Understanding the Factors Influencing the Mental Health and Emotional Well-being of Women Residents at the Witches' Camps of Northern Ghana

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Abstract

Background: Witchcraft accusations have occurred in Ghanaian society and elsewhere in Sahara, Africa, for many decades. Witchcraft accusations commonly reveal a cultural predisposition to apportion blame for mishaps in the community, such as a disability or misconceptions surrounding ageing and dementia. Such labelling severely curtails the lives of the women, who are banished to live in the “witches” camps with resultant social isolation and accompanying stressors impacting their well-being. Yet, little is known specifically about these women’s mental health and emotional well-being. This research aimed to understand the factors influencing older women’s mental and emotional well-being in the witches’ camps in northern Ghana.

Methodology: A two-phase exploratory sequential mixed methods design was employed, using the socio-ecological model, Kleinman's explanatory model, and the social determinants of health as framing lenses. In phase one, an interpretive descriptive approach was used, drawing on purposive sampling to recruit and interview 15 women from one of the "witches' camps" in northern Ghana, along with three allied stakeholders. Additionally, observational photos of the camp's facilities were taken to provide further triangulated data to supplement the interviews. The precise ages of the women were unavailable due to their unknown birth dates. The participants stayed in the camp for a period ranging from 8 to 30 years.

Phase two aimed to investigate anxiety and depression symptoms among a cohort of women from the camps and validate the Dagbani Hospital Anxiety and Depression Scale (HADS). A cross-sectional descriptive method was applied, utilizing the cross-culturally translated HADS. A total of 168 women were recruited through random sampling from the witches' camps, and 100 women from the general population completed the Dagbani version of the HADS.

Findings: Thematic analysis of phase one data identified nine broad themes: ‘the presence of physical health problems impacting general health and well-being’, ‘anxiety, nervousness, and suicidal ideation’, ‘forgetfulness’, and ‘loneliness, sadness from family disconnection’. Other themes included ‘stigma – self and others’, ‘lack of resources for basic needs and social facilities’, ‘health access barriers affecting general

and mental healthcare', 'enabling factors for improving social connections', and 'recommendations for improving mental health and general well-being'. These themes, in turn, were contextualised by the subthemes of 'poor housing conditions', 'lack of healthcare facilities', 'lack of potable water' and 'psychological support' and 'problems with sleep or difficulty sleeping at night', 'frailty and loss of independence', 'feeling restless' or 'can't sit still', 'worried and scared', 'expressing thoughts of suicide and anger', 'difficulty concentrating', 'confusion', 'being sad and alone', 'worries associated with separation and lack of family support in the camp', 'loss of respect and dignity ("Dariza")', 'feelings of helplessness, unhappiness and despair', 'feelings of shame, hopelessness, and isolation'. Data from phase two revealed that anxiety and depression were more prevalent in women in the camps than in the general population of women. A breakdown of the mean scores by group demonstrated higher scores for both anxiety (mean 14.73, SD 1.46) and depression (mean 17.85, SD 1.55) for women in the camp when compared with women from the general population (mean 4.18, SD 2.43, and mean 6.18, SD 3.00, respectively).

Conclusion: The triangulation of the two phases provides a contextualized response to the research aim. Common mental health concerns were identified, including anxiety and depressive symptoms among women in the camps and women from the general population. Recommendations are provided for addressing mental health and general well-being, focusing on culturally targeted health and social care provision. These include providing critical and basic social and health care resources and amenities, such as good housing, food, safe drinking water, healthcare facilities, and insurance coverage. In addition, resilience training through counselling and linking the women with psychological support is highlighted. Importantly, this study constituted the first time the Dagbani HADS has been translated and validated. Further recommendations are made for the long-term reintegration of these women safely back into their communities.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Yakubu H. Yakubu 26/10/2022

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Signature Date

Acknowledgements

To begin this thesis, I am grateful to Allah for the gift of life and the opportunity to undertake this PhD. I thank Him for blessing me much more than I deserve.

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Ethics Approval

The study was approved in stages by the Auckland University of Technology Ethics Committee (AUTEC) in New Zealand, with reference number 19/213. The initial approval was granted to stakeholders dated on 29th July 2019 (see Appendix A). AUTEC granted full approval on 17th September 2019 (see Appendix C). The Ghana Health Service Ethics Committee approval number GHS-ERC002/09/19 was granted on 8th November 2019 (see Appendix B).

Chapter 1 Introduction

1.1 Introduction

This research explored older women's mental health and emotional well-being in the witches' camps of northern Ghana. Every society has socio-cultural practices and beliefs that protect, prohibit, and optimise daily challenges. Witchcraft is one of these beliefs still practised in some Sub-Saharan African (SSA) countries and some parts of Asia and the Pacific, such as Papua New Guinea, India, and Fiji (Adinkrah, 2015). Witchcraft, broadly, is a term that carries diverse cultural and societal meanings and expectations, and enactments and thus can be challenging to define. In general terms, "witchcraft" refers to any influence of a person with an assumed or proclaimed magical power on another person's mind, body, or property against their will.

Witchcraft beliefs and practices are prevalent and differ greatly across the globe. However, witchcraft is often associated with entrenched gender imbalances that limit the socio-economic power of women accused of being witches (Chaudhuri, 2012). Gender stereotypes and beliefs result in both susceptibility and exclusion, with women disproportionately affected by prejudicial attitudes (such as being accused of witchcraft). Due to their restricted economic independence and lower social standing within the community, women are particularly susceptible to unexpected challenges and witchcraft accusations (Adinkrah, 2022; Azongo et al., 2020; UNICEF, 2022). Witchcraft accusations tend to stem from cultural predispositions to assign blame for misfortunes beyond common understanding, such as sudden illness, disability, or other issues related to ageing misconceptions. Over time, the primary function of belief in witchcraft has been to offer a final interpretation for unfortunate occurrences in individuals' lives and thereby aid with coping (Gershman, 2022). These witchcraft accusations are particularly problematic in low-resource communities where older women may already face complex physiological and social health-related challenges and where there is a limited safety net and community support for older people (Forsyth, 2016; Gray, 2001; Kusters, 2015; Spittel, 2014; Truxler, 2006). As a result, women accused of witchcraft may be lynched or forced to flee from their homes and reside in camps, which can harm their well-being, depriving them of their family and emotional support systems (Baba, 2013).

Accusing women of witchcraft is a longstanding practice in some African societies, dating back to much earlier times (Adinkrah, 2011), as evidenced in the 1930s (Gray, 2001). In Sub-Saharan Africa (SSA), witchcraft is often associated with poverty and the breakdown of social support (Koning, 2013). It significantly impacts the social construction of cultural beliefs surrounding community and village health protection and risk avoidance. Furthermore, it affects the health-seeking behaviours of women accused of witchcraft (Koning, 2013). However, apportioning blame and banishing older women to witches' camps, where they are deprived of the essential care and support provided by their extended family networks in the context of low resources, is an unfortunate consequence of these deeply entrenched beliefs.

Witchcraft beliefs are a deeply ingrained cultural phenomenon in Ghana (Whitaker, 2012), leading to violent attacks on women accused of witchcraft (Awuni, 2017). These attacks impact the physical safety of the accused and their mental health and emotional well-being ("Kafaba Lynching: I Was Possessed", 2020; Adinkrah, 2011). Studies have shown that accusations of witchcraft can lead to emotional disturbances and stigmatization, exacerbating mental health issues among marginalized individuals who already face challenging life trajectories. Moreover, Ghana's lack of mental health services and support makes it difficult for women in these situations to receive adequate care. Overall, the entrenched beliefs surrounding witchcraft in Ghana significantly impact the mental health and well-being of those accused of witchcraft, highlighting the need for greater attention to be given to mental health services in Ghana (Read & Doku, 2012).

Although witchcraft beliefs are widespread across Africa and other parts of the world, only Ghana has established "witch camps." Two of these camps have been closed in recent years through collaborative efforts between ActionAid Ghana, the Ministry of Gender, Children and Social Protection, and the Commission on Human Rights and Administrative Justice (CHRAJ). However, there are still five remaining camps, all located in northern Ghana, where populations are relatively stable due to regular movement in and out of the camps. Some of these camps have even become multi-generational "witch villages," such as Gnani, where the current population in October 2019 was reported as 362 women and 14 men by the "Tindanas" (Owner of the land) or the Earth Priest (refer to individuals who serve as the guardians or caretakers of the

earth.) and his junior brother (younger brother). Unfortunately, many more women who have been accused of witchcraft cannot return home due to a variety of reasons. According to 2015 figures, approximately 1,000 women and 700 children lived in the northern Ghana camps (Awuni, 2017), with anecdotal evidence suggesting that mental health problems among residents are common and support is lacking.

In 2020, Ghana reportedly had many individuals suffering from mental health disorders. Specifically, it was reported that there were approximately 650,000 individuals suffering from severe mental illnesses and an additional 2,166,000 individuals suffering from moderate to mild mental health disorders (Harvard Global Health Institute, 2020). It is important to note that these numbers may be higher due to data collection limitations. Moreover, older adults are particularly vulnerable and require crucial health and social support to enhance their psychological well-being and overall quality of life. Unfortunately, in the African context, limited formal interventions are available for older adults with disabilities and chronic diseases.

Furthermore, Ghana's poverty further exacerbates the situation by limiting access to necessities such as food and healthcare resources, a common challenge for low-resource countries (World Health Organization, 2021b). This lack of resources often worsens Ghana's mental health crisis, which, unfortunately, already receives limited policy attention. In 2016, Ghana's poverty rate had decreased to 13.3% at an income of $1.90 per day, lower than the mean poverty rate of Sub-Saharan Africa and middle-income countries (United Nations Development Programme [UNDP], 2020). However, in 2020, the UNDP reported that poverty and vulnerability are more concentrated in the three Northern regions (Northern, Upper East, and Upper West) and the Volta region, leading to widening social and economic disparities that further impact health negatively.

1.1.1 Main aim of this study

To understand the mental health and emotional well-being of older women in witches' camps of Ghana with a view to contributing to policy and practice for enhancing the health and well-being of these women.

1.1.2 Study objectives

1. To understand older women's common health and emotional health challenges when living in witches' camps in northern Ghana.
2. To describe the socio-cultural and emotional needs and practices that influence their health-seeking behaviours.
3. To examine experiences of accessing health services in the camps.
4. To recommend health service and policy directives that meet mental and emotional needs concerning culturally appropriate health and social care provision for women in the camps.

1.1.3 Design of this study

The study employed a pragmatist approach with a multi-phase mixed-method design. Specifically, a two-phase exploratory sequential mixed-method design was employed, which involved collecting qualitative and quantitative data sets over two study phases. This approach was chosen as it focuses on marginalized groups whose values and perspectives are integral to creating a fairer society. By utilizing this approach, the study aimed to achieve its overall objectives and shed light on this underserved population's mental and emotional health needs (Mertens, 2007).

The study was grounded in three guiding frameworks: Bronfenbrenner (1979)'s socio-ecological model (SEM), Kleinman's explanatory model (Kleinman et al., 1978) and the social determinants of health (World Health Organization, 2008).

The SEM was chosen to provide a lens for exploring the complex connections and landscape in which mental and emotional health can be examined for the highly marginalized population of older women in witches' camps in Ghana. This model allowed for exploring behavioural choices, social agency, and political and economic landscapes that impact their health and well-being. It is worth noting that the SEM is widely used in public and nursing research, and its application to the cultural banishments of women accused of witchcraft might provide relevant insights into determining health and social care needs.

On the other hand, the explanatory model (Kleinman et al., 1978) enabled a perspective on the culturally determined beliefs that individuals and communities hold

about misfortune, suffering, illness, and health. Adopting this framework helped the researchers understand the complex process of making sense of one's conditions, ascribing meanings to symptoms, evolving causal attributions, and expressing suitable expectations of treatment and related outcomes. The researchers believed that an African perspective through an explanatory model provided flexibility in explaining the topic's more personalized and socialized aspects.

The social determinants of health and the Sustainable Development Goals (SDGs) 1, 2, 3, 5, and 10 informed the SEM and explanatory models. These SDGs aim to eradicate extreme poverty, achieve zero hunger, provide good health and well-being at all ages, reduce societal inequalities, and ensure gender equality. The use of these frameworks underscores the relevance and importance of this study in contributing to policy and practice for enhancing the health and well-being of older women in witches' camps in Ghana (United Nations Children's Fund [UNICEF], 2017).

1.1.4 Overview of Ghana

Ghana is a West African country on the Gulf of Guinea, bordered by Togo to the east, Burkina Faso to the north, La Côte d'Ivoire to the west, and the Atlantic Ocean to the south. It covers 238,533 square kilometres and contains Lake Volta, the world's largest artificial lake (National Commission on Culture, n.d.).

The capital is Accra, the country's largest city (Addei et al., 2012). Ghana is divided into 16 administrative regions (Northern, Northeast, Oti, Savannah, Central, Greater Accra, Asante, Ahafo, Bono East, Eastern, Western, Western North, Volta, Upper East, and Upper West regions), which are further divided into 254 District Assemblies responsible for mobilizing resources for planning and developing the districts. As the first sub-Saharan African nation to gain independence from British colonial rule in 1957, Ghana is among the most stable democracies in the region, with a history of peaceful transitions of power. Ghana is a major exporter of cocoa and gold(Elbra, 2017) and has recently begun producing oil. Although the arrival of oil and gas in 2010 offered new economic opportunities(Edwina, 2018; Skaten, 2018), it also presented significant risks. Despite the challenges, Ghana has many accomplishments and continues to face new challenges in the future(World Health Organization, 2011).

1.1.5 Socio-demographics

The preliminary report by the Ghana Statistical Service (2021), the total population of Ghana is estimated to be 30.8 million, with 50.7% of the population being females (Ghana Statistical Service, 2021). The population of individuals aged 65 and above has increased from 1,167,532 in the 2010 census to 1,322,545, as estimated in the recent census conducted in late 2021. However, the gender figures for this age group are not yet presented, and only provisional figures have been reported(Ghana Statistical Service, 2021). In 2012, the population of individuals aged 65 and above was 1,167,532, with females accounting for 57.35% (669,579) and males accounting for 42.65% (497,953)(Ghana Statistical Service, 2012a). The average life expectancy at birth in Ghana is approximately 60 years, with females having a higher life expectancy of 64 years compared to males at 57 years (World Health Organization, 2011).

Ghana is a diverse country with varying cultural, linguistic, and religious practices. The largest ethnic group is the Akan-speaking group, which includes Ashantis, Kwahus, and Akwapims, making up 47.5% of the population. Other ethnic groups, such as the Mole-Dagbani (16.6%), Ewe (13.9%), and Ga-Dangme (7.4%), also exist. Ghana is home to many ethnic groups, and as such, as many as various groups speak 50 to 100 languages and dialects. Despite this linguistic diversity, English remains the official language (Ghana Statistical Service, 2012a).

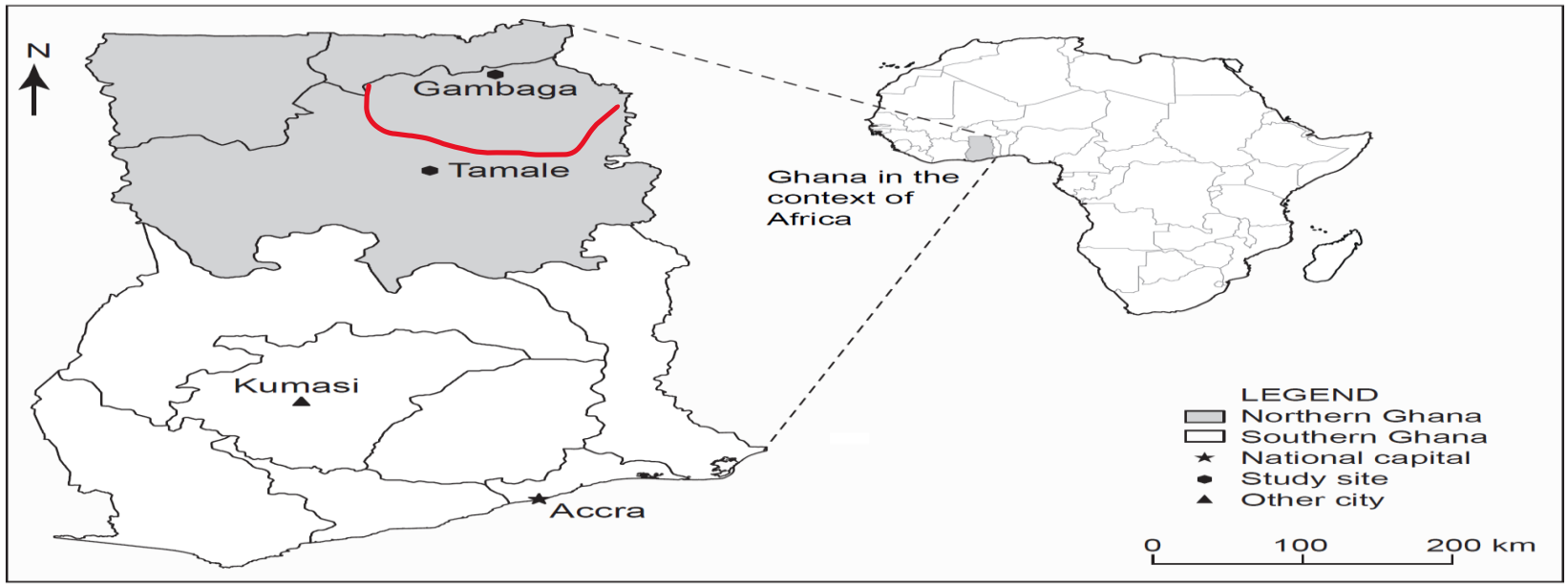
Over the years, Ghana has experienced rapid urbanisation, with the proportion of people living in urban areas increasing from 43.8% in 2000 to 50.9% in 2010 (Ghana Statistical Service, 2012a). Agriculture, forestry, and fishing employ about 41.5% of the working population, making it the predominant sector for economically active people aged 15 years and above. The industry employs 15% of the population, while the remaining 25% work in services, primarily trading, transportation, and communication (Ghana Statistical Service, 2012a). Ghana has made significant progress in education, with an adult literacy rate that increased from 57.9% in 2000 to 79.04% in 2018(Knoema, 2018a). This improvement represents an average annual growth rate of 17.02%.

Ghana's religious diversity is an important aspect of its culture (US Department of State, 2022). Most of the population is Christian, around 71%, while approximately

18% is Muslim. A significant proportion of the population adheres to traditional religions, which include animism and ancestor veneration. Even among those who follow Christianity, Islam, or other faiths, traditional beliefs regarding ancestors and other supernatural forces are often respected (Chris, 2013; Ross, 2013; US Department of State, 2022).

Figure 1.1

Map of Ghana



Note. Map of Ghana showing Tamale and Gambaga, 2018. Courtesy of Issahaka Fuseini from the work of Mutaru (2018), Conducting anthropological fieldwork in northern Ghana: Emerging ethical dilemmas*, Anthropology Southern Africa, 41*(3), 185–198.

The map shown in Figure 1.1 depicts the geographical location of Ghana, including its major cities such as Accra, Kumasi, and Tamale, which are among the most populated cities in the country. It is worth noting that the study was conducted in Tamale, which serves as the capital of the Northern region of Ghana.

1.1.6 Overview of health systems in Ghana

The Ministry of Health and the Ghana Health Service play crucial roles in providing leadership and direction to Ghana's healthcare system. They are responsible for coordinating the implementation of sector policies and ensuring that sector objectives are achieved through partnerships with health sector partners at all levels. Figure 1.2 below illustrates the organisational structure of Ghana's health services delivery. Despite these efforts, Ghana's healthcare system faces significant challenges in improving and maintaining the health and well-being of its citizens. The system must address poverty-related illnesses and health illiteracy caused by a lack of education while dealing with increasing population pressure, socially determined problems, inadequate funding and resources, and the burden of infectious disease epidemics such as HIV/AIDS (Adua et al., 2017; Ghana Statistical Service 2003)

Figure 1.2

The organisational structure of Ghana health services delivery

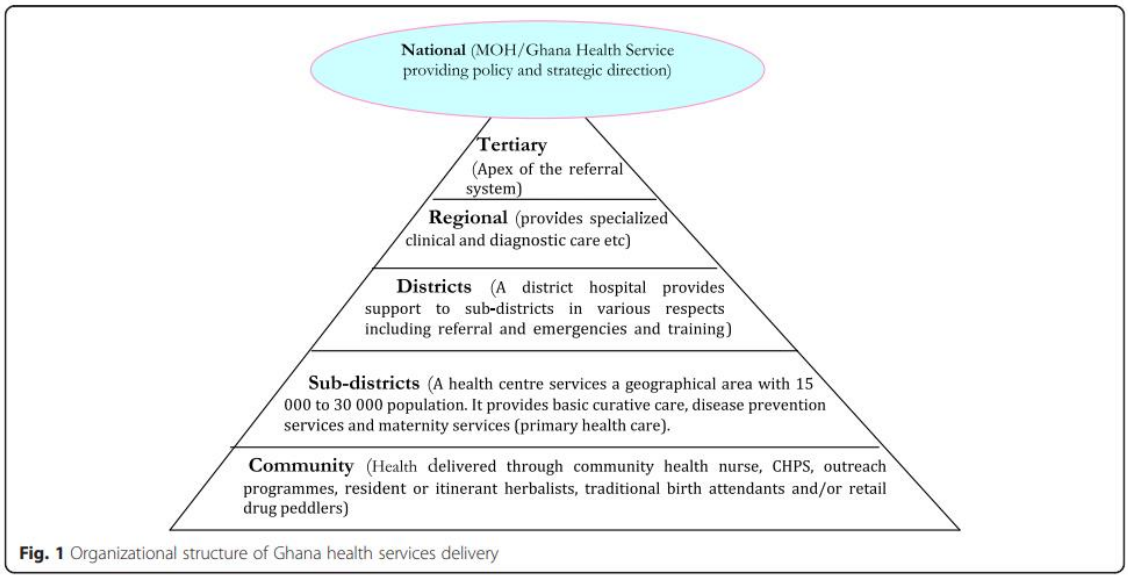


Fig. 1 Organizational structure of Ghana health services delivery

Note: Adapted from Awoonor-Williams et al. (2016, p. 4).

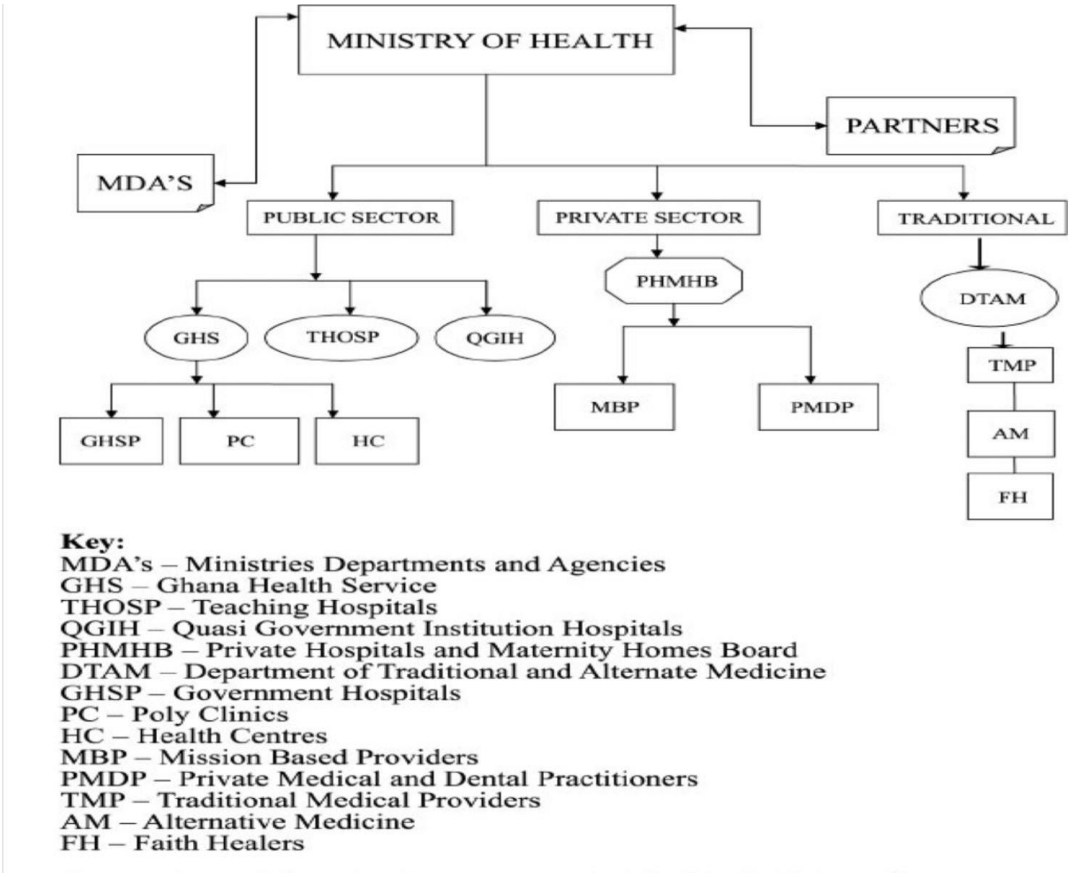
Ghana, like other low-resource countries such as Nigeria, Senegal, The Gambia, Togo, and Benin, faces a shortage of medical facilities, equipment, and health workforce. As of 2014, the total number of doctors was estimated to be 3,016 (Knoema, 2018b), and the total number of nurses was 38,228 (Salifu, 2017). Despite being a middle-income country, Ghana's funding for mental healthcare is very low, with only 1.4% of health expenditure allocated to mental health, and the majority of that being concentrated in urban areas. The country has only three psychiatric hospitals to serve the entire population (Roberts et al., 2014).

In Ghana, the scarcity of medical resources and personnel, coupled with high medical costs, has resulted in a continued reliance on traditional herbal medicine, traditional religious beliefs, alignment towards the occult and divination, and a myriad of ritual specialists. Various practitioners, such as faith healers, occult practitioners, fetish priests, witchdoctors, fortune tellers, and diviners, claim to treat physical and mental maladies and evil spirits, or serve as worldly mediators between ancestral spirits and their human clientele (Adinkrah, 2011).

The proliferation of spiritual churches has further added to this trend. These churches, such as the International God’s Way Church Accra, the Anointed Palace Chapel, and the Ebenezer Miracle Worship Center, often attribute mishaps and diseases to the cause of demonic and other spiritual doings, seeking culturally based understandings of the causes of mental illness (Roxburgh, 2014, 2016, 2017).

Figure 1.3

Structure of the health sector in Ghana



Note. Structure of the health sector in Ghana adapted from Abor et al. (2008).

Figure *1.3* above provides an overview of the healthcare system in Ghana, with the Ministry of Health and Ghana Health Service responsible for developing health policies to ensure accessible and affordable healthcare for the Ghanaian population. Ghana has five levels of healthcare administration, ranging from national to community-based services, with tertiary teaching hospitals, secondary hospitals at the regional and district levels, and primary healthcare facilities at the sub-district and community health planning services (CHPS) centres. Health professionals, including nurses, doctors, and pharmacists, are trained at college and university levels with varying levels of specialization. However, anecdotal evidence suggests that the curricula for many professional training courses have been based primarily on the World Health Organization's recommendations, often lacking cultural, social, and sociological

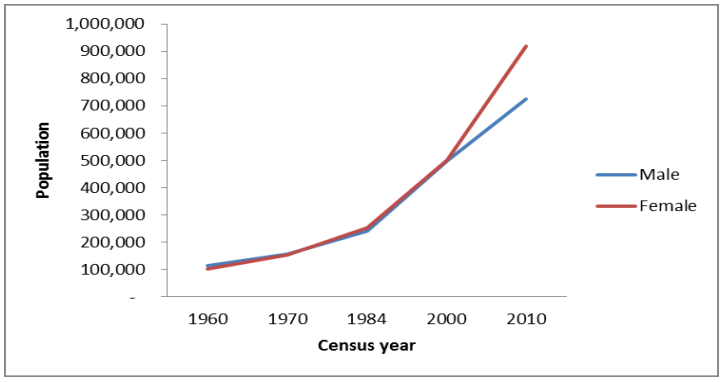
content that can affect health determinants. In particular, mental health syllabi for nursing trainees have been based on WHO and UNICEF recommendations.

1.1.7 Ageing in Ghana

The population of older adults in Ghana has been increasing, and more than half of them live in rural areas with little formal education. The global population of older adults is expected to double by 2050, and this requires widespread and universal health and social care support. Despite the adoption of the National Ageing Policy (Association of Ghana's Elders, 2016), older adults in Ghana still face several challenges, such as disabilities, chronic non-communicable diseases, and limited policies that address their needs, including access to social security and pensions. Moreover, family and traditional support systems for older adults have decreased due to rural migration, which is contrary to the acknowledged nature of African collective societies (Ghana Statistical Service, 2014). As a result, subpopulations of older adults are exposed to cultural practices that endanger their lives, marriages, partnerships, and social relationships (Kpessa-Whyte, 2018). The changing realities in Africa, such as increased individualism, have contributed to this situation, as marriage, religion, ethnicity, and nationality are no longer guaranteed sources of well-established social support for the aged (Badasu et al., 2016). The Ghana Statistical Service (2012b) defined an older adult as someone above 60 years old; young old as 60-74; old-old, 75-

Figure 1.4

The growth of the elderly population (1960- 2010)



Note. The growth of the elderly population (1960- 2010) adapted from Ghana Statistical Service (2013).

1.1.8 Mental health services in Ghana

In Ghana, mental health services are primarily provided at the secondary levels of healthcare. The country has three psychiatric hospitals that offer acute mental health services. These hospitals are located in the coastal south, and there are smaller psychiatric units in five regional hospitals. Additionally, mental health services are provided by the three teaching hospitals, one in the southern city of Accra, one in the central city of Kumasi, and one in the northern city of Tamale. While these teaching hospitals provide mental health services on a small scale, each has at least one psychiatrist and inpatient and outpatient departments.

Despite the limited availability of mental health services, the demand for them is high. To address this need, community psychiatric nurses provide mental health services to individuals who live in rural or underserved areas. These nurses often collaborate with other healthcare professionals, such as traditional healers, to provide comprehensive care to those who may not have access to formal mental health services (Smalls-Mantey, 2019).

Overall, the provision of mental health services in Ghana is limited, especially in rural areas. There is a need for increased resources and training to expand mental health services and improve access to care.

Mental health is a growing concern worldwide, with 12% of the global disease burden attributed to mental health concerns in 2000 and an expected increase to 15% by 2020 (World Health Organization, 2017c). Developing countries, including Ghana, are also expected to see an increase in mental health problems. However, data on the epidemiology of mental disorders in Ghana is inadequate, making it difficult to accurately compute the burden of these disorders (Harvard Global Health Insitute, 2020; Roberts et al., 2014; World Health Organization, 2007). The World Health Organization estimated that 13% of Ghana's population suffers from mental disorders, with 3% having severe mental illnesses and another 10% having mild to moderate mental disorders.

In the past, Ghana's mental health laws did not adequately address the integration of mental health into primary care, the protection of patients' human rights, or the curtailing of psychiatric hospitals (Forster, 1971). However, in 2003, the Mental Health Department of the World Health Organization provided financial and technical support to Ghana's Ministry of Health, resulting in the successful passage of a Mental Health Act in March 2012 (Doku et al., 2012). This is seen as a significant milestone in addressing mental health as a public health issue and in protecting the human rights of people with mental disorders in Ghana (Doku et al., 2012).

In Ghana, the Mental Health Authority (MHA) is responsible for proposing, promoting, and implementing mental health policies, while the Ghana Health Service is responsible for their implementation. These policies are aimed at providing culturally appropriate, humane, and integrated mental healthcare throughout the country. Although Ghana has three public psychiatric hospitals, these are all located in the southern region, which can limit access to care for individuals living in other parts of the country. To address this issue, the 2012 Mental Health Act encouraged the establishment of community-based psychiatry units within community health centers, which are managed by community psychiatric nurses. These nurses provide direct care and referrals to patients living away from psychiatric hospitals and follow-up care to patients who have been discharged. However, the majority of Ghanaians (70-80%) still seek traditional or spiritual healing when facing a mental health problem(Barke et al., 2011). In 2013, there were only eight psychiatrists and 591 psychiatric nurses serving Ghana's population of 28 million (Jack et al., 2013).

1.1.9 Witches' camps in Ghana, camp life, and the setup of the camps

Witch camps in Ghana are safe havens for people accused of witchcraft who risk being lynched by their families and communities. The primary goal of these camps was to prevent witchcraft from being practised within their walls and to protect the accused witches from harm. There are five witch camps in the Northern region of Ghana, including Kukuo, Gnani, Kpatinga, Gambaga, and Nabuli (Baba, 2013). The oldest and most well-known of these is the Gambaga witch camp, which has existed since pre-colonial times and is considered the ancestral home of all people from the Northern region (THUDEG & Anti-Witchcraft Allegation Campaign Coalition, 2011). The camp was established to provide a safe haven for accused witches, and it continues to serve

that purpose. Religious leaders, such as the Imam, have played a vital role in protecting accused witches' lives and ensuring they receive fair treatment. According to Mohammed (2020), in the early 1900s, Alhaji Mesuhna Yahaya, an Islamic cleric, revealed that women accused of witchcraft were routinely executed. This practice was prevalent in the early 1900s, and it was only after a successful intervention to save the life of Adisa of Simba, a woman accused of witchcraft, that the mosque in Gambaga became a place of refuge for her (Bekoe, 2016).

Accused women seeking refuge at the Gambaga witch camp are provided shelter in mud rooms built by their families within the camp (Baba, 2013). However, families are often unwilling to build mud huts, so the Earth Priest and his elders are responsible for building them (Bekoe, 2016). The Gamba-Rana, chief of Gambaga, is believed to possess special powers that can neutralize any evil present within the camp. Women in the witches' camps are forced to rely on subsistence farming and other manual labour to survive. Some residents help community members with farming tasks, highlighting the interdependence among community members. Other activities carried out by residents include burning and selling charcoal, firewood and local soap, brewing local beer, engaging in subsistence farming, spinning cotton, and extracting shea butter. However, they often lack access to food, water, and medical care.

Efforts to address the issue of witch camps by the government of Ghana have been ongoing for several years. Some NGOs and human rights organizations have advocated for the closure of the camps, arguing that they are a form of culturally institutionalized discrimination against women (Action Aid, 2012). Others have called for more comprehensive social support programs to help accused witches reintegrate into their communities and reduce the prevalence of witchcraft accusations. Despite the challenges, many of the women in the witch camps formed strong bonds with one another, creating a sense of community and solidarity in the face of adversity. In addition to the positive relationship between the traditional authority and community members, I observed that the relationship among resident informants was also strong. This was evident in how they relied on each other in need. The lucky ones also had their grandchildren staying with them to provide support for their day-to-day activities. This meant that the witchcraft accusation did not come from the immediate family of these people. Unfortunately for many of them, they do not have the family support.

Typically, it is the responsibility of family members of the residents to periodically replace the roofs of their family members' rooms in the camp. The traditional authority faced pressure from the attitudes of family members who often failed to show up when it was time to replace the roofs of their family members' rooms. This put additional strain on the traditional authority.

1.1.10 An overview of the formal and informal Social Protection Program in Ghana

There has been the promotion of 'global social policy' to improve lives through the Social Protection Floors initiative led by the International Labour Organisation (ILO) (Deacon, 2013). The 'global social policy' developed through this initiative is not truly global in terms of both its making and its diffusion. African governments had minimal involvement in the making of this global social policy. African governments generally accept this global policy-making, expecting it to have little impact on them. In most of Sub-Sahara Africa, there is little evidence of any significant effect resulting from this global social policy (Union African, 2008, 2011). The social protection strategy documents adopted by the African Union and national governments, usually drafted by external consultants, do not directly incorporate the concept of the social protection floor (Union, 2008). Instead, these documents emphasize the commitment to pre-existing 'comprehensive' and appropriate social protection measures (Seekings, 2019). However, we need a social protection policy that is consistent with cultural context to improve lives in Ghana and other Sub-Sahara Africa where some cultural practices can have an influenced of individuals being disadvantaged and need social protection to ensure their safety and general well-being. There is a disconnect between the global social policy discourse and its implementation at the African level.

The informal nature of Ghana's economy and the low levels of wages and salaries contribute to poverty among older persons, potentially infringing upon their economic rights. Reports suggest that older individuals are often rejected by younger generations, leading to increasing rates of neglect, physical abuse, and poverty among the elderly population in Ghana. To address this issue, the government has implemented several social protection programs for older persons in the country.

One such program is the National Health Insurance Scheme (NHIS), which exempts older people from paying premiums. However, evidence on whether older people are aware of and enrolling in these schemes is lacking. Individuals who are 70 years and older are automatically covered by the NHIS in Ghana, while those between 65 and 70 must pay premiums to join the scheme. This policy aims to improve the accessibility of healthcare for older persons in the country.

The Livelihood Empowerment Against Poverty (LEAP) program provides cash transfers to households facing extreme poverty on a bi-monthly basis, and one of the criteria for eligibility and targeting of this program is old age. Individuals who are 65 years and older and without productive capacity are eligible to benefit from the program. The aim of the transfers is to protect beneficiaries from shocks to their livelihoods and improve their access to basic social services such as healthcare and education.

In addition, a three-tier pension system is currently in place in Ghana to encompass the informal economy, which comprises approximately 84 percent of the workforce and is where the majority of older persons operate. The system includes a voluntary contribution aspect that aims to address the needs of older individuals who may work in the informal sector, accounting for around 13 percent of the workforce.

The Legal Aid program offers support to financially disadvantaged older individuals who cannot afford the cost of legal services. This program enables eligible individuals to receive free legal assistance throughout the dispute process, providing additional protection for older persons.

Apart from government initiatives, faith-based organizations (FBOs) and communities have historically played a significant role in providing social protection in Ghana. Many FBOs continue to provide relief and social assistance, as well as promoting financial and productive inclusion. FBOs are uniquely positioned to leverage the influence of religious leaders and their capacity for social mobilization in addressing the needs of vulnerable populations.

Finally, the private sector, non-governmental organizations, organized labour, and civil society organizations all have a role to play in providing social protection for older persons in Ghana. Through collaborations with government initiatives and community-

based organizations, these entities can contribute to improving the economic rights of older persons and reducing poverty among the elderly population in the country.

1.1.11 Developing the research focus

As an African and Ghanaian, I have grown up with a deep understanding of our culture, its strengths and limitations. Ghana is widely recognized for its beautiful culture, as a cocoa-producing nation, and as a beacon of democracy where power is peacefully transferred between political parties. However, Ghana is also known for the presence of witches' camps, where accused women are banished by their communities to live for the rest of their lives. These aspects are interconnected and have significantly influenced the lives of these women and their families, particularly in northern Ghana.

My interest in researching the health and emotional needs of older women in witches' camps stemmed from my voluntary work with alleged witches, facilitated by an ActionAid consultant in partnership with the local organisation I founded. While the focus was initially broad, a discussion with friends and my PhD supervisor helped refine the research topic. It was clear that the needs of older women in these camps were largely ignored, with no known agencies addressing their mental and emotional well-being. Furthermore, older women are often seen as symbols of witchcraft, contributing to their marginalization.

Upon conducting an integrated literature review, it was evident that there was little research on the mental health and emotional well-being of the women in witches' camps in northern Ghana. This highlighted the potential of my research to contribute new knowledge that could improve the lives of these women. It was also recognized that these women are marginalized by the institutions and structures that should protect them and provide a safe haven for their health and well-being.

In summary, my interest in researching the health and emotional needs of older women in witches' camps in northern Ghana emerged from my voluntary work with alleged witches and discussions with my PhD supervisor. The research focus was refined through an integrated literature review, and it was evident that this topic held the potential to contribute new knowledge that could transform the lives of older women living in witches' camps in northern Ghana.

1.1.12 Significance of this study

The present study has significant implications for policymakers in Ghana and Africa who are committed to improving the well-being of marginalized groups, including women living in witches' camps and other vulnerable populations with similar social dispositions. As women's health has become a crucial component of global development goals, it is imperative that policymakers take into account the findings of this research to develop evidence-based policies and programs that can help address the complex issues related to discrimination against women that hinder progress towards achieving SDG 5. Although Ghana has made strides towards achieving gender equality and women's empowerment, there are still complex issues related to discrimination against women that hinder progress. The United Nations (2017) notes that eliminating discrimination against women and girls requires urgent action to address the root causes that curtail their rights and freedoms in communities. Various forms of violence and cultural practices that impede women's access to healthcare and emotional well-being hamper progress towards SDG 5 (United Nations, 2017).

Therefore, research data from developing countries like Ghana are critical in informing policymakers on how best to allocate limited resources to improve the lives of women and eliminate cultural practices, such as witch camps, that are barriers to achieving SDG 5. Although Ghana met one of the Millennium Development Goals (MDGs) by halving extreme poverty, significant disparities persist in poverty levels across social groups and regions, with women in rural areas being disproportionately affected (United Nations, 2017). Largely, elder abuse represents a substantial concern within contemporary society, encompassing critical dimensions of public health, social justice, and human rights (Haukioja, 2016).

To promote gender equality and improve the socio-economic conditions of women in Ghana, a multifaceted approach is needed that tackles the root causes of poverty, discrimination, and social exclusion. This requires policies and programs that protect women's rights, increase their access to healthcare, education, and economic opportunities, and eliminate harmful cultural practices that perpetuate gender discrimination and violence that threaten the efforts to achieve the global targets set by the SDGs (SDGs 1, 2, 3, 5, and 10) (United Nations, 2017). Adinkrah (2004) contended that religious beliefs and cultural practices permeate the entire social fabric

of Ghanaian society, including education, economic affairs, and politics. Furthermore, low financial status and poverty pose additional risks for violence and witchcraft accusations. Insufficient and inaccessible health facilities, and cultural practices and beliefs constitute significant and consequential impediments to achieving the SDGs (United Nations, 2017).

The current study's recommendations and policies could benefit similarly marginalized residents and those in refugee camps within the African continent and beyond. Empirical data from the study may also help effectively communicate camp conditions and improve health outcomes. Such research about the social and structural determinants of the mental and emotional health of the women at the camps will be both novel and timely and will inform intersectoral service development. Furthermore, this research project's recommendations and policies could benefit similarly marginalised residents and those in conflict driven refugee camps within the African continent and beyond.

Research to date in Ghana and Africa addressing the mental health and emotional needs of older women accused of witchcraft is scarce. Poor mental health profoundly impacts physical health; for example, older adults with physical health conditions such as heart disease have higher rates of depression(World Health Organization, 2017a).

In the context of a growing Ghanaian older population, Spittel (2014) contended that ageing policies that enhance a social safety net and support older adults socially and emotionally may better support older women, especially those with various forms of cognitive decline. The current study emphasises the development of empirical data that informs social and health service delivery and policy that could destigmatise old age, mental decline, and women in poverty, to improve societal mental health outcomes. Adinkrah (2004) contended that the impact of witchcraft accusations on the emotional health of accused witches is immeasurable due to the defamation and loss of reputation. Those engaged in economic ventures lose their customers, which is a significant cause of further poverty, social isolation, emotional trauma, depression, and mental distress. No studies have been located to date exploring older women's mental health and emotional well-being in Ghana or Africa. This study empirically identifies some of the cultural practices that impede the attainment of some of the global goals.

In conclusion, this study aims to make a modest contribution towards empirical evidence and raise awareness regarding the impact of witchcraft accusations on women's mental health and emotional well-being in Ghana. It will also benefit other nations experiencing a similar challenge since social and cultural practices profoundly influence marginalized women's health. Largely, the body of scientific literature on aging in Africa, similar to many developing countries, is limited in extent and scope (Niyonsaba, 2020). Policymakers in Ghana and Africa need to consider the findings of this research to develop evidence-based policies and programs that can help address the complex issues related to discrimination against women that hinder progress towards achieving SDG 5.

1.1.13 Structure of the thesis

This thesis contains nine chapters. Overall, the chapters cover different aspects of the study, including the background and context, literature review, theoretical framework, research methodology, research methods, qualitative and quantitative findings, linguistic validation, and discussion of the results.

Chapter 1: provides a clear and concise introduction to the study, including the research aim, objectives, significance, design, and purpose of the research. It also outlines the structure of the thesis, which helps the reader understand what to expect from the subsequent chapters.

Chapter 2: presents a well-rounded literature review that synthesizes the existing empirical and grey literature on the witchcraft phenomenon in Ghana and globally. It highlights the relevant gaps in knowledge about the mental health and emotional well-being of older women in the witches' camps of northern Ghana.

Chapter 3: presents and critiques the relevant theoretical frameworks that guide the study, which include the SEM, HBM, Kleinman's explanatory model, and the SDGs. The chapter also provides justifications on how these frameworks underpin the study approach and analysis and contribute to the discussion.

Chapter 4: outlines the ontology and epistemology that guide the generation of research knowledge. It also provides an outline of the mixed-method methodology

approach and justifies why pragmatism and mixed methods have been chosen to guide the current study.

Chapter 5: presents the research methods adopted to answer the research aim and objectives. It provides an overview of how the mixed-method research design was applied in this study to answer the research questions. The chapter also outlines the ethical considerations, approval processes, data collection, analysis, and management methods of Phase One and Phase Two of the study.

Chapter 6: presents the qualitative findings of Phase One of the study, including the interviews with the witch camp women and the interviews with the allied stakeholders, and the photo content analysis.

Chapter 7: describes the linguistic translation and cross-cultural adaptation of the HADS in Ghana and provides the justification for using the HADS for this study.

Chapter 8: presents the validation of the Dagbani version of the HADS and the psycho-social experiences of the women in the camp and the general population obtained from using the translated HADS.

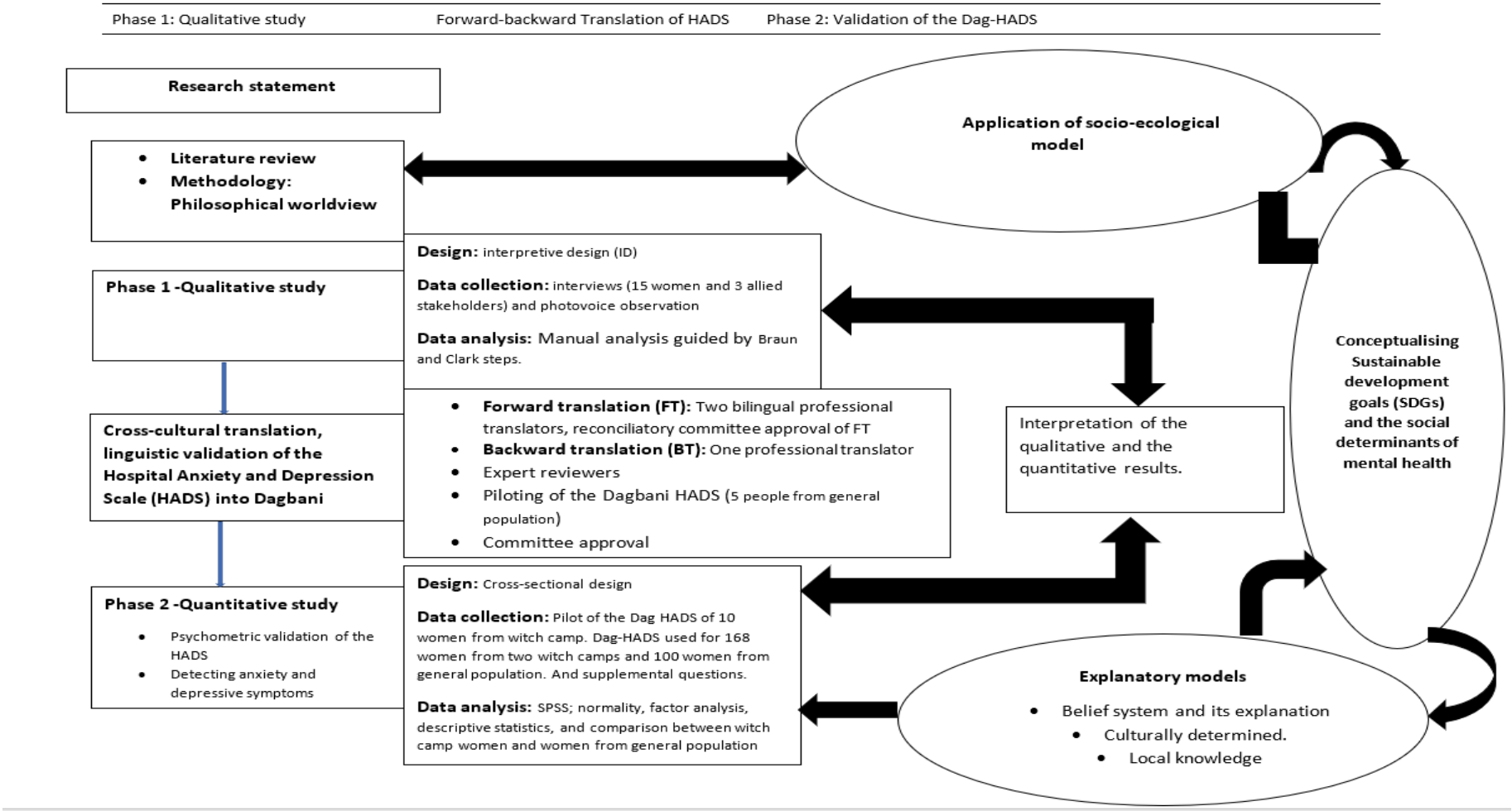
Chapter 9: presents a discussion based on the findings in Chapters 6, 7, and 8. The chapter discusses the results in the context of existing literature.

Chapter 10: presents the conclusion and recommendations based on the findings. It also provides an overview of the thesis, critically considers the strengths and limitations of the research, and provides recommendations for further study.

Overall, the structure of the thesis covers all relevant aspects of the study. The structure allows for a logical flow of information and makes it easy to follow the research process and to understand the results. The figure below is a step-by-step outline of the research phases and pilot testing (and the study sites) that would be applied in the thesis. To aid clarity, I have created a graphical representation of the work carried out in the field.

Figure 5

Illustration of graphical overview of the study's design in summary



Chapter 2 Literature review

2.1 Introduction

The first chapter presents the background and overview of the study on the impact of witchcraft accusations on the mental health and emotional well-being of older women in Ghana's witch camps. Labelling these women as witches limits the traditional familial support system for health and social care, which warrants further investigation. An integrative review was conducted on the witchcraft phenomenon and older women's mental health, revealing a significant gap in understanding the factors that influence their well-being. Subsequent literature reviews on mental health among women, older adults, and marginalized societies provided context for examining mental health in underserved communities and identified limitations in existing research. The impact of COVID-19 on the witches' camps and accusations during data collection is also discussed. The literature reviews helped identify the gap in knowledge and limitations of existing research, which informed the research questions and theoretical models that underpin this study. The literature reviewed also gave direction to the context of the subsequent chapter on the theoretical models that underpin this study. The following section outlines the approach to the integrative review conducted on the witchcraft phenomenon and older women's mental health and emotional well-being.

2.2 Approach to integrative review

This literature review provides a comprehensive overview of the empirical, policy-related, and grey literature on the topic of witchcraft and its impact on older women's mental health in developing countries. The review was guided by specific keywords and conducted through online searches of various medical, social science, cultural studies, and health service databases, including CINAHL Full Text, Medline through EBSCO Host, Sage, AnthroSource, Scopus, PubMed, Web of Science, Scopus, Google Scholar, Cochrane, Elsevier, and Science Direct. The author also conducted a purposive search of key local and international journals such as *Health Care for Women International, The Anthropologist, The Gerontologist, Social Science and Medicine,*

Global Public Health, Lancet, Journal of International Women's Studies, Anthropology & Aging Quarterly, and African Health Sciences.

Grey literature, which includes materials that are not formally published, such as reports, conference proceedings, and other unpublished documents, was included in this literature review because the focus of the inquiry was on topical socio-cultural issues, particularly witchcraft as a social phenomenon. These issues are often highly newsworthy and may be covered by local newspapers, social media, and blogs. As a result, policy documents, reports from non-governmental organizations (NGOs), and blog posts that were deemed relevant to the study were included. A number of news agencies and blogs have reported on witchcraft accusations, including ('It will be a 'Priceless Gift', 2020; "90-year-old woman lynched, 2020; Whitaker, 2012).

The literature review conducted in this study involved a systematic and comprehensive search using a range of databases and journals. To ensure a thorough analysis, a set of search terms were employed, including keywords related to the phenomenon of witchcraft, elderly women's health, mental health, stigma, aging, and relevant theories. Geographical terms were also incorporated to provide a broader perspective on the issue.

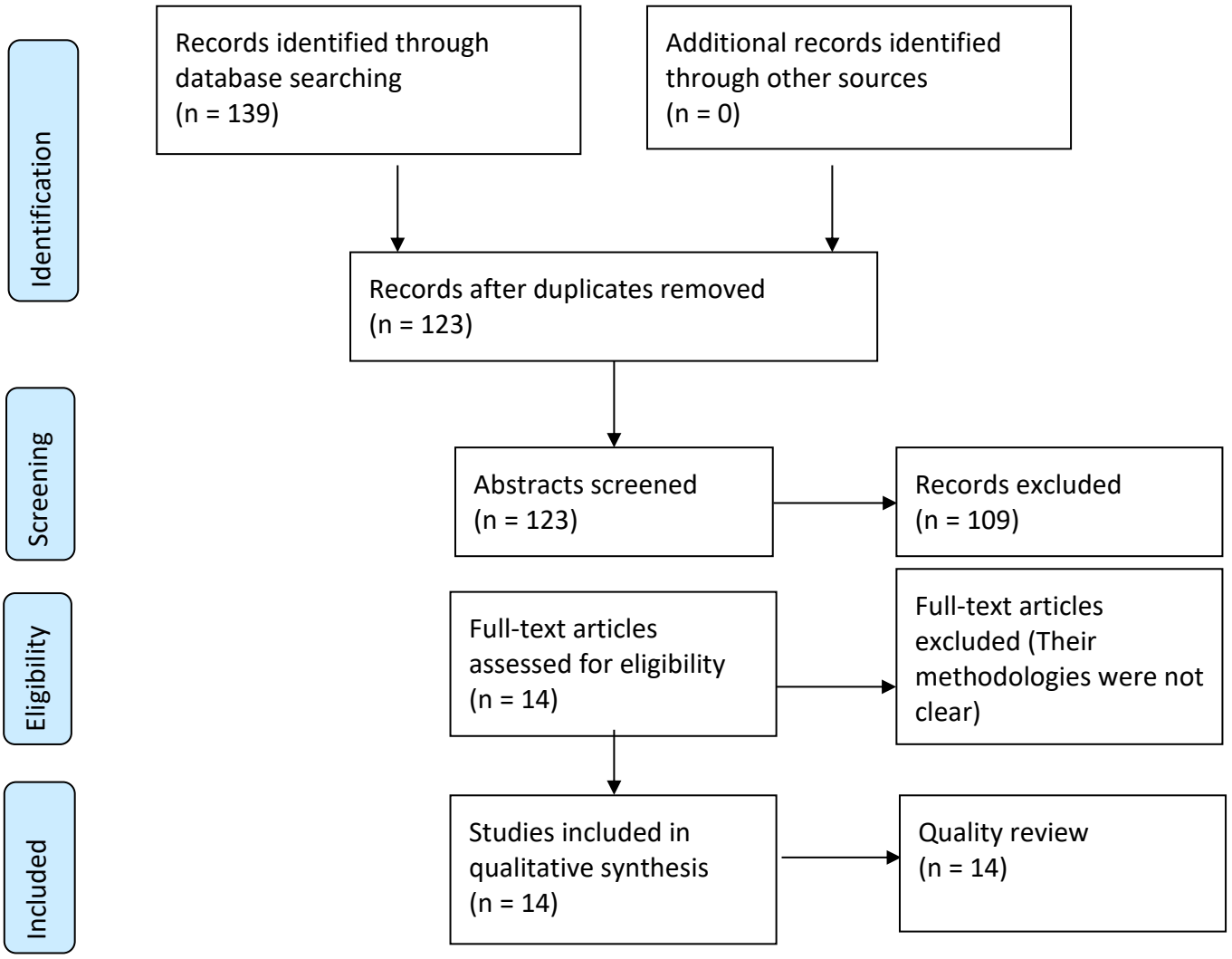
The Boolean operators 'OR' and 'AND' were used to combine the search terms, and only articles written in the English language were included in the review. No limitations were imposed on the publication date to capture the full spectrum of relevant studies.

The following search terms were used: 'witchcraft', 'witches', 'witch', 'malicious elderly women', 'older women health', 'aged', 'mental health' and 'stigma', 'older adults', 'dementia and related disparity', 'depression in old age', 'resilience', 'Goffman's theory of stigmatization', 'theory of symbolic interactionism', 'theory of scapegoating', 'conflict theory', 'socio-ecological model', 'quantitative', 'qualitative', 'mixed method', and 'pragmatism'. For the geographical areas, key terms were 'Africa', 'Africa and West Africa', 'Africa and East Africa', 'Africa and South Africa', 'Tanzania', 'Nigeria', 'India', 'Papua New Guinea', 'developing countries', 'global', 'Ghana', 'low- and middle-income countries' and 'northern region'. The Boolean operators 'OR' and 'AND' combined the terms.

A total of 139 articles were initially identified through the search process. After removing duplicates and screening the titles and abstracts (123 articles were screened) against the inclusion criteria, 14 articles were included in the literature review. The exclusion of articles (One hundred and nine) was based on various reasons such as being on witchcraft studies not related to women, focusing on children or historical studies of medieval Europe, examining witchcraft as the cause of HIV/AIDS, and not presenting any research method. All articles that were included in the literature review were read in full to assess their eligibility. Figure 2.1 below provides an overview of the search and screening process (See **Figure *2.1*** below).

Figure 2.1

PRISMA flow diagram



Note. Study selection procedures according to "Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement" (Moher et al., 2009).

2.3 Key themes

Although a considerable amount of literature on witchcraft accusations involving older women exists, no published literature that specifically explores the mental health and emotional well-being of women accused of witchcraft was identified in the papers that met the criteria for the integrative literature review. The process for selecting the empirical research data for the review involved analyzing common themes present in various literature from different countries that were relevant to the experiences of older women and witchcraft accusations. These themes were further reviewed and confirmed with my supervisors.

Three papers that were reviewed suggested that behavioural changes that occur during old age, such as dementia, may be a possible explanation for why older women are accused of witchcraft. This may be because residents in villages lack understanding of dementia, and there is little awareness of it in Ghana and South Africa (Spittel, 2014; Spittel et al., 2021; Spittel et al., 2019). The relevant themes that emerged from the analysis include the social phenomenon of witchcraft and its associated world views, the context of witchcraft in Ghana, social relations involving witchcraft, the impact of aging, mental health and stigma on older women, the association of witchcraft accusations with dementia, mental health, and well-being, the lack of basic needs and social amenities in witch camps, and government directives on witchcraft in Africa. The following themes were deemed relevant:

- Witchcraft as a social phenomenon and associated world views
- The context of witchcraft in Ghana
- Witchcraft and social relations
- Ageing, mental health, stigma, and older women
- Witchcraft accusations and associations with dementia mental health and well-being
- Lack of basic needs and social amenities in the witch camps
- Government directives regarding witchcraft in Africa

The following sections provide a detailed discussion of the above themes

2.3.1 Witchcraft as a social phenomenon and associated world views

Witchcraft beliefs and practices are prevalent social phenomena across the world. These practices have been documented in various societies, including Asia, Africa, and Native American cultures. Witches were often held accountable for causing natural disasters, accidents, diseases, and other unfortunate events(Adinkrah, 2004). The study of witchcraft has benefited greatly from the extensive archives of witchcraft accusations and confessions found in Europe, colonial America, and other parts of the world (Adinkrah, 2015).

Historical records show that approximately one thousand witches were executed in England between 1559 and 1736 for allegedly causing witchcraft-related deaths (Burns, 1973). The accused were often blamed for using witchcraft to harm neighbours' livestock, crops, and children.

In Asia, industrialisation has been linked to the decline of witchcraft beliefs, although the change has been too recent to eliminate such beliefs altogether (Alyson, 2007). In China, for example, poor farming policies that led to a depletion of farming investment sparked a belief from the 1960s that witches were responsible for the depletion (Koning, 2013). Foreign insurgents were classified as witches and labelled as "evil landlords" and "white devils." However, after local institutions gained control and began to support agricultural growth and industrialisation, belief in witchcraft began to decline, although different forms of such beliefs can still be found (Koning, 2013). In India, women are still subjected to witchcraft accusations in recent times (Soutik, 2016).

2.3.2 The context of witchcraft in Ghana

Witchcraft is a deeply rooted cultural belief and practice in northern Ghana, upheld by traditional rulers in the region. Unfortunately, the majority of those accused of witchcraft are older women, who are often found guilty based on the verdict from the chief’s palace, which is given by a spiritual man who uses magical powers to confirm the accusation(Adinkrah, 2015). According to a report by ActionAid (2012), although both men and women can be accused of witchcraft, women are the most common targets. More than 70% of residents in Kukuo camp, one of the witches’ camps in northern Ghana, are women who were accused and banished to the camp after the

death of their husbands. This means that the witchcraft allegation can enable the family to take control of the widow's property and inheritance. Supreme Court Justice Rose Owusu stated that the accusation of witchcraft practice violates numerous clauses in section 5 of Ghana's 1992 Constitution, which is intended to protect human rights and outlaw cultural practices that dehumanize or injure a person's physical and mental well-being (Gottardi, 2019).

Women accused of witchcraft face grave dangers, including being lynched or banished to a camp that ignores their health status and deprives them of family and emotional support systems (Baba, 2013). Due to limited access to conventional healthcare, most of the alleged witches at the camp resort to using local or herbal medicine supplied by the camp's Tindana (the chief priest) and caretaker.

2.3.3 Witches and disrupted family relations

Witchcraft accusations have devastating effects on family relations, causing disruptions and fractures (Atata, 2018). In communities that hold witchcraft beliefs, individuals often consult witch doctors or spiritualists when faced with incomprehensible misfortunes. These consultations often identify a family member, particularly a mother or stepmother, as the cause of the misfortune (Ajala & Ediomo-ubong, 2010). Witchcraft accusations are also used as a means of gaining access to limited resources within the family, such as inheritance, leading to family feuds (Sambe et al., 2014). In Ghana, the accused are predominantly older women who are banished from their homes and subjected to violence by family members, following household calamities (Adinkrah, 2004). Adinkrah (2004) found that perpetrators of witch homicides were often family members. This association profoundly disrupts the social relations of older women, their families, and members of their communities (Atata, 2018). Some scholars suggest that the Christian church indirectly perpetuates belief in witchcraft practices (Okon, 2012; Sambe et al., 2014).

2.3.4 Older women and stigmatisation in Africa

The literature reviewed reveals that stigmatisation is a prevalent and significant consequence for older women accused of witchcraft in Africa(Adinkrah, 2004; Ajala & Ediomo-ubong, 2010; Atata, 2018; Crampton, 2013; Eboiyehi, 2017; Erol et al., 2016; Sambe et al., 2014). According to Adinkrah (2004), stigmatised older women often

experience a loss of market sales and businesses due to information about the accusations being spread on social media and at rural market centres. Furthermore, this stigmatisation often leads to the isolation and rejection of the accused 'witch' by their respective families (Mkhonto & Hanssen, 2018b).

Stigma is manifested in various forms, including self-stigma, social stigma, and public stigma. As Goffman (1963) posits, stigma is "an attribute deeply discrediting within a particular interaction" (p. 3), leading others to view stigmatised individuals as untrustworthy, 'tainted', or incompetent. Stigma is a socially constructed notion of social unacceptability based on identity and association.

2.3.5 Witchcraft accusations and associations with dementia mental health and well-being

Accusations of witchcraft in Africa have far-reaching consequences for older women, as evidenced by their stigmatisation, loss of businesses, and even harm to family members (Eboiyehi, 2017; Meel, 2009a; Mkhonto & Hanssen, 2018b). The consequences of these accusations extend to mental health and well-being, particularly among older women who migrate to urban areas to escape mistreatment, only to experience psychological strain, depression, and severe mental health problems (Eboiyehi, 2017). Furthermore, in many African societies, including South Africa, mental illnesses such as dementia are often attributed to witchcraft, resulting in the banishment and isolation of older women (Mkhonto & Hanssen, 2018b).

Studies have shown that there is a poor understanding of dementia, and the belief that it is witchcraft has contributed to many older women being accused of witchcraft and persecuted in their communities (Brooke & Ojo, 2020b; Kehoua et al., 2019; Khonje et al., 2015; Mkhonto & Hanssen, 2018b; Mushi et al., 2014). These accusations leave older women vulnerable to violent acts, with many cases of witchcraft accusations resulting in harm to these vulnerable individuals (Meel, 2009a). The situation is further compounded by the fact that traditional healers often provide treatment for all mental illnesses and attribute mental health issues to having a ‘witch’ in their family or community (Kibuga & Dianga, 2000).

As the elderly population in sub-Saharan Africa continues to grow, the number of those at risk of dementia is also increasing. Studies have shown that poor knowledge

and beliefs about dementia and other mental health problems are the cause of many older women being labelled as witches and persecuted in their communities(Khonje et al., 2015; Mkhonto & Hanssen, 2018b; Mushi et al., 2014). However, advocacy by NGOs in rural communities has intensified, with the aim of educating individuals about dementia and other related old-age conditions to reduce stigmatisation and persecution (Nyirongo).

It is crucial to recognise the link between persons with dementia and an elevated risk of being labelled a witch, as it can contribute to advocacy efforts seeking justice for these misunderstood older women who often are accused of being witches. As demonstrated by Johnson (2021) in Namibia, being the first to identify the connection between dementia and accusations of witchcraft motivated him to raise awareness about the issue and advocate for this vulnerable group. Therefore, addressing the stigmatisation and persecution of older women accused of witchcraft is essential for promoting mental health and well-being in sub-Saharan Africa.

2.3.6 Lack of basic needs and social amenities in the witch camps

The Kukuo witches' camps in Ghana are known for their poor social and environmental conditions that pose high health risks to women who are perceived as witches. In a qualitative study conducted by Azongo et al. (2020), the researchers used a purposive sampling technique to recruit eight participants to examine the psycho-social and health-related condition of these women. The study found that the women in the camps had low economic status, exposed to poor social and environmental conditions, and that witchcraft accusations were associated with old age. The researchers reported that the women did not have health insurance and relied on traditional herbal medicine sold to them in the camp.

These conditions violate the human rights of the women living in the witches' camps, and it is important to address them. It is also important to note that no studies have reported the health-related conditions in the other four witches' camps in Ghana (Azongo et al., 2020). Therefore, further research is needed to assess the conditions of women living in these camps and to identify potential solutions that would improve their quality of life. Addressing the lack of basic needs and social amenities in the

witches' camps is critical to promoting the health and well-being of these women and ensuring their human rights are respected.

2.3.7 Government directives regarding witchcraft

Government interventions in witchcraft accusations have been recognised in both African and global contexts. Research by Crampton (2013), Machangu (2015), and Mkhonto and Hanssen (2018b) highlights the need for a multi-pronged approach to address the complex problem of witchcraft-related killings. However, Eboiyehi (2017) found that in Nigeria, there is a lack of scholarly work and insufficient government policies to address the issue adequately. Additionally, Eboiyehi (2017) noted that law enforcers mandated to protect accused older women from witchcraft accusations only arrest the perpetrators but fail to prosecute them for the inhumane acts meted out to the victims. The Tanzanian Government has also been criticised for not responding adequately to the killing of older people in the Fipa region, despite the implementation of the British government Witchcraft Ordinance of 1922 (Machangu, 2015). Unfortunately, these laws failed to control witchcraft accusations against older women, and the killings persisted in the Sumbawanga district (Machangu, 2015).

The following sections of this review will discuss the mental health of marginalised communities and populations, including older women who have been accused of witchcraft. The literature review will examine empirical studies exploring dementia in older women and its link to witchcraft accusations. Additionally, this review will also include newspaper and online reports about the witchcraft phenomenon and its impact on vulnerable witches during the COVID-19 pandemic.

2.3.8 Mental Health Disparities in Marginalized Populations: A Focus on Displaced Individuals

Millions of individuals around the world undertake dangerous journeys in search of safety, hoping to escape violence, poverty, and persecution. However, the challenges do not end once they find themselves in a new environment. Persecuted people often face discrimination and isolation, leading to higher rates of mental health problems and disorders than the general population (Priebe, Matanov, Schor, et al., 2012; World Health Organization, 2014).

In particular, marginalised populations in Africa and elsewhere are at significant risk of developing mental disorders. This is largely due to their limited access to social resources, including housing, income, employment, education, social support, and healthcare.

Bonful and Anum (2019) conducted a study in Ghana, which found that older women with low education and those who are unemployed are more vulnerable to mental health problems, including depression. Furthermore, individuals with economic disadvantages or experiencing economic strains are also at a higher risk of depression. Being a member of more than one marginalised group is significantly associated with having more chronic pain, poorer health conditions, and a greater likelihood of high levels of psychological distress or illness compared to the general population (World Health Organization, 2014).

Social marginalization, therefore, has detrimental effects on mental health, particularly in populations with limited access to social resources. It is essential to prioritize mental health services for marginalized communities to promote well-being and address the mental health disparities that exist.

2.3.9 Mental health challenges among older women: A global perspective

Mental health is a pressing issue worldwide, affecting millions of people. Despite progress, mental and neurological disorders remain a significant public health challenge globally. The prevalence of mental health disorders among older adults is a growing concern, and it is essential to examine the impact of mental health issues on this population.

Depression is a prevalent mental health disorder that affects over 300 million people worldwide. The World Health Organization reports that 15% of adults aged 60 and over suffer from a mental or neurological disorder(Sorsha, 2018). Mental and neurological disorders account for 6.6% of the total disability in this age group, measured in disability-adjusted life years (DALYs). Dementia and depression are the most common mental and neurological disorders in older people, affecting 5% and 7% of the world's older population, respectively. Anxiety disorders are also prevalent among older people, affecting 3.8% of the population. Furthermore, a significant

proportion of deaths from self-harm occur among people aged 60 and above (World Health Organization, 2017b).

In Africa, mental health disorders receive little attention from governments, and policymakers often view mental health issues as a low priority(Desjarlais et al., 1995). Several factors contribute to the lack of attention, including the historical context, limited local empirical studies, and low levels of formal education among the population. Additionally, cultural practices and beliefs, such as witchcraft beliefs, can affect the way mental health disorders are perceived in African societies(Njenga, 2007).

Older people are particularly vulnerable to mental health disorders, and the prevalence of these disorders is a growing concern worldwide. Governments and policymakers must prioritize mental health issues and take steps to address the factors that contribute to the lack of attention given to mental health disorders in some societies. Addressing these challenges will go a long way in improving the mental health and well-being of older adults worldwide.

2.3.10 Older women and chronic illness

The process of ageing among older adults is a natural phenomenon that is characterized by a decline in physical and mental capabilities and an increased susceptibility to chronic diseases. Kwak et al. (2016) conducted a significant study in Korea, which revealed that older women with urinary incontinence are likely to experience high levels of stress and depression, negatively impacting their quality of life. Similarly, , Pinkas et al. (2016) found that older women commonly suffer from geriatric problems, such as chronic pain, visual impairment, urinary incontinence, falls, fainting, stool incontinence, and cognitive and functional decline, leading to a significant reduction in their overall quality of life, including their physical, psychological, and social well-being.

In contrast, Quashie and Andrade (2018) highlighted the importance of family and social networks in providing much-needed social support for older adults. The absence or dissolution of these relationships can have significant mental health implications, as mental health and physical health are interconnected. For instance, older adults with physical health conditions, such as heart disease, are more likely to experience

depression World Health Organization (2017b). Therefore, it is crucial to recognize the value of social relationships and their impact on older adults' mental and physical health, especially in societies where familial ties play an important role.

2.3.11 Witchcraft-related violence and COVID-19

Witchcraft-related violence in Ghana and West Africa has received significant attention from both local and international media. The Northern region of Ghana, where several witch camps are located, has been particularly noted for increasing incidents of persecution related to witchcraft. However, the COVID-19 pandemic has further exacerbated the already dire situation for these women accused of witchcraft.

In August 2020, a 90-year-old woman in Kafaba, Savannah Region, was lynched on camera due to accusations of witchcraft. This incident was widely reported by local and international media and gained significant attention on social media. Many people suggested that the closure of the witch camps by the Gender Ministry in 2012 had led to the woman's death, as she may have been sent to one of the camps for her safety. COVID-19 was also used as a call for the closure of these camps, as the living conditions were deplorable, and the women were vulnerable to the pandemic due to their age and health conditions("90-year-old woman lynched, 2020; "Why 90-year-old alleged witch was lynched", 2020; Duodu, 2020).

In addition to the incident in Kafaba, three other women were killed due to accusations of witchcraft during the pandemic. Two were beaten to death in Nalerigu, Northeast region, and one had her properties burnt by a mob in Zabzugu, Northern region(Delali, 2021). The pandemic has made life in the witch camps even more challenging, as women have reduced access to food, healthcare, and essential supplies like sanitizers and facemasks. The reduction in donations to the camps due to COVID-19 has worsened the already dire living conditions of these women.

The banishment of women accused of witchcraft to camps is a long-standing tradition in Ghana, and the women are often shunned by society and live in dire conditions. Two NGOs are working to rehabilitate these women and return them to their former villages. However, accusations of witchcraft are still prevalent and often based on personal jealousy, sexism, or ageism. Women with mental or physical disabilities are

also often condemned as witches and sent to these camps ("90-year-old woman lynched, 2020; "Kafaba Lynching: I Was Possessed", 2020).

In conclusion, the COVID-19 pandemic has worsened the already dire situation for women accused of witchcraft in Ghana's witch camps (Ajiambo, 2020). The government's lack of intervention to provide essential supplies and support for these women has been criticised, and there are fears that COVID-19 could be misjudged as being caused by witchcraft, leading to more accusations and violence. The banishment of women to these camps based on accusations of witchcraft is a violation of their human rights, and efforts must be made to address and eliminate this practice (Hibbatullah Wumpini & Barak, 2021).

2.3.12 The gap in knowledge

The literature reviewed on older women's mental and emotional well-being in witches' camps is lacking in various ways. The research papers and grey literature reviewed failed to report on the factors that influence the mental and emotional well-being of older women in these camps. Instead, they focused mainly on the sociological aspects and sensationalism of the witchcraft accusations, as well as the poor living conditions in the camps.

Furthermore, there is a scarcity of evidence regarding Ghanaian communities' understanding and knowledge about mental and emotional health, which is crucial for understanding the experiences of older women living in witches' camps. Mixed-method design studies that investigate the experiences of these women, including their mental and emotional well-being, are also absent.

The increasing population of older adults in Ghana, with women being a significant group, coupled with the widespread and long-standing accusations of witchcraft, highlights the need for more research in this area. The cultural misconception of ageing and dementia is often the root of witchcraft accusations against older women, limiting social support for them in the camps. It is possible that they are more vulnerable to mental and emotional challenges than women from the general population, but data to confirm or refute this is currently non-existent.

Therefore, this research seeks to fill this gap in knowledge by exploring the mental and emotional well-being of older women living in witches' camps in northern Ghana. The findings of this study will contribute to a better understanding of the experiences of these women and inform interventions aimed at improving their mental and emotional health.

2.3.13 Chapter summary

This chapter provides a literature review of the witchcraft phenomenon, with a particular focus on the mental health of older women in witches' camps. Additionally, it reviews empirical research on the mental health of marginalised communities, as well as grey literature reports on witchcraft and witches' camps during the COVID-19 pandemic. The review highlights gaps and limitations in current knowledge regarding the mental health and emotional well-being of women in witches' camps. No existing research has investigated this topic, indicating a significant gap in knowledge that this thesis seeks to address.

The factors identified in this chapter provide a foundation for determining the most appropriate methodology and methods for the study. The next chapter outlines the research worldview, theoretical frameworks and models, and methodology that underpins this study. By addressing the gap in knowledge, this research aims to contribute to a better understanding of the experiences of older women in witches' camps and inform interventions aimed at improving their mental and emotional well-being.

Chapter 3 Theoretical models

3.1 Introduction

This chapter aims to present and evaluate various theoretical frameworks that were used to guide the study. The models and theories discussed include the SEM (Bronfenbrenner, 1979), Kleinman's explanatory model (Kleinman et al., 1978), and the social determinants of health (World Health Organization, 2008). These theoretical frameworks provide a foundation for selecting appropriate policies, financial strategies, cultural, interpersonal, cognitive, social and belief systems that are relevant to addressing the research question and providing context.

Theoretical frameworks are crucial to shaping the methodology of the study and informing the discussion. Thus, this chapter also creates a framework for the methodology and subsequently informs the discussion. Each approach is critically evaluated by outlining its development, application to healthcare and, where applicable, mental health, subsequent modifications, and relevance to the current research aim and objectives.

The following section provides a critical analysis of potential models and theories that are deemed unsuitable for application in the current study. One of the theories is conflict theory, which was first introduced by Karl Marx (1967). This theory examines social phenomena and acknowledges that inequality generates conflict and social change. However, it does not provide a lens for insight into how older African women, as witch camp residents, experience mental health and emotional well-being within a cultural and resource context. Conflict theory predominantly focuses on political and economic welfare.

Another theory that is critiqued in this passage is scapegoating theory, which originates from the biblical book of Leviticus (Wenham, 1979), and was introduced by Crossman (2018). The biblical notion of scapegoating involves using a goat to symbolically take away the sins of a community, while human cultures have adapted this theory to apply to women labelled as witches in India and South Africa, (Chaudhuri, 2012; Meel, 2009b). Scapegoating theory pays attention to blame and attribution; however, it has a significant limitation as it fails to review cultural

causation and social-economic conditions that underscore the aim of the current study.

While both conflict theory and scapegoating theory offer valuable insights into social phenomena and the attribution of blame, they do not provide an adequate lens to investigate the mental health and emotional well-being of older African women as witch camp residents. A cultural and resource context-based approach is required to gain a better understanding of the complex issues surrounding this topic.

Another model reviewed and critiqued is the HBM. The Health Belief Model (HBM) is a framework used by health professionals and social scientists to predict health behaviours by understanding people's health perceptions. Developed in the 1950s by Irwin Rosenstock, Godfrey Hochbaum, Stephen Kegeles, and Howard Leventhal, the model is based on the idea that people's willingness to change their health behaviours is mainly due to their perceptions of health (Rosenstock, 2005).

The HBM is derived from behavioural theory and consists of six constructs, the first four of which were developed as the standard of the HBM in the 1950s (Hochbaum et al., 1952). The last two were added later as research evidence about the HBM evolved (Rosenstock, 1974; Wayne, 2019). The six constructs include perceived threat of sickness or illness, perceived consequence, potential positive benefits of action, perceived barriers to action, exposure to factors that prompt action (cues to action), and confidence to succeed or self-efficacy.

The US Public Health Service uses the HBM to understand public failure to adopt disease prevention strategies or screening tests for the early detection of disease(Rural Health Information Hub, 2018). However, the HBM is limited in its ability to account for a person's attitudes or social constructs that dictate the acceptance and normalization of health-related behaviour. This limitation is particularly relevant in the African religious population context, where behaviours may be influenced by social acceptability or stigma avoidance.

Moreover, the HBM does not account for environmental or economic costs, such as the cost of living and low-resource contexts that may prohibit or promote the recommended action. Despite these limitations, the HBM remains a valuable tool for

understanding health behaviours and identifying factors that may influence behaviour change.

In addition to its Western-centric approach, the Health Belief Model (HBM) assumes that everyone has equal access to social capital, including health literacy and social standing(Flanagan, 1989; Moscona et al., 2018). However, African social systems are highly hierarchical, with elderhood, servitude, and social rank defining the social structure(Cramer, 2002; Moscona et al., 2018). These principles influence health education and health promotion information flow, including health literacy, in ways that the HBM does not address. As a result, the HBM was not used in this study because it could not be fully applied.

These principles impact and influence health education and health promotion information flow, including health literacy, in ways that the HBM in its current form ignores. Therefore, the HBM was not applied in this current study because the researcher could not utilise the HBM in its entirety as health action was not a focus of the study.

Considering the lack of attention to specific and highly personalised social, cultural, and ecological constructs in the theories referred to above, the researcher explored more explanatory and determinant-focused public health models that consider specific social, cultural, and ecological constructs. These models include Bronfenbrenner's Social Ecological Model (SEM) (Bronfenbrenner, 1979), the World Health Organization's Social Determinants of Health (World Health Organization, 2003), and Kleinman's Explanatory Model(Kleinman et al., 1978) for African belief systems and cultural contexts. By incorporating these models, the study can better address the unique social and cultural contexts of African communities and their impact on health.

3.2 Socio-ecological model (SEM)

The Socio-ecological model (SEM), introduced by Bronfenbrenner (1979), is a theoretical framework that seeks to understand the various personal and environmental factors that influence human behavior. The SEM is based on a socio-ecological approach to human development and behavior, which emphasizes the importance of considering the whole ecological system in which growth occurs. This

framework was further developed by Stokols (1996), who coined the social ecology model of health promotion, enabling a more comprehensive approach to public health by focusing on the complex interplay between individual, relationship, community, and societal factors.

Bronfenbrenner argued that to understand human development, we must consider the personal and genetic developmental antecedents of individuals, as well as their physical and social environment. The development and application of the SEM came into prominence from the work of McLeroy et al. (1988), who identified five different levels of influence on health behavior: intrapersonal factors, interpersonal processes, organizational/institutional factors, community, and public policy. However, the physical environment and its links to mental health had been omitted in earlier work, which has been addressed in more recent research, such as the work of Hennein et al. (2021) and Reupert (2017), on mental health applications.

In addition, Amuyunzu-Nyamongo (2013), researched the influence of socio-culture and social stigma on African mental illness outcomes, highlighting the importance of considering cultural and social factors within the SEM. The SEM provides a dynamic understanding of the various personal and environmental factors that influence human behavior and can help identify communities' behavioral and organizational influences. By using this framework, researchers and practitioners can better understand the complex interplay between individual, relationship, community, and societal factors, which is crucial for developing effective interventions and promoting public health (Stokols, 1992). The SEM subsequently developed into a social system with four main elements which intertwine, inter-relate, and link:

- The **microsystem** is the immediate setting surrounding the individual.
- The **mesosystem** layer encompasses the interplay among various components within an individual's microsystem. In the mesosystem, a person's individual microsystems are not isolated entities, but rather interconnected and mutually influential. These interconnections have an indirect effect on the individual.
- The **ecosystem** is the linkage and process between two or more settings.

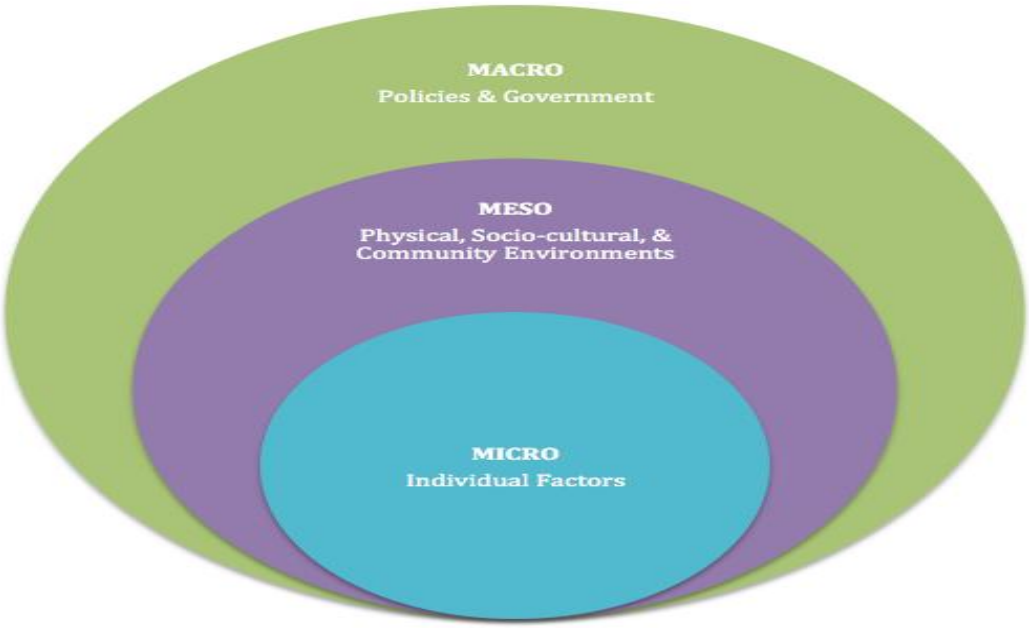
- Lastly, the **macrosystem** relates to the culture or sub-culture which encircles the individual. This includes political, legal, social, and economic factors (Bronfenbrenner, 1993, p. 645)

Another **chronosystem** layer consists of the time dimension) (Bronfenbrenner, 1976; Bronfenbrenner & Morris, 1998). See **Figure *3.1***

Ecological model

Figure 3.1

Ecological model



Note. This image of ecological model was adapted from Story et al. (2008)

3.2.1 Application of socio-ecological model

In recent years, mental health research has increasingly focused on the social and ecological determinants that impact population-based mental health and wellness (Newman & Zainal, 2020). The socio-ecological (SEM) model has been widely utilized in mental health and public health research in various regions of the world, including Africa and Asia, to explore different approaches to mental health issues such as depression (Atilola, 2014; Lakhan, 2013; Poleshuck et al., 2019).

For instance, in the United States, the SEM was used to study the effects of the family check-up in promoting early adolescent mental health and social adaptation, (Stormshak et al., 2011). When considering the complexity of health or mental health service-seeking behaviour and utilization in African countries, it is crucial to take into account community-level cultural values, norms, and national policies within collectivist social structures and avoid a sole focus on the individual. This approach has been applied in mental health research in Africa, such as in studies conducted in Ghana and South Africa (Khuzwayo & Taylor, 2018; Ngwenya et al., 2020).

In rural Ghana, for example, several overlapping factors, including access, affordability, acceptability, and societal stigma within the mesosystem, affect people's ability to utilize health services (Ngwenya et al., 2020). As a result, specific populations may be at a higher risk of experiencing inequitable health outcomes due to limited-service availability. In a recent South African study utilizing the SEM, young people reported negative attitudes towards mental health providers, while fear of stigmatization and gossip at the social and community levels hindered health service utilization (Ngwenya et al., 2020).

Overall, the SEM model enables a comprehensive understanding of the complex interactions between individual and societal factors in mental health research, providing insights into the design of adaptive interventions to promote better mental health outcomes.

3.2.2 Limitations

While the SEM is a widely-used and adaptable framework in public health and allied health research, it has some limitations. One of these limitations is its failure to acknowledge culturally specific personal factors that impact mental health and emotional well-being. This is particularly relevant in low-resource countries where rural tribalism and secluded communities prevail, and mental and emotional health adaptations are yet to be developed. Thus, no study has applied the SEM to understand factors influencing mental health in these settings.

Moreover, the SEM does not provide a context for factors related to human rights, economics or employment, and political landscapes that inform health outcomes, perceived health risks, health-seeking behaviours, and health service utilization. The

model also does not facilitate an in-depth examination of religion and the hierarchical nature central to African belief systems and treatment-seeking options. Previous studies have shown that cultural contexts and associated stigmatization and gender disparities influence health-seeking behaviours and outcomes(Abubakar et al., 2013; Hackney & Sanders, 2003; Khumalo et al., 2014; Mashaphu et al., 2021; Nyirongo; Sarfo, 2015).

Finally, the SEM fails to address complexity and intersectionality, which are essential in predicting behaviours in specific cultural contexts (Meer & Müller, 2017). Personalized adaptation is crucial to the growth of gendered and cultural circumstances since individuals from different cultural backgrounds have different ways of understanding illness, its consequences, and how best to treat it. Therefore, it is crucial to review context-specific factors and personalize interventions to address the complex interplay of individual and societal factors that influence mental health outcomes model (Hallenbeck et al., 1996).

3.3 Explanatory models

Explanatory models originated in the work of anthropologist Arthur Kleinman et al. (1978) in cultural psychiatry; an explanatory model is defined as a model with a complex, culturally determined process of making sense of one's illness. Moreover, the process ascribes meanings to symptoms, evolves causal attributions, and expresses suitable expectations of treatment and related outcomes.

An explanatory model adds value when trying to successfully understand, explain or in some other way relate to the reality of the world around a social group. Generally, it is used only to emphasise awareness of the incompleteness of an explanation due to intentional simplification or lack of knowledge and understanding. In this study, the researcher utilised the explanatory model to augment the SEM throughout the approach to data analysis and discussion. In the context of the African cultural setting, belief in magical powers is inherent and deeply rooted in the social context (Kohnert, 2003). The explanatory model helped to explain and address the African belief component of mental illnesses, their causes, and cultural ways of remedying diseases.

The above notion is supported by Asare (2017), who writes that the causes of mental health conditions mainly seem to be challenging to Africans and therefore are easily attributed to spiritual powers. Similarly, White (2015) found that traditional African religious medicine is not opposed to Western medical treatment or healing processes; however, followers believe Western medicine cannot treat some diseases and these need spiritual attention. Spiritual belief provides hope for Africans, families, and communities when a disease condition's treatment challenges Western medical treatment. For instance(Monteiro, 2015), who researched mental health problems in Africa, proposed focusing on the socio-cultural-spiritual factors that are the basis of many traditional explanatory models of mental illness in Africa and are also important determinants of illness, health, and well-being.

More simply, explanatory models might be described as the culturally determined beliefs that individuals and communities hold about misfortune, suffering, illness, and health. These models are shaped by societal expectations of the key sickness and health roles, illness behaviours and help-seeking. Several studies (Laws, 2016; Sumathipala et al., 2008; Tirodkar et al., 2011) have shown that explanatory models are not static entities or single constructs but can be fluid, multi-layered and complex constructs that may change in response to several factors and over time. These factors include the type of questioning and the relationship with formal and healthcare practitioners. Similarly, the seminal work of Evans-Pritchard (1937) on witchcraft elicited the way people make sense of and understand their misfortunes. Recent evidence shows how exploring explanatory models can help shape treatment and outcomes for some of the most common categories of mental illness, such as depression (Atilola, 2016). Mayston et al. (2020) applied an explanatory model in their qualitative study on depression among people living in SSA countries. Their findings suggest that it is essential that practitioners and researchers have significant knowledge of local conceptualisations and are aware of local resources to address depression. Spiritual causes are frequent explanations for mental health concerns with African traditional belief systems in the African context. For example, in Ghana, mental health problems are often attributed to the influence of bewitchment (Kpanake, 2018; Okasha, 2002). Moreover, traditional healers in Ghana are shown to believe they have the expertise to address these misfortunes caused by spiritual dissonances (Lambert et

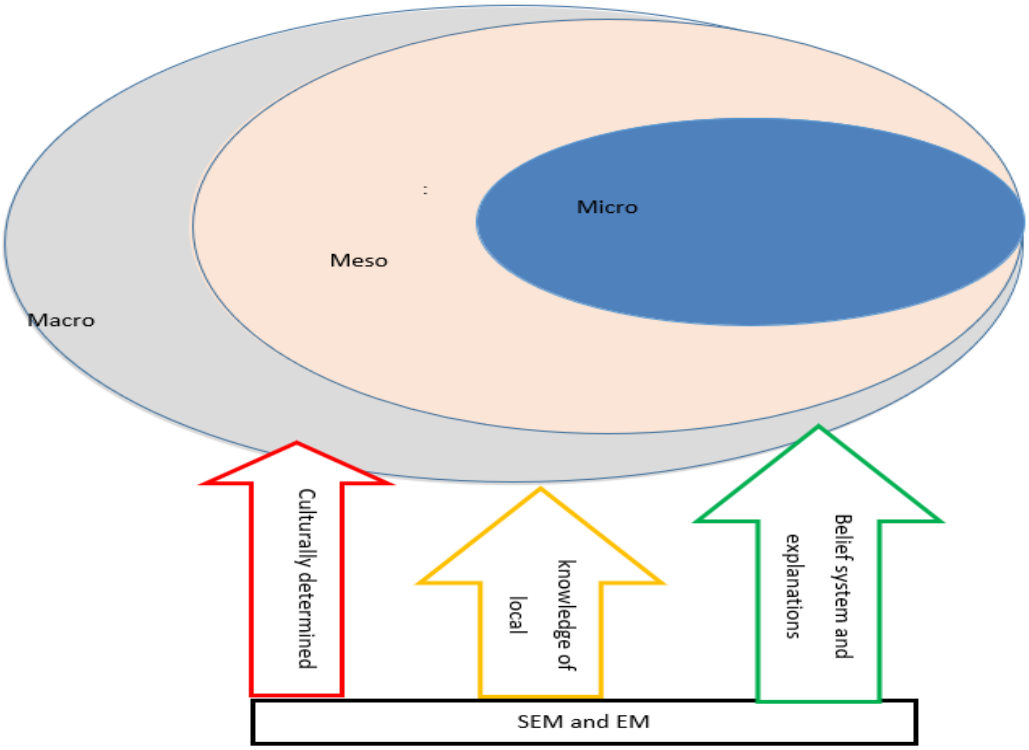
al., 2020). The models focus on personal views and the cultural location of these beliefs that determine the presence of mental ill-health.

Moreover, the use of explanatory models may go some way to explain or attempt to find socially and morally satisfying answers to social and emotional descriptions (Hallenbeck et al., 1996; Mayston et al., 2020). Cultural variations result in diverse conceptualizations of the individual, which serve as foundations for self-understanding and self-representation. These underlying concepts significantly impact various aspects of individuals' life experiences, including their perceptions of illness and expectations regarding recovery (Kpanake, 2018). However, no literature has been located to date that has applied explanatory models in African communities for older women's mental health and emotional concerns.

In summary, the critical reason for employing both highly cultural and personalised explanations together with a broader public health model in this current study was to provide evidence to accommodate all the beliefs and social systems of all the study participants (women, NGO social welfare workers, Gender Ministry officers and Ministry of Health Mental Health Authority officers). Moreover, the research aims, and questions sought to address all sectors within African belief systems, contexts, and social systems.

Figure 3.2

Diagram of the overlay of the socio-ecological model and explanatory model



3.4 Social determinants of health

Social determinants of health (World Health Organization, 2008) have become a foundational public health framework and have received significant attention in recent decades. The term 'social determinants of health' has been used in health research to explain the impact of social factors impacting upon health outcomes and access to health services. The work of the World Health Organization's Global Commission on Social Determinants of Health portrayed the concept of social determinants of health

at the World Conference on Social Determinants of Health in Brazil in 2011 (Commission on Social Determinants of Health, 2008a).

In 2000, the World Health Organization facilitated academic and political work on social determinants, providing a deep understanding of global health disparities (Dixon, 2000; Wilkinson & Marmot, 2003; World Health Organization, 2003).

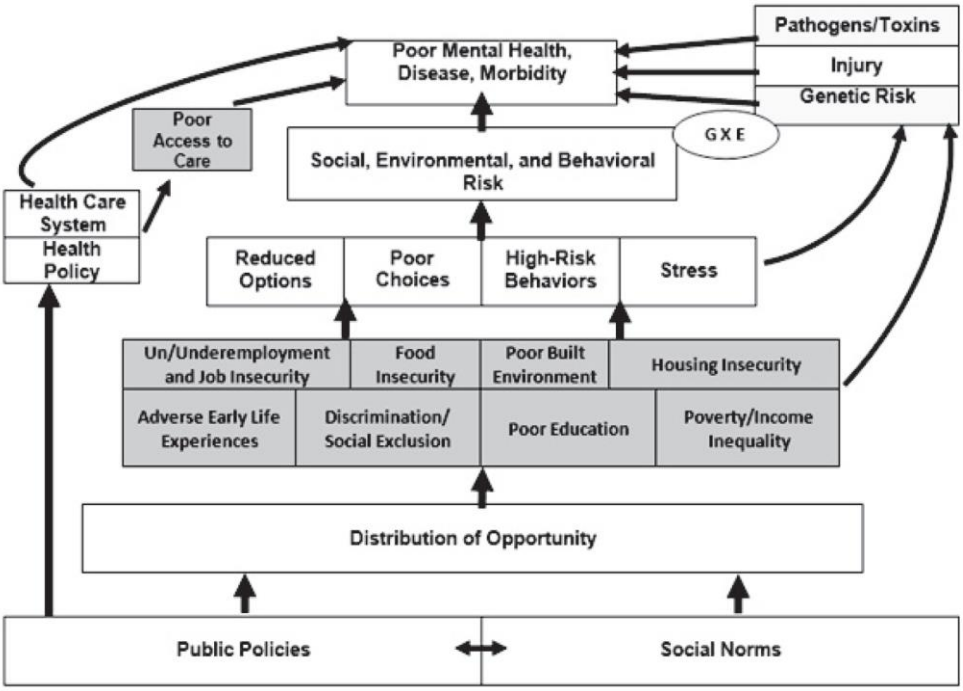
The World Health Organization (2008) stated the following are examples of social determinants of health that may influence health equity positively and negatively.

- income and social protection
- education
- unemployment and job insecurity
- working life conditions
- food insecurity
- housing, basic amenities and the environment
- access to nutritious foods and physical activity opportunities
- social inclusion and non-discrimination, and violence
- structural conflict and
- access to affordable health services of decent quality.

Social determinants of health are a conceptual framework for the public health discipline serving two equally important purposes. The framework guides empirical work to enhance understanding of determinants of a phenomenon and inform policymaking of entry points for interventions and policies. In this current study, the social determinants of the health serve to highlight the social factors that influence the mental health and emotional well-being of marginalised women excluded from the broader social benefits of mainstream society. The impacts of social determinants on the health of a population and health inequalities are characterised by many causal factors such as housing, food, jobs, and education. In 2014 WHO contended that stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transportation were all key social determinants of health (Braveman & Gottlieb, 2014a).

Figure 3.3

Conceptualising the social determinants of mental health



Note. Adapted from Compton and Shim (2015, p. 420).

The social determinants of health constitute the conditions in which individuals are born, grow, work, live, and age, and the broader set of social forces and systems shaping the needs of daily life. These forces and systems include economic and social norms, social policies, and political systems. Specific population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances interrelated with gender.

A significant body of work now emphasises the need for a life course approach to understanding and tackling mental and physical health inequalities in development or low-resource contexts. This approach considers the various experiences and impacts of social determinants throughout life. Risk factors for many common mental disorders are associated with social inequalities, whereby the more significant the disparity, the higher the inequality in risk. Poverty influences poor physical or psychological conditions, lack of clean water, poor sanitation, and lack of access to basic healthcare services. These factors constitute immediate risk factors for health and have been

reported as major causes of illness and mortality among the poor in Africa (Eshetu & Woldesenbet, 2011).

3.4.1 Sustainable development goals (SDGs) and the social determinants of health

The SDGs were developed as a blueprint for achieving a better and more sustainable future. They address global challenges, including poverty, inequality, climate change, environmental degradation, peace, and justice. The SDGs were set up in 2015 by the United Nations General Assembly to be achieved by 2030. Specific SDGs (United Nations, 2015) are recognised social determinants of health. Some of the social determinants impacting health match with those of the SDGs. For example, SDG 3 promotes 'Good Health and Well-being'.

Social determinants of health influence health outcomes, and include social factors such as housing, income, jobs, and social protection (United Nations, 2015). If SDGs are not achieved this can significantly increase health equity gaps within a country's population.

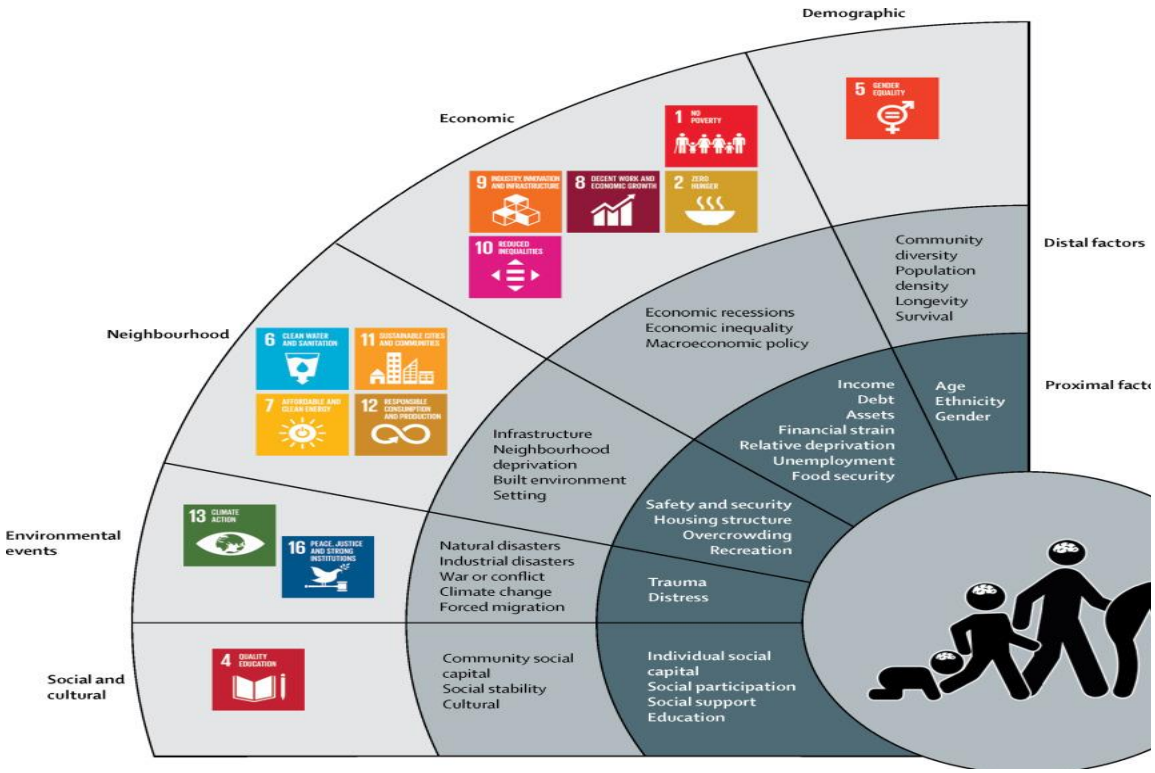
In 2018, the UK Government was reported to be using Western diagnostic tools and interventions to close the mental health treatment gap without recognising the fundamental importance of societal determinants of health. Because of this, Cosgrove et al. (2020) conducted the Lancet Commission on global mental health and sustainable development. They contended that using the societal determinants of health that could help improve mental health and bridge the inequality in mental healthcare services. Cosgrove et al. (2020) argued that focusing on societal determinants and political economy could open new possibilities for global mental health beyond narrow individualised interventions.

Additionally, Cosgrove et al. (2020) suggested that a politically informed societal determinants of health framework was needed to move global mental health in a more emancipatory direction. Stigma, a widely debated potential new societal determinant of mental health, was pointed out as being an important social determinate by the Lancet Commission(Commission on Social Determinants of Health, 2008b) and others (Cosgrove et al., 2020; Patel et al., 2018). The Lancet research explained that mental distress caused by biological factors is more stigmatised by

society than mental distress thought to be caused by societal determinants like social exclusion and trauma. Biological explanations are more likely to increase public desire for distance than contextual explanations, such as distress due to trauma or difficult living conditions. Thus, psycho-social explanations of mental disorders serve to address stigma and increase empathic responses from others. In the present study, older women who are banished from their communities to live in the witches' camps may face a highly stigmatised future life trajectory. Therefore, the social determinant of health was considered a critical model in explaining the factors influencing women's mental health and emotional well-being when excluded from society. A continued commitment to a more coherent management of health determinants is grounded in research evidence and policies designed to promote mental health and well-being, especially the most marginalised population groups. **Figure 3.4**
Sustainable development goals below shows the SDGs.

Figure 3.4

Sustainable development goals



Note. Adapted from United Nations (2015).

Research shows that social determinants can be more important than healthcare services or lifestyle choices in influencing health. Social determinants of health have been applied in research in a cross-sectional study in Africa by Peltzer and Pengpid (2020), who investigated the social determinants of depression in six provinces in South Africa with a large sample of 4,052 adults. Their study found that low economic status (low income, lack of basic amenities, residing in informal settlements or traditional dwellings, and multiple families living in a single dwelling), discriminatory experiences, and perceived community violence were associated with depression. Further, their study found that older age and female gender were associated with depression.

Using social determinants of health, Mwoka et al. (2021) conducted a comparative policy analysis across three countries (Kenya, Singapore, and the UK) to document how housing policies address health and well-being, highlighting commonalities and differences among them. Their analysis demonstrated that housing policies must be viewed as public health policies, and they could significantly impact the health and well-being of populations, especially vulnerable groups. Their study further highlighted the essence of the notion of 'health in all policies' (Mwoka et al., 2021). Utilising a social justice and equity lens in addressing the social determinants of health ensures that housing, educational, and other social policies influence or determines people's mental health and well-being.

Individuals experiencing poor housing and homelessness are particularly vulnerable to COVID-19 due to a lack of social support and access to basic facilities, such as healthcare and sanitation, and existing comorbidities, such as chronic mental and physical conditions (Maremmani et al., 2017; Tsai & Wilson, 2020)

The application of the SEM, the explanatory model, and the social determinants of health in this current study represent an attempt to frame the relevant issues with complexity and recognise the need to view all factors that influence the mental health and emotional well-being of the women living in witches' camps, in the interplay between the individual, relationship, community and government levels.

Thus, this research draws on the SEM (Bronfenbrenner, 1979), explanatory models (Kleinman et al., 1978) and the social determinants of health (World Health

Organization, 2008) to frame and investigate thoroughly the factors influencing the mental health and emotional well-being of older women residents excluded from their communities in witches' camps. The ecological perspective is a valuable framework for understanding the systemic factors influencing health and well-being. The social determinate of health provides a socially informed public health focus, and EM provides a framing for in-depth cultural and personalised meanings which fits into the microsystem of the SEM.

3.5 Chapter summary

This chapter reviewed the theoretical models underpinning the current study. The models and theories reviewed included the SEM, health belief model, Kleinman's explanatory model, conflict theory, and scapegoating theory. I have justified why I used the SEM, Kleinman's explanatory model, the SDGSs and the social determinants of health and reviewed models not utilised. The chapter that follows presents the methodology utilised for this current study.

Chapter 4 Methodology

4.1 Introduction

The previous chapter outlined the theoretical framing. This chapter provides an overview of ontology and epistemology, the philosophical stances of this study, mixed-methods research, the approach for the two-phase explanatory design, and the reason for selecting a mixed-methods design for this study.

4.2 The main aim of the research

The overall aim of this study was to understand the mental health and emotional well-being of older women at the witches' camp in northern Ghana.

4.3 Study objectives

1. To understand older women's common health and emotional health challenges when living in witches' camps in northern Ghana.
2. To describe the socio-cultural and emotional needs and practices that influence their health-seeking behaviours.
3. To examine experiences of accessing health services in the camps.
4. To recommend health service and policy directives that meet mental and emotional needs concerning culturally appropriate health and social care provision for women in the camps.

4.4 Overview of ontology and epistemology

This section presents an overview of the concepts that shape and align with the researcher's world view. It explains the paradigms employed, including ontology and epistemology. Understanding philosophy is essential because research can only be meaningfully interpreted when there is precision about the decisions that influence the research strategy and its outcomes.

4.4.1 Ontology

Ontology concerns the existence of reality. It helps researchers to affirm that reality exists and can be known, studied and experienced (Moon & Blackman, 2014). Knowing

that reality exists prompts and heightens the researcher's zeal to look for ways to know something about it. In simple terms, ontology is about the central phenomenon of inquiry, what a researcher sets out to examine (Crotty, 2020). In this current study, the researcher sought to understand the reality of the mental health and emotional needs of older women living in witches' camps after being banished by their communities.

4.4.2 Epistemology

Epistemology is a philosophical study of the nature, origin, and limits of human knowledge. The study of knowledge concerns the aspects of the scope of, and the valid methods used in the acquisition of knowledge. It deals with what constitutes knowledge and how one acquires and justifies it (Anderson, 2006). This influences how researchers obtain knowledge. In effect, it affects how researchers frame their research to discover the knowledge they can justify. The basic presumption is that individuals acquire knowledge from their previous ways of knowing, perceived disagreements, external triggers, and interactions with the environment they live in (Anderson, 2014). In the context of this thesis, the study was intended and has striven to understand the factors influencing the mental health and emotional well-being of older women living in witches' camps in northern Ghana.

In summary, ontology and epistemology create a holistic view of how knowledge is viewed, how the researcher sees this knowledge and the methodological strategies the researcher uses to uncover it. Awareness of philosophical assumptions increases the quality of research and contributes to the researcher's creativity. Therefore, this research adopted a problem-solving and practical approach to understanding the factors influencing the mental health of older women in witches' camps in regard to both internal and external contexts, which aligns with the epistemology of the philosophy of pragmatism.

4.4.3 Philosophical stance

The study was underpinned by pragmatic paradigms across the two-phase research process (Creswell & Clark, 2017). The philosophical position of pragmatism is underpinned by the fact that reality is constantly renegotiated, debated, and interpreted. Pragmatist philosophy emanates from the work of Charles Sanders Peirce

(1839-1914), William James (1842-1910), and John Dewey (1859-1952). Pragmatism charts the path of practical effects, problem-solving, and action (Peirce, 1878, p. 286). Proponents of pragmatism contend that thought should be utilised as a tool to predict, act upon, and solve problems rather than describe, represent, or reflect reality(James, 1909). John Dewey developed a pragmatic theory of inquiry to provide intelligent methods for social progress (Dewey & Ross, 2008). John Dewey's pragmatist ideology informs the current study because it is considered "the most detailed and developed"(Biesta, 2010, p. 97) form of pragmatism. In Dewey's pragmatic theory, answers are sought regarding "knowledge, reality and the conduct of inquiry" (Biesta, 2010, p. 97). Therefore, Dewey's pragmatism regards research inquiries as flexible, context-specific, and dedicated to the well-being of individuals and the community (Jones, 2014). This current study employed John Dewey's pragmatist theory to further understand the fundamental concepts of ontology, epistemology, theoretical model, and methodology, as discussed in this chapter.

In Ghana, accusations of witchcraft against older women have been of interest to academics and health and social welfare sectors for many decades (Adinkrah, 2011). Nevertheless, in-depth explanations and records of the perspective and experience of the older women at the witches' camp are scarce: see Chapter 2, the literature review, where this is outlined. It is assumed that inequalities exist in the world. Therefore, pragmatic paradigms provided an in-depth explanation and, equally, aimed to provide practical, grounded recommendations to improve a marginalised community's mental health. This study brings together a heterogeneous variety of views to argue that pragmatism has the propensity to engage and empower marginalised and oppressed communities and provide hard evidence for the macro-level discussion. There is no point in identifying the problems and indicators that impact marginalised communities' social and health conditions without recommending approaches to alleviate the inherent social injustices.

Tashakkori et al. (1998) argued that pragmatism is constructed on the proposition that researchers should use the philosophical and methodological approach that works best for the research problem being studied. A single quantitative or qualitative methodology was considered inadequate to answer the research question and achieve the study's aims, as outlined in the above section. The literature review revealed that

the mental health issues among older women in profoundly marginalised communities had not yet been examined. A mixed-method approach was deemed to be the best approach in that it aligns well with a pragmatic stance to explore this phenomenon and fully appreciate the problem. The best method is the one that aligns the internal consistency with the research aim and objectives, and change is the underlying aim. "We need a moral and methodological community that honours and celebrates paradigm and methodological diversity" (Denzin, 2010, p. 425). The current study therefore utilised a mixed-method research approach that fits and allows methodological diversity to address the phenomenon.

4.5 Mixed-methods research

A mixed-methods approach is characterised by combining at least one qualitative and one quantitative research constituent (Schoonenboom & Johnson, 2017). The mixed-methods approach represents an alternative research methodological approach to traditional qualitative or quantitative research approaches, facilitating the undertaking of a detailed exploration of complex phenomena by health researchers (Halcomb & Hickman, 2015). There is continuous tension around the definitions and differences between mixed-methods and 'multi-methods research'. Nonetheless, there is a level of agreement that mixed-methods research is slightly different to multi-methods research (Halcomb & Hickman, 2015; Halcomb & Andrew, 2009). While mixed-methods research combines qualitative and quantitative research in a single study, multi-methods research involves data collection using two methods from the same paradigm (Halcomb & Andrew, 2009). Mixed-methods research has several strengths associated with its use, making it useful for researchers and health practitioners (Creswell, 2014).

The mixed-method approach was defined by Johnson et al. (2007) as:

> the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e. g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration. (p. 123)

The mixed-methods approach developed because of the paradigmatic disagreements between quantitative and qualitative approaches. Many authors back in the 1960s and 1970s contended that each approach entailed different philosophical and paradigmatic assumptions and therefore made arguments in ways that were not compatible with each other. Nonetheless, the dual paradigms accelerated after a reconciliation during the 1980s (Darracott, 2016). The mixed-methods approach has many strengths; it allows a research question to be studied from different perspectives. The approach also allows the methods respective strengths and weaknesses to complement one another. (Wisdom & Creswell, 2013). It can also strengthen the findings, ensuring the triangulation of the two methods (Regnault et al., 2018). It is suggested that students are more likely to benefit from using a "roadmap" for a mixed-method design (Polit & Beck, 2012).

The mental health and emotional well-being issues of older people are complex and diverse and can require multiple study methods to explain them. A single method, qualitative or quantitative, can be helpful but might be inadequate in addressing such complexities. The general purpose and central premise of mixed-methods studies are that combining qualitative and quantitative approaches provides a better understanding of research problems and complex phenomena than either approach alone(Lee, 2019).

4.5.1 Selecting the type of mixed-methods design

Literature has provided different typologies for classifying mixed-methods designs (Creswell & Clark, 2011; Teddie & Tashakkori, 2009). Design typologies were useful primarily because of their value in communicating an approach to others in research theses and articles. Creswell & Clark (2017) recommended three core mixed-method designs: convergent parallel, explanatory sequential, and exploratory sequential. Mixed-methods researchers need to familiarise themselves with the core types of mixed-methods designs and the critical decisions behind these designs to adequately consider available options (Creswell & Clark, 2017). Convergent designs implement quantitative and qualitative strands concurrently and mix the two to interpret the study findings. Explanatory sequential mixed-methods design involves two phases: the collection of quantitative data in the first phase, the analysis of the results, and then using the results to plan (or build into) the second qualitative phase. The exploratory

sequential mixed-methods strategy is a two-phase in which the researcher first collects qualitative data and then uses the qualitative phase results to build on for or inform the second quantitative data collection and analysis (Creswell & Creswell, 2017). This study utilised a criterion used in the research literature to inform an exploratory mixed-methods designs. The general goal of employing a mixed-methods research approach in this current study is to expand and strengthen the study's conclusions and contribute to the published literature (Schoonenboom & Johnson, 2017).

The key design decisions include sequencing, prioritisation, and integration. For example, a mixed-method study in Rwanda(Betancourt et al., 2011) evaluated a family-strengthening intervention and examined the mental health problems facing HIV-affected children utilising an exploratory sequential approach and began with a qualitative phase of interviews. The researchers then conducted an extensive review to locate standardised measures that matched their qualitative findings(Betancourt et al., 2011).

The approach applied in the current study was the exploratory sequential design, a two-phase method. An exploratory sequential mixed-methods approach is a design in which the researcher begins by exploring qualitative data and analysis and then uses the findings to inform the second study, the quantitative study (Creswell, 2003). The qualitative data were collected first, then analysed, and then the quantitative data were collected (Creswell & Clark, 2007). This study used this sequential mixed-methods approach to provide a more robust set of results with triangulation between the qualitative and quantitative research. In the mixed-methods approach, the assumption is that collecting diverse data types best provides a more complete understanding of a research problem than quantitative or qualitative data alone (Creswell, 2014c).

I used the main themes from the analysis of phase one and the literature review to identify the Hospital Anxiety and Depression Scale which was used in the phase two study. After the phase one thematic analysis, anxiety and depressive symptoms were the central manifestations that emerged, and this necessitated further inquiry.

This study, therefore, aimed to understand the factors influencing the mental health and emotional well-being of older women at the witches' camps of northern Ghana.

This study consisted of multiple phased approaches using the two primary methodologies, qualitative and quantitative. The approach was born out of the nature of the research aim, and the researcher's interest. I recognised that qualitative and quantitative methods could help address the research objectives. (Creswell & Clark, 2017c) further advised researchers to meticulously select a design that best matches the research problem and that researchers need to consider mixing to implement and describe the study. This mixed-methods study explored and illuminated the societal inequalities and social injustices and suggested grounded recommendations for improving the lives of women in the camps. Creswell (2013) noted that researchers sometimes collect qualitative data to inform structured instruments for use in research or practical applications. The reason for collecting both qualitative and quantitative data was to understand the phenomenon under study and generate new knowledge while suggesting an evidence-based approach to better the lives of these older women and their mental health and emotional well-being. Therefore, using various data sources and analyses, the mixed-methods approach was suitable for addressing gaps in knowledge and understanding the complexities of older women's well-being as residents at the witches' camp.

It is also argued that mixed methods provide a better and more comprehensive understanding of research problems because they address exploratory questions, provide more robust inferences, and allow varied views to be conveyed (Tashakkori et al., 2003). The central premise of this approach is that qualitative and quantitative methods provide a better understanding of the research problem than a single approach alone (Creswell & Clark, 2017c).

4.6 Chapter summary

This chapter presented the methodology applied to address the research aims. The main purpose of the study and the specific research questions were highlighted. The chapter detailed the philosophical stance underpinning the study, pragmatism. In this chapter, I presented the mixed-methods design and the justification for selecting the exploratory sequential mixed-methods approach.

Chapter 5 Research methods

5.1 Introduction

The previous chapter presented the philosophical and methodological approaches that guided the current study's design. In this chapter, the researcher provides an overview of how the mixed-methods research design was employed to answer the research questions. Additionally, I discuss the ethical considerations and approval processes for Phases One and Two. The following sections outline the recruitment, sampling, data collection, analysis, and approaches for both phases, including the use of photo elicitation analysis in Phase One.

5.2 Overview of research methods

The current study utilized a mixed-methods research design due to the lack of knowledge on the mental health and emotional well-being of older women living in witches' camps in Ghana. Obtaining both qualitative and quantitative data was essential to understanding the factors that impact this population's mental health and emotional well-being. The study employed an exploratory sequential mixed-methods design, where qualitative and quantitative data complemented each other to address the research aim and objectives.

In Phase One, a qualitative interpretive descriptive design was utilized to explore the mental health and emotional well-being issues commonly experienced by older women in the witches' camps of northern Ghana. The focus was on identifying key themes relevant to women's mental health and emotional problems, as well as ways to improve their mental health and social care provisions.

After Phase One, an appropriate tool was identified to measure anxiety and depression symptoms. Based on the literature reviewed, the Zigmond and Snaith (1983b) HADS was deemed the most appropriate. A linguistic and cross-cultural translation of the HADS was then conducted to reflect the cultural context of the research participants in northern Ghana. In addition to the HADS, supplemental questions were developed by the researcher to address significant issues not captured by the HADS, which were included in Phase Two of the study.

Creswell (2014b) recommends that in an exploratory sequential mixed-methods design, the researcher begins by exploring qualitative data and analysis before using the findings to inform the second quantitative phase. In this study, the Phase One results were used to identify or develop a tool that reflects the cultural setting of the participants for the measure used in Phase Two.

Phase Two of the study involved practically administering the translated HADS and supplemental questions to older women in two witches' camps, as well as women from the general population. This allowed the researcher to compare the prevalence of anxiety and depression symptoms between women in the camps and those from the general population to determine whether staying in the camps impacted women's anxiety and depressive symptoms. **Figure *5.1*** provides an overview of the research methods used in each phase, while Table 5.1 articulates how the two phases and activities of the study align with the study objectives.

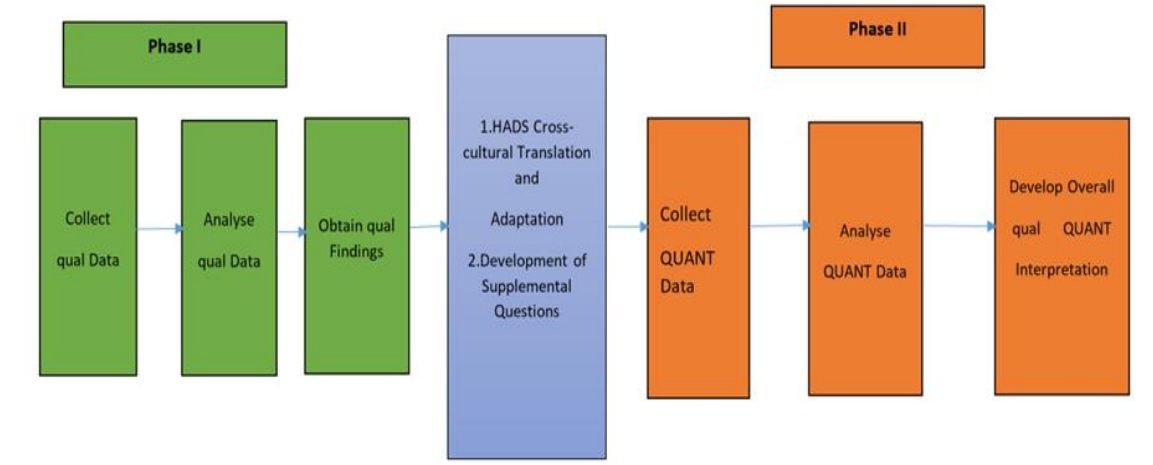
Table 5.1

Phases and activities aligned to the objectives of the study

Phase	**Objective(s) and Activities**
I: **Qual** Interviews, photos,	1. What are the common mental health and emotional challenges faced by these women? 2. How do their socio-cultural practices and emotional needs influence their health-seeking behaviours?
II: **Quant** Pilot test, translate HADS tool	1. What are these women's experiences of accessing health care services? 2. What are the recommendations from these women and allied stakeholders serving this population group?

Figure 5.1

Overview of research methods



5.3 Ethical considerations

The study obtained ethical approval from the Auckland University of Technology Ethics Committee (AUTEC) in New Zealand, with reference number 19/213. The approval process was done in stages, starting with the stakeholder interviews with government and NGO officials and the Earth Priest in July 2019. AUTEC required complete information about the interviews with the women before any recruitment or data collection for that stage occurred. They also needed clarification on how voluntary consent was to be assured, counseling support provided for women participants should there be a need, provision of the structured interview instruments, and evidence about further consultation around cultural appropriateness and safety. The points raised were all addressed and submitted to AUTEC, and full approval was granted on September 17, 2019.

As the research setting was overseas, local ethics approval was also required in Ghana. The researcher, with the help of a field supervisor (Dean for the School of Nursing and

Midwifery, University of Ghana), applied for ethical clearance from the Ghana Health Service Ethics Committee on August 6, 2019. The Ghana Health Service Ethics Committee required full ethical approval from AUTEC to complete the application process. The application was reviewed on September 25, 2019, and the full ethics approval letter from AUTEC was requested. The approval was granted on November 8, 2019, with an approval number GHS-ERC002/09/19.

Due to the COVID-19 pandemic, changes were made to the research process, such as taking de-identified photos of the camp structures and conducting online interviews for stakeholders. An amendment to the ethics approval was made, and it was approved by AUTEC on June 23, 2020. The researcher submitted an ethics progress report (EA2) to AUTEC on June 8, 2021, which was noted by AUTEC on July 5, 2021. Appendices contain the approval documents in pages 256 - 264.

The Phase Two study design followed the ethical considerations outlined below:

In February 2020, I obtained permission (Ref no. 6293456580) from GL Assessment to use the HADS. Please see Appendix F for more details.

- Mapi Research Trust granted permission (Number: 2102086) for the translation of the HADS from English to Dagbani. Please see Appendix *H* for more information.

- I sought permission from the Ghana Health Service Ethics Committee (GHS-ERC002/09/19) to conduct Phase Two at the witches' camps. Please refer to Appendix *B* for further details.

- All potential participants were given written and verbal information about the study.

- Potential participants who expressed a willingness to participate in the study were provided with an information letter containing details of the study and asked to provide written informed consent.

- Throughout the study, participant privacy and confidentiality were maintained by using code numbers instead of real names on all HADS questionnaires. The

researcher stressed the importance of not sharing the details of the discussion with others outside of the interviews. Participant details in the records, transcripts, and research publications were changed to maintain confidentiality.

- Overall, during the ethics application and preparation, I understood the need to protect and be accountable to highly vulnerable groups when undertaking research. I came to understand the difficulty in studying within complex social and political environments while striving to uphold ethical principles.

5.4 Implementing the Phase One Study: Qualitative design

This section presents the methodology used for the Phase One qualitative study. It includes details about the research design, research setting, participant recruitment, inclusion/exclusion criteria, sampling technique, development of the interview guide, gaining access to the research site, data collection procedures, and qualitative data analysis procedure, as well as measures taken to ensure rigor.

5.4.1 Phase One: Research design

The Phase One study employed an interpretive descriptive design. The interpretive description (ID) strategy is a qualitative research method rooted in nursing science (Thorne, 2016), aligned with a constructivist and naturalistic orientation to inquiry (Thorne, 2008). Constructivists assume that reality is constructed through the meaning and understandings developed socially and through experience and observation, indicating that we build knowledge through our experiences and social interactions with other people (Guba & Lincoln, 1994). The ID approach was first proposed in 1997 by Thorne, Kirkham, and MacDonald-Emes as a noncategorical methodological approach for applied disciplines (Thorne et al., 1997). Open-minded methodologies are advocated for by Thorne et al. (1997), which have inherent flexibility, contextually crucial for the current study, which needed inherent flexibility and responsiveness to settings. The study explored the meaning of human experiences and actions to facilitate the inquiry into the central phenomenon of the study with older women in the witches' camps of Northern Ghana.

5.4.2 Interpretive description

The interpretive descriptive approach is concerned with the systematic construction of individuals' experiences and their worlds, as well as the meanings they ascribe to their lives, within the context of the social settings that shape their reality. This approach is rooted in the constructivist and naturalistic epistemologies and is based on a non-categorical methodological approach that is flexible and responsive to the contextual needs of applied disciplines. Thorne (2008) defines ID as a research method that aims to develop a deep and rich understanding of a particular phenomenon by systematically examining the experiences of individuals and the meanings they ascribe to their lives within the context of their social and cultural settings.

The definition of ID by Thorne (2008) provides further clarification:

> Interpretive description is a qualitative research approach that requires integrity of purpose deriving from two sources: (1) an actual practice goal and (2) an understanding of what we do and do not know based on the available empirical evidence (from all sources). It constitutes a method that generates questions from that grounding, pushes one into the "field" in a logical, systematic, and defensible manner, and creates the context in which engagement with data extends the interpretive mind beyond the self-evident … to see what else might be there. (p. 35)

Since its inception, interpretive description has been applied by key health researchers in various applied health disciplines to provide a logical structure and philosophical rationale for design decisions in qualitative inquiries (Morse, 1994; Morse & Chung, 2003; Sandelowski, 1993). It establishes conceptual linkages that support the location within the general, the state within the process, and the subjectivity of experience within the commonly understood and objectively recognized conventions that contemporary healthcare contexts represent as the temporal and symbolic location for health.

Thorne (2008) has consistently emphasized the practical nature of ID, focusing on inquiry that addresses a practice question so that research can be most useful to practitioners in the social nature of practical work and action. This understanding of health experiences helps guide real practice decisions made by healthcare professionals (Thorne, 2016), which is consistent with the primary purpose of this

research, which aimed to generate knowledge that could influence recommendations for policy directions on addressing the mental and emotional health of older women in the camps. Moreover, ID allowed for flexibility in data collection while still being able to inform and influence future practice rigorously.

To begin with, I conducted an extensive review of ethnography (Fetterman, 2010; Roper & Shapira, 2000) and focused ethnography, in search of a methodology suitable for use in a culturally diverse location and a transformative approach. However, I adapted Thorne et al. (1997) ID for the current study because it aimed to understand the subjective experiences of older women and their mental health concerns within Ghana. Moreover, ID has the capacity to generate research that focuses on deeply personalised experiences and tentative truths and how they are communicated to professionals, educators and policymakers (Rashid et al., 2015; Stahlke Wall, 2014), making it an appropriate choice for my study. Unlike the grounded theory approach or ethnography, ID aims to influence practice rather than theorising, promoting a means of rigorously generating novel knowledge and understandings involving direct and accessible experiences, individualised and implicit aspects of the human health experience (Thorne, 2016), and in my research, highly sensitive and first-time data.

5.4.3 Setting

This study (Phase One) was conducted in Gambaga, a community in northern Ghana (see Chapter 1, section 1.1.3). The ethnic composition of the Gambaga community includes Mamprusis, Bimobas, Konkombas, Dagombas, and other minority groups (Npong, 2014). It is important to note that the majority of women in the Gambaga camp come from the Mamprusi and Bimoba ethnic groups, which are the dominant groups in the northeastern region of Ghana.

The Gambaga witches' camp is made up of approximately 25 round huts that house around 100 women. It is important to note that the camp lacks social services such as health facilities, although there is a health post in the nearby Gambaga community staffed by a community nurse. Women in need of medical attention are often referred to the Nalerigu Baptist Medical Center, which is about 8 kilometers away. The camp has a mechanised borehole that provides water for the women, but it cannot be used for drinking. In addition, the camp lacks indoor plumbing and standing pipes, which are

common in most northern homes. There is only one toilet facility available, and it is separated from the camp's living quarters. Consequently, most women resort to using the surrounding bush for their sanitation needs. The camp has a lobby area, which contains a small office used by the social worker. The lobby's roofing consists of zinc sheets, with wire netting providing ventilation during meetings. Women inside the lobby sit on benches, and the space is utilised for meetings and church services. Women in the camp practice the three dominant religions in Ghana: Islam, Christianity, and African traditional religion.

As mentioned in Chapter 1, Section 1.1.8, the study participants reside in "witches" camps, which are settlements where individuals suspected of witchcraft can seek refuge to avoid being lynched by their neighbours (Bekoe, 2016). These camps were established as safe havens where witchcraft could not be practiced, providing a secure environment for those accused of being witches (Action Aid, 2012). There are five such camps in northern Ghana, namely Kukuo Camp in Bimbila, Gnani Camp in Yendi, Kpatinga Camp in Gushiegu, and Gambaga and Naboli. The Gnani camp is the largest in Ghana (Baba, 2013); however, the oldest and ancestral home of all the people of northern Ghana is the Gambaga witch camp (THUDEG & Anti-Witchcraft Allegation Campaign Coalition, 2011), **as shown on the map** in **Figure *1.1*** above.

5.4.4 Gaining access to the field

The primary researcher's approach to the consultative procedures was influenced by their knowledge and understanding of the study site and socio-political context. The researcher recognized that social hierarchies are respected in the Ghanaian context, and therefore, building appropriate informal relationships with the Earth Priest and other key stakeholders in the research setting was crucial to gaining access to the camp, establishing relationships, and conducting pilot and main interviews (Hammersley & Atkinson, 2007).

Furthermore, the highly marginalized population under study requires sensitivity in establishing and maintaining appropriate relationships with community members to facilitate mutual understanding between the researcher and participants as the relationship develops. Understanding the values, beliefs, and underlying forces that

make up the cultural system is essential for maintaining respectful entry into the community (Stahlke Wall, 2014).

The primary researcher's understanding of power relations and traditional authority structures was essential to gain access to the field. By establishing appropriate relationships with the Earth Priest and other social actors, the researcher gained necessary information to understand the dynamics, navigate cultural sensitivities, and minimise conflict that could adversely affect data collection (Hammersley & Atkinson, 2007). Contacting the Earth Priest and appropriate traditional authorities, persons, and organizations was crucial in gaining access and piloting the study. The Gambaga witch camp was chosen for convenience and because it is one of the oldest camps in northern Ghana. As a member of the Mole-Dagbani ethnic group and the family of the "gong gong" beaters, the researcher understands from history and stories told by elders that Gambaga is the ancestral home of the three main ethnic groups (Dagbon, Mamprugu, and Nanung), and all three settled there during their expeditions to conquer lands and expand the Naa Gbewaa state. Therefore, choosing the Gambaga witches' camp for the fieldwork was central to ethically informed access to participants and to address the research aim in the first phase of the study.

To ensure respectful and appropriate access, the primary researcher made two visits in August and September 2019 to the Earth Priest of the Gambaga witch camp to acknowledge customs and appease the skin. Chiefs in the Mole-Dagbani ethnic group sit on animal skin as a sign of chieftaincy, much like the British Queen wears a crown. The Earth Priest, known locally as ‘Tindana’, leads the sanctuaries, and the Dagbani term ‘Tindana’ means ‘the one who owns the land’. As the physical custodian of the camp, the Earth Priest's blessings were essential before any field visit, and the Earth Priest also perform rituals to determine the guilt or innocence of the accused.

To ensure successful entry and engagement in the field, it was important to establish rapport and maintain positive relationships with the participants. By doing so, they felt comfortable expressing their opinions to both me and the female RA without any barriers (Chua & High, 2009; van der Borgh et al., 2019), thus encouraging their autonomy.

To gain access to the camp, I followed the gatekeeper's approach. I was introduced to the Assemblyman of Gambaga by a colleague who worked in healthcare. The Assemblyman is a community leader who resides in the oldest witches' camp in northern Ghana. As a sign of respect, I visited the Earth Priest's home and presented cola nuts as a traditional ceremonial gift, in accordance with local customs. In northern Ghana, it is customary to bring a gift when visiting an elder, and cola nuts are often given and shared as a symbol of hospitality. As the Nigerian writer Achebe and Irele (2009) aptly put it, "he who brings cola brings life". Cola nuts are widely used in Ghana and many West African countries for traditional hospitality and cultural and social ceremonies.

I explained the purpose of my visit and research to the Earth Priest and gifted him the cola nuts. He granted me access to the camp after understanding the study's objective. After one month, I revisited the community and met the Assemblyman for the second time. We then went to the Earth Priest's palace, where a palace boy was asked to lead me to the camp to meet the social worker and the "magaazie" (women's leader). I presented more cola nuts and explained the purpose of my visit and research to the social worker and magaazie. After two weeks, a date was set to test my indicative questions in the form of an interview in the camp. The palace boy advised me to get beverages, sugar, soap, and salts if I could afford them so that we could present them as support, as most of the women in the camp need help with these items. On my next visit, I presented the purchased items along with the interview questions to pilot the Gambaga witches' camp study.

5.4.5 Development of the semi-structured interview guides and approach to the interviews

The development of the semi-structured interview guide was an iterative process that began with the identification of open-ended questions from the literature review. The first interview guide was reviewed by my supervisors, and a field supervisor Professor Lydia Aziato, including a Ghanaian national who was an academic and lecturer of mental health nursing. Subsequently, the questions were reviewed and worded to reflect the laypersons' understanding of mental health and emotional well-being, considering the potential psychological effects of reminding the women of their pain

and stress. I also encouraged the women to share their experiences in the camp and life before coming to the camp while being mindful of their emotional state.

To ensure cultural appropriateness and support content validity, I organized a meeting with my field supervisor in her office to review the indicative questionnaire before seeking local ethical approval. In addition, I consulted with a mental health lecturer from the Department of Mental Health Nursing at the University of Ghana and a member of the local supervisor's staff to review the indicative questionnaire for cultural appropriateness and content. After receiving their feedback, minor modifications were made accordingly.

The indicative questions began with collecting biographical data from all study participants. Separate sets of biographical questions were developed for the women and allied stakeholders and included information on age, gender, educational status, and place of work.

The semi-structured interview guide for the study was developed through an iterative process that began with open-ended questions identified from the literature review. Biographic information questions were also developed separately for the women and allied stakeholders, including age, gender, educational status, and place of work.

The interview with the women in the Gambaga witches' camp began with general questions about their health and well-being, their understanding of mental health, perceptions of the causes of poor mental health, and any services they felt they needed. Additional questions on stigma or what others thought about them were included in subsequent interviews to probe deeper into their experiences. Separate interview guides were developed, and content validated with a mental health lecturer and my field supervisor for the three allied stakeholder groups in the study, including staff members from the Ministry of Gender, Children and Social Protection, mental health professionals from the Ministry of Health, and a social work/NGO support organization (see Appendix E).

The interviews with the allied stakeholders began with a general question requesting participants to tell the researcher about themselves, serving as an icebreaker. The interview guide for the social worker working in the Gambaga witches' camp centred

on 'what witchcraft is', followed by questions about the general health concerns reported to him by the women in the camp and the socio-cultural and emotional needs and practices that influence the women's health-seeking behaviours and perceptions of women's experiences in accessing healthcare services while living in the camp. The final question was about ways to improve the mental health and emotional well-being of the women in the camp and the social care provisions that would improve their lives. The allied stakeholder interview guide was further reviewed after the first interview at the Gambaga witches' camp to accommodate the different participant groups.

To develop a culturally appropriate and content valid semi-structured interview guide for allied stakeholders, a meeting was held with my field supervisor and a mental health lecturer from the Department of Mental Health Nursing, University of Ghana. The indicative questionnaire was reviewed for cultural appropriateness, and minor modifications were made. Separate interview guides were developed for each of the three allied stakeholders: a staff member from the Ministry of Gender, Children and Social Protection, healthcare professionals from the Ministry of Health, and a social worker/NGO support organization.

The interviews with the allied stakeholders began with a general question about themselves to serve as an icebreaker. The allied stakeholder interview guide was further reviewed after the first interview to accommodate different participant groups. For the social worker working in the Gambaga witches' camp, questions centered around witchcraft and general health concerns reported by the women in the camp. Questions also focused on socio-cultural and emotional needs that influence the women's health-seeking behaviours and perceptions of women's experiences in accessing healthcare services while living in the Gambaga witch camp. The final question was about ways to improve the mental health and emotional well-being of the women in the camp and the social care provisions that would improve the lives of the women in the camp.

The Ministry of Gender, Children and Social Protection staff member was asked about their involvement in social protection for women, how the ministry helped improve social care provisions for women, and their perceptions of women's experiences in

accessing health and other social care provisions. Social support was explored by asking about the ministry's existing support for women living in the witches' camps.

For healthcare professionals from the Ministry of Health and the policymaker, the interviews began with questions about common mental health problems associated with older people and women with social exclusions, and the existing support systems available for the witches' camps. These questions were then followed up from initial discussions concerning the women's health in the camp. Specific questions about the establishment and experiences in managing the camp were asked of the social worker, along with common health concerns, health care support given to the women, and suggestions on how to improve the women's well-being.

All allied stakeholder interview guides concluded with exploring the need for health service and policy directives that met mental health and emotional needs in terms of culturally appropriate health and social care provision for the women.

5.4.6 Translation of the interview guide for the women

To ensure cross-cultural accuracy, the indicative semi-structured interview guide for women was translated into the local language Dagbani by a professional translator. The translated guide was then back-translated into English by an independent translator, and two English versions were compared. A Ghanaian national and lecturer from the Nursing Department at the University for Development Studies independently reviewed the English versions, and minor modifications were made to the original guide for improved clarity. The allied stakeholder guides did not require translation as these interviews were conducted in English.

5.4.7 Piloting the semi-structured interview guides

In In the initial pilot study, three older women who met the inclusion criteria were recruited from the Gambaga witches' camps with the assistance of a social worker. During the pilot phase, an NGO visited the camp to provide training on personal hygiene and soap making to the women. The interviews took place in the courtyards of the huts where the women resided. The demographic characteristics of the women selected for the pilot test are as follows: The first participant was estimated to be 90 years old. She indicated that she had been living in the camp for approximately 20

years (please note that ages are often unknown due to the absence of birth records). The second interviewed woman was 60 years old and had been residing in the camp for three years. The third woman stated her age as 80, and she had been living in the camp for five years. All three women were from northern Ghana, with two belonging to the Mampruli ethnic group and one from the Bimoba ethnic group. They had been living in the camp without any family members or support. Unfortunately, the 90-year-old woman passed away a few months after the interview, during the height of the pandemic. The cause of her death was unclear, but the social worker suspected it to be COVID-19.

The pilot study was conducted independently of the main study to allow the researcher to pre-test the indicative Phase One semi-structured interview questions, assess the timing, and uncover any ambiguity. It also provided the researcher with an opportunity to gain familiarity with conducting research interviews and to identify any potential difficulties that might arise in the primary interviews. Additionally, it allowed the researcher to double-check the practice and training given to the research assistant for the interviews. The women had all been living in the camp without any family members or support.

The pilot study indicated that the interviews with the older women lasted between 45 minutes to 1 hour, with sufficient breaks. Therefore, there was no need to extend the interview time during the main study. However, the cultural setting where this study was conducted required some additional preparation to establish rapport with the participants. The pilot interviews helped the researcher to become more familiar with the camp's setup.

To create a positive rapport and allow the older women to ventilate their opinions, the primary researcher found it necessary to enable participants to begin by discussing their admission into the camp and their life before entering the camp. Although this, to some extent, triggered emotional responses, this was managed accordingly by stopping the interviews in some cases, as per AUTEC requirements. The participants were referred to the social worker, who was also their pastor.

Reflecting on the pilot, the primary researcher realised that a more detailed self-introduction was necessary during the main study to establish a positive rapport. The

questioning line needed more probing to ensure that respondents gave more detailed information and descriptions. The participants needed to be guided and directed towards the topic of mental health and emotional well-being, while being mindful of the feelings that could affect and upset them. Participants primarily talked about their physical health problems. Upon reflection with supervisors, including the field supervisor, the primary researcher realised that they needed to ask more personal questions, particularly about mental health and emotional well-being and symptoms, without traumatising the women's mood and psychological well-being. They then followed up with the "why," "how," and "where" questions. Reflecting on this, the same mental health expert who had provided input reviewed the interview questions and confirmed that most people with mental health problems would sometimes complain about their physical health problems first, so a decision was made to ask about general health initially.

In summary, the pilot study expanded the researcher's understanding of the women's lives and the camp's setup. In consultation with supervisors, the researcher realised that they needed to amend the ethics approval for the study to include environmental observation of the camp by taking de-identified pictures of the women's homes. The ethics application was amended, submitted to AUTEC for review, and approved on June 23, 2020.

Additionally, the researcher conducted a pilot study to test the interview guides developed for the allied stakeholders, which included NGO staff, gender and social welfare ministry staff, and Ministry of Health staff members. The field supervisor assisted in organizing a pilot interview with one of her staff members who was a mental health lecturer and researcher. From the pilot study, the researcher learned the importance of staying focused on the research question and using probing questions as invitations for participants to share their thoughts.

5.4.8 Study participants

In Phase One of this study, the participants were older women from the Gambaga witches' camp, and three allied stakeholders were also included. The next section outlines the inclusion criteria for the women from the Gambaga camp. The stakeholders consisted of a staff member of the Ministry of Gender, Children and

Social Protection under the social welfare department, a staff member of the Mental Health Authority, and a social worker/NGO who worked in the Gambaga witches' camp and had specialized knowledge or information about the camp. These individuals were actively involved in the camp's activities and the phenomenon of witchcraft accusations. The stakeholder interviews were essential because they played a significant role in the camp. For instance, the staff member of the social welfare department had the mandate to ensure that the welfare needs of older people in Ghana and the camp residents are provided, especially their basic welfare needs such as food and health (Baba, 2013). The social worker/NGO had relevant insights into the camp conditions and the residents' livelihood conditions as he worked there to support the Gambaga witches' camp's residents (Baba, 2013).

In this research context, multiple sources of information or data were used to validate the data about the phenomenon under study and inform the trustworthiness of the generated findings. Triangulation, as defined by Carter et al. (2014), involves using multiple data sources in qualitative research to develop a comprehensive understanding of phenomena. Furthermore, including stakeholders informs the acceptability of the study's recommendations, as well as the direction and formulation of policymaking.

Eligibility criteria for older women:

The eligibility criteria included

- Older women living in a witches' camp
- Lived at least six months in the witches' camp and
- Able to engage in a conversation in the local dialect (Dagbani or Mampruli language).

Exclusion criteria for older women

- Any woman who is living in the camp as an accused person but identified herself as being younger were excluded.

- Also, any resident who was less than six months old in the camp were excluded from this study because experiences within the camp enhanced the richness of this study's data.

- Any NGO officer who has not been working with the women for more than three months was not recruited.

- Serious mental illness or physical ill-health as diagnosed by a qualified medical practitioner was an exclusion.

- Family members of the women accused women were excluded

Eligibility criteria for allied stakeholders:

Eligible allied stakeholders were

- 18 years of age or older and were

- Familiar with the cultural phenomenon of witchcraft practice.

- Play a lead role in the witches' camp ritual are related stakeholders, such as key staff from the Ministry of Gender, Children and Social Protection, or social worker/NGO in the camp - who supported and saw the welfare of the women in the camp in their daily activities.

- Policymaker from the Ministry of Health

To achieve the objectives of the study, key staff members from the Ministry of Health, Ministry of Gender, Children and Social Protection, and NGO officers with formalized service roles in the camps or critical roles in government policymaking that affect women and older people's health were included as stakeholders. The purpose of their inclusion was to solicit recommendations on health service and policy directions that address the mental health and emotional needs of the women through culturally appropriate health and social care provision, thereby improving their lives.

Exclusion criteria for allied stakeholders

- Excluded were any key stakeholders, such as NGO workers in the camp, who were on duty leave.

5.4.9 Sampling and recruitment methods

Selection of Women Participants:

The study utilized purposive sampling (Creswell, 2003) to recruit older women as participants. Purposive sampling involved the selection of older women who had experienced the central phenomenon or key concept being studied. Participant recruitment was based on a sampling strategy that aimed to cover diverse demographic characteristics, including age (over 40 years), tribe, ethnicity, and region, to ensure varied perspectives on the phenomenon (Patton, 2002). The study recruited older women primarily from the Gambaga witches' camp for the qualitative interviews. The Gambaga witches' camp is the oldest in northern Ghana. In interpretive research design, the researcher seeks participants with in-depth knowledge and experience of the topic under study.

Selection of Allied stakeholders Participants:

Allied stakeholders were recruited using purposive sampling (Creswell, 2014a) based on specific inclusion criteria. These individuals had direct experience with the witchcraft phenomenon and/or were involved in the welfare of women in the camps. They were also involved in policy directives that affected the women in the camps. The stakeholder groups recruited for this study included a mental health policymaker who worked as a psychiatrist, an officer from the Ministry of Gender, Children and Social Protection (social welfare department), and a social worker. The mental health policymaker was recruited because their policies directly affected women in the camps with mental health problems, and they had scientific knowledge of mental health. The officer from the Ministry of Gender, Children and Social Protection was recruited due to their department's involvement in social welfare, and the social welfare worker was chosen due to their work in the Presbyterian Go-Home Project program, which operates in the Gambaga camp and supports the women (Delali, 2020). The social worker had worked in the Gambaga camp for 10 years and had direct knowledge of the day-to-day activities in the camp (Jeff, 2020; Wuni, 2017).

5.4.10 Recruiting the women and allied stakeholders

As discussed in section 5.4.4, a local representative facilitated the recruitment of older women. A nurse colleague introduced the researcher to the son of the Earth Priest and

the social worker, who then introduced the researcher to the Earth Priests and the social worker/NGO agencies involved in advocacy against witchcraft and working with the women. In August 2019, the Earth Priest was revisited with a gift of cola, and permission was sought to enter the camp. The process of gaining access took two weeks due to its importance. The women at the Gambaga witches' camp were informed of the proposed research project and recruitment process through the social worker in the camp. The voluntary nature of the research was explained to each woman, and the Participant Information Sheet (PIS) (see Appendix Q) explained the research project's anonymity. Women were given two weeks to consider their participation.

Potential interviewees who expressed interest through the social worker were allowed to ask questions in person to the female research assistant. Before the women thumb-printed the consent form, the researcher and the research assistant explained important matters involving confidentiality and privacy protection. These included the use of participant IDs instead of names and confidential arrangements for data storage and disposal. The nature of the research required establishing and maintaining appropriate relationships with members of the camp and community to allow for understanding between the researcher and participants as the relationship developed (Hammersley & Atkinson, 2007). Sensitivities, such as power relations in the hierarchical Ghanaian context, were taken into account to avoid damaging relationships and conflicts that could negatively affect data collection.

A total of 15 older women were deemed eligible, provided informed consent, and were recruited for interviews. The researcher collected thumbprint consent forms before all interviews and gave each participant a copy.

5.4.11 Women's demographics

The ages of the women were uncertain as most women did not have knowledge of their exact ages and date of birth, and there were no records of their ages in the camp. According to the social worker, their ages were usually estimated whenever necessary. Birth registration has been a challenge in Sub-Saharan Africa, and although some African governments have made progress in this regard, many people in the past did not have birth registration, which led to inaccurate age determination (Pirlea, 2019;

Sankoh et al., 2020; United Nations Children's Fund [UNICEF], 2017). Approximately 10 of the women had lived in the camp for more than eight years, and two of them had been there for 12 years. Another two had lived in the camp for about three years. One of the women, was said to be the oldest woman had lived in this camp for about 30 years.

No participant refusals were recorded, except for one woman who appeared emotional and expressed interest in participating in the research but did not meet the inclusion criteria. This woman had been admitted to the camp on the third day of interviews and had previously been accused of witchcraft two years ago. After the Earth Priest performed rituals, it was determined that she was not responsible for the accusation and the accuser was charged. However, she has continued to be stigmatized and suspected in her community and was recently accused again. In this case, the accusers refused to follow-up with the Earth Priest, and no further rituals were performed.

Key allied stakeholders were also recruited for this study, including a social worker (NGO worker in the camps), a staff member from the Ministry of Gender, Children and Social Protection (department of social welfare), and a mental health professional (psychiatrist) from the Ministry of Health. The selection of these stakeholders was purposive, based on their understanding of the phenomena, availability to participate, and ability to articulate their thoughts clearly to help answer the research questions (Creswell & Clark, 2017b; Polit & Beck, 2014). Morse (2016) emphasized that the sampling of participants is an essential process in qualitative research, as each interview shapes the understanding of the phenomena under study.

The allied stakeholders were selected based on their expertise and experiences in dealing with organizations concerned about women's health and social protection. Their unique knowledge was sought to obtain their opinions on the challenges faced by the women in the camp, and to gather recommendations for health service and policy directives that could meet the mental health and emotional needs of these women through culturally appropriate health and social care provision. Please refer to **Table *5.1*** for a summary of the demographic characteristics of the allied stakeholders.

Table 5.2

Stakeholder demographic characteristics

Participant	Age	Gender	Department
SW	38	Male	Gambaga witch camp social worker/NGO
MHA	-	Male	Mental Health Authority – Ministry of Health of Ghana
GM	37	Female	Department of Social Welfare and Gender – Ministry of Gender, Children and Social Protection

Note. PGM= personnel from Gender Ministry; PMHA= Personnel from Mental Health Authority; SW=Social worker.

5.4.12 Data collection

In this qualitative Phase One, face-to-face interviews were conducted with older women at convenient times for them, inside the forecourts of the women's huts, and in a safe and private environment. Establishing rapport and sustaining positive relationships were critical interpersonal approaches to ensure productive fieldwork and informal relationships with key stakeholders within the research setting, which was vital to the conduct of the study (Draper, 2015; Hammersley, 2007). The researcher established relationships with the women and allied stakeholders to promote participants' autonomy so that they could engage with the researcher to express their views freely and without fear (Bourgois, 1990). The interviews were conducted in the Dagbani language, and it was noticeable that the older women were comfortable in a one-to-one interview because they trusted the researcher when the topics were being explored concerning life in the camp. A research assistant facilitated the face-to-face interviews, and the researcher took field notes. Before the interviews, the research assistant signed a confidentiality agreement. Each interview session began by welcoming and thanking participants for accepting to participate in the study, and they were encouraged to elaborate on health and share their experiences and issues that affected their mental health and emotional well-being. A semi-structured interview guide was used for the interviews (see Appendix O), and further probing was done based on the conversations with the women where necessary. At the end of each session, the researcher thanked the participants for sparing time for the interview.

In addition, the researcher conducted face-to-face interviews with the allied stakeholders at a convenient time for each stakeholder. These interviews were conducted in English, as it was the language in which the stakeholders felt most comfortable expressing themselves. Each session began with the researcher welcoming and thanking the allied stakeholder for their participation in the study.

Finally, I took photos of three camps, Gambaga, Kpatinga and Gnani witches camps to expand and shine mor light on the social care provision problems of these camps to provide my readers with pictorial evidence of what really exit in the camps.

5.4.13 Data analysis

The researcher conducted 15 face-to-face interviews with older women in the forecourts of their huts. These interviews were conducted in Dagbani, and the women were encouraged to tell their stories in a safe and private environment. Establishing rapport and positive relationships with the women and key stakeholders were critical to ensure productive fieldwork, which was essential to the study(Gibbs, 2018). A semi-structured interview guide was used for the interviews, and further probing was done where necessary. Each session was started by welcoming and thanking the participants for their time.

The 15 interviews with the women were transcribed verbatim from Dagbani into English text and used for data analysis. As the researcher was fluent in both Dagbani and English, there was no reliance on professional translation services. Thematic analysis was used to systematically identify, organize, and provide insight into patterns of meaning (themes) across the data set, following the method outlined Braun and Clarke (2012b). Braun and Clarke (2012b), defined Thematic analysis as “a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set” (p. 57).

After transcribing each interview, I immersed myself in the data by repeatedly reading and familiarizing myself with the contents. To reduce the amount of data into small chunks of meaning, I manually conducted an initial coding based on the research aim. This was followed by the generation of relevant themes or patterns in the data that were mindful of the research objectives. To ensure the accuracy of the identified themes, my field supervisor and primary supervisors reviewed and modified them. The

preliminary themes were documented in a Word document through 'cut and paste', and I included relevant text from participants' statements to stay focused and avoid drifting away from the relevant points (Bree & Gallagher, 2016). This data was then examined to identify and categorize themes and critical issues that emerged from the data. The coding process allowed me to acquire deep, comprehensive, and thorough insights into the research data while making it easily accessible and retrievable (Skjott Linneberg & Korsgaard, 2019).

In the next stage of the analysis, I defined the themes to help purify them and “identify the ‘essence’ of what each theme was about” (Braun & Clarke, 2006, p. 92). This helped me as a researcher to interact with the theme and understand how the subthemes related to the main themes, as emphasized by Guba and Lincoln (1994). Finally, this stage involved “identifying, analyzing and reporting patterns (themes) within data” in line with (Braun & Clarke, 2006, p. 6). The thematic analysis approach is flexible, allowing for systematic analysis of data in different ways, and is particularly suited to the detailed analysis of content and textual data. Additionally, it is compatible with the SEM, which is one of the philosophical frameworks underpinning this study(Braun & Clarke, 2006).

The final analysis was framed underscored by SEM, which helped identified the layers that corresponded to the codes and themes. The SEM provided a comprehensive understanding at each analytic level. The SEM provided a comprehensive understanding at each analytic level.

In addition to the methods mentioned above, I conducted a photo content analysis to gain a better understanding of how images relate to the mental health and emotional well-being of the women in the witches' camps. Since common mental health problems are linked to demographic and socioeconomic factors and based on the themes from phase one of the study, I examined factors such as the lack of social amenities like freshwater and privacy in the camp. To address these factors and answer the research question, I consulted with my supervisor and field expert, Prof. Lydia Aziato, and decided to analyse photos from the camps. I referred to the UNCHR's minimum standards and best practices of refugee settlements or camps (UNHCR, 2021a, 2022) during the analysis.

5.4.14 Rigor

Rigour refers to the quality of being careful, thorough, and accurate. In qualitative research, it is essential to strive for precision to reflect the trustworthiness of the research outcome. To achieve rigor in this qualitative phase one research, measures were taken to ensure the trustworthiness of the study's outcomes.

To enhance and maintain clarity, the qualitative phase employed the strategies and framework suggested by Whittemore et al. (2001), which include: 1) authenticity, 2) credibility, 3) criticality, and 4) integrity. These measures ensured the trustworthiness of the research outcome.

Authenticity, which involves paying attention to the voices of participants, was maintained by conducting interviews with the women in a private area where they could express themselves freely. For instance, the interviews were held in their rounded huts. Furthermore, the transcripts were checked by my supervisor for accuracy until a consensus was reached.

To ensure the credibility of the research outcome, prolonged engagement and consultations with stakeholders were conducted before, during, and after the fieldwork. Multiple sources of information were obtained, along with expert opinions and reviews, and translation of interview questions to maintain accurate information and elicit participants' true experiences. Women and allied stakeholders were recruited based on the inclusion criteria, and they gave a detailed account of their experiences of the central phenomenon. The women explained how their experiences in the camp affected their health and well-being, and the results were supported with English-translated verbatim quotes from participants.

Criticality, the critical appraisal of every decision made throughout the research process, was achieved through the field supervisor's monitoring of the fieldwork activities, including the development of interview guides and ethical applications. This was to ensure cultural appropriateness and to avoid ethical dilemmas that could affect the study's trustworthiness. In addition, criticality was further achieved and maintained through an audit trail, which provided documentary evidence of the research process.

Integrity was demonstrated by the ongoing reflection and self-criticality of the researcher. The researcher reflected on their own biases and discussed them with their supervisor before data collection and analysis. The purpose was to ensure that the Phase One process was rigorous to build into the Phase Two study design. The findings of this exploratory phase were then used to inform and build into the quantitative phase and measures. According to Creswell (2014c), mixed-methods researchers should pay careful attention to the qualitative data analysis step because it is crucial for informing and building the second, quantitative phase. The next section will describe how Phase Two of the research, the quantitative design, was constructed.

5.5 Quantitative study method: Phase two

This section provides an overview of the research methods used in Phase Two of the study. It includes details on the research design, setting, study participants, inclusion/exclusion criteria, sample size and sampling, and recruitment procedure. Additionally, it describes the measures used in the study, briefly discusses the 'forward-backward' translation of the Hospital Anxiety and Depression Scale (HADS) and outlines the data collection procedures and analysis. Finally, it discusses the ethical considerations applied to address the need for participant protection and manage the inherent complexities in recruitment, engagement, and data handling during Phase Two of the study.

5.5.1 Research design

In Phase Two of this study, a cross-sectional descriptive survey was used to assess levels of anxiety and depression among women in the witches' camps, as well as a sample of women from the general population in northern Ghana. This survey was informed by the thematic findings of Phase One. In addition to assessing anxiety and depression, participants were asked to suggest ways to improve their mental health and emotional well-being in the camps, as well as appropriate social and healthcare provisions to support their mental well-being.

5.5.2 Target population

The target population for this study consisted of older women (as defined in Chapter 1, section 1.1.6) residing in the Gambaga and Gnani witches' camps, as well as older

women from the general population of the Mion district in the northern region of Ghana and the Gambaga community in the northeastern region of Ghana. The Gambaga and Gnani witches' camps were purposively selected as they represent the largest and oldest witch camp facilities in Ghana. During the proposal development stage, it was revealed that the Gambaga witch camp had 100 women and the Gnani witch camp had over 360 women and 150 men in 2019. However, as of July 2021, the population at the Gambaga witch camp had decreased to 95 women due to two deaths and three women who had been reintegrated back into their communities.

5.5.3 Recruitment of participants

To raise awareness about the survey, the researcher explained the purpose of the second phase again to the Earth Priests, with whom an initial dialogue had been held in Phase One. Subsequently, a meeting was held with both the social worker and the 'Magazia' (women's leader in the camp) from the Gambaga witch camp, and with the Earth Priest and his younger brother from the Gnani witch camp. Although the Gnani witch camp was not part of Phase One, the researcher carried out a familiarisation visit in December 2019 by visiting the Earth Priest. The purpose of the research was explained to them as outlined in ethics EA1, section C.3.5.1, and their assistance was sought to recruit eligible potential participants. In June 2020, the researcher conducted a brief information session in the Dagbani language, with the support of the female research assistant. All eligible residents who volunteered to participate in the survey received further face-to-face verbal explanations about the study, including a verbal description of the participants' information sheet and consent form in Dagbani.

The Assembly members of the Gambaga and Mion district supported the recruitment of women from the general population within their communities. The women recruited from the general population received a verbal explanation of the participants' information sheet and consent form. Both groups of participants provided their thumbprint on the consent form since they were illiterate.

5.5.4 Inclusion and exclusion criteria for the study participants

Inclusion criteria

1. Women from the camps: Women living in a witches' camp for at least six months.

2. Women from the general population: Women from the general population who were at least 40 years living in the community.

Exclusion criteria

1. Women from the camps: This study excluded those women included in the first phase of this study.

2. Women from the general population: Women from the general population who were identified as coming from southern Ghana.

5.5.5 Sample size and sampling

In this study, the researcher consulted a biostatistician to determine the required sample size to power the survey, given the limited contextual research available for sample size calculations. Considering the nature of the central phenomenon under investigation, there was also an anticipated dropout rate. For example, older people might have physical illnesses and cognitive impairments that could influence their capacity to participate in studies, and mortality during lengthy recruitment phases may reduce participation (Palonen et al., 2016). Herzog and Rodgers (1988) reported that response rates among older people decline linearly with increasing age in surveys. Therefore, it was determined that 170 older women from the witches' camps and 100 women from the general population were required to power the survey. Additionally, because the survey measured emotional health issues such as anxiety and depression, this may have stigmatized and influenced active participation (Labott et al., 2016).

To ensure a representative sample of participants, the researcher employed a convenience sampling strategy to recruit women from the camps and a simple random sampling technique to recruit women from the general population. Probability sampling methods are often preferred for this purpose (Creswell & Clark, 2017b).

5.5.6 Data collection

During the Phase Two data collection, the researcher requested older women who expressed their willingness to participate in the study to contact the social worker in the camp. Each woman was invited to voluntarily thumbprint the informed consent form. The research assistant collected the thumb-printed consent forms from the women in the social worker's office in the camp. Then, the women who had thumb-

printed their consent forms were invited to complete three questionnaires: the first one contained demographic questions, the second was the translated version of the HADS (Zigmond & Snaith, 1983b), and the third questionnaire aimed to explore themes from the Phase One findings that were not captured in the translated HADS (see Chapter 7 for more details on the translation procedures of the HADS instrument). These questionnaires were translated from English to Dagbani language to reflect the cultural perspective of the women participants. It is worth noting that women in the camps are fluent in the Dagbani language, which is the native language of most northerners.

Measures

In Phase One of the study, 15 women were interviewed and a thematic analysis was conducted, revealing a high prevalence of sadness and anxiety (Zigmond & Snaith, 1983b). The Hospital Anxiety and Depression Scale (HADS) was selected as a relevant instrument to measure these emotional states and was subsequently translated and adapted to ensure its applicability to the Ghanaian cultural context.

5.5.7 Hospital Anxiety and Depression Scale (HADS)

The Hospital Anxiety and Depression Scale (HADS) is a questionnaire consisting of 14 items, with seven items indicating anxiety and seven indicating depression(Zigmond & Snaith, 1983b). Each item has four response options, and scores range from 0 to 3 on a four-point Likert scale, with a maximum score of 21 for both anxiety and depression. Scores of 11 or more on either subscale represent a significant case of psychological morbidity, while scores of 8–10 represent borderline, and 0–7 represent normal (see Chapter 7 for details). Although the anxiety and depression questions are spread throughout the questionnaire, these two items must be scored separately.

Translation of the HADS

The HADS was translated from English to the Dagbani language using the 'forward-backward' procedure (Epstein et al., 2015; Mapi Research Trust, 2018).Two professional translators carried out forward translation, and another retired professional and language expert carried out the backward translation. Healthcare professionals, including a psychiatrist and nurses, independent of the bilingual translators, reviewed both the forward and backward translated versions until a

standard Dagbani version of HADS was agreed upon by the research team and adopted for this study. Some culturally untranslatable terms, such as 'wound up', 'butterflies in the stomach', and 'slowed down', were further adapted. After a consensus was reached by all researchers (PhD student and supervisors), the final version was developed. Another questionnaire was used in addition to the HADS in the second phase to further draw on the thematic analysis of phase one, and the following paragraph describes it. (For more details, see Chapter 7.).

Supplemental questions

In the current study, supplemental questions (see Appendix N) were developed to address themes that emerged in Phase One but were not covered by the HADS. The supplemental questionnaire comprised 15 items: 13 closed-ended questions with a follow-up question that required brief answers, and two entirely open-ended questions. The questions covered topics such as participants' health-seeking behaviors in the camp, loneliness, lack of social amenities, and housing problems. It is important to note that these supplemental questions were only administered to women from the witches' camps as they were generated based on their perspectives and experiences.

Phase two pilot study

Pilot testing was conducted on both the HADS and the supplemental questions (i.e., the demographic questions, the translated HADS questionnaire, and the supplemental questions). The pilot test also provided additional guidance for the main Phase Two study. The primary objective of the pilot test was to assess the acceptability, simplicity, appropriateness, and comprehensibility of the HADS and supplemental questions. The following subsection outlines the procedures for conducting the HADS pilot test.

HADS pilot test

As described in the previous section, the HADS questionnaire was the first to be pilot tested. The pilot study recruited older women (over 40 years old) who were native speakers of the Dagbani language from the Kpatinga witches’ camp. The pilot test was conducted through individual interviews with participants who agreed to take part, supported by a female research assistant. A sample size of 10 was used for the pilot test, in line with recommendations from the European Organization for Research and

Treatment of Cancer (EORTC), which suggests a minimum of 10-15 participants for a pilot test on a tool that has undergone cross-cultural translation (Koller et al., 2007).

During the pilot testing, each item and its respective response options were carefully read to the participants to ensure they understood before making informed choices. The pilot interviews were carried out in the forecourt of the women's residences to ensure privacy. Results from the HADS pilot test are presented in Table 7.1. After each pilot test, participants were asked to rate their understanding of the questions and response options and indicate if they had any difficulty understanding them. They were also asked if the translated HADS questionnaire was challenging, confusing, or offensive, and if they had any recommendations for alternative translations.

In summary, the Dagbani version of the HADS used in the pilot study showed that participants did not have difficulty understanding the item statements and response options. The translated questionnaire items were not found to be challenging to answer, confusing, difficult to understand, or offensive to participants. Only one participant did not complete the pilot survey, and the reason was unclear. However, her emotional state did not appear affected when observed. In conclusion, the HADS questionnaire was found to be acceptable, appropriate, and comprehensible during the pilot test. It was also simple to administer, and participants could understand the items and response options. No modifications were made to the questionnaire after the pilot test. Participants who were asked for further refinement offered no recommendations or suggestions. The average administration time for the HADS questionnaire was 16 minutes.

Supplemental questions pilot test

The pilot testing conducted in this study also included the supplemental questions developed from the themes that emerged in Phase One but were not captured by the HADS (refer to Chapter 6). These supplemental questions were originally developed in written English and were later translated into Dagbani. The fact that the researcher was fluent in both languages provided flexibility in making translation-related decisions, eliminating the need for professional translation services. This approach was also reported by . Baumgartner (2012) and Plugor (2013) in their studies, as they had fluency in multiple languages and did not require professional translation, saving time

and costs. To ensure rigor, the supplemental questions were also reviewed by the researcher's supervisors (EH, RS, and KC), who provided feedback on the alignment to the research aim and improved the English version of the questions. Two health professionals proficient in English and Dagbani also reviewed the questions before the pilot testing and suggested small changes to improve clarity. The supplemental questions' pilot was carried out at the Kpatinga witches' camp with a sample size of five older women (over 40 years old) who were native Dagbani speakers.

The pilot test results for the supplemental questions revealed that all five participants understood the item statements and response options without difficulty. The questions were not found to be challenging, confusing, or offensive, and all participants completed the survey in an average time of 16 minutes. These results demonstrate good acceptability, appropriateness, and comprehensibility of the questionnaire, as well as its ease of administration. No further modifications or suggestions were made after the pilot test.

5.5.8 Data analysis

The data collected using the questionnaire testing the Dagbani Hospital Anxiety and Depression Scale (HADS-Dag) and the supplemental questionnaire were separately entered into an Excel spreadsheet. Afterward, the data sets were exported to IBM SPSS Statistics version 23 for analysis. The two questionnaires were analyzed in separate sessions, as follows:

5.5.9 The Dagbani HADS (HADS-Dag) questionnaire

To summarize demographic characteristics and distribution scores on the HADS-Dag questionnaire, descriptive statistics were conducted, which included mean scores and standard deviations for individual items. Subscale scores and overall scores were not calculated until the scale's construct validity was confirmed through psychometric analyses. Before these analyses, the data were assessed for normality by determining the distribution curve and inspecting values of skewness and kurtosis scores.

This study used an exploratory factor analysis to analyze the HADS-Dag questionnaire. Previous literature and evidence suggest a correlation between anxiety and depression factors (Wondie et al., 2020; Zigmond & Snaith, 1983b). Therefore, a principal

components analysis (PCA) with a correlation matrix, an unrotated factor solution, and scree plot was used to determine the factor structure of the anxiety and depression samples separately. The number of factors extracted was determined by the Kaiser criterion of eigenvalues above 1.00 and a maximum iteration convergence of 25. The factor rotation solution method was Promax with a kappa of 4, and smaller loadings with an absolute value below 0.30 were suppressed. However, a factor loading of at least 0.30 was considered acceptable.

The HADS-Dag questionnaire was evaluated for its reliability, validity, and factor structure. The reliability of the two subscales was assessed using Cronbach's alpha coefficient, which examines the interrelationships of items within a subscale or scale. An alpha value greater than 0.70 was considered good for internal consistency.

I calculated the anxiety and depression subscales of the HADS-Dag questionnaire separately for the women living in the camp and those from the general population. The resulting means, standard deviations, skewness, and kurtosis statistics for the 14 items are presented in Table 8.5, which can be found in Chapter 8. Additionally, I calculated the overall means, standard deviations, skewness, and kurtosis for the two subscales.

5.5.10 Supplemental questionnaire analysis

In order to summarize the data collected from the supplemental questionnaire, the responses were entered into an Excel spreadsheet and then exported to IBM SPSS statistics version 24 for analysis. Frequencies were calculated to provide an overview of the scores on additional psychological problems, lack of social amenities and suggested solutions, and approaches that met the mental health and emotional needs. The analysis also looked at culturally appropriate health and social care provision, as well as improved healthcare service experiences.

5.5.11 Chapter summary

This chapter describes the research design used to address the research objectives, including the specific methods employed in each phase and the ethical considerations. The study was implemented using exploratory sequential mixed methods in two phases: qualitative interviews followed by a quantitative survey. The qualitative phase

was conducted first, in accordance with the principles of exploratory sequential mixed methods, and the results of this phase will be presented in the next chapter. Throughout the process, the researcher consulted local experts and a field supervisor for guidance on field entry, local ethics applications, and cross-cultural validation.

Chapter 6 Findings from Phase One

6.1 Introduction

This chapter presents the qualitative findings of Phase One of the study. Its objective was to address several research questions, including identifying common mental health and emotional challenges, exploring experiences with healthcare services, and examining socio-cultural and emotional needs that influence women's health-seeking behaviours. The chapter is structured as follows: First, a table of themes is presented, followed by a comparison and contrast of the thematic analysis of interviews with women and the allied stakeholders - camp staff and policymakers. Additionally, relevant photo content analysis is included to highlight each theme. The triangulation of data sources and stakeholder groups provides methodological rigor. Finally, recommendations for improving women's mental health and emotional well-being are presented.

Phase One of this study involved conducting in-depth interviews with 15 purposefully sampled women from the Gambaga witches' camp, as well as social workers/NGOs (n=1) and policymakers (n=2) from the Ministry of Health and the Ministry of Gender, Children, and Social Protection. The demographic information of the participants was presented in Chapter 5. Thematic analysis, the established method of (Braun & Clarke, 2019; Terry et al., 2017), was used to identify the study's key themes and subthemes.

The interview findings from the women and the allied stakeholders are presented, followed by a triangulation of themes and interview extracts. To provide a comprehensive understanding of the data, the findings are organized into main themes, subthemes, and related codes. The main themes and subthemes from the interviews with the women participants are presented in **Table *6.1***
Findings framework obtained using a thematic analysis approach , below.

Table 6.1

Findings framework obtained using a thematic analysis approach (Clarke et al., 2015a)

Main themes	Subthemes
Physical problems (chronic body pain) impacting upon general health and well-being	Problem with sleep or difficulty sleeping at night Frailty and loss of independence
Anxiety, nervousness, and suicidal ideation	Feeling restless, 'can't sit still' Worried and scared Expressing thoughts of suicide and anger
Forgetfulness	Difficulty concentrating Confusion
Loneliness, sadness from family disconnection	Being sad and alone Worries associated with separation and lack of family support in the camp
Stigma – self and others	Loss of respect and dignity ('Dariza') Feelings of helplessness, unhappiness, and despair Feelings of shame, hopelessness, and isolation
Lack of basic needs, and inadequate social facilities	Lack of space and unsafe rooms – 'Feeling hemmed in a hole' Lack of recreational facilities Food security conditions
Barriers to accessing general and mental healthcare	Lack of healthcare facilities Belief system and cultural health practices Lack of money for prescriptions and uninsured residents Long walking distances to the clinic Lack of social care provision Challenge of limited resources to support the camps**
Enabling factors for improving social connections	Seeking solace and protection through religion (God) and village-based religions Finding solace through singing and talking with others

	Attending meetings
Recommendations for improving mental health and general well-being	Build homes with larger rooms and improve housing resources Provision of potable drinking water Provision of ability to secure a livelihood Provision of health facility, and insurance cover More guaranteed food supplies Reintegration of the women into the community** Resilience training** 'Building them up'* Counselling and linking up with psychologist*

Note. The findings framework idea was adapted from Clarke et al. (2015b). ** = themes and * = subthemes related to allied stakeholders.

Photo observation themes

The photo data analysis produced two main themes and six related subthemes that elucidated the impact of living conditions in the camp on the residents' health, which are social determinants of health. The first main theme is "Lack of basic and social amenities," while the second theme is "Problems with security and safety in the camps." The subthemes under these main themes include lack of drinking water, livelihood problems, lack of recreational facilities, poor sanitation, cracked walls, and unfenced buildings.

These themes and related subthemes are integrated into the interview findings of the women and presented throughout this chapter with photo evidence. The photo observation themes are a valuable addition to the study, providing a visual representation of the living conditions in the camp. The integration of these themes with the interview findings allows for a comprehensive understanding of the impact of these social determinants of health on the residents' mental health and emotional well-being.

6.2 Physical problems impacting upon general health and well-being

The first theme, which focuses on the physical problems that impact the general health and well-being of the women in the witches' camps, highlights the chronic physical health problems associated with their experiences and how these affect their overall and mental health. Chronic body pain is an important subtheme that emerged from the interviews, whereby women reported experiencing "knee," "waist," and "leg pains," as well as aching joints, legs, waists, headaches, stomach aches, and other unexplained bodily pains. The consequences of these pains made it difficult for them to walk and carry out household chores and activities of daily living, such as bathing, dressing, toileting, eating, and fetching firewood from the bush. Additionally, these body pains affected their sleep and ability to earn a livelihood, as most participants were unable to work on nearby farms to earn income for food and living costs. One participant explained the pain in the following manner:

> *"I am not well. I am saying this because I have not been able to do anything or work the whole year. I have pains in my legs. I have not been able to go farm." P5 age unknown*

Another woman participant explained:

> *"I have pains in my knees and waist pains. So, it has been difficult for me to walk. I also sometimes have stomach aches. So, because of the pain, sometimes I can't go to help people on the farm when they invite me." P1,*

The above excerpt suggests that these physical symptoms, such as leg pain, not only reinforced their anxieties about earning a livelihood but also had a negative impact on their overall well-being. Some participants even reported that remembering the accusations that led to their banishment to the camp kept them awake and made it challenging for them to accept their situation.

Interestingly, a mental health worker explained that some of these physical health problems were actually mental health concerns or somatizations. This highlights the complex interplay between physical and mental health and how mental health concerns can manifest as physical symptoms.

> *"It is the other way round; the mental health problems are giving rise to these physical problems, so it is not like that. So, it is psychosomatic, called somatisation. So, there are mental health issues, largely depression, that the women are going through, manifesting as such. Hence, people verbalise depression through somatisation. As a psychiatrist, I have visited the camps with an NGO and saw everything. The women are going through difficult situations with no one to help them with daily life as old as they are." MHA*

In addition to the loss of employment, there were other consequences that further impacted the women's well-being, such as problems with sleep, rumination at night, feelings of frailty, and loss of independence. As such, the subthemes identified within the main theme of physical problems impacting upon general health and well-being were "Problem with sleep or difficulty sleeping at night" and "Frailty and loss of independence."

6.2.1 Problems with sleep or difficulty sleeping at night

The subtheme regarding problems with sleeping at night was a common thread throughout all the women's interviews and was identified as a significant factor that strongly influenced their mental health and emotional well-being. Many of the participating women attributed their sleep problems to the stress of remembering how they narrowly escaped being lynched and the physical and emotional abuse they endured after being accused of witchcraft. Inadequate sleep, or "not enough or poor sleep," was seen by the women as having a significant impact on their psychological states and was linked to mental health concerns such as anxiety and depression.

> *"I have many problems. I cannot just sleep when I remember the assaults and all those things I went through; it hurts. I can't sleep when I remember this." P5*

An allied stakeholder participant, as well as a mental health worker, similarly observed the women's sleep problems and attributed them to post-traumatic stress disorder (PTSD). They linked the inability to sleep to the trauma of the accusations and the physical and emotional violence they may have experienced from their families and communities. They explained that anxious rumination, or the persistent thinking or worrying about past events, contributed to insomnia or sleep problems. Racing thoughts at night are a common cause of sleep issues, and the women's experiences of trauma and violence can exacerbate this problem.

6.2.2 Frailty and loss of independence

Most of the women in the witches' camp expressed their inability to participate in activities of daily living or carry out their household chores due to their chronic physical health conditions. According to the women participants, living with chronic physical conditions often led them to experience emotional stress and considerable pain, captured above as "body pain", which they associated with losing their independence and, importantly, their ability to perform household chores. In the words of one of the women:

> *"You can see I am weak and can't do anything for myself. I rely on the other women to help me. I don't have anybody, no family in this camp to help. I was chased away from my community, and the Earth Priest accepted me to live in this camp. I can't walk, I can't cook, so the other women here help me." P5*

In contrast, a few participants discussed their ability to carry out household chores and walk without physical health problems and, in so doing, they would help other women by fetching water and cooking and sharing food. One participant explained that

> *"I try my best to be active, work hard, cook, and go to fetch water myself. I also sometimes cook for other women who don't have the energy to cook or fetch water by themselves. Even though I am hurt, I try my best to do things for myself." P4*

6.3 Anxiety, nervousness, and suicidal ideation

Feelings of anxiety and nervousness were another of this study's dominant themes. Most of the participants expressed experiencing severe feelings of fear or worry. According to the participants, these feelings come on frequently, and impacted on their ability to function. The subthemes identified within this main theme were 'Feeling restless, 'can't sit still', and 'Worried and scared' and 'Expressing thoughts of suicide and anger'.

6.3.1 Feeling restless, 'can't sit still'

The subtheme, 'Feeling restless, 'can't sit still'' was evident throughout the data as one of the factors contributing to the anxious state and emotional problems of the women in the witches' camp. Most of the participants had experienced restlessness, describing this as "I can't sit still" and as if they had that state of an "uncomfortable urge to

move" when they had nowhere to go to. The participants also described their hearts beating fast or "suhu tora bei ndarita". As expressed by one of the women:

> *"I sometimes find it difficult to sit still, and when this happens, I see that my heart beats faster as if someone was chasing and running after me to harm. I feel so restless. This is happening because I don't have peace of mind, but what can I say? I give everything to God. Sometimes it appears I have somewhere to go to; meanwhile, I have nowhere to go to … Hmmm!" P13*

6.3.2 Worried and scared

The subtheme 'worried and scared' was evident throughout the data as one of the factors influencing the women's emotional well-being. Most of the women mentioned how anxious they were and how worried and scared they were while staying in the camps. They worried because their children had left them behind, and they also missed their farms and were scared to go back home or visit home. They felt that members of their prior villages wanted to kill them and that there was nowhere to go. For instance, one of the women had this to say:

> *"I was scared and anxious, they wanted to break my door." P13*

and another participant explained that:

> *"I feel so worried leaving my farm behind in the village, and I was crying." P15*

In contrast, one of the participants indicated that she felt safe in the camp and was not anxious, thanking God she was here and out of sight of those who tried lynching her. She noted that she had a calm mind and was not bothered anymore. However, the only reason she wished at times that she was at home was to carry on her small business and farming. However, since there was nothing, she could do about it, she felt okay and did not worry about something she could not change. She had given up hope of going home and was learning to accept the 'inescapability' of the situation that life has brought onto her.

> *"Ah! Me, I am fine. I don't worry about things I can't change. I was lucky they didn't kill me, or I didn't die. So, why should I worry myself again? I am okay. However, I know that I am not going back to the village. I don't get scared or something like that. No! I don't feel*

anxious or restless. That is what life has brought to me, so I accept it." P4

A mental health worker interviewed explained that some of the women have learnt to be helpless, which he described as learned helplessness. The stress of life and uncontrollable situations have pushed some women in the camp to adopt the learned helplessness as a way of coping. The mental health worker explained this as follows:

"I told you I have visited the camps before and saw everything for myself. Some women appeared to be okay, but they were not okay. They have just learnt to be helpless and try to adapt to the situation of life trauma." MHA

The above extract indicates that some women took up maladaptive coping mechanisms after experiencing stressful or traumatic situations and emotional challenges.

6.3.3 Expressing thoughts of suicide and anger

Most of the women indicated that they had thoughts of committing suicide over their witchcraft accusations. They expressed their experiences with the painful and provocative events of being accused of killing and being alleged witches. They expressed the anger that filled their hearts over the witchcraft accusations. Several women indicated explained how they nearly committed suicide as the thoughts of suicide kept racing in their minds.

"My husband didn't even want me to come here but I was so hurt that I wanted to kill myself, so my brother came and told my husband that he should allow me to come to Gambaga witches' camp" P8

"I wanted to kill myself but for my brother I would not have been sitting here speaking to you. I just wanted to kill myself and that." P9

"I wanted to commit suicide. Yes, I wanted to kill myself. Hmmmm! But I thank God, I didn't do it." P8

Another woman had this to say:

"I was psychologically broken. I even thought of dying. The thoughts of committing suicide came to mind. I attempted suicide but for the timely intervention of some family members, I wouldn't have been alive. I even tried drinking battery water (ground dry cells, mixed with

> *water) but for the vigilance of other women in my house I would have killed myself in drinking this chemical." P3*

And another:

> *"Be tempted to commit suicide. You know what, for God's sake, I told people that, if they say I am a witch I was going to take DDT to commit suicide." P2*

6.4 Forgetfulness

The theme 'Forgetfulness' was also identified. Difficulty remembering everyday things while living in this camp was another term that emerged as a common factor seen by the participants to contribute to their emotional and mental health status. Most women participants had trouble remembering things, for example, where they kept their cooking utensils. This memory loss was seen to affect their daily life activities. For instance, they said that they sometimes forgot to eat and to bathe. They attributed the cause of this memory loss to a lack of peace of mind and previous emotional trauma. One of the women made this statement:

> *"I told you at the beginning about my forgetfulness. I have experienced those countless times. That one is there; I experience that more often. My heart sometimes talks to me about so many things as I sit here. To the extent, I will put my money under my mat or pillow and turn to forget where I kept the money, all because of emotional pain." P3*

Two subthemes were identified from this theme: 'Difficulty concentrating' and 'Confusion.'

Various comments were made on these subthemes such as:

> *"It is difficult for me to remember things. Sometimes I place my cooking utensils somewhere and will look for them if I can't find them." P9*

> *"I easily forget where I keep it. So, forgetfulness is there. I don't know why. Maybe it is part of my ill health. This is affecting me a lot, sometimes I want to cook, but I will forget." P2*

> *Hmmm! So as for forgetting, I forget a lot." P8*

> *"I don't remember things again; I don't know what is happening to me. I forget even to eat sometimes." P11*

6.4.1 Difficulty concentrating

Most women indicated that they easily lost concentration and attributed this to their presence in the camp and the situation that had brought them into the camp. They stated that they kept thinking about the accusations that hurt their lives and this affected their concentration spans. Many women indicated that when they were walking to nearby farms for work, they were nearly hit by motorbikes because of loss of concentration and were preoccupied with the accusations that brought them to the camp. One of the women explained that.

> *"When I was accused and came here, I couldn't concentrate, and I couldn't just do anything. And I was thinking badly. It was not an easy thing for me. Hmmm! Nevertheless, I give everything to God. I couldn't concentrate, and one day I was nearly knocked down by a motorbike." P1*

and others:

> *"My mind is just anyhow, and I can't concentrate." P8*

> *"I was hurt, and I couldn't just concentrate on anything, and I couldn't eat food." P4*

> *"I keep thinking and cannot concentrate, so I knew I will get sick." P2*

6.4.2 Confusion

On the other hand, most women said they were confused about who they were now and the outcome of the accusations and felt maybe someone may have given them a gift of magic. So, they thought they had the magic power of witchcraft to kill someone yet had not done this through exercising choice. Such confused thoughts meant they had a poor ability to concentrate. They were concerned that harbouring ill thoughts could lead to suicide, and public stigma with people talking ill about them and pointing fingers at them in social gatherings like funerals and naming ceremonies in the communities.

As one woman explained:

> *"I felt so bad when I was accused of killing my grandson. I had bad feelings. I couldn't just think right. I thought maybe someone gave me a gift with witchcraft magic in it without my knowledge because they say sometimes you can also acquire it through gifts. I could not just concentrate, and I had ill-thoughts." P11*

6.5 Loneliness, sadness from family disconnection

Family disconnections, sadness, and emotional distancing were other themes referring to the perception of women participants' inability to contact their families and the impact of this social disconnection on their well-being. Some of the effects of the family disconnections were loneliness, worries associated with separation and lack of comfort in the camp. The emotional distress from their family disconnections worsened the plight of these women, leaving them to stay in these camps in deep distress, without their children and unable to see or play with their grandchildren. One of the women had this to say:

> *"I feel sad because of the absence of my children, and I am not home to help care for my grandchildren. It hurts me that they don't even know me, and if they should meet me somewhere, they will not know this is their grandmother." P6*

In a statement by one of the participants, such emotional disruptions were explained as breeding hurt and unexplainable unstable chronic medical conditions such as hypertension and other physical ailments.

> *"It is emotional thinking; I developed it here; I got hypertension here. I never had this condition. I became emotionally destabilised at the time I was accused. I used not to have this condition." P3*

In contrast, one of the women interviewed appeared not to care about missing her children since the son accused her of being a witch, which had led to her banishment from the camp. She indicated that she felt safe and comfortable in this camp despite being away from home.

> *"I was accused by my son who said I was trying to kill his son, my grandchild, hmmmm. So, I don't miss them, I am living here in peace without being disgraced by my son." P9*

6.5.1 Being sad and alone

The feeling of loneliness was a salient subtheme. Some key factors contributing to loneliness were feeling bad about themselves, a nostalgic sense of home and doing the chores without any support at the camp. The consequences of these feelings were sadness and sitting alone or rumination at night. This sense of distress and loneliness, being awake at night, thinking about the accusation and overall impact and problems with sleep. In contrast, the women also used "singing and talking" to save time and socialise with other inmates.

Being sad and alone was commonly stated, with women reporting they were sad and felt alone simultaneously. One of the women reported feeling sad and said, *"I feel so sad leaving my farm behind at the village, and I was crying" (P15)***.** Another woman reported being sad and alone when she was called to the chief's palace after being accused of being a witch. She became frightened. She knew she was in trouble and would possibly be lynched should the chief's verdict not go her way. She saw the youth from her community shouting and saying they would kill her if she did not leave the community. The woman explained that.

> *"I was anxious and sad, they wanted to kill me, and all the village young men wanted to break my door." P14*

Being sad and alone added to the worry and manifested in poor concentration and anxiety. Similarly, some of these consequences manifested as physical symptoms, such as leg and knee pain, as stated at the beginning of this chapter and feeling helpless, unhappy, and despairing.

The social worker and an allied stakeholder indicated that the women went through many emotional challenges and sadness'. According to the social worker, being sad was common among the women in the camp. He explained that:

> *"I think they feel hurt, sorrowful, and sad. Sometimes you will see one of the women sitting alone, crying and being sad, and when that happens, I try on my small way to make the place pleasant and crack jokes to make them happy and remove the sadness. But I think they are sad because of the homesickness and the distress they are going through." SW/NGO.*

6.5.2 Worries associated with separation, and lack of family support in the camp

Several participants disclosed their worries about being separated from their family members. The women participants feared being estranged from their family members because of the separation, especially their grandchildren. They were worried because no family members supported them when they needed help with cooking and bathing. Participants experienced excessive worry regarding separation from home and from people to whom the women participants have a strong emotional attachment. For instance, a participant described separation from her husband and caregivers (daughters and grandchildren, significant other) as a big worry. The family separation affected their well-being and disrupted social attachments. The consequence of this includes an overall lack of comfort with dwelling in the camp and emotional imbalances. A woman participant explained that.

> *"It is emotional thinking. I developed it here and got hypertension here. I never had this condition. I became emotionally destabilised at the time I was accused. I used not to have this condition, and being away from home or loved ones, especially my family and grandchildren, hmmm! I don't feel comfortable being away from home and my family." P3*

6.6 Stigma – self and others

The women repeatedly mentioned public stigma as a key factor distressing them. The women felt that the public stigmatised them because of their witchcraft accusations and their presence in the camp. Consequently, they flet that they had lost their dignity and ended up doubting themselves. They saw people "pointed fingers" at them and talking ill when they saw them in public places. The reports from all participants about the witchcraft accusation was seen to inform the public stigma against them with people treating them with fear, avoidance, and discrimination. One of the participants reported, *"People will not talk to me".* People often avoided them at social gatherings or funerals when they visited home for compelling reasons. For example, when a husband or very close relative died, and they needed to attend the funeral. Another one of the participants reported that "*People see me as a bad person.*" This set of negative attitudes and beliefs of the public fuels pervasive stereotypes that accused older women of witchcraft are dangerous or unpredictable and can cause harm. A few

women managed this stigma by relying on God for solace, *"but I give everything to God."* This is explained by one of the participants:

> *"What else will they see me as? People call me a witch, but I give everything to God. People stigmatised me, and when my brother died, and I went to the village to mourn him, people pointed fingers at me and called me a witch, and they did not even want to talk to me or come close to me hmmm!" P9*

The consequences of the public stigma were manifest in refusal to return home, internalised shame, ostracism, discrimination, social seclusion or isolation, and mental health issues. Moreover, the long-term impact of the discrimination depressed the women and precipitated suicidal thoughts.

A mental health worker participant explained that

> *"The suicidal tendencies are expected in people who have been ostracised, isolated, and socially excluded. They are going through isolation or ostracism. All of these engender depression, and depression is a major precipitating factor for suicide. We are lucky they are not committing suicide." MHW*

An allied stakeholder from the social welfare department of the northern region under the Ministry of Gender, Children and Social Protection espoused the view that some of the women often refused to return home because of the impending discrimination and shame they might experience in their original communities. It was indicated that other agencies like the ActionAid Ghana have tried repatriating the women. However, many felt reluctant to return home to be reintegrated because they felt unsafe going back home to meet the people who accused them of being witches, leading to their shameful banishment. They lived out a difficult emotional and mental struggle each day. The shame frequently made the women feel worthless, causes low self-esteem, and makes them sad and anxious. This social worker explained that

> *"As an officer in charge of the social welfare department here, I have visited all the camps and sometimes with other NGOs like the ActionAid Ghana to see the women's welfare. However, I can tell you that some of the women have feelings of internalised shame. They feel shame to go back to their communities. However, they are other people who want to go back home, and we support them to go back home and talk to their families before they get repatriated so they can reintegrate very well." SWD.*

6.6.1 Loss of respect and dignity ('N lan ka Dariza')

Dignity – 'dariza' – was also a critical point raised by the women. 'Dariza' or 'Jilma' in Dagbani means dignity and respect. Most women complained that they had lost their dignity and respect once they were banished to live in these camps associated with people from their communities not respecting them.

One of the women explained that:

> *"It is very painful that all that I used to have, and my reputation is lost, I have lost my dignity and all the respect people gave me are all lost." P15*

In contrast, one of the women now felt more respect and dignity in the camp. She felt safe now that she knew those accused of being a witch would dare not come to the camp to further hurt her.

> *"The people here respect me, and the Earth Priest is good to us, so I don't care about the respect from my community again; once I have peace of mind here, I am fine. They cannot even see me again. So, I am now free of disrespect from my community people." P15*

6.6.2 Feelings of helplessness, unhappiness, and despair

The subtheme of feeling helpless, unhappy, and despairing was evident throughout the interviews as factors that contributed to the sadness of the women. This has made them feel "hurt", "pained", and "bad". The consequences for their mental and emotional health were excessive worry, poor concentration, feeling bad, and being ashamed. Some women explained this as follows:

> ***"****I don't feel happy staying in this camp. My major worry now is I want to go home. But I also know the village people would chase me out again." P8*

> *"I feel sad and unhappy at the same time, but I remember Job in the Bible, what he faced, and he survived the worldly troubles." P5*

> *"It is emotional thinking; I developed it here; I got hypertension here. I never had this condition. I became emotionally destabilised at the time I was accused. I used not to have this condition." P3*

The mental health worker explained that the women had lost interest in daily activities. He indicated that the sense of apathy and social withdrawal is much more common in people who have lost hope and are helpless, which has significant implications for their mental well-being. He saw that it significantly impacted daily functioning, such as carrying out bathing and personal hygiene care. He explained that

> *"Social withdrawal and apathy are all manifestations of depression. So once depression is there, then they will be withdrawn. Further, they will be apathetic; they go through learned helplessness; they feel helpless that they can't do anything. They have learned to be helpless." MHW*

6.6.3 Feelings of shame, hopelessness, and isolation

The subtheme of feeling inadequate and ashamed and the sense of self-stigma was evident from the data. The women felt terrible and embarrassed that they were not at home to take care of their grandchildren. While some felt ashamed of not being able to walk because of physical symptoms such as knee and joint pains, others felt bad that they could not attend the funeral rites of their loved ones at home. Some of the women explained that.

> *"I feel ashamed that I was not there to care for and see my mother die. I am personally not happy, but I give everything to God." P6*

And similarly:

> *"Sometimes, I feel bad and ashamed. It makes me cry sometimes." P7*

> *"I feel sad and ashamed that I can't walk and do what I used to do." P9*

> *"Unfortunately, I am not at home to care for and play with my grandchildren; I feel ashamed and not happy." P10*

6.7 Lack of basic housing, fresh water supply and inadequate social facilities

Poor housing conditions, and a lack of social facilities and drinking water were one of the themes evident throughout the interviews. Participants revealed their displeasure with the nature of their houses. Participants indicated how poor these buildings were

with cracks, loose windows, and doors, and not being fenced. The subthemes identified within this main theme were 'Lack of space and unsafe rooms' (Feeling hemmed in a hole) and 'Lack of drinking water'.

6.7.1 Lack of space and unsafe rooms

Another sub-theme from this study was having no space in the room or small rooms without light. They stated that their rooms were not spacious, and they were sometimes paired with other women to live in these huts. The consequences of these insufficient spaces and dilapidated rooms were that the women felt *hemmed in a hole.* One of the stakeholders with a mental health background explained that poor housing and lack of space had an impact on the women's' mental well-being. When an individual feels holed-up, this posed stress and emotional problems, including somatisation and depression:

> *"the rooms we live in have no space, and they look like rooms for sheep. It doesn't look like rooms for humans." P13*

Inferentially, feeling and having concerns about one's accommodation lessened the dignity of an individual and led to emotional trauma, self-stigma, and low self-esteem.

> *"People want to feel free to have enough aeration, light, and room to move about." P6*

The allied stakeholders unanimously agreed with the women that their accommodation was dilapidated and of weak structure. Stresses associated with inadequate housing, a poor state of repair, dampness in rainy seasons, cracked walls, lack of proper doors on the rooms, and pest infestations, have adversely affected the women's mental health and well-being. The stakeholders had a number of things to say on this subtheme.

A social worker who worked in the Gambaga camp where the interviews were conducted indicated that the women had considerable problems affecting their sleep. He indicated that poor housing and lack of space were also reasons the women did not have good sleep. He explained that at follows:

> *"Let me tell you something. It is worst in the rainy season because some of their rooms are leaking, so how can you sleep in this*

> *situation. One woman died last year because her room fell on her when it was raining. We did not want it to make news, so we invited her relatives to come, and we buried her in this community. So, when it is raining, most of them can't sleep because of the nature of their rooms." SW/NGO*

In addition, the social worker/NGO further had this first-hand information about the housing situation in the camp:

> *"Accommodation is a problem., especially the rainy season, we are always worried you don't know which room will collapse they are not strong ones. Sometimes, we merge you with another when it becomes critical." SW/NGO.*

Another allied stakeholder, an officer from the Ministry of Gender, Children and Social Protection, had this to say:

> *"I have visited almost all the camps in Ghana, and their accommodation is not the best for our women, especially when looking at human rights issues. Yes, it is not the best for them. The rooms are some dilapidated buildings, some 'round houses'." SWD*

And a mental health worker, who was also a policymaker in mental health, indicated that:

> *"everybody wants to feel that she is not 'hemmed in a hole'. So, if a woman feels 'holed-up', it will negatively impact her mind and stress her. It will give her all kinds of emotional problems, including somatisation, depression, why am I hemmed in a hole, am I not a human being? So, these are all issues, which is why people should have enough aeration, light, and room to move about and link with a similar world. Moreover, accommodation is inadequate, so it abuses their rights. The right to decent accommodation." MHW*

In contrast, one of the women said she did not feel hemmed in a hole because she saw the camp as a safe haven. She accounted her ordeal and how she was chased away from her community. She said she was not ready to go back home because she did not want to be killed and humiliated. Moreover, she does not want her family and house people to be persecuted. She explained that.

> *"'I decided to come to the camp because my house people will feel comfortable, and I will also be safe." P2*

The photo observations below also revealed small, dilapidated, and cracked rooms, and a lack of space in the rooms of the women, The women from the camps live in mud houses roofed with a thatched roof of leaves harvested during the dry season. The nature of most women's homes is depicted through participants' photographs documented below. Each woman lives in these rooms except those who share with other residents. The environment is dilapidated (with cracked walls) and has a mud floor. Some rooms have no windows, and the doors are covered with clothes and mosquitoes' nets to serve as a cover.

Figure 6.1

Gnani camp: Cracked and unsafe rooms for the women

Note. Photo taken during this study's field work, June 2021.

Figure *6.2* below shows a woman's room inside the witches' camps. The rooms are small and do not also meet the essential requirement of rooms in refugee camps, according to the United Nations High Commissioner for Refugees (UNHCR). Inside a woman's room below are cooking utensils, calabashes, eating bowls, drinking cups, and a 1.5L plastic bottle used for kerosene for lanterns at night.

Figure 6.2

Inside the room of a woman at the Gambaga witches' camp

Note. From *Life in Ghanaian Alleged Witch Camps Under COVID-19*, by Prince Barak, July 31, 2021, GO Humanity.

In addition, the photo observation revealed that the witches' camp lacked privacy. The witch camp settlement is not walled or fenced, and the women are exposed to passers-by, who will easily see over the short walls into the forecourt of the women in the camp. See Figure 6.3

Unwalled room of Gnani resident with privacy below.

Figure 6.3

Unwalled room of Gnani resident with privacy

Note. Photo taken during this study's field work June 2021.

There was also very limited safety and security in the witches' camps. Even though Earth Priests is said to be providing the women with protection, security and privacy

are not prioritised in the camps. In this current Phase One of the study, the women interviewed indicated that thieves sometimes come into the camp and steal their menial earnings from the firewood sales.

6.7.2 Lack of recreational facilities

A recreational facility is an essential component of every refugee camp (UNHCR, 2021a). However, none of the camps has a recreational facility. Only the Gambaga camp had a lobby for the women to use for their meetings. The photos below show the hall at the Gambaga witches' camp that participants use as a recreational facility and a church. The other camps I visited did not have a place of worship, and they held meetings under trees.

Figure 6.4

Lobby used for meetings and recreational facility at Gambaga camp

Note. Photo taken during this study's field work June 2021

6.7.3 Poor sanitation and lack of potable drinking water

In the interviews with the women participants, the lack of potable water was pronounced. The photo observation revealed challenges to obtaining drinking water and evident poor sanitation. In the witches' camps of northern Ghana, fresh drinking water supply and sanitation facilities remain limited. For instance, the Gambaga camp has only two toilets for about 100 women. The other two camps (Kpatinga and Gnani) I

visited did not have sanitation facilities. The women residents at the Kpatinga and Gnani camps visited the nearest bush for 'Yogni' – urination and defecation.

Poor sanitation and lack of privacy for bodily functions reduce human well-being and social and economic development due to its impacts on anxiety and the potential risk of sexual assault. Moreover, poor sanitation may also be linked to the transmission of diseases such as cholera, diarrhoea, dysentery, and typhoid fever (UNHCR, 2021a).

Figure 6.5

Community dumping ground close to the Gambaga witch camp

Note. Photo taken during this study's field work June 2021.

6.7.4 Food insecurity

Food insecurity was one of the subthemes that was evident in the data. The women participants complained of not having enough to eat and relying on benevolent donations from the public and other organisations. Some women also explained that mostly they helped other community members on their farms during crop sowing and got paid during harvesting season. One of the women explained that;

> *"we don't have food. When the Earth Priest children have harvested on the farms, they call us to help them and then give us some part of the produce. And sometimes the community members here when they have harvested in the farms, we go to help them, and they give us some food." P1*

The social worker in the camp confirmed this assertion. He also indicated that the women sometimes did not have food to eat. He further indicated that one programme

(Presbyterian GoHome Project) sometimes supports the women with food, making it difficult to support them when they run out of funds. However, some women helped on nearby farms. The social worker indicated that a lack of nutritious food for the women might sometimes be responsible for their ill-health. He explained that;

> *"sometimes there is no food but that one we also try to support but sometimes too they have the bad feelings again!" SW*

6.8 Barriers to accessing general and mental healthcare

The sixth theme identified from the women's interview data, focused on the healthcare accessibility experiences of the women in the witches' camp, this theme was profoundly pronounced in the interviews of the women in the camp, with subthemes including the lack of healthcare facilities, inappropriate cultural health practices during a medical encounter, lack of money for prescriptions, long walking distances, and lack of mental and social care provision.

6.8.1 Lack of healthcare facilities

The subtheme 'Lack of healthcare facilities; was evident throughout the data as one factor influencing their access to healthcare needs. Nearly all the women repeatedly mentioned the lack of health services in the camp as a critical factor influencing their general health and mental well-being, making it very difficult to access healthcare services.

The lack of health facilities in the camp was identified as the cause of the death of one of the women because they did not have access to urgent first aid. *" Last year, one of the women just died like that in the night, and we couldn't help her, and Mr XX was not there to help" (P5)*. The women said that was because of the difficulties in accessing healthcare in the camp.

> *"The other day somebody was sick, and, in the night, it became serious, but because we didn't have a doctor in this camp or hospital, we called Mr. X (social worker), but she died." P12*

The photo observation confirmed that there was no healthcare facility that the women could access. To access healthcare, the women needed to walk long distances to nearby communities to get healthcare services. The women, therefore, find this

frustrating, considering that they are aged and frail. Consequently, this does not meet the essential requirement of a camp by the UNHCR standards (UNHCR, 2021, 2022).

Furthermore, the women do not also have any form of psychological support or counselling facility in any camps.

6.8.2 Belief system and cultural health practices

Aside from the lack of healthcare facilities in the camp, these women's health belief systems and cultural health practices further affected their health-seeking behaviours. For instance, most women resorted to using local herbs for ill-health related to boils on the skin. This is because they believed that sickness like a boil on the skin must not be sent to the hospital because of the risk of dying from an injection while suffering from a boil infection. Some women preferred applying local herbs and bark of trees ground into powder and mixed with water. Most unexplained illnesses did not present to the hospital or clinics because of the folk belief systems held by the participants.

6.8.3 Lack of money for prescriptions

The subtheme 'Lack of money for prescriptions' was pronounced in the camp as one factor affecting women's access to healthcare services. Most participants indicated that financial constraints prevented them from meeting healthcare needs. The women said on rare occasions when they were prescribed medications to buy at a nearby community health facility, they could not afford to purchase the medicines. According to them, most facilities also did not have the required medicines to dispense, so they were required to buy these prescriptions. As a result, most of them resort to local herbs to treat their illnesses. The financial barriers influenced participants' ability to access or obtain healthcare, e.g., prescription drugs and mental health counselling. So, financial constraints were critical to their inability to access to health.

> *"We do not have a hospital in this camp. So, we sometimes go to the Nalerigu Hospital, but they do not have medicine, and they will write for me to go and buy the medicine, but we do not also have money to buy." P1*

6.8.4 Long walking distances to the clinic

Most participants indicated that they had to trek long distances to the other communities to access healthcare services when feeling unwell and ill. Participants

complained that their joint pains and other physical symptoms like knee pain made it difficult to walk to the health centres to seek medical care. However, even after walking a long distance to these health facilities, they are faced with the problem of a lack of medicines, and they were unable to buy prescriptions given to them because they did not have money.

6.8.5 Lack of social care provision

Participants indicated that there was a complete lack of social care support in the camp, even for those who appeared vulnerable and unable to support themselves or were just in need of occasional extra support. Most participants complained of physical health problems that affected their activities of daily living such as doing household chores independently. They do not have any social care that would provide them with physical, emotional, and social support to live their lives. The lack of social care provision commonly meant they could not attend to their personal hygiene and grooming, nor could they cook. Consequently, a few women depended on the small number of residents who are still strong enough to help them. However, most participants indicated they did not have anyone to help them do these chores.

> *"There is no one to help. I am just here alone, and I can't walk or do anything, so I relied on the benevolence of other residents. They cook and share their food with me. Some of the residents also help fetch water for me. I sit here every day because I can't do anything by myself." P7*

In contrast, another woman said she had her granddaughter coming irregularly to help. According to the participant, her granddaughter helped cook, washed her clothes and dishes, and fetched water and firewood from the bush, which she sold for her upkeep.

All allied stakeholders agreed that the camps lacked social care support and facilities. However, they attributed this concern to the very limited financial resources to support the camps. However, the social welfare department official from the Ministry of Gender, Children and Social Protection indicated that the ministry sometimes partners with NGOs to provide for some of the basic social support needs of the women.

6.9 Enabling factors for improving social connections

Despite the emotional ambivalence and loneliness in the camp, the women engaged in occasional key activities that promoted social connections. They attended meetings called by the social worker to meet organisations that visited the camp. Most women also said they found solace through singing and talking with other inmates when they felt emotionally down. Some of the key activities engaged in by the women that promote these social connections are explained below.

6.9.1 Seeking solace and protection through religion (God) and village-based religions

The onslaught of the witchcraft accusations has left many women banished to these witches' camps and had seen these women seek solace in prayer. Many women interviewed resorted to prayers to forget about their worries. Some relied on prayers when they felt sick and ill and had no money to go to the hospital. They talked about the social worker and the pastor helping them with some of their needs or praying for them. Again, some of the women would consult the village-based gods to seek solace for comfort and find the right herb for their sickness. For instance, three of the women had these things to say about how they sought support:

> *"when I need help, I tell the pastor to pray for me so we can be fine. The pastor is doing well, and he is nice to us." P7*

> *"I always pray to God to help me forget my worries so that I can* sleep*, and sometimes God helps me sleep. Any time I think about what happened the sleep will not come, and you can't close your eyes." P4*

> *"usually, when I am sick, I will get some money and give it to somebody to consult the soothsayer who will show me the herbs and where I can go to get treatment." P15*

6.9.2 Finding solace through singing and talking with others

Most of the women mentioned that some of the key activities that improve social connections within the camp were singing, 'yila yilbu', meeting the pastor, and sometimes conversing with fellow residents by dancing. Most participants also said

they sometimes while away time by having conversations with other residents to alleviate loneliness. One of the women explained that:

> *"Mr. xxx will create a play, and we laugh small, and happiness will return. Sometimes I will also join the other old women, and we sing local songs and clap our hands." P1*

6.9.3 Attending meetings

The subtheme of going to meetings was evident throughout the data as one of the factors that promoted the cohesion and social connections of the women in the camp. They attested to going to Sundays, meetings with the camp's pastor, who is also the social worker, to pray, sing and dance out their problems. The meeting with the pastor also occurs occasionally when one of them is unwell or unhappy.

Furthermore, meetings were sometimes held in the camp with some NGOs who came to talk to them about personal hygiene and soap-making and provided them with gifts such as mini bags of rice and cooking oil and beverages. At such meetings, the women sang and danced. A woman explained that:

> *"We have meetings like on Sundays when we go to church, Mr X will create a play, and we laugh small, and happiness will return. Sometimes I will also join the other old women, and we sing local songs and clap our hands and we are happy." P1*

6.10 Recommendations for improving mental health and general well-being

The women recommended providing health and social care, food supplies, drinking water and better housing support to improve their mental health and well-being. Most of the women interviewed indicated they needed the government to provide adequate accommodation (larger rooms with more space) and improve their home infrastructure as well as providing potable water in the camp and a healthcare facility. Furthermore, they suggested the provision of health insurance cover, guaranteed food supplies, work availability, improved living conditions, and guaranteed remuneration, and installing televisions.

6.10.1 Build homes with larger rooms and improve housing resources

Building homes with larger rooms and providing them with other vital home resources such as mattresses, beds and television was one of the recommendations featured in the conclusions of the interviews with the women. Most women felt that their rooms did not have enough space to house them. According to most women, stresses related to inadequate housing, and poor room space, the poor state of repair, and dilapidation resulted in discomfort and was felt to affect their mental health adversely. They complained that they didn't even have mattresses to sleep on. Most of them lay on the bare floor of their huts, making sleeping difficult. During the rainy season, they lived in fear because they had an experience where one of them died, as one woman explained that another woman's room had collapsed upon her during heavy rain.

> *"We need spacious rooms, our rooms don't have spaces, and they are not strong, one of the women died last two years because the room fell on her, it was raining heavily." P9*

Another woman explained that:

> *"My room looks like room for goats. Before I enter my room, I have to bend, and there is no space in the room. If you can help me build a house, we will be happy." P15*

And another:

> *"the rooms we live in have no space, and they look like rooms for sheep (animal), it doesn't look like rooms for humans." P13*

One woman explained that:

> *"our rooms in this camp have little space, and we force to keep all our belongings on one side and sleep on the other side of the room." P12*

Interestingly, allied stakeholders had split views regarding building older people's homes. While the member of the Gender Ministry was against building older people's homes for the women, the social worker in the camp felt older people's homes should be built for the women to make them more comfortable and less stigmatised. Since the social worker worked in the camp, he saw the need to build women's homes. The staff member of the Gender ministry aimed to close the camps and reintegrate the women, so felt there was no need to build older people's homes for the women.

6.10.2 More guaranteed food supplies

The women living in the witches' camp also indicated that a regular supply of nutritious food should be provided. They explained that securing a consistent supply of food was a major challenge to them in the camp, and they recommended that government and civil society organisations could help them with a guaranteed food supply in the camp. A woman explained that:

> *"We need food. We would be happy if you or the government could help us with a regular food supply." P10*

6.10.3 Provision of potable drinking water

In addition to the request for homes and larger rooms, most of the women interviewed suggested that the provision of potable water in the camp could greatly enhance their well-being. Most of the women's interviewed stated they were not strong enough to walk a long distance to fetch water from the stream. Most also said that the lack of water in the camp affected their personal grooming, and sometimes they did even have water to drink or cook. A woman interviewed explained that

> *"We also need spacious rooms and water in this camp it will help us a lot. Some of us are not strong enough to go and fetch water, so if we get pipe water in this camp, it will help us." P9*

Interestingly, even though the Gnani and Gambaga camps have water facilities (as seen in Figure 6.6 and Figure 6.7 below), the women stated that the water had never flown through the pipes. The Gambaga camp water system (Solomon, 2021) used mechanised boreholes but still did not enable water to flow through these water systems. The Gnani camp resident women depended on the tributary of the Oti stream, which supplies water to the entire Gnani community. This stream or river is about half a kilometre from the camp. The women complained about the distance they had to walk from the camp to the riverside when frail.

Figure 6.6 and Figure 6.7 show the water system and sanitation situation in Gnani and Gambaga witches' camps. The blue wall in Figure 6.6 shows the Gnani water system sponsored by Australia Aid and ActionAid Ghana (2022). In Figure 6.7 and Figure 6.8 the water system of the Gambaga witch camp is shown. Figure 6.7 is a water reservoir mechanised with a borehole, but the borehole does not have water, so water does not

flow through the standing pipe seen in Figure 6.8. One of the camp women was arranging firewood sticks for sale by the standing pipe in Figure 6.8. Concerning sanitation, Figure *6.7* shows the dumping site at the Gambaga witches' camp. A camp resident in the Gambaga community dumps their refuse close to the camp. According to the women interviewed, the stench from these dumping sites was very bad during the rainy season.

Figure 6.6

Water sources in the Gnani witches' camps

Figure 6.7

Water sources in the Gambaga witches' camp

Note. On the left is a standing pipe sponsored by AustraliaAid for the women from the Gnani witches' camp. On the right is a dried-up water reservoir from the Gambaga witches' camp. Photos taken during this study's field work, 2020-2021.

Figure 6.8

Gambaga witch camp standing pipe that does not provide water

Note. Firewood for sale is arranged under a dried standing pipe tap from the Gambaga witches' camp. Photo taken during this study's field work, June 2020.

6.10.4 Provision of healthcare facilities and insurance cover

Most women participating in the interviews indicated their experiences had been challenging because of difficulties in accessing healthcare services or, most commonly, that healthcare services were unavailable. Therefore, they suggested that providing a healthcare facility in the camp could address their acute and chronic general and mental healthcare needs. One woman shared her experience of another resident who had been taken ill at night and had no healthcare support. She explained that *"the other day somebody was sick, and, in the night, it became severe, but because we didn't have a doctor in this camp or hospital, we called Mr X (social worker), but she died" (P12).*

Another woman from the camp suggested that.

> *"we need a clinic in this camp, build a hospital here, and let the nurses and the doctors treat us when we are sick, the clinic will be good for us and attend to our health needs." P11*

The women also indicated that the government should provide universal insurance cover to help them access health services in the nearby communities. They explained

that some time ago, the Ministry of Gender, Children and Social Protection registered them under the National Health Insurance Scheme Cover, but after one year, it expired and has not been renewed.

6.10.5 Provision of ability to secure a livelihood

The women participants indicated that they needed the opportunity to earn a livelihood to support themselves, such as from productive work in the camp. They indicated that, sometimes, an NGO would come and train them, for example, on how to make local soap, but they do not have the money to buy the products to produce the soap for sale. Most women interviewed stated they turned to petty trading to support their existence. A woman indicated that.

> *"I could buy a charcoal sack and retail to get something small to live on if I had money. So, I think if we get help like money, we can do petty trading to live on." P14*

Most women worked on nearby farms to earn livelihoods and fetched firewood from the bush to sell.

Figure 6.9

Firewood arranged for sale by the women for livelihood purposes

Note. On the left is a room of a woman from Gnani witches' camp, with firewood arranged for sale. On the right is an arranged firewood under a dried pipe tap for sale from the Gambaga witches' camp. Photos taken during this study's field work 2020-2021.

The section below presents recommendations from the allied stakeholders' (social work and NGO worker, an officer from the gender ministry, an officer from the Ministry of Health, and a mental health practitioner) on the best way to manage and improve the women's' mental health and emotional well-being in the witches' camps that fall outside of the themes generated from the data from the interviews with the women. These suggestions include 'resilience training' and 'reintegration 'of the women back into society. These themes are discussed in detail in the following sections.

Resilience training

The first theme, resilience training, highlights allied stakeholders' views about how the general and emotional well-being of the women in the camps could be improved. A general opinion among the stakeholders was that these women faced multiple and complex life challenges. Also, that there needed to be support for them to cope with the societal rejection in order to prevent suicide ideation and general mental breakdown. The subthemes identified within this main theme were 'building them up' and 'counselling and linking up with psychologists.'

'Building them up'

Allied stakeholders' participants verbalised that since most women are going through stigmatisation and felt helpless, they need professional help to boost their morale against the negative perceptions of others since this could make them break down mentally. Participants stated that promoting good family relationships in the camp could be important to improve the mental well-being of the women in the camp. A stakeholder from the Mental Health Authority of the Ministry of Health explained that

> *"the residents being stigmatised against you need to be built up. They can be told they are worth more than stigmatising, and resilience training will help build them up. This will help improve their emotional lives against stigma from their communities and the larger society". MHA*

In contrast, though the social worker of the allied stakeholders agreed that building them up could help improve the women's emotional well-being, he indicated that the most important and fundamental aspects to improve well-being was to provide for their basic needs. He indicated that.

> *"If you build someone up and the person doesn't have food to eat or can't afford the basic needs, they can't be happy" SW/NGO*

Counselling and linking up with psychologists

All allied stakeholders indicated that counselling was a way to improve the women's emotional well-being in the camps. They explained that setting up counselling units in the camps to cater to the women's counselling needs could improve their mental and emotional well-being. Participants believed that the counselling units could help fill the women's life with positivity and assist them in having a positive approach to life.

> *"Some may require simple counselling, and the counselling is given." MHA/MHW*

This part of the subtheme about 'linking up with psychologists' reflected concerns about the lack of psychological support for the women in the camp. Participants mentioned that a psychologist could make appointments in the camps to help the women cope with stressful situations and overcome the trauma life has brought on them; however, understaffing also prevented this from occurring.

The officer from the Ministry of Gender, Children and Social Protection had this to say:

> *"As an officer of the social welfare department under the Ministry of Gender, I am with the department, and we are so understaffed, so I can't be everywhere, but we need a psychologist even if not employed the person to be working with the department or the ministry on that, but we can have that psychologist. Okay! Let's say the ministry will contract so that once a while that person can move with the department to the camps, have that one on one with the residents just to support them like I mention to build their psychological well-being like to take away that stress on them and let them feel that life needs to move on even though you have need denied some of these rights." SWD*

The mental health worker, a policymaker at the Ministry of Health under the Mental Health Authority of Ghana, indicated that the Ghana Health Service could link up regional psychologists or mental health coordinators with the women in the camps to offer psychological help to the women. For instance, he explained that.

> *"Yes, Ghana Health Service can offer psychological support to the women, then link them up with the regional psychologist or regional mental health coordinators so that it could be sustained." MHA*

In addition, the social worker/NGO explained that

> *"Aside from having a counsellor, we need a psychologist in the camps and the health personnel to encourage them to forget their past and troubles, so they can sleep because it is not easy. And if someone is feeling worried." SW/NGO*

These excerpts demonstrate allied stakeholders' beliefs around the need for psychological support to overcome the post-traumatic events of the witchcraft accusations that caused their banishment to these camps.

6.10.6 Reintegration of the women into the community

The allied stakeholders universally wanted the camps to be disbanded and the women reintegrated into back into their original communities. According to them, the camps deprived the women of their human rights, good health, and proper sanitation. They noted that the government been previously engaged in discussions with Earth Priests and chiefs of the camps on how to disband the camps and bring the women back to their communities. Ghana's government is currently exploring ways to support the accused women and children banished by their communities to 'witches' camps' in the north and reintegrate them into their home villages. The allied stakeholders also noted that the Ministry of Gender, Children and Social Protection was currently unconcerned about building and rehabilitating the camps because they wish to disband the camps for human rights violations.

> *"what we are looking out for and what we want to do, and it all has to do with the reintegration process, so we start doing the reintegration at a point in time if there is nobody at the camp, then the camp will be closed down." SWD*

However, one of the allied stakeholders indicated that reintegration was a complex and difficult task. The women need to be rehabilitated mentally before reintegration and the government needs to work with the communities to discourage attacking alleged witches before insisting on sending the women home. According to the social worker in the camp,

> *"The government must pay more attention to the communities where witchcraft accusations and beliefs are practised. Reintegrating the women and disbanding the camps without this would worsen the plight of the women when they get back home." SW/NGO*

The allied stakeholders had the following recommendations and 'guidelines' for reintegrating the women in the witches' camps back into their communities:

- Traditional leadership engagement – with the chiefs of the northern region.
- Community education and awareness dispel and discourage witchcraft beliefs, practices, and accusations.
- Educating Earth Priests, the camp owners.
- Educate the women and provide them with accommodation in their original communities.
- Providing the women in the camps with work training and sources of economic livelihood.
- Get the community to appreciate the physical and physiologic changes associated with old age, organise conferences, and eventually disband the camps.
- Periodic regular visits to the communities to ensure the women's well-being and educate community members.
- Continuous follow-up and psychological support provided when the women go back home.

The social welfare officer from the Ministry of Gender, Children and Social Protection explained that

> *"what we are doing is to say that we are just closing the camps, so if anybody is accused, we should handle the person in the community, you know what we do is a long process. We meet with the traditional leadership, we meet with the camp owners, we educate them, and they all get to understand what we are looking out for and what we want to do, and it all has to do with the reintegration process, so we start doing the reintegration at a point in time if there is nobody at the camp, then the camp will be closed down." SWD/MOG*

6.11 Highlights of the qualitative findings

The highlights drawn from the qualitative findings of the Phase One study are summarised as:

- Women participants reported physical health problems impacting their abilities to perform activities of daily living. For example, walking and carrying out personal care was difficult, and I could not fetch water from nearby places.
- They also reported feeling sad, lonely, confused, having difficulty concentrating, felt restless, anxious, and nervous, with occasional suicidal thoughts and worries associated with family separation and disconnections.
- Self and public stigma were also evident, attributed to a loss of dignity, harbouring bad feelings and shame after accusations and banishment.
- The poor quality of essential housing, water and food supplies and health and social amenities also affected their mental health and well-being. For example, the women reported poor housing, lack of potable water, and lack of healthcare facilities in the camp and other social and recreational facilities that determine general health and emotional well-being.
- Furthermore, allied stakeholders were unanimous on the camp's lack of social and health care amenities, further highlighted in the photo observations. In addition, photo content analysis revealed a lack of security and privacy in the camp, a lack of recreational facilities, a lack of potable water and difficulties earning an economic livelihood for the women.
- Participants reported that providing health and social care facilities, for example, larger rooms with spaces, healthcare facilities, food, and potable water, would improve their mental health and well-being.
- Finally, the allied stakeholder offered suggestions for effective reintegration processes and the eventual disbandment of the witches' camps.

6.12 Chapter summary

Qualitative Phase One was conducted to address research objectives on the common mental health and emotional well-being problems and socio-cultural and emotional needs, practices, and experiences of the women in the witches' camp. In addition, Phase One addressed the factors informing the women's experiences on general

healthcare services and provided recommendations for improving their general, mental health and social care needs. The thematic findings of the qualitative Phase One were used to identify a suitable instrument, the HADS (Zigmond & Snaith, 1983b), for cross-cultural translation and linguistic validation (described in the next chapter, Chapter 7) and obtaining measurements presented in Chapter 8.

Chapter 7 Cross-cultural translation, linguistic validation, and adaptation of the Hospital Anxiety and Depression Scale (HADS)

7.1 Introduction

This chapter focuses on the linguistic translation and cross-cultural adaptation of the Hospital Anxiety and Depression Scale (HADS) in Ghana. The first section justifies the use of HADS for the study. The subsequent section describes the original HADS and its psychometric properties. I presented a figure illustrating the cross-cultural translation and adaptation process, which includes translation planning, forward translation, and backward translation. The chapter also discusses the pilot tests carried out during the translation process. Finally, a summary of the cross-cultural translation process used to ensure the linguistic validation of the Dagbani HADS is presented.

7.2 Justification of the use of the HADS

The current study used an exploratory sequential mixed-methods design to investigate the common mental health problems of older women residing in the witches' camps of northern Ghana. In this approach, qualitative research is conducted first, and the findings are then used to inform the subsequent quantitative research phase. According to Creswell and Clark (2017a), qualitative research can help identify the variables that require further investigation in a quantitative study. Qualitative findings may also be used to develop an instrument for the quantitative phase. As discussed in Chapter 2, the literature review indicated that anxiety and depression are prevalent psychological health issues among older adults in Ghana (Lloyd-Sherlock et al., 2019) and socially excluded communities (Mkhize, 1994). After analyzing the qualitative data obtained in Phase One (see Chapter 6), physical health concerns such as body pains, headaches, joint pains, stomach aches, nausea, vomiting, fatigue, and emotional and anxiety problems were identified as significant aspects of the women's health experiences in the camp. This finding supports the notion that mental health can impact physical health and vice versa. For instance, older adults with physical health conditions such as heart disease have higher rates of depression (National Collaborating Centre for Mental Health, 2010; Pilling et al., 2009). In this study, anxiety

and depression were identified as key thematic findings in the qualitative research, highlighting the need for further empirical inquiry in Phase Two. The databases were searched to identify an appropriate anxiety and depression tool for the study (see Chapter 7), and several instruments were found to be potentially useful, including the Geriatric Depression Scale (Yesavage, 1988), Patient Health Questionnaire (Kroenke et al., 2003), Mental Health Continuum-Short Form (Keyes, 2006), and the Hospital Anxiety and Depression Scale (HADS) developed by Zigmond and Snaith (1983a).

Although none of the scales identified was developed in Africa, the Hospital Anxiety and Depression Scale (HADS) has been extensively used in Ghana (Calys-Tagoe et al., 2017), Ethiopia (Wondie et al., 2020), South Africa (Pappin et al., 2012), and Nigeria (Abiodun, 1994), with good, reported validity and reliability. Moreover, the HADS has been translated into 115 languages worldwide, including the Yoruba, Xhosa, and Zulu, making it suitable for global research (Mapi Research Trust, 2018). Recent studies, such as that conducted by Faye-Schjøll and Schou-Bredal (2019) in Norway, demonstrate that the HADS remains relevant in assessing the psychological stress of research participants, despite being developed around 40 years ago in 1983.

The Hospital Anxiety and Depression Scale (HADS) was originally developed by Zigmond and Snaith (1983a) to measure anxiety and depression in hospital and community settings. The scale is a self-rating questionnaire consisting of 14 questions, seven questions each for anxiety and depression, and can be completed in two to five minutes. The validity and reliability of this psychological tool have been found to be acceptable, making it suitable for researchers assessing emotional disorders in adults.

Each question on the questionnaire is assigned a score ranging from 0-3. This means that a person's score for anxiety or depression can range from 0 to 21. Scores of 11 or higher on either subscale are considered to indicate a significant case of psychological morbidity. Scores between 8 and 10 are considered *borderline*, while scores of 0 to 7 are considered normal. The HADS-A subscale has a specificity of 0.78 and a sensitivity of 0.90 for anxiety, while the HADS-D subscale has a specificity of 0.79 and a sensitivity of 0.83 for depression (Stern, 2014). HADS is a standardized tool that can quickly detect the presence and severity of mild mood disorders, such as anxiety and depression, using a single brief questionnaire.

The researcher selected the HADS to evaluate anxiety and depression symptoms among the general population. In a study conducted in Sweden by Djukanovic et al. (2017), the factor structure of the HADS was assessed in individuals aged 65-80, and the researchers found the HADS items to be acceptable. Djukanovic et al. (2017) recommended using the HADS to evaluate psychological distress among a general population of the same age group. Another study conducted in Nigeria by Ogbolu and Omidiji (2018) found that anxiety and depression were prevalent among individuals with an unknown diagnosis, indicating that these conditions are common among individuals who have not been diagnosed with any medical condition. Although the HADS has been used in Sub-Saharan Africa, it has not been utilized among older adults nor translated into the Ghanaian language yet.

The HADS is a valuable tool for the early detection of anxiety and depression, providing separate scores for each condition to facilitate appropriate referral of research participants to services. It is easy to score and interpret and provides clear cut-off scores indicating the severity of the disorder, making it ideal for screening, outcome, and research purposes (Wu et al., 2021). For this study, HADS was chosen and used quantitatively. However, ensuring that the tool reflected the setting, participants' culture, and worldview was also necessary. According to Creswell and Clark (2017a), the Phase Two design of an exploratory sequential study should be based on the participants' culture rather than using a pre-existing tool. While there is increasing diversity worldwide due to globalisation and migration, localised cultural differences still exist. Therefore, it is essential to adapt instruments for local use in communities worldwide (Sweetland et al., 2014).

Although there is evidence of universality in the experience of depression and anxiety in SSA, differences in culture, tradition, salience, manifestation, and expression of symptoms suggest the need for translation and adaptation of instruments. However, there is no universal standard for adapting an instrument in another cultural and linguistic setting (Gjersing et al., 2010). Investigating conceptual and item equivalence is essential and emphasizes ensuring that concepts within an instrument are equivalent between the original and target language, time, and context. Therefore, the HADS was identified as suitable for the quantitative inquiry and was linguistically translated to reflect the cultural context of Ghana and adapted for the quantitative

phase of the study. Parra Cardona et al. (2012) argued that the concept of cultural adaptation pertains to the systematic adjustment of an intervention protocol to account for language, cultural factors, and contextual considerations in a manner that is consistent with the client's cultural patterns, meanings, and values. Scholars who specialize in cultural adaptation maintain that before disseminating interventions to ethnic minorities, it is necessary to modify these interventions to enhance their cultural appropriateness and resonance (Domenech Rodríguez et al., 2011; Smith et al., 2011). Alegria et al. (2010) propose that in order to enhance mental health care, it is imperative to prioritize diversity, culture, and context, while establishing natural support systems. This recommendation arises from the recognition that a uniform approach is insufficient, as different individuals and communities require tailored interventions that address their unique needs and circumstances.

7.3 Planning and recruitment for translations

In February 2020, the researcher obtained permission from GL Assessment Education Limited to use the HADS. Although Zigmond and Snaith (1983a) developed the HADS, GL Assessment is part of the GL Education Group in the United Kingdom that holds the copyright to distribute the HADS, which is currently available for purchase. Mapi Research Trust (2018) granted permission to translate the HADS from English to the Dagbani language, as they also hold the copyright for the translation of the HADS.

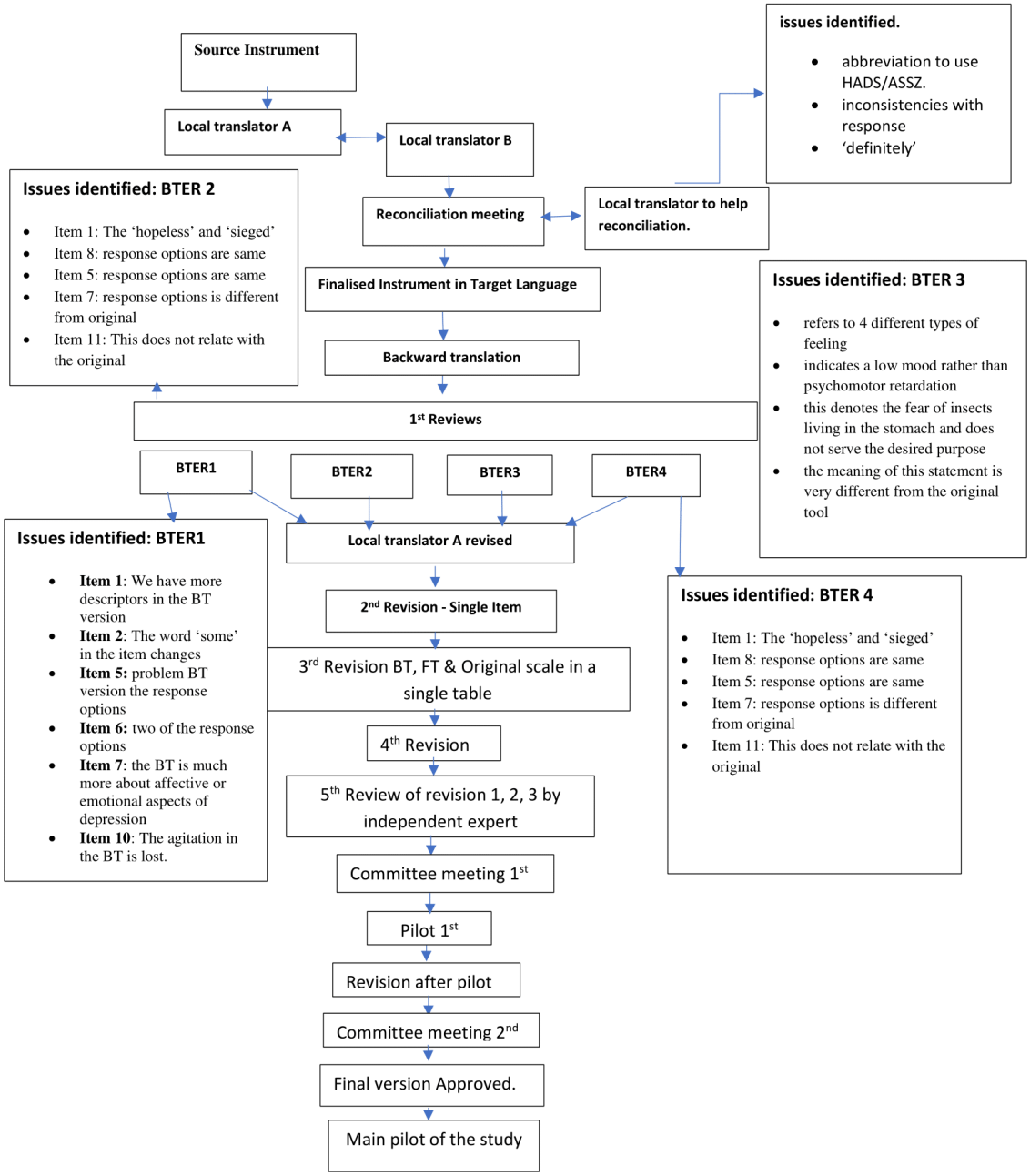
To begin the HADS translation, it was necessary to secure appropriate resources to ensure the validity of the work. The researcher acted as the Translation Coordinator (TC) to initiate the translation process. According to Koller et al. (2007), the TC is responsible for starting the translation process and developing the TC-A protocol to direct and oversee translators for the translation process. The researcher enlisted the services of two local translators to carry out the forward translation (FT) from English to Dagbani. Translator A, the first translator, held an MPhil in Ghanaian Languages and worked at the Bureau of Ghana Languages in Tamale, the northern regional capital of Ghana. The second forward translator, Translator B, was a professional teacher who had a bachelor’s degree in Ghanaian Language (Dagbani) and had been teaching Dagbani language for 21 years at senior high schools. A third translator, referred to as the Reconciliation Translator (RT), was appointed to help resolve any differences

between the two forward translations during a committee meeting. Following the recruitment of translators, A and B for the FT, a fourth professional translator, referred to as Backward Translator C, was engaged to carry out the backward translation (BT) from Dagbani back to English. C was a retired language expert, a professional translator, and a part-time communication skills lecturer at Technical University College in the northern region of Ghana. He had authored numerous Dagbani books and had studied in colleges in northern Ghana. Finally, expert reviewers in clinical psychology, psychiatry, mental health, and nursing education were enlisted to review each stage of the FT and BT. The expert reviewers involved in the BT stage were called Backward Translation Expert Reviewers (BTERs). See Figure 7.1 for the translation process.

The process of cross-cultural translation of the HADS from English to Dagbani involved two stages: forward translation (FT) and backward translation (BT). According to Mapi Research Trust (2018), FT involves translating the questionnaire from the original (English) into the target (Dagbani) language. Conversely, BT entails translating the Dagbani version back into English. In other words, the FT bridges the gap between the source and target languages, while BT ensures the accuracy and consistency of the translation. The process followed for the translation of the HADS from English to Dagbani is illustrated in Figure 7.1.

Figure 7.1

Sequence of the translation flow chart



7.4 Forward translation and report

Figure 7.1 depicts the translation process that was followed, which began with the FT. Two professional translators (local translators A and B) independently translated the original version of the HADS in English, including the items' statements, instructions, and response choices, into Dagbani. They were not aware of each other's translations and completed their work within a week. The TC then invited them to a committee meeting, which was also attended by the RT, who was employed to reconcile any disparities between the translations of local translators A and B. The third translator did not participate in the FT but was invited to the committee meeting to provide an independent opinion to help address any discrepancies between the translations. The meeting was held at the Bureau of Ghana Languages in Tamale with the aim of obtaining a single FT version in the target language for the BT.

The meeting took place on February 17, 2021, starting at 3 pm and ending at 6:30 pm (GMT). At the committee meeting, the team reviewed the translated titles and instructions and identified some inconsistencies with the second translator's translations of the response choices. One concern was the abbreviation of the title of the FT version. It was agreed to use the original title, HADS, instead of the translated initials, ASSZ (Ashibiti ni Suhuzohigu mini Suhudamli Zahimbu), in brackets, as the latter would not affect the linguistic meaning of the instrument and HADS is the universal acronym for the tool.

There were also discrepancies with the translation of "definitely" in items 2, 7, and 10 response options, as well as with the translation of "pick" or "tick" in "Tick the box beside the reply." The committee agreed to use "tick the box" instead of "picking" the box.

Another issue was with item 11, which was translated to mean "I cannot breathe" by both translators instead of "I feel restless as I have to be on the move." The committee resolved the issue, and a final Dagbani version of the HADS was completed and sent for BT. The next section provides a detailed description of the BT procedure. (See Appendix L for the final Dagbani version).

7.5 Backward translation

The next phase of the translation process involved the backward translation (BT) of the Dagbani version of the HADS back into English. The researcher sent the FT to a retired language expert, who completed the BT within a week. The BT was then compared with the original HADS document, and some issues were identified.

For example, the first item "I feel tense or wound up'" was mistranslated as "My heart beats fast". This was discussed with the professional translator and the item was corrected to "I feel tense” or 'hopeless', 'sieged', 'trapped'" before the expert review stage.

Expert reviewers with a background in health, psychology, mental health, and proficiency in both English and Dagbani were then invited to review and address any issues that arose from the BT. The expert review comments are described in detail in the section below.

7.5.1 Expert reviews of backward translation

After completing the BT, the researcher coordinated the first review with four expert reviewers. The BT version and the original HADS (in English) were sent to the expert reviewers to ensure that the items and response choices did not lose their original meaning. The four expert reviewers included health workers with mental health, psychology, and nursing qualifications working in the university, a psychiatrist who works in a tertiary health facility and lectures at the university, and a professor of clinical psychology who is a native English speaker with experience in tool development and transcultural translations of instruments. These reviewers were labelled BTERs and were denoted as BTER1, BTER2, BTER3, and BTER4. Details of each of their reviews are explained in the following sections.

7.5.2 Backward translation expert reviewer one (BTER1)

BTER1's role was to make the BT more readable and understandable for the participants. Upon reviewing the BT version, BTER1 found concerns with five items and the response options, regarding their wording, contextual meaning, formatting, and some response options. For instance, item 1, ‘I feel tense or 'wound up, was translated into ‘I feel tense or 'hopeless', 'sieged', and 'trapped'. BTER1 noted that this item had

more descriptors than the original version and conveyed a different sense of meaning. The original item elicits tension and anxiety, whereas the BT version suggests more of a depressed mood. Additionally, item 2 of the original version states, 'I still enjoy the things I used to enjoy'. This item was translated to 'I still enjoy some of the things I used to enjoy', and the word 'some' changes it significantly. In the HADS item seven, 'I feel as if I am slowed down', and the BT item was translated to 'I feel as if my spirit is down'. BTER1 reported that both statements depict depression, but the original version specifically elicits psychomotor retardation or vegetative symptoms. The BT was more about the affective or emotional aspects of depression. Finally, item 10 of the HADS says, 'I feel restless as I have to be on the move', but it was backward translated to 'I feel unease that things are not moving as expected'. The HADS asks about agitation, which gets lost in the BT.

The BT version response options in item 5 did not differ, especially 3 and 2 and the same response options 1 and 0. They were translated as '3. this is very often', "2. very often', '1. it happens from time to time' and '0 is only from time or 'not always'. In item 6, it was translated as 'I can sit quietly and feel relaxed', but two of the BT response options referred to laughing (0, 1), which was not mentioned in the original HADS item, and the next two response options (2, 3) did not include it.

7.5.3 Backward translation expert reviewer two (BTER2)

BTER2 was the second expert reviewer who identified issues with items 1, 5, and 8. In item 1, he noted that the BT version had three descriptors ('hopeless,' 'sieged', and 'trapped') instead of one as in the original HADS questionnaire. He also suggested a review of item 8, which was backward translated as "I feel as if my spirit is down," as it denoted emotional depression instead of the original intended meaning of psychomotor depression ('I feel as if I am slowed down'). Regarding item 5, BTER2 pointed out that response options 1 and 0 were translated to have the same meaning and needed revision. Therefore, option 1 was revised to read as 'It happens from time to time, not frequently', and option 0 was changed to 'Intermittently only'.

7.5.4 Backward translation expert reviewer three (BTER3)

The third expert reviewer, BTER3, who was a psychiatrist working with the University for Development Studies and Tamale Teaching Hospital in Ghana, suggested revisions

for items 1, 8, 9, 10, and 11. BTER3 specifically identified a problem with item 11. The original HADS item 14 states, ‘I can enjoy a good book or radio or TV program’, which refers to the ability to enjoy these activities. However, in the translated version, the item read as ‘I can read and listen to interesting information from books, radio, and television’, which only depicts the ability to read and listen, but not necessarily enjoy the activity.

7.5.5 Backward translation expert reviewer four (BTER4)

The fourth expert reviewer (BTER4) also identified issues with item 1's three descriptors and suggested replacing ‘hopeless’, ’sieged’, and ‘trapped’ with ‘unease’ or ‘choked’. BTER4 recommended revising option 2 of item 4 to "Yes, but not as much now." Additionally, BTER4 proposed modifying item 10 to better convey its intended meaning, as the backwards translation resulted in ‘I feel unease (uncomfortable) that things are not moving as expected’ instead of ‘I feel restless as I have to be on the move’. Similarly, BTER4 recommended re-translating item 14, as the backwards translation resulted in ‘I can read and listen to interesting information from books, radio, and television’, which describes the ability to read and listen but not the ability to enjoy the activity. BTER4 also suggested revising option 1 of item 5, as ‘It happens from time to time’ and ‘It's only from time to time/not always’ were deemed to have the same meaning. Details of this review can be found in Appendices I-K.

To address these concerns, the forward translator discussed them with the backward translator, and the BT version was revised to accurately reflect each item's statement and response choices to match the original HADS. After completing the four expert reviews and making the necessary revisions, the researcher coordinated a second round of revision on the BT.

In the second round of revisions for the backward translation process, tables were created for each of the 14 individual items to ensure that reviewers paid attention to the details of each item in their review, and to improve the translation. These tables included the original HADS, the FT, and the BT response options, with the aim of ensuring that reviewers paid close attention to the details of the translation. For example, reviewers identified an issue with item 2, where the original HADS did not indicate being the recipient of something awful, whereas the translated item

suggested that something was wrong with the participants' minds. Another issue was identified with item 5, where the translated item did not specifically capture the notion of rumination.

The reviewers also raised concerns about item 8 and its response options, with the BT reading as ‘I feel as if my life has retrogressed’, which was different in meaning from the original HADS, which read as ‘I feel as if I am slowed down’. These concerns were addressed by discussing them with one of the forward translators before consulting the third backward translator. The details of all the reviews are found in Appendix I-K, along with their tracked reviews and suggestions.

In the third round of reviews, all 14 items were put into a table containing the FT, BT, and original HADS versions, which were reviewed by experts fluent in Dagbani and English and were health workers. They suggested revising item 7’s response option 0 to ‘Certainly’ instead of ‘That is true’ from the translated version, which was in line with the original HADS version reading ‘Definitely’. The fourth revision involved putting three or four items in a single table with the original HADS, Dagbani, and BT versions, which aimed to improve the tool and ensure that no item with ambiguity was left unattended.

For the fifth and final revision, independent reviewers were recruited, including two psychology professionals who were native English speakers and a nurse who was a tutor at a nursing training college in Ghana and a native speaker of the Dagbani language. They identified minor concerns with item 1, and the other concerns raised by the reviewers were addressed to improve the backward and forward translations. The final revision was conducted by a female native speaker of the Dagbani language who was also fluent in English to ensure that no item or response option was missed, and that the BT version closely reflected the true meaning of the original HADS.

After the fifth revision, the first committee meeting to review the BT took place, and committee members identified some concerns with items 3 and 8’s response options. The researcher, who was fluent in both Dagbani and English, was able to make translation-related decisions without solely relying on professional translation. All concerns raised were addressed, and corrections were made where needed before piloting the translated instrument to observe any issues that might arise and

understand participants' perceptions and understanding of the BT before actual data collection.

7.5.6 Pilots

A pilot study is a small-scale study that tests research protocols, data collection instruments, recruitment strategies, and other research techniques in preparation for the main study (Hassan et al., 2006). Two pilot tests were conducted: the first was the pilot for the Dagbani HADS during the translation process, and the second was for the main study. As with any study, a pilot test is usually conducted on a smaller sample of participants according to research protocols and sample recruitment techniques (In, 2017). The pilot test helps in planning and modifying the main study. This section discusses the translation process pilot test, while the subsequent section considers the main study pilot test. The main pilot test is discussed in this translation chapter because it is also believed to add face and content validity to the translation procedure.

The first pilot study of the translated HADS

The first pilot study aimed to assess participants' understanding of the translated statements and response options, providing clarity from their perspective before the final version of the BT was approved at a committee meeting for the main study's pilot testing before the fieldwork. To test the first pilot, the researcher recruited participants with similar socio-economic status as the intended participants in the main study. The study was conducted in Nanton, approximately 135km from the Gambaga witches' camp, and took advantage of a district health conference held for the community. The researcher contacted a nurse friend who works in the community and used their connection to recruit participants through the district health Durbar.

Table 7.1

Participant characteristics of the first pilot study

Participant	Age	Gender	Employment status	Educational status
P1	50	F	Petty trading	None
P2	50	F	Farmer	None
P3	40	F	Farmer	Some Arabic education
P4	35	M	Farmer	Non-formal education
P5	52	M	Farmer	Arabic studies
P6	45	M	Farmer	None

Table ***7.1***, above, illustrates the demographic characteristics of the participants in the first pilot study. Out of six participants in the pilot, five were farmers, and just one person was a petty trader. None of them had formal education. Three were females and three were males. The minimum age of participants was 35 years, and the maximum age was 52 years.

7.5.7 Observation and reflections after the first pilot study

The researcher approached each participant individually to complete the questionnaire. After each pilot test, the researcher asked the participants to rate their understanding and indicate if they had difficulty understanding any items or response options. The participants were also asked if the translated HADS questionnaire was challenging to answer, confusing, or offensive. Additionally, they were asked to recommend or propose an alternative translation.

During the first pilot study, it was observed that participants often needed to read the words twice and connect them to the response options before understanding them

and making a choice. One of the expert reviewers identified that "Quite often" and "very often" were translated incorrectly and were subsequently re-translated to "Di tooi niŋda" and "Di tooi niŋdi pam," which mean "it happens often" and "it happens more often," respectively. The first pilot study helped the researcher understand how to present the items and response options to ensure participants understood them before making their choices. Generally, the participants did not have difficulty understanding the statements and response options. Additionally, a second committee meeting was held with three supervisors and a nursing tutor from Ghana, who reviewed the first pilot's observations and addressed concerns to improve the final version of the BT for use in the field. The final version was approved for use in the field, and the researcher conducted a pilot study for the main study, which further improved the translated instrument.

7.5.8 Main pilot study

A second pilot study was conducted to determine the acceptability, simplicity, appropriateness, and comprehensibility of the translated FT. This pilot test phase was considered the main pilot test because the HADS and a supplemental questionnaire developed in Phase One were tested together to explore issues that were not obtained in the HADS by itself. However, for this chapter, the focus is on the pilot test of the HADS, which may also be referred to as the second pilot test or the main pilot test of the HADS, as this stage holistically improved the translation process. Before conducting each pilot test, the researcher asked every participant to rate their understanding and indicate whether they had difficulty understanding any items and their response options. Participants were also asked to provide feedback on whether the translated HADS questionnaire was challenging to answer, confusing, or offensive and to recommend alternative translations. Specific instructions were given to participants to improve the translation process of the HADS, and this served as a rehearsal of the research study, allowing the researcher to test the research approach with a small number of participants before conducting the main research (Hassan et al., 2006).

As mentioned earlier, the HADS questionnaire was the first to be tested in the main pilot phase, and the participants were recruited from the Gambaga and Kpatinga witches' camps. Older women (above 40 years) who were native speakers of the Dagbani language were recruited for the pilot test. The pilot test was conducted

through individual interviews with participants who agreed to participate in the pilot study. A sample size of 10 was used for the HADS pilot test, based on recommendations from the European Organization for Research and Treatment of Cancer (EORTC) of a minimum of 10-15 participants for a pilot test on a tool that has undergone cross-cultural translation (Koller et al., 2007).

During the pilot testing, the researcher ensured that each item and its respective response options were read carefully to the pilot participants before they made their informed choices. The pilot interviews were conducted in the forecourt of the women's residence to ensure privacy.

In summary, the Dagbani version of the HADS was used for the pilot study, and participants did not have difficulty understanding the item statements and response options. The translated questionnaire items were neither difficult to answer nor confusing, difficult to understand, or offensive to the participants. The HADS questionnaire was found to be acceptable, appropriate, and comprehensible to pilot participants. It was also simple to administer, and participants could understand the items and response options. No recommendations or suggestions were offered by participants after the pilot interviews. The average time for administering the HADS questionnaire was 16 minutes. No modifications were made after the second or main pilot test.

7.6 Summary of the steps of translation/adaptation

The following is a summary of the steps taken in the translation/adaptation process:

- In February 2020, I obtained permission from GL Assessment to use the HADS for my research.

- After receiving permission, I sought approval from Mapi Research Trust (2018) to translate the HADS from English to Dagbani language.

- As the TC and researcher, I developed a protocol and recruited two local translators for Forward Translation (FT).

- The first local translator had an MPhil in Ghanaian Languages and worked with the Bureau of Ghana Languages in Tamale, the northern regional capital of Ghana.

- The original HADS in English was given to each forward translator privately, and they were given two weeks to translate it into the Dagbani language.

- After completing the FTs, a committee meeting was arranged to reconcile the two translators' versions. An additional translator was also invited to give their opinion on reconciliation at the meeting.

- The Dagbani version was then sent to another professional translator for Backward Translation (BT), which was completed in two weeks.

- The BT version was reviewed by four experts in clinical psychology, psychiatry, mental health, and nursing education. Concerns raised by the experts were addressed in consultation with one of the forward translators before it was sent back to the backward translator for further translation from Dagbani to English.

- The revised BT version was sent back to the experts for further revision until a consensus was reached.

- The FT, BT, and original versions were compared to ensure equivalence and meaning using tables with three items and their response options (see Appendix G). Revisions were done after comments from the experts.

- To ensure that no items or response options were missed in terms of their meanings and equivalence, the FT, BT, and original versions were compared and put into a single table.

- My supervisors reviewed the BT version and the original version of the HADS several times to ensure no ambiguities existed in any of the items and their response options. Revisions were done with the help of a colleague who was a bilingual health tutor to ensure meaning equivalence.

- My supervisors and a health tutor from Ghana approved the backward and Dagbani versions via a Zoom meeting.

- The translated tool was then piloted with six people from the general population to understand participants' perceptions of the translated version's item statements and response options. The aim was to revise the translated version before final approval of the BT version at a committee meeting.

- Finally, a committee meeting approved the translated tool.

7.7 Chapter summary

This chapter focused on the translation and cross-cultural adaptation of the HADS for the study. It discussed the rationale for selecting the HADS and provided details of the translation process, including the recruitment of translators, the forward and backward translation, and the expert reviews. The chapter also presented the observations and reflections on the translation process, as well as a summary of the steps taken. Chapter 8 will discuss the validation of the Dagbani HADS in the Phase Two study.

Chapter 8 Validation of the Dagbani HADS: Phase Two study

8.1 Introduction

The previous chapter detailed the process of conducting forward-backward translation and linguistic validation of the HADS. This chapter aims to present the results of testing the reliability and validity of the Dagbani version of the HADS (HADS-Dag) and investigating the anxiety and depressive symptoms experienced by women in the camp compared to the general population of northern Ghana. In addition, the women were asked to suggest ways and strategies to improve their mental well-being in the open-ended section of the questionnaire.

8.2 Participants' demographic profile

Out of the 170 older women from the witches' camps in northern Ghana invited to participate in the Phase Two study, 168 completed the questionnaire, resulting in a response rate of over 98%. Additionally, all 100 women from the general population (Northeast and Northern regions) who were invited to participate in the study consented to do so, resulting in a response rate of 100%. The ages of both groups of women were not reported due to the lack of clarity around their birthdates. According to the social worker (see Chapter 6), the women did not have any records of their ages and often estimate their birthdate. Birth registration has been an issue in SSA, with many people not having a birth registration and, therefore, no record of their age (Pirlea, 2019; Sankoh et al., 2020; United Nations Children's Fund [UNICEF], 2017). During the fieldwork in the Gambaga witches' camp, the social worker estimated the minimum and maximum ages of the women to be 65 and 95, respectively.

All participants in the camp lacked any educational or non-formal education background and were fluent in the Dagbani language. They were also unable to report their monthly or annual income levels. The majority of women participants in the witches' camps were of Konkomba ethnicity, while Chekosi, Frafra, Kamba, and Kusasi were the smallest ethnic groups in the camps. A summary of the demographic data is presented in Table 8.1

Demographic profile of the participants (women in camp and women from the general population) , below.

Table *8.1*

Demographic profile of the participants (women in camp and women from the general population)

Variable	Women in the camp* (n = 168)	General population (n = 100)	Total *N=268*
Region			
Northeast	83(49.4)	75(75)	158
Northern	82 (48.8)	24(24)	106
Upper east	2 (1.2)	1(1)	3
Savannah	1 (0.6)	0(0)	1
Religion			
Christian	107(63.7)	83(83)	190
Muslim	34(20.2)	17(17)	51
Traditional	27(16.1)	0(0)	27
Ethnicity			
Bimoba	3(1.8)	13(13)	16
Chekosi	1(0.6)	0(0)	1
Dagomba	6(3.6)	12(12)	18
Frafra	1(0.6)	0(0)	1
Kamba	1(0.6)	19(19)	20
Konkomba	121(72)	0(0)	121
Kusasi	1(0.6)	56(56)	57
Mampriga	34(20.2)	56(20.8)	90
Work		Previous work	Current work
Shea butter making		13(7.7)	3(3)
Petty trading		14(8.3)	23(23)
Farming		123(73.2)	73(73)
Pito brewing		7(4.2)	-
Housewife		11(6.5)	1(1)

Note. *n (%)

Out of the 168 women who responded to the questionnaire in the witches' camps, all but one had their own room. The majority of the women (n=157, 93.5%) did not receive any assistance with their day-to-day activities from anyone in the camp. Only eight (4.8%) of the women had their grandchildren living with them as helpers, but they were often too young to provide significant assistance. Additionally, only a small number (n=31, 8%) had another resident in the camp as a support person.

The questionnaire also included a question about who had accused the women of witchcraft, which resulted in their banishment to the camp. A total of 138 (82.1%) women indicated that members of their community had accused them, while 30 (17.9%) were accused by a co-wife. In this context, community members included co-tenants, extended family members, and neighbours from the village.

Regarding employment, prior to being banished to the camps, approximately 73.2% of the women worked in farming, including pig farming, fowl rearing, and cereal cultivation. Additionally, 8.3% were petty traders, 7.7% engaged in shea butter production, 7.1% were housewives, and 4.2% engaged in pito brewing. However, after arriving at the witches' camps, many lost their jobs or had to switch occupations. Table 8.2 below presents the current employment status of the women in the camp (n=168), with raw values and percentages.

Table *8.2*

Current work of the women in the camp (n=168)

Type of Work	N	%
Not working	76	45
Selling firewood	53	32
Helping people on their farms	39	23

8.3 Only 23% of the women in the camp earned their livelihood by helping people on their farms, while 32% resorted to picking firewood from the bush to sell and 45% were unemployed.

8.4 Factor analysis

This study conducted an exploratory factor analysis (EFA) on the HADS-Dag, separately for the anxiety and depression subscales. Before factor extraction, the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was calculated, and Bartlett's Test of Sphericity (BTS) was conducted to verify that the dataset characteristics were suitable for the EFA (Hadi et al., 2016). For the anxiety subscale, the KMO measure confirmed the sampling adequacy for the analysis with a value of 0.91. The BTS (X^2= 976.20, df=21, $p < .001$) also indicated that the data were suitable for factor analysis. Similarly,

for the depression subscale, the dataset's suitability was confirmed with a KMO of 0.92, and a significant BTS (X^2= 991.91, df = 91, p < 0.000).

The communalities for both the anxiety and depression subscales were high, indicating that all the items related to anxiety and depression shared some common variance. Communalities represent the proportion of an item’s variance explained by the factors fa. Prior to extraction, all the variance associated with a variable was assumed to be common variance. The communalities for all items were above .30, except for item 5, which had a value of .10. This confirms that each item shared some common variance with other items, except for item 5. These overall indicators suggested that the factor analysis was suitable (Table 8.3).

Additionally, a correlation matrix for the HADS items was computed, revealing that 13 of the 14 items had a correlation of at least .30 with at least one other item, further supporting the appropriateness of conducting a factor analysis. Item 5 was the only item that did not correlate well with the other items, with the highest value being -.250. Research suggests that moderate to high correlation is expected between anxiety and depression factors (Clark & Watson, 1991b).

As the Dagbani language differs significantly from English, no assumptions were made regarding the factor structure. The number of factors extracted was not restricted and was determined by applying Kaiser's criterion of eigenvalues above 1.00 (Braeken & Van Assen, 2017; Kaiser, 1958; Yeomans & Golder, 1982), the cumulative percentage of variance extracted (at least 50%), and the scree test (scree plot and eigenvalues that produce a departure from linearity). For the anxiety subscale, exploratory factor analysis (EFA) revealed a one-factor structure. However, only one item, namely item 5 ("I have worries"), from the anxiety subscale loaded poorly. Therefore, item 5 was removed as it failed to meet the minimum criterion of having a primary factor loading of .3 or above and did not contribute to a simple factor structure. After the deletion of item 5, the anxiety subscale explained 68.33% of the variance (eigenvalue of 4.10). Figure 8.1 shows the anxiety subscale's scree plot, which helps interpret the output of factor analysis and determine the number of factors to extract. In this case, the scree plot confirmed that a one-factor solution was the most viable option, as adding a second factor would provide minimal additional gain in the ability to explain variance.

EFA also revealed a one-factor structure for the depression subscale, with all items loading strongly. All items from the depression subscale contributed to a simple factor structure and significantly exceeded the minimum criterion of having a primary factor loading of .30 or above. The depression subscale explained 62.28% of the variance (eigenvalue of 4.36). The scree plots shown in Figure 8.2 show the output of factor analysis, and in this case, confirm a one-factor solution for depression items. Overall, the unrotated factor structure revealed a single factor corresponding to each of the anxiety and depression subscales of this study.

Table 8.3

Communalities

Items	**Communalities**
1. I feel tense or "nervous"	.649
3. I get a feeling of fear as if some misfortune or something bad is going to happen	.553
5. I have worries	D*****
7. I can sit quietly and feel relaxed	.698
9. I feel frightened	.692
11. I can't sit still because I have to move about	.732
13. I get a sudden feeling of fear	.777
Depression items	**Communalities**
2. I still enjoy the things which used to give me enjoyment:	.512
4. I can laugh and recognise the fun in things:	.552
6. I feel happy	.596
8. I feel slow	.721
10. I have lost interest in taking care of my personal appearance	.675
12. I look forward to things with joy	.768
14. I can read and enjoy interesting information from a book and programs on radio and television	.535

Note. *D = Deleted.

Figure 8.1

Scree plot for anxiety (with item 5 deleted)

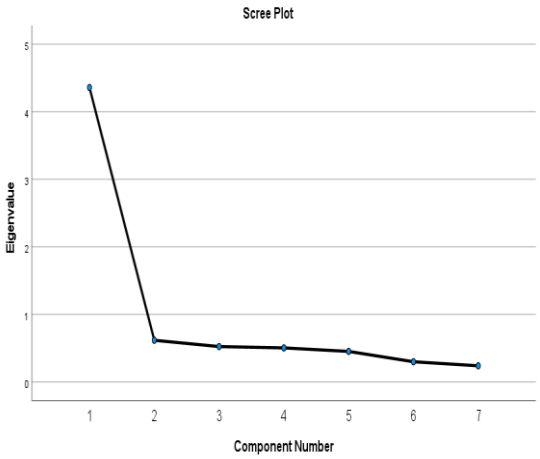


Figure 8.2

Scree plot for depression items

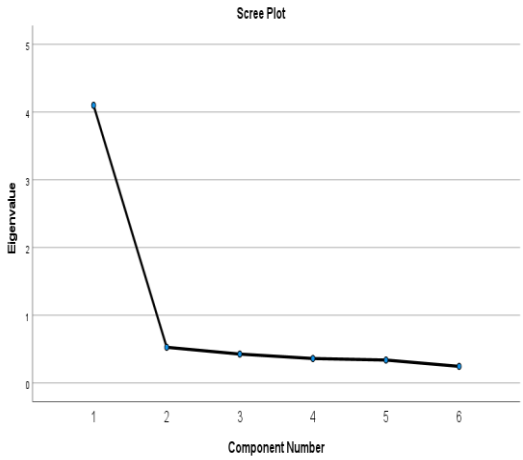


Table 8.4 below displays the factor structure for the entire sample dataset (n=268), showing the factor loadings for the anxiety and depression subscales. To ensure accuracy and precision, the factor loadings and communalities are presented to three decimal places in Table 8.3 and Table 8.4. As mentioned earlier, only one item (item 5, 'I have worries') from the anxiety subscale had a loading that was insufficiently high, and it was thus eliminated (shown in Table 8.3 above and in Table 8.4 as D*). A re-analysis was conducted, and the initial construct validity findings of the HADS-Dag using the two single-factor structures of the original measure were deemed acceptable.

Table 8.4

Factor structure for the entire sample dataset (n=268)

Items	Anxiety Factor	Anxiety Factor (No item 5)
1. I feel tense or "nervous"	.808	.806
3. I get a feeling of fear as if some misfortune or something bad is going to happen	.729	.743
5. I have worries	-.314	D*
7. I can sit quietly and feel relaxed[R]	.836	.836
9. I feel frightened	.831	.832
11. I can't sit still because I have to move about	.856	.855
13. I get a sudden feeling of fears	.878	.881
Items	**Depression factor**	
2. I still enjoy the things which used to give me enjoyment:	.716	
4. I can laugh and recognise the fun in things:	.743	
6. I feel happy[R]	.772	
8. I feel slow	.849	
10. I have lost interest in taking care of my personal appearance	.822	
12. I look forward to things with joy	.876	
14. I can read and enjoy interesting information from a book and programs on radio and television	.731	

Note. *D = Item 5 deleted. Only factor loadings above 0.4 are shown for clarity in the re-run. KMO = Kaiser-Meyer-Olkin measure of sampling adequacy; $\chi 2$ = Bartlett's test of sphericity tested with chi-square; $p < 0.001$. Extraction method: principal components analysis; rotation method: Promax with Kaiser Normalization; and maximum iterations convergence of 25. Questionnaire was completed in Dagbani but is presented here in English for the reader's understanding. [R] In the table above, in positively worded items the Likert-scale response options were reversed so that a higher score indicates more psychological distress.

8.4.1 Internal reliability and concurrent validity

Internal reliability tests were conducted separately for the anxiety and depression subscales of the HADS-Dag. The Cronbach's alpha coefficient for the anxiety subscale was initially 0.83, but after eliminating item 5, it increased to 0.90. For the depression subscale, Cronbach's alpha coefficient was 0.89. McDonald's omega test was also

conducted separately for each subscale. The McDonald's omega score for the anxiety subscale was 1.04, and for the depression subscale, it was 0.90.

Regarding individual item reliability, item 5 had unreliable internal consistency and was removed from the analysis. After the removal of item 5, the anxiety subscale had a McDonald's omega score of 0.91, while the depression subscale had a score of 0.90. Overall, both subscales passed the Cronbach's alpha test and McDonald's omega test, with scores above 0.70, indicating acceptable internal consistency for both subscales.

8.5 Descriptive statistics for anxiety and depression

In this section, we examine the normality of the HADS data for the entire Phase Two study sample. The whole dataset was assessed for normality, skewness, and kurtosis, and found to be moderately skewed. Specifically, the anxiety and depression scores were found to be left-skewed, with skewed values of -.567 and -.611, respectively. Additionally, the kurtosis values for anxiety and depression were -1.373 and 1.304, respectively, indicating that the distribution was platykurtic, producing fewer and less extreme outliers than the normal distribution. The sample data results for individual means, standard deviations, skewness, and kurtosis are presented in Table 8.5 below.

Figure 8.3

Anxiety histogram

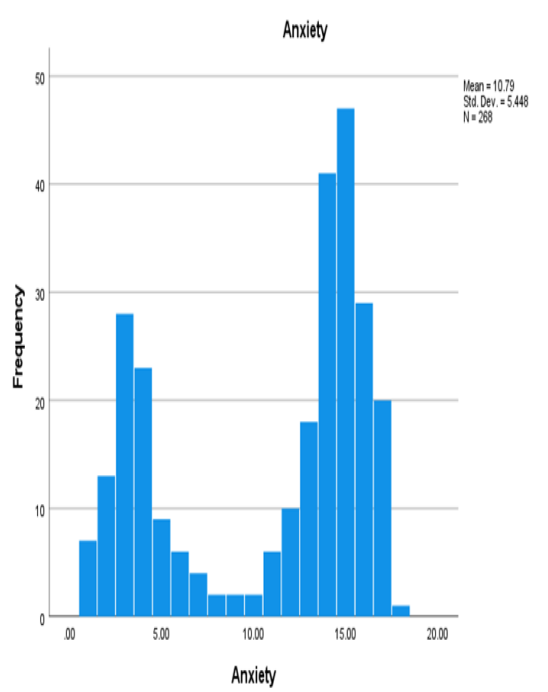
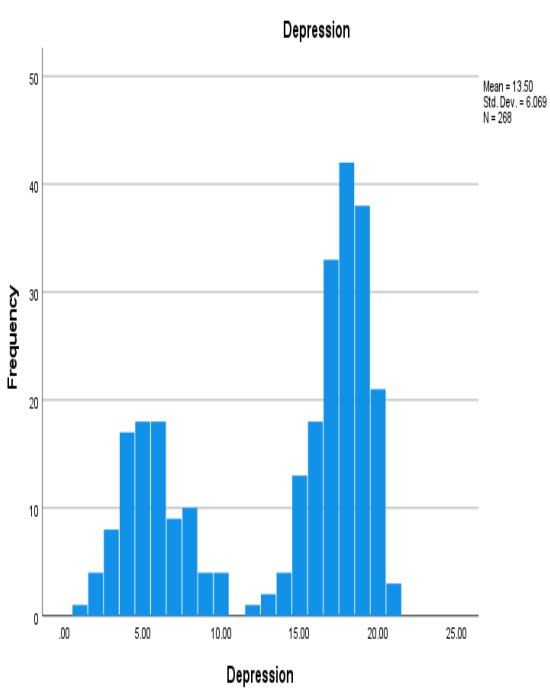


Figure 8.4

Depression histogram



8.6 Mean and standard deviation score

In section 8.6, the mean and standard deviation scores for anxiety and depression subscales are reported. The mean score for anxiety was found to be 10.79 (SD 5.45) for all participants, with a range of 1 to 18. On the other hand, the mean score for the depression subscale was higher, at 13.50 (SD 6.07), with a range of 1 to 21. Furthermore, an analysis was conducted to compare mean scores for anxiety and depression between women in the camp and women from the general population. The results showed that women in the camp had significantly higher mean scores for both anxiety (mean 14.73, SD 1.46) and depression (mean 17.85, SD 1.55) than women from the general population (mean 4.18, SD 2.43 and mean 6.18, SD 3.00, respectively). Table 8.5, titled "Means, standard deviations, skewness, and kurtosis of Dagbani Hospital Anxiety and Depression Scale items", presents detailed information on the means, standard deviations, skewness, and kurtosis of the individual items in the dataset.

Table 8.5

Means, standard deviations, skewness, and kurtosis of Dagbani Hospital Anxiety and Depression Scale items

Anxiety items for women in camps	Mean	Standard Deviation	Skewness	Kurtosis
5.I have worries	2.52	0.67	-1.31	1.39
9.I feel frightened	2.51	0.67	-1.41	2.07
1.I feel tense or "nervous"	2.43	0.70	-1.26	1.82
3.I get a feeling of fear as if some misfortune or something bad is going to happen	2.43	0.70	-1.26	1.82
11.I can't sit still because I have to move about	2.42	0.71	-1.02	0.52
13.I get a sudden feeling of fears	2.26	0.66	-0.71	1.08
7.I can sit quietly and feel relaxed [R]	1.82	0.70	0.27	-0.95
Depression items for women in camps				
8.I feel slow	2.62	0.57	-1.18	0.42
10.I have lost interest in taking care of my personal appearance	2.60	0.58	-1.30	1.70
14.I can read and enjoy interesting information from a book, and programs from radio, and television	2.59	0.61	-1.53	2.73
4.I can laugh and recognise the fun in things	2.55	0.75	-1.72	2.52
6.I feel happy[R]	2.54	0.62	-1.32	2.12
12.I look forward to things with joy	2.52	0.60	-1.02	0.94
2.I still enjoy the things which used to give me enjoyment	2.43	0.70	-1.26	1.82
Anxiety items for women from the general population				
5.I have worries	2.38	0.91	-1.41	1.07
3.I get a feeling of fear as if some misfortune or something bad is going to happen	1.26	0.65	0.16	0.04
7.I can sit quietly and feel relaxed [R]	0.98	0.38	-0.23	4.40
1.I feel tense or "nervous"	0.63	0.71	1.02	1.07
13.I get a sudden feeling of fears	0.45	0.88	2.06	3.23
9.I feel frightened	0.43	0.78	2.18	4.57
11.I can't sit still because I have to move about	0.43	0.82	1.86	2.45
Depression items for women from the general population				
14. I can read and enjoy interesting information from a book, and programs from radio, and television	1.27	0.83	1.06	1.86

6. I feel happy[R]	1.20	0.68	1.46	0.81
4. I can laugh and recognise the fun in things	1.11	0.99	1.48	2.39
2. I still enjoy the things which used to give me enjoyment:	1.06	0.72	0.53	-0.74
8. I feel slow	0.60	0.99	1.61	1.19
10. I have lost interest in taking care of my personal appearance	0.59	1.02	2.51	5.66
12. I look forward to things with joy	0.35	0.78	-0.22	-0.95

Note. The items are rank in order from highest mean (most frequent) to lowest mean (least common symptom). [R] In the table above, in positively worded items the Likert-scale response options were reversed so that a higher score indicates more psychological distress.

8.7 Scores for the Dagbani anxiety and depression scale

Table 8.6 and Table 8.7 display the frequency of individual items for the anxiety and depression scales, respectively, for women in the camps and women from the general population. These tables provide information on the mean and standard deviation of each item after the deletion of item 5.

Table 8.6

Anxiety and depression scores for the camp women

Item score statistics (N=168)	Score distribution (N)				M (SD)
	0	**1**	**2**	**3**	
HADS anxiety score for women in the camp					
1. I feel tense or "nervous"	4	8	67	89	2.43(0.69)
3. I get a feeling of fear as if some misfortune or something bad is going to happen	2	11	53	102	2.52(0.67)
7. I can sit quietly and feel relaxed[R]	3	8	57	100	2.51(0.67)
9. I feel frightened	2	15	61	90	2.42(0.70)
11. I can't sit still because I have to move about	3	11	94	60	2.26(0.65)
13. I get a sudden feeling of fears	1	4	58	105	2.59(0.57)
HADS depression score for women in the camp					
2. I still enjoy the things which used to give me enjoyment	4	8	67	89	2.43(0.69)
4. I can laugh and recognise the fun in things	5	11	39	113	2.55(0.74)
6. I feel happy[R]	2	5	61	100	2.54(0.61)
8. I feel slow	0	7	50	111	2.62(0.56)
10. I have lost interest in taking care of my personal appearance	1	5	55	107	2.60(0.58)
12. I look forward to things with joy	1	6	65	96	2.52(0.59)
14. I can read and enjoy interesting information from a book, and programs on radio, and television	2	5	53	108	2.68(0.61)

Note. [R] In the table above, in positively worded items the Likert-scale response options were reversed so that a higher score indicates more psychological distress. This follows the developers of the scale.

Table 8.7

Anxiety and depression scores for the women from the general population

Item score statistics (N=100)	**Score distribution(N)**				
	0	**1**	**2**	**3**	**M(SD)**
HADS anxiety score for women from the general population					
I feel tense or "nervous"	50	45	4	1	0.63(0.70)
I get a feeling of fear as if some misfortune or something bad is going to happen	9	58	31	2	1.26(0.64)
I can sit quietly and feel relaxed[R]	8	86	6	0	0.98(0.37)
I feel frightened	69	25	0	6	0.40(0.78)
I can't sit still because I have to move about	74	13	9	4	0.43(0.82)
I get a sudden feeling of fears	73	17	2	8	0.45(0.88)
HADS depression score for women from the general population					
I still enjoy the things which used to give me enjoyment	16	69	8	7	1.06(0.72)
I can laugh and recognise the fun in things	32	37	19	12	1.11(0.99)
I feel happy[R]	6	77	8	9	1.20(0.68)
I feel slow	67	15	9	9	0.60(0.98)
I have lost interest in taking care of my personal appearance	67	17	3	12	0.59(1.01)
I look forward to things with joy[R]	78	15	1	6	0.35(0.78)
I can read and enjoy interesting information from a book, and programs on radio, and television	21	39	43	3	1.27(0.82)

Note. [R] In the table above, in positively worded items the Likert-scale response options were reversed so that a higher score indicates more psychological distress. This follows the developers of the scale.

Table 8.8

Comparing means for anxiety and depression in the camp women and women from the general population

Variables	Mean	Standard deviation	Standard error	Independent t-test
Women in the camp – anxiety	14.73	1.46	0.11	t=39.33 p < 0.01
Women from the general population – anxiety	6.18	2.43	0.24	
Women in the camp – depression	17.85	1.55	0.12	t=36.11 p < 0.01
Women from the general population – depression	4.18	3.00	0.30	

An independent-samples t-test was performed to compare the anxiety and depression scores of women in the witches' camps and women from the general population. The results revealed a significant difference in the anxiety scores for women in the camps (M=14.73, SD=1.46) and for women from the general population (M=6.18, SD=2.43). Similarly, a significant difference was observed in the depression scores between camp women (M=17.85, SD=1.55) and women from the general population (M=4.18, SD=3.00), with the corresponding t-test values and p-values provided in Table 8.8. These findings indicate that anxiety and depression are more prevalent among camp women. Specifically, the results suggest that the women in the camps experience higher levels of psychological distress than the women from the general population, even though the latter group also reports some degree of psychological distress.

8.8 Summary of psychometric properties

The Phase Two study examined the psychometric properties of the Dagbani version of the HADS by estimating validity, reliability, and factor structure with women from witches' camps and women from the general population. The key findings of the study are summarised as follows:

- 168 older women from witches' camps in northern Ghana and 100 women from the general population in the northern region completed the HADS.
- Exploratory factor analyses (EFA) were conducted on the entire sample of participants, revealing a one-factor structure for each of the two subscales (Table 8.4).
- The first principal component of the anxiety subscale accounted for 68.33% of the variance (eigenvalue of 4.10), while for the depression subscale the first PC accounted for 62.28% of the variance (eigenvalue of 4.36).
- All items loaded strongly, except item 5 ('I have worries') from the anxiety subscale, which had an insufficiently high loading (-.314) and was deleted.
- After deleting item 5, reliability tests were conducted separately for the anxiety and depression subscales, measuring internal consistency using Cronbach's alpha and scale-item correlations. Results showed acceptable Cronbach's alpha values of 0.90 and 0.89 for the anxiety and depression subscales, respectively.
- McDonald's omega tests were also conducted, with the anxiety subscale scoring 1.04 before deleting item 5 and 0.91 after the deletion. McDonald's omega score for the depression subscale was 0.90.
- In conclusion, the Dagbani version of the HADS is a reliable and valid self-assessment scale for assessing the psychological status of women from the witches' camps and the general population. It is recommended for use in community assessments of vulnerable populations.

8.9 Results of supplemental and open-ended questions

This section provides details on the supplemental questions that were included in the Phase Two data collection. These questions aimed to capture issues that were not covered by the HADS scale but were related to the Phase One findings. The Phase One results highlighted the lack of critical social amenities that can impact an individual's mental health and emotional well-being, as well as the absence of healthcare and psychological care support in the camps. The supplemental questions were intended to ensure completeness and clarity since the Phase One findings informed the Phase Two study. In an exploratory sequential mixed-methods study, researchers often use the results from one phase to inform inquiry in the subsequent phase. Therefore, this section provides an explanation of the health and psychological experiences of women in the camps, excluding women from the general population.

8.10 Women's psycho-social experiences and support in the camp

This section describes the psycho-social experiences and support provided to women in the camp. It covers their current and previous health status, health-seeking behaviour, and the need for psychological support while in the camp.

The women were asked about their health status before and after coming to the camp. As shown in Table 8.9, the majority (89.9%, n=151) reported no health problems before coming to the camp, while 10.1% (n=17) reported having health issues such as joint pains, headaches, and difficulty walking. However, after coming to the camp, 81.5% (n=137) reported experiencing health issues such as joint pains, general body pains, and waist and knee pains. Some also reported piles, hypertension, vision issues, and difficulty walking. Only 18.5% (n=31) reported having no health issues while living in the camp.

The women were also asked whether they sought medical attention when they felt unwell. The majority (67.3%, n=113) reported seeking medical attention, while 32.1% (n=54) did not. Additionally, all women reported that there was no clinic available in the camp.

The emotional experiences and stigmatization faced by the women, as well as their access to drinking water and psychological support, are detailed in Table 8.9. It was

found that most women experienced emotional distress and stigmatization due to their status as alleged witches. The lack of access to clean drinking water was also a significant concern. Psychological support was not readily available, and many women expressed the need for such support to cope with their traumatic experiences.

In summary, the women in the camp experienced various health issues, sought medical attention, when necessary, but faced challenges due to the absence of a clinic in the camp. They also experienced emotional distress, stigmatization, and a lack of access to clean drinking water. The need for psychological support was expressed by many women.

Table 8.9

Camp women's experience of psychological support

Question	Not answered	Yes *n* (%)	No *n* (%)
Does a community psychologist visit the camp?	0 (0)	0(0)	168 (100)
Do you have potable drinking water in this camp?	0(0)	168 (100)	0(0)
Do you ever feel hemmed in a hole?	0(0)	168 (100)	0(0)
Do you feel that larger dwelling rooms should be built in this camp?	0(0)	168 (100)	0(0)
Do you feel lonely at times?	3(3)	160 (95.2)	3 (1.8)
Do you feel isolated from your home community?	0(0)	165 (98.2)	3 (1.8)
Do you feel at times that people from the community are pointing fingers at you?	0(0)	165 (98.2)	3 (1.8)
Do you sometimes feel that people are talking ill about you?	0(0)	98.2(165)	1.8(3)
Do you have anybody to talk to about your worries and concerns?	16(9.5)	32 (19)	120(71.4)
Do you attend a clinic when you are unwell?	1(0.6)	112 (66.7)	55 (32.7)

Note. Though there are no clinics in the camps, the women attend a clinic in nearby villages.

Table 8.9 reveals that none of the women in the camp received any psychological support during their stay. In Phase One, the women reported relying solely on the social worker for psychological care when they experienced sadness or emotional distress.

In contrast, the women from the general population surveyed by the DHADS were asked about their current health status. The majority (94%) reported having no health concerns, with only 5% complaining of joint pains and waist pains, and one woman (1% of the sample) did not provide an answer as she claimed not to know.

The women in the camp were also asked about the circumstances under which they would return home. More than half (50.6%, n=85) stated that they would return home if their families wanted them back, while 31.5% (n=53) indicated that they would return home if their children came to the camp to get them. However, 17.9% (n=30) reported that they would never return home.

Regarding traditional medicine use, the majority (64.9%, n=109) of women in the camp used it when they felt unwell. Around 31.5% (n=53) did not use traditional medicine, and only 3.6% (n=6) did not provide an answer. The women who used traditional medicine were asked about the type and reason for use. Approximately 35.1% (n=59) reported using herbs for any sickness or illness, while 31.5% (n=53) used herbs for malaria and other diseases like boil infections. Additionally, 16.1% (n=27) and 15.5% (n=26) used local herbs for toothache, body, and joint pains, respectively. Only 1.8% (n=3) did not answer this question.

8.11 Ways and strategies to improve the women's mental well-being

This section describes the strategies suggested by the women to improve their mental well-being while in the camp. The women identified basic health and mental health needs, social amenities, infrastructure, economic empowerment, and healthcare support as key areas that needed improvement.

According to the women, the provision of basic necessities such as food, potable water, clothing, mosquito nets, and adequate security was crucial in improving their health and well-being in the camps. Social amenities such as decent housing, larger

rooms with space, a clinic, electricity, and sanitation facilities like Kumasi Ventilated Improved Pit latrines (KVIP) were also mentioned.

For those who had their grandchildren with them in the camps, the women requested a school for their grandchildren. Additionally, they wanted a corn mill to ease the burden of processing their grains manually. To earn a livelihood and gain financial support for their upkeep, the women requested support to farm independently and educational bursaries to cater for their grandchildren.

The women also suggested that the government register them on the national health insurance scheme and build a hospital in the camp. They emphasized the need for clinics and healthcare staff to care for their healthcare needs, which would go a long way in improving their mental well-being.

8.12 Chapter summary

This chapter validates the Dagbani version of the HADS and provides descriptive statistics. The chapter also presents the women's psycho-social experiences in the camp and their suggestions for improving their mental well-being. These findings will inform the discussion and concluding chapter, where recommendations for public health action will be outlined.

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Chapter 9 Discussion

9.1 Introduction

Previous Chapters 6, 7 and 8 have presented the findings from the qualitative study (Phase One), the translation of the HADS, and the validation of the Dagbani version of the HADS with witches' camp women and women from the general population in Phase Two of the study.

In this chapter, the key findings from each phase will be reported and critically discussed in relation to the literature. This is important because it provides a comprehensive understanding of the results from both Phases One and Two. According to Creswell (2014b), the interpretation of an exploratory sequential mixed-methods study should be presented in a specific order. In the current study, this includes reporting on the qualitative findings that helped identify the instrument for the quantitative study in Phase Two. This chapter will therefore begin by summarizing the key findings of Phase One, followed by the steps taken to identify the HADS instrument, then the cross-cultural translation of the HADS, and finally, a summary of the quantitative results from the second and final phase of the study.

Phase One aimed to explore the factors that influence the mental health and emotional well-being of older women residing in witches' camps in northern Ghana. This phase utilized a qualitative interpretive approach, which involved conducting face-to-face interviews with older women (n=15) and allied stakeholders (n=3) to gather data. Braun and Clarke's (2012a) thematic analysis approach was used to analyze the data, resulting in the emergence of nine themes and 31 subthemes. The findings indicated that anxiety and depressive symptoms were prevalent, based on the participants' expressions and experiences.

The findings from Phase One informed the instrument used in Phase Two. After considering the prevalence of anxiety and depression found in Phase One, Zigmond and Snaith's (1983) HADS was identified as a suitable instrument to use in the quantitative Phase Two study. To ensure the instrument reflected the participants' culture and setting, the HADS was linguistically translated before use. As noted in Chapter 5 of this thesis, Creswell (2014b) argued that while an exploratory sequential

design is intended to develop better measurements with specific populations for the quantitative phase, it is not limited to this use. Researchers can also analyse qualitative data to develop new variables, identify scale types in current instruments, or form categories of information for exploration in the quantitative phase. Therefore, a cross-cultural and linguistic translation was conducted on the HADS, from English to the Dagbani language, as presented in Chapter 7.

Phase Two employed a cross-sectional descriptive quantitative survey to validate the Dagbani version of the HADS linguistically and to investigate levels of anxiety and depression among women in the witches' camps, as well as a sample of women from the general population in northern Ghana. The data was gathered using the HADS-Dag (detailed in Chapters 7 and 8), along with a list of additional questions addressing the psychological support experiences of women in the camps, which were administered to both groups (n=168 for witches' camps and n=100 for general population). Consequently, Chapter 8 presented the results of the quantitative study after administering the Dagbani HADS to both women in the camps and the general population.

In this chapter, the results of the two phases of this study are critically discussed in light of existing literature to inform evidence-based actions and interventions aimed at addressing the mental health and emotional well-being of women in the camps. The chapter synthesizes the main findings resulting from the research aim and objectives, and identifies areas in which this study aligns with, challenges, and expands on the existing body of knowledge in the context of the SEM (Bronfenbrenner, 1979), the explanatory model (Kleinman et al., 1978), and the social determinants of health (Commission on Social Determinants of Health, 2008a, 2008b; World Health Organization, 2003). The key findings from the two phases are interpreted and examined in this chapter as follows.

9.2 Discussion of key findings

This study aims to understand the factors that affect the mental health and emotional well-being of older women residing in witches' camps in northern Ghana. The specific objectives of this study are:

1. understanding their common mental health and emotional well-being challenges

2. describing the socio-cultural and emotional needs and practices that influence their health-seeking behaviours

3. examining their experiences of health services in the camps; and

4. recommending health service and policy directives that meet their mental and emotional needs concerning culturally appropriate health and social care provision.

9.3 Mental health and emotional health challenges of older women residents in witches' camps

Regarding the first objective of the study, the qualitative data provided an in-depth understanding of the factors that affect the mental health and emotional well-being of older women in witches' camps in northern Ghana. To address this objective, data were extracted and synthesized from interviews with women participants. The participants reported various physical health problems that had an impact on their overall and emotional well-being. These physical health problems included hypertension, chronic pain (such as leg and joint pain and unexplained bodily discomfort), difficulty walking, and others.

Allied stakeholders in this study held the view that physical health problems can lead to mental health problems, with the latter being manifested subconsciously. Women who participated in the study reported experiencing physical health problems such as chronic pain, joint pains, and difficulty walking, which impacted their emotional and general well-being negatively. These physical symptoms also affected their ability to conduct daily activities such as cooking, bathing, and walking, leading to frailty and loss of independence. For instance, one woman from the witches' camp reported not bathing because she felt weak and could not walk. These findings are consistent with Bronfenbrenner (1979) ecological systems theory at the micro level, which suggests that chronic pain affects people's ability to function and carry out daily activities.

The study's findings also align with the Matheson et al. (2014) study conducted in Canada, which showed that physical health problems increase the risk of developing mental health problems. According to their research, almost one in three people with a long-term physical health condition also had a mental health problem, with depression and anxiety being the most common mental health problems. The relationship between mental health and chronic physical conditions can significantly impact people's emotional well-being and quality of life (De Hert et al., 2011; M et al., 2011; Mentalhealth.org.uk, 2022; Osborn, 2001; Robson & Gray, 2007).

Additionally, a recent quantitative study conducted in Nigeria by Igwesi-Chidobe et al. (2021a) reported that participants expressed emotional and psychological distress through physical symptoms, which they believed provided cultural legitimacy. This may explain why women interviewed from the witches' camps in northern Ghana expressed how their physical health problems impacted their emotional well-being. In Burkina Faso, Duthé et al. (2016) found a strong association between mental disorders such as depression and various factors such as reported chronic health problems, functional limitations, household food shortages, being a victim of physical violence, and regularly drinking, through a quantitative study.

Furthermore, the banishment of these women to the witches' camps led to disrupted family connections, resulting in loneliness and sadness that further impacted their mental health and emotional well-being. The women reported feeling lonely and despairing due to being isolated from their families. The loss of contact with their families negatively impacted their emotional well-being, leaving them feeling deeply distressed. The ongoing effects of family disconnections included constant worries associated with separation, lack of emotional comfort in the camp, and ongoing loneliness. This emotional distress was exacerbated by the fact that these women missed their children and were unable to see and play with their grandchildren. Previous studies have shown that older adults' experiences of loneliness worsen when younger generations do not spend ample time with them and promote familial intimacy (Lin et al., 2015; Robb et al., 2020; Zhang, 2022). The women in this study expressed worry about the absence of family support, which would have been available in the villages where they previously lived. With family support, these women could have enjoyed family cohesion in their villages and received assistance with daily

activities such as fetching firewood, cooking, and bathing. In contrast, one of the interviewed women did not feel the need for family support. She explained that her son had accused her of witchcraft, leading to her banishment to the camp. She expressed feeling safe and comfortable in the camp as it provided a sense of distance from her home.

Furthermore, the present study found that the women participants experienced simultaneous feelings of sadness and loneliness. Some women reported feeling sad because they had lost their farm and means of livelihood when banished to the camp. This finding is consistent with several studies that reported on the vulnerability of aged women, many of whom were frail, to social isolation and loneliness due to the forcible separation from their families, which in turn led to attendant health problems such as depression, cognitive decline, and heart disease (Cacioppo & Cacioppo, 2014, 2018; Donovan & Blazer, 2020). In the context of this current study, aged women alleged to be witches are banished and forcibly separated from their families to live in camps where many of them are deprived of support, despite being too frail to fend for themselves.

As previously noted, the participants' responses suggested that common mental health and emotional well-being problems manifested as disrupted sleep, loneliness, anxiety, suicidal thoughts, forgetfulness, and self-stigmatization. It is therefore important to develop community interventions aimed at promoting mental health and social equity and targeted efforts addressing the mental well-being of individuals within a community should be ensured while addressing social disparities and inequities. These interventions should typically focus on empowering individuals and communities, enhancing social support networks, and creating environments that foster mental health and social justice (Castillo et al., 2019).

9.3.1 Housing and health

The women's concerns about their well-being were further compounded by poor housing and limited space in their rooms. They expressed their dissatisfaction with the nature of their houses, which they felt affected their dignity and mental health. Chapter Six of the study includes photo observations that show the women living in dilapidated homes with cracks, open windows, and unfenced doors. These homes are

built with mud, roof, and thatch, as seen from the photos. During the rainy season, some of the rooms or homes are known to collapse, causing fear and discomfort among the women. The poor conditions of their rooms and the fear they experience during the rainy season may worsen their problems with sleep and rumination at night, on top of the pain and physical health symptoms associated with the witchcraft accusations.

Moreover, research has shown that persistent housing problems have been associated with poor mental health outcomes (Commission on Social Determinants of Health, 2008b; Howden-Chapman et al., 2011; World Health Organization, 2008). Additionally, an allied stakeholder participant in the study confirmed the negative impact of poor housing on individual mental health, stating that it made the women feel "hemmed in a hole," further exacerbating their already poor mental health. Sighted in the National Ageing Policy document of Ghana, it was reported that the informal nature of Ghana's economy and the low levels of wages and salaries mean that many individuals experience poverty as they age, potentially infringing upon the economic rights of older persons in the country. Reports have emerged of older individuals being rejected by younger generations and forced to vacate family homes or rooms, which are subsequently rented out for profit. This troubling trend contributes to the increasing rates of neglect, physical abuse, and poverty among the elderly population in Ghana and further exacerbating the witchcraft abuse and accusations of older people (Government of Ghana, 2010).

Furthermore, based on the women's experiences and photo observations, it was evident that the lack of other social facilities, such as a meeting room and security, had a negative impact on their mental well-being. Many of the women confirmed this during the interviews.

Housing is a critical physical and social facility that plays a significant role in promoting security, dignity, comfort, and well-being. Inadequate housing and social inequalities are risk factors for many common mental disorders, and the provision of key amenities such as housing and healthcare is crucial for addressing these issues. Previous research has demonstrated that persistent housing problems are associated with poor mental health (Pevalin et al., 2017).

9.3.2 Food insecurity and mental health

The present study highlights the significant issue of food insecurity among the women living in the witches' camps. The women heavily rely on occasional donations from benevolent individuals and organizations for their food. The social worker in the camp confirmed this and stated that the women lacked sufficient nutritious food and sometimes went without food, exacerbating their poor health and frailty. These findings emphasize the impact of social determinants, such as the social, economic, and physical environments, on mental health and common mental disorders (Marmot & Wilkinson, 2005; World Health Organization, 2008). Myers (2020)reviewed the association between food insecurity and psychological distress and found a strong correlation between the two. Similarly, Fang et al. (2021)conducted research in a low-resource nation and reported that food insecurity due to the COVID-19 pandemic increased the risk of mental illness. It is worth noting that in March 2021, Kombat (2021) reported that the witches' camps suffered from a lack of food, and the women frequently went hungry (Men et al., 2021).

Similarly, the SDG 3, ‘Good Health and Well-being’ (United Nations, 2015) aligns with the negative impact of poor housing and lack of critical social amenities on women’s mental health and emotional well-being, as highlighted in the current study (Peltzer & Pengpid, 2020).. These findings are consistent with a study conducted in South Africa, which reported that low income, lack of basic amenities, residing in informal settlements or traditional dwellings, discriminatory experiences, and perceived community violence were associated with mental distress. The study also found that depression was associated with being of an older age and female gender.

In addition, it is important to note that the lack of access to safe water and adequate sanitation can have significant implications for the psycho-social well-being of individuals and households (Bisung & Elliott, 2017). Brewis et al. (2021)also reported high levels of depression and anxiety symptoms among participants who experienced water insecurity in eastern Ethiopia. The effect of water insecurity on depression was attributed to the unfair distribution of this critical resource to their communities. The current study's findings further suggest that the mental health and well-being of the women in the camps are influenced by the lack of social amenities, food and water insecurity, and trauma resulting from being persecuted and banished from their

families to live in witches' camps. These factors contribute to the failure to meet the SDG 3 regarding 'Good Health and Well-being'. The failure to achieve SDG 3 may also directly and indirectly lead to not achieving other SDGs and targets (World Health Organization, 2008).

9.4 Socio-cultural and emotional needs and practices that influence women's health-seeking behaviours.

In Phase One, various factors, including cultural and local belief systems, financial constraints, and the lack of critical social amenities and social care provision (as outlined in Chapter 6), were found to have influenced the women's socio-cultural and emotional needs and practices, and appeared to have affected their health-seeking behaviour.

Apart from the lack of healthcare facilities in the camp, deeply rooted belief systems and cultural health practices also had an impact on the women's health-seeking behavior. Due to the consequences of financial constraints and the unavailability of medicines, many women relied on local herbs to treat illnesses such as boils on the skin. Participants generally did not seek medical attention for their unexplained illnesses, preferring instead to put their faith in their folk belief systems. The women interviewed did not typically seek medical explanations for the causation of their ailments, instead holding onto locally influenced cultural beliefs or attributions (Kwame, 2018). For instance, they traditionally and culturally believed that the presence of boils was a spiritual disease of the air (Kwame, 2018).

In the population of northern Ghana, there is a common cultural belief that most illnesses are caused by spiritual factors, which leads individuals to seek out traditional healers for both the cause and the cure of their ailments (Kwame, 2021; Warren et al., 1982; World Health Organization, 2019). This finding is consistent with Gyasi et al. (2016) report on health-seeking behaviour in Ghana, which highlights the significant role of cultural beliefs in shaping the use of non-traditional treatments. Gyasi et al. explained that discomfort with western medicine and its medicalization steers individuals back to traditional medicine. Factors such as cultural norms, health beliefs, and perceptions of illness and causes also influence traditional medicine use (Hartog & Hartog, 1983). Helman (1984) and Tabi et al. (2006) similarly reported strong cultural

influences on spiritual and religious beliefs, leading people to prefer local herbal medicines that may lack evidence of efficacy over hospital treatment. The study's theoretical framework contextualizes the influence of underlying cultural beliefs, in line with Kleinman (1978) explanatory models, which contend that prior beliefs about illness causation, perception, experiences, and traditional beliefs profoundly influence health-seeking behaviours.

Furthermore, how people perceive, interpret, and respond to illness is influenced by cultural and social contexts, and not solely by the illness itself (Lilhare et al., 2020).. Therefore, the women in the camps and the Earth Priest's prior beliefs regarding the causation, perception, experiences, and traditional beliefs may have affected their choice to use local herbs, and not only the lack of healthcare facilities and other barriers to accessing health services (Dinos et al., 2017; Mathews et al., 2019). Additionally, for Africans, well-being is not solely about the healthy functioning of the body through proper healthcare and lifestyle; spiritual involvement is also crucial(Asare, 2017).

The World Health Organization (2019) has reported that traditional medicines and local herbs play a significant role in healthcare in many African communities. This is due to factors such as easy access to traditional healers, availability, affordability, cultural acceptance, and spiritual, religious, and social values. In Ghana, similar to other low-resource countries like Nigeria, Senegal, Gambia, Togo, and Benin, there is a scarcity of necessary medical facilities, equipment, health workforce, and associated services. For instance, in 2014, there were only 3,016 doctors estimated in Ghana (Knoema, 2018b), nurses at 38,228 (Salifu, 2017), and only 1.4% of the health expenditure goes towards mental health, which is significantly skewed towards urban areas. Ghana only has three psychiatric hospitals (Roberts et al., 2014), all located in the southern regions, as detailed in Chapter 1. This reinforces the use of traditional healers for illnesses and misfortunes.

Additionally, due to limited medical resources, personnel, and high costs, many Ghanaians rely heavily on traditional herbal medicine and religious beliefs, seeking help from various ritual specialists such as faith healers, occult practitioners, fetish priests, witchdoctors, fortune tellers, and diviners to treat physical and mental

ailments (Adinkrah, 2011). These practitioners attribute mental illness to evil spirits and serve as intermediaries between ancestral spirits and their human clients in difficult-to-understand situations such as mental disorders. Furthermore, the proliferation of spiritual churches, such as the International God's Way Church Accra, the Anointed Palace Chapel, and the Ebenezer Miracle Worship Center, that attribute every mishap to demonic and other spiritual causes, including diseases, has made spiritual healing an attractive option for Ghanaians (Roxburgh, 2014, 2016, 2017). All of this implies that cultural and belief systems play a significant role in the health-seeking behaviours of most Ghanaians, potentially including the women in the camps.

The health-seeking behaviour of women in the camp was affected by their difficulties in accessing healthcare and lack of social care support, as previously indicated. Participants expressed a complete lack of social care provision, which affected their well-being. According to Allen et al. (2004), social care provides formal social care support, personal care, protection, or social services to adults in need, at risk, or with needs arising from illness, disability, old age, or poverty. Social support is a critical factor that affects mental health (Harandi et al., 2017). Poor social support has been linked to depression and loneliness, and it has been shown to alter brain function and increase the risk of suicidal thoughts and cardiovascular diseases like hypertension (Cherry, 2020). This may explain why the women who participated in the Phase Two survey scored highly on having health concerns after being banished to the witches' camps.

The UNHCR focuses on meeting the social needs of refugees, including those who are socially or economically disadvantaged, such as unaccompanied older adults, the disabled, and the chronically sick (Bakewell, 2003; UNHCR, 2021b). Similarly, women interviewed from the witches' camps relied on the camp social worker, who also acted as a pastor and led Sunday church services, praying for the women, and providing a consoling atmosphere. However, the lack of formally trained social workers in the camps to support the ailing women who have been banished from their communities impacts their social needs and mental well-being.

The UNHCR has established minimum standards for refugee camps or settlements, which aim to ensure that refugees can live in a healthy environment with security and

dignity, improving their mental health and general well-being (UNHCR, 2021a). According to the UNHCR, a well-designed camp should provide physical facilities such as good shelter, food, and sanitation like latrines, which should be located near shelters to protect women from violence. Additionally, the camp should offer support for the socio-cultural and emotional needs of refugees. For instance, good counselling and psychological support should be available to address the harsh and uncertain conditions that put their mental health under significant stress. The UNHCR emphasizes the importance of integrating mental health and psycho-social support into medical services for refugees and similar vulnerable groups and advocating for the inclusion of refugees into national mental health systems.

Participants reported that their physical health problems made it difficult for them to perform daily activities and that they lacked support for their household chores. The lack of social care support and facilities in the camps was acknowledged by all stakeholders. They cited limited resources and financial constraints within their departments as a significant challenge in providing support for the women's social care needs. The stakeholder from the social welfare department of the north under the Ministry of Gender, Children, and Social Protection noted that, due to a lack of funds, they sometimes collaborated with local NGOs such as Songtaba (2020)to provide social care provisions for the women in the camp. Recent literature has also recognized the inadequacy of current support (Ashirifi et al., 2022).

Meeting emotional needs, such as feeling safe, cared for, and protected, is essential for the well-being of older adults. Unfortunately, the women in the camps lacked these necessities. They lived in substandard housing facilities and had inadequate access to drinking water, recreational facilities, and food supplies. Furthermore, they lacked security and safety and could not earn a livelihood through employment. The absence of these basic needs threatened their emotional stability and impacted their health. The photo observations revealed that the witches' camps lacked key social and healthcare facilities that support the general physical, social, and mental well-being of any population. The women who were interviewed and surveyed lived in a deprived and socially excluded community within a low-resource country that severely curtailed health and social resource allocations. This inadequacy in support has also been well-documented in recent literature (Ashirifi et al., 2022).

9.5 Experiences of accessing health services in the camps

The thematic findings and photo observation data of the participants were synthesized to address the research objective in Phase One. The lack of healthcare facilities was reported by participants as a critical factor that influenced their access to healthcare. Almost all women participants repeatedly mentioned the absence of health services in the camp, which affected their general health and mental well-being. The women reported that there was no first aid available in the camp, which, in turn, resulted in the death of some women. None of the camps had a health facility, and women had to walk long distances to nearby communities to access healthcare services, often while feeling unwell.

The majority of women participants experienced joint pains and other physical symptoms, such as knee pain, which made it difficult for them to walk to the distant health centres for medical care. Even after managing to travel such long distances, they still faced the challenge of a lack of medication and financial constraints. Most participants reported that their healthcare needs went unmet due to financial constraints, such as the cost of prescription drugs and mental health counselling. The camp social worker occasionally assisted by purchasing some of the prescriptions when necessary. Therefore, most women in the camp turned to local herbs to treat their illnesses. These findings align with Kwame (2018),work on local herbs and healing among the Dagombas in Ghana and John (2021) research on camps for alleged witches in northern Ghana.

The women in the camps faced challenges in accessing healthcare due to the lack of health insurance and limited financial resources. As previously mentioned, Baba (2013) and John (2021) have both reported on the women's lack of access to healthcare in the camp, which was compounded by their financial constraints.

Shame and stigma significantly affect these women's access to healthcare. Due to their status as residents of witches' camps, older women feel ashamed when interacting with healthcare providers. They also express guilt concerning conditions that they deem embarrassing because some healthcare professionals make derogatory statements or point fingers at them. The social worker expressed disappointment at the stigma and shame expressed by some health professionals towards the women.

Nyblade et al. (2019) noted in their review of the literature that stigma in healthcare facilities is a barrier to seeking healthcare. Stigma affects health-seeking behaviours, particularly for people from marginalized communities. Stigma within healthcare interactions has many manifestations, including verbal and physical abuse, denial of care, and the provision of low-quality care, all perpetrated by healthcare professionals (Hamann et al., 2014; Karadag Caman et al., 2018). Dodor et al. (2009), conducted a qualitative study in Ghana and noted that healthcare professionals' negative attitudes towards specific categories of people, such as vulnerable patients, reinforce social stigma and poor perceptions of them.

In addition, Holder-Dixon et al. (2022) recently conducted a study that highlighted how previous experiences of inadequate care related to discrimination by healthcare professionals and the healthcare system contribute to increased medical avoidance among marginalised populations. As discussed in Chapter 6, Section 6.6, the women living in witches' camps also faced discrimination and verbal abuse from healthcare professionals, adding to their stigmatization. Like many vulnerable groups, socially disadvantaged and discriminated individuals have a greater risk of developing mental health problems. Studies have shown that mental health disorders are associated with more frequent life stressors among socially marginalised people. Discrimination can have detrimental psychological and physical health outcomes, particularly in marginalised populations (Matheson et al., 2019).

Furthermore, social marginalisation occurs when people or groups face limitations in performing essential activities of daily life or accessing vital services and opportunities, resulting in their social exclusion (Mowat, 2015). This means that they are unable to meet the standards set by mainstream society and fully participate in its way of life. Social marginalisation is often associated with social exclusion, which has consequences for accessing crucial social services like healthcare (Andersen, 1996; Morgan et al., 2007) and is often regarded as a result of economic deprivation.

In addition to the aforementioned barriers, the lack of family and social support also significantly limited the women's access to healthcare. Research indicates that the presence of trusted support or family members commonly promotes health-seeking behaviours. For example, a qualitative study conducted in Egypt by Ohashi et al. (2014)

found that women could access support resources for healthcare more easily when they went through their extended family members. The same study found that women received considerable support from co-residential family members, natal family, and neighbours, who helped them seek health services. Unfortunately, in this study, most women in the camp had no family network to support their healthcare seeking and engagement, primarily because witchcraft accusations often originated from their immediate families.

Importantly, the women living in the witches' camps lacked access to any formal psychological support services such as trained counsellors or psychiatrists, which is an important issue. As previously discussed in Chapter 8, mental health services in Ghana are almost completely absent, particularly in rural areas (Fournier, 2011),and mental health services are not universally funded (Addo et al., 2013). This situation leaves mental health highly stigmatised (Dako-Gyeke & Asumang, 2013). Marginalised community members, such as women living in witches' camps who are predisposed to mental disorders and poor psychological well-being, require affordable access to psychological support and counselling facilities.

Based on the above, these findings are consistent with those of Murray et al. (2010), who reported that marginalized people with experiences of persecution, physical and emotional trauma, and forced relocation are more susceptible to psychological disturbances, and the lack of counselling facilities can exacerbate their mental health issues(Lewis et al., 2015; Murray et al., 2010; Schmitt et al., 2014). Studies and a recent literature review have shown a higher prevalence of psychiatric disorders in marginalized populations than in the general population (Fazel et al., 2008; Priebe, Matanov, Barros, et al., 2012; Rössler et al., 2010).

9.6 Application of the Hospital Anxiety and Depression Scale (HADS) to the study

In this study, the HADS was translated from English to the Dagbani language (HADS-Dag) and was used to measure anxiety and depression in both marginalized women living in witches' camps and women from the general Dagbani-speaking population in Ghana. The HADS is widely used to measure psychological distress (Igwesi-Chidobe et al., 2021a; Montazeri et al., 2003b; Ramkisson et al., 2016; Reda, 2011; Stern, 2014;

Wondie et al., 2020; Wouters et al., 2012; Wu et al., 2021; Zigmond & Snaith, 1983a), and the linguistically validated HADS-Dag was explored using EFA after normality testing was performed on the entire dataset. Given the significant differences between Dagbani and English, no prior assumptions were made about the factor structure. The results showed that the HADS-Dag had a two single-factor structure, and after the removal of item 5 ("I have worries"), the psychometric properties were found to be adequate. Compared to other studies that used the HADS for validation, the Dagbani version showed acceptable psychometric properties (Annunziata et al., 2020; Clark & Watson, 1991a; Djukanovic et al., 2017; Herrero et al., 2003; Hinz & Brähler, 2011; Igwesi-Chidobe et al., 2021a).

The current study differs from that of Smith et al. (2002) in terms of the statistical models used, with Smith et al. (2002) employing hierarchical or second-order factor analysis, while this study used exploratory factor analysis. The construct validity findings of the HADS-Dag using the two single-factor structures of the original measure were found to be acceptable in this study, with significant correlation between the anxiety and depression factors. These findings are consistent with those of the Nigerian study (Igwesi-Chidobe et al., 2021a), which also reported acceptable construct validity using a two-factor structure. However, in contrast to the Nigerian study, item 5 (“Worrying thoughts go through my mind”) of the translated HADS-Dag was found to be problematic and was deleted, possibly because it conveyed a suggestion of more generalized mental problems rather than a specific mental concern. This may be due to cross-cultural differences in the interpretation of the item, with British idioms and colloquialisms being unfamiliar to the Ghanaian culture. This issue has been reported in other non-English survey adaptations (Igwesi-Chidobe et al., 2021b; Maters et al., 2013).

It is worth noting that in this study, the HADS-Dag questionnaire was administered through face-to-face interviews conducted by the researcher and a trained female research assistant, as the research participants were illiterate (refer to Chapter 8 for more information). It should be mentioned that face-to-face interviews can introduce a social desirability bias, particularly in sensitive areas such as mental health assessment, as reported by Lyons et al. (1999). However, the extent to which this may have affected the results in this study is unknown.

This approach is consistent with other studies conducted in African countries and Iran, where the HADS was validated using illiterate participants for data collection. For example, a study conducted in Ethiopia that translated the HADS to Amharic recruited illiterate respondents (Wondie et al., 2020), and in Nigeria, Igwesi-Chidobe et al. (2021a) validated a cross-culturally adapted and psychometrically tested HADS with rural and urban Nigerian Igbo populations who were also described as illiterate. However, Wondie et al. (2020) and Igwesi-Chidobe et al. (2021a)indicated that although the literacy level was challenging, it did not significantly impact their study outcomes. Similarly, in this current study, the reliability indices of the Igbo-HADS using the two-factor structure of the original measure appear adequate (Igwesi-Chidobe et al., 2021a).

Consistent with most studies, the reliability (Annunziata et al., 2020; Herrero et al., 2003; Jerković et al., 2021), of the HADS-Dag version showed satisfactory internal consistency for the anxiety and depression subscales. The current study also found a strong correlation between the two subscales, as reported in previous research (Montazeri et al., 2003a). However, item 5 did not load highly on either factor in this study, while all other items showed significant correlations with each other. The Ethiopian study, which translated the HADS into Amharic for cancer patients in a hospital setting, also reported a significant correlation between the two subscales (Wondie et al., 2020).

The Cronbach alpha of the current study sample was reported separately for the two subscales and the values were found to be very good, consistent with several other studies (Hinz & Schwarz, 2001; Igwesi-Chidobe et al., 2021a; Montazeri et al., 2003a; Ramkisson et al., 2016; Reda, 2011; Smith et al., 2002; Wondie et al., 2020; Zigmond & Snaith, 1983a), as well as the developers (Zigmond & Snaith, 1983a). For the HADS-Dag anxiety subscale, the Cronbach's alpha was 0.83. However, after deleting item 5, the Cronbach's alpha coefficient of the HADS-Dag anxiety subscale increased to 0.90. For the depression subscale, Cronbach's alpha coefficient was 0.89. Both subscales met the accepted Cronbach's alpha criterion, scoring above 0.70, which is within acceptable limits.

A study conducted in Nigeria, which translated the HADS into Yoruba for use in community settings of developing countries to screen for suspected mental disorders in marginalized populations, showed findings consistent with the current study (Abiodun, 1994).

Other authors have reported different findings from my study, where they proposed the HADS as a unidimensional scale by excluding three items and recoding one item, resulting in improved structure and validity (Montazeri et al., 2003b; Ramkisson et al., 2016). However, in my study, only one item was excluded, and while there was an improvement in the structure and validity of the Dagbani version of the HADS, it remained a two-factor instrument. Montazeri et al. (2003b) suggested that the HADS could function as a unidimensional scale with a global score for the entire instrument due to the close relationship between its two subscales. It could also be argued that the instrument measures general psychological distress in addition to anxiety and depression.

In comparing the results of the current study, women from the witches' camps, women from the general population of northern Ghana, and Ethiopian study participants (Wondie et al., 2020), it was observed that the women from the witches' camps and the general population were more anxious and severely depressed than those from Ethiopia. However, the current study had half of its sample from the witches' camps, where mental health problems were expected to exist. The HADS mean scores of the women from the witches' camps for anxiety (10.79) and depression (13.50) were markedly higher than those obtained in other countries such as India (anxiety: 6.5; depression: 6.8) (Chittem et al., 2013) and Ethiopian participants (anxiety and depression both 4.0) (Wondie et al., 2020). The current study participants reported more anxiety and high depressive symptoms, which may be attributed to their highly marginalized and socially excluded status, living with no income, food, and housing insecurity as outlined above. These pose risk factors for developing anxiety and depression. In 2008, WHO launched the final report of the Commission on Social Determinants of Health (CSDH), published in *The Lancet*, which concluded that social injustice and health inequalities that may be influenced by socio-economic status equally affect individuals' health statuses (Marmot et al., 2008). In countries at all

income levels, health and illness follow a social gradient: the lower the socio-economic position, the worse the health (World Health Organization, 2003, 2008, 2014).

9.7 Prevalence of anxiety and depression among the witches' camp women and women from the general population

The results of the quantitative phase, as measured by the HADS-Dag, indicated that anxiety and depression were prevalent among women in the witches' camps. Specifically, the analysis revealed that the levels of anxiety and depression symptoms in women residing in the witches' camps of northern Ghana were higher than those in women from the general population; for more details, please refer to Chapter 8, section 8.6. It is worth noting that depressive symptoms are more common in older women, as they are more susceptible to stress (Lampert & Rosso, 2015), and depression is the most common mental health issue among older people in the community (McCombe et al., 2018; Parkar, 2015). Consistent with other studies (Cole & Dendukuri, 2003; Martin G. Cole & Nandini Dendukuri, 2003; Wilkinson et al., 2018), the results of this study suggest that anxiety and depression are prevalent in both the women in the camp and among the women from the general population, even though the prevalence of anxiety and depression was higher for women in the camp (Hinz & Brähler, 2011).

The current study differs from that conducted by Hinz and Brähler (2011) in Germany in that it surveyed older women from a marginalized community (witches' camps) and women from the general population. While anxiety and depression were prevalent in women in their study, it was also conducted in the general population for comparison purposes. It is important to note that anxiety and depressive symptoms are common among older adults, especially among females, which is consistent with the literature (Hinz & Brähler, 2011).

The prevalence of anxiety and depressive symptoms among women in the general population may be attributed to their gender and older age, which are risk factors for depression due to their increased vulnerability as socially excluded members of patriarchal societies such as Ghana. Additionally, for women in the witches' camps, the prevalence of anxiety and depressive symptoms may be due to the loss of social support systems, which are typically a vital part of older adulthood, or living in the

constant threat of such a loss, as well as ongoing psychological and social stressors. During Phase One of the study, the women in the witches' camps reported difficulty sleeping at night. A systematic review and meta-analysis by Cole and Dendukuri (2003) found that sleep disturbance, disability, and female gender were major risk factors for depression among older adults in a community setting. Specifically, the results of this study suggest that women in the witches' camps experience higher levels of psychological distress than women in the general population.

9.8 Recommendations for improving mental health and general well-being

This section highlights the recommendations made by women in Phase One regarding changes that they believe could enhance their mental health and emotional well-being. Their recommendations include providing access to food, clean water, healthcare facilities, financial support, and livelihood opportunities. These suggestions align with the social determinants of health (Commission on Social Determinants of Health, 2008a; World Health Organization, 2008, 2014) and will help improve the women's mental health, contributing to achieving SDG goals 3 and 5 (United Nations, 2015).

In Phase One of the study, most women interviewed emphasized the need for the government to provide better accommodation with larger rooms, more space, and privacy. Furthermore, improving home infrastructure and providing potable water, food security, and accessible healthcare facilities were deemed essential to address mental and emotional well-being. The absence of social support and healthcare increases the risk of mental illness and negative health outcomes (World Health Organization, 2014). Therefore, addressing social determinants of health in Ghana and SSA is crucial for improving mental health and reducing long-standing health inequities. This requires action from all sectors, including civil society. The women in the witches’ camp also suggested that a consistent food supply should be ensured since the lack of a reliable food supply was a major challenge. They recommended that the government and civil society organizations such as the Social Welfare Department under the Ministry of Gender, Children, and Social Protection of Ghana, Australian Aid, ActionAid Ghana, and Songtaba Group could help them with a guaranteed food supply

in the camp. Addressing witchcraft means addressing a disparity that persists between the "global social policy" implemented at the global level and the corresponding policies adopted in Africa (Seekings, 2019).

Furthermore, earning a livelihood through activities such as local farming, soap making, and petty trading could increase self-esteem and self-determination, leading to better financial and emotional well-being. This recommendation is supported by recent research in Ghana by Kwame (2018) and Azongo et al. (2020), which call for economic empowerment in rural and marginalised communities through skill training, soft loans, and farming inputs. Policymakers, both in the public and private sectors, are increasingly involved in a global discourse regarding the economic and social implications of population aging (He et al., 2020). Consequently, empowering women economically would alleviate the economic and social burdens that relegate them to marginalized positions.

Overall, my findings are in line with existing studies that demonstrate a significant correlation between the provision of housing services and quality accommodation and improved measures of health and well-being (Karjalainen, 1993; Marmot et al., 2008; Organization, 2018; Rolfe et al., 2020; Thompson, 2013). The human rights framework for the provision of shelter and safety highlights the need to understand the relationships between housing, health, and general well-being. The findings of this study provide an essential link to the social determinants of health model (see Chapter 3) and the theoretical understanding that the provision of sound housing may positively impact health and well-being.

The women from the camps consistently emphasized the need for safe drinking water, and they appealed to the government and charitable organizations for a reliable supply. Access to clean water is a fundamental human right and providing it to the women in the witches' camps is crucial for improving their mental health and well-being. This is in line with Bronfenbrenner's (1979) socio-ecological model (SEM) at the macro ecological level, which emphasizes the importance of policymakers and the government in protecting and providing basic amenities that support life and health. These efforts align with the social determinants of health (Commission on Social

Determinants of Health, 2008b; Health & Organization, 2008; World Health Organization, 2008, 2014) and address the SDGs goals 3 and 5.

To improve the mental health and well-being of women in the witches' camps, it is recommended that the Ministry of Gender, Children and Social Protection of Ghana collaborates with other agencies, including the Ghana Health Services and civil society organizations. Together, they should aim to build the witches' camps to a standard that meets the dignity of the women and humanity, providing homes that promote their mental health.

In comparison to UNHCR's key information on minimum standards and best practice for refugee settlements or camps, it is recommended that similar changes be made to the witches' camps in Ghana. The UNHCR has established minimum standards required for refugee camps or settlements to enable the refugees to live with security and dignity in a healthy environment, thereby improving their mental health and general well-being (UNHCR, 2021a).

According to the UNHCR, a well-designed camp should provide protection for residents from harm and external violence (UNHCR, 2016, 2021a, 2022). It should offer sound shelter from the elements, access to food, water, and sanitation systems such as nearby latrines, and should protect women against violence. The facilities should also provide refugees with the possibility of sustainable livelihood, healthcare facilities, counselling, and psychological support (UNHCR, 2021a). Therefore, it is recommended that the Ministry of Gender, Children and Social Protection of Ghana works towards building witches' camps that meet these UNHCR standards and guidelines, to provide a more dignified, secure, and healthier environment for the women residing in the camps.

The effects of many social determinants of mental health can be modified through individual-level interventions, programmes, and policy changes, similar to income inequality (Alegría et al., 2018; Thomson et al., 2022). Mental health professionals, including psychiatrists, have a role to play in public and policy discourse on issues such as discrimination, social exclusion, adverse early life experiences, unemployment and economic insecurity, poor access to healthy food, poor housing quality and instability, adverse features of the built environment, and poor healthcare access. Most women

indicated that their healthcare experiences had been challenging due to the lack of available healthcare services, and thus, recommended that providing a healthcare facility in the camp would greatly assist their general and mental healthcare needs.

All the recommendations made by the interviewed women are interconnected and require collective action from national, local, and individual levels to bring about change. In addition, they suggested that improving their social well-being would require universal health insurance coverage (as discussed in Chapter 6), guaranteed food supplies, increased work opportunities for women in the camps, financial support, and the provision of televisions. Adequate housing is also essential for security and shelter, along with sanitation facilities to promote healthy hygiene practices, which ultimately supports quality of life and personal dignity. While the long-term plan is to integrate these women back into their communities, constructing housing and residential care homes for older people within the camp structure would signal a commitment from the government to ensure the ongoing social well-being of this marginalized population.

The present study serves as an advocacy piece, shedding light on the social injustices faced by older women residing in witches' camps. Given the gravity and urgency of the psycho-social experiences and related issues, it is crucial to give due consideration to these highlighted concerns. The systematic marginalization and stigmatization of women accused of witchcraft, particularly older women, represents a severe violation of human rights and a blight on society's conscience. The study provides an opportunity to contextualize and frame the findings within the broader socio-political landscape, emphasizing the pressing need for policy and programmatic interventions that address the root causes of these injustices. By presenting the rich experiences and voices of older women living in witches' camps, this study serves as a vital call to action for researchers, practitioners, and policymakers to prioritize the needs and rights of this vulnerable and marginalized population. This chapter that follows presents the conclusion and recommendations of the study.

9.9 Highlighting the Social Injustices and advocacy in this thesis

The deeply troubling issue of these witchcraft accusations persists, and older women living in witches' camps bear the brunt of social injustices. The witches' camps, which

are sometimes referred to as Safe Heaven, are in fact maybe symbols of society's discrimination and stigma against accused women of witchcraft. Therefore, this thesis serves as an advocacy piece that sheds light on the difficulties older women in these camps face concerning their general well-being and mental health, aiming to raise awareness, provoke empathy, and demand a call to action to address this social injustice.

9.9.1 Stigmatisation

Older women are labelled witches, condemned by unfounded superstitions and malicious accusations. They become isolated from their families and exiled from society. The stigma leads to psychological distress, further exacerbating their vulnerability and isolation (UNICEF, 2022). The public stigma against women accused of witchcraft needs to change, and new strategies need to be developed. Three methods—protest, education, and contact—have been combined to form the change strategies for public stigma (Corrigan & Gelb, 2006; Corrigan & Penn, 1999; Nawka & Reiss, 2002; Rüsch et al., 2005; Sartorius, 2002). However, I contend that public education should be used to de-stigmatize women because witchcraft is connected to belief systems.

9.9.2 Lack of Basic Amenities

As seen in the photo observations section in Chapter 6, the witches' camps lack adequate and dignified shelters and other socially basic amenities such as clean water, sanitation facilities, and adequate healthcare. As old age-related health issues exist, older women accused of witchcraft practices and banished to these camps grapple with age-related health issues and are left to suffer without proper care or support. The absence of essential services deprives them of dignity and threatens their general health and well-being. According to the World Health Organization (2014), basic social amenities like housing, water, and sanitation affects an individual’s health outcome. Social determinants of health (SDH) are the non-medical factors that influence health outcomes (Braveman & Gottlieb, 2014b). The government and other civil society organisations must address the lack of basic social amenities in the camps to improve health and well-being outcomes of the women. SDH must be properly addressed to

improve health and lessen enduring health inequities, which calls for action from all sectors and civil society (Solar & Irwin, 2010; Taylor et al., 2016).

9.9.3 Absence of Legal Protection

Women accused of witchcraft are banished to live in witches' camps, so they do not get legal protection. They face physical abuse and unjustified banishment, and some are forced to work on the farms of the Earth Priest. Their rights are blatantly violated with no repercussions, which feeds the cycle of unfairness and helplessness. Legal frameworks must be created and enforced to safeguard and protect these women's rights and dignity.

9.9.4 Economic Marginalisation

Older women in witches' camps struggle to secure their livelihoods. They lack employment and social support services and are excluded from some state social support services like the Livelihood Empowerment Against Poverty (LEAP)(Handa et al., 2013; Quinones et al., 2023). The LEAP programme provides cash transfers to poor people, particularly in households with orphans or vulnerable children, older people, and people with extreme disabilities (Akweongo et al., 2022; Sackey, 2019; UNICEF, 2022). Beneficiaries also receive free national health insurance. However, at the time of conducting this study, none of the women from the five witches' camps were on this social protection scheme. They are denied access to free health insurance and LEAP benefits and left without means to sustain themselves. The women should be enrolled in these social support services. Economic empowerment initiatives should be implemented to equip these women with skills and resources to break free from the cycle of poverty.

9.9.5 Reintegration Challenges

The reintegration of accused women into their communities is faced with difficulties in relation to rejection and stigma. Due to the deeply-rooted superstitions that surround them, older women, even if proven innocent, face great difficulty reintegrating into society. Community awareness campaigns and educational programmes on local radio and TV are crucial to dispelling the witchcraft myths and fostering acceptance and inclusion in the communities. This thesis has offered a procedure by which the

reintegration of this woman should be carried out to ensure a successful 'going back home' in peace and happiness.

In a nutshell, the plight of older women banished and trapped in witches' camps is an urgent social injustice that demands well-meaning people's attention, including the government of Ghana and NGOs, civil society organisations, and even the World Health Organisation and the UN, since this cultural practice of accusing and banishing older women of witchcraft affects the attainment of some of the SDGs, including 'Clean Water and Sanitation', 'Good Health and Well-Being', and "Gender Equality," by ending all discrimination against women(United Nations, 2015). Africa is where these witchcraft accusations occur. It is incumbent upon us as a society to advocate for their rights, challenge discriminatory practices, and work towards their reintegration and empowerment by raising awareness, fostering empathy, demanding policy changes, and striving to create a society where no woman is affected by cultural practices that endanger their health and well-being, regardless of age or circumstance. The world can unite to end the social injustices older women face in witches' camps and build a future of compassion and equality for all to ensure good mental health and the achievements of the SDGs set out by the world bodies.

Chapter 10 Conclusion and recommendations

10.1 Introduction

This chapter concludes the thesis by emphasizing the fundamental nature of the right to health, which is crucial for ensuring human dignity. Mental health is an essential component of health as defined by the World Health Organization (2006) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p. 1). Unfortunately, despite its importance, the right to health remains largely unfulfilled worldwide, with a significant burden of disease affecting a considerable portion of the global population. In particular, Sub-Saharan Africa (SSA) faces a disproportionately large burden of disease, with mental health problems becoming increasingly prevalent in the region (Sankoh et al., 2018).

In Africa, it is estimated that approximately 29.19 million people suffer from depression(Gbadamosi et al., 2022), with a higher prevalence among females (World Health Organization, 2017a). Prevalence rates also vary by age, with the highest rates among older adults aged 55 to 74 years and a 7.5% rate among females (Gbadamosi et al., 2022; World Health Organization, 2017a). The Beijing Declaration emphasizes that women's rights are human rights, and gender equality is vital for health and well-being(Beijing Declaration, 1995; United Nations, 1995; Women UN, 2015). However, improving mental health for women in low-income countries like Ghana is challenging due to widespread complex and health-prohibitive social and cultural practices. For instance, in northern Ghana, the practice of accusing older women of witchcraft and banishing them to witches' camps impedes their fundamental right to mental and general well-being. Thus, this study aims to explore the factors influencing the mental health and emotional well-being of older women in witches' camps in northern Ghana.

This chapter provides a summary of the theoretical frameworks used in this study, as well as the key qualitative and quantitative findings for each phase. The chapter also discusses the original and novel contributions of the study to knowledge, its strengths, and limitations, and provides recommendations. Additionally, it includes a reflective account of the research journey and process. Finally, the chapter summarizes the study's conclusion.

10.2 Theoretical models

Theoretical models, such as the social determinants of health(World Health Organization, 2008), explanatory models(Kleinman et al., 1978), and the social-ecological model (SEM) (Bronfenbrenner, 1979), inform recommendations for policy, education, service provision, and socio-cultural considerations. In this study, these frameworks were utilized to explain factors that affect the mental health and emotional well-being of older women residing in witches' camps. The SEM provides insight into the systemic factors of the environment and context, as well as the interpersonal relationships that impact women's mental health and well-being. The social determinants of health offer a public and global health perspective on the social context of low-resource constraints that further influence women's mental and emotional health. The explanatory models prioritize personal beliefs and cultural meanings that align with the microsystems of the SEM. These models help frame the current realities and experiences of seeking, accessing, and engaging with mental and general health services, as well as identifying the barriers and enablers of these behaviours, as reported by the study participants.

10.3 Summary of the key qualitative and quantitative findings

The study focused on understanding the factors that influence the mental health and emotional well-being of older women residing in the witches' camps of northern Ghana. It comprised two distinct phases, with Phase One being qualitative. The findings presented in this thesis offer a novel and unique understanding of the complex and overlapping factors that impact the mental and emotional well-being of older women in the camps.

The results of Phase One highlighted that physical health problems significantly impacted the women's general and mental well-being. The women reported experiencing daily physical pain, which made it difficult for them to walk, conduct their household chores and activities of daily living, and caused sleeping difficulties. These issues led to frailty, loss of independence, and depressive feelings.

The study also found that anxiety and nervousness were common among the women in the camps, which impacted their ability to function and made them feel restless, expressed as “I can’t sit still”, “being worried, or scared”. Some participants expressed suicidal thoughts at times. Additionally, memory loss was reported by some women in the camps, who attributed it to a lack of peace of mind due to past emotional trauma, poor concentration, and confusion.

During Phase One of the study, it was discovered that family disconnections resulted in emotional upheaval, sadness, and emotional distancing. The women experienced further emotional distress due to their inability to contact their families, which caused social disruption. The effects of family disconnections included loneliness, excessive separation-related worries, and general discomfort. The women also experienced public stigmatization from their original communities, which resulted in denial of the ability to return home, internalized shame, ostracism, discrimination, social seclusion or isolation, and a decline in mental health. As a result of this discrimination, the women experienced further depression, which led to suicidal thoughts, feelings of inadequacy, shame, helplessness, unhappiness, and despair. The women explained this as "losing their dignity and respect" (termed "dariza" or "jilma" in Dagbani, meaning "dignity" and "respect"). The study found that the experience of stigma in the form of self-stigma and stigmatization from others was a recurring theme in Phase One. Some women began to doubt themselves due to the witchcraft accusations, which then led to the spreading of public stigma, causing ongoing fears, avoidance behaviours, and discrimination.

According to the women, the camps lacked adequate housing and social facilities. Photo observations showed poor living conditions and limited space, leading the women to feel as if they were living in a cramped space. Rooms were often small with small windows, which resulted in insufficient light. Privacy was also non-existent, and one camp lacked sanitation facilities. Food insecurity was another issue in the camp, where food supplies were not guaranteed, and the lack of nutritious food was linked to the women's ill health. Additionally, the women reported a lack of access to potable water. Pictures captured the lived experience of the women participants and provided insight and deeper understanding about the women’s living conditions to further strengthen their interview conversations. It also provided a more profound

comprehension of their environment. Also, photovoice arts-based methods (Wang & Burris, 1997) were used to explore the lived environments in relation to housing and basic living connections in the witches' camp setting. In this study, the photos have been used to provide evidence and strength to the voice of the women. It also strengthens the findings and presents a clear condition of living in marginalized society. Wang and Burris (1997), argue that photos are a powerful communication means, challenging stereotypes and providing a platform for more intense and emotionally engaging reflection.

During Phase One, the study also examined the obstacles that hindered the women's access to general health and mental healthcare services. These obstacles included a lack of healthcare facilities, insufficient funds to buy prescriptions, the need to travel long distances to access healthcare, and the lack of essential resources such as food, clean water, shelter, healthcare, and safety. The UN charter for refugees in Garrett (2004) and Goodwin-Gill (2014) work indicated that inadequate mental health services and cultural health practices deeply ingrained during medical encounters also prevented access to healthcare. For example, some women refused to report skin boil infections to the hospital and instead used herbs to treat themselves.

Despite the challenges faced by the women, they engaged in various activities to improve their social connections, such as attending camp meetings, actively practicing Christian and folk-based religions, and singing and talking with other residents.

Based on the Phase One findings, the researchers identified the HADS as an appropriate survey instrument. The HADS was linguistically translated from English into the Dagbani language and administered to two cohorts: women from the witches' camps (n=168) and women from the general population (n=100). The researchers then used EFA to examine the psychometric properties of the Dagbani version of the HADS. The KMO and BTS values and results (outlined in Chapter 8) indicated that the dataset was suitable for factor analysis.

To ensure the suitability of the HADS instrument for use in the Dagbani language and the fact that the Dagbani language is quite different to the English language in which the HADS instrument was developed, no assumptions were made regarding the factor structure, given the significant differences between the two languages. A reliability

test was then conducted on the entire sample of participants (n=268). The internal consistency of the anxiety and depression subscales, as measured by the reliability test, was deemed satisfactory, except for item 5 (“I have worries”) of the anxiety subscale, which did not load correctly in the factor analysis. Consequently, item 5 was eliminated, and a re-analysis was conducted. The resulting two factors were significantly correlated, indicating acceptable construct validity findings for the HADS-Dag when using the two single-factor structures of the original measure.

The data collected in Phase Two revealed that women living in the camps had higher levels of anxiety and depression compared to women in the general population. The mean scores for anxiety and depression were much higher for women in the camp than for women from the general population.

In Phase Two, an independent-samples t-test was conducted to compare the anxiety and depression scores of women in the witches' camps with those of women surveyed from the general population. The results revealed a significant difference in anxiety scores between the two groups, as well as depression scores. Detailed t-test values and p-values are presented in Chapter 8, Table 8.8. These findings indicate that women in the camps experience higher rates of psychological distress compared to women from the general population, who also reported some level of psychological distress. The high levels of anxiety and depression among women in the witches' camps underscore the urgent need for psycho-social care to address this unmet need.

In the Phase Two study, supplemental open-ended questions were added to cover the key themes from Phase One that were not addressed by the HADS. These Phase One themes identified that the women lacked essential social amenities and psychological support, which had negative impacts on their mental and emotional well-being and affected their healthcare experiences. Almost all the women surveyed indicated that they did not have any significant health issues before being banished to the camps, as described in Chapter 8. However, after residing in the camps, most women subsequently developed health issues, including joint pains, waist pains, headaches, and difficulty walking. Others reported health issues included haemorrhoids/piles, hypertension, and blurred vision. The findings also revealed that most women did not attend health clinics when they felt unwell, primarily due to the lack of healthcare

facilities, insufficient funds to buy prescriptions, the absence of health insurance cards, and the inability to travel long distances to nearby communities to see a doctor.

The supplemental questions in Phase Two revealed that the women in the camps did not receive any psychological support or counselling. Instead, they relied on traditional medicine and attended Sunday church, where they asked the pastor to pray for them for social support. They also used herbs to treat various ailments such as malaria, toothache, joint pains, and body pains. The women expressed feelings of self-doubt and reported that people in the community were often accusatory towards them and "pointing fingers" them. They also revealed that they did not have anyone they could confide in as there were no psychologists or counsellors in the camps.

In the supplemental questions of Phase Two, the women suggested several ways to improve their general health, mental health, and overall well-being. They expressed a need for basic amenities such as water, food, clothes, shelter, and larger rooms with increased privacy. They also wanted to be registered in the national health insurance scheme, which is universally available to the general population. Building a hospital or clinic on-site and providing medicines and doctors in the camps was also suggested. The women recommended that the government provide financial support for their upkeep and introduce support measures for them to engage in subsistence farming. Furthermore, the women suggested offering bursaries for their grandchildren's school fees. Most women and allied stakeholders also indicated the need for adequate accommodation, which includes larger rooms with more space, potable water, and a healthcare facility in all camps. Additionally, installing televisions was strongly recommended.

Overall, my findings are consistent with previous research, which indicates that providing housing services and quality accommodation is significantly associated with improved health and well-being measures (Karjalainen, 1993; Marmot et al., 2008; Organization, 2018; Rolfe et al., 2020; Thomson et al., 2013). This highlights the interconnectedness of housing, health, and well-being, which underpins the right to life and dignity, as framed by the social determinants of health.

10.4 Recommendations

The study findings propose the following recommendations to improve the mental health and emotional well-being of women in the camps and to address witchcraft accusations against older women in Ghana. These recommendations are categorized under three headings: 1) Mental health practices; 2) Nursing and mental health education; and 3) Public policy and health promotion campaigns.

10.4.1 Mental health practice

The current study provides empirical information to make targeted recommendations for building and strengthening healthcare infrastructure and the mental health workforce's capacity to provide interventions for the mental well-being of marginalized populations, particularly in mental health practices. While no mental health services are currently provided to women in the camps, policymakers and service providers must advocate for establishing health infrastructure such as key buildings and supplies to address the psychological distress found in this study. For example, the Ghana Health Services should establish a counselling clinic with psychologists, mental health nurses, and access to psychiatry to address the psychological needs of women and provide targeted counselling to those in need. These psychologists should work alongside community mental health nurses in the camps. The ministers responsible for the Ministry of Gender, Children and Social Protection, the Department for Social Welfare, and Ghana Health Services need to work together to ensure that women in the camps have access to services such as mental health evaluations, social care support, and counselling for their mental health and well-being.

In the Phase One study, the allied stakeholders suggested that an initial step to curtail the trauma of women's stigma would be public awareness, sensitization, and education on destigmatizing alleged witches. All healthcare professionals should receive education on health promotion to educate the public about progressive conditions of old age, such as dementia and Alzheimer's, which may be misconstrued as witchcraft behaviours by the community. Public awareness campaigns, which could be conducted by healthcare and mental health practitioners, would help prevent needless witchcraft accusations and concurrent stigmatization of alleged witches in the community. Studies by Mkhonto and Hanssen (2018a) and Brooke and Ojo (2020a)

reported that the belief in Sub-Saharan Africa is that dementia is witchcraft, and people living with Alzheimer's and dementia in Zambia are commonly accused of witchcraft. Many older adults experience symptoms such as wandering and getting lost in the neighbourhood (Nyirongo).

Stakeholders, such as Ghana Health Services and the Ministry of Gender, Children and Social Protection, need to consider providing "resilience" (Anzansi) training to the women in the witches' camps. The training should focus on emotional, cognitive, physical, and spiritual resilience. By providing basic amenities and health infrastructure, including trained staff, and teaching the women to view life's challenges as opportunities, they can improve their resilience, enhance their quality of life, and reduce stress and anxiety. The Gender Ministry of Ghana should collaborate more with the Ministry of Health to provide psychological support to the women in the camps. Haddadi and Besharat (2010) supported the idea of resilience training based on a study in Iran. Their research indicated that resilience was positively associated with psychological well-being and negatively associated with vulnerability indices such as psychological distress, depression, and anxiety. In addition, the social welfare department together with the camp managers can at least organise periodic meetings between some of the women in the camps with their families, since family separation stressed the coping skills of individuals; thus family can provide enormous support to every individual’s mental health. UNICEF (2022) stated in their report on vulnerability and exclusion in Ghana that receiving support from friends and family is an essential coping mechanism when facing unexpected challenges, and during crises, religious institutions are a crucial source of assistance. However, it is important to note that modern religious affiliations are often involved in witchcraft accusations, as individuals seeking solace from difficulties in life are sometimes told by soothsayers that the cause is witchcraft. This can lead to accusations of witchcraft against family members.

Distinct levels of resilience influence psychological health and vulnerability indices through factors such as self-esteem, personal competence, tenacity, tolerance of negative affect, control, and spirituality. Therefore, building the women’s resilience with the support of a clinical psychologist would positively enhance and promote their mental and emotional well-being while addressing the scarcity of resources, facilities, and mental health service delivery staff. Community psychiatric nurses could be

deployed to the witches' camps to assess the women's mental health and refer those who need psychological attention to a clinical psychologist. While the closure of the witches' camps is being planned, clinical psychologists could conduct regular visits to the witches' camps to ensure the mental and emotional needs of the women are identified and supported. Until the witches' camps are no longer needed, it is crucial to address the physical and mental health needs of the women held there. Psychological resilience would allow the women to cope successfully with adversities occurring during stressful periods related to the accusations and life in the witch camps, which may otherwise trigger mental illness and emotional challenges (Afek et al., 2021; Zautra et al., 2010). The provision and training of psychologists to support the building of the women's psychological well-being are essential.

10.4.2 Nursing and mental health education

Ghana urgently requires training programs for mental health support workers and social workers. The government should review all current training programs through the Ministry of Health and the Mental Health Authority agency with a focus on primary care provision and prevention. Although educational institutions have trained social workers at the undergraduate level for some years, this training does not concentrate on mental health. Unfortunately, most of the trained social workers are currently working either in district assemblies or as teachers. The educational curriculum for training social workers, mental health support workers, and psychologists should be geared towards providing community mental health support services, health promotion, and social care provisions. Students in these programs would develop the knowledge and skills necessary to support older adults with behavioural difficulties in their communities. These support workers, with knowledge and skills in managing behavioural disorders, can assist with screening and intervening in the early diagnosis of mental health disorders and behavioural difficulties.

The nursing curriculum needs to place more emphasis on dementia care. The current nursing and mental health education curricula should incorporate cultural and spiritual care and belief systems into undergraduate education, as well as postgraduate mental health nursing education. It is crucial to provide education on localised spiritual and cultural beliefs concerning mental health and conditions related to old age, such as

dementia, to provide more psycho-social and evidence-based care for older rural populations.

In addition, there is a need to introduce geriatric/older adult nursing programs to enable prospective nurses who wish to specialize in gerontology nursing. This education provides the knowledge and skills required to support public health initiatives and educate the public on the health challenges associated with old age, including the socio-physiological and behavioural changes. Core elements in the curriculum for undergraduate and postgraduate students should include cultural beliefs and old-age-related behavioural changes. According to the World Health Organization, Ghana's population over 60 is predicted to reach 12% by 2050, up from 7% in 2010, due to demographic changes and rapid urbanization (World Health Organization, 2013). More than half of Ghana's population now live in cities, and global migration is further altering the dynamics of how families care for older people (Kwasi Gyamfi, 2020 ; World Health Organization, 2013, 2021a).

Furthermore, the Nursing and Midwifery Council (NMC) of Ghana needs to work with home care agencies such as Rosilia Home Care, AnsMed Home Care, and Comfort For The Aged to develop a suitable curriculum for home-based carers. This will equip the carers with the essential skills to provide personalized, social, and culturally safe care for the growing population of older adults in Ghana.

The NMC of Ghana should also collaborate with the few aged care homes in Ghana and develop a new interprofessional degree program focused on nurse psychology and social work to train health professionals for home and community care for older adults. By understanding the behavioural changes associated with aging, society can seek support and care from older people’s homes, and these facilities will require trained personnel regulated by the NMC of Ghana. As Mkhonto and Hanssen (2018a) argued, trained personnel or nurses can serve as mediators and assist in eradicating witchcraft beliefs associated with old-age-related conditions such as severe dementia.

10.4.3 Public policy and health promotion campaigns

A sustained public awareness campaign is urgently needed to raise awareness and sensitize the general population of Ghana to human rights violations against alleged witches and other marginalized groups. This campaign should emphasize the

consequences of breaching the rights of any member of society, including threats, physical abuse, torture, and murder. To assist with this effort, films centered around the question of human rights could be sponsored in local languages. The media, which have contributed to promoting beliefs in witchcraft in the past, could also be used to combat human rights abuses against alleged witches.

In the Phase One study, allied stakeholders suggested embarking on a public awareness, sensitisation, and education campaign to destigmatise women and curtail the trauma of stigma. It is imperative to educate and sensitise the public and communities on the evidence-based understanding of dementia and physical and physiological changes associated with old age, which are sometimes misinterpreted as witchcraft. Therefore, it is necessary to educate rural communities about old-age-related behavioural changes through trained health professionals and care workers at the grassroots level. District community mental health nurses could engage in supporting this education in communities, with the support of the Ministry of Health, in collaboration with the Ministry of Chieftaincy and Traditional Affairs and the Ministry of Gender, Children and Social Protection, to make destigmatisation a key imperative. This education will enable the public to understand old-age behavioural changes, which will mitigate against witchcraft labelling. Spittel et al. (2021) reported that low dementia awareness rates in SSA relate to misinterpreting dementia symptoms as witchcraft.

To address the issue of witchcraft accusations and their long-term consequences, a targeted commission, inquiry, and subsequent national policy development are necessary.

Furthermore, there should be a policy aimed at disbanding witches' camps through cultural dialogue with traditional leaders, chiefs, and leaders from regions where witchcraft beliefs and practices are prevalent. Members of the communities where witchcraft accusations are common should participate in designing solutions to disband the witches' camps and eradicate witchcraft accusations. It is also important to employ strategies that work to ensure that witchcraft beliefs and accusations in the Ghanaian communities are discouraged. This is evident as Parra-Cardona et al. (2021) argued that to enhance a Culture of Prevention in Low- and Middle-Income Countries,

it is essential to navigate the interplay between scientific expectations and contextual realities. This culture fosters a proactive approach to identifying and understanding risk factors, implementing evidence-based interventions, and promoting resilience and well-being at individual, community, and societal levels. It involves a broad range of sectors, including health, education, policy, and community engagement, to create an environment that supports and encourages prevention efforts. The culture of prevention aims to shift the focus from reacting to crises or problems to anticipating and averting them through comprehensive and sustained preventive measures. The culture of prevention initiatives provide evidence that the crucial steps in fortifying a culture of prevention in low- and middle-income countries (LMICs) involve the support of local prevention leadership and the integration of cultural and contextual resources. These elements are considered essential prerequisites for the development and reinforcement of effective preventive practices in LMIC settings (Parra-Cardona et al., 2021; Petras et al., 2021). Therefore, the fight against witchcraft beliefs and the accusations of older women about unfounded witchcraft practices should be based on a cultural contextual initiative that seeks to solve the problems using a preventive, rather than a reactive, approach (Petras et al., 2021).

To ensure that the rural women in these camps receive adequate support, the government should make funds available for regional social welfare departments to visit and regularly follow up in the camps. The lack of funds has been identified by the social welfare stakeholders in the current study as a significant impediment to providing support for the women. The Ministry of Health, in collaboration with the Ministry of Gender, Children and Social Protection, could institute psychological and mental health outreach services for the women in the camps through district community mental health nurses. These nurses could regularly assess the mental health profiles of the women in the camps, their families, and rural communities, and evaluate the interventions carried out.

Moreover, the government should ensure that the rural women in the camps have access to basic healthcare services, including regular check-ups and treatments. The government could also explore alternative means of providing livelihoods to these women to reduce their dependence on witchcraft accusations for their survival. The

proposed solutions should be sustainable, culturally appropriate, and sensitive to the needs and concerns of the affected women and communities.

In the past, the Ministry of Gender, Children and Social Protection enrolled residents of the Gambaga witches' camp in social intervention programs like the LEAP, which aimed to improve their living conditions. Unfortunately, the LEAP intervention for the women in the witches' camps was stopped, while those in rural communities continued. To improve the mental well-being of women in the camps, the Ministry should consider re-enrolling them in the LEAP program and developing employment schemes for them. Additionally, policy development for health and social care facilities is necessary to ensure adequate care for the women in the camps.

To improve the living conditions of the women in the witches' camps, the Ministry of Gender, Children and Social Protection should collaborate with other agencies, such as the Ghana Health Services and civil society organizations, to build infrastructure that meets the UNHCR's minimum standards and best practices for refugee settlements or camps (UNHCR, 2021a, 2022). This will ensure that the camps provide for the women's basic needs and dignity, as well as promote their mental health and well-being.

The provision of safe homes for the elderly in rural Ghana through the affordable housing would undoubtedly be an important step towards reducing neglect and abuse of elderly people. Safe homes can provide a secure and supportive environment for elderly people who may not have access to adequate care or support in their own homes. Consistent with this is a study (Motsoeneng, 2022) conducted in South Africa about lived experiences of elderly women accused of witchcraft in a rural community. The provision of safe homes for the elderly would reduce neglect, as well as witchcraft accusations in South Africa (Motsoeneng, 2022). In addition, safe homes can also offer protection to elderly people who may be vulnerable to witchcraft accusations or other forms of abuse in their communities. However, it is important to note that the provision of safe homes alone is not sufficient to address the root causes of neglect and abuse of elderly people. It is also essential to address the social, economic, and cultural factors that contribute to these problems, such as poverty, inequality, and discriminatory attitudes towards elderly people.

In addition, it is important to ensure that safe homes are of high quality and provide appropriate care and support to residents. This may involve training and supporting camps staff, implementing effective management systems, and ensuring that residents have access to appropriate medical care, social activities, and other support services. While safe homes can be an important tool in the fight against neglect, abuse, and witchcraft accusations, they need to be part of a broader strategy that addresses the underlying causes of these problems and ensures that elderly people are treated with dignity and respect.

Additionally, civil society organizations and NGOs interested in supporting the women should register with the Social Protection Unit of the Ministry of Gender, Children and Social Protection. This will ensure that they provide safe, legal, and ethical support services for the women, with accountability measures in place to prevent any witchcraft accusations against older women. Enforcing criminal law can certainly be an effective way to deal with perpetrators of violence and abuse against elderly women who are accused of witchcraft (Motsoeneng, 2022). However, it is important to recognize that criminal law enforcement is not always enough to address the root causes of such violence and abuse.

It is essential to work towards changing attitudes and beliefs that lead to the persecution of elderly women accused of witchcraft. This may involve community-based education and awareness-raising campaigns, as well as the promotion of alternative dispute resolution mechanisms that prioritize dialogue, mediation, and reconciliation over punishment. Furthermore, it is critical to ensure that elderly women who have been victimized by violence and abuse have access to appropriate support services, including medical care, legal aid, and counselling. By addressing the root causes of violence and abuse against elderly women and providing them with the necessary support and services, we can work towards creating a safer and more just society for all.

To promote healthy and non-stigmatized ageing, the Ghanaian national ageing policy drafted in 2010 (see Chapter 1 for details) needs to be updated and implemented (is “sitting on ice”). The policy draft identified cultural factors and the informal nature of the Ghanaian economy as some of the reasons older persons, especially women,

experience widespread gender-based discrimination and are the sub-population most vulnerable to financial, physical, and emotional abuse (Antai et al., 2014; Johnson et al., 2022; Owusu Adjah & Agbemafle, 2016).

Legal support and police protection

Legal support should be provided to women accused of witchcraft. Families and communities must be encouraged to report cases of witchcraft accusations to the police and social welfare offices in regions where witchcraft accusations are common. Posters in villages should also be put up to promote reporting, and whistle-blowers must be protected by law. The police should receive training on how to handle cultural issues regarding witchcraft accusations and lynching in communities. The Social Welfare Department previously advocated for the Ghana Legal Aid Scheme to prosecute those who made unfounded accusations and protect accused women and their families. However, this has been ineffective, as many more women continue to be accused of witchcraft. Some women in the camps have reported being exploited and having their rights abused (Ministry of Gender Children and Social Protection, 2015). The current study's social welfare officer stated that some NGOs previously supported district assemblies in enacting by-laws on witchcraft accusations and providing basic welfare needs such as food and health for women in the camps, but these have not been enforced. Therefore, the Social Welfare Department and the Ministry of Gender, Children and Social Protection must enforce these by-laws to protect women's rights. According to Pierre (2018) at the McGill Centre for Human Rights and Legal Pluralism, a community service legal support and legal empowerment process to eradicate witchcraft-related violence is more promising and beneficial for women than criminalizing witchcraft beliefs, accusations, and witch camps. This is consistent with Motsoeneng (2022), it was noted that the government could enforce the Witchcraft Act, which criminalizes the accusation of witchcraft and the punishment of alleged witches. This would help protect elderly women from being wrongly accused of witchcraft and facing violent retribution from their communities. Additionally, the government could also work with local community leaders and religious organizations to educate communities about the dangers of witchcraft accusations and the importance of protecting the rights of elderly women. Such efforts would help to promote a culture of tolerance and respect for human rights in these communities.

Since witchcraft allegations are not about to cease immediately and the need for sanctuaries will remain, it is considered that, rather than focus on the closure of witches' camps, efforts such as those outlined above need, in the first place, to be deployed towards improving living conditions in the camps. In addition to providing basic amenities, steps must be taken to prepare prospective recipient communities for the return of the women from the camps. Providing access to education for children in the camps may also promote intergenerational shift for long-term development instead of perpetuating stigmatized settlements.

10.4.4 Reintegration process

As discussed in Chapter 6, it is crucial to reintegrate the women back into their communities in the medium to long term. This integration is essential to improving both the women's mental and emotional well-being, as well as that of the general population. The reintegration of the women should be conducted carefully, as outlined in Chapter 6, with all stakeholders consulted, and effective public campaigns conducted to ensure their families and communities accept and accommodate them upon their return.

To ensure the women's safety and livelihood upon their return, they must be mentally and economically prepared. For example, they should be trained in skills such as local soap making, making groundnut paste, groundnut cake ('Kulikuli') or beads. Livelihood support for the women should be provided before reintegration to prepare them economically and enable their independence, rather than making them dependent on their families and community members. However, merely having social safety nets in place may not be enough to entirely eliminate vulnerability and exclusion, as crucial factors that contribute to individual well-being, such as full employment and access to public services, necessitate engagement with more extensive processes related to political, economic, and social inequality (Sarwar et al., 2022; UNICEF, 2022).

In 2020, the Rural Initiative Ghana Foundation trained the Kpatinga witch camp residents in poultry keeping and provided each woman with guinea fowls and local breeds of chickens (Francis, 2020). Additionally, many women would need appropriate housing to stay in when they return to their original villages, as they may have lost everything during the period of accusation and banishment. The Ministry of

Chieftaincy should liaise with traditional rulers (chiefs) since, without their permission, the women cannot be banished. The chiefs would play a key role in disbanding and abolishing the camps that dehumanized the women before their reintegration. Michel et al. (2019) argued that Africa has the opportunity to avoid replicating the errors made in Western societies of institutionalizing older adults. This call means that reintegrating the women of the witch camps back to their communities would help Ghana to avoid the mistakes made by some western countries where older people are sent to institutions to care for them.

10.4.5 Contribution to knowledge

This PhD study contributes novel knowledge on mental health, stigmatization, older women, and socially excluded communities within a low-resource context in Ghana. It also describes the creation of a linguistically translated version of the HADS into Dagbani, a Ghanaian language. When distributed, this version shows that anxiety and depression are more prevalent among women living in the witches' camps compared to women from the general population.

This concluding chapter has summarized the rationale for this research topic, demonstrated how the research questions were addressed, and outlined the research journey. The key findings from the exploratory sequential qualitative and quantitative phases have been summarized. The results can potentially inform policymakers across different sectors about strategies for addressing and reducing the psychological and emotional distress experienced by women living in northern Ghana's witches' camps. The findings will also inform planning and strategic interventions for rural communities, health educators, and mental and general health service providers.

10.5 Strengths of the study

This study aimed to explore the factors that influence the mental health and emotional well-being of older women in the witches’ camps of northern Ghana. The study utilized a mixed-methods approach, incorporating SEM, and utilized the social determinants of health and the explanatory model as guiding frameworks.

Through Phase One interviews, the study provided an in-depth understanding of the mental health and emotional well-being challenges faced by the women living in the

camps. The survey results showed a high prevalence of anxiety and depression among the women in the camps than the women from the general population who also exhibited unexpected symptoms of anxiety and depression. The comparative survey design and mixed-methods research approach were key strengths of this study.

Additionally, the study explored the suitability of the HADS as a measure of anxiety and depression symptoms for non-English speaking participants with limited literacy. The study also revealed the good acceptability of the HADS-Dag items, making it a valuable tool for measuring anxiety and depression symptoms in Ghanaian languages. To the best of my knowledge, this is the first study to translate HADS into a Ghanaian language.

The major strength of this study lies in its mixed-methods research design. Despite the challenges in finding an appropriate tool for assessing anxiety and depression in a low-resource context, the initial qualitative phase provided deep insights and ‘thick descriptions’ of the mental health and emotional well-being of older women living in witches' camps. The subsequent quantitative phase focused on the women's psychological distress, specifically anxiety and depression, experienced in the study context. The supervisory team, which included a field supervisor and later a third supervisor with linguistic expertise, helped to ensure the research process was rigorous. Additionally, developing a protocol for local ethics helped ensure a steady rollout of the study, taking into account the complex nature of the research setting and the cross-cultural translation of the HADS instrument.

The findings from Phase Two are likely to be generalizable to other witch camps, refugee camps, and marginalized communities with similar cultural backgrounds. The use of an exploratory sequential mixed-methods approach, as recommended by Creswell and Clark (2017a), helped to demonstrate the transferability of qualitative results to distinct groups (Morgan, 2014) and to explore the phenomenon in depth while measuring the prevalence of its dimensions. Another strength of this study is that it gave voice to older women in the witches' camps who are often marginalized, discriminated against, and silenced. Conducting research in a non-clinical setting can provide longer-term preventive benefits to clinical populations, as argued by Roberts et al. (2017). Reducing psychological problems, such as anxiety and depression,

through a general population-based approach can lead to fewer people suffering in the longer term who might need clinical attention. This can also reduce the health economic burden on the nation and communities with already ailing health service models.

10.6 Limitations of the study

The present study had several limitations that future research should address. First, due to limited time and resources in this PhD project, the number of participants recruited from the general population was limited. However, this did not reduce the richness and depth of the research data. The sample size was sufficient to generalize anxiety and depressive symptoms for women from other witches' camps – the primary research aim. However, the sample size for the general population of women was not large enough to make definitive conclusions about the prevalence of anxiety and depression in this population. Therefore, the generalizability of these findings is subject to certain limitations, at least for the general population category.

However, the inclusion of the sample of women from the general population provided insights into whether anxiety and depressive symptoms were pre-existing concerns before the banishment to the camps. This allowed for comparisons at the group level, and it is plausible that the women in the camps may have already had some level of anxiety and depressive symptoms before their banishment. Nonetheless, the low literacy rates posed a challenge, and the use of face-to-face interviews by the female research assistant may have introduced subject bias, variability, and measurement errors that could have influenced the Phase Two findings. According to Lyons et al. (1999), social desirability bias can arise during face-to-face interviews, particularly in sensitive areas such as psychological health assessment. Additionally, this study did not explore the experiences and perceptions of family members whose relatives had been banished to the witches' camps, although not all the women were accused by their immediate family members.

In addition, this study has other limitations related to its scope, participant selection, and the impact of COVID-19. Due to limited time and resources, the sample size of women from the general population was small, and face-to-face interviews may have increased subject bias and measurement errors. Additionally, the study did not cover

the experiences of family members of the banished women. COVID-19 restrictions and the researcher's emotional distress due to the sensitive nature of the research and the participants' vulnerability also impacted the study. The complexity and intersectionality of various factors such as politics, poverty, culture, gender, and stigmatization made this research challenging to conduct. As a male researcher, the involvement of a female research assistant was necessary, and working with older women accused of witchcraft living in witches' camps presented challenging ethical dilemmas. Regular communication with the Earth Priest, stakeholders, and the women helped to mitigate these challenges and ensure the women's participation commitment and research outcomes' successful rollout.

Despite the limitations mentioned, the Phase Two study has produced findings that support the generalization that anxiety and depressive symptoms are prevalent mental health conditions among women living in witches' camps. Additionally, the study has examined the factors that contribute to the presence of these symptoms in this population.

10.7 Recommendations for further research

This study aimed to understand the factors influencing the mental health and emotional well-being of older women in the witches' camps of northern Ghana. While the findings suggest the need for a long-term recommendation for the reintegration of these women back into their communities (see Chapter 6), a more focused and in-depth qualitative study is required to understand the co-design steps necessary for successful reintegration. Additionally, an interventional study with a pre- and post-design and a participatory approach that treats community members as equal collaborators is needed to identify effective reintegration solutions with long-term follow-up. Co-design can facilitate valuable conversations that change how people think about and understand the phenomenon (Steen et al., 2011). Furthermore, an intervention study investigating the benefits and specific indicators of adding psychological interventions to routine care for common mental disorders is necessary. This could benefit not only the women in the witches' camps but also other vulnerable populations facing similar situations.

Additionally, it is recommended to conduct a large-scale population-based quantitative study to determine the prevalence of depression among women and older individuals in Ghana. Such a study would provide policymakers with comprehensive evidence that could guide the allocation of resources to improve the mental healthcare system.

Other future research areas include:

- Assessing resilience ("Anzansi" in the Dagbani language) among older women in witches' camp communities, with a focus on unique cultural perspectives and factors through ethnographies. This requires longitudinal and chronological analyses to examine the level of vulnerabilities and resilience. Findings can be shared with other developing low-resource contexts and refugee camps in the sub-region.
- Conducting population-based research on the Ghanaian public's attitudes and beliefs towards stigma and dementia, with further mixed-methods design to understand the enactment of stigma and other old age-related conditions.
- Conducting qualitative research on the level of vulnerability of older women in rural communities in northern Ghana.
- Exploring ways to reduce stigma and discrimination against older people with behavioural disorders, by sampling chiefs, healthcare professionals (doctors and nurses), and the general population. This may prevent witchcraft accusations against older women and their subsequent banishment to witches' camps.

This study did not include the experiences and perspectives of family members whose relatives were banished to the witches' camps. Therefore, further qualitative research is needed to understand the impact of witchcraft accusations on the mental health of family members. It would also be valuable to conduct participant-observation research to investigate how older adults living in witches' camps cope and maintain their spirituality.

Furthermore, given the conservative cultural beliefs in traditional healing among spirit healers in northern Ghana, as well as Ghanaians in general, conducting a qualitative study on healthcare professionals' and nurses' attitudes and beliefs towards mental health, dementia, and witchcraft in the older adult population is a worthwhile area of investigation. Claims have been made to suggest a link between dementia and

witchcraft among older women (Brooke & Ojo, 2020c), but there has been no consensus to prove or disprove these correlations. Therefore, research is needed to determine the prevalence rate of dementia among newly accused women to identify whether they have underlying dementia or not before being admitted into the camps.

As mentioned earlier, it is recommended that more extensive quantitative and qualitative studies be conducted to examine ageism and sexism in the healthcare system in Ghana. This would provide a more robust basis for implementing elder-friendly healthcare policies in hospitals. Additionally, future research on loneliness among older adults in Ghana is crucial to understanding its impact on mental health, as chronic loneliness can lead to depression. Research on the relationship between loneliness and mental health issues in older adults in Ghana, as well as key interventions, is also needed. Moreover, further studies are needed to explore the impact of illiteracy on questionnaire responses and how to interpret questionnaire items in the context of cultural differences.

A potential research direction could be to examine the broader socio-economic and legal factors that contribute to the marginalization and disadvantage experienced by women in the witches' camps and from the community (Gershman, 2022). The study could investigate the ways in which gender inequality intersects with other forms of social inequality, such as ethnicity, and class to create complex and multi-layered challenges for women (Gershman, 2022).

The research could use a mixed-methods approach, combining quantitative surveys and qualitative interviews with women in the community, as well as with relevant stakeholders such as policymakers, healthcare providers, social service providers, community leaders, and legal experts. The study could also engage with local community members to gather their perspectives on the challenges faced by women and the types of solutions that could be implemented at a community level.

The findings of the research would inform the development of policies and programs that address the broader structural factors that contribute to the marginalization of women, with a view to promoting gender equity and social justice. The research would also highlight the importance of local community participation and policy support in addressing these issues, with a view to promoting sustainable and community-led

solutions. The proposed research could make an important contribution to the field by shedding light on the complex and interrelated challenges faced by women in northern Ghana communities, and identifying potential areas for policy and programmatic interventions that could better support their needs (Gershman, 2022).

Finally, it is essential to develop a validated mental health instrument that reflects the cultural beliefs of older Ghanaians and has acceptable psychometric properties for detecting mental health problems in older adults.

10.8 Research implications from this thesis

Based on the key discussion provided in this study in chapter 9, some research implications identified are:

Interventions for physical health problems: The study highlights the need for interventions targeting the physical health problems experienced by older women in witches' camps. Further research could explore effective strategies for managing chronic pain, improving mobility, and addressing other physical health issues to enhance overall well-being and potentially reduce the risk of mental health problems.

Understanding the relationship between physical and mental health: The findings emphasize the association between physical health problems and mental health issues. Future research could investigate the mechanisms through which physical health conditions contribute to the development of mental health problems, such as depression and anxiety. This could provide insights into potential preventive measures and treatment approaches.

Family connections and social support: The study underscores the detrimental impact of disrupted family connections on the mental health and emotional well-being of older women in witches' camps. Further research could explore strategies to promote family cohesion and support, even in the context of banishment or separation. This could involve interventions that facilitate communication, maintain relationships, and provide emotional comfort to mitigate the negative effects of family disconnections.

Addressing loneliness and social isolation: Loneliness and social isolation emerged as significant challenges for the women in the study. Future research could investigate

interventions to alleviate loneliness and enhance social connectedness among older women in similar marginalized settings. This could include interventions that promote community engagement, facilitate social interactions, and provide opportunities for emotional support.

Exploring self-stigmatization and mental health symptoms: The participants reported experiencing self-stigmatization along with various mental health symptoms. Further research could delve deeper into the experiences of self-stigmatization and its impact on mental health outcomes. Understanding the underlying factors contributing to self-stigmatization and its relationship with different mental health symptoms could inform the development of targeted interventions to reduce stigma and promote mental well-being.

Contextual factors and cultural legitimacy: The study highlights the influence of cultural and contextual factors on mental health experiences. Further research could explore the specific cultural beliefs, norms, and practices that shape the perceptions of mental health and well-being in similar settings. Understanding the cultural context could help develop culturally appropriate interventions and strategies to improve mental health outcomes for marginalized populations.

Overall, these research implications aim to provide a foundation for future studies to address the mental health challenges faced by older women in witches' camps and similar marginalized populations, with a focus on interventions, relationships, social support, stigma, and cultural considerations.

10.9 Concluding remarks

This chapter presents the key findings of the research's two phases, which address the study's objectives. The significant findings are highlighted within the context of the cultural and resource background of rural Ghana, which includes specific cultural imperatives. Overall, the study demonstrates that mental health and psychological distress, including anxiety and depression, are critical population health concerns among women in the witches' camps of northern Ghana. Efforts must be put in place to improve the lives and psychological well-being of these women. The study generates novel and unique knowledge that shows how anxiety and depression are

prevalent not just in the women in the camps but also, to a lesser extent, in women from the general Ghanaian population. The perspectives shared by the older women in the witches' camps and allied stakeholders and policymakers inform strategies to improve the women's mental health and emotional well-being. The study also highlights the barriers to accessing and engaging with general healthcare and mental health services in the camps.

I have summarized the key findings from the exploratory sequential qualitative and quantitative design phases and acknowledged the strengths and limitations of this study. This concluding chapter outlines the key findings and recommendations underscored by the theoretical models utilized in this thesis. The recommendations outline an approach to effectively reintegrating women back into their communities. Additionally, this PhD study is the first to cross-culturally translate and validate the HADS into Dagbani, a Ghanaian language. The outcomes of this PhD thesis have contributed to the knowledge of the mental health of older women in the witches' camps of Ghana and suggest further research.

This study shows that actions and public policies to address existing health inequalities need to be universal, inclusive, and proportionate to need. When assessing risk points or triggers and introducing protective factors for mental health at various levels, including socio-ecological factors and social determinants, responses must be multi-layered and multi-sectoral. Health, welfare, and housing sectors must be involved and contribute to a 'health in all policies' approach. Adopting the current research recommendations is essential to improve the mental health and emotional well-being of older women residents at the witches' camps. The adoption of these recommendations would also provide cultural reintegration while maintaining women's mental health and ensuring their safety in their communities.

10.10 Reflective account of the research process: My journey

This reflective account focuses on the research process that led to the study of factors influencing the mental health and emotional well-being of older women residents at the witches' camps in northern Ghana. Reflective practice aims to assess one's thoughts and actions for the purpose of personal learning and development (Jasper & Rosser, 2013; Schön, 2017). Reflection is crucial in professional life (Jasper, 2003), as it

allows researchers to be competent practitioners and not just technicians. Reflecting deeply is essential in this regard. Thus reflection is “a turning back onto a self” (Steier, 1991, p. 163).

I used Gibb’s reflective cycle (1988) as the model for my reflection. This cycle consists of six stages: description, feelings, evaluation, analysis, conclusion, and action plan. The model is a continuous cycle of improvement for a repeated experience, acknowledging the relevance of feelings in reflection.

The reflective model used in this account is the Gibbs Reflective Cycle (1988), which provides a cyclical framework for examining experiences and promoting learning and development. The model consists of six stages: description, feelings, evaluation, analysis, conclusion, and action plan, and is designed for repeated experiences to support continuous improvement. One of the strengths of the Gibbs model is its recognition of the role of emotions in the reflective process.

The description of the situation – The motivation for this PhD project originated from my experience as a youth volunteer participating in a program called Youth Forum. Through this program, I had the opportunity to discuss with a speaker who later invited me to take part in a program called *Towards Effective Reintegration of Alleged Witches in Northern Ghana: Challenging the Stereotypes by ActionAid Ghana*. While volunteering, I observed that the witches’ camps lacked basic health facilities and the women lacked access to basic health and social care provisions. The situation was worsened by the fact that the women lacked livelihoods and struggled to feed themselves. Although the Ghanaian government and civil society organizations aimed to close the witches’ camps due to political pressure and the advocacy of human rights organizations, the women continued to live in deplorable conditions in the camps. Additionally, many women continued to be accused and banished in contemporary times. I noted that these women could be suffering or impacted by the distressing life events brought about by the accusations and subsequent banishment, as well as the resulting social and family exclusions. Therefore, I decided to explore the mental health and emotional well-being of older women residents in the witches’ camps of northern Ghana.

The identified research area received support from the AUT Vice-Chancellor's Doctoral Scholarship Scheme 2017 due to its relevance to the country. During the development of the proposal (PGR9), I had the opportunity to attend and present an abstract of the literature review at a conference held in New Zealand (Midwifery and Women's Health Conference, Auckland University of Technology, New Zealand, Monday, Feb 11, 2019).

Feelings –During the process of developing the proposal, data collection, and translation of HADS, I experienced a mix of emotions, including fear, motivation, and joy. At first, I was fearful when I realized the magnitude of the task and the time required. According to the Vice-Chancellor's Doctoral Scholarship regulations, I was initially required to spend only six months outside New Zealand for data collection and complete the PhD within 36 months. Completing the two phases of the study involving qualitative and quantitative methods within six months was almost impossible. Fortunately, with the support of my supervisors, it was agreed that I could use 12 months for data collection. Unfortunately, COVID-19 disrupted the entire social fabric, including free movement within regions in Tanzania and globally. Ghana declared a lockdown in March 2020, and the witches' camps were housing older people, making it a no-go area until restrictions were lifted. Offices were also closed, and I could not recruit stakeholders for phase one interviews. Internet connectivity was down and slower, creating distressing feelings.

The stories shared by the women in the camp were emotional and sad, but not surprising. I felt deeply saddened for these highly vulnerable women banished to witches' camps to live in exclusion without their families and support. Their physical health problems impacted their general health and well-being as they experienced chronic body pains, joint, and vision problems, affecting their activities of daily living, sleep, and independent ability to function. The women felt disconnected from their families and were sad and lonely. Anxiety and nervousness, suicidal ideation, internalized and public stigma worsened the plight of the women.

Throughout the data collection period, I was motivated by the great support I received from my supervisors, the advisory team, and the participants. The women participants lacked critical social amenities such as healthcare facilities, potable water, and psychological support, which worsened the situation in the camp.

This PhD project provided a wonderful opportunity to understand the factors influencing women's mental health and emotional well-being. The women and allied stakeholders were enthusiastic about sharing their experiences. I am happy that I was able to accomplish the research process and resultant thesis despite the emotional and logistical complexities.

Experience evaluated – The experience challenged my understanding of the factors that affect the lives and mental health of marginalized populations. The health-seeking behaviours of the women in the camps were sometimes influenced by their belief system, while at other times they were hindered by factors beyond their control, such as financial constraints and lack of health insurance cards. I also appreciated that while the government and other civil society groups aim to close the camps, more needs to be done to ensure that women are appropriately reintegrated into their communities and can live with dignity and improved well-being.

Through interactions with my supervisory team and participants, I realized that targeted provision of social and health care amenities and workforce could significantly improve mental well-being and overall health. Overall, I gained an understanding of the challenges of studying complex social and political environments while upholding ethical principles. After Phase One, I also realized that I could have interviewed and surveyed family members of accused women to better understand the context and their perspectives. However, this was not part of the original aim of my study.

Reflection (learning opportunities) – During my interactions with stakeholders, I learned about the process of gaining safe entry into communities and research settings without causing any offense. I also realized that instruments used in developed countries may not always apply to developing countries such as Ghana, due to cultural and resource infrastructure differences. As a result, this experience emphasized the importance of using instruments that reflect participants' literacy level, understanding, and cultural context.

Conclusion –From my PhD journey and findings, I have come to the following conclusions: the mental health and emotional well-being of the older women residents of the witches' camps were influenced by physical health symptoms, internalized stigma, and lack of critical social factors such as poor housing, lack of medical facilities,

and food insecurity (see Chapter 6). Moreover, the journey was immensely rewarding as it was the first to translate the HADS into Dagbani for Ghana and provided new data to improve the lives of these women. I feel proud of this accomplishment.

Future – My experience in conducting the PhD research project has enhanced my professional competency in numerous ways. Firstly, it has developed my critical thinking skills towards resolving research and ethical issues that often arise in studies of this nature. Secondly, my writing skills have significantly improved as a result of being involved in the PhD study.

Personally, engaging in this research project has been a very enriching experience for me. Particularly, writing the thesis, which has a word count of almost one hundred thousand words, including this personal reflection, has prepared me to take up a full-time research position upon completing my PhD. This study has also heightened my interest in researching older adults' health, and I intend to publish various articles from my thesis, such as the qualitative findings, the quantitative findings, and the translation of the Dagbani HADS.

Furthermore, I plan to send a report to key policymakers and training providers, as well as to organize community-based workshops with the Earth priest NGO staff to disseminate these findings to grassroots organizations where change can occur.

Finally, I would like to highlight that my PhD journey has enhanced my professional interest in the general and mental well-being of older adults. I intend to continue researching and advocating for older adults to access quality care and mental health services. Specifically, I plan to work on developing a mental health diagnostic tool that reflects the cultural ingredients of the Ghanaian people. Additionally, I believe there is a need for more culturally sensitive instruments developed for use in Sub-Saharan Africa to better reflect the actual experiences of the population.

Moreover, I would like to conduct a post-doctoral study to investigate the presence of ageism and sexism in Ghana's healthcare delivery system. This study will provide an empirical basis for developing age-friendly healthcare policies in our communities and hospitals.

The most significant benefit I have gained from this PhD program is the belief in my research skills and critical thinking capabilities. The thesis writing and networking within my cycle have also awakened my desire to approach research as a lifelong process.

Another notable benefit of this journey is the ability to view, accept, and critically examine criticism to drive the fullest benefits from it. I am proud to have persevered in the last period of this work. Although the PhD journey is tough, only those who persevere can receive the accolade, as the saying goes in African parlance.

> " Not everyone who chased the zebra caught it, but he who caught it chased it".

And

> “Only when you have crossed the river can you say the crocodile has a lump on his snout”.
>
> Source: https://proverbicals.com/ghanaian-proverbs

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Appendices

Appendix A Ethics approval by AUTEC in New Zealand

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
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T: +64 9 921 9999 ext. 8316
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29 July 2019

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application **in stages** at their meeting on 22 July 2019, subject to the following conditions:

1. Clarify around the appropriateness of some of the questions for the Earth Priest and Stakeholders;
2. Provision of more detail in the indicative questions for the stakeholders;
3. Clarification about who the research assistant is likely to be and provision of a Confidentiality Form;
4. Provision of a peer review about the validity of the research protocol from the local supervisor with the material for the second stage and clarification of how access to the camp is managed and how easy it is to access.

This approval is for the initial stakeholder interviews with the government and non-government organisation official and the Earth Priest only. Full information about the interviews with the women needs to be submitted to and approved by AUTEC before any recruitment or data collection for that stage occurs. This information needs to include:

1. *Clarification of how voluntary consent will be assured;*
2. *Provision of advice to the participants about the options for counselling support should they need them and how they will be able to access them. Any such support needs to be at no charge to the participants;*
3. *Provision of the structured interview instruments that will be used and clarification of how they will be administered;*
4. *Provision of evidence about further consultation around cultural appropriateness and safety.*

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection

may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

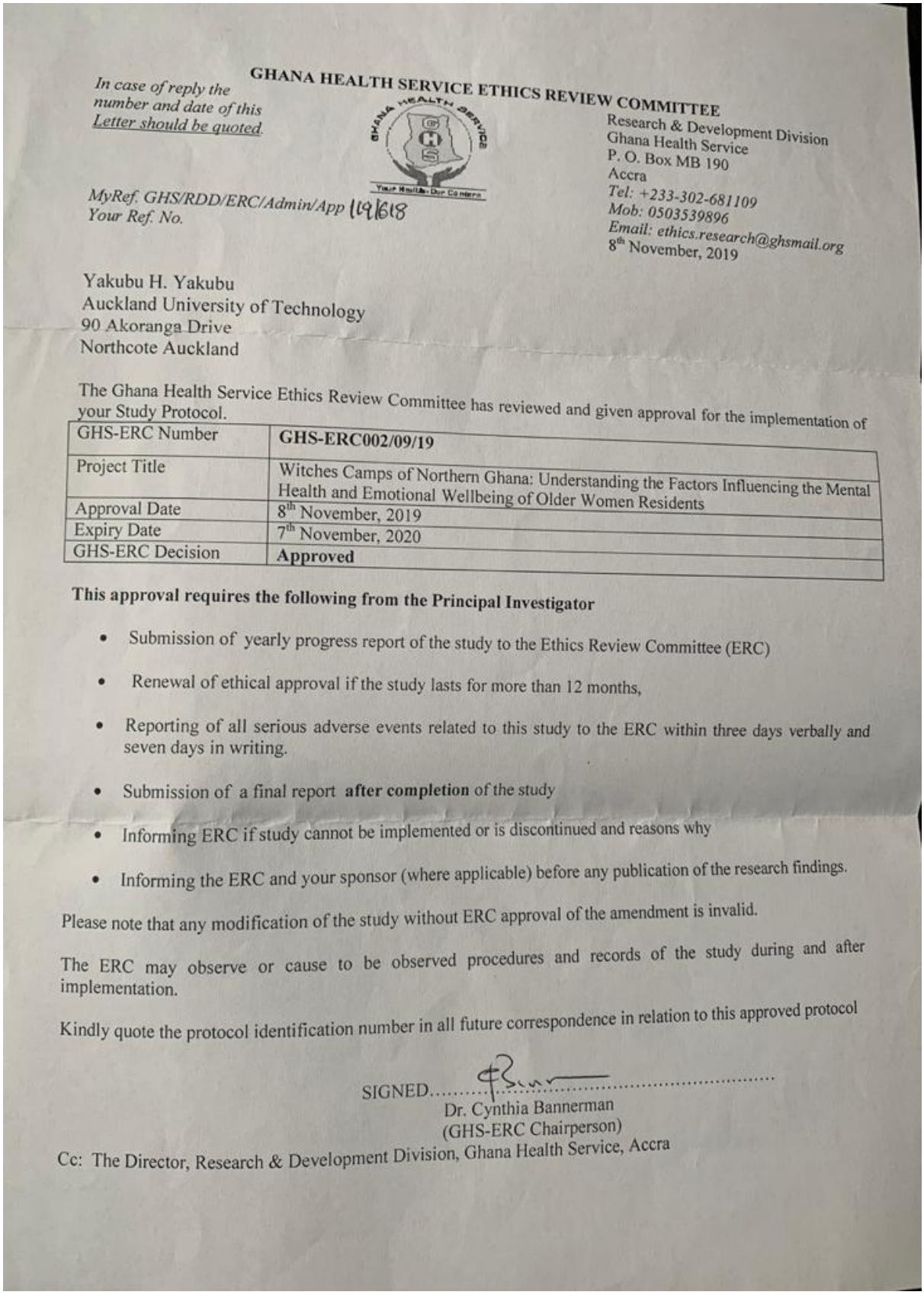
I look forward to hearing from you,

Yours sincerely

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair; Margaret Sandham

Appendix B Local ethics approval by the Ghana Health Sciences Ethics Committee in Ghana



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Mob: 0503539896
Email: ethics.research@ghsmail.org

MyRef. GHS/RDD/ERC/Admin/App 119/18
Your Ref. No.

8th November, 2019

Yakubu H. Yakubu
Auckland University of Technology
90 Akoranga Drive
Northcote Auckland

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC002/09/19**
Project Title	Witches Camps of Northern Ghana: Understanding the Factors Influencing the Mental Health and Emotional Wellbeing of Older Women Residents
Approval Date	8th November, 2019
Expiry Date	7th November, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
Dr. Cynthia Bannerman
(GHS-ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Appendix C Amendments to ethics approval by AUTEC in New Zealand

Auckland University of Technology Ethics Committee (AUTEC)

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17 September 2019

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been **approved in stages** for three years until 17 September 2022.

I note that the original 'approval subject to conditions' was for the priest and NGO interviews only. AUTEC acknowledges that the researcher has explained that he will recruit suitable female RA (already working as a helper in the camp), has done consultation, and has a relevant field academic overlooking him. Therefore, this approval covers the experts, and the women in the camp.

> Note: This approval is only for interviews with stakeholders and older women. Should a survey of a wider group of women be envisioned post interview, then an amendment application for this, including the survey being used, a recruitment protocol and a data management plan needs to be provided to the committee.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair; Margaret Sandham

Auckland University of Technology Ethics Committee (AUTEC)

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Advice that 18 June 2020

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re: Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

Thank you for your advice that Margaret Sandham is no longer part of the supervisory team. The file has been updated.

I remind you of the **Standard Conditions of Approval**.

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

17 June 2020

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

Thank you for submitting your application for amendments to your ethics application. We are pleased to advise that the amendment to the data collection protocol (remaining interviews online) and photographs of the camp buildings and layout is approved subject to the above conditions

1. Provision of the Information Sheet and Consent Form updated with the new data collection and consent protocols;
2. Provision of an assurance that the Zoom interview will be audio-recorded only;
3. Clarification about how the necessary permissions and any informed and voluntary consent process to take photographs of the camps and layout will be obtained and provision of an assurance that no photographs of people will be taken.

Please provide us with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

We look forward to hearing from you,

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair; Margaret Sandham

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

23 June 2020

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

Thank you for submitting your responses to the conditions for the amendment to your ethics application. The following are issues that are still outstanding:

1. It is possible to undertake a Zoom interview using the video function, and afterwards to save only the audio file. This method is preferable because no video recording is saved, thus protecting the identities of the interviewee as well as any incidental participants. Please update the Information Sheet to reflect this.

2. The ethical concern with the proposed photos is the identification of people living in a high risk situation and the potential impact of this on their safety. With this in mind, please clarify how the necessary permissions and any informed and voluntary consent process to take photographs of the camps and layout will be obtained and provision of an assurance that no photographs of people will be taken.

Please provide us with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

We look forward to hearing from you,

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair

Auckland University of Technology Ethics Committee (AUTEC)

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D-88, Private Bag 92006, Auckland 1142, NZ
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E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

30 June 2020

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re: Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

Thank you for your request for approval of amendments to your ethics application.

The amendment to the data collection protocol (for remaining interviews to be conducted online and photographs of the camp buildings) is approved.

I remind you of the **Standard Conditions of Approval**.

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair

Appendix D Full ethics approval by AUTEC in New Zealand

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

9 July 2021

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Ethics Application: **19/213 Witches' camps of Northern Ghana: Understanding the factors influencing their mental health and emotional health of older women residents**

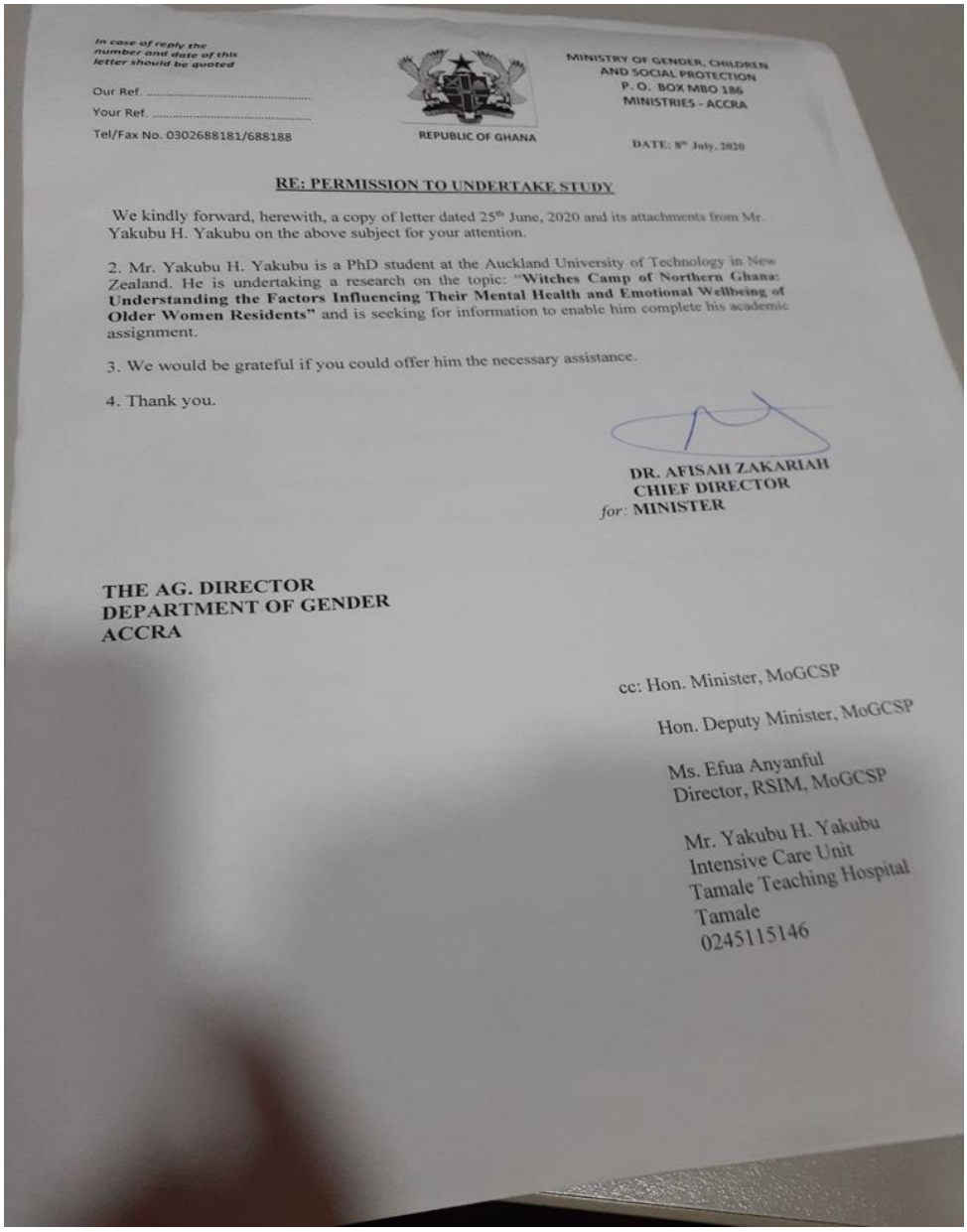
At their meeting of 5 July 2021, the Auckland University of Technology Ethics Committee (AUTEC) received the report on your ethics application. AUTEC noted your report and asked us to thank you.

On behalf of AUTEC, we congratulate the researchers on the project and look forward to reading more about it in future reports.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6038.

(This is a computer-generated letter for which no signature is required)
The AUTEC Secretariat
Auckland University of Technology Ethics Committee
Cc: kubuhabi2002@gmail.com; Valerie Wright-St Clair

Appendix E The Ministry of Gender, Children and Social Protection Ghana permission letter



In case of reply the number and date of this letter should be quoted

Our Ref. .....

Your Ref. .....

Tel/Fax No. 0302688181/688188

REPUBLIC OF GHANA

MINISTRY OF GENDER, CHILDREN AND SOCIAL PROTECTION
P. O. BOX MBO 186
MINISTRIES - ACCRA

DATE: 8th July, 2020

RE: PERMISSION TO UNDERTAKE STUDY

We kindly forward, herewith, a copy of letter dated 25th June, 2020 and its attachments from Mr. Yakubu H. Yakubu on the above subject for your attention.

2. Mr. Yakubu H. Yakubu is a PhD student at the Auckland University of Technology in New Zealand. He is undertaking a research on the topic: **"Witches Camp of Northern Ghana: Understanding the Factors Influencing Their Mental Health and Emotional Wellbeing of Older Women Residents"** and is seeking for information to enable him complete his academic assignment.

3. We would be grateful if you could offer him the necessary assistance.

4. Thank you.

DR. AFISAH ZAKARIAH
CHIEF DIRECTOR
for: **MINISTER**

THE AG. DIRECTOR
DEPARTMENT OF GENDER
ACCRA

cc: Hon. Minister, MoGCSP

Hon. Deputy Minister, MoGCSP

Ms. Efua Anyanful
Director, RSIM, MoGCSP

Mr. Yakubu H. Yakubu
Intensive Care Unit
Tamale Teaching Hospital
Tamale
0245115146

Appendix F Permission letter from the GL Assessment License the GL Assessment (countersigned User Agreement) for Hospital Anxiety and Depression Scale

Permissions Granted Ref no 6293456580 Inbox ×

Permissions <permissions@gl-assessment.co.uk>
to me

Feb 11, 2021, 2:36 AM

Dear Customer

Please find attached the countersigned User Agreement and template by way of permission granted to use within your study. If you have requested translations on your user agreement, please contact eprovide@mapi-trust.org who will assist you with your application.

The questionnaire is copyrighted worldwide and if adapted for use in software applications, it must be stored on a secure server with the user gaining access via a unique user name and password. A screenshot of the questionnaire must be sent to Permissions for authorisation before the questionnaire goes live. It is also restricted from being downloaded and stored on mobile devices to prevent unauthorised copying.

If you have any further queries, please don't hesitate to contact by telephone on +44 (0) 800 652 1019 or by email to permissions@gl-assessment.co.uk
Please note that Permissions queries are dealt with in the afternoons of Monday to Friday (except Bank Holidays)

Kind Regards

Mandy Pritchard
Rights & Permissions Department, GL Assessment

T: +44 (0)800 652 1019 E: permissions@gl-assessment.co.uk

Please note that permissions are dealt with in the afternoons' Mon – Friday (except UK bank holidays)

From: Yakubu H. Yakubu <kubuhabi2002@gmail.com>
Sent: 03 February 2021 14:17

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    (b) If the Licensee shall at any time be in breach of any of the terms and conditions of this Agreement and if capable of being remedied, such breach is not remedied within 15 days of receipt of written notice thereof; or

    (c) If the Licensee is declared insolvent or bankrupt or goes into liquidation (other than voluntary liquidation for the purpose of reconstruction only) or if a Receiver is appointed or if the Licensee is subject to any similar event anywhere in the world.

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    Upon termination of this Agreement for any reason the Licensee shall immediately cease to use the Material.

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16. Counterparts; Electronic Signatures: Where permitted according to applicable law, this Agreement may be executed in two or more counterparts, each of which shall be deemed an original, and all such counterparts together shall constitute one and the same instrument. Where counterparts are not permitted according to applicable law, this Agreement must be executed (i) either in paper form, in as many original copies as there are parties to the agreement, each copy to be signed in full by each party on the same instrument, or (ii) in electronic form through a validated electronic signing software, where the electronic version is signed in full by each party on the same electronic instrument. Electronically executed or electronically transmitted (including via fax) signatures shall have the full force and effect of original signatures.

17. This Agreement constitutes the entire agreement between the parties in respect of the Material and supersedes all prior oral or written proposals, agreements or undertakings concerning the same.

18. This Agreement shall not be amended or modified in any way other than by an agreement in writing and signed by both parties or their duly authorised representatives and shall come into effect on receipt of the payment in full as specified above and a counter-signed copy of this Agreement.

19. This Agreement shall be governed by and construed in all respects in accordance with English Law and the courts of England and Wales shall have exclusive jurisdiction to settle any dispute arising out of or in connection with this Agreement, its subject matter and formation, including non-contractual disputes or claims.

20. Data Protection: your personal data will be processed by GL Assessment which is part of the GL Education Group Ltd. in accordance with any applicable law relating to the processing, privacy and use of personal data, as applicable to you and/or the Services, including the Data Protection Act 1998, the General Data Protection Regulation (EU) 2016/679 and any subsequent UK data protection legislation and our Privacy Policy. We will only process the data provided by you for the purposes stated.

21. The permission comes into effect on receipt by GL Assessment of the payment in full within thirty days of invoicing and the return from GL of a counter-signed copy of the permission agreement.

AS WITNESS THE HANDS OF THE PARTIES hereto the day and year first above written

Signed for and on behalf of:
GL Education Group Limited
Unit 28 Bramble Road
Swindon
SN2 8HB
United Kingdom
Company number: 02603456
M. A Pritchard 03/02/2021
Rights & Permissions Department

Signed on behalf of GL Assessment Limited

.....

Signed by the Licensee: ***Please print this page, sign, and attach this signature page as a scanned document along with your typed User Agreement form, sent as a Word document. Electronic signatures are acceptable.***

User's Signature (handwritten):	**Company/Organisation Stamp (if applicable):**
_____	
Title: _____	
Company/Organisation: AUCKLAND UNIVERSITY OF TECHNOLOGY _____	
	
Date: 18/01/2021 _____	

PLEASE READ THE FOLLOWING NOTES BEFORE YOU COMPLETE THIS AGREEMENT

Note 1. Licensee's Name	This is the contracting party for the permissions agreement. Please ensure the Licensee is authorised to sign legally binding documents on behalf of the contracting organisation.
Note 2. Vat Number	This is only applicable to EU countries. If you do not include

	your VAT number and are based in the EU, you will be charged VAT at 20% on your invoice.
Note 3. Details of where invoice should be sent.	If the invoice needs to be sent to someone other than the Licensee whose details have been provided on this form already, you must provide the full details of where and to whom the invoice should be sent. Please include the FULL name and address, contact telephone number and **email address**. If you require a purchase order number, study number or any other specific detail to appear on the invoice in order to have it processed, please include this information in section 5 above. The invoice cannot be sent elsewhere/changed once it has been created. All payments must be made in £ sterling by credit card or cheque drawn on a UK bank or sterling funds transferred directly to the GL Assessment bank account – details of which will be included on the invoice. **To make a payment:** **Proforma invoices**: to pay by credit card, please contact the permissions department on (UK) 0800 6521019 (Int) +44 800 652 1019 If you are unable to call to make a payment, please contact permissions@gl-assessment.co.uk for alternative arrangements. **Sales Invoices:** please contact credit control on 01793 516347 int +44 1793 516347 If you are unable to call to make a payment, please contact permissions@gl-assessment.co.uk or credit.control@gl-assessment.co.uk for alternative arrangements.
Note 4. GL Reader Code GL Qualification Code	GL Assessment products are restricted to qualified and registered users. You will be issued with a Reader Code and Qualification Number once your application has been processed. If the Licensee for the study is different to that of the registered user, please provide the name of the registered user along with the reader code and qualification number in section 4 above.
Note 5. University Course and Supervisor's Name/Supervisor's GL Reader Code. / qualification code	Complete only if you are an undergraduate student and not qualified to register with GL Assessment yourself. Your supervisor must register and sign an agreement on your behalf.
Note 6. Details of project	Ensure you include study title, project title, name of study group.
Note 7. Total number of Administrations	Administrations mean the number of times the scale is to be used not the number of participants/subjects in the study i.e. test to be administered 3 times to 50 participants/subjects = 150

	administrations. If the study is international it should include the total number of administrations, whatever number of countries/languages involved (**excluding** those administered in the German language; see below).
Note 8. Translations of the HADS/GHQ	The HADS questionnaire is distributed in its translated forms by the MAPI Research Trust. **For all queries re. availability and status of translations, please contact Mapi Research Trust in France at** eprovide@mapi-trust.org Tel: +33 472 13 65 75 Please note that further costs, in addition to those charged by GL Assessment for the use of the scale(s), may be charged by the MAPI Research Trust when obtaining the translations of the scale. You must liaise directly with the MAPI Research Trust regarding translations and any additional associated fees. Each new translation must undergo a full linguistic validation process by Mapi Research Institute, according to standard recognized methodology of translation, as described in Acquadro C, Conway K; Giroudet C, Mear I. Linguistic Validation Manual for Patient-Reported Outcomes (PRO) Instruments. Mapi Research Institute, 2004. **Please note that GL Assessment do not hold the rights to the GERMAN translation of the HADS, therefore you will be unable to obtain the German translation of the scale either through ourselves or the MAPI Research Trust. If you require the German translation of the HADS you should contact Sylvia.Schlutius@hogrefe.ch at Hogrefe AG, Bern, Switzerland. Please do not include any number of administrations that are intended for German usage on this form as you may be charged twice.**

Ends.

Appendix G Tools: Original version of Hospital Anxiety and Depression Scale

Hospital Anxiety and Depression Scale (HADS)

GL assessment

Name:_____ Date: _____

FOLD HERE

Clinicians are aware that emotions play an important part in most illnesses. If your clinician knows about these feelings he or she will be able to help you more.

This questionnaire is designed to help your clinician to know how you feel. Read each item below and **underline the reply** which comes closest to how you have been feeling in the past week. Ignore the numbers printed at the edge of the questionnaire.

Don't take too long over your replies, your immediate reaction to each item will probably be more accurate than a long, thought-out response.

A	D			A	D
		I feel tense or 'wound up'	**I feel as if I am slowed down**		
3		Most of the time	Nearly all the time		3
2		A lot of the time	Very often		2
1		From time to time, occasionally	Sometimes		1
0		Not at all	Not at all		0
		I still enjoy the things I used to enjoy	**I get a sort of frightened feeling like 'butterflies' in the stomach**		
	0	Definitely as much	Not at all	0	
	1	Not quite so much	Occasionally	1	
	2	Only a little	Quite often	2	
	3	Hardly at all	Very often	3	
		I get a sort of frightened feeling as if something awful is about to happen	**I have lost interest in my appearance**		
3		Very definitely and quite badly	Definitely		3
2		Yes, but not too badly	I don't take as much care as I should		2
1		A little, but it doesn't worry me	I may not take quite as much care		1
0		Not at all	I take just as much care as ever		0
		I can laugh and see the funny side of things	**I feel restless as if I have to be on the move**		
	0	As much as I always could	Very much indeed	3	
	1	Not quite so much now	Quite a lot	2	
	2	Definitely not so much now	Not very much	1	
	3	Not at all	Not at all	0	
		Worrying thoughts go through my mind	**I look forward with enjoyment to things**		
3		A great deal of the time	As much as I ever did		0
2		A lot of the time	Rather less than I used to		1
1		Not too often	Definitely less than I used to		2
0		Very little	Hardly at all		3
		I feel cheerful	**I get sudden feelings of panic**		
	3	Never	Very often indeed	3	
	2	Not often	Quite often	2	
	1	Sometimes	Not very often	1	
	0	Most of the time	Not at all	0	
		I can sit at ease and feel relaxed	**I can enjoy a good book or radio or television programme**		
0		Definitely	Often		0
1		Usually	Sometimes		1
2		Not often	Not often		2
3		Not at all	Very seldom		3

Now check that you have answered all the questions

	A	D
TOTAL		

Appendix H Agreements and authorisation to perform the translation of the HADS by Mapi Research Trust

Good morning,

All the agreements being in place, you are now authorized to perform the translation of the HADS in Dagbani .

Please find attached the material to be used for your translation:

· English original version should have been provided to you by GL Assessment, we are not allowed to deliver the UK source

· Linguistic validation guidelines

Once the translation is finalized, please send it to me with a report of translation.

We greatly appreciate your collaboration and hard work; it will be extremely useful to future researchers wanting to use the Dagbani version of the HADS in future studies.

I would be very grateful if you could inform me if you decide to abandon this translation. I wish you all the best in translating and in your research. Please do not hesitate to contact me if you have any questions.

Best regards

Hoissila

Hello,

I have submitted the filled form.

Dear Yakuba,

thanks for sending a copy of the license you put in place with GL Assessment, this is perfect. for you know and in case helpful only we have a Yoruba translation available but no Ghanaian one.

See attached the documents you have to complete and sign to be authorized to perform the HADS Ghanaian translation.

In case you want to use the Yoruba translation, you only have to complete and sign the attached request for translation from, in case you want to translate in Ghanaian , then please complete 2 forms, the request for translation form and the translation agreement form.

Looking forward to hearing from you.

Hoissila

Appendix I Experts' review of the backward translation of the HADS

Hospital Anxiety and Depression scale

Tick the box that lies by the reply that is closest to how you have been feeling last week.

Don't take too long over your replies: your quickest reply is best.

D	A		D	A	
		I feel tense or unease, chocked "hopeless" "sieged" "trapped":			**I feel as if my spirit is down:**
	3	Many times,	3		Nearly all the time I feel downhearted
	2	Frequently	2		All the time
	1	Occationally	1		Occasionally
	0	It doesn't happen to me	0		It doesn't happen to me
		I still enjoy some of the things which used to give me enjoyment:			**I sometimes have the fearful feeling that there is an insect in my stomach:**
0		Yes, there are many things I still enjoy		0	It doesn't happen
1		I no longer enjoy much of those things		1	Occasionally
2		I enjoy just a few of those things		2	It happens often
3		It doesn't happen at all		3	Always
		I get worried as if some misfortune or something bad is going to befall (happen) me:			**I have lost interest in taking care of my personal appearance:**
	3	Yes, it happens frequently/badly	3		Yes, I don't take care of myself
	2	Yes, it happens many times but not so serious	2		I don't take care of myself as much I should
	1	It happens a few times but it has no negative effect on me	1		Sometimes I do not take care
	0	It doesn't happen	0		I take care of myself as I should
		I can laugh and recognise the fun in things:			**I feel unease(uncomfortable) that things are not moving as expected:**
0		I laugh as much as I can		3	That's right
1		I dont laugh so much		2	Most of the time
2		Yes, but not so much now		1	Its not the best
3		It doesn't happen at all		0	It doesn't happen
		I have a lot worrying my mind			**I look forward to things with joy:**
	3	This is very often	0		It's the same as I used to do
	2	Very often	1		I do it less now
	1	It happens from time to time	2		Yes, it is less than how i used to do it
	0	Its only from time to time/not always	3		It doesn't happen
		I feel happy and inspired:			**I get sudden feeling of fears:**
3		It doesn't happen, I don't feel happy		3	It happens to me often
2		Not always		2	It normally happens
1		Sometimes I feel happy		1	Not all the time
0		All the time/always		0	It doesn't happen
		I can sit quietly and feel relaxed:			**I can read and listen to interesting information from books,radio, and television:**
	0	I laugh as much as I can	0		Always
	1	I don't laugh as much as I now	1		From time to time
	2	Yes, not so much now	2		Not always
	3	It doesn't happen	3		Occasionally

Scorings:

The total score: Depression (D)_____ Anxiety (A)_____

0-7 = Normal score

8-10 = Middle score

11- 21 = Not normal score

Commented [WU1]: These two may not help.

Commented [WU2]: They are the same.

Commented [WU3]: These are different from the original response. Check again.

Commented [WU4]: This does not relate with the original

Commented [WU5]: They are the same.

Commented [WU6]: Not part.

Commented [WU7]: This is different from the original questionnaire.

Dr Bill Koomson's review-Expert review

Item 1:

I feel tense or "hopeless" "sieged" "trapped": the question is not specific as it refers to 4 different types of feeling

Item 8:

I feel as if my spirit is down: this indicates a low mood rather than psychomotor retardation

Item 9:

I sometimes have the fearful feeling that there is an insect in my stomach: this denotes the fear of insects living in the stomach and does not serve the desired purpose

Item 10:

I feel unease(uncomfortable) that things are not moving as expected: the meaning of this statement is very different from what is in the original document.

Item 11:

I can read and listen to interesting information from books,radio, and television: this statement depicts the ability to read and listen and not the the ability to enjoy the act

Nursing and mental health - Expert review

Item 1:

I feel tense or unease, chocked "hopeless" "sieged" "trapped":

These two may not help, "**hopeless" "sieged". Dr. Adjorlolo suggest I feel tense or unease, or chocked.**

Item 3:

I get worried as if some misfortune or something bad is going to befall (happen) me:

Dr. Adjorlolo suggested, **I get worried as if some misfortune or something bad is going to happen to me**

Item 4:

I can laugh and recognise the fun in things:

Dr. Adjorlolo suggested that option 2 of the above item should be; Yes, but not so much now. Yes has been added as highlighted in red

Item 5:

I have a lot worrying my mind

Dr Adjorlolo thinks option 1 should be re-looked at.He thinks option 1 "It happens from time to time**" and option is 0** "Its only from time to time/not always"are the same.

He has also corrected an omitted score of the options. Thanks for that.

Item 10:

I feel unease(uncomfortable) that things are not moving as expected:

Dr.Adjorlolo thinks the above item This does not relate with the original. He thinks it should be re-translated.

Item 14: I can read and listen to interesting information from books,radio, and television:

Dr. Adjorlolo thinks this is Not part as highlighted and makes it different from the original source.

Hospital Anxiety and Depression scale

Tick the box that lies by the reply that is closest to how you have been feeling last week.

Don't take too long over your replies: your quickest reply is best.

D	A		D	A	
		I feel tense or unease, chocked "hopeless" "sieged" "trapped":			**I feel as if my spirit is down:**
	3	Many times,	3		Nearly all the time I feel downhearted
	2	Frequently	2		All the time
	1	Occationally	1		Occasionally
	0	It doesn't happen to me	0		It doesn't happen to me
		I still enjoy some of the things which used to give me enjoyment:			**I sometimes have the fearful feeling that there is an insect in my stomach:**
0		Yes, there are many things I still enjoy		0	It doesn't happen
1		I no longer enjoy much of those things		1	Occasionally
2		I enjoy just a few of those things		2	It happens often
3		It doesn't happen at all		3	Always
		I get worried as if some misfortune or something bad is going to befall (happen) me:			**I have lost interest in taking care of my personal appearance:**
	3	Yes, it happens frequently/badly	3		Yes, I don't take care of myself
	2	Yes, it happens many times but not so serious	2		I don't take care of myself as much I should
	1	It happens a few times but it has no negative effect on me	1		Sometimes I do not take care
	0	It doesn't happen	0		I take care of myself as I should
		I can laugh and recognise the fun in things:			**I feel unease(uncomfortable) that things are not moving as expected:**
0		I laugh as much as I can		3	That's right
1		I dont laugh so much		2	Most of the time
2		Yes, but not so much now		1	Its not the best
3		It doesn't happen at all		0	It doesn't happen
		I have a lot worrying my mind			**I look forward to things with joy:**
	3	This is very often	0		It's the same as I used to do
	2	Very often	1		I do it less now
	1	It happens from time to time	2		Yes, it is less than how i used to do it
	0	Its only from time to time/not always	3		It doesn't happen
		I feel happy and inspired:			**I get sudden feeling of fears:**
3		It doesn't happen, I don't feel happy		3	It happens to me often
2		Not always		2	It normally happens
1		Sometimes I feel happy		1	Not all the time
0		All the time/always		0	It doesn't happen
		I can sit quietly and feel relaxed:			**I can read and listen to interesting information from books,radio, and television:**
	0	I laugh as much as I can	0		Always
	1	I don't laugh as much as I now	1		From time to time
	2	Yes, not so much now	2		Not always
	3	It doesn't happen	3		Occasionally

Commented [WU1]: These two may not help.

Commented [WU2]: They are the same.

Commented [WU3]: These are different from the original response. Check again.

Commented [WU4]: This does not relate with the original

Commented [WU5]: They are the same.

Commented [WU6]: Not part.

Commented [WU7]: This is different from the original questionnaire.

Scorings:

The total score: Depression (D)_____ Anxiety (A)_____

0-7 = Normal score

8-10 = Middle score

11- 21 = Not normal score

RE: BACKWARD TRANSLATION AND ORIGINAL HADS

Inbox

Richard Siegert <richard.siegert@aut.ac.nz> Apr 1, 2021, 4:11 PM

Dear Yakubu

I have had a close look at the original HADS and the current back-translated version which you sent me today and while you have made substantial progress, I think that we might need to do some more work on it. There are some items in the BT version that concern me a little.

Item 1:

HADS: I feel tense or 'wound up'. This becomes – I feel tense or 'hopeless' 'sieged' 'trapped'.

We have more descriptors in the BT version, and they have a different sense or meaning. Feeing tense or wound-up means feeling tension or anxiety now but feeling hopeless (about the future) is more suggestive of depressed mood.

Item 2:

HADS: I still enjoy the things I used to enjoy. This becomes - I still enjoy some of the things…. So, including the word 'some' in the item changes it quite a bit.

Item 5:

In the BT version the response options go: 3. This is very often; 2. Very often; 1. It happens from time to time; 0. Its only from time to time/not always.

I think there is not if any difference in 3 and 2 or for that matter 1 and 0?

Item 6

The item is about "I can sit quietly and feel relaxed' but two of the response options refer to laughing (0,1) and then the next two don't mention it (2,3). My main point is that the original HADS item does not mention laugh or laughter?

Item 7

The HADS item says, “I feel as if I am slowed down” and the BT item says “I feel as if my spirit is down.

Both are about depression, but the HADS is asking about psychomotor retardation or vegetative symptoms whereas the BT is much more about affective or emotional aspects of depression.

Item 10

HADS says I feel restless as I have to be on the move – this becomes “I feel unease that things are not moving as expected.

The HADS is asking about agitation, and this gets lost somehow in the BT translation. So, I think that what is missing here is the expert clinical voice that can speak both languages fluently and understands mental health. Hopefully your clinical/field supervisor can help to fill this gap.

Yakubu, I have just spoken to Assoc Prof Chris Krageloh who is doing work with translating questionnaires in India and quite expert in this area. Chris has suggested we form a translation/back translation committee, and he is happy to be a part of this. It might also include your field supervisor – we really need an academic or senior clinician who speaks Dagbani and English and is knowledgeable about anxiety and depression.

I hate to slow you down with data collection Yakubu, but it is essential that we do this stage of the research carefully and thoroughly. I have asked Chris if he can join us on Thursday 15th and with your permission, I will share the various versions of the HADS with him before then.

I hope this all makes sense Yakubu. Please get back to me with any questions.

Warm regards

Richard

Hospital Anxiety and Depression scale

Tick the box that lies by the reply that is closest to how you have been feeling last week.
Don't take too long over your replies: your quickest reply is best.

D	A		D	A	
		I feel tense or "trapped":			**I feel as if my spirit is down:**
	3	Many times,	3		Nearly all the time I feel downhearted
	2	Frequently	2		All the time
	1	occationally	1		Occasionally
	0	It doesn't happen at all~~to me~~	0		It doesn't happen ~~to me~~at all
		I still enjoy the things which used to give me enjoyment:			**I sometimes have the fearful feeling that there is an insect in my stomach:**
0		Yes, there are many things I still enjoy		0	It doesn't happen at all
1		I no longer enjoy much of those things		1	Occasionally
2		I enjoy just a few of those things		2	It happens often
3		It doesn't happen at all		3	Always
		I get worried as if some misfortune or something bad is going to ~~befall~~ happen to me:			**I have lost interest in taking care of my personal appearance:**
	3	Yes, it happens frequently/badly	3		Yes, I don't take care of myself
	2	Yes, it happens many times but not so serious	2		I don't take care of myself as much I should
	1	It happens a few times but it has no negative effect on me	1		Sometimes I do not take care
	0	It doesn't happen at all	0		I take care of myself as I should
		I can laugh and recognise the fun in things:			**I feel unease(uncomfortable) that things are not moving as expected:**
0		I laugh as much as I can		3	That's right
1		I dont laugh so much		2	Most of the time
2		Yes, not so much now		1	Its not the best
3		It doesn't happen at all		0	It doesn't happen at all
		I have a lot of worrying in my mind			**I look forward to things with joy:**
	3	This is very often	0		It's the same as I used to do
	2	Very often	1		I do it less now
	1	It happens from time to time	2		Yes, it is less than how i used to do it
	0	Its only from time to time/not always	3		It doesn't happen at all
		I feel happy ~~and inspired~~:			**I get sudden feeling of fears:**
3		It doesn't happen at all~~, I don't feel happy~~		3	It happens to me often
2		Not always		2	It normally happens
1		Sometimes I feel happy		1	Not all the time
0		A lot of ~~All~~ the time~~/always~~		0	It doesn't happen at all
		I can sit quietly and have feel relaxed:			**I can read and listen to interesting information from books,radio, and television:**
	0	I laugh as much as I can	0		Always
	1	I don't laugh as much as I now	1		From time to time
	2	Yes, not so much now	2		Not always
	3	It doesn't happen at all	3		Occasionally

Please look through to ensure that you have answered all the questions,

Scorings:

The total score: Depression (D)_____ Anxiety (A)_____

0-7 = Normal score

8-10 = Middle score

11- 21 = Not normal score

Hello,

Please kindly look at the statements in the table below to assist me to review my translation. I would like you to look at the Backward translation column and the one labeled HADS. The HADS is the original statement whiles the Backward T. is the translated version that needs a look. I want to make sure that the meaning of the translated version is not lost as from the Original version (HADS)

ITEM 5: BACKWARD T.	ITEM 5: HADS(ORIGINAL)	ITEM 5: FORWARD T.
I have a lot worrying my mind:	**Worrying thoughts go through my mind:**	**Ɛlimuɣusira zooi n zuɣu:**
3 Most of the time	3 A great deal of the time	3 Saha maa pam ni
2 It takes a lot of the time	2 A lot of the time	2 Saha maa zaa ni
1 It happens from time to time, not always	1 From time to time, but not too often	1 Di niŋdi la saha saha, pa saha kam
0 Intermittently only	0 Only occasionally	0 Saha saha ko

Commented [DSA1]: The original item is specific: Worrying thoughts in my mind. But the translated item appears to convey the notion that something is wrong with mind of the participants. This is suggestive of some mental problems. This should be revise.

NOTE: Please kindly review the one marked with yellow colour by comparing it with the Original version labelled **HADS(ORIGINAL)**

Hello,

Please kindly look at the statements in the table below to assist me to review my translation. I would like you to look at the Backward translation column and the one labeled HADS. The HADS is the original statement whiles the Backward T. is the translated version that needs a look. I want to make sure that the meaning of the translated version is not lost as from the Original version (HADS)

ITEM 2: BACKWARD T.	ITEM 2: **HADS(ORIGINAL)**	ITEM 2: FORWARD T.
I get worried as if some misfortune or something bad is going to befall me:	**I get a sort of frightened feeling as if something awful is about to happen:**	**N suhu sayinda ka maa binshɛɣu din biɛ n yɛn niŋ la:**
3 Yes, it happens frequently/badly	3 Very definitely and quite badly	3 Di niŋda ka bi viɛla
2 Yes, it happens but not so serious	2 Yes, but not too badly	2 Iii, amaa ka lee bi biɛ n yayi
1 It happens a few times, but it has no negative effect on me	1 A little, but it doesn't worry me	1 Di pora, ka lee bi damdi ma
0 It does not happen at all	0 Not at all	0 Ka bi niŋda

Commented [u1]: This original did not indicate the recipient of something awful. But the translated item was specific: befall me> Would take a look a reconcile?

NOTE: Please kindly review the one marked with yellow colour by comparing it with the Original version labelled **HADS(ORIGINAL)**

Hello,

Please kindly look at the statements in the table below to assist me to review my translation. I would like you to look at the Backward translation column and the one labeled HADS. The HADS is the original statement whiles the Backward T. is the translated version that needs a look. I want to make sure that the meaning of the translated version is not lost as from the Original version (HADS)

ITEM 8: BACKWARD T.	ITEM 8: HADS	ITEM 8: FORWARD T.
I feel as if my life has retrogressed:	**I feel as if I am slowed down:**	**Di be mi ka n behagu labla nyaaŋga:**
3 Nearly all the time I feel retrogressed. **2 All the time** **1 Occasionally** **0 I do not feel retrogressed at all**	3 Nearly all the time 2 Very often 1 Sometimes 0 Not at all	3 Di niŋdi saha kam 2 Saha kam 1 Saha saha 0 Di bi niŋda

NOTE: Please kindly review the one marked with yellow colour by comparing it with the Original version labelled **HADS(ORIGINAL)**

Commented [u1]: Retrogressed is far from slowed down. Change the word.

Commented [u2]: "All the time" should be 3 and "Nearly all the time I feel retrogressed" should be 2.

Hello,

Please kindly look at the statements in the table below to assist me to review my translation. I would like you to look at the Backward translation column and the one labeled HADS. The HADS is the original statement whiles the Backward T. is the translated version that needs a look. I want to make sure that the meaning of the translated version is not lost as from the Original version (HADS)

ITEM 7: BACKWARD T.	**ITEM 7: HADS (ORIGINAL)**	ITEM 7: FORWARD T.
I can sit quietly and feel relaxed:	**I can sit at ease and feel relaxed:**	**N ni tooi ʒini vuhi bahi n maŋa:**
0 That is true **1 That is how it has been** **2 Not often** **3 It does not happen at all**	0 Definitely 1 Usually 2 Not Often 3 Not at all	0 Lala n kul nyɛli or Pali n nyeli 1 ~~Din nya chem~~Di zooya lala 2 Ka saha kam 3 Di bi niŋda

NOTE: Please kindly review the one marked with yellow colour by comparing it with the Original version labelled **HADS(ORIGINAL)**

Commented [AA1]: Certainly?

Commented [AA2]: Normally? Or Mostly?

Commented [AA3]: Chirgili

BACKWARD T.	HADS(ORIGINAL)	DAGBANI FORWARD
ITEM 1	**ITEM 1**	**ITEM 1**
I feel tense or "uneasy, choked": **3 Many times,** **2 Frequently** **1 Occasionally** **0 It does not happen at all**	**I feel tense or 'wound up':** 3 Most of the time 2 A lot of the time 1 From time to time, occasionally 0 Not at all	**N suhuzohira bee "N suhu tora":** 3 Saha kam zaa 2 Saha maa zaa ni 1 Saha saha 0 Di bi niŋda
ITEM 2	**ITEM 2**	**ITEM 2**
I still enjoy the things which used to give me enjoyment: 0 Definitely as much 1 No longer as much 2 Just a few of those things 3 Does not happen at all	**I still enjoy the things I used to enjoy:** 0 Definitely as much 1 Not quite so much 2 Only a little 3 Hardly at all	**N na kuli wumdi nyaɣisim ni binyari shɛŋa ni daa pun wumdi di nyagisim:** 0 Iii di galisiya 1 Di dii bi galisi yaha 2 Biɛla ko 3 Di bi niŋda
ITEM 3	**ITEM 3**	**ITEM 3**
I get worried as if some misfortune or something bad is going to happen: **3** Yes, it happens and badly **2** Yes, it happens but not so bad **1** Few times, but it has no negative effect on me **0** It does not happen at all	**I get a sort of frightened feeling as if something awful is about to happen:** 3 Very definitely and quite badly 2 Yes, but not too badly 1 A little, but it doesn't worry me 0 Not at all	**N suhu saɣinda ka maa binshɛɣu din biɛ n yɛn niŋ la:** 3 Di niŋda ka bi viɛla 2 Iii, amaa ka lee bi biɛ n yaɣi 1 Di pora, ka lee bi damdi ma 0 Di bi niŋda
ITEM 4	**ITEM 4**	**ITEM 4**
I can laugh and recognise the fun in things: 0 As much as Always 1 Do not so much for now 2 Yes, not as much for now 3 It does not happen at all	**I can laugh and see the funny side of things:** 0 As much as I always could 1 Not quite so much now 2 Definitely not so much now 3 Not at all	**N ni tooi la ka nya binyari shɛŋa din mali lari:** 0 N ni ni tooi la shɛm tariga 1 Di bi tooi galisi punpoŋɔ 2 Iii,di dii bi galisi yaɣi punpoŋɔ 3 Di bi niŋda

Commented [RS1]: I am still unsure about "choked".

Commented [RS2]: This option sounds quite different altogether?

Commented [RS3]: Is 'worried' equivalent to frightened?

The response options seem quite good.

Commented [RS4]: This is not very grammatical in English?

Hello,

Please kindly look at the statements in the table below to assist me to review my translation. I would like you to look at the Backward translation column and the one labeled HADS. The HADS is the original statement whiles the Backward T. is the translated version that needs a look. I want to make sure that the meaning of the translated version is not lost as from the Original version (HADS)

ITEM 4: BACKWARD T.	ITEM 4: **HADS(ORIGINAL)**	ITEM 4: FORWARD T.
I can laugh and recognise the fun in things:	**I can laugh and see the funny side of things:**	**N ni tooi la ka nya binyari shɛŋa din mali lari:**
0 I laugh as much as I can	0 As much as I always could	0 N ni ni tooi la shɛm tariga
1 I dont laugh so much now	1 Not quite so much now	1 Di dii bi tooi galisi punpoŋɔ
2 Yes, not so much now	2 Definitely not so much now	2 Di dii bi galisi yaɣi punpoŋɔ
3 It does not happen at all	3 Not at all	3 Di bi niŋda

NOTE: Please kindly review the one marked with yellow color by comparing it with the Original version labeled **HADS(ORIGINAL)**

***Please you can also look at the Dagbani version IN RED**

MY COMMENTS

1. I agree that, the main headings **I can laugh and recognise the fun in things:** and **I can laugh and see the funny side of things** mean the same semantically. However, I don't same to identify the backward translation as a direct translation of the Dagbani version. The meaning may be the same but the translation may not be a true verbatim representation of the Dagbani version. You will appreciate this if you analyse and compare the two sentences word for word. Though i am not an expect in that regard, i would have translated the Dagbani version "**N ni tooi la ka nya binyari shɛŋa din mali lari"** as ***"i can laugh and recognise things that stimulate/cause laughter"***. The original version was perfectly translated into Dagbani. But i see a little diffrence between the Dagbani version and the backward translation.
2. I don't have any issue with number "0". Original version well translated into Dagbani and the backward translation is also a verbatim translation of the Dagbani version. You will realize that the word "laugh" appears in the backward translation but not in the original version. This is

REVISED AND RESPONSES TO THE COMMENTS

ITEM 1

Prof Richard:

1. the original has 2 words tense/wound up and the BT version now has 3 tense, uneasy, nervous.

ANS: I think I will delete one of them, if that is fine.

2. what happened to 'choked'. I had concerns about it but how and why exactly did it get removed?

ANS: we look up the meaning of wound up and realized it meant 'very worried, nervous, or angry' or 'anxious and worried'

I will choose 'nervous'

BACKWARD T.	HADS(ORIGINAL)	DAGBANI FORWARD
ITEM 1	**ITEM 1 HADS(ORIGINAL)**	**ITEM 1**
I feel tense or "nervous": **3 Many times,** **2 Frequently** **1 Occasionally** **0 It does not happen at all**	**I feel tense or 'wound up':** 3 Most of the time 2 A lot of the time 1 From time to time, occasionally 0 Not at all	**N suhuzohira bee "N suhu ŋoorimi":** 3 Saha kam zaa 2 Saha kam 1 Saha saha 0 Di bi niŋda

ITEM 2:

Prof Chris:

"Not entirely" could still mean a large extent. For example, 90% agreement. Are you sure, the Dagbani options are clearly separate and that option 1 is less than 2?

ANS:

Yes option 1 is less than 2 in the Dagbani version

Option 1 'Not entirely' has been changed to Not so much

Prof Richard:

- I am pretty happy with the main item wording but less happy with the Response Options.
- They are mostly about how much this is true but option 2 refers specifically to how many ("only a few") of the things that used to be enjoyed.

This is not consistent with 0, 1 and 3. Not entirely happy with "Scarcely'???

ANS:

1. option 2 refers specifically to how many ("only a few")

ITEM 4:

Prof Richard:

I think allowing for the subtleties of translation etc this one looks OK.

May be Option2 ? 'not so much for now' looks a bit out of place here??

ANS: Option 2 has been changed to

"Yes, not so much now"

ITEM 4 BACKWARD T.	ITEM 4 HADS(ORIGINAL)	ITEM 4
I can laugh and recognise the fun in things: 0 As much as I could Always 1 Not entirely so much now 2 **Yes, not so much now** 3 It does not happen at all	**I can laugh and see the funny side of things:** 0 As much as I always could 1 Not quite so much now 2 Definitely not so much now 3 Not at all	**N ni tooi la ka nya binyari shɛŋa din mali lari:** 0 Di tooi niŋda kamaa n hankali tariga 1 Di bi tooi galisi punpoŋɔ 2 Iii,di bi galisi yaɣi punpoŋɔ 3 Di bi niŋda

ITEM 5:

Prof Richard:

Hmmm. This is about worry but does not capture the notion of rumination or repetitive negative thoughts. Worries could refer to external things - financial concerns for example.

Prof. Chris

If it is hard to get this one into idiomatic Dagbani, can you at least try to word it as "I have worrying thoughts"?

ANS: I remember the initial BT was "I have worrying thoughts" but Dr. Adjorlolo had a concern about it. Worrying thoughts go through my mind is different from "I have worrying thoughts" because it is suggestive of a mental problem the original version says 'go through'

But since this has come up again, I may have to use the statement: "**I have worrying thoughts**"

Prof: Richard ITEM 5 responses"

I am not sure which of the verbal descriptors should be the 3 and which should be the 2? It is probably OK?

ANS: This has been edited to "A little"

2. Not entirely happy with "Scarcely'???

ANS: Edited now to Rarely

ITEM 2 BACKWARD T.	ITEM 2 HADS(ORIGINAL)	ITEM 2
I still enjoy the things which used to give me enjoyment: 0 Certainly, as much 1 **Not so much** 2 A little 3 **Rarely**	**I still enjoy the things I used to enjoy:** 0 Definitely as much 1 Not quite so much 2 Only a little 3 Hardly at all	**N na kuli wumdi nyaɣisim ni binyari shɛŋa ni daa pun wumdi di nyagisim:** 0 Iii di galisiya 1 Di dii bi galisi yaha 2 Biɛla ko 3 Di niŋbu pora

ITEM 3:

Prof Richard:

Again, I think that I am happy with the Item but not the response options.

Options 2 and 3 could be confused with the Item's idea of something bad happening because the words are similar – as opposed to the frequency of such thoughts???

I am also not sure what Option 1 means by "A few"? This suggests quantity or number but not frequency.

ANS:

1. Option 2 and 3 has been edited as follows;

   3 Yes, and quite badly
   2 Yes, but not so bad
   1 A little, but it has no negative effect on me

Prof Chris

I agree with Richard. But it might just be the backtranslation and the Dagbani is OK.Yakubu – can you please confirm?

ITEM 3 BACKWARD T.	ITEM 3 HADS(ORIGINAL)	ITEM 3
I get a feeling of fear as if some misfortune or something bad is going to happen: **3 Yes, and quite badly** **2 Yes, but not so bad** **1 A little,** but it has no negative effect on me **0** It does not happen at all	**I get a sort of frightened feeling as if something awful is about to happen:** 3 Very definitely and quite badly 2 Yes, but not too badly 1 A little, but it doesn't worry me 0 Not at all	**N suhu saɣinda ka maa binshɛɣu din biɛ n yɛn niŋ la:** 3 Iii di niŋda ka bi viɛla 2 Iii, amaa ka lee bi biɛ n yaɣi 1 Biɛla, ka lee bi damdi ma 0 Di bi niŋda

ANS: I think it I will shift option 3 to option 2

ITEM 5 BACKWARD T.	ITEM 5 HADS(ORIGINAL)	ITEM 5
I have worrying thoughts: 3 Frequently 2 Most of the time 1 It happens time to time, not frequently 0 Intermittently only	Worrying thoughts go through my mind: 3 A great deal of the time 2 A lot of the time 1 From time to time, but not too often 0 Only occasionally	Yɛlimuɣusira zooi n zuɣu 3 Saha kam 2 Saha maa pam ni 1 Di niŋdi la saha saha, pa saha kam 0 Saha sheŋa

ITEM 8

Porf. Richard:

This is not bad but still does not really capture the notion of psychomotor retardation where severely depressed people actually walk and talk slowly or with delayed initiation.

Prof Chris

Yes, it has the connotation of being slowed down by something.

ANS: I have tried to edit to

I feel as if I am held back

ITEM 8 Responses concern

Prof Richard: More frequently than when or what? Why 'more'?

ANS: This has been changed to 'more often'

ITEM 8 BACKWARD T.	ITEM 8 HADS(ORIGINAL)	ITEM 8
I feel as if I am held back: 3 Almost all the time 2 More often 1 Sometimes 0 It does not happen at all	I feel as if I am slowed down: 3 Nearly all the time 2 Very often 1 Sometimes 0 Not at all	Di ŋmala n behagu labla yaanga: 3 Di miri saha kam 2 Di niŋdi pam saha kam 1 Saha shɛŋa 0 Di bi niŋda

ITEM 9

Prof Chris

This is a new idea and not in the original English – there, it doesn't say anything that is about to happen. The English is also not about being nervous but frightened. Like being afraid of something and not knowing what exactly it is that you are afraid of.

ANS: This has been edited to read below

I feel frightened

Prof Richard:

Maybe unsure about whether 2 and 3 should be the other way around. If it normally happens is this more frequently that 'more frequently'?

Xmas normally happens once a year?

Chris this raises the question for me of whether we should dichotomise the scoring?

ITEM 9 BACKWARD T.	ITEM 9 HADS(ORIGINAL)	ITEM 9
I feel frightened: 0 It does not happen at all 1 Occasionally 2 It normally happens 3 More often	I get a sort of frightened feeling like 'butterflies' in the stomach: 0 Not at all 1 Occasionally 2 Quite Often 3 Very Often	N Suhu gun ŋoorimi: 0 Di bi niŋda 1 Saha saha 2 Di tooi niŋda 3 Di niŋdi pam saha kam

ITEM 13

Prof Richard

The grammar is not great here but otherwise the meaning comes across fine.

ANS: I get a sudden feeling of fears

Prof Richard ITEM 13 responses

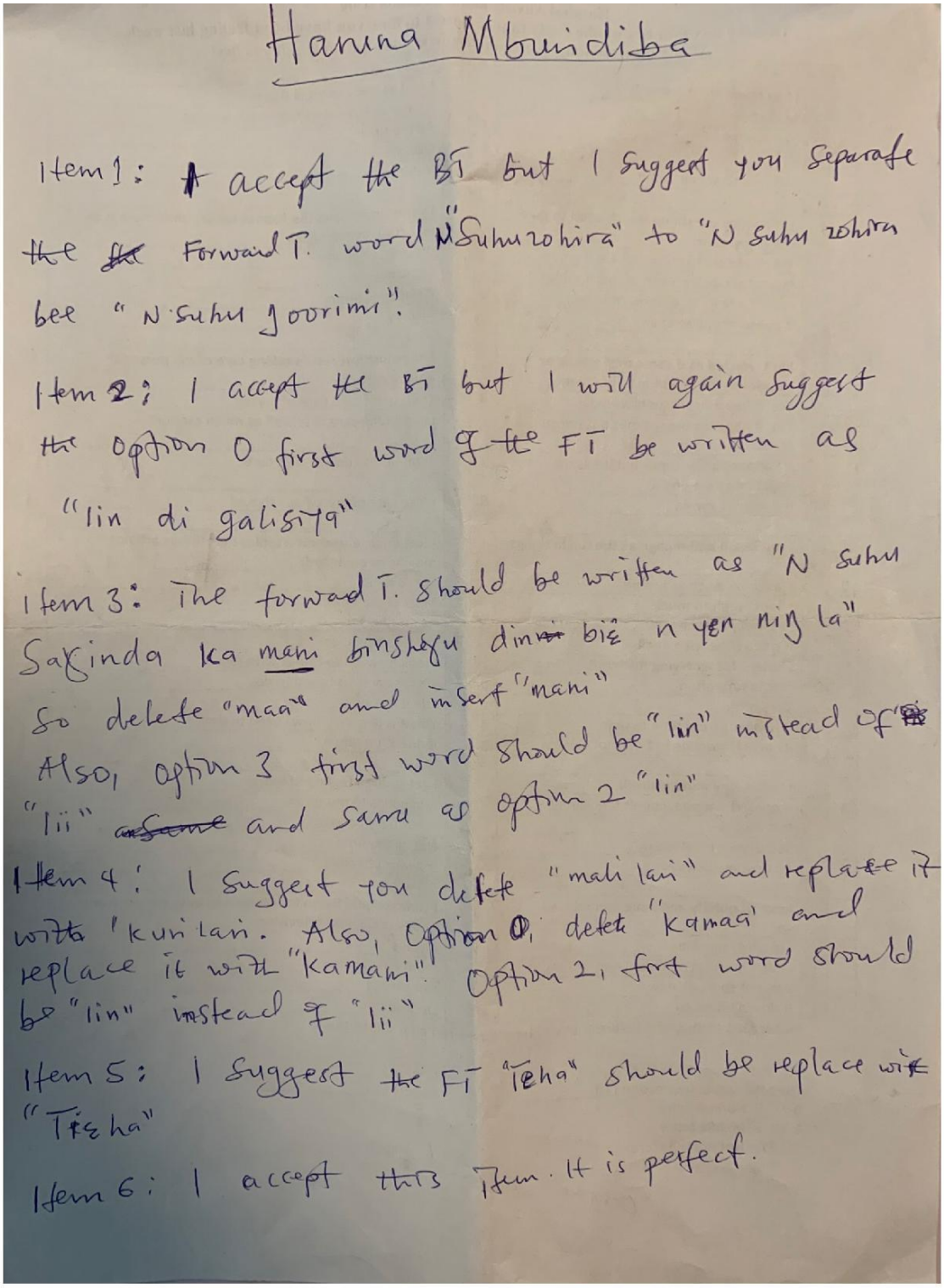
Ditto above. Re 'more frequent' than what and normally mean regularly but infrequently as in Xmas example.

ANS: This has been changed to read as below

Option 3: Its really very often

ITEM 13 BACKWARD T.	ITEM 13 HADS(ORIGINAL)	ITEM 13
I get a sudden feeling of fears: 3 Its really very often 2 It normally happens 1 Not frequent 0 It does not happen at all	I get sudden feelings of panic: 3 Very often indeed 2 Quite often 1 Not very often 0 Not at all	N nyɛri suhusaɣingu ka di libigiri ma: 3 Di niŋdi pam saha kam 2 Di tooi niŋda 1 Ka saha kam 0 Di bi niŋda

Appendix J Expert's review of the backward translation of the HADS for last version



Hanna Mbuidiba

Item 1: I accept the BT but I suggest you Separate the Forward T. word "Suhu zohira" to "N suhu zohira bee "N suhu goorimi".

Item 2: I accept the BT but I will again suggest the option 0 first word of the FT be written as "lin di galisiya"

Item 3: The forward T. should be written as "N suhu Sakinda ka mani binshegu dinii bie n yen nin la" So delete "maa" and insert "mani" Also, option 3 first word should be "lin" instead of "lii" and Same as option 2 "lin"

Item 4: I Suggest you delete "mali lani" and replace it with 'kuni lani. Also, Option 0, delet 'kamaa' and replace it with "kamani" Option 2, first word should be "lin" instead of "lii"

Item 5: I Suggest the FT "Teha" should be replace with "Tiɛha"

Item 6: I accept this Item. It is perfect.

Item 7: I equally accept item 7.

Item 8: I suggest it should be written as "Di niŋdimmami lca n niŋgbuna ka la yaala", Also Option 2 should be "Di niŋdi panitaba / Waa waaliŋa

Item 9: "N subu gun ŋoonimi". 'gun' should be written as "gon" and not "gun"

Item 10: Option 2 "din" shoud be replace with "dini"

Item 11: "Zɛni" should be replaced with "ʒini" and "chendi" shoud also be replaced with "Chandi" Also option 1 should be "lca pam n-di nyɛli"

Item 12: "Sheŋa" should be "Shɛŋa" and nyɛgisim should be "nyaŋisim". And option 2 should be "lin" and not "lii"

Item 13: "nyɛri" should be replaced with "nyari"

Item 14: "kaadiɔ" Should be written as "Leedio" And "puuni" the last word should be written as "Zuŋu"

Appendix K Expert's review of the HADS including response options and Dagbani version

Ibrahim Yakubu

Item 1 = I think the translation is perfect.

Item 2 = Alternatively, in the forward dagbani translation, I suggest it is put "N na kuli wumah nyagisim n binyani shegu n daa pun mah wumah nyagisim"

Item 3 = In the forward dagbani translation, option 1 could read "Binigda ka tom bi veila"

Item 4 = I subscribe to the translation in the final version

Item 5 = There have been improvement in the final version

Item 6 = The translation is accurate by my assessment

Item 7 = I think the translation is accurate.

Item 8 = No better option comes of mind, otherwise I would have suggested a change in option 3 in the final version. May be "saha pam ni"

Item 9 = I don't understand "N sulm gun gbirim" however, the translation of the options are okay

Item 10 = I suggest the statement to be "N yili Zaka ka che n-niggbena ni be shem"

Item 11 = I suggest the statement to be "N ku tooi Zeni baahim dama chendi na bai ma": the option 3 could also read "pali nyaki" as in the third version.

Item 12 = ~~Alternatively~~ The revisions are good, but I also suggest " Nmal tahma ~~Zamchang~~ tuhri bin sheega din mali nyagi sum soli

Item 13 = I subscribe to the translation and I think it is accurate.

Item 14 = The translation is perfect.

Appendix L Dagbani version of the HADS

Suhuzohigu mini Suhudamli Zahimbu Asibiti ni (SSZA)
Dalimmi adakabili din baɣi a ka miri labsibu din jɛndi din daa be a shɛm bakoi din gala ni.
Di di saha waɣinli a labsibu maa ni: A labsibu yom viɛla

D	A		D	A	
		N suhu zohira bee "N suhu ŋoorimi":			**N niŋgbuna niŋla soa:**
	3	Saha maa pam ni	3		Kamani saha kam
	2	Saha kam	2		Di tooi niŋdi pam
	1	saha saha	1		**Saha shɛŋa**
	0	Di bi niŋda zaa	0		Di bi niŋda zaa
		N na kuli wumdi nyaɣisim ni binyari shɛŋa ni daa pun mali wumdi di nyaɣisim:			**N Suhu gɔn ŋoorimi:**
0		lin,di galisiya		0	Di bi niŋda
1		Di dii bi galisi yaha		1	Saha saha
2		Biɛla ko		2	Di tooi niŋda
3		Di bi yoli		3	Di tooi niŋdi pam
		N suhu saɣinda ka mani binshɛɣu din bɛ n yɛn niŋ la:			**N yihi zaɣa ni n maŋmaŋ biɛhigu:**
	3	lin di niŋda ka bi viɛla	3		Lala n nyɛli
	2	lin, amaa ka lee bi biɛ n yaɣi	2		N bi niŋ zaɣa dini tu ni niŋ shɛm
	1	Biɛla, amaa ka lee bi damdi ma	1		Din tooi niŋ ka n bi niŋ zaɣa
	0	Di bi niŋda	0		N kuli niŋ la zaɣa din tu shɛm
		N ni tooi la ka nya binyari shɛŋa din kuri lari:			**N ku tooi ʒini baalim dama chandi na bie ma:**
0		Di tooi niŋda kamani n hankali tariga		3	**Pam n nyɛli**
1		Di bi tooi galisi punpoŋɔ		2	Di zooya bela
2		lin,di bi galisi yaɣi punpoŋɔ		1	Ka pam **n nyɛli**
3		Di bi niŋda		0	Di bi niŋda
		Yɛlimuɣusira tiɛha be n suhu ni			**N lihiri tuhuri binyari sheŋa soli ni nyɛɣisim:**
	3	Saha kam	0		Di saɣisi la n ni pun niŋdili shɛm
	2	Saha maa pam ni	1		N ni niŋdili shɛm di pora ni ni daa pun niŋdili shem
	1	Di niŋdi la saha saha, pa saha kam	2		lin, di pori ni ni yi pun niŋdili shɛm
	0	Saha sheŋa	3		Di bi yoli
		N mali ningbuŋ nyambo:			**N nyɛri suhusaɣingu ka di libigiri ma:**
3		Di bi niŋda		3	**Di shiri niŋdi pam**
2		Ka saha kam		2	Di tooi **niŋda**
1		Saha shɛŋa		1	Ka saha kam
0		Saha maa pam ni		0	Di bi niŋda
		N ni tooi ʒini vuhi bahi n maŋa:			**N tooi wumdi nyaɣisim zaŋ chaŋ lahibali din be buku ni bee leedio ni bee talivisa zuɣu:**
	0	Lala n nyɛli	0		Saha kam
	1	Di zooya lala	1		**Saha shɛŋa**
	2	Ka saha kam	2		Ka saha kam
	3	Di bi niŋda	3		Di dii bi niŋ**da**

Dim suɣulo niŋmi vihigu n_nya a labsi bohisi maa zaa,

Pɔri pubu:
Pɔri maa zaa din jɛndi: Suhudamli (D)_____ Suhuzohigu (A)_____
0-7 = din saɣisi
8-10 = din yaɣi tariga (sariya karibu tariga)
11- 21 = din gam sariya

Appendix M Backward translation of the HADS from Dagbani language

Anxiety and Depression Scale used in the Hospital

Mark the box that is close to the way you are feeling in the past week. Don't take too long over your replies, your immediate reply to each item will probably be more accurate.

D	A		D	A	
		I feel tense or "nervous":			**I feel slow:**
	3	Most of the time,	3		**Almost all the time**
	2	Frequently	2		**It happens more often**
	1	occationally	1		Sometimes
	0	**It does not happen at all**	0		It does not happen at all
		I still enjoy the things which used to give me enjoyment:			**I feel frightened:**
0		Certainly, as much		0	It does not happen at all
1		**Not so much**		1	Occasionally
2		A little		2	It happens often
3		Rarely		3	**It happens more often**
		I get a feeling of fear as if some misfortune or something bad is going to happen:			**I have lost interest in taking care of my personal appearance:**
	3	Yes, and quite badly	3		Certainly
	2	Yes, but not so bad	2		I Don't take care as much I should
	1	A little, but it has no negative effect on me	1		Sometimes, I do not take care
	0	It does not happen at all	0		Take care as I should
		I can laugh and recognise the fun in things:			**I can't sit still because I have to move about:**
0		As much as I could		3	Very much
1		Not entirely so much now		2	Just a lot
2		**Yes, not so much now**		1	Not so much
3		It does not happen at all		0	It does not happen at all
		I have worries			**I look forward to things with joy:**
	3	Most of the time	0		It is the same as I used to do
	2	Frequently	1		Somewhat less than I used to do
	1	It happens time to time, not frequent	2		Yes, it is less than how I used to do it
	0	Intermittently only	3		It does not happen at all
		I feel happy:			**I get a sudden feeling of fears:**
3		**It does not happen at all**		3	It's really very often
2		**Not frequent**		2	It happens often
1		**Sometimes**		1	Not very frequent
0		**Most of the time**		0	It does not happen at all
		I can sit quietly and feel relaxed:			**I can read and enjoy interesting information from a book, and programs from radio, and television:**
	0	**Certainly**	0		Frequently
	1	**Normally**	1		**Sometimes**
	2	**Not frequent**	2		Not frequently
	3	**It does not happen at all**	3		Hardly

Please look through to ensure that you have answered all the questions,

Scorings:

The total score: Depression (D)_____ Anxiety (A)_____

0-7 = Normal score

8-10 = Middle score

11- 21 = Not normal score

Appendix N Supplemental questions for women from witches' camps and from general population.

Biographic data

No	Questions	Response			
1	What is your Age	Under 40 40-49 50-59 60- 69 70-79 80+ I don't know			
2.	Which community are you from?				
	What is your educational status?				
	If no to the above, do you have non-formal education?	YES	NO		
3.	Which region are you from?				
4.	What is your ethnicity?				
5.	What is your religion?				
6.	What language/s do you speak?				
7.	Are you living in your own room?	YES	NO		
8.	If no, how many others to do share a room with ?				
9	Do you have someone helping you with daily activities in this camp	YES	NO		
10	If yes above, what is the relation of this person to you?				
11	Who accused you?	Son	Co -wife	husband	Daughter
		Co-worker	Co-tenant	Community member , **Other**	
12					
14	What is your current monthly income in this camp?				
15	What was your previous work before coming to the camp?				
16	What work do you do while in this camp?				
	How was your health prior to coming to the camp?				
15	Do you regularly attend a clinic or hospital in this camp?	YES	NO		
	If yes why ?				
	If no, where do you go to seek healthcare when you are sick?				

Supplementary short answer questions

1. Does a community psychologists visit the camp? YES ☐ NO ☐ Don't know ☐
2. Do you have potable drinking water in this camp?

   YES ☐ NO ☐, what could improve this ____

3. Do you feel that larger dwelling rooms should be built in this camp?

   YES ☐ NO ☐- what should be included----------

4. Do you feel lonely at times?

5. Do you feel isolated from your home community?
   YES ☐ NO ☐ Note sure ☐

6. Under what circumstances might you go back to your home community? .....

7. Do you feel at times that people from the community are pointing fingers at you?

   YES ☐ NO ☐ When do you think this is ….

8. a) Do you sometimes feel that people are talking ill about you?

   YES ☐ NO ☐ why---

   b) If yes, when does this occur? ……

9. Do you ever feel hemmed in a hole? –YES ☐ NO ☐
   If so, when? Or when does this happen---

10. Do you have anybody to talk about your worries and concerns?
    YES ☐ NO ☐, if this helpful ----------
11. What counselling support is available for you in the camp?
    YES ☐ NO ☐, if yes, by whom? ----------

12. a.Do you use Local or traditional medicine when you are feeling emotionally unwell?
    YES ☐ NO ☐

    b. What traditional medicine

13. Suggests that you feel will make life better for you in this camp.

Appendix O Interview questions for older women from witches' camp

Interview questions- semi structured

Objectives of the study

1. To gain an in-depth understanding of the common mental health and emotional health challenges of older women living in witch camps in northern Ghana
2. To describe the sociocultural and emotional needs and practices that influence their health-seeking behaviours
3. To examine the experiences of accessing health services in the camps
4. To recommend health service and policy directives that met the mental health and emotional needs concerning culturally appropriate health and social care provision.

A. To gain an in-depth understanding of the common health and emotional health challenges of older women living in witch camps in northern Ghana

a. Common mental health problems – Indicative questions under objective one

While in the camp, can you describe in detail how you see your health?

Tell me the things that affect your health?

Tell me about how you remember things?

Can you tell me about any significant worries?

Can you please tell me about your eating?

Tell me about your sleep?

b. Emotional health Problems questions- Indicative questions under objective one

How did you feel when you were accused of witchcraft?

Can you tell me about the common problems affecting your happiness in the camp?

How do you feel about your presence here in the camp?

Can you tell me what you do when you have bad feelings?

Tell me how you have felt over the last six months?

Tell me how people see you?

B. To examine the experiences of accessing health services in the camps

Indicative question under objective two

a. How do you access health care in this camp? When and why and who?

b. What are the barriers to accessing health services

C. To describe the sociocultural and emotional needs and practices that influence health-seeking behaviours

Indicative question under objective three

a. Can you tell me how you seek emotional support?

b. Can you tell me how and where you get treatment when you feel emotionally unwell?

D. To recommend health service and policy directives that met the mental health and emotional needs concerning culturally appropriate health and social care provision.

Indicative questions under objective four

a. In your opinion, can you tell me more about what can be done to improve your mental wellbeing and conditions in the camp?

Appendix P Interview questions for stakeholders

Q UESTIONNAIRE

(THE STAKEHOLDERS – IN-DEPTH INTERVIEW)

TITLE: **Witches' camps of Northern Ghana: Understanding the Factors Influencing their Mental Health and Emotional wellbeing of older women residents.**

Please be assured that your responses will be treated with utmost confidentiality. Consequently you need not provide your name

NAME OF INTERVIEWER…….....

PLACE OF INTERVIEW…..…….....

DISTRICT…….....

REGION…….....……..

DATE OF INTERVIEW…….....…

SECTION A

SOCIO-DEMOGRAPHIC DATA FOR KEY STAKEHOLDERS

1. Sex:

   Male ……..

   Female…….

2. Age:

What is your age?

3. Educational Background (Highest Attainment):

What is your educational level?

4. Occupation:

   What is your occupation?

   Which department of the ministry do you work for?

5. Marital Status

   Single

   Married

   Separated

   Divorced

   Other……

6. Religion:

   Christian

   Muslim

   Traditionalist

   Any Other (specify)……

INDICATIVE QUESTIONS FOR STAKEHOLDERS - MINISTRY OF HEALTH

1. Can you tell me what witchcraft is?

2. Can you tell me what the ministry of health has done to improve general health and wellbeing of the women in the camps?

3. Can you tell me what the ministry of health has done to ensure the health safety of the older women at the witches' camps in the north?

4. The women in the camp experience anxiety and social disconnection to society, can you tell me what can be done to ensure the psychological wellbeing of the women?

5. The women in the camp experience emotional trauma and public stigma, can you tell me what can be done to ensure the emotional wellbeing of the women?

6. While in the camp, the women experience suicidal tendencies can you describe in detail what measures can be put in place to make them feel better and happy and not rejected?

7. Social withdrawal and apathy

8. Can you tell me more about the accommodation situation at the witches' camp? What and how?

9. In your opinion, can you tell me more about what can be done to improve the mental wellbeing of the accused women and conditions in the camp?

INDICATIVE QUESTIONS FOR STAKEHOLDERS - MINISTRY OF WOMEN, GENDER AND SOCIAL WELFARE

1. **Can you tell me what witchcraft is?**

2. **Can you tell me what your ministry has done to improve the general health and wellbeing of the women in the camps?**

3. **Can you tell me what the women and social welfare has done to ensure health safety of the older women at the witches' camps in the north?**

4. **The women in the camp experience anxiety and social disconnection to society, can you tell me what can be done to ensure the psychological wellbeing of the women?**

5. **The women in the camp experience emotional trauma and public stigma, can you tell me what can be done to ensure the emotional wellbeing of the women?**

6. **While in the camp, the women experience suicidal tendencies can you describe in detail what measures can be taken to make them feel better and happy and not rejected?**

7. Social withdrawal and apathy

8. **Can you tell me more about the accommodation and safety policies that will improve the mental wellbeing of the women at the camp?**

9. **Can you tell me the social protection plan this section of the ministry has put in place to improve the wellbeing of the older women at the witches' camps?**

10. **In your opinion, can you tell me more about what can be done to improve the mental wellbeing of the accused women and conditions in the camp?**

Appendix Q Participant information sheets

Participant information sheet for key stakeholders-Government officials (Ministry of Health and Ministry of Gender, Women Social Welfare.

Date Information Sheet Produced: 30 May 2019

Project Title: Witches' camps of Northern Ghana: Understanding the Factors Influencing their Mental Health and Emotional wellbeing of older women residents.

An Invitation: Hello, my name is Yakubu H. Yakubu, a PhD Student, and I am a naïve of Tamale. I am inviting you to participate in my study. This study is a requirement of the Auckland University of Science and Technology, New Zealand to obtain a Doctor of Philosophy qualification. Your reply will be kept confidential. Therefore, please feel free to answer the questions. However, participation is voluntary, and you are free to withdraw from the study at any time without giving any reason and without there being any negative consequences. Thanks.

Identify and introduce yourself and invite the reader to participate in your research. Remember to address your information to the potential participants (consistent use of the 1st person when referring to yourself and the 2nd person when referring to the potential participant is highly recommended). If the research will contribute to a qualification, this is the place to state that also. If there are potential conflict of interest issues this is the place to tell participants that whether they choose to participate or not will neither advantage nor disadvantage them.

What is the purpose of this research?

The purpose of this research to find out about the mental health and emotional wellbeing of older women who have been banished to live in witches' camps in northern Ghana. The study will collect data through face-to-face semi-structured interviews with older women. The findings of this research may be used for academic publications and presentations.

The advice here should reflect your response to sections A.6 and B.9 of the EA1 application. Remember to include the details of any qualifications, presentations, or publications that will result from your research. A useful statement to use is

The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

This is a study about older women who have been banished to live in the witches' camps of Northern Ghana. Your perspective as a government official (key stakeholders) will help provide in-depth information

about the problem and help find solutions through recommendations. You have been identified to take part in the study because you a key stakeholder in Ministry Health, Ministry Gender, Women and Social Welfare and you are more than 18 years and have knowledge in the witchcraft phenomenon in northern Ghana.

This information sheet is to help you understand the process of this study and explain to you more about the reasons for selecting you to take part in this study.

Describe the recruitment and selection process involved. Tell the potential participants how and why they have received this Information Sheet. Advise them of the inclusion criteria for your study. If your selection process has exclusion criteria, this is the place to identify those criteria.

How do I agree to participate in this research?

As a key stakeholder, you can confirm your participation by calling the primary researcher on the phone. Before then, you will sign a consent form to confirm your agreement to take part in my study. The consent form will be delivered to your office.

Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, the removal of your data may not be possible.

Also, key informants (Government officials) who may be participants will be given sufficient time to read the ICF and the opportunity to ask questions. The participant will give written consent. The primary researcher will collect signed consent forms before entering the study. A copy of the ICF will be given to the participant.

How do potential participants let you know that they want to take part in the research? Do they need to complete a Consent Form and if so, where do they obtain it? If they do not need to complete a Consent Form, describe what will occur. Also, make clear that participation is voluntary. You need to include the following wording:

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research will involve interviewing participants for at least one and a half hour each. This will be done at the comfort of your office and at your chosen date and time. It will involve the researcher and the participant only. The conversation will be audio-taped. This will only happen after you have agreed and consented by signing the form. It is voluntary. The information collected through the interviews will be used for only the purpose of this research. You will be de-identified.

Describe in adequate detail what the project involves and what the participants will have to do. If there will be a control group involved, this is a good place to provide advice about that. Remember that consent cannot be valid unless it is adequately informed and that you are able to use the data you collect only for the purposes for which it has been collected.

What are the discomforts and risks?

You may experience minor emotional distress when discussing the banishments of older women who could be a mother or a family member. You may also experience some empathy and some emotional distress if your family member has suffered this witchcraft banishment or consequences before. However, the interview questions and interviews are not designed to put participants in an uncomfortable position.

Provide a full, and friendly description.

How will these discomforts and risks be alleviated?

It is not anticipated that participants will experience extreme discomfort and the risk of embarrassment or incapacity. Should this occur, the primary researcher will look for signs of discomfort and stop the interview or take a break if needed.

Provide a full, and friendly, description. If you have decided to make counselling or other support opportunities available, please provide the contact details and terms for the counselling service or services to which you are referring the participants. If this will be AUT Health, Counselling and Wellbeing, then you will need to include the following wording:

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The study may help the government to use the findings to improve the lives of the older women at the witches' camps and other marginalised communities in similar cultural practice.

The researcher will gain research experience and a Doctor of Philosophy Health qualification. The researcher will also enjoy the experience of helping older people and marginalised community to have their voices represented in research and bring positive results to affected communities.

The wider community may benefit as the results of this study are expected to feed into a priority health and social concern in the Ministry of Women, Gender and Social Welfare and Ministry of Health, and the revised Health of Older Persons Strategy. It may help to promote community support for older women and witchcraft victims, free them from social injustices and reduce inequities in health.

Please read the guidelines for this exemplar before answering. If the research may assist you in obtaining a qualification, this is a good place to advise potential participants about this.

How will my privacy be protected?

Maintaining participant confidentiality is of the utmost importance in this study. Your confidentiality will be maintained when you participate in this study. Your name will be replaced with a pseudonym and any potential detail identifying you will be de-identified in the dissertation and any reports, presentations, or publications arising from the research. All material about the study, including transcripts of interviews, will be stored in a locked filing cabinet.

During the interviews, your privacy will be maintained as the interviews will be conducted in your office or a comfortable place without any interference.

Address any issues of confidentiality that have not already been identified in the sections on discomforts and risks. State clearly what level of confidentiality is achievable and how this will be implemented. Remember that anonymity means that the researcher does not know who the participant is; in all other cases the issue is one of confidentiality and the words 'anonymous' and 'anonymised' are not to be used.

If participants will be identified, then make sure they are told that and that appropriate options are included in the Consent From.

What are the costs of participating in this research?

No monetary cost is involved when you participate in this study. The study will, however, involve one and a half hour of your time for the interviews.

Remember to include a realistic indication of the cost in terms of the participant's time.

What opportunity do I have to consider this invitation?

You will have at least one month to consider whether you wish to participate in this study or not.

Remember to provide a reasonable timeframe. AUTEC recommends that one month is usually a reasonable period of time for potential participants to be given.

Will I receive feedback on the results of this research?

You and your Ministry will be provided with the key findings as this will be useful for decision and policymaking to improve lives at the camps. I will also make available to you a url to read any publication that might emanate from this study.

When people have been kind enough to provide you with information for your research, it is courteous for you to let them know what it was that you found out. A one or two page summary of the findings is sufficient. For anonymous surveys, it is recommended that you provide the participants with an url at which they will be able to read a summary of the findings. If the answer is 'no', then provide the participant with the reason and if the answer is 'yes' then explain how this will happen.

What do I do if I have concerns about this research?: *Any on concerns potential participants might have about the nature of this research should feel free to contact Prof. Lydia Aziato, the acting Dean of School of Nursing and Midwifery, University of Ghana. Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,*

1. Professor Eleanor Holroyd, eleanor.holroyd@aut.ac.nz and Phone: 09 921 9999 ext 5298

2. Lydia Aziato, laziato@ug.edu.gh, and a +233-(0)302-500381.

The wording here is mandatory. Make sure you include the international prefix if the participants are likely to be calling from overseas.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Yakubu H. Yakubu Tamale Teaching Hospital, Ghana. Email: kubuhabi2002@gmail.com

Professor Lydia Aziato(Field Supervisor): Acting Dean School of Nursing and Midwifery, University of Ghana.
Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Yakubu H. Yakubu Tamale Teaching Hospital, Ghana. Provide the name and all relevant contact details. Note that for personal safety reasons, AUTEC does not allow researchers to provide home addresses or phone numbers.

Project Supervisor Contact Details: Professor Eleanor Holroyd, 90 Akoranga Drive, Northcote Auckland, New Zealand.

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Participant Information Sheet for older women.

Date Information Sheet Produced: 30 May 2019

Project Title: Witches' camps of Northern Ghana: Understanding the Factors Influencing their Mental Health and Emotional wellbeing of older women residents.

An Invitation

Hello, my name is Yakubu H. Yakubu, a PhD Student, and I am a naïve of Tamale. I am inviting you to participate in my study. This study is a requirement of the Auckland University of Science and Technology, New Zealand to obtain a Doctor of Philosophy qualification. Your reply will be kept confidential. Therefore, please feel free to answer the questions. However, participation is voluntary, and you are free to withdraw from the study at any time without giving any reason and without there being any negative consequences. Thanks.

Identify and introduce yourself and invite the reader to participate in your research. Remember to address your information to the potential participants (consistent use of the 1st person when referring to yourself and the 2nd person when referring to the potential participant is highly recommended). If the research will contribute to a qualification, this is the place to state that also. If there are potential conflict of interest issues this is the place to tell participants that whether they choose to participate or not will neither advantage nor disadvantage them.

What is the purpose of this research?

I am doing this research to help me understand your psychological health and feelings whiles you are in this camp. I will be talking to you, but there will be a female research assistant to support me in talking to you about your health and feelings. This will also help me to get a Doctor of Philosophy qualification. I will thank you for your contribution to my success.

The advice here should reflect your response to sections A.6 and B.9 of the EA1 application. Remember to include the details of any qualifications, presentations, or publications that will result from your research. A useful statement to use is

The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

In my research, I want to know the health and feelings of older women who live in the witches' camps of northern Ghana. You were identified to take part because you live in the camp and as an older woman. But older women lived in the witch camp for less than six months, will not be invited to talk or take part in my research because I want those who have lived long in the camp and have much experience in the camp and also, they should be 40 years or older.

Describe the recruitment and selection process involved. Tell the potential participants how and why they have received this Information Sheet. Advise them of the inclusion criteria for your study. If your selection process has exclusion criteria, this is the place to identify those criteria.

How do I agree to participate in this research?

When you agree to take part in my research, you will be able to tell my female research assistant who is close to your home. Also, when you agree to take part in my research, I will read a consent letter to you and record your voice to show that you agreed to talk to me about my research. I am going to record your voice because you may not be able to sign the consent form.

But it is your choice to agree to talk to me about my research or not, and even when we start talking, and you later do not feel like talking to me again, you have the choice not to talk to me. My female research assistant will be around to help me do this. But we will allow you to make a choice between deleting what we have already recorded that has your voice. You will also have the choice to allow us to use what we have already recorded that contains your voice and once we have used the information in the final stage of my work, we cannot remove it again.

How do potential participants let you know that they want to take part in the research? Do they need to complete a Consent Form and if so, where do they obtain it? If they will not need to complete a Consent Form, describe what will occur. Also, make clear that participation is voluntary. You need to include the following wording:

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

I will be talking to you for about one and half hour. I will ask you some questions concerning your health and feelings. You will have the opportunity to choose where we should sit to have this conversation, for example, a place you can be comfortable with. I will also record our conversation once you have agreed to talk to me. This recording will only be used to help me know your health and feelings and for my research work. Your name will not be mentioned, and nobody will know you spoke to me.

Describe in adequate detail what the project involves and what the participants will have to do. If there will be a control group involved, this is a good place to provide advice about that. Remember that consent cannot be valid unless it is adequately informed and that you are able to use the data you collect only for the purposes for which it has been collected.

What are the discomforts and risks?

In talking to me, you may have some uncomfortable and painful feelings about what has happened to you in the past and present. You may also have bad feelings about not being able to see, meet and talk to your family members because you are now living here in the camp. You may also have some little fears for talking to me because you do not know me very well and have to share your experiences with me. But do not worry I have put some measures in place to protect the information you will give me by talking to me. Take me as your son talking to you and do not feel worried about our conversation and recording.

Provide a full, and friendly, description.

How will these discomforts and risks be alleviated?

Love when you feel worried, uncomfortable or have bad feelings when we start talking, I will stop the conversation briefly to help you regain your comfort so that we can talk another time or day if you agree with me. But if I see that your bad feelings are extreme and wearing you down, I will talk to the village chief Imam (Islamic Cleric) to help us by guiding and talking to you (counselling) to help you regain your good feelings.

Provide a full, and friendly, description. If you have decided to make counselling or other support opportunities available, please provide the contact details and terms for the counselling service or services to which you are referring the participants. If this will be AUT Health, Counselling and Wellbeing, then you will need to include the following wording:

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The benefit of talking to me may help you get to know about your health and feelings. You will also have an opportunity to have talked about your health, feelings, and what your worries are while living in this camp. It will also help me to know the worries and how I can use this to talk to people who can help you out of your situation. It will also help me with research experience, and I will get a Doctor of Philosophy Health qualification, and I will thank you for this.

Despite this benefit, participation is still voluntary, and you are free to withdraw from the study at any time without giving any reason and without there being any negative consequences. Thanks.

Please read the guidelines for this exemplar before answering. If the research may assist you in obtaining a qualification, this is a good place to advise potential participants about this.

How will my privacy be protected?

I will keep the recording of your voice away from people (confidential). Your name will not be mentioned in any place in my research. You can be assured that I will not share your privacy information with anybody. All the voice recordings and what I will extract from the voice recording into writing (transcripts) will be kept (stored) in a locked cabinet.

Address any issues of confidentiality that have not already been identified in the sections on discomforts and risks. State clearly what level of confidentiality is achievable and how this will be implemented. Remember that anonymity means that the researcher does not know who the participant is; in all other cases the issue is one of confidentiality and the words 'anonymous' and 'anonymised' are not to be used. If participants will be identified, then make sure they are told that and that appropriate options are included in the Consent From.

What are the costs of participating in this research?

There will be no cost involved in taking part in my research. I will always travel to your camp to talk to you. But our conversations may involve one and half hour. I will bring cola so we can get our mouths busy whiles we talk and maybe some bread for tea or porridge.

Remember to include a realistic indication of the cost in terms of the participant's time.

What opportunity do I have to consider this invitation?

You will be given some time to think about whether (my invitation) you would like to talk to me or take part in my research or not. You have two weeks to think about this.

Remember to provide a reasonable timeframe. AUTEC recommends that one month is usually a reasonable period of time for potential participants to be given.

Will I receive feedback on the results of this research?

Yes, I will come back to speak to you about the results or what I have found about our conversations that are concerning your health and feelings. But I will make sure nobody identifies you through my feedback or when I come back to speak to you. I will speak to you in Dagbani.

When people have been kind enough to provide you with information for your research, it is courteous for you to let them know what it was that you found out. A one- or two-page summary of the findings is sufficient. For anonymous surveys, it is recommended that you provide the participants with an url at which they will be able to read a summary of the findings. If the answer is 'no', then provide the participant with the reason and if the answer is 'yes' then explain how this will happen.

What do I do if I have concerns about this research?

You can talk to the following people if you want to know anything about my research or have any concerns you should feel free to contact **Professor Lydia Aziato**, *the acting Dean of School of Nursing and midwifery, University of Ghana*

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

1. Professor Eleanor Holroyd, eleanor.holroyd@aut.ac.nz and Phone: 09 921 9999 ext 5298

2. Lydia Aziato, laziato@ug.edu.gh, and a +233-(0)302-500381.

The wording here is mandatory. Make sure you include the international prefix if the participants are likely to be calling from overseas.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Yakubu H. Yakubu Tamale Teaching Hospital, Ghana.

Email: kubuhabi2002@gmail.com

Professor Lydia Aziato (Field Supervisor)

Acting Dean School of Nursing and Midwifery, University of Ghana.

Researcher Contact Details:

Yakubu H. Yakubu Tamale Teaching Hospital, Ghana.

Project Supervisor Contact Details:

Participant Information Sheet for NGO officials

Date Information Sheet Produced: 30 May 2019

Project Title: Witches' camps of Northern Ghana: Understanding the Factors Influencing their Mental Health and Emotional wellbeing of older women residents.

An Invitation

Hello, my name is Yakubu H. Yakubu, a PhD Student, and I am a naïve of Tamale. I am inviting you to participate in my study. This study is a requirement of the Auckland University of Science and Technology, New Zealand to obtain a Doctor of Philosophy qualification. Your reply will be kept confidential. Therefore, please feel free to answer the questions. However, participation is voluntary, and you are free to withdraw from the study at any time without giving any reason and without there being any negative consequences. Thanks.

Identify and introduce yourself and invite the reader to participate in your research. Remember to address your information to the potential participants (consistent use of the 1st person when referring to yourself and the 2nd person when referring to the potential participant is highly recommended). If the research will contribute to a qualification, this is the place to state that also. If there are potential conflict of interest issues this is the place to tell participants that whether they choose to participate or not will neither advantage nor disadvantage them.

What is the purpose of this research?

I am doing this research to help me understand the psychological health and feelings of older women in witch camps of northern Ghana. I will be talking to you to help me get more information about their mental health and feelings. This will help me to obtain a Doctor of Philosophy qualification.

The advice here should reflect your response to sections A.6 and B.9 of the EA1 application. Remember to include the details of any qualifications, presentations, or publications that will result from your research. A useful statement to use is

The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You were identified to take part in my research because you know the witch camp and the older women who live in these camps. I am choosing you to take part in my research because you have been identified as one of the NGOs who work with the older women in the witch camp. I want to know the mental health and emotional wellbeing of the older women in the witch camp. This information sheet is to help you understand the process of my research and the interviews process.

Describe the recruitment and selection process involved. Tell the potential participants how and why they have received this Information Sheet. Advise them of the inclusion criteria for your study. If your selection process has exclusion criteria, this is the place to identify those criteria.

How do I agree to participate in this research?

You will be able to call me to confirm your participation. But you will be required to sign a consent form to show your agreement to participate in my research. The consent form will be delivered to you your office. The primary researcher will collect signed consent forms before the interview. A copy of the ICF will be given to you as a participant.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

How do potential participants let you know that they want to take part in the research? Do they need to complete a Consent Form and if so, where do they obtain it? If they will not need to complete a Consent Form, describe what will occur. Also, make clear that participation is voluntary. You need to include the following wording:

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research will involve interviewing participants for at least one and a half hour each. This will be done at the comfort of participants and their chosen date and time. It will involve the researcher and the participant only. The conversation will be audio-taped. This will only happen after a potential participant has agreed and consented by a signed form. The data or the information collected through the interviews will be used for only the purpose of this research. You will be de-identified as a participant of this research.

Describe in adequate detail what the project involves and what the participants will have to do. If there will be a control group involved, this is a good place to provide advice about that. Remember that consent cannot be valid unless it is adequately informed and that you are able to use the data you collect only for the purposes for which it has been collected.

What are the discomforts and risks?

You may experience minor emotional distress when discussing the banishments of older women who could be your mother or family member. You may also experience emotional distress if you have a family member who has suffered this witchcraft banishment or consequences before. However, this interview is not designed to put you as a participant in an uncomfortable position.

Provide a full, and friendly, description.

How will these discomforts and risks be alleviated?

It is not anticipated that you will experience extreme discomfort and risk of embarrassment or incapacity. Should this occur, the primary researcher will look for signs of discomfort and stop the interview or take a break if needed.

Provide a full, and friendly, description. If you have decided to make counselling or other support opportunities available, please provide the contact details and terms for the counselling service or services to which you are referring the participants. If this will be AUT Health, Counselling and Wellbeing, then you will need to include the following wording:

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that

have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The nature and approach of my research may help policy makers to use the findings to improve the lives of the older women at the witches' camps and other marginalised communities in similar cultural practice. You will appreciate that your contribution may bring positive results for other older, marginalised people who face similar unpleasant cultural practices. It may help to promote community support for older women and witchcraft victims, free them from social injustices and reduce inequities in health. The Ministry of Women, Gender and Social Welfare and the Ministry of Health may use the findings of this research to support the women in these camps.

The researcher will gain research experience and a Doctor of Philosophy Health qualification. The researcher will also enjoy the experience of helping older people and marginalised community to have their voices represented in research and bring positive results to affected communities.

Please read the guidelines for this exemplar before answering. If the research may assist you in obtaining a qualification, this is a good place to advise potential participants about this.

How will my privacy be protected?

Maintaining your confidentiality is of utmost importance to me as a primary researcher. A pseudonym will be used to identify you instead of your real name and to change any potentially identifying details in the transcripts, as well as the dissertation and any reports, presentations, or publications arising from the research. All material about the study, including transcripts of interviews, will be stored in a locked filing cabinet.

During the interviews, your privacy will be maintained as the interviews will be conducted in your private office without any interference.

Address any issues of confidentiality that have not already been identified in the sections on discomforts and risks. State clearly what level of confidentiality is achievable and how this will be implemented. Remember that anonymity means that the researcher does not know who the participant is; in all other cases the issue is one of confidentiality and the words 'anonymous' and 'anonymised' are not to be used. If participants will be identified, then make sure they are told that and that appropriate options are included in the Consent From.

What are the costs of participating in this research?

No monetary cost will be involved in this study. However, the interview will be about one and a half hour of your time.

Remember to include a realistic indication of the cost in terms of the participant's time.

What opportunity do I have to consider this invitation?

You have enough time or two weeks to decide to take part or confirm your participation in my research or not.

Remember to provide a reasonable timeframe. AUTEC recommends that one month is usually a reasonable period of time for potential participants to be given.

Will I receive feedback on the results of this research?

You will be provided with the key findings as this will be useful for decision and policymaking to improve lives at the camps. Also, a url will be provided to you to read any publication that might emanate from this study. I may also come to share or make a presentation of my findings in your office.

When people have been kind enough to provide you with information for your research, it is courteous for you to let them know what it was that you found out. A one- or two-page summary of the findings is sufficient. For anonymous surveys, it is recommended that you provide the participants with an url at which they will be able to read a summary of the findings. If the answer is 'no', then provide the participant with the reason and if the answer is 'yes' then explain how this will happen.

What do I do if I have concerns about this research?

Any potential concerns participants might have about the nature of this research should feel free to contact ***Prof. Lydia Aziato,*** *the acting Dean of the School of Nursing and midwifery, University of Ghana.*

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

1. Professor Eleanor Holroyd, eleanor.holroyd@aut.ac.nz and Phone: 09 921 9999 ext 5298

2. Lydia Aziato, laziato@ug.edu.gh, and a +233-(0)302-500381.

The wording here is mandatory. Make sure you include the international prefix if the participants are likely to be calling from overseas.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Yakubu H. Yakubu Tamale Teaching Hospital, Ghana.

Email: kubuhabi2002@gmail.com, Professor Lydia Aziato (Field Supervisor) Acting Dean School of Nursing and Midwifery, University of Ghana.

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Yakubu H. Yakubu Tamale Teaching Hospital, Ghana.

Provide the name and all relevant contact details.

Project Supervisor Contact Details:

Note that for personal safety reasons, AUTEC does not allow researchers to provide home addresses or phone numbers.

Professor Eleanor Holroyd, 90 Akoranga Drive, Northcote Auckland, New Zealand.

Provide the name and all relevant contact details. Note that for personal safety reasons, AUTEC does not allow researchers to provide home addresses or phone numbers.

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Consent form AUT For use when interviews

For use when interviews are involved.

Project title: ***Witches' camps of Northern Ghana: Understanding the Factors Influencing their Mental Health and Emotional wellbeing of older women residents.***

Project Supervisor: ***Professor Eleanor Holroyd***

Researcher: ***Yakubu H. Yakubu***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd..... mm..... yyyy.....
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature :

.....

Participant's name : .....

Participant's Contact Details (if appropriate) :

.....

.....

.....

Date :

***Approved by the Auckland University of Technology Ethics Committee on** type the date on which the final approval was granted **AUTEC Reference number** type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and satisfactorily explained to me in a language I understand (……*name of language*). I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name or Initials of Participant…….. ID Code ……..

Participants' Signature ……OR Thumb Print…… OR Mark (Please specify)……

Date:……

INTERPRETERS' STATEMENT (where applicable)

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (……*name of language*) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter……

Signature of Interpreter……..
Date:……

Contact Details

Statement Of Witness

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (….*name of language*)

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:……

Signature…… OR Thumb Print …….... OR Mark (please specify)……..

Date:……

INVESTIGATOR STATEMENT AND SIGNATURE
Brief statement or declaration that investigator has given enough information to participants to make informed decisions.

Example: I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name……**YAKUBU H. YAKUBU**……

Signature ……

Date……