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Gender and Sexuality on Sexual Consciousness of Diseases and Mental Health Among Ghanaians

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ABSTRACT

The study investigates the interplay between gender, sexuality, and sexual awareness of diseases and mental health among Ghanaians, focusing on sexual orientations, disease awareness, and mental health management strategies. Key objectives include assessing sexual consciousness levels, examining the influence of gender and sexuality on sexual health education, and identifying implications for public health interventions. A mixed-methods approach was employed, integrating quantitative and qualitative data from 145 respondents via an online survey. Findings reveal a marginal association between sexual orientation and mental health issues, yet no significant differences in disease awareness across sexual orientations. However, the research underscores the challenges faced by non-heterosexual individuals in accessing sexual healthcare and mental health services. Individuals identifying as homosexual are found to be more prone to sexual abuse compared to other orientations. These insights are valuable for healthcare professionals and mental health service providers, emphasising the need for tailored diagnostics and policies. The study highlights the critical importance of targeted public health interventions that cater to the unique needs of diverse genders and sexual identities. The findings highlight important implications for public health interventions and the need for targeted initiatives that address the unique needs and challenges of different genders and sexual identities.

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1. INTRODUCTION

The healthy or unhealthy nature of sexuality is subjective. The recent focus is on the discussion of unwanted sex and how satisfied people are with their sexuality and sexual life (Čierna & Bianchi, 2024). The issue of sexuality has been skewed as most scholars studying sexuality have predominantly focused on non-heterosexuality (Saalim *et al.*, 2023; Snapp *et al.*, 2015; Jorm *et al.*, 2002; Munoz-Plaza *et al.*, 2002). The word sexuality was first used in the 18th century and was first used about human identity in 1897 (Nyarko, 2021). Numerous scholars and studies have studied the consciousness of sexuality, diseases, and mental health and have focused on developed countries and a few on developing countries (Fasciana *et al.*, 2022; Potki *et al.*, 2017; King & Bartlett, 1999). The study of these issues by scholars is influenced by the relevance of sex life to the total quality of life of individuals. Sexual well-being is crucial for an acceptable sexual life and is intently associated with a person's psychical, physical and social health (Ahn *et al.*, 2020).

In Ghana, scholars have studied sexuality, focusing on same-sex issues, sexual minors and sexual stigma. Such scholars have focused on understanding the sexual behaviours and perceptions among adolescents, HIV/AIDS, social perceptions, and the connection between religion and homosexuality (Kanwetuu *et al.*, 2018; Asante *et al.*, 2014; Meijer, 2022; Owusu *et al.*, 2013). According to UNAIDS, in Ghana, over 350,000 people are living with HIV, with adults aged 15 and over constituting 320,000 of those living with HIV. Of these, 110,000 are men aged 15 years and above. The HIV prevalence rate among such men is 1.0 and 2.0 among women; it is 0.4% among young men and 0.7% among young women (UNAIDS, 2023).

Between 2008 and 2021, the number of people living with HIV has increased by 17%, with AIDS-related deaths averaging a little above 5000 per annum. While there has been improvement in new HIV infection since 2010—i.e., it has dropped by 19%--and death-related cases have dropped by 35%, the prevalence ratio is 5.32 and the mortality ratio at 1.21. In Ghana, of the 350,000 people living with HIV, about 220,000 know their HIV status, with 150,000 of all HIV+ people being on antiretroviral therapy (ART) and 130,000 people with HIV viral load either undetectable or suppressed (UNAIDS, 2023).

Among the 150,000 people on ART, 109,314 are women, 36,895 are men, and 5317 are children. Among men who have sex with men (MSM), the HIV prevalence rate is 26.1%, with HIV testing and status awareness at 58%. Despite this gloomy picture, 92.1% of them are on ART, with 58% of them using condoms. Also, 6.2% of them have Hepatitis B and coinfection with HIV. 3.5% of MSM avoid healthcare because of stigma and discrimination (UNAIDS, 2023).

The intersectionality of gender, sexuality and health is complex and multidimensional, mainly related to sexual consciousness and its implications for disease susceptibility and mental health (Amoah & Afoakwah, 2023). Gender equality and equity are critical commitments in Ghana's health policies. With the emergence of COVID-19, it has become essential for Ghana to strengthen its primary health care and mental health systems; thus, the Government of Ghana and its development partners, such as the World Health Organisation and the Government of Canada have initiated series of competence training to improve the knowledge, skills and competencies on gender aimed at leveraging on evidence-based approaches to integrate gender into its healthcare and health systems to further equity, gender and fundamental rights to enhance essential health services (WHO, 2022).

Despite the progress in promoting health equity, significant disparities persist in the differentiation and addressing of health concerns among diverse sexual orientation groups. The paper investigates the sexual consciousness of Ghanaians with a specific focus on the relationship between gender, sexuality and awareness of diseases and mental health issues. The exploration of sexual consciousness is significant to appreciating and understanding the nuances of health outcomes among Ghana's sexually diverse population. By examining the relationships among gender, sexuality and health awareness, the research aims to contribute to developing targeted interventions and policies to promote inclusive and equitable healthcare systems. The research is guided by three objectives: (1) to assess the levels of sexual consciousness concerning diseases and mental health issues among Ghanaians of varying sexual orientations; (2) to explore the strategies employed by sexually conscious individuals to manage their mental health issues, and (3) to investigate the effects of gender and sexuality on sexual consciousness. Additionally, the following research hypotheses were established:

H_1: There is a positive association between sexuality and mental health issues.

H_2: Heterosexuals are more likely to be sexually conscious than homosexuals and bisexuals.

H_3: Homosexuals are more likely to be sexually abused compared to heterosexuals and bisexuals.

H_4: People who have experienced sexual infections and diseases are more likely to experience mental health issues.

H_5: There is a relationship between people who do not use protectives during their first sexual encounter and getting infected with sexually transmitted diseases and infections later.

The present research paper is organised into five distinct sections: Section One focuses on the Background to the Study, Section Two provides the analysis of the arguments in the literature review and conceptual framework, Section Three demonstrates the research methodology, Section Four approximates the outcomes and decode the results and Section Five concludes and provides the implications and limitations of the study.

2. LITERATURE REVIEW

The literature review forms a significant part of understanding the research topic as it provides a foresight into existing conversations about the research problem, and it provides a context for the readers to have an overview of the scholarly conversations as well as appreciate the contribution of the researcher to the conversation (Mauer & Venecek, 2022; Synder, 2019). An efficient and practical review of scholarly knowledge provides a firm basis for advancing knowledge, theory development, and the areas in which research is distinct and interdisciplinary (Synder, 2019).

A closer examination of the existing literature has focused on sexual minorities and the perception of heterosexuals on

homosexuality in both developing and developed countries (Luvuno *et al*., 2019; Wong *et al*., 2009; Brickell, 2005). However, in the area of Ghana, there is no extensive study which solely investigates the relationship between gender, sexuality and sexual consciousness, where gender is the socially ascribed label; sexuality is conceptually defined as one's sexual orientation, and sexual consciousness encompasses two constructs—sexuality awareness and mental health. Therefore, in writing the research paper, some significant scholarly works and texts were evaluated using the integrative approach. The integrative approach was crucial as it allowed for the assessment, critique and synthesisation of scholarly propositions; it also helped contribute to a conceptual framework and the emergence of new perspectives (Synder, 2019).

The history of sexuality is a complex and multidimensional field of interest that has explored how societies have understood, regulated and experienced sexuality across time and culture. The evolution of sexuality began with temple prostitution and sacred marriage rituals. However, with the spread of Christianity in the 5th century, particularly in Europe, sexuality became the focus of the suppression of non-reproductive sex (homosexuality, prostitution and pederasty). This repression continued into the 12th century and reached its zenith in the 14th century in Europe (Weeks, 2017; King & Bartlett, 1999; Laqueur, 1992; Foucault, 1976). The repression was due to the intolerance in papal and secular institutions towards what these institutions considered an aberration from the norm. The repression was integrated into dogmas, moral and legal anthologies in Europe for over a millennium (King & Bartlett, 1999; Foucault, 1976).

With colonisation and the supremacy of the British monarchy in the 17th century, the spread of intolerance became entrenched in almost every society under the British sphere of influence, particularly under the Victorian Era (Weeks, 2017). By the closure of the 19th century, sexuality became synonymous with homosexuality and masturbation (Brickell, 2005). The word homosexuality is derived from the Germanic word 'Homosexualitat', used by Karoly Benkers in 1869 in an argument against the extension of Prussian laws against sodomy in the newly established unified German state (King & Barlett, 1999). However, the medicalisation of sexual behaviour began with Richard von Krafft-Ebing's Psychopathia Sexualis of 1894, which presented for the first time a comprehensive catalogue of sexual sins, and Ellis Havelock and Symonds John Addington expanded the lexicon to encompass homosexuality and transvestism in 1897 (Krafft-Ebing, 1894; Ellis & Symonds, 1897).

With the criminalisation of homosexuality, labels such as 'catamite', 'bugger' or 'tribade' were used to describe same-sex behaviour and the term, homosexual' was expanded to include females (lesbians) in the 20th century during the sexual revolutions, feminists' movements and LGBTQ+ rights from the 1960s to 1980s, in which Faderman (1985) interpreted as the 'pathologisation of women's relationships' (King & Bartlett, 1999, Butler, 2006; Sedgwick, 1990).

As societies in Europe began to see non-heterosexual romantic affairs and sexual behaviours as sexual transgressions, they began to institutionalise sexual education. Sex education emerged in the late 19th century, and the proponents hoped that it would inculcate self-control and moral decency among the youth. The emergence of sexual education began with the concentration of homosexuality and masturbation as acts of sexual perversion socially, which required the uprightness and purity of the psychological makeup to resist this so-called sexual perversion (Brickell, 2005). The relevance of sexual education was crucial in 1922 as a committee investigating venereal disease blamed the absence of 'proper training and instruction of the young' for 'a great deal of the evil that has been shown to exist' (Brickell, 2005). With this social disposition, homosexuality—the focal point of sexuality education—society began to see homosexuality as a corruption of the soul (mind), but later, it evolved as a burlesque or mental disorder in the 19th century (King & Bartlett, 1999).

Nonetheless, the significance of sex education intensified during the Second World War due to the migration of people and the mass movements of soldiers, leading to an increase in the prevalence of sexually transmitted infections. After the end of the Second World War, sex education focused on the dangers of masturbation, the human reproductive system and the use of contraceptives. In the 1980s, sex education focused on the realisation of the existence and extent of gender inequalities, as well as HIV/AIDS, when it was realised that HIV was spreading rapidly in numerous countries. Sex education as a political avenue has always been evident since the 5th century (Hall *et al*., 2016; Pardini, 1998).

As sex education emerged due to the prevalence of homosexuality condemnation, nations perceived the act or the identity as an illness and a punitive act for men, which led to discrimination, atrocious treatments, shame, guilt and trepidation for those who did not align with heterosexuality (Brickell, 2005). The emergence of homosexuality as a sexual behaviour or psychological disorder is attributed to the number of individuals who departed from heterosexuality with those of the political majority (King & Bartlett, 1999). Thus, with the turn of the 20th century, the world began to be mapped or considered as assignable as either a homosexual or heterosexual, the birth of binary identity (Johnson, 2006).

The provision of sexual education, particularly knowledge and skills, is vital for developing one's personality and totality as a human. Sexuality education offers and facilitates the development of a person's attitudes, beliefs and values about sexuality, as well as assists in relationship development and interpersonal skills (Gürşimşek, 2009). The integral relevance of sexuality education also aids in informing the individual to develop a positive self-image and values related to sexuality and sexual decisions; it further assists in increasing knowledge on sexual issues and gender (Gürşimşek, 2009).

Sexual well-being is vital for a satisfactory sexual life, and it is closely linked to the physiological, psychological and social health of individuals (Ahn *et al*., 2020). Aside from Western countries, discussing sexual behaviours has been conterminous, causing a lack of research on sexual behaviour; however, in the last score and a half years, public awareness about sexually transmitted infections (STIs) and HIV/AIDS has evolved tremendously, invoking interests on human sexuality and sexual behaviours (Ahn *et al*., 2020). The prevalence of STIs has increased and is partially linked to sexual behaviours

related to early sexual engagement, commercialisation of sex and the low usage of condoms.

Sexually Transmitted Diseases (STDs) are a major health issue, and they mainly affect young people in both developed and developing countries. In developing countries, the issue of STDs/STIs is worsened by the unavailability of diagnostic tests, the expensive nature of testing and the geographically inaccessible nature of these tests (Fasciana *et al.*, 2022). It is for this reason that sexuality education must focus on sexual self-concept. Sexual self-concept is a significant component of sexual health and at the core of sexuality. Scholars and healthcare providers believe that the mental and emotional characteristics of sexual welfare are the most critical aspects of sexual health (Potki *et al.*, 2017). The sex life is the most crucial aspect of an individual's life, and structural sexual self-concept is evolving and multidimensional—i.e., it is developed based on one's understanding of personal identity (Potki *et al.*, 2017).

The understanding of sexual desires is developed based on social expectations and along with socio-psychological growth and sexual representation. Sexual self-concept imitates the process of sexual behaviours associated with social formation and guides sexual behaviours (Potki *et al.*, 2017). There is a close association between sexual self-concept and sexual conscientiousness and consciousness. Sexual consciousness is a positive dimension of sexual self-concept and could be affected by expressive sexual events such as strong copulatory or non-copulatory sexual deeds, losing virginity or a history of sexual abuse in childhood (Potki *et al.*, 2017).

The term 'homosexual' predates the term 'heterosexual', and since its emergence, the pressing issue and argument has been: why? What facilitates or influences homosexuality: nature or nurture, biology or environment? The emergence of the 20th century witnessed an absolute fixation on defining sexualities. This fixation resulted in terminologies of sexual orientation and sexual preferences as identities (Eliason, 1996). Identity is succinctly defined as 'what you can say you are according to what they say you can be' (Johnston, 1973). This means that identity has two components: a self-evaluation and a socially deterministic range of choices or categories (Eliason, 1996). Both terminologies have been utilised almost interchangeably; however, both have slightly different theoretical nuances. Sexual orientation is generally about an innate disposition for the gender of sexual or affectional partners, whereas sexual preference describes the choice between genders for sexual or affectional behaviours (Eliason, 1996).

Accordingly, Eliason (1996) asserts that until a word gains broader usage in the culture, a category or type of person does not exist, and identity is best understood using Habermas' model of ego development. Ego development begins in the first year of life of the symbiotic stage, when infants are dependent on the environment for all their needs; the egocentric stage is next and it is when the young child learns to distinguish between self and others, yet remains very self-centred. The third stage is the sociocentric phase, where the child learns the social norms and roles of the culture and finally, in the universalistic stage, the adolescent can critically evaluate social norms and develop a strong sense of personal identity.

The argument about sexuality as ascribed or achieved is old. Sexual orientation is assigned, and sexuality is a social profile of sexual orientation; therefore, people cannot be homosexual, bisexual, heterosexual or any other sexuality, as it is only the behaviours that can be formed. The sexual behaviour in which a person is involved does not define sexual orientation or desire. However, it is an indicatory point of the social construction of the actuality being depicted by the individual and the motivations for that particular sexual act (Coleman, 2015).

Identity is a complicated issue for individuals who have been sexually abused. One's interaction with one's surroundings predominately influences the construction of an identity. The awareness of identity starts with the internalised representation of the expectancies of others as to how a person should think and behave as a sexual being. Such consciousness and identity construction inform one's beliefs, values, and standards, forming an image of behaviours and attitudes in different life circumstances. The process of identity construction is categorised into two distinct and significant stages—gender identity formation (sexual identity) and core gender identity, and the formation of gender-role identity. These distinct stages begin at age two, continue during adolescence, and are marked by psychological reformation (Tremblay & Turcotte, 2005).

Identities educe a set of cognisance, feelings and behaviours that are associated with defining features and relations. Most people desire to hold positive self-images, but the contradictions of their identities with social expectancies, coupled with discrimination and stereotyping, yield identity concealing. The pride in identity is understood through the knowledge of the perspectives of positive identity—i.e., virtue, evaluative, developmental and structural perspectives (Roberts & Creary, 2012).

Furthermore, identity concealment affects sexual minorities with potentially complicated psychological implications. Accordingly, Munoz-Plaza and colleagues (2002) assert that sexual minorities are at high risk for a diverse number of health problems, including suicide ideation and attempts, harassment, substance abuse, homelessness and declining academic and working performance. Young people who are struggling with issues of sexual orientation face incredible challenges and lack many of the fundamental supportive systems available to their heterosexual compatriots. However, the prevalence is hinged on the magnitude of social support and ties with friends, partners and families (Munoz-Plaza *et al.*, 2002).

Bisexuals have poorer psychological health compared to homosexuals, except for suicidality, anxiety and depression. The prevalence of sexual orientation tends to increase in young adults compared to middle-aged; women aged 16-24 also have a higher prevalence of recent homosexual partners than men of the same age, as men have a higher prevalence from the ages of 24 to 44 years (Jorm *et al.*, 2002). Concealing the identity of a sexual minority has the potency to generate the stress of hiding but also safeguard against the stress due to discrimination (Pachankis *et al.*, 2020). Stigma is associated with adverse mental, affective, behavioural and self-evaluative effects. The psychosocial problems of concealable stigma are a critical and developmentally early stressor defining the significant incongruences of psychiatric health issues affecting sexual minorities (Pachankis *et al.*, 2020). Sexual minorities usually become conscious of their sexualised minority during

the phase of adolescence and disclose their sexual identity in early adulthood after several years.

The disclosure of sexual minority identity is an essential step towards developing a positive identity despite the repercussions of 'coming out' such as social stigma, prejudice and upheaval in their present relationships (Ullrich *et al.*, 2003). The concealment of sexual identity is partially crucial in understanding the progression and risk of being diagnosed with mental health, chronic health issues, cancer and infectious diseases compared to HIV-seropositive individuals who do not hide their sexual identity (Shannon *et al.*, 2015). Therefore, expressing thoughts and feelings about stressors is associated with better physical health and a well-functioning immune system (Ullrich *et al.*, 2003). The concealment of sexual identity by sexual minorities is associated with higher depressive symptoms, lower social support satisfaction and higher social constraints.

Mulya and Hutahaean (2019) posit that depression among sexual minorities, particularly homosexuals, is thrice compared to the heterosexual population. This discrepancy is associated with factors such as prejudice, discrimination and acts of violence experienced by these sexual minorities as a result of their sexual orientations (Balfe *et al.*, 2010; Jorm *et al.*, 2002). Sexual minorities encounter stigma and stress when seeking healthcare services. The sexual stigma and its associated stressors by healthcare personnel and the broader society are justified by these people using political, moral and religious beliefs to define their reactions to sexual minorities. These experiences influence sexual minorities to avoid seeking assistance from facilities they believe to be hostile and unwelcoming to them (Balfe *et al.*, 2020). Homosexuals tend to experience minority stress in the form of stigma consciousness, which affects their mental health. Minority stress is defined as the conflict between the values of minority groups with the predominant values of the wider society and the experiences of outcome of these conflicts with the social environment. Cultural sanctions, differentiation of inferior status, social prejudices and discrimination are the primary causes of minority stress. These causal factors can alter individuals' mental health and adaptation (Mulya & Hutahaean, 2019).

Sexual minorities encounter diverse structural and common barriers, obstructing access to quality healthcare, such as the scarcity of health facilities that offer minority-targeted resources and the inadequacy of healthcare personnel skilled in dealing with health issues faced by sexual minorities, the obliteration of these minority populations in the healthcare system through the lack of utilisation data and the notion that there exists no sexual minorities (Balfe *et al.*, 2010).

Additionally, sexual minorities have a higher tendency to experience suicide. Suicidal ideation is an established factor for self-destruction and is a life-threatening behaviour. Suicidal ideation is influenced by exploration and potential understanding of one's self-conscious realm of emotional experience; therefore, the extent of shame and guilt predominate suicidal considerations, and it is associated with the heuristic context in which these sensations are embedded. Individuals who suffer from childhood sexual abuse are prone to intense shame effects, which may influence suicidal urges as an ultimate manifestation of self-denunciation (Kealy *et al.*, 2017).

Shannon and colleagues (2015) further suggest that sexual minorities, especially LGBTQ+ youth, have compromised physical and psychological health and family rejection is a significant predictor. Sexual minorities who face parental condemnation of their sexual orientation during adolescence are 8.4 times more likely to commit suicide, 5.9 times more likely to experience depression and 3.4 times more prone to engage in illegal drugs and risky sexual behaviours compared to peers from families and communities who show acceptance or are minimal in condemnation of their sexual orientation (Shannon *et al.*, 2015). Homosexuals have a higher prevalence of childhood sexual abuse, ranging from 11% to 37%. An estimated 16% of homosexuals have histories of childhood sexual abuse, and this experience is associated with HIV-positive status, a history of engaging in sex for money and the use of sex-related drugs. Those who experience childhood sexual abuse are seven times more likely to engage in the commercialisation and monetisation of sex, six times more likely to be a current user of sex-related drugs, thrice more likely to have reported being diagnosed with STI and thrice more likely to contract HIV or be HIV-positive (Kealy *et al.*, 2017; Brennan *et al.*, 2007).

Men who have sex with men (MSM) have the highest sex-behaviour-related risks for STIs; therefore, STD teams need to implement counselling and recommendations to share with patients to provide tips on how to approach sexual health education and counselling, thereby promoting patient-centred approaches and educational programmes (Fasciana *et al.*, 2022). Older people and people with lower educational levels tend to be more prone to use condoms never or seldom use condoms with casual partners. The rationale is a feeling that condoms are bothersome to use, the perception that condoms decrease sexual pleasures and occasionally, sexual partners objecting or requesting no use of condoms (Ahn *et al.*, 2020). A history of sexual relationships with casual partners is a concerning sexual behaviour since those who engage in this behaviour are exposed to a high degree of risk of STIs, and the identified vulnerable groups are men in their 20s and 30s who are sexually active (Ahn *et al.*, 2020).

Additionally, among HIV-positive people, heterosexuals have a high rate of contracting HIV and testing positive compared with homosexual men or same-sex coital acts. Heterosexuals are four times more prone to contracting HIV compared to homosexuals, as a history of STI infection increases one's chances of contracting HIV (Wong *et al.*, 2009). STIs are, therefore, public health issues because of their associated risks, such as infertility, ectopic pregnancy and pelvic inflammatory diseases. The dire consequences of these infections and their associated diseases make it imperative for the need for early detection and treatment to mitigate the associated risks, which, if unaddressed, could determine the risk of transmission to partners and the severity of sequelae, squeamishness and sequaciousness (Balfe *et al.*, 2010). Emotions in the forms of shame, guilt and mortification, as well as individual experiences, play a significant role in seeking treatment for suspected STIs and positive diagnosis. Therefore, there is a need to be embracing to encourage young adults to freely discuss their STI status with past, present and future sexual partners, thus raising the risk of developing STI-associated squeamishness.

2.2. Conceptual framework

The research model explores both the mediating and moderating effects of sexual experience and education on the relationships between sexuality (sexual orientation), gender and sexual consciousness. Sexuality and gender are the independent variables that influence the outcome variable, which is sexual consciousness—sexual disease awareness and mental health. Sexual consciousness is measured using two dimensions, which are sexual education awareness and mental health awareness. Sexual education awareness consists of the age of first sexual experience, the type of sexual encounter, whether there was the use of protection, the source of primary sexual education and the perception of the adequacy of sexual education. The mediating variables are the type of sexual experience and sexual education; the moderating variables are the degree of sexual education and age of first sex, while the confounding variables are the adequateness of sexual education and societal norms.

Additionally, the model evaluates the confounding effects of the adequacy of sexual education on the relationship between gender, sexuality and sexual consciousness. The confounding variables are the adequateness of sexual education and societal norms. Therefore, the conceptual framework is demonstrated in Figure 1.

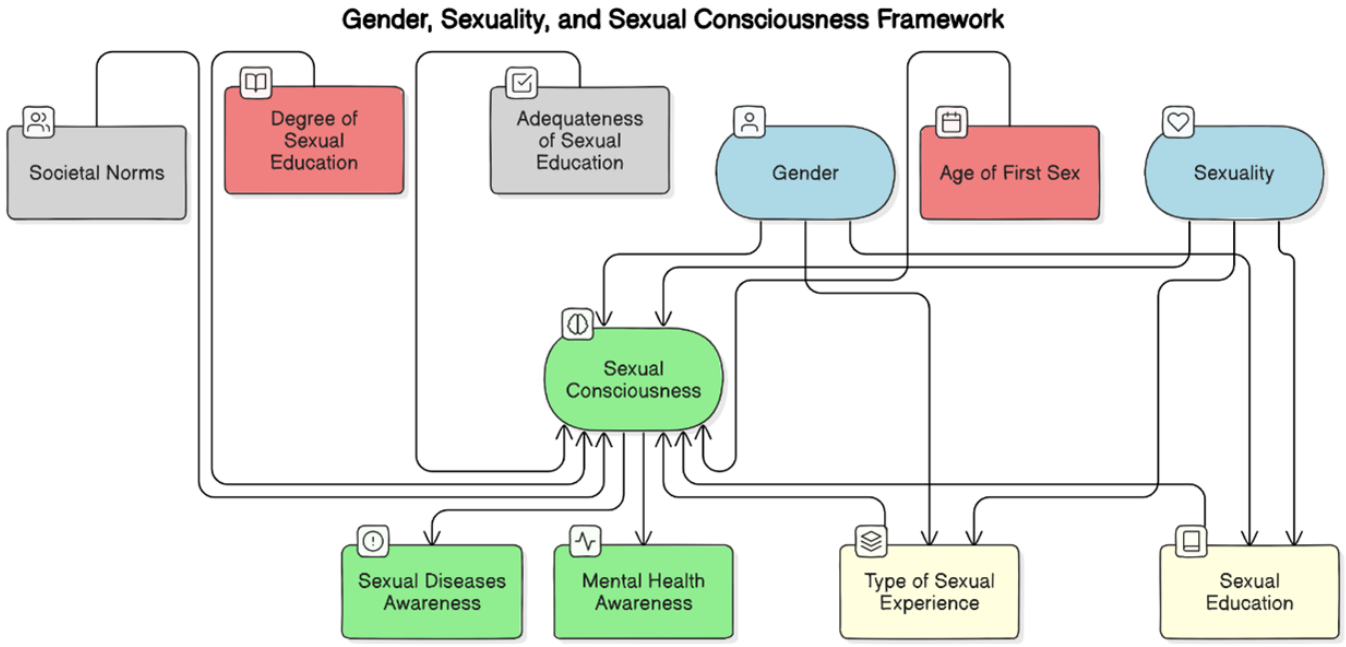

Figure 1. Conceptual Framework

3. METHODOLOGY

The paper utilised a quantitative cross-sectional design to explore the relationship between gender, sexuality, and sexual consciousness regarding diseases and mental health among Ghanaians. The primary aim was to gather and analyse data that would provide insights into how sexual orientation influences awareness of sexual health issues and mental well-being. It deployed a praxis-based and 'phronetic' approach, where qualitative data were systematically gathered, organised, interpreted, analysed and communicated to address the relationship between gender, sexuality and sexual consciousness. The approach clarifies and deliberates the investigated topic in full knowledge, as ultimate answers to the issue under investigation cannot be achieved (Tracy, 2020). The praxis-based and 'phronetic' approach prioritises practice in context and assumes that perceptions are always self-reflexive and that the socio-historical foundations of an issue herald personal motivations and actions.

The narrative inquiry and autoethnography described by Tracy (2020) were utilised, which is appropriate for the investigated topic. Narrative inquiry provides a casement for appreciating and understanding how interpretations of specific situations are executed and create a reality that they, in turn, act upon. Autoethnography allows for a systematic study, analysis and narrative description of one's experiences, connections, culture and identity. The research paradigm is a methodological triangulation because of its reliability to replication and the opportunity for a formal generalisability—i.e., social phenomena exist not only in the awareness of the mind but also in the real world and that some reasonably stable relationships can be found among the idiosyncratic messiness of life (Miles *et al.*, 2014; Tracy, 2020).

The study used both probability and non-probability sampling techniques. With the non-probability sampling, the paper utilised snowball sampling because it allows the researcher to select participants who are relevant to the research questions, especially its ability to allow the researcher to reach hidden and marginalised sexual minorities (Almaqtari, 2024). The probability stratified sampling allowed for dividing the population into homogenous smaller groups based on socio-demographics. This mixture of probability and non-probability sampling techniques allows for exploring respondents'

experiences and perspectives and ensures the representation of each characteristic in the sample (Iliyasu & Etikan, 2021).

A comprehensive online survey was developed to capture the experiences and perceptions of Ghanaians related to these topics. The survey consisted of a series of structured questions, focusing on participants' sexual orientation, levels of sexual consciousness, and awareness of diseases, along with their mental health management strategies. The paper consisted of fifty-one items and was structured into five constructs. The study sampled one hundred and forty-five (145) respondents through the online questionnaire distributed via Google Forms. The survey was distributed through various social media platforms, particularly Facebook, Telegram, and WhatsApp groups, and included required questions and participant-friendly statements for closed-ended questions. A concise letter was attached to the questionnaire and distributed through the platforms.

In interpreting the data gleaned, the paper utilised the Aristotelian phronesis—i.e., practical wisdom is best crafted by examining phenomena in their natural context. Descriptive statistics were calculated to summarise demographic information and assess the levels of sexual consciousness among different sexual orientations. Further inferential statistical tests were conducted to investigate associations between sexual orientation, disease awareness, and mental health issues. The data collection period spanned four weeks, allowing sufficient time for participant engagement and responses. Ethical considerations were paramount, with the survey ensuring anonymity and confidentiality for all respondents. Participants were informed about the purpose of the study, and consent was obtained prior to their participation. By employing this quantitative cross-sectional approach, the study aimed to provide a clearer understanding of the intersection between gender, sexuality, and public health awareness in Ghana, revealing important implications for healthcare strategies and mental health support services tailored to diverse sexual identities.

4. RESULTS AND DISCUSSION

Participants sampled comprised 29% of females, 67.6% of males, and 2.8% non-binary, with 0.7% not subscribing to the genders as mentioned earlier. Out of the 145 participants, 49% of them are between 18 and 25 (i.e., 71), 25.5% are between 25 and 29 years (i.e., 37), 19.3% are between 30 and 39 years (19.3%), 5.5% are between 40 and 49 (i.e., 8) with 0.7% (i.e., 1) being 50 years and above. In analysing sexual orientation, there were 4.8% (i.e., 7) of respondents were asexual, 25.5% were bisexual (i.e., 37), 41.4% were heterosexual (i.e., 60), 26.9% were homosexual (i.e., 39), with 0.7% (i.e., 1) being demisexual or pansexual. Also, respondents from the Ashanti region (37) constituted slightly above a quarter of all participants (25.5%), 33.8% of them were sampled from the Greater Accra region (i.e., 49), 16.6% (i.e., 24) were from Central region, 9% (i.e., 13) were from Western region and 2.1% were from Western North (i.e., 3). Two respondents were sampled from the Bono, Bono East, Northern, and Upper East regions. These four regions constituted 5.6% of total respondents; 4.8% of respondents were from Eastern (i.e., 7) and one respondent each from North East, Savanna, Upper West and Volta regions.

Additionally, the sexual relationship status of respondents was surveyed. The data showed that approximately 43% are single, approximately 38% are dating, 8% are married, 5% are in open relationships, 4% are partnered, and 2% are in committed relationships. The educational backgrounds of participants were analysed. Most surveyed respondents had senior secondary education as the minimum educational qualification. Less than 2% of the sampled respondents had junior high education as their highest education, with 10.3% having senior high education as the highest academic qualification. About 54% of the respondents were either in the university or college—i.e., 80 respondents were enrolled in college or university, while about one-third of the sampled participants were graduates (i.e., 48).

Respondents were also asked to answer questions concerning their first sexual intimacy. One-fifth of participants (i.e., 29) had their first sexual intimacy when they were between 9 and 15; a little over half of them had their first sexual encounter during the peak of their adolescence (i.e., between 16 and 19 years). Also, less than 1.5% of sampled participants had their first sexual intimacy when they were at least 30 years old, while 43.4% of them had their sexual intimacy experience when they were between 20 and 29 years old. Regarding sexual intimacy, respondents were asked to indicate the nature of the sexual experience. One-fifth of them had engaged in anal sex, a little above one-tenth (11%) had engaged in masturbation, 12.4% (i.e., 18) had oral sex as their first sexual intimacy, and 56.6% (i.e., 82) of them had engaged in penile-vaginal coitus.

Additionally, the respondents were asked to answer questions regarding who the person was they had their first sexual encounter with. The finding revealed that 38 of the 145 respondents had their first sexual encounter with their classmates (i.e., 26.2%), 51 of them had their first sexual activity with their neighbours (i.e., 35.2%), 40 of them (i.e., 27.6%) had their first sexual experience with friends, 12 of them had it with their relatives (i.e., 8.3%), 0.7% with teachers and 2.1% with their church member or pastor. The results further revealed that 77 participants had their first sexual encounter through their connection with online people, representing 53% of all respondents. 14.5% were from Facebook, 6.9% from Grindr, 1.4% each from TikTok or Instagram, 0.7% from Tinder, and 22.1% (i.e., 32) from other social media platforms. However, of their sexual experience, close to two-fifths (i.e., 36.6%) of them used protectives, while 63.4% (i.e., 28) used no protectives.

Hypothesis 1 was analysed using the cross-tabulation. This was used to find the relationship between sexual orientation and mental health. Mental health focuses on the experience of depression and anxiety. Fifty-five (55) participants, representing approximated 38%, have experienced mental health issues. Almost two-fifths of them were homosexuals (i.e., 38.2%), about one-third were bisexuals (i.e., 32.7%), and one-quarter of them were heterosexuals (i.e., 25.5%), with less than 0.4% being asexual. The association was evaluated using the contingency coefficient (C). The contingency coefficient provides an interpretation of the association between mental health experience and sexual orientation, whether these two variables are independent or dependent on each other. The contingency coefficient value is 0.286, with an approximate significance of 0.024. These figures imply that there is a slight relationship between sexual orientation and mental health

issues, and there is a more statistically significant result in the data. Hence, it is concluded that the sexuality of a person is significantly associated with mental health issues.

Furthermore, in focusing on anxiety only, the findings revealed that 66 of all respondents reported experiencing anxiety. Participants were asked to indicate when they experienced the feeling of being anxious. Forty per cent of those who daily experienced anxiety were homosexuals, with twenty-eight per cent each being bisexual or heterosexual. On a weekly basis, half of the sampled were homosexuals; fifteen per cent were heterosexuals, five per cent were asexual and thirty per cent were bisexual. On a monthly basis, heterosexuals experienced anxiety often compared to other sexual identities. Seventeen per cent of those who experienced anxiety on a monthly basis were either bisexual or homosexual, with five per cent being asexual. On the issue of depression, one-third of respondents who experienced it daily were homosexuals, twenty-seven per cent were bisexuals, and forty per cent were heterosexuals. Forty-one per cent of those who expressed depression weekly were homosexuals, thirty-six per cent were bisexuals, and twenty-three were heterosexuals. On the monthly experience of depression, twenty-eight per cent of them experience depression monthly, forty-four per cent of them as heterosexuals, seventeen per cent as bisexuals and eleven per cent asexual. In summary, thirty-two per cent of the sampled who experienced depression were homosexuals or heterosexuals, and twenty-five per cent were bisexuals.

In testing for Hypothesis 2, "Heterosexuals are more likely to be sexually conscious than homosexuals and bisexuals," the Chi-Square was used. The cross-tabulation showed that out of the thirty-six (36) who had contracted sexually transmitted infections and diseases, 12 were bisexual, 13 were homosexuals, and 9 were heterosexuals. Also, nine people said they are likely to have contracted infections and diseases, with three respondents each across the three aforementioned sexual orientation groups. The Pearson Chi-Square value was 8.316, whereas the expected cell count assumption indicated that 66.7% of all counts are less than 5—i.e., there are some cells which had an expected cell count of more than 5, so the assumption that heterosexuals are more likely to be sexually conscious than homosexuals and bisexuals was not met. Nonetheless, the corresponding p-value of the test is $p = 0.598$. Since the p-value is greater than the chosen significance level ($\alpha = 0.01$), the null hypothesis cannot be rejected as there is insufficient evidence to suggest an association.

However, when cross-tabulation is employed with sexual consciousness concentrated on the use of protectives on their first sexual encounters, sexual topics, adequacy of sexual education, degree of sexual information and whether one had experienced sexual abuse, the collated data revealed that out of the ninety-two (92) who did not use any protective on their first sexual encounter, about three-tenth (29.3%) were homosexuals, slightly one-third (34.8%) were heterosexuals, slightly above one-quarter (27.2%) were bisexuals, less than one-tenth were asexual, pansexual and demisexual (8.7%). Of the fifty-three (53) who used condoms on their first sexual experience, a little over half (i.e., 52.8%) were heterosexuals, and slightly one-fifth (22.6%) each were either homosexual or bisexual. The use of condoms was to prevent pregnancy and not necessarily because of STIs/STDs. This indicates that young heterosexuals are more concerned about pregnancy prevention than the preventions of sexually transmitted infections and diseases. Homosexuals and most bisexuals did not use condoms because they argued that there is no pregancy involved and that "raw" sex is more intimate and "sweeter" than the use of rubber (condom).

On the issue of sexual topics, 61.5% of those who received sexual education on HIV/AIDS were homosexuals, 23.1% were heterosexuals, and 15.4% were bisexuals. On the education of STIs/STDs, except HIV/AIDS, 53% of those who received such education were heterosexuals, with 40% of them being homosexuals and bisexuals, with 7% being asexual. The study revealed that the issue of contraceptives is not a significant issue when it comes to sex education topics, as only 9 out of 145 respondents stated that the single topic they received in their sex education was contraceptive usage. A further cross-tabulation was done for sexual orientation and the issues of sexual topics. The contingency coefficient value was 0.628, showing there is a strong relationship between sexual orientation and the nature of topics taught or offered in sex education.

Respondents were surveyed on who or what institution was the primary source of sexual education. Almost half of the surveyed respondents received their sexual education from school (i.e., 46.2%), slightly above one-half (i.e., 21.4%) received it from friends, almost one-fifth (i.e., 18.6%) received it online, and about 13.1% of the participants received their sexual education from family. About 2% of all surveyed participants received their sexual education from healthcare providers. The sexual education is centred on sexually transmitted infections and diseases.

On the issue of the adequacy of sexual education, using a Likert scale of 4, heterosexuals received 'very adequate' information (i.e., 60.3%) compared to homosexuals (i.e., 20.7%) and bisexuals (13.2%). This difference lies in how society perceive homosexuals; hence, most people who identify as non-heterosexuals are not provided with the needed sexual education as they are perceived as "sinners" or "abominable" people. The contingency coefficient value was 0.416 when a cross-tabulation was performed on sexual orientation and the degree of sexual education offered. The value indicates that there is a moderate association between the sexual orientation of a person and how adequately sexual education is offered. Based on the degree of sexual orientation, the collated data revealed that heterosexuals are very informed sexually in terms of sexually transmitted diseases compared to homosexuals and bisexuals; however, homosexuals are slightly more informed sexually aware (sexual consciousness) than bisexuals in terms of sexually transmitted infections and diseases.

H_3: Homosexuals are more likely to be sexually abused compared to heterosexuals and bisexuals.

The findings revealed that slightly more than thirty per cent (i.e., 32.4%) of surveyed respondents had experienced sexual abuse. This implies that three out of every ten Ghanaians are likely to experience sexual abuse, irrespective of their sexual orientation. However, homosexuals and bisexuals are more likely to face sexual abuse because of their sexual orientation (i.e., 59.6%). On a comparative scale, heterosexuals are more

likely to experience sexual abuse, especially females, but homosexual men's sexual abuse is 12 times higher compared to heterosexual men.

H_4: People who have experienced sexual infections and diseases are more likely to experience mental health issues.

There were fifty-five respondents (55) who had experienced mental health issues in the last twelve months. This implies that about two-fifths (i.e., 37.9%) of the sampled have experienced mental issues in their lives. Men have a higher tendency to experience mental health issues compared to women, as they have a risk of 3.4 times compared than females. Of those who have experienced mental health issues, about two-fifths (i.e., 38.2) were homosexual, about one-third were bisexual (i.e., 32.7%), and about one-quarter were heterosexual (i.e., 25.5%). The revealing data indicate that homosexuals are 1.5 times more likely to have mental issues compared to heterosexuals and 1.2 times compared to bisexuals. Homosexuals are 1.4 times more likely to experience anxiety daily compared to bisexuals or heterosexuals; homosexuals and heterosexuals have the same prevalence rate in experiencing depression, but are 1.3 times more likely to experience depression compared to bisexuals. People are more likely to contract chlamydia, genital warts and gonorrhoea.

H_5: There is a relationship between people who do not use protectives during their first sexual encounter and getting infected with sexually transmitted diseases and infections later.

A cross-tabulation was executed to understand the relationship between the type of sexual experience and the disease contracted. The findings revealed that of the ninety-five (95) people reporting having engaged in sex and contracting infections or diseases, about fifteen per cent (i.e., 14.7%) had engaged in anal sex contracting gonorrhoea and HIV/AIDS as the most typical diseases; those who engaged in oral sex constituted 10.5% and had gonorrhoea as the most typical sexual infection while those who engaged in heterosexual intimacy constituted 61.5% with the commonest infection being gonorrhoea, then chlamydia and genital warts. Those who used no protectives showed that about 27.3% contracted gonorrhoea, 14.5% contracted HIV, 11% contracted chlamydia, and 7.3% contracted anal warts. The findings further revealed that the use of no protection shows that there is a 75% chance of contracting anal warts in the case of homosexuals and a 25% chance in heterosexuals; the prevalence of contracting chlamydia among heterosexuals is 33% and 16% among homosexuals; therefore, it implies that heterosexuals have a higher prevalence rate of contracting chlamydia. Also, a 60% chance of contracting gonorrhoea when using no protective measures, but in the case of homosexuals and bisexuals, the prevalence rate was 1.25 and 1.5 times higher when compared with heterosexuals. Homosexuals have three times the prevalence rate of contracting HIV when compared with heterosexuals, and bisexuals have four times the prevalence rate of contracting HIV when compared to heterosexuals and 1.33 times higher when compared to homosexuals.

The paper explored the strategies employed by people who experience mental health issues. The data showed that 77 people (i.e., 53.1%) experienced anxiety or stress either occasionally or regularly; however, only 23.4% of those who experienced mental health issues sought mental health help because of sexual health concerns. Participants were asked how supportive their social network was regarding mental health, and approximately one-tenth of all respondents sought professional help for mental health issues. On the strategies used as coping mechanisms for mental health issues, 61.2% engaged in creative expressions such as art, music and writing, 42.2% used online resources, 29.9% sought spiritual direction, and 25.9% sought help from support groups. Respondents were asked how comfortable they were disclosing their sexual orientation to mental health professionals; 34.9% of them were comfortable, 24% were very uncomfortable, and 21.9% were neither comfortable nor uncomfortable.

Finally, the barriers preventing one from seeking mental health services were assessed. The findings revealed that close to sixty per cent of the reasons were attributed to the cost of seeking mental health services, 36.3% of respondents attributed it to lack of LGBT-friendly facilities and personnel, 31.5% attributed it to stigma, and 18.5% attributed it to insurance limitations.

5. CONCLUSIONS

The paper highlights the relationship between gender, sexuality and mental health among Ghanaians by assessing the sexual consciousness concerning diseases and mental health of Ghanaians of varying sexual orientations. Sexuality, with its knowledge of identity and consciousness, is critical for the development of a person physically, psychologically and socially. The availability of sexual education, particularly on sexually transmitted infections and diseases and coping mechanisms of mental health, increases one's knowledge of sexual health issues and attitudes towards sexuality. The findings revealed that there is a relationship between one's sexual orientation and their experience of mental health issues, which supports the hypothesis. The finding is consistent with the outcomes of previous studies (Fasciana *et al.*, 2022; Pachankis *et al.*, 2020). The paper did not find any significant difference among heterosexuals, homosexuals and bisexuals in sexual consciousness. This contradicts the findings of Wong and colleagues (2015). The findings revealed that homosexuals are more likely to be abused sexually compared to bisexuals and heterosexuals; therefore, this confirms the study conducted by Brennan and colleagues (2007).

The paper has significant contributions to the strand of literature. It explores the association of sexuality, sexual consciousness and mental health. The findings have real-life implications for understanding the complexities of issues faced by people, especially their sexual lives. The analysis may assist mental health professionals and healthcare providers in identifying respectively, areas of focus in helping their patients when assessing health-related services, and researchers to identify areas for further investigations, furthering knowledge expansion, practical insight and academic perspectives.

The findings align with existing literature that highlights the intricate relationship between gender, sexuality, and health outcomes. Research indicates that marginalised sexual orientations often face additional barriers to healthcare access and are at a higher risk of mental health issues due to stigma and discrimination. This study's insights resonate with theories of intersectionality, which emphasise how overlapping identities

shape individual experiences. By illustrating the specific challenges encountered by non-heterosexual Ghanaians, the study contributes to a deeper understanding of how societal norms impact sexual health, echoing calls for more inclusive public health strategies tailored to diverse communities.

Despite the insightful revelations of the current paper, it has specific limitations. First, the study is limited to Ghanaians and the sample size was concentrated predominantly on participants from the Southern part of the country; thus, further research could be considered using a comparative study across regions. Secondly, the paper is limited because it focuses on anxiety and depression, as mental health issues are multifaceted. It does not examine sexual consciousness beyond sexual intimacy and knowledge of condoms and sexually transmitted infections and diseases; it does not consider the self-efficacies of respondents in dealing with anxiety or depression. The method of analysis and sample size limit the generalisability of the findings to a broader scale. Accordingly, future research could investigate the issues using quantitative inferential statistical methods of regression analysis and factorial analysis to better ascertain the relationship between the variables and predict and forecast the probabilities of such occurrences among the diverse sexual orientation groups.

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