial and organizational configuration of services further restricts equity. The concentration of SGM-friendly or SGM-competent services in urban centers, specialized HIV clinics, or donor-funded programs means that access is often contingent upon living in particular locations or being connected to specific non-governmental organizations or networks (Duby *et al.*, 2018; Luvuno *et al.*, 2019). In rural clinics and small-town facilities, service availability is limited, and providers rarely receive training to address SGM health needs; physical infrastructure may not allow for privacy, further deterring disclosure. Even where services are technically available, they may not be acceptable or of adequate quality for SGMs, who experience them as hostile or unsafe. These patterns illustrate how inequities in the social determinants of health, such as poverty, geography, education, and social exclusion, intersect with institutional failures to produce cumulative disadvantages for SGMs in relation to SDGs 3 and 10.

Mental health and psychosocial well-being emerge as critical cross-cutting concerns. Several studies have described high levels of depression, anxiety, internalized stigma, and exposure to violence among SGMs, often linked directly to negative healthcare encounters or fear of discrimination in health settings (Duby *et al.*, 2018; Fish *et al.*, 2019). Participants reported using avoidance strategies, self-medication, and reliance on informal networks in place of formal mental healthcare, which they perceive as inaccessible or unsafe. These findings underscore that barriers are not limited to HIV or sexual and reproductive health services but extend across the spectrum of care, reinforcing the argument that health equity for SGMs must be understood as a broad population health issue rather than a narrow "key populations" concern.

3.3. Interventions and governance approaches

Within this landscape of systemic barriers, the review identified a range of interventions and governance

Table 1. Overview of included studies on SGMs and health equity relevant to South Africa

References	Study design	Population/ SGM focus	Setting/scope	Primary focus/ intervention	Key contribution to this review
Beyrer <i>et al.</i> (2016)	Narrative global review	MSM	Global, with relevance to South Africa	Global HIV response in MSM	Contextualizes how structural and programmatic gaps affect HIV outcomes among MSM, highlighting the need for targeted interventions and rights-based approaches.
Müller (2017)	Qualitative/ Mixed-methods study	SGMs	South Africa	Access, availability, acceptability, and quality of care	Documents multiple dimensions of access barriers for SGMs in South Africa, showing a misalignment between legal protections and everyday healthcare experiences.
Poteat <i>et al.</i> (2014)	Narrative study/ review	Transgender populations	Global, with implications for South Africa	Strategies for engaging transgender people in HIV prevention and care	Identifies service models and strategies that can inform transgender-inclusive HIV prevention and care in South Africa.
Seretlo <i>et al.</i> (2024)	Qualitative study	SGMs in South Africa	South Africa (various settings)	Health inequities and social determinants	Explores how structural, social, and health system factors intersect to produce inequities among SGMs, especially in relation to HIV and mental health.
Human Rights Watch (2011)	Qualitative/case documentation	LGBT individuals	South Africa	Unequal access to healthcare	Provides rights-based evidence of discrimination and denial of services in public facilities, reinforcing the need for accountability and policy enforcement.
Luvuno <i>et al.</i> (2019)	Scoping review of interventions (quantitative+ qualitative)	LGBT individuals	South Africa	Barriers to health equity	Analyzes institutional and attitudinal barriers to health equity, emphasizing persistent stigma and service fragmentation.
UNAIDS (2021)	Global report	Key populations, including SGMs	Global, including South Africa	Inequalities in HIV, COVID-19, and beyond	Highlights structural inequalities affecting SGMs and outlines rights-based, multi-sectoral responses relevant to South African policy debates.
Duby <i>et al.</i> (2019)	Intervention study (quasi-experimental/ mixed)	Healthcare workers serving key populations, including MSM	Rural South Africa	Healthcare worker training to reduce discrimination	Evaluates training initiatives aimed at reducing discriminatory practices and improving provider attitudes in rural health facilities.
Pulerwitz <i>et al.</i> (2024)	Randomized controlled trial	Transgender women	African context (including South Africa's applicability)	Peer counseling and mental health	Group-based psychosocial intervention to reduce stigma and improve HIV wellness and mental health.
Duby <i>et al.</i> (2018)	Qualitative baseline study	SGM	South African MSM populations	Contextual barriers to HIV prevention and care (including PrEP) among MSM and other key populations	Shows how targeted awareness campaigns can enhance uptake of HIV prevention technologies (PrEP) among MSM.
Fish <i>et al.</i> (2019)	Quantitative study (cross-sectional with longitudinal follow-up)	LGBTQ youth	African/Broader context with applicability to South Africa	LGBTQ youth-serving community-based organizations and health promotion	Highlights advocacy strategies to improve service access for bisexual youth, underscoring the neglect of this subgroup in policy and programming.
Müller (2017)	Policy/Health systems analysis	SGMs in urban contexts	Urban South Africa	Systemic barriers to health equity	Examines urban health system structures that reproduce inequities, including fragmentation, stigma, and weak governance.

(Cont'd...)

Table 1. (Continued)

References	Study design	Population/ SGM focus	Setting/scope	Primary focus/ intervention	Key contribution to this review
Cele <i>et al.</i> (2015)	Cross-sectional/ analytical study	Sexual minorities	Health settings (various)	Discrimination in healthcare and health impacts	Documents how discrimination in healthcare settings undermines health outcomes and deters service use among sexual minorities.
Scherf, 2024)	Policy analysis/ qualitative study	SGMs	South Africa	Health policies and inequalities	Critically analyzes South Africa's health policy response to SGMs, identifying gaps in enforcement and implementation.
Nxumalo <i>et al.</i> (2024)	Participatory mixed-methods protocol	Sexual minorities	South Africa (health governance)	Participatory governance in healthcare	Provides an explicit example of participatory, community-engaged governance and implementation planning in the health sector for SGMs.

Abbreviations: LGBTQ: Lesbian, gay, bisexual, transgender, or queer; MSM: Men who have sex with men; PrEP: Pre-exposure prophylaxis; SGM: Sexual and gender minority.

strategies aimed at transforming provider practices, service delivery models, and institutional arrangements. Although heterogeneous and sometimes small-scale, these initiatives provide valuable insight into what may work to advance health equity for SGMs in South Africa.

Healthcare-worker training and sensitization programs are among the most frequently documented intervention types. Evaluations of these programs, which often combine didactic content on SGM health with interactive reflection and contact-based sessions, report improvements in providers' knowledge about sexual orientation and gender identity, as well as increased self-reported comfort in engaging with SGM clients (Duby *et al.*, 2019; Pulerwitz *et al.*, 2024). Qualitative accounts from both providers and SGMs suggest that such training can reduce overt expressions of prejudice, promote more respectful communication, and encourage providers to move beyond risk-only framings of SGMs toward more holistic understandings of their health needs. At the same time, the evidence indicates that one-off or short courses may be insufficient to shift deeply rooted attitudes or institutional cultures, particularly in settings where broader organizational support is lacking. Outcome measures are not standardized across studies, and few evaluations include follow-up beyond the immediate post-training period, limiting the ability to assess sustainability and quantify effects on service utilization and health outcomes.

Community- and peer-led interventions form the second major strand. These initiatives, frequently conceptualized and implemented by SGM-led organizations or community-based groups, create safe spaces for psychosocial support, health education, HIV prevention, and navigation of public services. Studies exploring these interventions describe peer counselors

and organizers as trusted intermediaries who share lived experience, understand local contexts, and can advocate on behalf of SGMs when discrimination occurs in clinics or hospitals (Cloete *et al.*, 2022; Fish *et al.*, 2019). Evidence from mixed-methods evaluations suggests that participation in peer-led support groups and community mobilization activities is associated with improved self-esteem, reduced isolation, increased uptake of HIV testing and prevention, and stronger links to affirming providers. These interventions align closely with rights-based and participatory governance principles by positioning SGMs as agents rather than passive recipients of care. However, their reach is often constrained by short-term funding cycles, limited geographic coverage, and fragile relationships with the public sector, raising concerns about sustainability and scalability.

Rights-based policy and governance approaches constitute the third domain. Policy analyses documented efforts to incorporate SGM health into national and provincial strategic plans, to develop guidelines for non-discriminatory and affirming care, and to include SGM-sensitive indicators in monitoring and evaluation frameworks (Scherf, 2024; UNAIDS, 2021). Some studies described the establishment of advisory committees or consultative forums in which SGM organizations participate in planning or oversight, creating spaces for dialogue and contestation. Where implemented meaningfully, such arrangements have been associated with improved alignment between service offerings and SGMs' articulated needs, better visibility of SGM health concerns in planning documents, and incremental improvements in responsiveness at the facility or district level (Nxumalo *et al.*, 2024; Scherf, 2024). However, the same analyses highlighted that implementation is uneven,

that participatory spaces are sometimes symbolic rather than substantive, and that accountability mechanisms for enforcing non-discrimination remain weak. The evidence thus suggests that governance reforms have the potential to advance SDGs 3 and 10, while also highlighting that institutional change is contested and incomplete.

Across these intervention domains, a key finding of the narrative synthesis is that multi-level strategies, which combine provider-focused initiatives, community- and peer-led interventions, and rights-based policy and governance reforms, appear more promising than isolated efforts. Studies that described interventions acting simultaneously across several levels reported more coherent narratives of change, for example, when trained providers are embedded within clinics that have institutional support for SGM-affirming care and are linked to active community organizations (Duby *et al.*, 2018; Scherf, 2024). However, the heterogeneity of designs and outcomes, coupled with limited longitudinal data, precludes firm conclusions about comparative effectiveness or cost-effectiveness. Meta-analysis was not feasible, and findings should therefore be interpreted as indicative rather than definitive.

3.4. Alignment with Sustainable Development Goals and remaining evidence gaps

The evidence synthesized in this review illustrates both progress and limitations in South Africa's movement toward SDGs 3 and 10 for SGMs. On the one hand, the presence of rights-based policies, emerging provider-training curricula, community- and peer-led interventions, and nascent participatory governance mechanisms signals a recognition that the health of SGMs is an equity and justice concern rather than a marginal issue (Beyrer *et al.*, 2016; UNAIDS, 2021; WHO, 2021). Interventions that increase access to HIV prevention and treatment, improve the acceptability and quality of services, and strengthen SGMs' participation in health decision-making contribute directly to SDG targets related to universal health coverage, reduction of communicable disease burdens, and the empowerment and social inclusion of marginalized groups.

On the other hand, substantial evidence gaps remain. Certain SGM subgroups, particularly bisexual, intersex, and non-binary people, SGMs in rural and under-resourced provinces, older SGMs, and those at the intersection of SGM identities with disability, migration, or extreme poverty were markedly underrepresented in the literature (Cloete *et al.*, 2022; Fish *et al.*, 2019; Seretlo *et al.*, 2024). Methodologically, few studies employed robust comparison groups, standardized outcome measures,

or medium- to long-term follow-up. Many rely on self-reported changes in knowledge or attitudes without clearly linking these to changes in service utilization, health outcomes, or structural conditions. Furthermore, the invisibility of SGMs in routine data systems and national surveys means that progress toward SDG-aligned targets cannot be reliably monitored at the population level.

Overall, the results indicate that South Africa has important building blocks for advancing health equity for SGMs, constitutional protections, policy commitments, and an expanding repertoire of promising interventions. However, these gains are constrained by systemic barriers, uneven implementation, and a fragmented evidence base. The next section interprets these findings within the conceptual frameworks of social determinants, AAAQ, and participatory governance, and considers their implications for policy, practice, and future research.

4. Discussion

This systematic review presents an integrated account of how SGMs in South Africa experience the health system, the types of interventions and governance approaches implemented to address inequities, and how these dynamics relate to the pursuit of SDGs 3 and 10. Synthesizing 15 diverse studies, the review showed that, despite South Africa's progressive constitutional and legal framework, SGMs continue to face pervasive interpersonal, institutional, and structural barriers in health settings. At the same time, it identified emerging interventions and governance initiatives, including healthcare worker training, community- and peer-led programs, and rights-based policy and participatory mechanisms, that offer promising pathways toward more equitable and inclusive care. However, the evidence base is heterogeneous, often small-scale, and rarely evaluated with robust, comparable outcome measures, limiting firm conclusions about the effectiveness of specific strategies and underscoring the need for sustained institutional reforms and more rigorous research.

The results confirm and deepen findings from prior work showing that SGMs experience disproportionate burdens of HIV, mental ill-health, and violence in South Africa, and that health services frequently reproduce, rather than mitigate, broader social inequalities (Beyrer *et al.*, 2016; Duby *et al.*, 2018; Fish *et al.*, 2019). This review adds value by shifting the analytic focus from individual-level risk and stigma to the health system and governance arrangements that structure those risks. Specifically, it showed how heteronormative and cisnormative assumptions within clinical encounters, gaps in provider training, and the invisibility of SGMs in routine information systems interact with weak accountability mechanisms and uneven policy

implementation to create cumulative disadvantages for SGMs across the dimensions of availability, accessibility, acceptability, and quality (Müller, 2017; UNAIDS, 2021). By locating these dynamics within the conceptual frameworks of social determinants of health, AAAQ, and rights-based, participatory governance, the review foregrounds the systemic nature of inequities and the need for multi-level responses.

A central implication of the synthesis is that legal and policy protections, although indispensable, are insufficient to secure health equity for SGMs. South Africa's Constitution and anti-discrimination laws provide a strong normative foundation; yet SGMs' accounts of disrespect, humiliation, and denial of care in clinics and hospitals demonstrate a persistent disjuncture between formal rights and everyday practices (Human Rights Watch, 2011; Müller, 2017). This gap is partly driven by the absence of coherent institutional mechanisms to translate legal principles into standards of care, training curricula, supervision systems, and facility-level accountability. In many of the studies reviewed, healthcare workers reported limited or no formal training on SGM health, uncertainty about clinical protocols, and a lack of organizational support when attempting to provide more inclusive care (Duby *et al.*, 2018; Seretlo & Mokgatle, 2022). Where policies mention SGMs, they are often framed narrowly in terms of HIV "key populations" rather than as rights-bearing citizens whose health needs span the life course and all tiers of care (Scherf, 2024).

The findings therefore support the argument that legal protections must be embedded in systemic reforms and inclusive health practices to be meaningful. Systemic reforms include, first, integrating SGM health competencies into pre-service and in-service training for all relevant cadres, not only those working in specialized HIV or sexual health services. Training needs to go beyond information about risk and epidemiology to address implicit bias, heteronormative assumptions, communication skills, and the ethics of confidentiality and respect, drawing on evidence that interactive, contact-based approaches are more effective in shifting attitudes than didactic lectures alone (Duby *et al.*, 2019; Poteat *et al.*, 2014). Second, reforms must target health information systems. The persistent invisibility of SGMs in routine data undermines planning, budgeting, and monitoring, making it difficult to assess progress toward SDG targets. Carefully designed and ethically implemented mechanisms for capturing sexual orientation and gender identity in health records and surveys would enable more accurate measurement of inequities while respecting privacy and safety concerns (UNAIDS, 2021; WHO, 2021).

Third, systemic reform requires strengthening accountability and participatory governance. The review

identified examples of advisory committees, consultative forums, and community provider dialogues in which SGM-led organizations participated; however, these arrangements were often fragile, unevenly implemented, or symbolic rather than substantive (Scherf, 2024). For governance reforms to be transformative, SGMs require sustained and resourced participation in decision-making at the facility, district, and national levels, with clear mandates, feedback loops, and mechanisms to influence resource allocation and service design. Complaints and redress systems must be accessible, trusted, and equipped to respond to discrimination on the grounds of sexual orientation and gender identity. Embedding such mechanisms into the fabric of the health system would help align frontline practice with constitutional commitments and link everyday experiences of care to broader democratic accountability.

At the level of inclusive health practices, the synthesis highlights the importance of community- and peer-led interventions in mitigating the harms of stigma and building bridges between SGMs and the health system. Peer educators, counselors, and community advocates often working within SGM-led organizations provide psychosocial support, health literacy, accompaniment to clinics, and advocacy when discrimination occurs, and they play a crucial role in shaping service design to be more responsive to SGM realities (Cloete *et al.*, 2022; Fish *et al.*, 2019). These initiatives embody the participatory governance principles articulated in global guidance and demonstrate the benefits of recognizing SGMs as partners in health rather than merely recipients of care (UNAIDS, 2021). However, their sustainability is undermined by short-term funding and limited institutionalization within the public sector. Without stable support and formal recognition, there is a risk that they function as temporary "patches" over structural inequities rather than catalysts for enduring change.

The review also suggests that multi-level interventions, those that combine provider training, community- and peer-led initiatives, and rights-based policy or governance reforms, are more likely to produce meaningful shifts than isolated efforts. Studies describing such configurations reported more coherent narratives of change, for example, when trained providers worked within facilities with explicit non-discrimination policies and established referral relationships with SGM-led organizations (Duby *et al.*, 2018; Scherf, 2024). This aligns with the social determinants and AAAQ frameworks, which emphasize the interaction between individual, community, and institutional factors in shaping health outcomes (Munn *et al.*, 2018; WHO, 2021). However, the heterogeneity of designs and outcomes, as well as the scarcity of medium- to

long-term evaluations, impose clear limits on what can be concluded about comparative or cost-effectiveness.

The findings must be interpreted in light of several important limitations. First, the review relied on a narrative thematic synthesis rather than a meta-analysis. Although quantitative synthesis and effect-size calculation were considered, the diversity of study designs, populations, interventions, and outcome measures, as well as the predominance of qualitative and mixed-methods research, precluded a robust meta-analysis. Narrative synthesis is suitable for complex social and governance questions, allowing for rich, contextualized interpretation. However, it does not yield aggregated, replicable estimates of intervention effectiveness and is more vulnerable to interpretive bias (Dixon-Woods *et al.*, 2005; Popay *et al.*, 2006). The conclusions presented here should therefore be understood as indicative and interpretive rather than definitive causal estimates.

Second, the evidence base itself is limited and uneven. The 15 included studies, while informative, do not capture the full diversity of SGM experiences in South Africa. MSM and transgender women, particularly in urban settings, were overrepresented relative to bisexual, intersex, and non-binary people, SGMs in rural and under-resourced provinces, older SGMs, and those living at the intersection of SGM identity, disability, migration, or extreme poverty (Cloete *et al.*, 2022; Fish *et al.*, 2019; Seretlo *et al.*, 2024). Many evaluations of interventions were small-scale, used non-standardized outcome measures, and lacked long-term follow-up, making it difficult to compare strategies or to assess the durability of effects. Policy and governance analyses, while rich in insight, often rely on document review and key informant interviews rather than systematic outcome data, and they may be influenced by the perspectives of particularly engaged actors.

Third, although the review employed a comprehensive search strategy and included gray literature, it is possible that some relevant studies were missed, particularly those published in less visible outlets or not explicitly framed around SGMs. The decision not to calculate formal inter-rater reliability statistics, such as Cohen's kappa, for screening and extraction reflects the modest number of included studies and the conceptual nature of eligibility decisions; however, it also means that the consistency of judgments cannot be quantified. These limitations are transparently acknowledged and partially mitigated by the use of independent screening, consensus discussions, and design-appropriate tools for risk of bias assessment (Higgins *et al.*, 2019; Sterne *et al.*, 2016).

Despite these limitations, the review has several strengths. It brings together empirical, programmatic,

and governance-oriented evidence that has typically been considered in isolation. It analyzes this body of work within an explicit conceptual framework that links social determinants, AAAQ, and rights-based, participatory governance. It extends the existing literature on SGM health by focusing not only on documenting stigma and risk but also on the architecture of interventions and governance arrangements that seek to address inequities. Importantly, it grounds the analysis in the specificities of the South African health system and constitutional context, while drawing on international norms and SDG commitments as reference points (Beyrer *et al.*, 2016; UNAIDS, 2021; WHO, 2021).

The implications for policy and practice are clear. Policymakers should move beyond rhetoric and isolated pilot projects toward comprehensive, system-wide strategies that mainstream SGM health across programs and levels of care. This includes embedding SGM competencies in health professional education; institutionalizing regular, well-designed training with supportive supervision; integrating sexual orientation and gender identity (SOGI)-sensitive indicators into information systems; and establishing robust mechanisms for community participation and redress. Donors and implementing partners should prioritize long-term partnerships with SGM-led organizations, recognizing their expertise and ensuring they are not relegated to marginal, short-term roles. For practitioners, the findings underscore the importance of reflexivity, respectful communication, and the recognition of SGMs as rights-bearing individuals whose health needs are legitimate and diverse.

Future research should build on this foundation by pursuing two complementary directions. First, there is a need for more rigorous, theory-informed intervention studies that use robust designs, standardized outcome measures, and sufficient follow-up to assess how and under what conditions multi-level strategies reduce inequities. Such studies should be co-designed with SGM communities and explicitly link their outcomes to SDG indicators and to the AAAQ dimensions. Second, research must address neglected populations and contexts, including bisexual, intersex, and non-binary people, SGMs in rural and small-town settings, older SGMs, and those with intersecting vulnerabilities. Mixed-methods approaches that combine quantitative indicators of service utilization and health outcomes with qualitative exploration of lived experiences, power dynamics, and governance processes will be particularly valuable in deepening understanding of how reforms play out in practice.

In summary, the review reveals that South Africa has robust legal and policy foundations, as well as a growing

repertoire of promising interventions and governance innovations; however, health equity for SGMs remains constrained by systemic barriers, uneven implementation, and a fragmented evidence base. Legal protections, while essential, must be operationalized through sustained systemic reforms and inclusive practices if they are to fulfill their promise. Advancing SDGs 3 and 10 for SGMs requires not only additional resources but also shifts in power, voice, and accountability within the health system, thereby moving SGMs from the margins of policy and practice to the center of health equity agendas.

5. Conclusion

This systematic review synthesized 15 empirical and policy-relevant studies to examine how SGMs in South Africa engage with the health system, the barriers they encounter, and the interventions and governance approaches that seek to advance health equity. The findings show that, despite a progressive constitutional and legal framework, SGMs continue to face pervasive stigma, discrimination, and structural exclusion across multiple levels of care. These inequities are sustained by heteronormative and cisnormative institutional cultures, gaps in provider training, the invisibility of SGMs in routine health information systems, and weak mechanisms for accountability and redress. Together, these dynamics undermine progress toward SDGs 3 (good health and well-being) and 10 (reduced inequalities), demonstrating that formal legal protections, while essential, are insufficient on their own to secure equitable, acceptable, and high-quality care.

At the same time, the review identifies a growing repertoire of promising responses. Healthcare worker sensitization and training initiatives, community- and peer-led psychosocial and HIV-prevention programs, and rights-based policy and participatory governance efforts each contribute, in different ways, to creating more enabling environments for SGMs within the health system. The evidence suggests that multi-level strategies, which combine these approaches, are more likely to produce meaningful and sustained improvements than isolated interventions. However, the current evidence base is heterogeneous, often small-scale, and rarely evaluated with robust, standardized outcome measures or long-term follow-up, thereby limiting firm conclusions about comparative effectiveness.

Advancing health equity for SGMs in South Africa will therefore require moving beyond pilot projects and rhetorical commitments toward comprehensive system-wide reforms. These include embedding SGM health competencies in professional education and continuing

training, integrating SOGI-sensitive indicators into health information systems, strengthening accountability and redress mechanisms, and institutionalizing meaningful SGM participation in health planning and oversight. Future research should prioritize rigorous, theory-informed evaluations of multi-level interventions and address critical gaps relating to bisexual, intersex, and non-binary people, rural and small-town contexts, and intersecting vulnerabilities. By aligning legal norms, institutional practices, and participatory governance with the lived realities of SGMs, South Africa can move closer to realizing the promise of its Constitution and the SDGs for all its citizens.

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