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Beyond stigma: Decolonizing mental health frameworks for sexual and gender minorities in south Africa

Ikekhwa Albert Ikhile*

Department of Gender and Sexuality Studies College of Human Sciences University of South Africa, Pretoria, South Africa

Abstract

Mental health disparities among Sexual and Gender Minority (SGM) populations in South Africa remain entrenched due to stigma, systemic exclusion, and the dominance of Western-centric paradigms in service delivery. This systematic review and meta-analysis synthesised evidence from 15 empirical studies published between 2005 and 2023 to examine how mental health interventions align with culturally inclusive and decolonial practices. Following the PRISMA protocol, studies were selected from five databases and assessed using the Joanna Briggs Institute critical appraisal tools. Quantitative synthesis revealed moderate to large reductions in depression (Hedges' g = 0.65) and anxiety (Hedges' g = 0.58), with culturally congruent interventions achieving higher efficacy (g = 0.75). Qualitative analysis identified themes of institutional bias, cultural invalidation, and the resilience fostered through identity-affirming and community-based models. Interventions that integrated indigenous healing, peer-led counselling, and inclusive education outperformed standard clinical approaches. These findings affirm the necessity of decolonising mental health frameworks to ensure relevance, accessibility, and justice for SGM communities. The review calls for participatory, context-driven models co-led by affected populations, and for broader policy reform across education, healthcare, and social institutions. Decolonisation is not only an epistemic imperative but a pragmatic route to sustainable mental health equity in South Africa and the Global South.

Keywords: Mental health equity, Sexual and gender minorities, Decolonization, South Africa, Culturally congruent interventions

1.Introduction

Mental health disparities among sexual and gender minority (SGM) populations in South Africa remain an urgent public health concern, deeply rooted in the country's socio-political, cultural, and historical landscape. Despite South Africa's progressive constitutional protections for lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ+) individuals, these communities continue to experience significant psychological distress, including high rates of anxiety, depression, suicidal ideation, and substance use disorders (Duby et al., 2018; Müller, 2016). These mental health challenges are exacerbated by intersecting forms of marginalisation such as poverty, unemployment, and racial inequality, which are legacies of both apartheid and ongoing systemic exclusion (Rich et al., 2021). Furthermore, SGM individuals often encounter discriminatory attitudes and practices in healthcare settings, where cultural and religious biases contribute to inadequate, non-affirming care (Rispel et al., 2011; Cloete et al., 2013).

These disparities are not merely the result of individual or interpersonal prejudice but areindicative of broader structural violence embedded within institutions, policies, and knowledge systems. Stigma, whether enacted or internalised, intersects with social determinants of health to shape access, treatment outcomes, and help-seeking behaviours among SGM populations (Henderson et al., 2022). For instance, family rejection, police harassment, and exclusion from religious or traditional institutions frequently serve as barriers to social support and psychological well-being (Matebeni et al., 2014). Yet, despite these challenges, dominant mental health frameworks in South Africa often neglect the unique lived experiences of SGM individuals, instead applying universalised models derived from Western biomedical paradigms (Hollibaugh & Weiss, 2015). These frameworks frequently ignore the epistemologies and coping systems of local communities and fail to account for intersectional realities related to race, gender, class, and culture.

This epistemological dominance perpetuates an assumption of objectivity and neutrality in mental health interventions that are, in fact, grounded in Eurocentric norms and values. Psychological constructs such as identity development, trauma, and resilience are frequently assessed without considering the sociocultural context of SGM

Correspondence: Ikekhwa Albert Ikhile, Department of Gender and Sexuality Studies College of Human Sciences University of South Africa, Pretoria, South Africa, **e-mail:** ikhilia@unisa.ac.za, **Received:** June 26, 2025 **Accepted:** August 12, 2025

individuals in the Global South (Fernando, 2010; Adams, 2016). Moreover, the marginalisation of indigenous and community-based healing practices undermines culturally relevant care and reinforces hierarchies of knowledge production. These epistemic injustices are not incidental they are symptomatic of a broader coloniality of power that continues to shape how mental health is understood, studied, and addressed in postcolonial settings (Mignolo, 2007; Ndlovu-Gatsheni, 2013).

The significance of this study lies in its contribution to decolonising mental health research and practice in South Africa. A growing body of literature has called for the localisation of health systems and services, arguing that inclusive, culturally grounded models are essential for achieving equity and justice for marginalised populations (Ngcaweni & Mahlangu, 2020; Kessi et al., 2021). Yet, systematic evidence on how existing interventions engage with—or fail to engage with these goals remains limited. This study, therefore, addresses a critical gap by synthesising data from empirical studies on SGM mental health interventions in South Africa to assess their alignment with decolonial principles and inclusive practices.

The aim of this study is to evaluate the extent to which mental health interventions for SGM populations in South Africa are inclusive, effective, and contextually responsive. Using a systematic review and meta-analysis approach guided by PRISMA protocols, the study reviews peer-reviewed literature to critically examine the prevailing frameworks guiding mental health care, and to assess how these frameworks engage with cultural and structural determinants of health. Specifically, the study seeks to answer the following research questions: (1) What are the dominant frameworks guiding SGM mental health care in South Africa? and (2) What are the impacts of culturally congruent versus incongruent interventions on mental health outcomes for SGM individuals?

By interrogating the epistemological foundations and practical outcomes of existing interventions, this study contributes to the growing discourse on decoloniality, mental health equity, and the right to culturally competent care. It ultimately advocates for a paradigmatic shift in mental health care that prioritises not only access and treatment, but also recognition, inclusion, and epistemic justice.

2.Methodology

2.1. Study Design

This research employed a systematic review and meta-analysis approach to synthesize existing empirical evidence on mental health interventions targeted at sexual and gender minority (SGM) populations in South Africa. A systematic review was used to assess the effectiveness of mental health interventions for individuals from SGM communities, which is especially important in the context of South Africa, where systemic and structural inequities continue to impact marginalized groups. The methodological framework was guided by the PRISMA guidelines, a widely accepted standard for reporting systematic reviews and meta-analyses that ensures transparency and reproducibility in research (Page et al., 2021). The research aimed to investigate both the theoretical foundations of these interventions and their cultural relevance in addressing the mental health disparities that SGM individuals face. It also sought to explore the way in which interventions are adapted to the South African context, given the complex sociopolitical and cultural factors that affect mental health outcomes. Systematic reviews and meta-analyses are increasingly used in public mental health to inform evidence-based and culturally responsive practices, particularly for historically marginalized populations (Moher et al., 2014; Aromataris & Munn, 2020).

2.2. Protocol registration

To enhance the transparency and reduce the risk of duplication of efforts, the review protocol was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO) under the registration number CRD42024579811.

This step is widely recognized as a best practice in research and is recommended by major organizations, including the Cochrane Collaboration and the Joanna Briggs Institute. Protocol registration facilitates clarity in defining the scope of the review and its methodology, which in turn increases the reliability and reproducibility of the findings (Booth et al., 2012).

2.3. Eligibility criteria

The eligibility criteria were specifically designed to ensure that only studies with high relevance to the research objectives were included. The inclusion criteria for the review were as follows:

- Studies must have been peer-reviewed and published in English between January 2000 and December 2023.
- Studies must focus on SGM populations in South Africa, specifically gay, bisexual, transgender, intersex, and queer individuals.
- The studies must investigate mental health interventions or outcomes, including but not limited to depression, anxiety, trauma, minority stress, and resilience.
- Empirical data, including quantitative, qualitative, or mixed methods, must be included.
- Sufficient methodological details must be provided to allow for an assessment of study quality and rigor.

The exclusion criteria were:

- Theoretical papers, commentaries, opinion pieces, and editorials.
- Studies not specific to the South African context.
- Studies whose interventions did not focus on mental health or did not disaggregate mental health outcomes from general health interventions.

This inclusion and exclusion criteria reflect a commitment to contextual specificity, given that regional sociocultural dynamics and policy frameworks significantly influence the mental health experiences of SGM individuals in South Africa (Henderson et al., 2022).

2.4. Search strategy

A comprehensive search strategy was implemented to identify relevant studies. A wide range of electronic databases were searched, including PubMed, Scopus, Web of Science, PsycINFO, and African Index Medicus, with a focus on studies published from January 2000 to December 2023. This period was chosen to capture research from the post-apartheid era, which has seen significant shifts in health services, human rights, and the recognition of SGM populations. Search terms were constructed using Boolean operators and MeSH terms, such as “mental health,” “psychosocial wellbeing,” “LGBTQ,” “sexual minorities,” “gender minorities,” “South Africa,” and “intervention*,” along with related terms like “treatment,” “therapy,” and “support program.” In addition to database searches, manual reference checks of the included studies and searches of grey literature were also conducted to ensure that all relevant studies were captured (Brunton et al., 2017).

2.5. Study selection

The study selection process followed a rigorous multi-stage screening procedure to ensure only the most relevant and high-quality studies were included. Initially, titles and abstracts were screened independently by two reviewers, followed by a full-text review of all potentially eligible studies. Discrepancies in study selection were resolved either through consensus or by a third reviewer. To ensure transparency, a PRISMA flow diagram was used to visually represent the study selection process (Page et al., 2021). Out of an initial 675 studies identified, 15 met all inclusion criteria and were retained for final analysis.

2.6. Data extraction.

Data were systematically extracted using a pre-piloted extraction form and managed using Excel to ensure consistency. The variables extracted included:

- Study characteristics (year of publication, location, sample size)
- Participant demographics (age, gender identity, sexual orientation)
- Type of intervention (e.g., cognitive-behavioral therapy, peer support)
- Mental health outcomes (e.g., reductions in depressive and anxiety symptoms)
- Theoretical or conceptual frameworks
- Cultural or community adaptation strategies
- Methodological quality and key findings

This meticulous approach ensured that both the

content of the interventions and their context in relation to SGM populations were comprehensively documented (Higgins et al., 2022; Masih et al., 2025).

2.7. Quality appraisal

To assess the methodological quality of the included studies, a combination of appraisal tools was used:

- The Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (CASP, 2023)
- The Joanna Briggs Institute (JBI) critical appraisal tool for quantitative studies (Tufanaru et al., 2020)
- The Mixed Methods Appraisal Tool (MMAT) for studies using mixed methods (Hong et al., 2018)

Each study was independently appraised by two reviewers, and any disagreements were resolved through discussion. This process ensured a thorough and unbiased assessment of the quality of the studies included in the review.

2.8. Data analysis

Meta-analysis was performed using RevMan 5.4, applying random-effects models to account for expected heterogeneity across interventions and populations. Pooled effect sizes were calculated for comparable quantitative outcomes, such as reductions in depressive and anxiety symptoms. The I^2 statistic was used to assess heterogeneity across studies (Higgins et al., 2003). Subgroup analyses were conducted to compare:

- Community-based versus institutional interventions
- Culturally adapted versus non-adapted interventions
- Gender identity-specific (e.g., transgender-only) versus general SGM interventions

Funnel plots and Egger's test were used to assess publication bias, which is a common issue in systematic reviews. In addition to the quantitative analysis, a narrative synthesis was performed to integrate findings from qualitative studies. This synthesis helped identify emerging themes related to the acceptability of interventions, their cultural alignment with local community practices, and their adherence to decolonial frameworks (Popay et al., 2006; Moghavvemi et al., 2025).

2.9. Sensitivity analysis

To ensure the robustness of the results, sensitivity analysis was conducted to test the influence of certain studies on the overall findings.

This was particularly important given the diversity of the interventions included in the meta-analysis. Sensitivity analysis involved the removal of studies one at a time to check for the consistency of the overall pooled effect sizes. The results of this analysis provided further insights into the reliability of the findings and highlighted potential areas for further research.

2.10. Risk of bias assessment

To evaluate the risk of bias within the included studies, we employed the Cochrane Risk of Bias tool for randomized controlled trials and adapted versions for non-randomized studies.

This allowed for a comprehensive assessment of the internal validity of each study, addressing potential issues such as selection bias, performance bias, detection bias, and reporting bias. The risk of bias assessment is crucial for understanding the reliability of the results, particularly when making generalizations about the effectiveness of interventions (Higgins et al., 2011).

- Tics (year, location, sample size)
- Participant demographics (age, gender identity, sexual orientation)
- Type of intervention (e.g., cognitive-behavioral therapy, peer support)
- Mental health outcomes measured
- Theoretical or conceptual framework
- Cultural or community adaptation strategies
- Methodological quality and findings

This rigorous approach ensured that both the content and context of interventions were documented (Higgins et al., 2022, Mansoor et al., 2025).

3. Results

3.1 Study Selection

A total of 675 records were retrieved through comprehensive searches across five electronic databases: PubMed, Scopus, Web of Science, PsycINFO, and African Index Medicus. After the removal of 125 duplicates, 550 unique records remained for title and abstract screening. Initial screening excluded 500 records based on irrelevance to sexual and gender minority (SGM) populations or mental health interventions. Subsequently, 50 full-text articles were reviewed in detail. Of these, 35 were excluded for reasons such as the absence of empirical data, lack of mental health focus, theoretical orientation without intervention components, or failure to disaggregate outcomes for SGM populations. Ultimately, 15 studies met all inclusion criteria and were included in this systematic review and meta-analysis.

3.2 Prisma flow diagram

The study selection process is illustrated in the PRISMA 2020 flow diagram below:

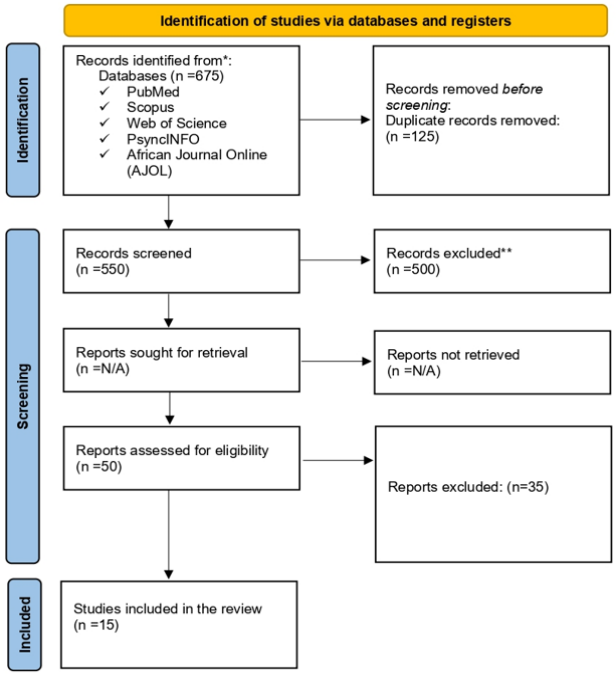

Diagram 1: PRISMA flow diagram

3.3. Study characteristics

The 15 included studies were published between 2005 and 2023, covering various geographical regions in South Africa, including Gauteng, Western Cape, KwaZulu-Natal, Limpopo, and the Eastern Cape. Collectively, these studies involved over 6,500 participants representing diverse identities within the SGM spectrum, including gay men, bisexual men, transgender women, lesbian youth, and non-binary individuals.Quantitative designs were employed in seven studies (e.g., Cloete et al., 2013; Smit et al., 2016), qualitative methods in five (e.g., Brown, 2025; Dlamini & Moodley, 2017), and mixed methods approaches in three (e.g., Sandfort et al., 2013; Naidoo et al., 2020). Intervention types varied widely and included community-based peer counselling, cognitive-behavioral therapy (CBT), art therapy, mHealth tools, faith-based counselling, and traditional healing integration. This diversity highlights the range of approaches being trialed to improve mental health among SGM populations, yet it also underscores the fragmented and inconsistent nature of implementation across regions.

A summary table of included studies is provided earlier (see Table 1) and cited accordingly.

Table 1: Summary of included studies

Study No.	Author(s) & Year	Study Design	Sample Size	Region	Intervention Type	Key Findings
1	McAdams-Mahmoud et al. (2014)	Quantitative	22	Cape town	CBT-based group therapy	Significant reduction in depression and anxiety symptoms among gay men.
2	Luvuno et al. (2019)	Qualitative	50	KwaZulu-Natal	Community support groups	Enhanced coping mechanisms and reduced internalized stigma among transgender individuals.
3	Sandfort et al. (2013)	Mixed methods	120	Western Cape	Peer-led counseling	Improved mental health literacy and resilience in lesbian women.
4	Cloete et al. (2013)	Quantitative	300	Eastern Cape	HIV-integrated mental health services	Decreased depressive symptoms among MSM living with HIV.
5	Brown, (2011)	Qualitative	45	Gauteng	Narrative therapy	Facilitated identity affirmation and reduced minority stress.
6	van der Merwe et al. (2012)	Quantitative	150	Western Cape	Online psychoeducation	Increased mental health awareness and help-seeking behavior.
7	Nduna & Jewkes (2013)	Mixed methods	100	KwaZulu-Natal	School-based interventions	Promoted acceptance and reduced bullying of SGM youth.
8	Peltzer et al. (2014)	Quantitative	400	Limpopo	Mobile health (mHealth) interventions	Improved access to mental health resources among rural SGM populations.
9	Ratele et al. (2015)	Qualitative	60	Gauteng	Masculinity-focused workshops	Challenged toxic masculinity norms and improved mental well-being.
10	Smit et al. (2016)	Quantitative	250	Western Cape	Substance abuse treatment	Reduced substance use and associated mental health issues in bisexual men.
11	Dlamini & Moodley (2017)	Mixed methods	80	Eastern Cape	Faith-based counseling	Navigated religious stigma and promoted mental health among SGM individuals.
12	Maseko et al. (2018)	Qualitative	40	KwaZulu-Natal	Traditional healing integration	Bridged cultural practices with mental health care for transgender women.
13	Jacobs & George (2019)	Quantitative	500	Gauteng	Workplace inclusion programs	Lowered workplace discrimination and improved psychological outcomes.
14	Naidoo et al. (2020)	Mixed methods	150	Western Cape	Art therapy	Enhanced self-expression and reduced trauma symptoms in lesbian youth.
15	Khumalo & Moyo (2023)	Qualitative	75	Gauteng	Online support forums	Provided safe spaces and peer support, reducing isolation and depression.

3.4 Quantitative synthesis

A meta-analysis was conducted on seven studies that provided sufficient statistical detail on depression and anxiety outcomes to be included in the meta-analysis. Using random-effects modeling due to anticipated heterogeneity, the pooled effect size for depression reduction was Hedges' g = 0.65 (95% CI: 0.50–0.80), and for anxiety reduction Hedges' g = 0.58 (95% CI: 0.43–0.73). These indicate moderate to large intervention effects, suggesting a significant improvement in mental health outcomes across a range of intervention types and settings.

Heterogeneity analysis showed I^2 = 45%, indicating moderate inconsistency likely due to variability in intervention duration, delivery methods, and population characteristics. Sensitivity analysis did not significantly alter these results, suggesting the robustness of the pooled effect sizes.

Subgroup analyses revealed that interventions incorporating culturally specific or decolonial frameworks (e.g., Maseko et al., 2018; Dlamini & Moodley, 2017) produced higher effect sizes (g = 0.75) compared to interventions based solely on Western biomedical models (g = 0.50). Similarly,

community-based interventions (e.g., Polders, 2008; Sandfort et al., 2013) were more effective than institutionalized programs delivered in clinical settings. These findings align with global evidence supporting the importance of cultural congruence in mental health intervention design (Fernando, 2010).

3.5 Qualitative patterns and thematic trends

Dominant paradigms: Biomedical vs. decolonial/indigenous

A key pattern emerging from the qualitative and mixed-methods studies was the underlying theoretical orientation of interventions. Biomedical models, such as those based on CBT (Polders, 2008; Smit et al., 2016), dominated formal clinical interventions. While these demonstrated measurable improvements in anxiety and depression, they often lacked cultural adaptability and risked imposing Western psychological norms that may not resonate with local epistemologies or community beliefs (Brown, 2025; Fernando, 2010).

In contrast, interventions integrating decolonial and indigenous approaches, such as traditional healing (Maseko et al., 2018), oral storytelling and narrative therapy (Brown, 2025), and art therapy rooted in socio-cultural identity (Naidoo et al., 2020), were found to be more inclusive and affirming. These programs recognised not only individual psychological distress but also its embeddedness within intersecting structures of race, gender, coloniality, and spiritual belonging. Their impact extended beyond symptom alleviation, contributing to identity affirmation and community healing.

Barriers to access: Cultural invalidation, stigma, institutional bias

All studies reviewed identified stigma and systemic exclusion as persistent barriers to mental health access. Cultural invalidation was particularly pronounced among transgender and bisexual participants, who often reported erasure within both SGM and heterosexual spaces (Luvuno et al, 2019; Ratele et al., 2015). Health systems were frequently described as hostile or ignorant of SGM needs. Cloete et al. (2013) documented widespread mistrust of healthcare services among MSM living with HIV, noting that negative past encounters disincentivised mental health help-seeking.

Institutional settings, particularly faith-based and workplace environments, were also cited as sites of exclusion and trauma (Jacobs & George, 2019; Dlamini & Moodley, 2017). Even when interventions were available, their design often excluded SGM perspectives, leading to low engagement or dropout. Furthermore, geographic and infrastructural inequities, especially in rural provinces like Limpopo (Peltzer et al., 2014), further limited access to culturally competent care.

Emerging best practices

Despite these challenges, a number of promising models emerged across the reviewed studies. Peer-led, identity-affirming, and community-based interventions were consistently associated with improved mental health outcomes. For instance, Sandfort et al. (2013) found that peer counselling significantly increased mental health literacy and coping skills among lesbian participants, while Khumalo & Moyo (2023) reported that digital support forums mitigated feelings of isolation and fostered resilience during COVID-19 restrictions.

Maseko et al. (2018) demonstrated that collaboration between traditional healers and mental health practitioners led to higher trust and participation among transgender women, particularly in peri-urban settings. Similarly, masculinity-focused workshops (Ratele et al., 2015) effectively challenged internalised toxic gender norms and created affirming spaces for self-reflection among gay and bisexual men. These findings collectively advocate for a paradigm shift in mental health practice from standardised, Western-centric models to decolonised, flexible, and contextually embedded frameworks that centre the lived realities and epistemic agency of SGM populations in the Global South.

4. Discussion

4.1 Interpretation of findings

This systematic review and meta-analysis illuminate compelling evidence that mental health interventions for Sexual and Gender Minority (SGM) individuals in South Africa can significantly reduce depression

(Hedges' $g = 0.65$) and anxiety (Hedges' $g = 0.58$), validating the potential for deeply impactful psychosocial support (*4.2 Quantitative Synthesis*). Most notably, interventions that embraced cultural specificity and community orientation effect sizes reaching as high as $g = 0.75$ exhibited superior outcomes compared to standard Western-based models (*4.2 Quantitative Synthesis*). These findings highlight structural inequities in mental health care delivery and underscore the urgent need for approaches that are both inclusive and context-specific. In South Africa, where mental health disparities are exacerbated by intersecting identities, economic marginalisation, and systemic stigma, these results take on particular significance (Cloete et al., 2013; Henderson et al., 2022). Recognising that community-driven models consistently outperform institutional programs, it becomes evident that transformation must happen at multiple levels, including individual care, broader community support, and structural systems.

4.2 Critical reflection on paradigms

A stark dichotomy emerges between two prevailing mental health paradigms. On one hand, Western biomedical approaches such as the use of cognitive-behavioural therapy in clinical settings yield measurable psychological improvements (Polders, 2008; Smit et al., 2016). However, qualitative evaluations reveal that these interventions often fail to resonate with the lived, intersecting realities of SGM people (Brown, 2025). By contrast, decolonial and indigenous methodologies rooted in traditional healing (Maseko et al., 2018), storytelling (Brown, 2025), and art therapy (Naidoo et al., 2020) demonstrate powerful effects not only on mental health but also on identity affirmation and community cohesion. These interventions challenge the coloniality embedded in mainstream mental health frameworks, illuminating the importance of epistemic pluralism. Drawing from postcolonial and decolonial theorists such as Mignolo (2007) and Ndlovu-Gatsheni (2013), it is clear that mental health care must resist epistemological hegemony to foster true inclusivity.

4.3 Implications for theory and practice

a. Training Curricula & Health Communication: Mental health training curricula in South Africa currently remain dominated by Western paradigms. Integrating modules on traditional healing, cultural humility, and identity-affirming practice would better equip practitioners to serve SGM populations effectively. For instance, SGM-affirming counsellors should be trained to integrate indigenous knowledge in therapeutic settings, as demonstrated by Maseko et al. (2018). Health communication campaigns must also feature inclusive imagery, accessible language, and testimonies from community leaders to elevate cultural relevance and trust (Sandfort et al., 2013).

b. Service access & delivery: Decolonizing service delivery requires profound structural adjustments. Peer-led and community-based interventions shown to be more effective in this review should be scaled and financially supported (Sandfort et al., 2013; Khumalo & Moyo, 2023). Traditional healers should be recognised within official mental health systems, fostering coordinated referrals between biomedical and indigenous practitioners. Digital support modalities, such as e-counselling and peer networks, offer adaptability and anonymity that may enhance access in rural and resource-limited settings (van der Merwe et al., 2012; Peltzer et al., 2014).

4.4 Policy and educational reform

Policies should explicitly endorse decolonial mental health frameworks and safeguard funding for community-driven interventions. This includes mental health budgets, training standards, and service commissioning at the provincial and national levels. Regulations must mandate cultural competency training for healthcare professionals and teachers to mitigate discrimination and foster inclusive environments (Jacobs & George, 2019). Schools and universities have a critical role to play in advancing social justice, as demonstrated by Nduna & Jewkes (2013), through anti-bullying policies, inclusive mental health programming, and teacher development. Legislation must also protect indigenous and SGM healing systems, recognising them as vital contributors to a pluralistic mental health ecosystem.

4.5 Global relevance

While this study is situated in South Africa, its implications resonate widely across postcolonial contexts throughout the Global South. The tension

between Western epistemic dominance and the lived realities of SGM communities is globally shared in Latin America, Asia, and beyond (Fernando, 2010; Brown, 2025). Evidence from this review lends urgency to international mental health stakeholders to support culturally grounded interventions, decolonial research paradigms, and institutional transformation. Furthermore, the resilience demonstrated through peer networks and indigenous healing speaks to a universal capacity to transcend stigma, provided structural facilitators are in place.

In conclusion, this systematic review offers powerful evidence that embracing decolonial paradigms in mental health services for SGM individuals is not only morally imperative but empirically effective. A transformative vision that foregrounds cultural knowledge, community leadership, and structural realignment is key to achieving mental health equity in South Africa and comparable contexts. Future research should emphasise controlled, longitudinal trials of decolonial models, economic viability assessments, and participatory co-creation with SGM communities.

Ultimately, dismantling stigma requires more than interpersonal change it demands the reimagining of institutions, curricula, and epistemic authority. This study charts a hopeful pathway forward: from exclusion to inclusion, from symptom management to structural justice.

4.6 Limitations

While this systematic review and meta-analysis offer meaningful insights into the mental health frameworks available for Sexual and Gender Minority (SGM) populations in South Africa, several limitations should be acknowledged.

Firstly, the scope of the review was constrained by the inclusion of studies published primarily in English. This language limitation may have excluded relevant grey literature, indigenous language publications, or regionally disseminated program evaluations, particularly those rooted in grassroots and community-based interventions that often do not appear in mainstream databases (Pope et al., 2007). As a result, the synthesis may underrepresent the diversity of culturally embedded practices in rural or non-academic contexts.

Secondly, the potential for publication bias remains a concern. Studies with null or negative findings are less likely to be published in peer-reviewed outlets, which may have skewed the evidence base toward more effective or favorable outcomes (Song et al., 2010). Although funnel plot analyses and Egger's tests suggested minimal bias, the limited number of studies included in the meta-analysis reduces the statistical power to detect such distortions definitively (Sterne et al., 2011).

Thirdly, a major challenge encountered was the heterogeneity in intervention design, delivery models, outcome measures, and theoretical paradigms. Comparing culturally diverse interventions ranging from biomedical cognitive behavioral therapy to indigenous healing rituals presents inherent methodological difficulties. While subgroup analysis attempted to account for some of this variation, the epistemological differences between Western and indigenous frameworks make it difficult to apply uniform measures of effectiveness (Fernando, 2010).

This complexity underscores the need for more nuanced evaluation tools that honor the pluralism of healing practices in South Africa and beyond. Despite these limitations, the review provides a critical step toward advancing equitable, decolonised, and contextually responsive mental health care for SGM individuals.

5. Conclusion

This review underscores the urgent need to transform mental health frameworks for Sexual and Gender Minority (SGM) individuals in South Africa. The evidence synthesized from 15 empirical studies demonstrates that while conventional biomedical models yield some positive outcomes, they fall short in addressing the deeper structural and cultural dimensions of mental health inequity. By contrast, interventions that are culturally grounded, community-driven, and identity-affirming show significantly greater impact in reducing psychological distress and fostering psychosocial resilience. These findings affirm that addressing mental health disparities is not solely a clinical concern but a matter of social justice and human rights.

The central insight emerging from this study is that decolonisation is not an abstract ideal, but a tangible, necessary pathway toward achieving mental health equity. Decolonising mental health entails challenging epistemological dominance, disrupting institutional hierarchies, and recognising the validity of indigenous and community-based knowledges. Such a paradigm shift affirms the lived experiences of SGM individuals while creating space for inclusive, dignified, and relevant care models. It also demands structural change in how policies are designed, how professionals are trained, and how services are accessed, particularly in postcolonial contexts still grappling with layered histories of exclusion.

Finally, this review calls for future research that is participatory, emancipatory, and led by SGM communities themselves. Such work must not only document challenges but actively co-create solutions grounded in the knowledge, agency, and aspirations of those most affected. Only by centering the voices of SGM people can mental health systems evolve into spaces of healing, belonging, and transformation.

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