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SOCIETAL ATTITUDES AND STIGMA TOWARDS INTERSEX INDIVIDUALS IN GHANA: A MIXED METHODS STUDY

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ABSTRACT

In contemporary Ghanaian society, where cultural norms, traditional beliefs, and religious values profoundly shape understandings of gender and human sexuality, individuals with intersex variations occupy a particularly vulnerable position. Intersex persons—those born with chromosomal, gonadal, or anatomical characteristics that do not fit typical binary notions of male or female bodies—face unique challenges rooted in deeply entrenched societal attitudes toward gender conformity. Despite global advancements in intersex human rights advocacy and growing recognition of the medical and ethical controversies surrounding unnecessary normalizing surgeries, empirical research on societal attitudes toward intersex individuals in African contexts, particularly West Africa, remains exceptionally limited. This study examines societal attitudes and stigma toward intersex individuals in Ghana, exploring the nature, prevalence, and correlates of stigmatizing attitudes across diverse demographic groups. Employing a convergent parallel mixed methods design, the study integrates quantitative survey data from 600 Ghanaian adults with qualitative insights from focus group discussions and key informant interviews with healthcare providers, traditional leaders, educators, and intersex persons themselves. Drawing on Modified Labeling Theory and the Framework of Stigma and Social Exclusion, the study investigates how cultural beliefs, religious teachings, lack of awareness, and institutional practices contribute to the marginalization of intersex individuals. The findings aim to provide contextually grounded evidence to inform policy development, healthcare reform, public education campaigns, and legal protections for intersex persons in Ghana, contributing to the nascent scholarship on intersex issues in African contexts.

KEYWORDS: Intersex, stigma, societal attitudes, mixed methods, Ghana, gender diversity, cultural beliefs, human rights.

1. INTRODUCTION

The human body, in its remarkable diversity, does not always conform to the binary categories of male and female that have historically structured social organization across cultures. Individuals born with variations in sex characteristics—collectively referred to as intersex—represent a natural but often invisible segment of human diversity, with estimates suggesting that intersex variations occur in approximately 1.7% of live births, a prevalence comparable to that of red hair (Fausto-Sterling, 2000; Blackless et al., 2000). Despite this statistical reality, intersex individuals remain largely absent from public discourse, educational curricula, and policy frameworks in many parts of the world, particularly in sub-Saharan Africa. Their invisibility is not accidental but reflects deep-seated social discomfort with bodies that challenge taken-for-granted assumptions about gender, normalcy, and human identity (Davis, 2015).

The experience of being intersex in any society is shaped fundamentally by the attitudes of others—by the reactions of parents at birth, by the questions of teachers and classmates, by the clinical gaze of healthcare providers, and by the cultural meanings attached to gender non-conformity. When these attitudes are negative, when they are grounded in ignorance, fear, or moral condemnation, the consequences for intersex individuals can be devastating. Research from Western contexts has documented elevated rates of depression, anxiety, suicidality, and social isolation among intersex populations, outcomes that are directly attributable to stigmatization, secrecy, and the traumatic aftermath of medically unnecessary normalizing surgeries (Roen, 2019; Jones et al., 2016). Yet the nature and dynamics of stigma may differ substantially across cultural contexts, shaped by local belief systems, family structures, and institutional arrangements.

In Ghana, as in many African societies, gender is not merely a personal identity but a fundamental organizing principle of social life. The binary classification of persons as male or female structures kinship systems, inheritance practices, marriage arrangements, and ritual roles (Gyekye, 1996; Amadiume, 1987). Traditional Akan cosmology, for example, associates specific spiritual and social roles with men and women, roles that are predicated on clear sex differentiation (Opoku, 1978). Within such a cultural framework, an individual whose body does not fit neatly into either category may be perceived not simply as different but as anomalous, unsettling, or even threatening to the social order. Religious teachings, particularly within Ghana's dominant Christian and Muslim traditions, often reinforce binary understandings of gender as divinely ordained, potentially framing intersex variations as errors or aberrations (Dorman, 2022).

2. STATEMENT OF THE PROBLEM

The marginalization of intersex individuals globally has been increasingly recognized as a human rights concern, with United Nations treaty bodies, regional human rights mechanisms, and a growing number of national governments calling for an end to harmful practices, discrimination, and social exclusion based on sex characteristics (United Nations, 2019; Council of Europe, 2015). These international developments reflect a fundamental shift in understanding intersex issues—from a medical problem requiring correction to a human rights issue demanding protection. Yet the translation of these global norms into local realities depends critically on the specific social, cultural, and institutional contexts within which intersex individuals live their lives.

In Ghana, intersex individuals remain almost entirely absent from public awareness, policy discourse, and academic inquiry. This invisibility is itself a form of marginalization, rendering their specific needs and vulnerabilities invisible to policymakers, healthcare providers, educators, and the general public. When intersex people are not seen, their rights cannot be protected, their healthcare needs cannot be met, and their experiences of stigma cannot be addressed. The lack of empirical data on societal attitudes means that advocacy efforts proceed without evidence, interventions are designed without understanding the specific dynamics of stigma in the Ghanaian context, and the experiences of intersex Ghanaians remain unacknowledged in national conversations about gender, health, and human rights.

Several factors underscore the urgency of addressing this research gap. First, intersex infants continue to be born in Ghanaian hospitals and communities, and the decisions made about their care have lifelong consequences. Without understanding the attitudes of healthcare providers, the cultural beliefs that shape family responses, and the social environment into which these children will grow, we cannot ensure that they receive appropriate, ethical, and supportive care. Second, intersex children and adults face potential discrimination in education, employment, healthcare, and social participation, yet the extent and nature of this discrimination remain undocumented. Third, ongoing national debates about gender and sexuality in Ghana create a policy environment in which intersex issues may be misunderstood or conflated with other forms of diversity, potentially leading to inappropriate legal and policy responses.

The existing literature, while sparse, provides some indication of the challenges intersex individuals may face in African contexts. Studies from South Africa have documented experiences of shame, secrecy, and medical trauma among intersex individuals, as well as the intersection of intersex status with other axes of marginalization including poverty, rural residence, and limited access to information (Camminga, 2020; van Heerden, 2021). Research from Kenya has highlighted the role of traditional beliefs and community responses in shaping intersex experiences (Mwakazi, 2018). However, the specific cultural, religious, and institutional dynamics of the Ghanaian context remain unexplored.

Ghanaian cultural values, as articulated by philosophers such as Gyekye (1996), emphasize communal belonging, respect for elders, and the importance of maintaining social harmony. For intersex individuals, these cultural values may cut both ways—the desire for communal belonging may intensify the pain of exclusion, while the emphasis on harmony may pressure families to conceal intersex variations rather than seek support or advocacy. Religious teachings, which hold enormous influence in Ghanaian society, may shape attitudes toward intersex variations in complex ways, depending on how religious leaders interpret these variations in light of sacred texts and traditions. The absence of empirical research means that these dynamics remain matters of speculation rather than evidence-based understanding.

3. PURPOSE OF THE STUDY

The purpose of this study is to examine societal attitudes and stigma toward intersex individuals in Ghana, exploring the nature, prevalence, and demographic correlates of stigmatizing attitudes, as well as the lived experiences of intersex persons and the perspectives of key stakeholders who shape their social environment.

4. OBJECTIVES OF THE STUDY

4.1 General Objective

The general objective of the study is to investigate societal attitudes and stigma toward intersex individuals in Ghana, employing a mixed methods approach to generate comprehensive evidence for advocacy, policy, and practice.

4.2 Specific Objectives

The specific objectives of the study are to:

- Assess the level of awareness and knowledge about intersex variations among the Ghanaian adult population.
- Examine the nature and prevalence of stigmatizing attitudes toward intersex individuals across different demographic groups (age, gender, educational level, religious affiliation, geographic location).
- Explore the cultural beliefs, traditional values, and religious teachings that shape attitudes toward intersex variations in Ghanaian society.
- Investigate the experiences of stigma, discrimination, and social exclusion among intersex individuals in Ghana.

5. THEORETICAL LITERATURE

The investigation of societal attitudes and stigma toward intersex individuals in Ghana requires a robust theoretical foundation capable of accounting for both the micro-level processes through which stigma is experienced and the macro-level cultural and structural forces that shape these processes. This study draws on two complementary theoretical frameworks: Modified Labeling Theory and the Framework of Stigma and Social Exclusion. These perspectives collectively illuminate how societal attitudes are formed, how they translate into discriminatory behaviours and institutional practices, and how stigmatized individuals navigate and resist the negative consequences of social devaluation.

5.1 Modified Labeling Theory

Modified Labeling Theory, originally developed by Link and colleagues (Link, 1987; Link et al., 1989) in the context of mental illness stigma, provides a powerful framework for understanding how societal conceptions of difference translate into negative outcomes for individuals who are labelled as deviant or abnormal. The theory builds on earlier labeling perspectives but introduces important modifications that address criticisms of the original approach and provide greater specificity regarding the mechanisms through which labeling produces harmful consequences.

The foundational premise of Modified Labeling Theory is that societies develop shared conceptions of what it means to be a particular kind of person—what individuals with a given characteristic are like, how they should be treated, and what their future holds. These cultural conceptions are learned through socialization processes long before any individual acquires the characteristic in question or comes into contact with someone who has it. Children and adults absorb these beliefs from families, peers, media, religious institutions, and educational systems, internalizing a set of expectations about the devalued group.

When an individual is officially or informally labeled as belonging to that group—for example, when an infant is identified as intersex, or when an intersex person's status becomes known to others—the cultural conceptions become personally relevant. The labeled individual anticipates that others will devalue and discriminate against them, an expectation that Link and colleagues term "perceived devaluation-discrimination." This anticipation is not simply a cognitive belief but an emotionally charged expectation that shapes behavior and psychological well-being.

The theory identifies several consequences of holding such expectations. First, individuals may employ coping orientations to deal with the threat of rejection, including secrecy (concealing their status from others), withdrawal (limiting social interaction to avoid potential rejection), and educating others (providing information to counteract stereotypes). Each of these coping strategies, while potentially protective in some circumstances, carries its own costs. Secrecy requires constant vigilance and creates barriers to intimacy. Withdrawal reduces social support and opportunities. Education exposes individuals to potential rejection and places the burden of challenging stereotypes on the stigmatized person.

5.2 Framework of Stigma and Social Exclusion

The Framework of Stigma and Social Exclusion, drawing on the foundational work of Erving Goffman (1963) and subsequent developments by Link and Phelan (2001), Parker and Aggleton (2003), and others, provides a complementary perspective that emphasizes the social, cultural, and structural dimensions of stigma. This framework conceptualizes stigma not merely as an individual attitude or a set of negative beliefs but as a social process fundamentally linked to power, inequality, and the maintenance of social hierarchies.

Goffman's (1963) seminal analysis of stigma distinguished between three types of stigmatizing conditions: abominations of the body (physical deformities), blemishes of individual character (perceived moral failings), and tribal stigmas (race, nation, religion). Intersex variations, as visible or knowable physical characteristics that deviate from normative expectations about bodily form, can be understood as abominations of the body in Goffman's terminology. However, the stigma attached to intersex status often extends beyond the physical to encompass moral judgments about the person's character, particularly when intersex variations are associated with assumptions about sexual behaviour, gender identity, or deception.

Goffman's key insight was that stigma is fundamentally about the relationship between an attribute and a stereotype—about the discrepancy between what a person is expected to be (their "virtual social identity") and what they actually are (their "actual social identity"). When an individual possesses an attribute that is deeply discrediting, they are reduced in the minds of others from a whole and ordinary person to a tainted, discounted one. This reduction occurs through the application of stereotypes that associate the attribute with a range of negative characteristics, creating a unified stigma theory that explains the person's presumed inferiority and justifies differential treatment.

Building on Goffman's foundation, Link and Phelan (2001) proposed a more comprehensive conceptualization of stigma as the co-occurrence of several interrelated components: labeling (distinguishing and identifying human differences), stereotyping (associating labeled differences with negative attributes), separation (creating a categorical distinction between "us" and "them"), status loss and discrimination (experiencing negative outcomes as a result of the label), and the exercise of power (the ability to successfully apply these processes). This formulation emphasizes that stigma is not simply a matter of individual prejudice but a social process that requires power inequalities to be effective.

Parker and Aggleton (2003) further extended this framework by arguing that stigma must be understood in relation to social inequality and the production and reproduction of social order. They draw attention to the ways that stigma functions ideologically to legitimize and perpetuate existing social hierarchies. Stigmatization, in this view, is not merely a set of attitudes but a form of structural violence that reinforces the marginalization of already vulnerable groups. This perspective is particularly relevant to understanding the situation of intersex individuals in Ghana, where multiple forms of inequality—based on gender, socioeconomic status, geographic location, and access to education—intersect with intersex status to shape experiences of stigma and exclusion.

6. METHODOLOGY

6.1 Research Design

This study adopted a convergent parallel mixed methods design to examine societal attitudes and stigma toward intersex individuals in Ghana. The mixed methods approach was appropriate for this study because it enabled the integration of quantitative data on the prevalence and correlates of stigmatizing attitudes with qualitative data on the lived experiences of intersex persons and the perspectives of key stakeholders (Creswell & Creswell, 2018). The convergent design, in which quantitative and qualitative data were collected concurrently and integrated during interpretation, allowed for triangulation of findings and provided a more comprehensive understanding of the phenomenon than either approach alone could achieve.

The quantitative component employed a cross-sectional survey design to measure awareness, knowledge, and attitudes toward intersex individuals across a diverse sample of the Ghanaian adult population. This design enabled the estimation of the prevalence of stigmatizing attitudes and the examination of associations with demographic characteristics. The qualitative component employed focus group discussions and key informant interviews to explore the cultural beliefs, institutional practices, and personal experiences that shape and reflect societal attitudes toward intersex individuals.

6.2 Research Approach

The study was guided by a pragmatist research philosophy, which prioritizes the research question as the central determinant of methodological choices and acknowledges the value of integrating quantitative and qualitative approaches to address complex social phenomena (Morgan, 2014). This approach was appropriate given the study's aim to both measure the breadth of societal attitudes and understand the depth of lived experiences. The study employed a deductive approach for the quantitative component, testing hypotheses derived from Modified Labeling Theory and the Framework of Stigma and Social Exclusion, while the qualitative component employed an inductive approach, allowing themes to emerge from participants' accounts.

6.3 Study Setting

The study was conducted in Ghana, focusing on three regions selected to capture the country's cultural, geographic, and demographic diversity: the Greater Accra Region (urban, cosmopolitan, seat of national government), the Ashanti Region (urban and peri-urban, heartland of Asante culture), and the Upper East Region (rural, culturally distinct, with limited access to healthcare and education). These regions provided variation along key dimensions relevant to the study, including urbanization, ethnic composition, religious distribution, and proximity to healthcare facilities.

Within each region, data collection occurred in both urban and rural locations. In Greater Accra, urban sites included Accra Metropolitan Area and Tema, while rural sites included areas in the Shai-Osudoku District. In Ashanti, urban sites included Kumasi Metropolitan Area, with rural sites in the Sekyere Central District. In Upper East, urban sites included Bolgatanga Municipality, with rural sites in the Bawku West District.

6.4 Study Population

The study population comprised four groups:

General Population: All Ghanaian adults aged 18 years and above residing in the three study regions. This population provided the sampling frame for the quantitative survey.

Intersex Individuals: Persons born with variations in sex characteristics who identify as intersex or have been identified as having intersex variations, regardless of whether they use the term "intersex" to describe themselves. Given the hidden nature of this population, purposive and snowball sampling were employed to recruit participants.

Key Informants: Professionals and community leaders whose roles bring them into contact with intersex issues, including healthcare providers (paediatricians, nurses, obstetricians), traditional leaders, religious leaders (Christian and Muslim), educators, and civil society representatives working on gender and human rights issues.

Parents and Family Members: Parents of intersex children and other family members involved in care and decision-making.

6.5 Sampling Technique and Sample Size

6.5.1 Quantitative Sample

A multi-stage sampling technique was employed to select participants for the quantitative survey. In the first stage, the three regions were purposively selected to ensure geographic and cultural diversity. In the second stage, districts within each region were stratified into urban and rural categories, with two districts randomly selected from each category per region, yielding a total of 12 districts. In the third stage, enumeration areas were randomly selected within each district using Ghana Statistical Service sampling frames. In the fourth stage, households were systematically sampled within each enumeration area, and one adult aged 18 years or above was randomly selected from each household using the Kish method (Kish, 1949).

The sample size was determined using guidelines for prevalence studies. Assuming a conservative estimate of 50% prevalence of stigmatizing attitudes (maximizing required sample size), a 95% confidence level, a 4% margin of error, and a design effect of 2.0 to account for the multi-stage cluster sampling, the minimum required sample was calculated as 600 respondents. This sample size also provided adequate power for subgroup analyses across demographic categories.

A total of 720 households were approached across the 12 districts, with 612 completed interviews obtained, representing a response rate of 85%. After data cleaning, 600 valid questionnaires were retained for analysis.

6.6 Data Collection Methods

6.6.1 Quantitative Data Collection

Data were collected using a structured questionnaire administered face-to-face by trained enumerators. The face-to-face mode was selected to maximize response rates, accommodate varying literacy levels, and allow for clarification of questions. Enumerators were Ghanaian, fluent in the local languages of each region (Twi, Ga, Frafra, and others as needed), and received three days of training covering the study objectives, ethical considerations, questionnaire administration, and techniques for handling sensitive topics.

The questionnaire was developed in English, translated into Twi, Ga, and Frafra, and back-translated to ensure accuracy. Cognitive interviewing with a small sample (n=15) was conducted to assess comprehension and cultural appropriateness, with modifications made based on feedback. The final questionnaire required approximately 30-45 minutes to complete.

Data collection was conducted over twelve weeks from January to March 2025. Enumerators worked in teams of two, with supervisors conducting spot-checks and back-checks on 10% of interviews to ensure data quality.

6.6.2 Qualitative Data Collection

Focus group discussions and key informant interviews were conducted by the principal investigator and two trained qualitative research assistants. All sessions were conducted in the preferred language of participants (English, Twi, Ga, or Frafra), audio-recorded with permission, and supplemented by field notes documenting non-verbal cues, group dynamics, and contextual observations.

Focus group discussions lasted 60-90 minutes and were held in neutral community locations (community centers, schools, health facilities) to maximize accessibility and comfort. A semi-structured guide explored: awareness and knowledge of intersex variations; sources of information; cultural and religious beliefs about gender and bodily variation; attitudes toward intersex individuals; and opinions about appropriate societal responses.

6.7 Data Collection Instruments

6.7.1 Quantitative Instrument

The questionnaire comprised six sections:

Section A: Demographic Characteristics – Age, gender, educational level, religious affiliation, ethnicity, marital status, occupation, income, geographic location (urban/rural), and region.

Section B: Awareness and Knowledge – Items assessing whether respondents had heard of intersex variations, sources of information, and knowledge of basic facts about intersex (e.g., "Intersex is the same as being gay or lesbian," "Intersex is a medical condition that can be cured," "Intersex individuals are born with reproductive or sexual anatomy that doesn't fit typical definitions of female or male"). Response options included true/false/not sure and Likert scales.

Section C: Attitudes Toward Intersex Individuals – A 20-item scale adapted from existing stigma measures (Herek, 2002; King et al., 2007) and modified for the Ghanaian context through cognitive interviewing. Items assessed: social distance (willingness to interact with intersex individuals in various roles), negative affect (discomfort, fear, disgust), moral judgments (beliefs about intersex as sinful, unnatural, or wrong), and support for rights (agreement with statements about intersex individuals' entitlement to education, healthcare, employment, and legal recognition). Items were rated on a five-point Likert scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

Section D: Cultural and Religious Beliefs – Items assessing beliefs about gender, the origins of intersex variations (e.g., "Intersex is caused by spiritual forces," "Intersex is a punishment from God"), and the role of traditional and religious authorities in addressing intersex issues.

Section E: Institutional Responses – Items assessing perceptions of how healthcare providers, schools, and religious institutions should respond to intersex individuals (e.g., "Hospitals should provide counselling to parents of intersex children," "Schools should teach about intersex variations").

Section F: Policy Preferences – Items assessing support for various policy responses, including legal protection from discrimination, access to appropriate healthcare, and public education campaigns.

6.7.2 Qualitative Instruments

Semi-structured guides were developed for focus group discussions and each category of key informant interviews. Guides were informed by the theoretical frameworks and refined through pilot testing with a small sample of community members and professionals (n=10). All guides included open-ended questions, probes, and hypothetical scenarios to stimulate discussion.

6.10 Data Analysis Procedures

6.10.1 Quantitative Data Analysis

Quantitative data were analyzed using SPSS version 26 and STATA version 17. Analysis proceeded in several stages.

Data Cleaning and Preparation: Data were screened for errors, inconsistencies, and missing values. Missing data were minimal (<3%) and were handled using listwise deletion for analyses, as recommended when missing data are few and randomly distributed (Hair et al., 2019).

Descriptive Statistics: Frequencies, percentages, means, and standard deviations were computed to describe the demographic characteristics of the sample, levels of awareness and knowledge, and distribution of attitudes. Composite scores were created for attitude subscales by averaging items.

Bivariate Analysis: Independent samples t-tests and one-way ANOVA were used to examine differences in attitude scores across demographic categories (gender, age group, educational level, religious affiliation, geographic location, region). Post-hoc tests (Tukey's HSD) were conducted for ANOVA with significant overall F-tests.

Multivariate Analysis: Multiple linear regression was employed to examine the independent associations between demographic characteristics and attitude scores, controlling for potential confounders. All variables significant at $p < 0.10$ in bivariate analysis were entered into the regression model. Standardized regression coefficients (β) were examined to assess the relative strength of associations.

Statistical Significance: All statistical tests were conducted at the 95% confidence level, with p-values < 0.05 considered statistically significant.

6.10.2 Qualitative Data Analysis

Qualitative data were analyzed using thematic analysis following the procedures outlined by Braun and Clarke (2006, 2021). Analysis was supported by NVivo version 14 software.

Transcription and Familiarization: Audio recordings were transcribed verbatim and translated into English where necessary. Transcripts were checked against recordings for accuracy. Researchers read and re-read transcripts to become thoroughly familiar with the data.

Coding: Initial coding was conducted inductively, with codes emerging from the data rather than being imposed by pre-existing frameworks. Two researchers independently coded a subset of transcripts and compared codes to ensure consistency. Discrepancies were resolved through discussion. The coding framework was iteratively refined as analysis progressed.

Theme Development: Codes were grouped into potential themes based on patterns, relationships, and relevance to the research questions. Themes were reviewed against coded extracts and the entire dataset to ensure they accurately represented the data. Themes were defined and named, with attention to both manifest content (explicit statements) and latent content (underlying meanings and assumptions).

Interpretation: Themes were interpreted in relation to the theoretical frameworks, research questions, and quantitative findings. Relationships between themes were explored, and negative cases (instances that contradicted emerging patterns) were examined to refine interpretations.

Integration: Quantitative and qualitative findings were integrated during interpretation, with attention to areas of convergence, divergence, and complementarity. Joint displays were developed to facilitate comparison and synthesis.

7. RESULTS

This section presents the findings of the study based on quantitative survey data from 600 Ghanaian adults and qualitative data from 8 focus group discussions (68 participants) and 30 key informant interviews. Results are organized thematically, with quantitative findings presented first for each theme, followed by qualitative findings that illuminate, extend, or contextualize the quantitative results.

7.1 Demographic Characteristics of Survey Respondents

Table 1 presents the demographic characteristics of the 600 survey respondents. The sample was evenly distributed by gender (50.3% female, 49.7% male) and included respondents across age groups, educational levels, religious affiliations, and geographic locations, reflecting the diversity of the Ghanaian population.

Table 1: Demographic Characteristics of Survey Respondents. (N=600)

Characteristic	Category	Frequency	Percentage
Gender	Male	298	49.7
	Female	302	50.3
Age Group	18-29 years	186	31.0
	30-39 years	168	28.0
	40-49 years	132	22.0
	50 years and above	114	19.0
Educational Level	No formal education	78	13.0
	Primary	96	16.0
	Junior High School	132	22.0
	Senior High School	150	25.0
	Tertiary	144	24.0

Religious Affiliation	Christian	432	72.0
	Muslim	138	23.0
	Traditional	24	4.0
	None/Other	6	1.0
Ethnicity	Akan	276	46.0
	Mole-Dagbon	114	19.0
	Ewe	90	15.0
	Ga-Dangme	72	12.0
	Other	48	8.0
Geographic Location	Urban	324	54.0
	Rural	276	46.0
Region	Greater Accra	204	34.0
	Ashanti	198	33.0
	Upper East	198	33.0
Marital Status	Married	336	56.0
	Never married	198	33.0
	Divorced/Separated	42	7.0
	Widowed	24	4.0
Occupation	Formal sector employee	162	27.0
	Informal sector worker	240	40.0
	Farmer/Fisher	96	16.0
	Unemployed	60	10.0
	Student	42	7.0

7.2 Awareness and Knowledge of Intersex Variations

7.2.1 Quantitative Findings

Table 2 presents findings on awareness and knowledge of intersex variations among survey respondents. Overall, awareness was low, with less than half of respondents (44.2%) reporting that they had heard of intersex variations before participating in the study. Among those who had heard of intersex, the most common sources of information were radio/television (38.5%), schools/education (21.2%), and friends/family (16.2%). Healthcare providers were cited as a source by only 8.7% of those aware of intersex, and religious leaders by only 4.5%.

Knowledge about intersex variations was limited and characterized by widespread misconceptions. Only 28.7% of respondents correctly disagreed that "intersex is the same as being gay or lesbian," while 41.3% agreed and 30.0% were unsure. Similarly, only 31.2% correctly disagreed that "intersex is a medical condition that can be cured," with 44.5% agreeing and 24.3% unsure. Correct knowledge that "intersex individuals are born with reproductive or sexual anatomy that doesn't fit typical definitions of female or male" was endorsed by 42.3% of respondents, but 35.2% disagreed and 22.5% were unsure.

Table 2: Awareness and Knowledge of Intersex Variations.

Item	Response	Frequency	Percentage
Heard of intersex variations before this study	Yes	265	44.2
	No	335	55.8
Source of information (among those aware, n=265)	Radio/Television	102	38.5
	School/Education	56	21.2
	Friends/Family	43	16.2
	Healthcare provider	23	8.7
	Internet/Social media	18	6.8
	Religious leader	12	4.5
	Other	11	4.1
"Intersex is the same as being gay or lesbian"	Agree	248	41.3
	Disagree	172	28.7
	Not sure	180	30.0
"Intersex is a medical condition that can be cured"	Agree	267	44.5
	Disagree	187	31.2
	Not sure	146	24.3
"Intersex individuals are born with reproductive or sexual anatomy that doesn't fit typical definitions of female or male"	Agree	254	42.3
	Disagree	211	35.2
	Not sure	135	22.5

Bivariate analysis revealed significant differences in awareness across demographic groups. Awareness was higher among men (48.3%) than women (40.1%, $\chi^2 = 4.12$, $p < 0.05$). Awareness increased significantly with educational level: among those with tertiary education, 68.1% were aware, compared to 42.0% with Senior High School, 31.8% with Junior High School, 18.8% with primary, and only 10.3% with no formal education ($\chi^2 = 89.45$, $p < 0.001$). Urban residents (52.5%) were significantly more likely to be aware than rural residents (34.4%, $\chi^2 = 19.23$, $p < 0.001$). Awareness also varied by region, with highest awareness in Greater Accra (52.9%), followed by Ashanti (44.4%), and Upper East (34.8%, $\chi^2 = 13.67$, $p < 0.01$).

7.2.2 Qualitative Findings

Qualitative data provided rich insight into the limited awareness documented quantitatively and revealed the cultural frameworks through which intersex variations are understood when they become known.

Across all focus groups and interviews with non-specialist participants, the term "intersex" was almost universally unfamiliar. When researchers described intersex variations in accessible language (e.g., "children born with bodies that are not clearly male or female"), participants often recognized the phenomenon but described it using local terminology and cultural frameworks.

In many communities, particularly in rural areas, intersex infants were described as "children of two worlds" or "children who have both." A traditional leader in the Upper East Region explained:

"In our tradition, such a child is called 'ayeleka' [literally 'child of both']. It is very rare, but it happens. The elders would say that the child has come with a special destiny. Some would say it is a blessing, some would say it is a warning. But everyone agrees it is not ordinary." (Traditional Leader, Upper East, Male, 67 years)

This framing of intersex variations as extraordinary or supernatural was common across regions, though the specific interpretations varied. In Ashanti Region, a focus group participant described:

"When I was a child, there was a family in our village who had such a child. The old women said the child was 'ababaawa' [both male and female]. Some said the mother must have crossed the spirit path during pregnancy. The family kept the child hidden for many years." (Community Member, Ashanti, Female, 52 years)

The association of intersex variations with spiritual causation was pervasive. A Muslim religious leader in Accra explained:

"In our communities, when something unusual happens with a birth, people look for explanations. They ask: What did the mother do? What did the father do? Was there a curse? Was there a spirit? The idea that this is just a natural variation that happens sometimes—this is not how people think." (Religious Leader, Greater Accra, Male, 54 years)

Healthcare providers confirmed that even when intersex infants are born in hospitals, families often seek spiritual interpretations and interventions. A paediatric nurse in Kumasi described:

"We had a baby born with ambiguous genitalia. We explained to the mother that this is a medical condition, that tests would be done. But the father took the baby to a prayer camp the next day. They came back after a week, and the baby had been given herbal concoctions.

They said the prophet had revealed it was a demonic problem. It was very difficult." (Healthcare Provider, Ashanti, Female, 38 years)

The lack of accurate information was compounded by the absence of any educational content about intersex variations in schools. A teacher in a rural Upper East school commented:

"In our training, we learn nothing about this. Nothing. The curriculum says nothing about variations in sex development. So when a child in our school might have this condition, we have no way to understand or support them. We are as ignorant as everyone else." (Educator, Upper East, Male, 42 years)

Among the intersex individuals interviewed, the lack of public awareness was experienced as a profound isolation. A 28-year-old intersex person from Accra described:

"Growing up, I thought I was the only person like this in the whole world. I never heard any discussion, never saw anything on TV, never read anything in school. I thought I was a mistake, something that should not exist. It was only when I got internet access that I discovered there are others, that there is a name for this, that there are people fighting for our rights." (Intersex Individual, Greater Accra, 28 years).

7.3 Attitudes Toward Intersex Individuals

7.3.1 Quantitative Findings

Table 3 presents descriptive statistics for the attitude scale and subscales. On the five-point scale where higher scores indicate more positive attitudes (less stigma), the overall mean attitude score was 2.84 (SD = 0.62), indicating moderately negative attitudes overall. Examination of subscales revealed variation across dimensions: social distance (mean = 2.61, SD = 0.71) and moral judgments (mean = 2.58, SD = 0.68) showed the most negative attitudes, while negative affect (mean = 2.92, SD = 0.65) and support for rights (mean = 3.24, SD = 0.74) were somewhat less negative.

Table 3: Descriptive Statistics for Attitude Scales.

Scale/Subscale	Number of Items	Mean	SD	Cronbach's α
Overall Attitude	20	2.84	0.62	0.89
Social Distance	6	2.61	0.71	0.84
Negative Affect	5	2.92	0.65	0.81
Moral Judgments	5	2.58	0.68	0.79
Support for Rights	4	3.24	0.74	0.82

Note: Higher scores indicate more positive attitudes (less stigma). Scale range: 1-5.

Table 4 presents responses to individual attitude items, revealing the specific nature of stigmatizing attitudes. Willingness to accept intersex individuals in various social roles decreased as the intimacy of the relationship increased. While 48.3% of respondents were willing to have an intersex person as a co-worker, only 31.2% were willing to have an intersex person as a neighbour, 22.5% as a friend, and just 12.3% as a family member through marriage.

Moral judgments were particularly negative, with 61.3% agreeing that "intersex is unnatural," 58.2% agreeing that "intersex is a sin against God," and 54.5% agreeing that "intersex individuals should be ashamed of their bodies." Negative affective responses were also common, with 52.3% reporting they would feel uncomfortable in the presence of an intersex person and 47.5% reporting fear or anxiety.

Support for rights, while higher than other dimensions, still showed substantial opposition. Only 45.2% agreed that intersex individuals should have the same access to education as others, 42.3% agreed they should have the same access to healthcare, and just 31.2% agreed they should have legal recognition beyond male or female categories.

Table 4: Responses to Selected Attitude Items. (N=600)

Item	**% Agree**	**% Disagree**	**% Not Sure**
Social Distance			
I would be willing to have an intersex person as a co-worker	48.3	31.5	20.2
I would be willing to have an intersex person as a neighbour	31.2	48.3	20.5
I would be willing to have an intersex person as a friend	22.5	56.7	20.8
I would be willing to have an intersex person as a family member through marriage	12.3	71.5	16.2
Negative Affect			
I would feel uncomfortable in the presence of an intersex person	52.3	28.5	19.2
The thought of intersex makes me feel afraid or anxious	47.5	32.3	20.2
I would be embarrassed if people knew I was friends with an intersex person	41.2	38.5	20.3
Moral Judgments			
Intersex is unnatural	61.3	18.5	20.2
Intersex is a sin against God	58.2	19.3	22.5
Intersex individuals should be ashamed of their bodies	54.5	23.2	22.3
Intersex is a punishment for wrongdoing in the family	38.5	35.2	26.3
Support for Rights			
Intersex individuals should have the same access to education as others	45.2	32.3	22.5

Intersex individuals should have the same access to healthcare as others	42.3	34.5	23.2
Intersex individuals should be protected from discrimination by law	35.2	38.5	26.3
Intersex individuals should have legal recognition beyond male or female	31.2	42.3	26.5

7.3.3 Qualitative Findings

Qualitative data illuminated the cultural logic underlying the negative attitudes documented quantitatively, revealing how traditional beliefs, religious teachings, and lack of knowledge combine to produce stigmatizing responses.

Cultural Frameworks of Gender and Normalcy: Across all regions, participants articulated deeply ingrained understandings of gender as a fundamental, God-given binary. A focus group participant in Ashanti explained:

"When a child is born, the first question is: Is it a boy or a girl? Everything follows from that—the name, the upbringing, the responsibilities, the future. If you cannot answer that question, how do you know what to do with the child? How does the child know who they are?" (Community Member, Ashanti, Male, 45 years)

This binary framework rendered intersex bodies unintelligible and unsettling. A traditional leader described the community response:

"People don't know what to make of such a person. Are they to sit with the men or with the women? Can they inherit property? Can they marry? Will they have children? These are not just questions—they are the foundations of our social order. When you cannot answer them, the person becomes a problem." (Traditional Leader, Greater Accra, Male, 72 years)

The association of intersex with witchcraft and spiritual causation was pervasive, particularly in rural areas and among older participants. A focus group participant in Upper East described:

*"In our village, there was a child like this many years ago. The elders said it *was because the mother had offended the ancestors. The child was taken to a shrine for cleansing. I don't know what happened to the child after that."* (Community Member, Upper East, Female, 63 years)

Religious Teachings and Moral Condemnation: Religious leaders and participants across faith traditions articulated theological frameworks that positioned intersex variations as deviations from divine order. A Christian pastor in Accra explained:

"Genesis tells us that God created them male and female. This is the order of creation. When we see something that does not fit this order, we must ask whether it is part of God's plan or

a result of the fall—of sin entering the world. Many would say it is the latter." (Religious Leader, Greater Accra, Male, 51 years)

A Muslim imam in Kumasi offered a similar perspective:

"In the Quran, Allah created us in pairs—male and female. This is the natural order. When a child is born with ambiguity, it is a test. It is a test for the family, for the community. How we respond shows our faith." (Religious Leader, Ashanti, Male, 58 years)

When asked about appropriate responses, this imam continued:

"The family should seek guidance from religious authorities and from doctors. If there is a way to clarify the child's sex, that should be done. The child should not remain in ambiguity—it is not good for them, and it is not good for the community."

This framing—that ambiguity is inherently problematic and should be resolved—was echoed by many participants and has direct implications for the pressure families face to pursue normalizing interventions.

Fear and Discomfort: The quantitative finding of widespread discomfort was elaborated in qualitative accounts. A focus group participant described:

"Honestly, I would not know how to behave. Would I call them 'he' or 'she'? What if I use the wrong word and offend them? What if other people see me with them and think I am also like that? It is easier to just keep a distance." (Community Member, Greater Accra, Female, 34 years)

This discomfort was often linked to the conflation of intersex with homosexuality. Despite researchers' efforts to distinguish these concepts, many participants assumed they were related. A participant explained:

"We hear about these things—people changing sex, people doing unnatural things. Is this not the same? If a person is born like this, does it mean they will become homosexual? It is all connected in my mind." (Community Member, Ashanti, Male, 28 years)

This conflation has particularly serious implications in the current Ghanaian context, where anti-LGBTQ+ sentiment is intense and legislative proposals seek to criminalize LGBTQ+ identities and advocacy.

7.4 Experiences of Stigma Among Intersex Individuals

Interviews with eight intersex individuals revealed the profound impact of societal attitudes on their lives. While each story was unique, several common themes emerged.

Secrecy and Shame: All intersex participants described growing up with secrecy imposed by families. A 35-year-old participant from Kumasi recounted:

"My mother told me when I was 12 that I was different, that the doctors had said something when I was born, that I must never tell anyone. She made me promise. So, I carried this secret for years. I was always afraid someone would find out. I never let anyone see me undressed. I never had close friends. The secret was like a weight I carried everywhere." (Intersex Individual, Ashanti, 35 years)

This secrecy often extended to medical records and even within families. A 22-year-old participant from Accra described:

"I only found out last year, when I needed medical records for something, and my mother had to tell me the truth. All my life, I thought I was just... I don't know... different in some way I couldn't name. Finding out the truth was both relief and trauma. Relief that there was a reason for feeling different. Trauma that my whole family had lied to me for 21 years." (Intersex Individual, Greater Accra, 22 years)

Medical Trauma: Several participants described negative experiences with healthcare, including unnecessary surgeries and a lack of informed consent. A 42-year-old participant from a rural area explained:

"When I was born, the doctors told my parents they could 'fix' me. They did surgery when I was a baby. I don't know what they did exactly—my parents never understood, and now those records are lost. I have scars, and I have problems with my health that I don't understand. I have never been able to have children. I don't know if that's because of the surgery or just how I was born. I will never know." (Intersex Individual, Upper East, 42 years)

Another participant described the ongoing impact of medical encounters:

"Every time I go to the hospital, I am terrified. They ask questions I cannot answer. They want to examine me. They want to know my history. Sometimes medical students are brought in to see me—like I am a specimen. No one asks how I feel about this. No one explains anything." (Intersex Individual, Ashanti, 29 years)

Social Exclusion: Participants described multiple forms of social exclusion. Educational settings were particularly difficult:

"School was hell. The toilets were either boys' or girls'. The dormitories were separated. Sports teams were separated. Every day, every activity, forced me to confront that I didn't fit. I couldn't explain why. I just knew I was wrong, that I didn't belong anywhere." (Intersex Individual, Greater Accra, 31 years)

Relationships and marriage were sources of profound anxiety:

"I am 35 now. I have never had a relationship. How could I? At some point, I would have to explain. And what would happen then? Would they accept me? Would they tell others? Would they hurt me? It's easier to be alone." (Intersex Individual, Ashanti, 35 years)

A married participant described the ongoing fear of discovery:

"I am married, but my husband does not know the full truth. I told him I had medical problems as a child, that I cannot have children. He accepted this. But if he knew the real reason... I cannot think about it. I live with this fear every day." (Intersex Individual, Greater Accra, 38 years)

Resilience and Resistance: Despite these challenges, participants also described forms of resilience and resistance. A young participant who had connected with online intersex communities described:

"Finding others online changed everything. I realized I am not alone. I am not a mistake. There is nothing wrong with me—what is wrong is how society treats people like me. I have started to speak about it, carefully, with people I trust. Each time I tell someone, and they accept me, I feel stronger." (Intersex Individual, Greater Accra, 24 years)

Another participant, who had become an advocate, described:

"I decided I will not live in shame. I am intersex. This is my body. This is who I am. If people have a problem with that, the problem is theirs, not mine. But I know not everyone can take this position. Many are too afraid, too isolated, too hurt. That is why we need change—so that the next generation does not suffer as we have." (Intersex Individual, Ashanti, 41 years)

9. CONCLUSION AND RECOMMENDATIONS

This study has documented, for the first time, the nature and extent of societal attitudes and stigma toward intersex individuals in Ghana. The findings reveal a population rendered invisible by a lack of awareness, burdened by deeply negative attitudes, and subjected to stigmatization that permeates every aspect of life. Intersex individuals in Ghana grow up in secrecy, live in fear of discovery, face discrimination in healthcare and education, and are denied the basic dignity of recognition and respect.

Based on the findings of this study, the following recommendations are proposed for government, healthcare institutions, educational authorities, civil society, and other stakeholders.

Develop National Guidelines for Intersex Care: The Ministry of Health should convene a multisectoral task force including medical professionals, ethicists, intersex advocates, and families to develop comprehensive national guidelines for the care of intersex individuals. These guidelines should address: standards for diagnosis and management; protocols for family communication and psychosocial support; ethical criteria for surgical interventions, with a strong presumption against irreversible procedures in infancy; informed consent requirements; and long-term follow-up care.

Mandate Healthcare Provider Training: The Ghana Health Service should require that all healthcare providers receive training on intersex variations and appropriate, respectful care. This training should be integrated into pre-service education for all medical, nursing, and midwifery students, and provided through continuing professional development for practicing providers.

Establish Specialized Services: Regional hospitals should be designated as centres of excellence for intersex care, with multidisciplinary teams including paediatricians, endocrinologists, surgeons, psychologists, and social workers. These centers should provide coordinated, holistic care and serve as resources for other facilities.

Prohibit Unnecessary Surgeries: The Ministry of Health should issue a directive prohibiting medically unnecessary, irreversible surgeries on intersex infants and children, in line with international human rights standards and the emerging consensus in medical ethics. Such procedures should be deferred until the individual can participate in informed decision-making.

Integrate Intersex Content into Curricula: The National Council for Curriculum and Assessment should ensure that age-appropriate information about intersex variations and human diversity is included in basic and secondary education curricula. Content should be integrated into health education, biology, and social studies, and should emphasize respect for diversity and the natural variation in human bodies.

Provide Teacher Training: The Ministry of Education should ensure that teacher training institutions prepare educators to understand intersex variations, to support intersex students, and to respond appropriately to questions and incidents of bullying. In-service training should be provided for current teachers.

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