2026 Volume: 02 Issue: 03 www.ijrpa.com ISSN 2456-9995 Research Article

International Journal Research Publication Analysis

Page: 01-23

# LIVED EXPERIENCES OF INTERSEX CHILDREN IN GHANAIAN FAMILIES: A PHENOMENOLOGICAL STUDY

**Jemima N. A. A. Lomotey**

Grace International Bible University.

**Article Received: 23 January 2026**
**Article Revised: 13 February 2026**
**Published on: 05 March 2026**

***Corresponding Author: Jemima N. A. A. Lomotey**
Grace International Bible University.
DOI: https://doi-doi.org/101555/ijrpa.7153

## ABSTRACT

Intersex children in Ghana face unique challenges shaped by cultural norms, family dynamics, healthcare systems, and societal attitudes toward sex and gender non-conformity. While global discourse on intersex rights and experiences has advanced in recent decades, limited empirical attention has been given to the lived realities of intersex children within African family contexts, particularly in Ghana. This study explores the lived experiences of intersex children in Ghanaian families, examining how cultural beliefs, family responses, healthcare encounters, and social interactions shape their upbringing and identity formation. Drawing on qualitative phenomenological inquiry, the study seeks to foreground the voices of intersex individuals and their families to understand how they navigate stigma, secrecy, medical interventions, and belonging within culturally prescribed gender norms. By providing contextually grounded insights, the study contributes to scholarship on intersexuality, childhood, family dynamics, and human rights in Ghana and offers evidence to inform policy, healthcare practice, and community-based interventions aimed at protecting the dignity and wellbeing of intersex children.

**KEYWORDS:** Intersex children, lived experiences, family dynamics, cultural norms, stigma, Ghana.

## 1. INTRODUCTION

The birth of a child is often accompanied by societal expectations rooted in binary gender classifications. Across most cultures, including Ghana, the announcement of a newborn's sex male or female initiates a range of social, cultural, and familial responses that shape the child's identity and place within the community. However, for intersex children those born with variations in sex characteristics that do not fit typical binary notions of male or female bodies this moment of gender assignment may be fraught with complexity, uncertainty, and intervention.

Intersex variations encompass a range of congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical. Globally, estimates suggest that intersex variations occur in approximately 1.7% of live births, making such variations as common as red hair (Blackless et al., 2000). Despite this prevalence, intersex children remain largely invisible in many societies, including Ghana, where cultural silence, stigma, and lack of public awareness surround variations in sex characteristics.

In Ghanaian society, gender plays a fundamental role in structuring social identity, family lineage, inheritance, and cultural expectations. Among many ethnic groups, including the Akan, Ga, and Ewe, gender determines not only social roles but also spiritual and ancestral belonging. The birth of a child is celebrated within extended family networks, with naming ceremonies and rituals affirming the child's place within kinship structures. However, when a child's sex is ambiguous or does not conform to binary expectations, families may face confusion, shame, and pressure to seek medical or traditional interventions to "normalise" the child's body.

The experiences of intersex children in Ghanaian families remain underexplored in academic literature. Existing research on intersexuality has predominantly emerged from Western contexts, focusing on medical management, psychological outcomes, and advocacy for human rights (Karkazis, 2008; Dreger, 1999). While these contributions are valuable, they may not adequately capture the culturally specific dynamics shaping intersex childhoods in African societies, where family honour, communal belonging, and traditional beliefs about gender and procreation carry significant weight.

In Ghana, limited attention has been given to intersex issues within health policy, education, and child protection frameworks. Healthcare providers may lack training in supporting intersex children and their families, while social welfare institutions remain ill-equipped to address the unique vulnerabilities of this population. Furthermore, cultural stigma and secrecy surrounding intersex variations often silence affected individuals and families, preventing open discussion and collective learning.

This study therefore seeks to explore the lived experiences of intersex children in Ghanaian families, with a focus on understanding how cultural beliefs, family responses, healthcare encounters, and social interactions shape their upbringing and identity formation. By centring the voices of intersex individuals and their families, the study aims to generate contextually grounded evidence to inform policy, healthcare practice, and community-based interventions aimed at protecting the dignity and wellbeing of intersex children.

## 2. STATEMENT OF THE PROBLEM

Despite growing international recognition of the rights and vulnerabilities of intersex persons, intersex children in Ghana remain largely invisible in public discourse, policy frameworks, and academic research. Cultural silence surrounding variations in sex characteristics, coupled with deeply entrenched binary gender norms, creates an environment in which intersex children may experience stigma, secrecy, and pressure to conform through medical or traditional interventions.

Families of intersex children in Ghana face significant challenges in navigating cultural expectations, healthcare systems, and social attitudes. Upon the birth of an intersex child, parents may receive little or no guidance from healthcare providers, who themselves may lack knowledge about intersex variations and appropriate support strategies. In some cases, medical professionals may recommend early surgical interventions to assign a binary sex, despite growing global consensus that such procedures should be delayed until the child can participate in decision-making (United Nations, 2015).

Cultural beliefs about gender, procreation, and family honour further complicate family responses. Among many Ghanaian communities, a child's sex determines lineage affiliation, inheritance rights, and social belonging. When a child's sex is ambiguous, families may fear social ridicule, spiritual explanations may be invoked, and pressure may mount to "correct" the child's body through traditional medicine or spiritual rituals. These responses, while often well-intentioned, may inflict lasting psychological harm on intersex children and reinforce secrecy and shame.

Furthermore, intersex children themselves face unique challenges as they grow and develop. Within school environments, peer interactions, and community settings, they may encounter bullying, exclusion, or intrusive questioning about their bodies. The lack of public awareness and sensitive educational materials means that intersex children often navigate these challenges in isolation, without adequate support from families, teachers, or healthcare providers.

Existing research in Ghana has addressed child rights, gender-based violence, and health disparities affecting children, yet intersex children have been systematically excluded from these discussions. No known qualitative study has explored the lived experiences of intersex children within Ghanaian family contexts, examining how cultural, social, and medical factors intersect to shape their childhoods. This gap limits the ability of policymakers, healthcare providers, and child protection agencies to develop informed, culturally sensitive responses to the needs of intersex children and their families.

The problem addressed in this study is the limited contextual understanding of how intersex children in Ghana experience family life, cultural expectations, healthcare encounters, and social belonging. Without such understanding, interventions risk reinforcing stigma, violating children's rights, and overlooking the unique vulnerabilities and resilience of this population.

## 3. PURPOSE OF THE STUDY

The purpose of this study is to explore the lived experiences of intersex children in Ghanaian families, with the aim of understanding how cultural beliefs, family dynamics, healthcare interactions, and social attitudes shape their upbringing, identity formation, and overall wellbeing.

## 4. OBJECTIVES OF THE STUDY

### 4.1 General Objective

The general objective of the study is to examine the lived experiences of intersex children in Ghanaian families, focusing on the cultural, social, and healthcare-related factors that influence their childhood experiences.

### 4.2 Specific Objectives

The specific objectives of the study are to:

- Explore how families of intersex children in Ghana respond to the birth and upbringing of a child with variations in sex characteristics, including initial reactions, decision-making processes, and coping strategies.
- Examine the cultural beliefs, traditional practices, and spiritual interpretations that shape family and community attitudes toward intersex children in Ghana.
- Investigate the healthcare experiences of intersex children and their families, including access to information, medical interventions, and support services.
- Explore how intersex children navigate social interactions within family, school, and community settings, including experiences of stigma, secrecy, acceptance, and belonging.
- Understand how intersex individuals reflect on their childhood experiences and identity formation within the Ghanaian socio-cultural context.

## 5. THEORETICAL LITERATURE

Theoretical perspectives provide an essential framework for understanding the lived experiences of intersex children within Ghanaian families. Given the study's focus on identity formation, social responses to bodily difference, and the intersection of culture, medicine, and family dynamics, this analysis draws on Social Constructionism, Minority Stress Theory, and the Biopsychosocial Model of Intersex Experience. These frameworks collectively illuminate how societal norms, family interactions, and institutional practices shape the experiences of intersex children.

### 5.1 Social Constructionism

Social Constructionism posits that meanings attached to human bodies, identities, and social categories are not fixed or natural but are produced through social processes, cultural discourses, and historical contexts (Berger & Luckmann, 1966). From this perspective, the binary classification of sex into male and female is not an objective biological given but a socially constructed framework that organises human experience and social order.

Applied to intersex experience, Social Constructionism challenges the assumption that bodies must conform to binary sex categories to be considered normal or legitimate. The theory directs attention to how medical, legal, and cultural institutions produce and enforce norms of sexed embodiment, often pathologising intersex variations as disorders requiring correction (Kessler, 1998). In Ghanaian society, where gender binary structures kinship, inheritance, and social belonging, Social Constructionism helps explain why intersex children may be perceived as disruptive to cultural order and why families may experience pressure to seek normalising interventions.

Furthermore, Social Constructionism emphasises that meanings attached to intersex variations are culturally specific. While Western medical discourse has historically framed intersex as a biomedical problem requiring surgical management, Ghanaian cultural frameworks may incorporate spiritual interpretations, beliefs about reincarnation, or concerns about family honour. Understanding these culturally constructed meanings is essential for interpreting family responses and the lived experiences of intersex children.

### 5.2 Minority Stress Theory

Minority Stress Theory, originally developed to explain health disparities among sexual and gender minority populations, provides a useful framework for understanding the psychological impact of stigma, discrimination, and concealment on intersex individuals (Meyer, 2003). The theory posits that individuals from stigmatised social groups experience excess stress resulting from prejudice, expectations of rejection, hiding of identity, and internalised negative societal attitudes.

For intersex children, minority stress may manifest in multiple ways. Within families, secrecy surrounding their condition may communicate shame and reinforce feelings of difference. In school and community settings, bullying, intrusive questioning, or social exclusion may generate chronic stress. The expectation of rejection may lead intersex children to withdraw from social interactions or develop hypervigilance about disclosure. Over time, these minority stressors may contribute to adverse psychological outcomes, including anxiety, depression, and low self-esteem.

Minority Stress Theory also highlights the role of protective factors, such as family acceptance, peer support, and community belonging, in buffering the effects of stigma. In the Ghanaian context, where extended family networks and community relationships are central to social life, understanding how intersex children access or are denied such protective resources is critical to interpreting their experiences.

### 5.3 Biopsychosocial Model of Intersex Experience

The Biopsychosocial Model, originally articulated in health psychology, provides a holistic framework for understanding how biological, psychological, and social factors interact to shape health and illness experiences (Engel, 1977). Adapted to intersex experience, this model recognises that intersex variations involve biological dimensions (chromosomal, hormonal, anatomical variations), psychological dimensions (identity formation, coping, self-concept), and social dimensions (family responses, cultural beliefs, healthcare interactions, stigma).

The biopsychosocial model is particularly valuable for moving beyond purely medical framings of intersex as a disorder requiring correction. Instead, it situates intersex experience within the full complexity of human development, recognising that wellbeing depends not only on medical management but also on supportive families, inclusive communities, and respectful healthcare practices. In the Ghanaian context, this framework directs attention to how cultural beliefs about gender, traditional healing practices, healthcare access, and family dynamics interact to shape intersex children's developmental trajectories.

## 6. EMPIRICAL LITERATURE

Empirical research on intersex experiences has evolved significantly over recent decades, shifting from clinical accounts focused on medical management toward qualitative explorations of lived experience, identity, and human rights. This section reviews empirical literature on intersex childhoods, family responses, healthcare experiences, and cultural contexts, with attention to global research and the limited African and Ghanaian scholarship.

## 6.1 Global Perspectives on Intersex Childhoods

Early literature on intersex variations emerged primarily from medical and psychological disciplines, focusing on clinical management, surgical outcomes, and gender assignment decisions. Researchers such as Money and Ehrhardt (1972) advocated for early surgical intervention to assign a binary sex, arguing that ambiguous genitalia would lead to psychological distress and social rejection. However, follow-up studies of intersex individuals who underwent such surgeries revealed significant physical and psychological harm, including loss of sexual sensation, trauma, and dissatisfaction with assigned gender (Dreger, 1999; Karkazis, 2008).

These findings prompted a paradigm shift in intersex research, with increasing emphasis on qualitative methodologies that centre intersex voices. Chase (1998), founder of the Intersex Society of North America, documented the emotional and physical suffering caused by medically unnecessary surgeries and called for an end to normalising procedures performed without informed consent. Subsequent qualitative studies explored intersex identity formation, revealing that many intersex individuals reject the pathologising language of "disorder" and instead embrace their bodies as naturally occurring variations (Davis, 2015).

Research on intersex childhoods highlights the importance of family acceptance and open communication. Preves (2003) found that intersex adults who grew up in families where their variation was discussed openly and without shame reported stronger self-esteem and more positive body image compared to those raised in secrecy. Conversely, secrecy and shame were associated with psychological distress, social withdrawal, and difficulty forming intimate relationships.

## 6.2 Family Responses to Intersex Children

Family responses to the birth of an intersex child have received increasing research attention. Studies indicate that parents often experience shock, confusion, and distress upon learning that their child has variations in sex characteristics (Gough et al., 2014). Healthcare providers' communication styles significantly influence parental responses, with sensitive, informative counselling associated with better psychological adjustment, while inadequate information or pressure to make rapid decisions about surgery contributes to long-term distress.

Parents may also face social pressures from extended family and community members. In many cultural contexts, including parts of Asia, Latin America, and Africa, the birth of an intersex child may be interpreted through spiritual or supernatural frameworks, leading to stigma, concealment, or seeking of traditional healers (Zayed & Elkins, 2020). These cultural responses can compound parental distress and influence decisions about disclosure and medical intervention.

Research also suggests that families vary widely in their coping strategies. Some families become advocates for their intersex children, seeking out information, connecting with support networks, and challenging medical authority to protect their child's bodily autonomy. Others may struggle with shame and secrecy, isolating themselves and their child from community life (Crissman et al., 2011).

### 6.3 Healthcare Experiences of Intersex Children and Families

Healthcare encounters represent a critical site of intersex experience, yet research consistently documents deficiencies in medical responses to intersex variations. Studies reveal that many healthcare providers lack adequate training in intersex issues, leading to misinformation, insensitivity, and pressure on families to consent to early surgeries (Liao et al., 2015). Parents report feeling rushed into decisions without full understanding of the risks and alternatives, and many later regret consenting to surgeries performed on their infants (Karkazis, 2008).

The psychological impact of repeated medical examinations, photography of genitals, and teaching presentations involving intersex children has also been documented. Intersex adults recall these experiences as traumatic and dehumanising, reinforcing feelings of being objects of medical curiosity rather than whole persons (Preves, 2003).

In recent years, human rights bodies have called for an end to medically unnecessary surgeries on intersex children and for the provision of psychosocial support to families (United Nations, 2015). However, implementation of these recommendations remains uneven globally, with many countries lacking policies to protect intersex children's rights.

## 7. METHODOLOGY

### 7.1 Research Design

This study adopted a qualitative phenomenological research design to explore the lived experiences of intersex children in Ghanaian families. Phenomenology is concerned with understanding how individuals experience and interpret significant life phenomena within their everyday contexts (van Manen, 2014). Given that intersex childhood is a deeply personal and relational experience shaped by cultural norms, family dynamics, healthcare encounters, and societal attitudes, a phenomenological design was considered most appropriate for capturing the lived experiences of intersex individuals and their families. The phenomenological approach enabled the study to move beyond clinical or statistical accounts of intersex variations to examine how intersex persons perceive their bodies, interpret family and community responses, and make sense of their identity formation within Ghanaian socio-cultural contexts. This design aligns with the study's objective of centring intersex voices and foregrounding subjective experience rather than measuring predefined variables (Creswell & Poth, 2018).

### 7.2 Research Approach

The study was guided by an interpretive (hermeneutic) phenomenological approach, which recognises that lived experiences are shaped by social, cultural, and historical contexts (Heidegger, 1962; van Manen, 2014). Unlike descriptive phenomenology, which seeks to bracket researcher interpretation, interpretive phenomenology acknowledges that meaning emerges through engagement between participants' narratives and the researcher's analytical interpretation. This approach was particularly suitable for examining intersex experiences in Ghana, where cultural beliefs about gender, traditional practices, and family dynamics are deeply embedded within specific ethnic and community contexts. The interpretive stance allowed the study to examine not only the forms of stigma, acceptance, or medical intervention experienced by intersex individuals but also how they understand and interpret these experiences within changing family and societal structures.

### 7.3 Study Setting

The study was conducted in selected urban and peri-urban communities in Ghana, including areas within Accra, Kumasi, and surrounding municipalities. These settings were chosen because they reflect environments where healthcare facilities, educational institutions, and diverse family structures are present, yet where traditional cultural beliefs about gender and procreation remain influential. Urban Ghana provides access to hospitals and clinics where intersex births may be identified and managed, while peri-urban and rural communities offer insights into how traditional beliefs and practices shape family responses. Conducting the study in these settings enabled an in-depth exploration of how cultural, medical, and social factors intersect to shape the experiences of intersex children and their families.

### 7.4 Study Population

The study population comprised intersex individuals aged 18 years and above who could reflect on their childhood experiences within Ghanaian families, as well as parents or primary caregivers of intersex children. Including adult intersex individuals allowed for retrospective accounts of childhood, while including parents provided insight into family dynamics, decision-making processes, and caregiving experiences. Eligible participants included intersex persons who grew up in Ghanaian families and were willing to share their experiences, and parents who had raised or were raising intersex children within Ghana. Both male and female parents were included, and intersex participants of all gender identities were eligible.

### 7.5 Sampling Technique

The study employed purposive sampling, which is appropriate for qualitative research seeking participants with rich, first-hand experience of the phenomenon under investigation (Patton, 2015). Participants were selected based on their direct experience of intersex childhood or parenting an intersex child. In addition, limited snowball sampling was used to reach intersex individuals and families who might otherwise be difficult to identify due to stigma, secrecy, or reluctance to discuss sensitive family matters. Healthcare providers, community leaders, and intersex advocacy networks (where accessible) assisted in identifying potential participants while ensuring voluntary participation and protecting confidentiality.

### 7.6 Sample Size and Justification

The study involved twelve (12) participants, comprising six (6) intersex adults and six (6) parents of intersex children. The sample size was determined based on qualitative research principles that prioritise depth, richness, and data saturation over numerical representation (Creswell & Poth, 2018). A sample of twelve participants was considered sufficient to achieve thematic saturation, where recurring meanings and patterns relating to family responses, cultural beliefs, healthcare encounters, and social experiences emerged across narratives. Previous phenomenological studies suggest that samples ranging between 10 and 20 participants are adequate for capturing meaningful lived experiences (van Manen, 2014).

### 7.7 Data Collection Method

Data were collected using in-depth, semi-structured interviews. In-depth interviews allowed participants to narrate their experiences of intersex childhood, family dynamics, healthcare encounters, and social interactions in their own words. This method facilitated emotional expression and reflective storytelling, which are essential in phenomenological research (Kvale & Brinkmann, 2015). Each interview lasted between 60 and 90 minutes and was conducted in a language comfortable for the participant, including English or local Ghanaian languages such as Twi, Ga, or Fante where necessary. Interviews were audio-recorded with participants' consent and later transcribed verbatim for analysis.

## 7.8 Data Collection Instrument

The primary data collection instrument was a phenomenological interview guide developed in line with the study objectives and theoretical framework. The guide consisted of open-ended questions designed to elicit detailed descriptions of participants' experiences.

Questions focused on areas such as:

- Initial family reactions to the discovery of intersex variation
- Cultural and spiritual interpretations of intersex within the family and community
- Healthcare encounters, including information received, medical interventions, and support
- Family communication patterns regarding intersex status
- Experiences within school and community settings
- Identity formation and self-perception
- Coping strategies and sources of support
- Reflections on acceptance, belonging, and resilience

Probing questions were used to clarify meanings and deepen understanding of participants' narratives, ensuring that responses reflected lived experience rather than superficial description.

## 7.9 Data Analysis Procedure

Data were analysed using Interpretative Phenomenological Analysis (IPA). IPA is particularly suited for examining how individuals make sense of significant life experiences and has been widely applied in health, sexuality, and identity research (Smith et al., 2009). The analysis followed several stages. First, interview transcripts were read repeatedly to achieve immersion and develop a holistic understanding of each participant's narrative. Second, initial descriptive and conceptual notes were generated. Third, emergent themes were identified within individual transcripts. Fourth, themes were clustered into superordinate themes reflecting shared meanings across participants. Finally, themes were interpreted in relation to the study's theoretical framework and socio-cultural context. Throughout the analysis, emphasis was placed on preserving participants' voices through the inclusion of verbatim quotations, while interpretive insights were grounded in theoretical perspectives and contextual realities.

### 7.10 Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional review body. Informed consent was obtained from all participants prior to data collection. Participants were assured of confidentiality, anonymity, and the right to withdraw from the study at any stage without consequence. Given the extreme sensitivity of discussing intersex status, family relationships, and potential trauma, interviews were conducted with empathy, cultural humility, and respect. Pseudonyms were used in all transcripts and reports to protect participants' identities. Audio recordings and transcripts were securely stored and accessible only to the researcher. Special care was taken to ensure that participation did not exacerbate emotional distress. Where necessary, participants were provided with information about available counselling and support services. Given the vulnerable nature of the participant population, additional safeguards were implemented, including offering participants the option to have a support person present during interviews and providing debriefing sessions after data collection.

## 8. RESULTS AND THEMATIC ANALYSIS

This section presents the findings of the study based on in-depth interviews conducted with intersex adults and parents of intersex children in selected urban and peri-urban communities in Ghana. Using Interpretative Phenomenological Analysis (IPA), recurring meanings and shared patterns were identified across participants' narratives. Six major themes emerged, reflecting the lived experiences of intersex children within Ghanaian families. The themes are presented with supporting verbatim quotations to preserve participants' voices and illustrate common experiences.

### Theme 1: Initial Shock, Confusion, and Secrecy

A dominant theme across interviews was the initial shock and confusion experienced by families upon discovering that their child had variations in sex characteristics. Many parents described feeling unprepared, uninformed, and distressed, with healthcare providers offering little guidance or reassurance.

"When my wife gave birth, they called me aside and told me they were not sure whether it was a boy or a girl. I was confused. I didn't understand what was happening. They said we should wait for tests, but nobody explained properly." (Parent 3)

Several parents reported that healthcare providers used confusing or frightening language, referring to their child as "abnormal" or "not complete," which intensified their distress and shame.

"The nurse said the child had a problem, that the private parts were not formed well. I felt ashamed. I didn't know what to tell my family." (Parent 5)

This initial shock often led to secrecy. Many families chose not to disclose their child's status to extended family members or community, fearing ridicule, gossip, or spiritual accusations.

"We kept it between me and my husband. We didn't tell anyone, not even our own mothers. We were afraid of what people would say." (Parent 2)

Intersex adults reflected on growing up aware of secrecy surrounding their bodies, even when details were not explicitly discussed.

"I knew something was different about me. Whenever the topic of birth came up, my mother would become quiet. I felt like there was a secret they were keeping." (Intersex Participant 4)

This theme highlights how inadequate healthcare communication, cultural stigma, and fear of community judgment converge to create an environment of secrecy from the earliest moments of an intersex child's life.

### Theme 2: Cultural and Spiritual Interpretations

Cultural beliefs and spiritual interpretations featured prominently in participants' narratives. Many families, particularly those in communities with strong traditional beliefs, sought explanations for intersex variations within spiritual frameworks.

"My grandmother said the child was a spirit child, that maybe he had come and gone before and was now returning. She wanted us to consult a traditional priest." (Parent 1)

Some participants reported that community members attributed intersex births to ancestral punishment, curses, or infidelity.

"People in the village said it was a curse because my father had offended someone. They said the child was proof that something was wrong in the family." (Intersex Participant 6)

These spiritual interpretations often led families to seek interventions from traditional healers or spiritualists, sometimes before seeking medical care.

"We went to a pastor who gave us water to bath the child. He said it would correct the problem. When it didn't change, we went to the hospital." (Parent 4)

For intersex individuals, growing up with knowledge of these spiritual interpretations shaped their sense of self and belonging.

"I heard stories that I was a sign of something bad. For a long time, I felt like I was wrong, like my body was a punishment." (Intersex Participant 2)

This theme illustrates how cultural frameworks for understanding bodily difference can pathologise intersex variations and contribute to stigma, while also shaping family decision-making about interventions.

### Theme 3: Medical Encounters and Interventions

Healthcare experiences emerged as a critical theme, with participants describing a range of encounters from supportive to deeply harmful. Many parents reported receiving inadequate information from healthcare providers, leaving them confused and anxious about how to proceed.

"The doctor said they could do surgery to make the child either a boy or a girl. He said we had to decide quickly so the child could grow up normal. We didn't know what to do." (Parent 3)

Some families consented to surgical interventions on their infants, often without full understanding of the risks, consequences, or alternatives. Intersex adults who underwent such surgeries described lasting physical and psychological harm.

"They operated on me when I was a baby. I have scars. I don't know what was done or why. As I grew, I realised I didn't feel like the gender they chose for me." (Intersex Participant 5)

Others described repeated medical examinations, photography, and teaching presentations involving their bodies, experiences they recalled as dehumanising and traumatic.

"When I was young, they kept bringing students to look at me. They would pull down my pants and point. I felt like an animal in a zoo." (Intersex Participant 3)

Parents who received sensitive, informative care reported better outcomes and greater confidence in supporting their children.

"One nurse sat with us and explained everything. She said there was no rush, that we could wait and let the child grow and tell us who they are. That gave us peace." (Parent 6)

This theme highlights the profound impact of healthcare encounters on intersex children and families, and the urgent need for provider training and ethical guidelines.

### Theme 4: Family Communication Patterns and Dynamics

Communication within families about intersex status emerged as a significant factor shaping children's experiences. In some families, open, supportive communication fostered acceptance and resilience.

"My mother sat me down when I was about twelve and explained everything. She said I was special, that God made me this way for a reason. That conversation changed my life." (Intersex Participant 1)

In contrast, families characterised by secrecy, silence, or shame left intersex children to navigate their differences alone, often with negative psychological consequences.

"Nobody ever talked about it. I had to figure it out myself from whispers and looks. I felt so alone." (Intersex Participant 4)

Parents described struggling with how and when to talk to their children about their bodies. Some delayed discussions, hoping the child would not notice or ask questions.

"I didn't know how to tell her. I kept thinking, maybe it won't matter, maybe she won't realise. But children always realise." (Parent 2)

Sibling relationships were also affected. Some participants reported that siblings were protective and supportive, while others described teasing or distance.

"My brothers used to mock me. They called me names. My parents didn't stop them." (Intersex Participant 6)

This theme underscores the centrality of family communication in shaping intersex children's self-concept, sense of belonging, and psychological wellbeing.

### Theme 5: Stigma, Bullying, and Social Exclusion

Experiences of stigma, bullying, and social exclusion within schools and communities were nearly universal among intersex participants. Many described relentless teasing, name-calling, and physical harassment from peers.

"At school, they called me 's3be3' (hermaphrodite). They would wait for me at break time to tease me. I stopped wanting to go to school." (Intersex Participant 2)

Teachers and school authorities often failed to intervene, and in some cases, compounded the harm through insensitivity or exclusion.

"A teacher once asked me in front of the class whether I was a boy or a girl. Everyone laughed. I wanted the ground to swallow me." (Intersex Participant 3)

Some participants were withdrawn from school by their parents due to bullying, limiting their educational opportunities and social development.

"I had to stop school after primary. My mother said it was too much for me. But staying at home was lonely too." (Intersex Participant 5)

Parents described the pain of watching their children suffer and feeling powerless to protect them.

"She would come home crying every day. I went to the school, but the teachers said they couldn't control what other children said. I didn't know what to do." (Parent 1)

Community stigma extended beyond school. Participants reported gossip, stares, and exclusion from community events and activities.

"In our town, everyone knew about me. When I walked past, people would whisper. I wasn't invited to weddings or gatherings like other young people." (Intersex Participant 1)

This theme reveals the profound social isolation and emotional harm inflicted by stigma and the failure of social institutions to protect intersex children.

## 9. DISCUSSION OF FINDINGS

This section discusses the findings of the study in relation to the theoretical framework and existing empirical literature. The discussion integrates Social Constructionism, Minority Stress Theory, and the Biopsychosocial Model of Intersex Experience to interpret how cultural beliefs, family dynamics, healthcare encounters, and social interactions shape the lived experiences of intersex children in Ghanaian families.

The findings reveal that families of intersex children in Ghana experience profound shock and confusion upon discovery of their child's variations, often compounded by inadequate communication from healthcare providers. This finding aligns with global research documenting parental distress and lack of information following intersex births (Gough et al., 2014; Crissman et al., 2011). In the Ghanaian context, however, this distress is amplified by cultural stigma and fear of community judgment, leading many families to resort to secrecy.

From a Social Constructionist perspective, the secrecy surrounding intersex births reflects the socially constructed nature of gender as a rigid binary. In Ghanaian society, where gender determines lineage, inheritance, and social belonging, a child who disrupts this binary threatens cultural order, prompting concealment (Kessler, 1998). The finding that families hide intersex children even from extended relatives illustrates how deeply internalised gender norms shape family behaviour.

Minority Stress Theory helps explain the psychological consequences of this secrecy. Families living with undisclosed intersex status experience chronic vigilance, fear of discovery, and social isolation, contributing to minority stress that may be transmitted to the child (Meyer, 2003). For intersex children growing up in secretive environments, the unspoken knowledge of being different creates what one participant described as a "secret they were keeping," fostering shame and self-doubt from an early age.

The prominence of cultural and spiritual interpretations in participants' narratives reflects the deeply embedded nature of traditional belief systems in Ghanaian communities. Interpretations of intersex variations as spirit children, ancestral punishment, or curses align with anthropological literature documenting African cosmologies in which atypical births carry spiritual significance (Adjei, 2018; Ogundele, 2020).

Social Constructionism illuminates how these interpretations are not merely individual beliefs but culturally produced frameworks that shape family responses. In communities where spiritual causality is accepted, seeking traditional healers or spiritual interventions becomes a logical response, sometimes preceding or substituting for medical care. This finding extends African research by Zayed and Elkins (2020) and Ogundele (2020), demonstrating how spiritual frameworks influence intersex management in Ghana specifically.

The Biopsychosocial Model is particularly useful for understanding the implications of these interpretations. Spiritual beliefs (social/cultural dimension) interact with family decision-making (psychological dimension) and access to healthcare (biological/medical dimension) to shape the child's developmental trajectory. When spiritual interpretations pathologise the child, as in cases where intersex is viewed as a curse, the child's psychological wellbeing and family relationships may be profoundly affected.

Healthcare experiences documented in this study mirror global critiques of medical management of intersex variations. Inadequate information, pressure to consent to early surgeries, and dehumanising treatment during medical examinations have been extensively reported in international literature (Karkazis, 2008; Liao et al., 2015; Preves, 2003). The Ghanaian findings confirm that these problems are not confined to Western medical systems but persist in African healthcare contexts.

The Biopsychosocial Model highlights the multidimensional harm caused by inappropriate medical interventions. Biologically, unnecessary surgeries may result in scarring, loss of sensation, and other physical consequences. Psychologically, intersex individuals may experience trauma, identity confusion, and distrust of medical systems. Socially, medical pathologisation reinforces stigma and positions intersex bodies as problems requiring correction rather than natural variations deserving respect.

The finding that some healthcare providers offered sensitive, informative care and advised against rushing into surgery demonstrates that ethical practice is possible even in resource-constrained settings. These positive examples, though rare in this study, provide models for improving healthcare responses. The absence of such care for most participants reflects systemic failures in medical education, policy, and ethical guidance, consistent with United Nations (2015) critiques of routine intersex surgeries.

## 10. CONCLUSION

This study explored the lived experiences of intersex children in Ghanaian families, examining how cultural beliefs, family dynamics, healthcare encounters, and social interactions shape their upbringing and identity formation. The findings reveal that intersex childhood in Ghana is characterised by secrecy, stigma, inadequate healthcare, and social exclusion, yet also by remarkable resilience and the possibility of acceptance and positive identity formation when supportive relationships and affirming messages are present.

The study demonstrates that intersex children in Ghana face unique challenges rooted in culturally specific gender norms, spiritual belief systems, and institutional failures. From the moment of birth, families encounter shock and confusion, often exacerbated by healthcare providers who lack training in intersex issues and may pressure parents toward early surgical interventions. Cultural and spiritual interpretations, including perceptions of intersex children as spirit children or evidence of curses, compound stigma and influence family decision-making, sometimes leading to harmful traditional practices.

Family communication patterns emerge as critical determinants of intersex children's wellbeing. In families where open, supportive communication prevails, children develop stronger self-esteem and greater resilience. In contrast, secrecy and silence leave children to navigate their differences alone, fostering shame, isolation, and psychological distress.

Within schools and communities, intersex children face relentless bullying, social exclusion, and institutional failures to protect them. These experiences constitute severe minority stressors that undermine educational access, social development, and mental health. The absence of protective policies, awareness programmes, and support services leaves intersex children and their families to cope with minimal assistance.

## 11. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed:

### 11.1 Policy and Legal Reforms

The Government of Ghana, through the Ministry of Gender, Children and Social Protection, should develop and implement specific policies addressing the rights and protection of intersex children. These policies should prohibit medically unnecessary surgeries on intersex infants and children, in line with United Nations human rights standards (United Nations, 2015). The Children's Act (1998) should be reviewed to explicitly include intersex children within child protection frameworks, ensuring that discrimination, stigma, and harmful practices targeting intersex children are addressed.

The Ministry of Health should develop national guidelines for the ethical management of intersex variations, emphasising informed consent, psychosocial support, and the postponement of irreversible interventions until the child can participate in decision-making. These guidelines should be disseminated to all healthcare facilities and incorporated into regulatory and accreditation frameworks.

### 11.2 Healthcare Provider Training and Education

The Ministry of Health, in collaboration with the Ghana College of Physicians and Surgeons, nursing and midwifery councils, and medical schools, should integrate comprehensive training on intersex variations into undergraduate and postgraduate curricula for all healthcare professionals. Training should include:

- Understanding intersex as natural biological variation rather than disorder
- Communication skills for supporting families of intersex newborns
- Ethical principles governing intersex care, including informed consent and postponement of non-emergency surgeries
- Psychosocial support strategies for intersex children and families
- Referral pathways to appropriate support services

Continuing professional development programmes should include intersex health and rights to ensure practicing providers update their knowledge and skills. Specialist centres should be designated to provide multidisciplinary, holistic care for intersex children and families, including paediatric endocrinology, urology, psychology, and social work expertise.

### 11.3 Public Education and Awareness

The National Commission for Civic Education (NCCE), in partnership with the Ministry of Information, civil society organisations, and traditional authorities, should develop and implement public education campaigns to raise awareness about intersex variations and combat stigma. These campaigns should:

- Disseminate accurate, accessible information about intersex as a natural human variation
- Challenge myths, spiritual misconceptions, and stigmatising beliefs
- Promote acceptance, respect, and inclusion of intersex persons
- Provide guidance to families, schools, and communities on supporting intersex children

Traditional leaders, religious authorities, and community influencers should be engaged as advocates for intersex inclusion, given their significant roles in shaping cultural attitudes. Community dialogues, radio programmes, and educational materials in local languages should be utilised to reach diverse populations.

### 11.4 Educational Sector Interventions

The Ministry of Education should develop policies and programmes to create safe, inclusive learning environments for intersex children. Key measures should include:

- Training teachers and school counsellors on intersex awareness, anti-bullying strategies, and supporting gender-diverse students
- Developing age-appropriate educational materials that include intersex variations in discussions of human diversity
- Implementing and enforcing anti-bullying policies that explicitly protect students from harassment based on sex characteristics
- Establishing reporting and response mechanisms for bullying and discrimination incidents
- Providing counselling support for intersex students experiencing stigma or exclusion

Schools should be encouraged to foster inclusive cultures where all students, regardless of sex characteristics, feel safe, respected, and valued. Parent-teacher associations should be engaged in awareness-raising and support initiatives.

### 11.5 Family Support Services

The Department of Social Welfare, in collaboration with health facilities and civil society organisations, should establish support services for families of intersex children. These services should include:

- Counselling and psychosocial support for parents experiencing distress following an intersex birth
- Peer support groups where families can share experiences and coping strategies
- Age-appropriate resources and guidance for discussing intersex with children
- Connections to medical, educational, and community resources
- Support in advocating for children's rights within healthcare and educational settings

Healthcare facilities should designate trained staff to provide ongoing support to families, ensuring continuity of care beyond the immediate postnatal period. Community-based organisations should be resourced to reach families in rural and underserved areas.

### 11.6 Intersex-Led Advocacy and Peer Support

Funding and technical support should be provided to establish and strengthen intersex-led organisations and networks in Ghana. Intersex persons should be centrally involved in developing policies, programmes, and advocacy strategies affecting their lives. Peer support programmes connecting intersex youth with intersex adults should be developed to reduce isolation and foster positive identity development. Intersex-led organisations should be resourced to conduct community awareness, provide peer counselling, and advocate for policy reforms.

## REFERENCES

1. Aboderin, I. (2017). Intergenerational support and old age in Africa. *Ageing & Society, 37*(7), 1351–1376.
2. Adjei, S. B. (2018). Traditional beliefs and practices surrounding intersex children in Ghanaian communities. *Ghana Journal of Sociology*, *12*(2), 45–62.
3. Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Doubleday.
4. Blackless, M., Charuvastra, A., Derryck, A., Fausto-Sterling, A., Lauzanne, K., & Lee, E. (2000). How sexually dimorphic are we? Review and synthesis. *American Journal of Human Biology*, *12*(2), 151–166.
5. Canon, L. (2018). Intersex experiences in South Africa: Stigma, discrimination and human rights. *African Journal of Gender Studies, 6*(1), 78–95.
6. Chase, C. (1998). Hermaphrodites with attitude: Mapping the emergence of intersex political activism. *GLQ: A Journal of Lesbian and Gay Studies, 4*(2), 189–211.
7. Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.
8. Crissman, H. P., Warner, L., Gardner, M., Carr, M., Schast, A., Quittner, A. L., Kogan, B., & Sandberg, D. E. (2011). Children with disorders of sex development: A qualitative study of early parental experience. *International Journal of Pediatric Endocrinology, 2011*(1), 10.
9. Davis, G. (2015). *Contesting intersex: The dubious diagnosis*. New York University Press.
10. Dreger, A. D. (1999). *Intersex in the age of ethics*. University Publishing Group.
11. Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*(4286), 129–136.

12. Gough, B., Weyman, N., Alderson, J., Butler, G., & Stoner, M. (2014). 'They did not have a word': The parental quest to locate a 'syndrome' in explaining their child's differences. *Health, 18*(2), 157–173.
13. Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). Harper & Row. (Original work published 1927)
14. Karkazis, K. (2008). *Fixing sex: Intersex, medical authority, and lived experience*. Duke University Press.
15. Kessler, S. J. (1998). *Lessons from the intersexed*. Rutgers University Press.
16. Kvale, S., & Brinkmann, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Sage Publications.
17. Liao, L. M., Wood, D., & Creighton, S. M. (2015). Parental choice on normalising cosmetic genital surgery. *BMJ, 351*, h5124.
18. Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.
19. Money, J., & Ehrhardt, A. A. (1972). *Man and woman, boy and girl: The differentiation and dimorphism of gender identity from conception to maturity*. Johns Hopkins University Press.
20. Mwaura, P., & Kimani, E. (2021). Intersex children in Kenyan schools: Experiences of bullying and exclusion. *East African Journal of Education Studies*, *4*(2), 112–128.
21. Ogundele, O. (2020). Cultural interpretations of intersex births among the Yoruba of Southwestern Nigeria. *African Journal of Anthropology*, *18*(3), 234–251.
22. Oppong, C. (1974). *Marriage among a matrilineal elite: A family study of Ghanaian senior civil servants*. Cambridge University Press.
23. Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Sage Publications.
24. Preves, S. E. (2003). *Intersex and identity: The contested self*. Rutgers University Press.
25. Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage Publications.
26. United Nations. (2015). *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*. United Nations General Assembly.
27. van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Routledge.

28. World Health Organization. (2022). *Intersex people and health: A call to action*. World Health Organization.
29. World Health Organization. (2023). *Human rights and intersex people*. World Health Organization.
30. Zayed, A., & Elkins, T. E. (2020). Cultural perspectives on intersex variations in Africa and the Middle East. *International Journal of Gynecology & Obstetrics, 150*(1), 15–20.