

Overview Review

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Reintegrating women accused of witchcraft in Northern Ghana: A culturally grounded reintegration framework for mental health promotion

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Abstract

Witchcraft accusations in Northern Ghana have led to the banishment of hundreds of older women to isolated camps, resulting in profound social exclusion and mental distress. While previous studies have explored their lived experiences, limited attention has been given to strategies that enable safe return and psychosocial recovery. To develop an evidence-informed, culturally grounded framework for mental-health promotion and sustainable reintegration of women previously accused of witchcraft in Northern Ghana. This conceptual paper draws on evidence from a mixed-methods doctoral programme comprising qualitative interpretive interviews, stakeholder discussions, and a cross-sectional survey of 268 camp residents in northern Ghana, supplemented by documentary and policy analysis. Framework development was guided by three complementary lenses – the socio-ecological model, Kleinman's explanatory model, and the social determinants of health – used to structure a Framework Method synthesis that informed the Culturally Grounded Reintegration Framework (CGRF). Reintegration is constrained by persistent stigma, precarious livelihoods, weak institutional protections, and limited access to mental health and social welfare services. Simultaneously, culturally authoritative mechanisms including mediated reconciliation by traditional and faith leaders, collective labour practices, and storytelling, provide meaningful pathways for restoring dignity, belonging, and psychological wellbeing. The CGRF integrates four mutually reinforcing components: (1) culturally adapted psychosocial support; (2) family and spiritual reconciliation; (3) community inclusion and livelihood security; and (4) legal and institutional safeguards. Reintegration is a therapeutic, social justice, and culturally mediated process rather than physical relocation alone. The CGRF offers a locally grounded, theoretically informed model aligned with WHO mhGAP principles and the Sustainable Development Goals, with potential relevance (with adaptation) for other settings facing spiritually mediated stigma, ageism, and gendered exclusion.

Impact statement

Hundreds of older women banished to camps for alleged witches in Northern Ghana live with profound mental distress, severe social exclusion, and minimal access to formal care, yet practical guidance for safe return and psychosocial recovery remains limited. Drawing on a doctoral programme combining qualitative interviews, stakeholder engagement, and a 268-person survey – alongside policy and documentary analysis – this paper proposes the Culturally Grounded Reintegration Framework (CGRF): a multi-level model integrating (1) culturally adapted psychosocial support, (2) family and spiritually legitimate reconciliation with safeguarding, (3) livelihood and social inclusion, and (4) legal and institutional protections. The CGRF reframes reintegration not as camp closure or relocation, but as a sustained process of restoring dignity, belonging, and safety, and it highlights how community health and social protection platforms (e.g., CHPS, LEAP, and NHIS) could be assembled to support implementation. With contextual adaptation, the framework may inform responses in other low-resource settings where stigma and violence are mediated through spiritual and moral meanings.

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Background

Across many parts of sub-Saharan Africa, witchcraft beliefs continue to influence social relations, moral reasoning, and health-seeking behaviours (Gershman, 2016). In Ghana, these beliefs remain particularly visible in the north, where older women accused of witchcraft are banished to designated camps for alleged witches. Throughout this paper, the term ‘camps for women accused of witchcraft’ is used as the default designation; the phrase ‘camps for alleged witches’ is retained only where it appears in direct quotations or referenced prior literature. These camps, originally intended as safe havens, have evolved into semi-permanent settlements where residents experience profound stigma, poverty, and social exclusion (ActionAid, 2012; Claire and Nicholas, 2025). Women expelled from their homes often lose family ties, economic resources, and access to health services (Adinkrah, 2014; Awuni, 2017), compounding vulnerability to anxiety, depression, and chronic physical illness (Azongo *et al.*, 2020; Yakubu *et al.*, 2025).

Yakubu *et al.* (2025) documented that more than three-quarters of camp residents demonstrated high levels of anxiety and depression on the Dagbani-validated Hospital Anxiety and Depression Scale (mean anxiety = 14.73, SD = 1.46; mean depression = 17.85, SD = 1.55), substantially higher than women from the general population. The psychosocial consequences of forced isolation are intensified by poor housing, food insecurity, limited water supply, and the near absence of formal mental-health care (Yakubu *et al.*, 2024). These conditions situate women residing in the camps among Ghana’s most marginalised groups and exemplify the intersection of gender, age, and poverty as social determinants of health (Adinkrah, 2014; Mabefam, 2019).

In Ghana, despite policy commitments, such as the Mental Health Act 2012 (Ghana Health Service, 2012) and the Livelihood Empowerment Against Poverty (LEAP) programme (Sackey, 2019), as well as efforts by NGOs like ActionAid Ghana and the Commission on Human Rights and Administrative Justice (CHRAJ), structured reintegration initiatives remain rare (ActionAid, 2017; Walker and Osei, 2017; Kombat, 2021). Government actions have mainly focused on closing camps without sustainable community-based reintegration or psychosocial follow-up. Consequently, many women fear returning home due to unresolved stigma and risk of re-accusation. National evidence indicates that the majority of women in camps for alleged witches are unwilling to return home due to fear of stigma and violence, with over 60% of communities reporting unwillingness to accept them (National Commission for Civic Education Ghana, 2010). Empirical evidence to inform culturally appropriate reintegration and mental-health promotion strategies is lacking.

Existing global frameworks, including the WHO Mental Health Gap Action Programme (mhGAP) and Sustainable Development Goals 3, 5 and 10, stress community inclusion and culturally sensitive care (United Nations Development Programme [UNDP], 2020; World Health Organization, 2023). Yet their translation into Ghana’s sociocultural context demands an understanding of how indigenous belief systems, faith institutions, and local governance can be mobilised as assets rather than obstacles.

This paper advances the conversation from problem description to solution design. It reframes reintegration not merely as resettlement, but as a therapeutic continuum that combines psychosocial healing, community reconciliation, livelihood support, and enforceable safeguards. By embedding intervention design within local cultural logics while keeping a clear rights-based focus, it contributes a practical model that can inform adaptation in other contexts affected by spiritually mediated stigma.

This article is a theory- and framework-building paper grounded in evidence from a broader programme of research. It draws on the author team’s qualitative, quantitative, stakeholder, and documentary work alongside relevant published literature to develop an integrative conceptual model and specify plausible mechanisms and implementation pathways for safe, dignified reintegration; detailed empirical reporting and psychometric analyses are presented elsewhere.

Accordingly, the paper is positioned for global mental health, public health, social science, and interdisciplinary health policy audiences. Its contribution is a culturally grounded account of how reintegration can be made safer and more sustainable in settings where stigma is socially and spiritually mediated.

Aim and objectives

This paper proposes culturally grounded, community-based approaches for mental health promotion and reintegration of women formerly accused of witchcraft in Northern Ghana. Specific objectives are to:

- Identify sociocultural and structural barriers and enablers influencing reintegration.
- Synthesise evidence from qualitative, quantitative, and policy data to inform a practical framework; and
- Situate the proposed framework within global health instruments and the Sustainable Development Goals.

What the CGRF adds

The CGRF integrates established models and frameworks (the socio-ecological model, cultural explanatory models, and social determinants of health) and extends them in three ways: (1) it specifies culturally legitimate mechanisms through which stigma can be negotiated (e.g., mediated reconciliation led by trusted traditional and faith authorities, and dignity restoration through socially valued roles); (2) it makes explicit the implementation pathways that connect psychosocial care to livelihood and social protection platforms, for example, CHPS, LEAP, and NHIS in low-resource settings; and (3) it treats safeguarding and enforceable protections as an essential condition for ethical cultural mediation, rather than an optional add-on.

Theoretical lens

This paper draws on three complementary theoretical lenses that inform the evidence synthesis and framework development: Bronfenbrenner’s (1979) socio-ecological model (SEM), which conceptualises health outcomes as shaped by interactions across individual, interpersonal, community, and policy levels; Kleinman *et al.*’s (1978) explanatory model, which illuminates how cultural meanings of illness and misfortune shape experience and help-seeking; and the social determinants of health framework (World Health Organization, 2008, 2025), which locates structural inequities, such as poverty, gendered power, and access to care as upstream drivers of health disparities.

Together, these frameworks facilitate a holistic understanding of reintegration as a multifaceted process that encompasses both mental health and social justice considerations, necessitating multi-level interventions.

Method

Study design

This paper presents a discursive, theory-informed conceptual synthesis grounded in a broader programme of research led by the first author and colleagues. The underpinning work used an exploratory sequential mixed-methods design, combining qualitative interpretive description (Phase 1) and a cross-sectional survey (Phase 2). In the present paper, these materials are used as evidence inputs for conceptual synthesis and framework development, rather than reported as a stand-alone empirical study.

Materials relevant to reintegration and mental-health promotion were re-examined alongside documentary sources, including Government of Ghana reports on witchcraft (National Commission for Civic Education Ghana, 2010), policy documents (Ministry of Employment and Social Welfare, 2010; Ghana Health Service, 2012, 2013; Ghana National Health Insurance Authority, 2013; Ministry of Gender Children and Social Protection, 2015), and NGO reports on witchcraft-related displacement and protection efforts (ActionAid, 2012; ActionAid Ghana, 2016; Songtaba, 2020; Amnesty International, 2025). Perspectives from traditional authority on witchcraft and reintegration were also included (Abdulai, 2014). The analysis was guided by the socio-ecological model, Kleinman's explanatory model, and the social determinants of health framework, which informed (1) the organisation of themes and (2) the translation of evidence into the Culturally Grounded Reintegration Framework (CGRF).

Secondary analysis

This paper presents a secondary conceptual analysis of data generated across two phases of a doctoral research programme conducted between 2019 and 2022 in the Northern Region of Ghana. The original programme examined factors influencing the mental health and emotional wellbeing of women residing in camps for women accused of witchcraft using an exploratory sequential mixed-methods design. Ethical approval was obtained from the Auckland University of Technology Ethics Committee (AUTC 19/213) and the Ghana Health Service Ethical Review Committee (GHS-ERC002/09/19). Detailed methods and primary findings have been reported elsewhere (Yakubu et al., 2024, 2025); only aspects relevant to the present synthesis are summarised here.

Original qualitative study

Phase 1 comprised in-depth interpretive interviews with 20 women residing in three camps in Northern Ghana (Gnani, Gambaga, and Kukuo) between March and July 2020. Participants were purposively selected to maximise variation in age, duration of camp residence, family contact, and camp location. Eligibility required a minimum of six months' residence and the capacity to provide informed consent. Interviews explored experiences of accusation and displacement, psychosocial wellbeing, family relationships, access to health and social services, spiritual coping, and views regarding reintegration and safety.

Interviews were conducted in Dagbani or English according to participant preference by the principal investigator (YHY), who is fluent in both languages and familiar with the local cultural context. Dagbani interviews were translated into English by the principal investigator, drawing on sustained familiarity with local idioms and expressions of distress. Member checking was undertaken during interviews through clarification and verification of meanings with participants.

Stakeholder interviews

Three key informants were interviewed: (1) a social welfare officer, (2) a mental health professional/policymaker, and (3) an NGO representative with experience collaborating with traditional and faith leaders. Interviews explored barriers and facilitators to reintegration, service gaps, the role of cultural and spiritual authorities, and the feasibility of community-based mental health interventions.

Cross-sectional survey

Phase 2 comprised a cross-sectional survey of 268 women conducted between September and December 2021 across the same three camps. Consecutive sampling was used to recruit eligible and consenting residents, representing the substantial majority of the accessible population. The survey incorporated the Dagbani-validated Hospital Anxiety and Depression Scale (HADS-Dag), together with measures of sociodemographic characteristics, health status, social support, access to services, and livelihood conditions. Validation of the HADS-Dag has been reported separately (Yakubu, 2022).

Role of primary data in the present synthesis

In this paper, qualitative transcripts, stakeholder interviews, and survey findings were used as evidence inputs for conceptual synthesis rather than being re-presented as independent empirical results. Survey findings primarily contextualised the extent of psychological distress and informed the individual-level component of the CGRF. Qualitative and stakeholder data contributed mechanism-level insights underpinning interpersonal, community, and structural components of the framework. Documentary and policy sources supplemented evidence across all four domains. Pseudonyms were used throughout, and camp identifiers were generalised where necessary to maintain confidentiality.

Framework method

The synthesis followed the Framework Method, an established approach for organising and analysing qualitative and multi-source documentary data in applied health research (Gale et al., 2013; Ritchie et al., 2013; Klingberg et al., 2024). The Framework Method is a comparative form of thematic analysis that combines inductive and deductive approaches to identify, describe, and interpret patterns across diverse evidence sources (Goldsmith, 2021). It is particularly suited to multidisciplinary health research where qualitative, quantitative, and documentary evidence must be integrated to inform practice and policy.

The analysis was conducted by the principal investigator (YHY), who collected and originally analysed the primary datasets during the doctoral programme. Sustained familiarity with the material facilitated contextual interpretation, while analytic decisions were documented in a reflexive journal to maintain an audit trail and enhance transparency.

The synthesis proceeded through five stages. First, repeated familiarisation with qualitative interview transcripts, stakeholder discussions, survey findings, and documentary materials enabled broad orientation to the evidence base. Second, coding combined deductive categories derived from the socio-ecological model, Kleinman's explanatory model, and the social determinants of health framework with inductively generated themes emerging from participants' narratives and stakeholder accounts. Inductive insights included concepts such as *dariza* (loss of dignity), camp-based

solidarity, and concerns regarding re-accusation. The unit of analysis varied by source type: the thematic segment for qualitative transcripts and stakeholder notes; the key statistical finding or variable for survey data; and the policy provision or stated commitment for documentary sources. Because the present analysis was interpretive and theory-building in nature, formal inter-coder reliability procedures were not undertaken.

Third, coded material was charted within a framework matrix that progressively consolidated evidence into four thematic domains: (1) psychosocial support and individual healing; (2) family and spiritual reconciliation; (3) community inclusion and livelihood security; and (4) legal and institutional safeguards. Fourth, the framework matrix was examined for patterns, convergences, tensions, and mechanisms across sources. The socio-ecological model provided the organising structure, Kleinman's explanatory model informed interpretation of cultural and spiritual mechanisms, and the social determinants of health framework maintained attention to structural influences on exclusion and vulnerability.

Finally, interpretive findings were translated into the Culturally Grounded Reintegration Framework (CGRF), with stakeholder roles and strategic actions specified for each domain. The evidence-to-component linkages underpinning each domain are summarised in Table 1.

Ethical considerations

Ethical approval for the primary research was granted by the Auckland University of Technology Ethics Committee (AUTC 19/213) and the Ghana Health Service Ethical Review Committee (GHS-ERC002/09/19). In February 2020, I obtained permission (Ref no. 6293456580) from GL Assessment to use the HADS. Mapi Research Trust granted permission (Number: 2102086) for the translation of the HADS from English to Dagbani. For this secondary analysis, permission was obtained from the principal investigator (author), and data were anonymised. Pseudonyms replaced all participant names, and camp identifiers were generalised to protect confidentiality.

Given the vulnerability of participants, psychological distress protocols were applied during the original interviews, including referral to local mental-health nurses. The present paper treats all data with heightened sensitivity, acknowledging that reintegration discourse may have direct policy implications for participants' safety and dignity.

Table 1. Evidence sources informing the CGRF

CGRF domain	Supporting evidence	Illustrative evidence
Individual psychosocial healing	Interviews + HADS survey	Participant 7: "If I go back..."; mean anxiety = 14.73; mean depression = 17.85
Family/spiritual reconciliation	Interviews + stakeholder discussions	Participant 10: "The chief poured libation..."; Stakeholder 1 on police inaction
Community inclusion/livelihood	Interviews + NGO reports	Participant 12: "If we can farm small..."; INAWARA (2024) project outcomes
Legal safeguards	Government documents + stakeholder data	Stakeholder 1: "They say it is our culture..."; Mental Health Act 2012

Rigour and conceptual trustworthiness

Rigour in a discursive, framework-building paper is evaluated differently from that in primary qualitative or quantitative research. While trustworthiness criteria such as those of Lincoln and Guba (1986) centre on primary data collection and analysis, rigour in conceptual and synthesis work encompasses the entire research endeavour, including the coherence of the frameworks developed, the adequacy of the evidence base, and the transparency of interpretive reasoning. Accordingly, the present paper's rigour is assessed against three criteria appropriate to conceptual synthesis, including theoretical coherence, evidence adequacy, and interpretive transparency (Maher, 2025).

Theoretical coherence refers to the logical alignment between the paper's epistemological assumptions, its theoretical frameworks, and the framework it proposes (Bonjour, 1998; Young, 2026). Ensuring philosophical, theoretical, and methodological coherence is crucial so that research decisions are logical, appropriate, credible, and thus rigorous. In this paper, theoretical coherence was ensured by selecting three complementary frameworks: the socio-ecological model, Kleinman's explanatory model, and the social determinants of health that operate at different levels of analysis, including structural, cultural, and individual, without contradicting one another. The CGRF components map directly and consistently onto these frameworks, ensuring that the proposed mechanisms are theoretically grounded rather than arbitrarily assembled. Tracy's (2010), criterion of meaningful coherence, which requires that a study meaningfully interconnect its literature, research questions, findings, and interpretations, provides a further benchmark for this alignment.

Evidence adequacy was achieved through the deliberate triangulation of qualitative, quantitative, stakeholder, and policy data drawn from a doctoral programme (Yakubu, 2022). A well-integrated conceptual framework is essential to establishing a research synthesis grounded in a thorough and integrated review of relevant evidence, where key concepts, principles, and theories are identified and integrated in ways that clearly demonstrate the research question is answerable, researchable, and important to advancing thinking and practice. Each proposition advanced in the synthesis is supported by at least two data sources, reducing the risk that framework components rest on isolated or context-specific findings. At the programme theory level, rigour involves an assessment of the resulting theory's explanatory coherence: whether it offers a better explanation of the available data than its rivals, explains a greater range of data, and aligns with credible existing theories. The CGRF meets this standard by integrating findings that converge across method types and by situating its components within established global health instruments including WHO mhGAP and the Sustainable Development Goals. The inclusion of a 268-person survey alongside interpretive qualitative data and documentary analysis strengthens the evidential base for a framework intended to inform practice and policy.

Interpretive transparency was maintained through reflexive engagement with the data, acknowledging the positionality of the first author as an insider to the northern Ghanaian context and as a Dagomba researcher and member of the Dagbani-speaking community the explicit mapping of evidence to framework components, enabling readers to trace how empirical findings were translated into actionable propositions. Analytical transparency requires a clear and detailed account of how raw data were transformed into findings, including how interpretations were reached; methodological transparency allows other researchers to assess the

trustworthiness of the study’s reasoning (Cypress, 2017; Dada et al., 2023). Verbatim participant quotations are retained throughout to ground interpretation and allow independent assessment of inferential claims. Transparency, as a dimension of sincerity in qualitative and conceptual work, requires researchers to provide a methodologically self-critical account of how the research was conducted, supported by clear documentation of research decisions throughout.

Findings

This section presents an argument-driven synthesis that advances four linked propositions about why reintegration succeeds or fails. These propositions are supported by selected quotations and quantitative and policy evidence, and they underpin the Culturally Grounded Reintegration Framework (CGRF) (Table 2).

In brief, reintegration stalls when stigma is treated as an interpersonal attitude rather than a multilevel system; when material insecurity and limited service access sustain distress and risk; and when culturally legitimate reconciliation is pursued without enforceable safeguards. These insights converge in the CGRF as a practical, multilevel reintegration pathway.

Barriers to reintegration

Four interrelated barriers to reintegration emerged from the synthesis: persistent stigma and community rejection, economic deprivation and dependence, health access and resource scarcity, and weak institutional protection.

Table 2. Main themes and subthemes generated through a framework method synthesis (Ritchie and Spencer, 2002; Gale et al., 2013)

Main themes	Subthemes
Barriers to reintegration	<ul style="list-style-type: none">• Persistent stigma and community rejection• Economic deprivation and dependence• Health access and resource scarcity• Weak institutional protection and limited policy implementation
Cultural and religious enablers	<ul style="list-style-type: none">• Faith and spirituality as coping mechanisms• The mediating role of traditional and religious leaders• Social support networks within the camp
Psychosocial needs and resilience-building strategies	<ul style="list-style-type: none">• Need for counselling and mental-health education• Group-based interventions• Livelihood empowerment as psychological healing• Family mediation and reconciliation
A proposed culturally grounded reintegration framework	<ul style="list-style-type: none">• Individual: Psychological healing and empowerment• Interpersonal: Family and spiritual reconciliation• Community: Social inclusion and livelihood• Policy/systemic: Legal and institutional support

Persistent stigma and community rejection

Stigma is the central mechanism that makes “return” unsafe and psychologically costly. The evidence indicates that being labelled a “witch” functions as an enduring social identity that restricts belonging, spiritual participation, and everyday security. Conceptually, this indicates that reintegration cannot be reduced to relocation; it requires a negotiated re-entry into moral community life, with credible protections against re-accusation and violence.

If I go back, they will still call me witch. I will not be safe in that house again. (Participant 7)

The idiom “*Dariza*” meaning “loss of respect” or “dignity,” captured how stigma becomes internalised and socially reproduced. For the CGRF, this supports pairing community-level stigma reduction with individual-level dignity-restoring supports, such as peer groups, counselling, and livelihood activities that rebuild valued social roles.

Reintegration is further constrained by limited community acceptance, as national data show that most communities are unwilling to receive accused women back, while many women themselves prefer to remain in camps for safety (National Commission for Civic Education Ghana, 2010).

Economic deprivation and dependence

Economic deprivation functioned as more than a background condition; it was a reintegration constraint and a driver of distress. Dependence on sporadic donations and low-paid informal work reinforced the older women’s marginal status and limited the practical feasibility of returning home. The implication for reintegration design is direct: psychosocial support without livelihood security risks becoming symbolic rather than protective, because material insecurity sustains exposure to stigma, hunger, and unsafe housing.

When the NGOs come, we eat. When they don’t come, we sleep with hunger. (Participant 2)

Health access and resource scarcity

Constrained access to basic health care, medications, and safe living conditions amplified distress and made recovery fragile. In practical terms, reintegration efforts that ignore routine health needs (e.g., chronic pain, sleep disruption, untreated infections) risk undermining psychosocial gains, because physical illness and depression co-occur and mutually reinforce one another. The CGRF therefore treats service access and environmental conditions as core reintegration mechanisms, not ancillary welfare issues.

When we are sick, we sit under the tree and pray. There is no nurse here. (Participant 9)

Even where the older women participants held National Health Insurance Scheme (NHIS) cards, service limitations, for example, stock-outs, distance, and discriminatory encounters reduced effective access, reinforcing the need for community-based delivery platforms to be part of reintegration planning (Ghana National Health Insurance Authority, 2013; Sarkodie, 2021).

Weak institutional protection and limited policy implementation

Institutional ambiguity allows stigma to persist as “culture” rather than being treated as a rights and safety issue. Although Ghana’s Mental Health Act (2012) and gender-related policies articulate protections for vulnerable groups (Ghana Health Service, 2012), witchcraft-related discrimination remains weakly addressed in

operational terms, and local enforcement is often hesitant. For the CGRF, this supports a policy/system layer that focuses on implementable safeguards – clear responsibilities, referral pathways, and monitoring – rather than relying on sporadic NGO-led reintegration.

They [the police] say it is our culture; they cannot fight culture.
(Stakeholder 1, community health nurse)

As a result, reintegration depended on sporadic NGO support rather than sustained government-led programs.

Cultural and religious enablers

A second proposition emerging from the synthesis is that cultural and religious institutions can function as reintegration assets. The analytic point is not to valorise tradition, but to recognise cultural legitimacy as a condition for implementation: interventions that bypass faith and traditional authority structures may struggle to secure community acceptance or sustain support.

Faith and spirituality as coping mechanisms

Faith practices (Islamic prayer, church fellowship, and selected traditional rituals) operated as everyday coping and meaning-making systems. In Kleinman's terms (Kleinman *et al.*, 1978), these practices shaped locally intelligible explanations of suffering and recovery, which can be used to design non-stigmatising psychosocial support that resonates with community idioms of distress.

God knows the truth; that gives me peace. (Participant 4)

Spiritual practices alluded to in the interviews helped reinterpret misfortune, reducing self-blame and restoring a sense of agency.

The mediating role of traditional and religious leaders

Traditional authorities, such as chiefs and Tindanas, and faith leaders (imams, pastors), were repeatedly identified as credible intermediaries who can legitimise return to homes and villages through locally recognised processes of dialogue and reconciliation. The conceptual implication is that mediated reconciliation can function as an interpersonal “bridge” in the CGRF but only if guided by explicit safeguards through key tribal or religious sanctions that emphasise voluntariness, non-violence, and protection from renewed accusations so that cultural mediation supports inclusion without reproducing harm.

The chief poured libation and said I was clean. That day I felt born again. (Participant 10)

Collaborations between religious and secular leaders could thus anchor reintegration within accepted cultural norms, reducing resistance from communities. Although culturally recognised rituals may facilitate acceptance and reconciliation, they also present ethical risks. If applied uncritically, cleansing ceremonies may inadvertently reinforce beliefs that accused women genuinely possessed harmful supernatural powers. The CGRF therefore does not endorse coercive or harmful ritual practices. Instead, it emphasises voluntary, rights-based and culturally negotiated approaches that prioritise dignity, safety, and protection from renewed accusations.

Social support networks within the camp

Peer solidarity inside the camps functioned as an informal psychosocial system. For an argument-driven synthesis, the key point is that reintegration programming can build on rather than replace

existing mutual-care routines by formalising safe group processes (peer support, facilitated storytelling, and psychoeducation) that are culturally familiar and low-cost.

We eat together, we talk about our past, and we laugh small.
(Participant 3)

Psychosocial needs and resilience-building strategies

Need for counselling and mental-health education. A third proposition is that psychosocial support must be culturally interpretable to be taken up and sustained. This pattern reflects the expression of distress through culturally embedded spiritual idioms, while stakeholders emphasised the need for counselling that does not dismiss belief systems. In practice, this positions culturally competent community psychiatric nurses as brokers who can translate between biomedical concepts and local moral/spiritual meanings without reinforcing stigma.

They [camp women] need counselling that respects their beliefs, not just medicine. (Stakeholder 2, NGO)

Community psychiatric nurses trained in cultural competence could bridge biomedical and spiritual paradigms, delivering non-stigmatising support.

Group-based interventions

Group processes are a culturally congruent delivery format because they mirror existing camp practices like storytelling, singing, prayer, and shared problem-solving. The design principle for the CGRF is to convert these familiar routines into facilitated, safeguarding-aware group interventions (peer support, resilience skills, and mental-health literacy) rather than importing highly individualised models of therapy. These group approaches may enhance social connectedness, collective coping, and mental-health literacy while building on existing camp practices.

Livelihood empowerment as psychological healing

Livelihood support emerged as a reintegration mechanism because it restores agency and socially valued roles – key conditions for dignity and community acceptance. Within the CGRF, livelihood inputs are treated as psychosocial interventions in effect: they reduce dependency, improve bargaining power within families, and create practical conditions for safe return.

If we can farm small or sell our shea butter, we will not feel useless.
(Participant 12)

Microenterprise grants and vocational training could serve dual roles: financial independence and mental-health promotion through self-efficacy.

Family mediation and reconciliation

Family reconciliation is not a “soft” outcome; it is a practical safety requirement for return. Even small gestures of contact when mediated and safeguarded signalled the possibility of re-establishing belonging. This supports the CGRF's interpersonal layer, which treats structured family dialogue and mediated visits as interventions rather than incidental outcomes.

My son came after ten years. He touched my hand; I cried.
(Participant 8)

Such gestures symbolised partial restoration of belonging, indicating that reintegration must include structured family dialogue.

Proposed culturally grounded reintegration framework

These propositions converge in the *Culturally Grounded Reintegration Framework (CGRF)*. The CGRF is offered as an evidence-informed organising logic for intervention design: it specifies how psychological recovery, mediated reconciliation, livelihood and inclusion, and enforceable protections can be assembled into a coherent reintegration pathway, consistent with socio-ecological thinking. Taken together, these findings indicate that reintegration requires coordinated action across multiple domains.

This framework as indicated in Table 3 underscores the interdependence of psychosocial, cultural, and structural interventions. Reintegration is envisioned not as a one-time relocation, but as a sustained process of restoring dignity, social participation, and psychological well-being.

The CGRF organises reintegration into four mutually reinforcing levels, each addressing a distinct but interdependent domain of exclusion and recovery. Critically, the levels do not operate in sequence; they operate simultaneously and feed back into one another. Progress at one level creates enabling conditions at adjacent levels, while failure at any single level constrains the others. A woman who receives psychosocial support without livelihood security remains materially dependent and socially marginal; a community reconciliation process unsupported by enforceable legal protections exposes returnees to renewed accusation and violence. The framework's central argument is that partial solutions camp closure alone, counselling alone, or legislative reform alone are structurally insufficient.

At the individual level, the focus is psychological healing and empowerment. This encompasses peer counselling and resilience training delivered by community psychiatric nurses, routine mental health screening using the Dagbani-validated HADS-Dag

instrument, and culturally adapted mental health literacy sessions that engage rather than dismiss local spiritual explanatory frameworks. Drawing on Kleinman's explanatory model, this level recognises that distress is expressed through culturally embedded idioms of spiritual suffering, loss of "dariza" (dignity), and moral injury, and that effective care must be interpretable within those idioms to be taken up and sustained.

At the interpersonal level, the framework addresses family and spiritual reconciliation as a precondition for safe return, not an optional add-on. Mediation by traditional authorities' chiefs, Tindanas, and faith leaders' imams and pastors provides locally credible legitimacy to reconciliation processes that biomedical frameworks alone cannot supply. Family visits, ceremonial forgiveness, and faith-based dialogue serve as interpersonal bridges between the camps and home communities. Crucially, this level is paired with explicit safeguarding requirements: protection from re-accusation, non-violence, and clear escalation pathways must govern all mediated dialogue. Cultural legitimacy and rights-based protection are treated as complementary conditions, not competing values.

At the community level, social inclusion and livelihood security are addressed as both practical necessities and psychosocial interventions. Group farming cooperatives, trade networks, and micro-enterprise support reduce economic dependency, restore socially valued roles, and increase women's perceived agency conditions that plausibly mediate recovery and reduce vulnerability to renewed exclusion. Facilitation of access to the Livelihood Empowerment Against Poverty (LEAP) programme and enrolment in the National Health Insurance Scheme (NHIS) connects reintegrating women to existing social protection infrastructure. Community sensitisation and anti-stigma education in receiving villages address the structural conditions that make return unsafe, treating stigma as a community-level mechanism rather than an individual attitude to be overcome.

At the policy and systemic level, the framework specifies legal and institutional safeguards as the enabling architecture for all lower-level interventions. Enforcement of Ghana's Mental Health Act (Act 846, 2012), integration of reintegration pathways into Ghana Health Service operational plans, and dedicated funding under the Ministry of Gender, Children and Social Protection are identified as necessary conditions for sustainable implementation. Without institutional accountability, reintegration remains dependent on sporadic NGO efforts rather than constituting a systematic state-backed process with monitoring, referral, and escalation built in (Ghana Health Service, 2012).

Implementation considerations

The CGRF should be viewed as an implementation framework rather than a prescriptive programme. Successful application depends on several enabling conditions, including community readiness, participation of traditional and faith leaders, availability of social protection mechanisms, and safeguarding procedures to protect women from renewed accusations. Reintegration should only occur when women voluntarily agree to return and when adequate community acceptance and safety assessments have been completed.

Existing initiatives in Ghana demonstrate that community-based approaches are feasible. Programmes implemented by ActionAid Ghana, Songtaba, and local advocacy organisations have supported mediation, livelihood assistance, and public education

Table 3. Culturally grounded reintegration framework

Level	Focus area	Strategic actions	Stakeholders
Individual	Psychological healing and empowerment	<ul style="list-style-type: none"> Peer counselling & resilience training Use of HADS-Dag for routine screening Culturally adapted mental-health literacy sessions 	Community psychiatric nurses, local counsellors
Interpersonal	Family and spiritual reconciliation	<ul style="list-style-type: none"> Mediation by chiefs, imams, pastors Family visits & reconciliation ceremonies Faith-based forgiveness initiatives 	Traditional/religious leaders, social workers
Community	Social inclusion and livelihood	<ul style="list-style-type: none"> Group farming or trade cooperatives Access to LEAP and NHIS enrolment Anti-stigma education in villages 	Local NGOs, social welfare officers
Policy/systemic	Legal and institutional support	<ul style="list-style-type: none"> Enforce mental health act (2012) Integrate reintegration into Ghana health service mental-health policy Establish funding under ministry of gender 	Government agencies, civil society, donors

to reduce stigma. In addition, a six-month mental health and psychosocial support initiative implemented by the Total Life Enhancement Centre Ghana (TOLEC GH), with support from the International Network Against Accusations of Witchcraft and Ritual Attacks (INAWARA), provided psychological assessments, individual and group counselling, volunteer training, and community awareness activities for women accused of witchcraft in Gambaga and Kpatinga. The project reported improvements in psychological well-being, strengthened local capacity for trauma-informed support, and increased community awareness of stigma and mental health challenges, demonstrating the practical feasibility of locally led, community-based interventions (International Network Against Accusations of Witchcraft and Ritual Attacks [INAWARA], 2024). In Papua New Guinea, locally led safe-house interventions and community reconciliation strategies have facilitated reintegration of survivors of sorcery accusation-related violence. These examples suggest that culturally grounded interventions can be operationalised when supported by local leadership and sustained institutional commitment. Implementation lessons reported in Papua New Guinea where survivors of sorcery accusation-related violence experienced safer reintegration when community leaders, churches, police, and local volunteers participated in ongoing monitoring and support. Reintegration without reconciliation frequently left survivors vulnerable to renewed accusations and insecurity (Kipongi, 2022; Main, 2024).

Importantly, reconciliation processes should not be interpreted as validating accusations. Rather, they serve as culturally recognised mechanisms for restoring social relationships and ensuring safety. Similar approaches in Papua New Guinea have emphasised public apology, community participation, and legal protection as complementary rather than competing strategies (Kipongi, 2022).

Figure 1 illustrates the nested, bidirectional structure of the CGRF. The four levels are represented as concentric domains, with the individual at the centre and the policy environment as the outermost containing structure consistent with Bronfenbrenner's (1979) socio-ecological model. The bidirectional arrows indicate reinforcement across levels: legal protections create conditions for community acceptance; community acceptance makes family reconciliation viable; family reconciliation enables sustained psychosocial engagement at the individual level; and individual recovery, in turn, generates visible evidence that challenges community stigma. This circular reinforcement is the mechanism through which reintegration becomes durable rather than fragile.

A schematic representation of the Culturally Grounded Reintegration Framework (CGRF) illustrating multi-level intervention points derived from the socio-ecological model. The inner circle represents individual psychological recovery, while the surrounding layers represent interpersonal (family and spiritual mediation), community (livelihood and inclusion), and policy/systemic (legislation

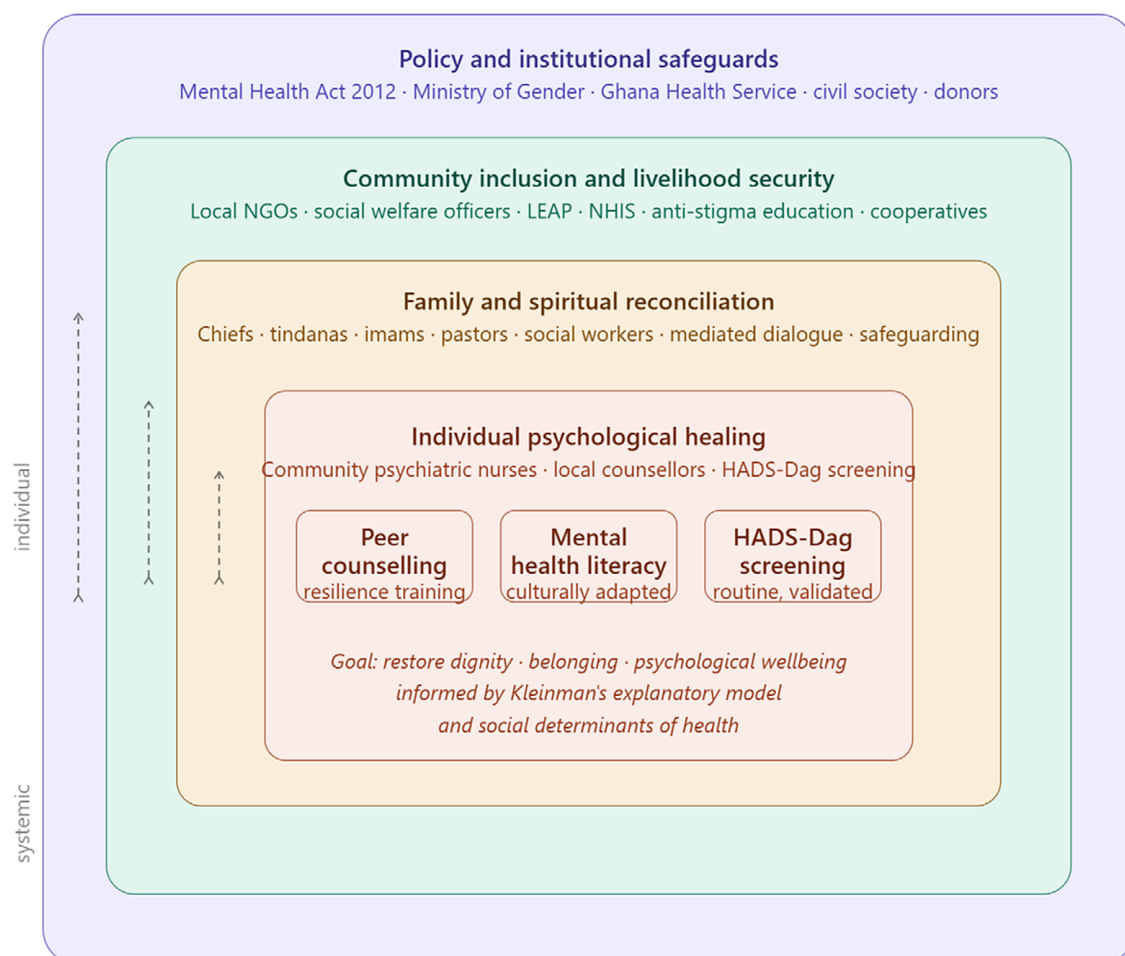


Figure 1. Culturally grounded reintegration framework (CGRF). Nested levels reflect the socio-ecological model. Dashed arrows indicate bidirectional reinforcement across levels.

and social protection) domains. Arrows indicate bidirectional feedback loops, showing how progress at one level reinforces progress at the others.

Discussion

This paper developed an evidence-informed, culturally grounded framework for mental-health promotion and sustainable reintegration of women formerly accused of witchcraft in northern Ghana. The synthesis suggests that (1) stigma functions as a multilevel system of exclusion rather than an interpersonal attitude; (2) material insecurity and constrained service access convert exclusion into sustained distress and ongoing risk; (3) culturally legitimate reconciliation mechanisms can support recovery when paired with rights-based safeguarding; and (4) these mechanisms converge in the CGRF as a structured, implementable reintegration pathway.

The discussion focuses on (1) stigma as a structural and relational barrier to reintegration, (2) how cultural and faith institutions can be engaged as implementation actors without reproducing harm (through explicit safeguarding), and (3) what the CGRF contributes beyond existing community-based and task-sharing frameworks in global mental health.

Traditional governance systems play a critical role in shaping reintegration outcomes. Decisions regarding return, exoneration, or continued exclusion are often negotiated through chiefs, elders, and religious authorities, reflecting the embedded nature of these processes within local socio-cultural systems (Abdulai, 2014).

Stigma as a structural barrier to reintegration and recovery

The findings suggest that reintegration is best understood as a psychosocial and culturally mediated process, not solely physical relocation from “a camp for women accused of witchcraft” to a village. Reintegration requires rebuilding self-worth, repairing social relationships, and regaining public dignity (“dariza”) in contexts where witchcraft accusations remain socially meaningful (Yakubu et al., 2024).

Stigma emerged as the central mechanism undermining reintegration; it restricts safety, participation, and access to services long after banishment. Applying a structural stigma lens identifies the concern is not only individual prejudice, but the routinisation of exclusion through community norms and social sanctions, coupled with local enforcement (Kimotho, 2018; Matambela and Tshifhumulo, 2025). Kleinman’s explanatory model helps explain why reintegration stalls when accusations remain interpreted as moral or spiritual “truths,” shaping both suffering and the terms under which acceptance can be renegotiated.

Rather than treating accusations as an individual pathology, the findings support scholarship showing they often operate as social regulation shaped by gendered ageism and material insecurity (de Koeijer, 2022; Grobler, 2025). In this sense, poverty, housing, food access, and care availability are not background variables; they are key pathways through which exclusion becomes chronic stress and manifests in heightened anxiety and depressive symptoms (Yakubu et al., 2024). As indicated in the work of Matambela and Tshifhumulo (2025), persistent trauma and anxiety associated with community stigma can make reintegration more difficult.

Even where individuals are formally exonerated through traditional or religious processes, community suspicion may persist, requiring sustained mediation efforts by local leaders to facilitate acceptance (Abdulai, 2014).

Mobilising cultural and faith institutions as reintegration assets

A key contribution of this study is showing that cultural and religious systems are not only implicated in accusations; they can also be leveraged carefully and ethically as pathways to reconciliation. The evidence identified traditional authorities and faith leaders as credible intermediaries who can legitimise “return” through locally recognised processes of cleansing, forgiveness, and social repair. However, such processes must be governed by explicit safeguards – including voluntariness and protection from re-accusation – to ensure that culturally mediated rituals do not inadvertently reinforce the narrative that accused women genuinely possessed harmful supernatural powers.

This challenges binary assumptions that position indigenous belief systems as incompatible with mental-health promotion. In practice, reintegration strategies may work better when they engage trusted local authorities, while also setting clear safeguards to avoid endorsing harmful narratives or coercive rituals.

Incorporating culturally resonant practices as mediated dialogue, storytelling, and faith-inclusive counselling may reduce resistance to support-seeking by aligning care with locally meaningful idioms of distress and recovery. The practical implication is not to idolise culture, but to treat cultural legitimacy as an implementation condition for sustaining community-based psychosocial support (Ziguras et al., 2004; Ahad et al., 2023).

What the CGRF adds

The CGRF translates the study’s themes into an organising logic for intervention design. Using the socio-ecological model, it links individual recovery supports, family and spiritual reconciliation processes, community inclusion and livelihood measures, and policy and institutional protection, emphasising that partial solutions, for example, camp closure alone, are unlikely to be safe or long-term. Reintegration, where it occurs, is mediated through culturally legitimate processes such as family negotiation and spiritual “disarming,” highlighting the importance of culturally grounded mechanisms within reintegration frameworks (National Commission for Civic Education Ghana, 2010).

Conceptually, the framework positions reintegration as both mental-health promotion and social protection. This framework leverages counselling and peer support together with mechanisms for material security and credible community-level mediation. This integrated view also clarifies why stigma reduction, livelihood support, and legal safeguards should be treated as mutually reinforcing components rather than separate “add-ons.”

The CGRF is consistent with mhGAP’s emphasis on community-based (Ghana Health Service, 2012; World Health Organization, 2023), culturally sensitive care and supports SDG 3, SDG 5, and SDG 10 through its combined focus on recovery, gender equity, and social inclusion (United Nations Development Programme [UNDP], 2020).

Unlike existing applications of the socio-ecological model, which primarily describe levels of influence, the CGRF specifies how change occurs through culturally legitimate mechanisms such as mediated reconciliation, dignity restoration processes, and faith-aligned psychosocial support. It also operationalises these processes within real-world service platforms, such as CHPS, LEAP, and NHIS, thereby linking theory to implementation. In doing so, the framework moves beyond explanation to provide a structured pathway for designing contextually appropriate interventions in settings where stigma is socially and spiritually mediated.

Evidence from traditional authority perspectives further underscores that reintegration is mediated through culturally legitimate processes, including ritual cleansing, family negotiation, and community validation. In Dagbon, exonerated or “cleansed” women may return home only after undergoing recognised spiritual or social processes, although stigma may persist despite formal clearance (Abdulai, 2014).

Implications for nursing, community practice, and policy

Nurses are central to operationalising the CGRF because they are often the most accessible mental-health workforce in rural Ghana. The added value is not only that nurses can deliver counselling, but that nurse-led care can bridge biomedical approaches with local spiritual idioms while maintaining non-stigmatising, trauma-informed practice.

For nursing and public-health education, the findings support targeted curriculum content on cultural psychiatry, trauma-informed practice, and stigma-sensitive community engagement. In service delivery, structured group approaches example facilitated storytelling, peer support, psychoeducation, can adapt practices already used in the camps into deliberate, safe interventions.

Collaboration with traditional authorities, faith leaders, NGOs, and social welfare services is an implementation requirement. Practically, this entails co-designed referral pathways, shared safeguarding protocols for returnees, and agreed procedures for mediated dialogue that can be monitored for safety, including clear escalation routes if re-accusation or threats emerge.

At a conceptual level, the CGRF extends socio-ecological thinking by specifying culturally legitimate mechanisms (mediation, ritual, faith-inclusive counselling) through which multi-level mental-health promotion may be enacted in this setting.

Across the dataset, livelihood insecurity operated as both a driver of distress and a constraint on safe return. The synthesis here is that livelihood interventions are psychosocial as well as economic: they restore social roles, reduce dependency on sporadic donations, and increase perceived agency, thereby potentially supporting recovery and reducing vulnerability to renewed exclusion (Wang *et al.*, 2017; Amnesty International, 2025).

Community and faith leaders matter for implementation because they shape what is viewed as legitimate evidence, acceptable reconciliation, and “safe” return. The findings imply that leader engagement should be paired with explicit human-rights and safeguarding principles, for example, non-violence and protection from re-accusation, so that cultural mediation supports inclusion without reproducing harm.

Global relevance and theoretical contribution

Witchcraft-related exclusion is a global public health and human rights concern, not a Ghana-specific phenomenon. Sorcery accusation-related violence (SARV) is well documented across Papua New Guinea, where the need to build an evidence base of current and promising interventions has been identified as a major challenge, with research into effective responses remaining limited (Main, 2024). In Tanzania, Nigeria, Zimbabwe, South Africa, and across the Pacific, accused women face ostracism, displacement, and lethal violence, yet structured reintegration frameworks remain scarce in the published literature (Zachrisson, 2007; Sambe *et al.*, 2014; Alagarasami *et al.*, 2024; Forsyth *et al.*, 2024). Yet few studies have proposed actionable frameworks for women’s reintegration into their communities.

Evidence from Papua New Guinea similarly demonstrates that reintegration of survivors of sorcery accusation-related violence requires more than physical return. Kipongi (2022) reported that successful reintegration depended on sustained community education, public reconciliation processes, active involvement of local leaders, monitoring mechanisms, and legal protections for survivors. Reintegration efforts that lacked reconciliation and follow-up frequently resulted in continuing fear, re-accusation, and social exclusion. These findings support the CGRF’s emphasis on culturally legitimate mediation combined with safeguarding and institutional accountability.

What the CGRF adds to this comparative landscape is not merely a description of the problem but a specification of the structural conditions under which spiritually mediated stigma can be addressed without reproducing harm. Three features make the CGRF potentially transferable across these settings. First, in each context, the central barrier to reintegration is not individual prejudice but the social and spiritual legitimacy of the accusation itself, meaning that community-level mediation by trusted authorities is a necessary precondition for safe return, just as it is in northern Ghana. Second, in each setting, material insecurity and weak institutional protection compound exclusion and make psychosocial support alone insufficient, reinforcing the CGRF’s insistence on integrating livelihood security and enforceable legal safeguards with therapeutic care. Third, the close connections between sorcery beliefs and health mean that equipping health workers with strategies to address these beliefs effectively is critical to delivering better health care and preventing violence related to sorcery accusations, and that properly funded pilots to trial and evaluate interventions are urgently needed, with findings shared nationally and internationally (Forsyth *et al.*, 2024). The CGRF’s nurse-led, community-embedded design is directly applicable to this implementation gap.

Critically, however, transferability requires contextual adaptation rather than wholesale replication. The most successful interventions in comparable settings are those made by internal members of the community, where interventions provide communities with direct experience of the humanity of those believed to have supernatural power (Main, 2024). This finding from the PNG Wanakipa safehouse project reinforces the CGRF’s core design principle: that cultural legitimacy is an implementation condition, not a cultural endorsement. Adaptation for other settings would require mapping the locally credible mediation authorities, the specific idioms of distress in use, and the social protection infrastructure available; the conceptual logic of the four-level framework travels; the specific mechanisms must be locally negotiated.

Theoretically, the CGRF advances transcultural mental health by demonstrating how frameworks developed in Global North contexts Bronfenbrenner’s socio-ecological model and Kleinman’s explanatory model can be recontextualised within African and Pacific settings without losing analytical coherence. Rather than treating culture as a complicating variable, the CGRF positions indigenous spiritual authority, community reconciliation practices (Cohen *et al.*, 2007), and locally adapted screening and support tools (Yakubu, 2022) as potential clinical and implementation assets while emphasising safeguarding and contextual adaptation.

Linking reintegration to SDG implementation

The CGRF implies that reintegration requires coordinated action across psychological support, culturally legitimate reconciliation, livelihood security, and enforceable protections. Positioning the

framework within the SDGs functions primarily as an accountability lens: progress should be evaluated not only by camp closure, but by measurable gains in mental well-being (SDG 3), safety and inclusion for older women (SDG 5), and access to social and economic participation (SDG 10) (United Nations, 2015).

The recommendations below translate the CGRF into feasible, multi-level actions aligned with existing Ghanaian delivery platforms such as CHPS (Abboah-Offei et al., 2021; Adusei et al., 2024) and the Community Mental Health Programme (Ghana Health Service, 2012; Osei, 2019; Nkansah and Enyonam Daitey, 2026). The CGRF's four levels operate as an integrated system rather than discrete components. Together, they demonstrate that reintegration requires coordinated action across psychological, cultural, and structural domains, reinforcing the framework's emphasis on multilevel intervention.

At the health-system level, the immediate priority is integrating nurse-led psychosocial support and HADS-Dag screening into existing CHPS compounds serving communities adjacent to the camps, with dedicated training in cultural psychiatry and trauma-informed care for community psychiatric nurses. Referral pathways linking primary care to social welfare and livelihood programmes should be formalised in district health operational plans rather than left to ad hoc coordination.

At the community level, district assemblies and faith councils should establish structured, safeguarded mediation protocols with explicit provisions for voluntariness, non-violence, and protection from re-accusation before any camp closure or relocation is initiated. Anti-stigma sensitisation in receiving communities should precede, not accompany, a woman's return.

Reintegration strategies should therefore engage traditional leadership structures, which remain central to dispute resolution and social reintegration processes. Chiefs and community elders can play a key role in mediating acceptance and ensuring that culturally legitimate pathways to reintegration are respected (Naa Yakubu Abdulai, 2014).

At the policy level, reintegration must be embedded as a funded line item in Ghana Health Service and Ministry of Gender operational budgets, with monitoring indicators tracking safety, service uptake, and mental well-being outcomes, not only camp population numbers. LEAP (Sackey, 2019) and NHIS (Atakorah et al., 2024) enrolment for camp residents should be treated as a baseline entitlement, not a discretionary benefit (Amnesty International, 2025).

For future research, the priority is participatory piloting and longitudinal evaluation of CGRF components, particularly nurse-led peer groups, faith-mediated reconciliation packages, and combined livelihood-plus-psychosocial interventions to generate the implementation evidence needed for national scale-up and adaptation to comparable settings in sub-Saharan Africa and the Pacific. The findings and framework directly support several global health and development agendas as seen in Table 4.

Limitations and research implications

While this study provides valuable insights, several limitations warrant caution. First, the findings are context-specific to northern Ghana and may not generalise to other regions with different cultural cosmologies. Second, as a secondary analysis, the study relied on existing qualitative and quantitative data rather than primary data focusing solely on reintegration expectations and experiences. Third, self-reported mental-health measures may under- or overestimate symptom severity due to social desirability or literacy limitations.

Table 4. Global and developmental alignment

Goal	Target	Alignment with findings
SDG 3 – good health and well-being	3.4: Reduce premature mortality from NCDs through prevention and mental-health promotion	Integrates psychosocial care and screening into community settings
SDG 5 – gender equality	5.2: Eliminate violence against women; 5.5: Ensure participation in leadership	Empowers women through reconciliation and livelihood opportunities
SDG 10 – reduced inequalities	10.2: Promote social, economic, and political inclusion	Advocates social protection and anti-stigma legislation
WHO mhGAP (2016)	Community-based, culturally sensitive mental-health care	Embeds mental-health services in CHPS and faith/traditional systems

Future research should therefore prioritise longitudinal and participatory designs, co-led by community members and local leaders, to evaluate pilot reintegration programs. Intervention studies testing the CGRF, particularly peer-support groups, faith-mediated reconciliation, and nurse-led counselling, would provide robust evidence of effectiveness. Comparative research across sub-Saharan Africa could further illuminate regional variations in belief systems and recovery pathways.

Conclusion

Reintegration of women accused of witchcraft is both a moral and public-health priority. Sustainable recovery requires integrating mental health promotion with cultural healing, livelihood empowerment, and targeted policy reform. The CGRF provides a roadmap for achieving this transformation through locally owned, nurse-led, and culturally congruent strategies. Beyond northern Ghana, the framework offers a transferable conceptual model for settings where stigma, spiritual beliefs, and structural inequalities intersect. Future implementation and evaluation studies are required to test its effectiveness and refine its adaptation across contexts.

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Data availability statement. The data that support the findings of this study are available from the corresponding author upon reasonable request.

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