



# An exploratory study of the mental health and emotional challenges of women inside Ghanaian witches' camps

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## Abstract

For years, older women accused of witchcraft have been persecuted and forced into sanctuaries known as witch camps. This highlights a lack of public policies and social support for older women facing disabilities, aging, and dementia. Labelling them as witches and isolating them from their families and familiar surroundings profoundly impacts their emotional well-being. However, little is known about the mental health of older women in witch camps in northern Ghana. This study interviewed 15 women from the Gambaga witches camp, identifying five main themes and 21 related sub-themes: 'Physical and Mental Health Issues,' 'Psychological Impacts of Displacement and Trauma,' 'Social Isolation and Emotional Distress,' 'Living Conditions,' and 'Community Support and Strategies for Improving Well-being.' The sub-themes included 'Physical problems (chronic body pain) impacting upon general health and well-being', 'Anxiety and nervousness', 'Sleep and restlessness- "can't sit still"', 'Suicidal thoughts and anger', 'Forgetfulness', 'Concentration and confusion', 'Loneliness, sadness from family disconnection' and 'stigma – self and others', 'Loss of respect and dignity ('Dariza')', 'Frailty and loss of independence', 'Feelings of helplessness, unhappiness, and despair', 'Lack of family support and dignity', 'Lack of basic needs, and inadequate social facilities'. Findings revealed the negative effects of cultural beliefs and discrimination on the mental health of these women. Addressing public stigma and challenging these beliefs can improve healthcare and outcomes, allowing older women to stay connected with their families, reduce depression, and lead meaningful lives.

**Keywords** Ghana · Witchcraft · Camps · Mental health · Older women

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## Introduction

In Africa and many other low- and middle-income countries, health research amongst women has tended to be primarily focused on maternal and reproductive health issues, with the neglect of mental health concerns. Women comprise nearly half of the global population and significantly influence the well-being of their families, communities, and economies. At the same time, as the world's population is ageing, most older people are women.

The preliminary report estimated by the Ghana Statistical Service (2021) indicated that the total population of Ghana at 30.8 million (more precisely, 30,832,019) (Ghana Statistical Service, 2021). Of this figure, 15,631,579, representing 50.7%, are females. However, the population aged 65+ is estimated at 1,322,545, up from 1,167,532 in the 2010 census. The gender figures for the older adult population are not yet presented, as the census was conducted only recently, in late 2021. Only the provisional figures were reported (Ghana Statistical

Service, 2021). However, as of 2012, there was a population of 1,167,532 aged 65 years and above, of whom females made up 669,579 (57.35%); their male counterparts numbered 497,953 (Ghana Statistical Service, 2021).

Globally, women's health has become a priority in global development goals, with Ghana making progress towards meeting the Sustainable Development Goal (SDG) 5, thus gender equality and women's empowerment. However, there still exist many forms of discrimination against women that stagnate social progress (United Nations, 2017). The practice of witchcraft highlights deeply entrenched gender imbalances and severely limits the socio-economic power of the women accused (Chaudhuri, 2012).

Witchcraft accusations reveal cultural predispositions to apportion blame for mishaps outside popular understandings, such as a disability, misfortune, or sudden illness commonly underscored by misconceptions of ageing. Commonly, women accused of witchcraft may be lynched or forced to flee from their homes to reside in camps, depriving them of family and emotional support systems (Baba, 2013). The effect of these accusations can be further exacerbated in low-resource communities due to severely limited old-age safety nets and community support for older women who may experience complex physiological and social health-related issues (Forsyth, 2016; Kusters, 2015; Spittel, 2014; Truxler, 2006). In Ghanaian society, the practice of accusing women of witchcraft remains widespread (Adinkrah, 2011), with accusations commonly revealing a cultural predisposition to apportioning blame for community calamities on older women being responsible for the misconception of ageing and dementia (Forsyth, 2016; Spittel, 2014).

However, little is known specifically about the effect of these witchcraft accusations and subsequent banishment on the accused women's mental health and emotional well-being. This research employed a qualitative design to understand the factors influencing older women's mental and emotional well-being in the witches' camps in northern Ghana. Thus, the aim of the study are; To Identify, and provide recommendations to address the Mental Health Challenges of Women living in a Ghanaian Witch Camp.

## Methods

An interpretive (Thorne, 2016) descriptive design was employed to generate knowledge relevant to the phenomena.

### Study setting

The study was conducted in the Gambaga witches' camp in northern Ghana. The Gambaga community, in terms of ethnic composition, consists of Mamprusis, Bimobas,

Konkombas, Dagombas and other minority ethnic groups (Francis, 2014). Mamprusis and Bimobas are the dominant ethnic groups in the northeastern region of Ghana, with most of the women of the Gambaga camp from these two ethnic groups.

A witch camp is a settlement where persons suspected or accused of being witches can go for safety and avoid being lynched by their families and communities (Bekoe, 2016). The Gambaga witch camp, also called the Gambaga Outcast Home, was established in pre-colonial times, and the camp existed before 1900 in the East Mamprusi District. Historically, it is said to have been where witches would have their powers neutralised by the local gods (Mohammed, 2020).

Historically, women who faced accusations of witchcraft levelled against them by their families and communities sought refuge at the camp. After that, families-built mud rooms to house accused relatives in the camp. The Earth Priest is the head of the camp and is believed to have special powers to neutralise any evil (Arnskov, 2012). There is no formal government funding allocated to run the camps. The camps are being managed by an Earth Priest known as the Tindana, the landowner. The Earth Priest is thought to have magic powers to de-witch accused women brought to the camp. The Earth Priest benefits financially and protects the women to create a mutually beneficial relationship. The Earth Priest provides the land for the mud houses. However, most families of the accused women are unwilling to put up the hut, so the Earth Priest and his elders often build these (Baba, 2013).

### Study population

The target population was older women accused of witchcraft and resident at the Gambaga witches' camp in northern Ghana. The research setting (witches' camp) has 25 round huts housing about 100 women. The camp does not have a healthcare facility. The study relied on an intended control sample known in advance being older women residing in witches' camps in northern Ghana. This control sample was drawn because witchcraft accusations in this part of the region are widespread and older women who are often the accused are banished to live in witches' camps. Research evidence suggests that, persecuted people often face discrimination and isolation, leading to higher rates of mental health problems and disorders than the general population (Priebe et al., 2012; World Health Organization, 2014). The researcher therefore relied on the older women in the witches' camps as study participants to fulfil the research objectives.

## Sample size and sampling technique

Participants who met the following inclusion criteria were invited to participate in the study: (1) were older women living in the Gambaga witches' c (2) lived at least six months in the witches' c (3) were able to communicate in Dagbani or Mampruli language; (4) volunteered to participate in this study. Women were ineligible for recruitment if they: (1): had a severe mental illness; (2) had difficulty completing the interview for various reasons(emotional); (4) tested positive for COVID-19; (5) had been in the camp less than six months.

## Data collection

Face-to-face interviews were conducted with older women inside the forecourts of the women's huts. The women were encouraged to tell their stories in this 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 first author conducted the interviews and established relationships with the women and allied stakeholders to promote participants' autonomy as they could engage with the researcher to express their views freely and without fear (Bourgois, 1990). The interviews were conducted in the Dagbani language. A female research assistant was employed to facilitate the face-to-face interviews. Before the interviews, a confidentiality agreement was signed by the female research assistant. Each interview session was started by welcoming and thanking participants for accepting to participate in the study.

## Data analysis

The interviews were transcribed from the Dagbani language into English text verbatim by the first author and used for data analysis to transform data into meaningful outputs (Gibbs, 2018). The first author is fluent in Dagbani and English, which offered him flexibility in making translation-related decisions. This meant that the researcher was not reliant on professional translation to transcribe the data from Dagbani interviews into English text as transcripts.

After the transcription, a qualitative thematic analysis was employed to analyse the data (Braun & Clarke, 2012). This was conducted in six stages: (1) familiarisation with the data. Authors repeatedly read and re-read the transcript to become familiar with the data. (2) Coding; the data was then organised in a meaningful and systematic way by generating initial codes. The initial coding was done based on

the research aim to reduce lots of data into small chunks of meaning. Similar codes were sorted and arranged into categories. (3) Searching for the themes. We then searched the data and generated relevant themes or patterns following the coding. We revised the identified themes, and we modified these themes to develop the preliminary themes. Reviewing themes. (4) The next stage of the analysis was to define the themes to help purify them or to "identify the 'essence' of what each theme was about" (Braun & Clarke, 2006, p. 92). Several subthemes are identified in this stage. Defining and naming themes. In this stage was the process of "identifying, analyzing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 6). The thematic analysis approach is flexible, allowing data to be analyzed systematically in different ways (Braun & Clarke, 2012). To address rigour and trustworthiness issues, three authors agreed on the coding construction (YHY, LA and EH). Discussions between the authors by emails were utilised to arrive at a consensus on themes and subthemes before drafting the manuscript.

## Ethical approval and consent to participate

This study was approved by the authors' institutional ethics committee. Informed consent was obtained before the interviews. The authors declare that they have no conflict of interest.

## Methodological rigour

To address rigour, the framework by Whitemore et al. (2001) was employed, which includes the following aspects: (1) authenticity, (2) credibility, (3) criticality, and (4) integrity. This ensures the trustworthiness of the research outcome. To maintain authenticity, interviews with the women were conducted in a private area where women had the freedom to express themselves. Credibility was achieved through prolonged engagement and consultations with stakeholders before the first author visited the camps, during and after the fieldwork. Multiple sources of information, expert opinions and reviews and translation of the interview questions were sought to maintain accurate information to elicit participants' experiences. The results were also supported with English-translated verbatim quotes from participants. Criticality is the critical appraisal of every decision made throughout the research process. A field supervisor monitored the first author during the fieldwork activities and the development of the interview guides and ethical applications. These were to ensure cultural appropriateness and to avoid all ethical dilemmas that could injure the trustworthiness of this study outcome. In addition, criticality was further achieved and maintained through an audit

trail—documentary evidence of the research process. The ongoing reflection and self-criticality of the researchers demonstrate integrity. To accomplish this, we reflected on the biases and consciously discussed these with the research team before data collection and analysis.

## Findings

In total, 15 interviews were conducted. The women’s ages were unclear, as they did not know their date of birth. It is important to note that in some African countries, governments have made efforts to register births, but many individuals still lack proper birth registration, leading to inaccurate age reporting (Florina, 2019; Sankoh et al., 2020; UNICEF, 2017). Out of the total number of women in the camp, approximately ten had lived there for more than eight years. Two of them had lived in this camp for 12 years. Another two women had lived in the camp for about three years. One of the women, who was said to be the oldest woman of the group of participants, had lived in this camp for about 30 years.

None of the women in the camp had any educational background or non-formal education. All the participants spoke and understood the Dagbani language. Most of the women participants from the witches’ camps were of Konkomba by ethnicity, and the smallest ethnic groups from the camps were Chekosi, Frafra, and Kusasi. The interviews lasted for a maximum of 45 min. The data analysis shows five main themes with 12 related sub-themes in Table 1.

## Physical and mental health concerns

The first theme, physical and mental health concerns, highlights chronic physical health problems associated with the women’s experiences in the witches’ camps and how these, in turn, influenced their general and mental health. The sub-themes identified within this main theme were, ‘Physical problems (chronic body pain) impacting upon general health and well-being’, ‘Problem sleeping and restlessness’ or ‘can’t sit still’, ‘Anxiety and nervousness’, ‘Suicidal thoughts and anger’, and ‘Frailty and loss of independence’.

### Physical problems (chronic body pain) impacting upon general health and well-being

Most participants complained of chronic body pain including “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 walking difficult. The bodily pain limited their ability to carry out household chores and activities of daily living, such as bathing, dressing, toileting, eating, and fetching firewood from the bush. These body pains also affected their sleep and ability to earn a livelihood since most participants could not go to work on the nearby farms to earn an income for food and living costs. One woman explained the pain as follows:

*“I am not well. I am saying this because I have not been able to do anything or work the whole year.”*

**Table 1** Findings framework obtained using a thematic analysis approach (Braun & Clarke, 2012)

Main themes	Subthemes
1. Physical and Mental Health Issues:	<ul style="list-style-type: none"> <li>• Physical problems (chronic body pain) impacting upon general health and well-being</li> <li>• Anxiety, and nervousness</li> <li>• Sleep and restlessness</li> <li>• Suicidal thoughts and anger</li> </ul>
2. Psychological impacts of displacement and trauma:	<p><b>Subthemes:</b></p> <ul style="list-style-type: none"> <li>• Forgetfulness</li> <li>• Concentration and confusion</li> </ul>
3. Social Isolation and Emotional Distress:	<p><b>Subthemes:</b></p> <ul style="list-style-type: none"> <li>• Loneliness, sadness from family disconnection</li> <li>• Stigma – self and others</li> <li>• Lack of basic needs, and inadequate social facilities</li> <li>• Barriers to accessing general and mental healthcare</li> </ul>
4. Living Conditions	<p><b>Subthemes:</b></p> <ul style="list-style-type: none"> <li>• Lack of family support and dignity</li> <li>• Limited space and recreational facilities</li> <li>• Food and healthcare insecurity</li> <li>• Long distances to clinic and limited social care</li> </ul>
5. Community Support and Strategies for Improving Well-being:	<p><b>Subthemes:</b></p> <ul style="list-style-type: none"> <li>• Enabling factors for improving social connections</li> <li>• Recommendations for improving mental health and general well-being</li> <li>• Resources to support livelihood and reintegration</li> <li>• Religious and cultural practices</li> </ul>

*I have pains in my legs. I have not been able to go farm.” P5.*

*“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 extract indicates that these physical symptoms, such as leg pain, reinforced their anxieties about earning a livelihood and negatively impacted their general well-being and mental health. Sometimes, they recounted that remembering being accused and banished to live in the camp kept them awake and was challenging to accept.

### **Problem sleeping and restlessness’ or ‘can’t sit still’**

The subtheme on the problems with sleep and rumination at night was apparent throughout all the women’s interviews as one of the factors that strongly influenced their mental health and emotional well-being. Most of the participating women said their sleep problems were attributed to the stresses of remembering how they escaped being lynched and the assaults meted out to them by their communities after the witchcraft accusations. Inadequate sleep or ‘not enough or poor sleep’ was seen by the women to affect their psychological states and linked to mental health concerns, such as anxiety or 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.*

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 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. The participants also described their hearts beating fast or “suhu tora bei ndarita” (I feel tense or “nervous”). 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.*

### **Frailty and loss of independence**

Some women expressed their inability to participate in activities of daily living or carry out their household chores due to their chronic physical health conditions. 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 women outlined their ability capacity to carry out household chores and walk without physical health problems enabling them 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.*

### **Anxiety, and nervousness**

Most of the participants expressed experiencing severe feelings of fear or worry. According to the participants, these feelings come on frequently impacting their ability to function. The subthemes identified within this main theme were ‘Feeling restless, ‘can’t sit still’, ‘Worried and scared’ and ‘Expressing thoughts of suicide and anger’.

### **Suicide thoughts and anger**

Most women indicated that they thought 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 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. Hmmm! But I thank God, I didn’t do it.” P8.*

*“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.*

*“Be tempted to commit suicide. You know what, for God’s sake, I told people that, if they say I am a witch, I will take DDT to commit suicide.” P2.*

## Psychological impacts of displacement and trauma

The second theme, ‘Psychological impacts of displacement and trauma’ mirrored the experiences and changes in the women’s cognitive abilities and memory, which affected their daily functioning and quality of life. Several participants discussed that they have experienced a decline in their cognitive abilities. Two sub-themes were identified including: ‘Forgetfulness’ and ‘Concentration and confusion’.

### Forgetfulness

The subtheme ‘Forgetfulness’ was also identified. Difficulty remembering everyday things while living in this camp was another common term used by the participants to describe their emotional and mental health status. Most women participants had trouble remembering things, such as where they kept their cooking utensils. This memory loss was seen to affect their daily life activities. For instance, they said they sometimes forgot to eat and 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 this 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.*

*“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.*

## Difficulty concentrating and confusion

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, affecting 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.*

*“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.*

Most of the women interviewed said they were confused about who they were now and felt that maybe someone may have given them a gift of magic. So, they thought they might hold a magic power of witchcraft to kill someone. Such confused thoughts meant they had a poor ability to concentrate. They were concerned that harbouring troubling thoughts could lead sadness and public stigma, with people talking ill and pointing fingers at them in social gatherings such as funerals and naming ceremonies in the communities.

*“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.*

### Social isolation and emotional distress

The third theme, ‘Social Isolation and Emotional Distress’ was important theme discussed by several participants. They indicated that social isolation had a significant impact on their mental and physical health. Emotional distress resulted from social isolation or other stressors in life. It affected their mood, behaviour, and quality of life. emotional distress interfered with their abilities to do daily activities. This main theme is explained by three associated sub-themes; ‘Loneliness, sadness from family disconnection’, Stigma – self and others, Loss of respect and dignity (‘N lan ka Dariza’).

### Loneliness and sadness from family disconnection

Family disconnections, sadness, and emotional distancing were other subthemes related to women’s inability to contact their families and how this social disconnection impacted upon their well-being. The effects of the family disconnections included loneliness, worries associated with separation and generalised discomfort. The emotional distress from their family disconnections worsened the plight of these women, causing a deeply distress state of mind, further exacerbated by being 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 women, 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 her son accused her of being a witch, which 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, hmmm. So, I don’t miss them, I am living here in peace without being disgraced by my son.” P9.*

### 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 presence in the camp. Consequently, they felt they had lost their dignity and ended up doubting themselves. They saw people “pointing fingers” at them and talking ill when they saw them in public places. The reports from all participants about the witchcraft accusation were 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”. The women commented that people often avoided them at social gatherings or funerals when they visited home for compelling reasons, such as 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 public negative attitudes towards the women 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 the women’s refusal to return home if permitted to do so, internalised shame, ostracism, discrimination, social seclusion isolation, and poor mental health. Moreover, the long-term impact of the discrimination was seen to further depress the women and precipitate suicidal thoughts. For instance, one of the participants indicated that she had given up hope of going home and was learning to accept the ‘inescapability’ of the situation that life has brought onto her.

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. One woman 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.*

### 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 ongoing sadness of the women. 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.*

### 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 people from their communities did 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 respected and that she held 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.*

### Living conditions

The fourth theme ‘Living conditions’ emphasised how their living situation significantly impacted upon their physical health, mental health, social connectedness, and overall happiness. Some of the common challenges related to living conditions include mobility limitations, inadequate housing, financial stress, and difficulty accessing healthcare and other services. The sub-themes identified included: Limited space and recreational facilities, Food and healthcare insecurity, long distances to clinic and limited social care, Barriers to accessing general and mental healthcare,

### Lack of basic needs, and social care facilities

During interviews women highlighted a lack of potable water, sanitation facilities, poor sanitation, and a lack of privacy. There was a lack of recreational facilities, which are deemed essential components of refugee camp. The camp did not have such a facility instead, the participants used a church for recreational purposes and at times meetings were held under trees.

### Barriers to accessing general and mental healthcare

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.*

Most participants indicated that they had to trek long distances to the other communities to access healthcare services when feeling unwell and ill, as well as lacking medicines through being unable to buy prescriptions.

### Limited space and problem with rooms

Another sub-theme identified in this study was the issue of limited or cramped living spaces, often characterized by small rooms without proper lighting. The participants expressed that their rooms were far too small, and at times, they were required to share these huts with other women. Consequently, the inadequate space and run-down condition of the rooms made the women feel trapped and *hemmed in a hole*.

*“the rooms we live in have no space, and they look like rooms for sheep. It doesn’t look like rooms for humans.” P13.*

An allied stakeholder with expertise in mental health explained how inadequate housing and limited space adversely affect women’s mental well-being, leading to heightened stress, somatization, and depression. The allied stakeholders unanimously reported that the women’s accommodation was dilapidated and structurally weak, with issues such as poor maintenance, dampness in rainy seasons, cracked walls, weak room doors, and pest infestations. These conditions had a negative impact on the women’s mental health and overall well-being.

A social worker explained that poor housing conditions and lack of sufficient space directly affected the women sleep quality. His explanation is as 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, he explained further that:

*“Accommodation is a problem. Last three years, one died like that, even though we didn’t make it news, she was sleeping, and the thing fell on her, and that led to her death, you see, so we don’t, especially if it is a 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 somatization, 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 to the previous accounts, one woman expressed a different perspective, stating that she did not feel trapped or confined in the camp because she viewed it as a safe haven. She shared her personal ordeal, recounting how she was chased away from her community. She expressed her unwillingness to return home due to the fear of being killed and humiliated. Additionally, she expressed concern for the safety and well-being of her family and those in her community, emphasizing her desire to protect them from persecution. She explained that.

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

### Food and healthcare insecurity

The women 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.*

Confirmed by one of the stakeholders interviewed;

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

## Community support and strategies for improving well-being

The fourth theme, ‘Community support and strategies for improving well-being’, highlights the suggestions provided by the women in the camp and allied stakeholders to improve mental and general well-being of the women. The theme is explained by four sub-themes: (1) Enabling factors for improving social connections, (2) Recommendations for improving mental health and general well-being. (3) Resources to support livelihood and reintegration. (4) Religious and cultural practices.

### Enabling factors for improving social connections

Most participants suggested that in order to ensure the well-being of the women in the camps there needs to be an improved social connection being and resilience.

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.*

## Recommendations for improving mental health and general well-being

Most women suggested provision of healthcare facilities and insurance cover will help improve their mental health and well-being. They indicated 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 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.

### Resources to support livelihood and reintegration

The women 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.

### Religious and cultural practices

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.*

## Discussion

Participants reported numerous physical health problems that impacted upon their general and emotional well-being. The physical health problems identified included hypertension and chronic pain, such as pains in the legs, joints, and the body generally, difficulty walking, and unexplained bodily discomfort.

The women expressed that their physical health problems led to or gave rise to mental health concerns, often manifested subconsciously. Women interviewed expressed these as physical health problems in the form of chronic pain in the body and joints. Consequently, these symptoms had negative implications on their ability to sleep at night, manifesting as rumination, difficulty walking, cooking, or conducting personal care, such as bathing, which predisposed them to frailty and loss of independence. These findings are consistent with several studies that provided evidence that physical health problems increase the risk factor for developing mental health problems (Doherty & Gaughran, 2014; Halfon et al., 2013). For instance, Matheson et al. (2014) in a Canadian study reported that physical health problems significantly increase the risk of developing mental health problems. In their research, nearly one in three people with a long-term physical health condition also had a mental health problem, especially depression or anxiety. A relationship between mental health and chronic physical conditions significantly impacts people’s emotional well-being and

quality of life (De Hert et al., 2011; M et al., 2011; Mental-health.org.uk, 2022; Osborn, 2001; Robson & Gray, 2007).

The above reason may explain the theme of physical health problems impacted their emotional distress. In Nigeria, a recent quantitative study by Igwesi-Chidobe et al. (2021) reported that participants expressed emotional and psychological distress using physical symptoms to provide cultural legitimacy. Duthé et al. (2016) in Burkina Faso, using a quantitative study, found a strong association between mental disorders such as depression and reported chronic health problems, functional limitations, household food shortages, and being a victim of physical violence.

In addition, loneliness, and sadness from disrupted family connections that banishment to the camps imposed impacted these women’s mental health and emotional well-being. Furthermore, some of the effects of family disconnections were ongoing loneliness, constant worries associated with separation, and a lack of social support in the camps. Previous studies suggest that older adults’ experiences of loneliness worsen when younger generations do not spend with them and promote familial intimacy (Lin et al., 2015; Zhang, 2022). The women in the current study were worried about the absence of family support, which would have been assured in the villages where they previously lived. The contention is that, with family support, these women could have enjoyed family cohesion in their villages and found assistance for the activities of daily living, such as fetching firewood, cooking, and bathing.

Moreover, in the present study, the women participants reported being sad and feeling alone simultaneously. For instance, some of the women reported feeling sad because they had lost their farm and means of livelihood when they were banished to the camp. This finding is similar to several studies which reported that the forcible separation of aged women, many of whom were frail, from their families meant that the women were profoundly vulnerable to social isolation and loneliness and that, in turn, appeared to give rise to attendant health problems such as depression, cognitive decline, and heart disease (Cacioppo & Cacioppo, 2014, 2018; Donovan & Blazer, 2020).

Marginalised communities or individuals who are socially disadvantaged and discriminated against have a considerable risk of developing mental health problems. Mental health disorders have been associated with more frequent life stressors among socially marginalised people. Discrimination has detrimental psychological and physical health outcomes, especially in marginalised populations (Matheson et al., 2019).

Furthermore, such social marginalisation occurs when people or groups are less able to do key activities of daily life or access essential services or opportunities, which highlights their social exclusion (Mowat, 2015). Social

marginalisation has been linked to social exclusion, and the consequences of social exclusion affect access to vital social services such as healthcare (Andersen, 1996; Morgan et al., 2007) and are frequently considered consequences of economic deprivation.

Inadequate access to healthcare facilities in the camp and its profound impacts on the health and well-being of the women highlight the significant challenges faced by the women in obtaining necessary healthcare services, leading to detrimental consequences. This lack of access to healthcare identified underscore a critical factor influencing their general health and mental well-being. The women express the difficulty in accessing healthcare services, which has a negative impact on their overall health status and contributes to their mental distress. The mention of a woman's death due to the lack of access to urgent first aid further emphasizes the severe consequences of inadequate healthcare facilities.

Another area was lack of potable water and poor sanitation emphasizes the challenges faced by the women in accessing clean and safe water. The absence of proper sanitation facilities further exacerbates the living conditions in the camp, creating unhygienic and potentially hazardous environments. Lack of privacy points out the lack of private spaces within the camp, which had significant implications for the women's sense of dignity and personal security. The absence of adequate recreational facilities is also highlighted, indicating that the camp fails to provide spaces for leisure, relaxation, and community engagement.

From a health determinants perspective, the World Health Organization (2008) developed a comprehensive model aimed at helping healthcare practitioners consider all social factors that may influence the health and well-being of individuals. These social determinants of health model, such as housing, access to basic amenities and sanitation, food insecurity, job stability, social inclusion, non-discrimination, and access to healthcare services. These social determinants of health (SDOH) have a significant impact on individuals' overall health, well-being, and quality of life. Moreover, SDOH also contribute significantly to the existence of disparities and inequalities in health outcomes. For example, in witches' camps, where women experience confinement and lack essential facilities, there is a higher likelihood of poor emotional balance and mental health among the residents. Additionally, food insecurity in such camps increases the risk of physical health conditions like heart disease and physical discomfort.

## Limitations of the study

The study has several limitations. The COVID-19 pandemic significantly decreased mobility due to restrictions and access to the witches' camps housing older people because of health and safety. Furthermore, we could not carry out member checking of the transcripts.

Of note is that the first author and RA experienced considerable emotional distress because of the sensitivity of the setting, the nature of the research question, and the heightened vulnerability of the participants involved. Furthermore, a significant compounding factor was the layers of complexity and intersectionality of politics, poverty, culture, vulnerability, the high illiteracy of the women residents, and the critical importance of acknowledging gender and stigmatisation issues associated with the research.

## Conclusions

The current study findings informed targeted recommendations for building and strengthening the healthcare infrastructure and mental health workforces in Ghana currently, no mental health services are provided to the women in the camps. Policymakers and service providers must advocate for establishing health infrastructure, such as key buildings and supplies that facilitate and address the psychological distress found in the current study. For instance, the Ghana Health Services could establish a counselling clinic with psychologists, mental health nurses and access to psychiatry to address the psychological needs of the women and provide targeted counselling to those who need it. These psychologists should work alongside community mental nurses in the camps. 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.

The importance of women's health, equality and empowerment is recognised in SDG five. Even though Ghana has made progress towards meeting SDG 5, many forms of discrimination against women that stagnates social progress still exist. United Nations (2017) indicated that gender equality requires urgent action to eradicate the many root causes of discrimination that still curtail women's rights in marginalised communities. We recommend that to devise urgent measures, research data like ours are required for nations from developing countries to use limited resources judiciously that will ameliorate the suffering of women and eliminate all cultural practices such as witch camps

hindering the mental health and emotional well-being and contribute to meet SDG Five.

## Clinical implications

Research in non-clinical settings like witches' camps gives marginalized individuals a voice, deepens understanding of their needs, and informs preventive measures, reducing psychological problems for both clinical and non-clinical populations and lessening the burden on healthcare systems.

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