Prevalence of Depression, Quality of Life and Gender Dynamics of Women Accused of Witchcraft in Northern and North East Regions of Ghana

CONDUCTED BY

Songtaba Ghana With Technical Support from Ghana Somubi Dwumadie

February, 2022

Acknowledgments

This research was conducted by Songtaba Ghana with technical assistance of Ghana Somubi Dwumadie and through the funding support of UK Aid from the British People.

Our special appreciation goes to Philip Teg-Nefaah Tabong, the Principal Investigator for the research for his role in developing the proposal and leading the entire research process. We are also grateful to the Co-Principal Investigators, Hajia Lamnatu Adam, the Executive Director of Songtaba Ghana and Peter Badimak Yaro, Executive Director of BasicNeeds Ghana for their leadership role in the project. The contributions of Abdul Kasiru Shani, Head of Programmes and Policy, Songtaba Ghana is well acknowledged.

We further acknowledge the tremendous contributions of Ghana Somubi Dwumadie team- Ibrahim Musah, Community-based Rehabilitation Technical Advisor, Adam Dokurugu Yahaya, Mental Health Integration Advisor, Emmanuel Osei-Mensah, Monitoring and Evaluation Advisor and Matthias Aneinini, Grants Advisor.

Finally, we express our gratitude to Sebastiana Etzo and Lyla Adwan-Kamara, the external reviewers of the report for their invaluable comments.

Executive Summary

Background

In postcolonial Africa, the continuing manifestation of witchcraft accusations has led to a renewed interest in African witchcraft and magic. In Northern and North East Ghana, people especially women are mostly accused of possessing such magical powers and banished from society to live in special camps designated as “witches camps”. The processes leading to their banishment, admission and living in the camps may affect their psychological wellbeing and quality of life. In addition, embedded in the beliefs and practices of witchcraft are gender dimensions. This study was conducted to determine the prevalence of depression, quality of life and the gender dynamics in witchcraft beliefs and accusation in four alleged witches’ camps.

Methods

A mixed quantitative qualitative methodology was adopted. All two-hundred and seven-seven (277) individuals accused of witchcraft in four camps located in Nanumba South, Yendi Municipal, Gushegu and East Mampusi Municipality in Northern and North East regions were included in the study. A structured questionnaire was developed using open data collection kit (ODK), and administered by three research assistants onsite using tablets. Aside the socio-demographic characteristics of participants, the Patient Health Questionniare-8 (PHQ-8) and the World Health Organisation WHO Quality of Life (WHOQOL) questionnaires were adopted to measure depression and health-related quality of life respectively. In addition, eighteen (18) key informants were recruited from the northern, north east and national level for an in-depth interview on beliefs about witchcraft, gender dimensions, reintegration and protection of human rights. The quantitative data was analysed using STATA version 16. A PHQ score ≥ 10 was used to determine the prevalence of depression. On the severity of depression, recoding was done to fit into the Diagnostic and Statistical Manual four (DSM IV) classification. A PHQ total score of 5 to 9 represents mild depressive symptoms; 10 to 14, moderate; 15 to 19, moderately severe; and 20 to 24, severe. For quality of life, the study adopted WHO classification of quality of life (QOL) benchmarks. Each item was rated on a 5-point Likert scale and was scored from 1 to 5 on a response scale with maximum score of 200. Domain scores were scaled in a positive direction (i.e., higher scores denote higher QOL). The classification of quality of life was done as follows: score ≤ 45 extremely low QOL; score 46–65 low QOL; score 66–86 moderate QOL, score 87–101 relatively high QOL and score ≥102, excellent QOL. The qualitative interviews were recorded and transcribed verbatim. Thematic analysis was employed with the aid of NVivo 13. Data triangulation strategy was adopted to merge the findings from the two data sources.

Findings

The key findings of this study include:

1. The prevalence of depression among the participants is high (52.7%) with 23. 5% having mild depression, 37.2% with moderate depression, 7.2% moderately severe depression whilst 2.9% had severe depression.
2. The sociodemographic factors that have statistically significant association with depression include gender (p=0.007), marital status (p=0.001), widowed or separated (p=0.004) and not having biological children (p=0.004).
3. Over 97% of alleged witches have low or extremely low quality of life. None have high or excellent quality of life.
4. About 93.5% of the people accused of witchcraft were females and 66.5% of them were widows.
5. All the females revealed they had been maltreated at their community of origin when they were accused of witchcraft before banishment. However, males who were accused of witchcraft reported no case of maltreatment.
6. Sociocultural practices, patriarchal nature of the society, lack of economic resources and poverty skewed witchcraft accusations towards females
7. Majority of the participants (73.3%) indicated they wanted to be reintegrated and the need to close down (abolish) the alleged witches' camps; however, concerns were raised about acceptance by community members as well as safety.
8. Collaboration between the local authorities (chiefs and opinion leaders) and the local government institutions is necessary to protect the human rights of the alleged witches in the community and for reintegration.
9. Education, advocacy and enforcement of laws are required to protect the human rights of women accused of witchcraft.

Conclusions

In conclusion, majority of the women accused of witchcraft have low or extremely low quality of life with high depression. Female gender and marital status of divorced, widowed, or separated were strongly associated with depression. These two factors and quality of life synergistically contributed to depression. Although witchcraft is framed within a sociocultural context, the narrative within its practice is highly gendered with power relations, and gender agency playing a critical role. Men who are accused of witchcraft have the opportunity and power of negotiating and renegotiating their destinies and the varied outcomes of witchcraft accusations, and are sometimes not banished and mistreated. Social norms dictate that women should not have magical powers and have no access to productive resources. The lack of resources works together with sociocultural beliefs about power put women more vulnerable in witchcraft accusations and banishment. Witchcraft accusation is therefore indicative of the marginal status of women and their subordination in communities in the Northern and North East regions of Ghana.

Recommendations

1.` Ghana Health Service should expand mental health services and periodic screening for residents of the alleged witches' camps as their living conditions and situation increases their risk of developing mental health conditions especially depression. Ghana Health Service could visit the camps with multidisciplinary teams for quarterly health screening and provision of other services.
2.` The government and district assemblies should allocate funding towards improving the living conditions of the alleged witches' camps to make them more habitable in the interim whilst initiating plans to relocate them to their communities. The current living conditions in the camps are deplorable and not fit for human habitation.
3.` While the continued existence of the alleged witches indicates the prevalence of witchcraft accusations and the belief system(s), it is important for government to initiate processes that would lead to the abolition of these alleged witches' camps. This is important in order to realise the 2030 agenda of universal health coverage and sustainable development, that "leaves no one behind"
4.` Intense community sensitization and education on witchcraft beliefs is required before abolition of the alleged witches' camps and reintegration of alleged witches. This presents an opportunity for civil society organizations and non-governmental organizations to lead the process.
5.` Sensitization and education of police service and government institutions involved in the human rights and social protection on witchcraft beliefs and practice should be done. This could be led by Songtaba Ghana and other non-governmental organizations who already have experience working with the alleged witches' camps.
6.` The government should enact laws to criminalize witchcraft accusation to ensure that accusers are severely punished. This could be done through collaboration with human rights lawyers in Parliament through a private member's bill.
7.` Civil Society Organizations (CSOs) should advocate for increase enrollment of girl child in schools in the northern and north east regions of Ghana. Embedded in the dynamics in witchcraft accusation is high level of illiteracy and poverty among women.
8.` There is the need further research on the causes of accusations, willingness of the communities to accept alleged witches to the community and the challenges of reintegration.

Acronyms

CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CHRAJ	Commission on Human Rights and Administrative Justice
CSOs	Civil Society Organizations
DOVVSU	Domestic Violence and Victim Support Unit
DSM	Diagnostic and Statistical Manual
GESI	Gender Equality and Social Inclusion
GHS	Ghana Health Service
IDIs	In-depth Interviews
MoGCSP	Ministry of Gender, Children and Social Protection
MoH	Ministry of Health
MOWAC	Ministry of Women and Children Affairs
NCCE	National Commission for Civic Education
NGOs	Non-governmental Organizations
PHQ	Patient Health Questionnaire
PI	Principal Investigator
PNDC	Provisional National Defence Council
QOL	Quality of Life
RAs	Research Assistants
SDC	Socio-demographic Characteristics
SDGs	Sustainable Development Goals
UN	United Nations
WHO	World Health Organization
WHOQOL	World Health Organization Quality of Life

Table of Contents

List of Tables

List of Figures

Chapter One

Introduction

1.1 Background to the Research

The belief in Witchcraft is widespread in Africa. Although it is an old belief system, there has been renewed interest in this concept because of the human right abuses that are associated with the practice. There are abundant cases of human rights violations across the African continent[1]. Many such violations and abuses thrive on, and are clearly visible in, political, ethnic and religious conflicts. Notwithstanding the fact that witchcraft accusations are rampant on the continent, rights violations and abuses in relation to witchcraft accusations have renewed calls for intervention to address these concerns[2].

In Northern and North East Regions of Ghana, hundreds of people, especially women are accused of witchcraft by relatives or members of their community are living in 'witch camps' after fleeing or being banished from their homes. The camps, which served as the home to around 800 women and 500 children in the past[3], offer poor living conditions and little hope of a normal life. Over the years, the number of residents in the alleged witches' camps have decreased. These people have fled from discrimination, threats or even mob justice after being accused of witchcraft and blamed for 'crimes' such as causing sickness, droughts or fires, cursing a neighbour or even just appearing in someone's dream[4].

It has been reported that some of these women have lived in the camps for as long as 40 years[5] – abandoned by their families and trapped in the camps until they die. Their only companions are young girls, often granddaughters or family members, who were sent to the camps with the women as 'attendants'. These women are often stigmatized and suffer discrimination with serious psychosocial consequences. Although both genders (male and female) can be accused of witchcraft, women are often more likely to be accused of possessing witchcraft power. As a result, witchcraft has gender dimensions which is exacerbated by sociocultural factors[6]. Gender discrimination, exclusion and protection of human rights of more

1 Mutaru, "An Anthropological Study of 'Witch Camps' and Human Rights in Northern Ghana."

2 Cimpric, "Children Accused of Witchcraft: An Anthropological Study of Contemporary Practices in Africa."

3 Mutaru, "An Anthropological Study of 'Witch Camps' and Human Rights in Northern Ghana."

4 Badoe, "'What Makes a Woman a Witch?'"

5 Adinkrah, *Witchcraft, Witches and Violence in Ghana*.

6 Nukunya, *Tradition and Change in Ghana*.

disadvantaged people are of global concern and clearly articulated in Sustainable Development Goals[7].

Gender equality and social inclusion (GESI) has received global attention in both policies and treaties. Gender equality according to the United Nations (UN) refers to equal rights, responsibilities and opportunities for women and men and girls and boys. Social inclusion is the removal of institutional barriers and the enhancement of incentives to increase the access of diverse individuals and groups to development opportunities. Gender equality and social inclusion are seen as not only as fundamental aspect of human rights and social justice, but also a precondition to improve the development process by putting social concerns at the forefront of interventions.

Although Ghana is signatory to UN treaties and conventions, locally the country has legislation which espoused gender equality and social inclusion (GESI). Article 17 (1) and (2) of the 1992 Constitution of Ghana stipulates that all persons are equal before the law[8.] This provision expressly guarantees gender equality and freedom of women and men, girls and boys from discrimination on the basis of social, economic status, race and ethnicity. Recognizing that removing barriers to social inclusion can allow for full equality and inclusion of women in the productive economy, the Government of Ghana has taken steps through the enactment of a national policy framework to promote GESI. In 2004, the Government developed her first gender and children policy under the Ministry of Women and Children Affairs (MOWAC). In 2013 the Ministry of Gender, Children and Social Protection (MoGCSP) was created to replace MOWAC. This ministry announced in 2011 that the alleged witches' camps should be closed down as soon as 2012. This however is yet to be done while women continue to be accused witchcraft and banished to these camps.

Banishment and the discrimination may predispose the alleged witches to trauma and psychological problems such as depression which can negatively affect their wellbeing. Depression is the leading cause of disability and is a major contributor to the disease burden worldwide. The global prevalence of depression and depressive symptoms has been increasing in recent decades. The lifetime prevalence of depression ranges from 20% to 25% in women compared to 7% to 12% in men[9]. A recent study has identified marginalization and socio-economic status as risk factors for depression[10.]

7 WHO, "Health in 2015: From MDGs to SDGs."

8 The Constitution of Ghana, *The Constitution of the Republic of Ghana*.

9 WHO, "The World Health Report 2002: Reducing Risks, Promoting Healthy Life."

10 Arias-de la Torre et al., "Prevalence and Variability of Current Depressive Disorder in 27 European Countries: A Population-Based Study."

Songtaba Ghana, a Non-governmental Organization has been at the forefront of advocating for the protection of human rights, and reintegration of the women with their families and into their communities. The decision to employ effective interventions by policy and decision-makers to improve wellbeing of women in the alleged witches' camps depends on the availability of resources and existing supporting scientific evidence. As a step towards initiating a national conversation towards protecting their human rights and reintegration to community, it is therefore important to gain an in-depth understanding of the extent of trauma and psychological problems among people resident in these alleged witches' camps as well as the gender dimensions. This research was conducted to provide the scientific data and evidence necessary for evidence-based decision making.

1.2 Research Questions

The study was conducted to answer the following research questions:

1. What is the prevalence of depression among people living in the alleged witches' camps in Northern and North East Regions of Ghana?
2. What is the health-related quality of life of people living in the alleged witches' camps in Northern and North East Regions of Ghana?
3. What are the gender dimensions of accusing women for witchcraft in Northern and North East Regions of Ghana?
4. What strategies can be adopted to reintegrate people accused of witchcraft back to their communities of origin?
5. How can the human rights of people accused of witchcraft be protected in the Northern and North East Regions of Ghana?

1.3 Objectives of the Study

The objectives of this study are divided into general and specific objectives.

1.4 General Objective

The general objective of the study is to determine prevalence of depression, quality of life and the gender dynamics in witchcraft accusation and banishment from the community in the Northern and North East Regions of Ghana.

1.5 Specific Objectives

The specific objectives of the study include:

1. To determine the prevalence of depression among people accused of witchcraft and living in the alleged witches' camps;
2. To determine the health-related quality of life of people accused of witchcraft and living in the alleged witches' camp;
3. To explore the gender dimensions of witchcraft accusation and banishment;
4. To explore ways of reintegration and improving the quality of life of people accused of witchcraft; and
5. To explore ways to protect the human rights of women accused of witchcraft.

Chapter Two

Literature Review

2.1 The Concept of Witchcraft

The belief of a Supreme Being is very common among Africans[11]. Apart from Supreme Being, Many Africans believe in the existence of other lesser gods who serve as intermediaries between man and the Supreme Being[12]. In addition, the belief that people may possess magical powers in the form witchcraft and sorcery is widespread. Furthermore, the belief that witches have powers to influence the lives of people in a negative way is widespread in all African communities[13]. Although it is difficult to prove this logically, witches are said to possess supernatural powers that can be used to destroy or harm human lives and property. Another Scholar, Evans-Pritchard, believes that witchcraft powers can be used for doing good in our society today[14]. Nonetheless, the belief in negative use of witchcraft power is more pervasive[15].

Evans-Pritchard identifies that the alleged witches have innate powers that are inherited from their parents. It is these powers that they use in influencing the lives of people. He calls this “inherent quality”. On the other hand, he distinguishes that from the powers that sorcerers use in influencing people lives in medicine, rituals and spells[16]. In Ghana, among the Ewes and several ethnic groups in the Northern part of Ghana such as the Mamprusi, and Dagomba, it is believed that a witch can use his or her power to influence people within and outside his or her own blood relations. On the other hand, the Akans (Fante, Akwapem and Asante) believe that a witch can only have influence or control over his or her blood relations[17]. This explains why witchcraft accusation is common in certain areas in Ghana. In addition, religion plays an important role in witchcraft accusation and how alleged witches are handled. For example, accused witches in southern Ghana are never transported to alleged witches’ camps located in the north. Instead, they are sent to Christian prayer camps for the witchcraft powers to be exorcised as part of their Christian beliefs.

2.2 Witchcraft and Human Rights

The Ghanaian legal system recognises the rights of all citizen irrespective of their ethnicity, age, sex, and religion. The Constitution of Ghana demands in Chapter Five, that citizens must have their rights protected. In 5 (13), it is enshrined that no

11 Nukunya, *Tradition and Change*.

12 Abotchie, *Social Structure of Modern Ghana*.

13 Awulolo, *Yoruba Beliefs and Sacrificial Rites*.

14 ActionAid, “Condemned without Trial: Women and Witchcraft in Ghana.”

15 Evans-Pritchard, *Witchcraft, Oracles and Magic Among the Azande*.

16 Arens, “Evans-Pritchard and the Prophets: Comments on an Ethnographic Enigma.”

17 Adinkrah, *Witchcraft Accusations and Female Homicide Victimization in Contemporary Ghana*; Adinkrah, *Witchcraft, Witches and Violence in Ghana*.

person shall be deprived of his life intentionally except in the exercise of the execution of a sentence of a court[18]. In Section 15, it is enshrined that the dignity of all persons shall be inviolable. Again, no person shall be subjected to torture or other cruel inhuman degrading treatment or punishment. In section 18, it is enshrined that every person has the right to own property either alone or in association with others.

In section 25 (5) of Chapter 5 every human person has the right to equal educational opportunities and facilities. In Section 28 stipulates that a child should not engage in work that constitutes a threat to their health or education. Children, as the Constitution states, shall not be subjected to torture or other cruel inhuman or degrading treatment. In addition, Ghana ratified the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) on 2nd February, 1986. This states in Article 2 that discrimination against women in all forms shall be condemned by all states[19]. In Article 5, all cultural and social patterns of conduct that introduces prejudice and inferiority shall be modified. In addition, Article 13(a) recognises the need for women and children to have access to medical and education. Furthermore, Article 14(b) acknowledges that every person has right to adequate health care facilities including information, counselling and services in family planning. Similarly, Article 14(h), states that everyone must enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communication[20]. Despite, these provisions, witchcraft accusation comes with denial of these basic rights and lack of access to the social amenities.

Federici argues in Women, Witch-hunting and Enclosures in Africa today, that although the belief in the existence of witchcraft has been prevalent in Africa since time immemorial, it is just recently that witchcraft killings have come to the attention of human rights organizations and the United Nations[21]. There are many laws and policies that have been formulated by national and international bodies to protect the rights of women and children accused of witchcraft. Some of these laws include the amended Criminal Code Act of 1998 (Act 554), the Children's Act (Act 560), the National Gender and Children's Policy 2004 and Early Childhood Care and Development Policy, 2004. Although these laws, covenants and policies are available at the national levels, they are not being translated into influencing local cultural beliefs and the protection of human rights in some communities especially where gender-related beliefs about witchcraft are common. As a result, many may consider these laws as ineffective and theoretical in nature. Again, accusations of women as witches are still common today. These harmful practices still prevail in our

18 The Constitution of Ghana, *The Constitution of the Republic of Ghana*.

19 UN, "Convention on the Elimination of All Forms of Discrimination against Women."

20 OAU, African (Banjul) Charter on Human and Peoples' Rights.

21 Federici, "Women, Witch-Hunting and Enclosures in Africa Today."

societies. This demonstrates that some human rights values have been unable to effectively penetrate our local cultures[22].

2.3 Gender Dimension of Witchcraft

Witchcraft accusations are common in patriarchal societies. In such societies, women are not supposed to inherit property in their own name. It is rather their male counterparts who are supposed to take control in political, legal, social, and economic affairs (including the inheritance of property)[23]. Most African societies are patriarchal in nature and as a result, women are not allowed to hold certain leadership positions or inherit family property. As a result, women who may insist on holding on to land and farm property are usually accused of having witchcraft powers[24]. Women who do not have older siblings who are males (elderly brothers) in the family are eventually accused of witchcraft. When it is time for family property to be shared, adult women who do not have brothers from the same mother face possible witchcraft accusation in an attempt to deny them their share of the family property. In an attempt of such women to protect their property, they may become resistant, and oppose other people who want to take such property from them. Because such women are left without the 'masculine voice' to speak on their behalf, they are said to be greedy, difficult and stubborn, just like witches[25].

Women in polygamous marriages have also been reported to increase witchcraft accusation in Africa. Co-wives who have conflicting relationships with each other tend to direct witchcraft accusations on each other. Polygamous marriages tend to create undue jealousies and competition among co-wives. In other circles, the distribution of the family's assets, especially land may result in conflicts, and later in witchcraft accusations[26]. Ludsin identified patterns of witchcraft accusation to include women, especially those who were poor and also were in jealous relationships such as the relationships between mothers-in-law and daughters-in-law or women in polygynous marriages[27]. Apter (2013) study of the witchcraft practice among Yoruba in Nigeria attributed it to family struggles and envy. According to him, the envy at the family level probably between co-wives could make one of the wives accuse the other, in order to sabotage her rival[28]. Polygamous marriages are more common in the Northern part of Ghana.

22 ActionAid, "Condemned without Trial: Women and Witchcraft in Ghana."

23 Lyons, "Witchcraft, Gender, Power and Intimate Relations in Mura Compounds in Dela, Northern Cameroun."

24 Federici, "Women, Witch-Hunting and Enclosures in Africa Today."

25 Badoe, "What Makes a Woman a Witch."

26 Federici, "Women, Witch-Hunting and Enclosures in Africa Today."

27 Ludsin, "Cultural Denial: What South Africa's Treatment of Witchcraft Says for the Future of Its Customary Law."

28 Apter, "The Blood Of Mothers: Women, Money, And Markets In Yoruba-Atlantic Perspective."

In terms of maltreatment, people who single, widowed or divorced women are more likely to suffer from such human rights abuses. Mostly, young women who have lived and worked with their partner to acquire substantial wealth and properties in marriage may also be accused of witchcraft on the demise of the husband. This usually happens when the widows decide to keep the properties, she acquired with her late husband[29]. Usually, relatives of the late husband may demand the property from her and her children. When she refuses to surrender the land and other properties, she is then accused of witchcraft. It is believed that accusing women of being witches is an easy way to let them avoid enforcing their land claims[30].

To curb this injustice, the Intestate Succession Act, 1985, (Provisional National Defence Council, PNDC Law 111) was introduced in Ghana to regulate the sharing of properties of the man or acquired during married after a man dies intestate or without making a will. Before the coming into force of the Act, people who died intestate had their self-acquired properties shared according to their family lineage which would often exclude the spouse of the deceased. Traditionally, Ghana has two different forms of inheritance. They include the patrilineal and the matrilineal system of inheritance. The patrilineal succession system is commonly practiced amongst the Northern Ewe – speaking people, the Anlo Ewes, the Ga Adangbes, and most tribes of the Northern and Upper Regions of Ghana. The property of an intestate under this system of succession devolves to the children. Children, both male and female succeed to the estate of an intestate. The eldest son of the deceased inherits as a trustee the right of the father to both the ancestral or family property, for example, land, and the self-acquired properties.

The Matrilineal succession system is where on the death of the man intestate, a member of the maternal family of the deceased intestate succeeds his estate. It is practiced mainly by the Akans including the people of Kwahu, Akyem, Bono, Ashanti's, a section of the Gas and the Fantes. The maternal family of the deceased succeeds to the property of the deceased, but then, the family elects a maternal nephew of the deceased to hold the property in trust. He is only a trustee for the family for the benefit of all those whom the right to possess and enjoy the property lies. The matrilineal system of inheritance tends to protect the right of women in acquiring properties than the patrilineal system[31].

Furthermore, poor people are usually blamed for being involved in witchcraft activities. When someone is very poor, he or she may be accused of possessing the witchcraft. It is therefore not surprising that most of the witchcraft accusations are at places where poverty levels are high. For example, in Ghana, witchcraft accusations

29 Hund, "Witchcraft and Accusations of Witchcraft in South Africa: Ontological Denial and the Suppression of African Justice."

30 Mutaru, "An Anthropological Study of 'Witch Camps' and Human Rights in Northern Ghana."

31 Awusabo-Asare, "Matriliny and the New Intestate Succession Law of Ghana."

and the establishments of the alleged witches' camps are heavily concentrated in the regions located in the northern part of Ghana rather than in the south [32]. The Ghana Living Standard Survey (round 7) conducted in 2017 reports classified the regions located in the northern part of Ghana as the poorest in the country and with low literacy rate among women[33]. Poverty and low educated women have also been identified as gender related factors in witchcraft accusation in the Northern and North East regions of Ghana[34].

2.4 Witchcraft Accusation and Depression

Depression is the commonest mental health condition in the general population[35] characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration[36]. In its most severe form, depression can lead to suicide[37] and increased risk of mortality. Depression often runs a chronic course and substantially impairs an individual's occupational potential and quality of life[38]. The World Health Organisation (WHO) has reported that depression is ranked the second in global disease burden and is one of the priority conditions covered by the WHO's Mental Health Gap Action Programme[39].

Prior studies have revealed that socio-demographic factors such as older age, parents' occupational status, marginalization[40], female gender[41], lower education levels of parents and living conditions of parents[42] were important risk factors for

32 Musah, "Life in a Witchcamp: Experiences of Residents in the Gnani Witchcamp in Ghana."
33 GSS, "Ghana Living Standards Survey (Round 7)."
34 ActionAid, "Condemned without Trial: Women and Witchcraft in Ghana."
35 Mazza et al., "An Examination of the Validity of Retrospective Measures of Suicide Attempts in Youth."
36 Sokratous et al., "The Prevalence and Socio-Demographic Correlates of Depressive Symptoms among Cypriot University Students: A Cross-Sectional Descriptive Co-Relational Study."
37 Nalugya-Sserunjogi, J Rukundo et al., "Prevalence and Factors Associated with Depression Symptoms among School-Going Adolescents in Central Uganda."
38 Kovacs, Obrosky, and George, "The Course of Major Depressive Disorder from Childhood to Young Adulthood: Recovery and Recurrence in a Longitudinal Observational Study."
39 Whiteford et al., "Global Burden of Disease Attributable to Mental and Substance Use Disorders: Findings from the Global Burden of Disease Study 2010."
40 Sokratous et al., "The Prevalence and Socio-Demographic Correlates of Depressive Symptoms among Cypriot University Students: A Cross-Sectional Descriptive Co-Relational Study."
41 Nalugya-Sserunjogi, J Rukundo et al., "Prevalence and Factors Associated with Depression Symptoms among School-Going Adolescents in Central Uganda."
42 Raheel, "Depression and Associated Factors among Adolescent Females in Riyadh, Kingdom of Saudi Arabia, a Cross-Sectional Study."

depression. In addition, psychosocial risk factors for depression are family disputes, low socioeconomic status, and undesirable academic performance[43].

Generally, the characteristics associated with depression have been described extensively in the general population but little among the people who have been accused of witchcraft and banished from their communities.

2.5 Quality of Life

Quality of life (QOL) is defined as the perception of individuals or groups that their needs are being fulfilled and they are not being denied opportunities to achieve happiness and satisfaction. It incorporates both a cognitive component (satisfaction) and an emotional component[44]. It is also defined as the state of wellbeing that is a composite of two components: the ability to perform everyday activities that reflect physical, psychological, and social wellbeing; and patient satisfaction with levels of functioning and control of the disease[45].

The measurement of health and the effects of health care must include not only an indication of changes in the frequency and severity of diseases but also an estimation of wellbeing and this can be assessed by measuring the improvement in the quality of life related to health care. Quality of life issues are crucially important because they may powerfully predict an individual's capacity to manage their disease and maintain long term health and wellbeing[46].

There is a broad consensus that various factors that influence QOL include physical, psychological, social, and environmental health[47]. Quality of life is an essential part of health outcomes especially the ageing population[48]. In Ghana, accused witches are frequently subjected to ridicule, ostracism, assault and torture, exile and murder. The properties of an alleged accused witch may be seized by family members and social privileges such as access to communal foods, water and land may be limited. Denying people of such privileges can negatively affect their QOL[49].

43 Siu, "Screening for Depression in Children and Adolescents: U.s. Preventive Services Task Force Recommendation Statement."

44 World Health Organization, "World Health Statisitics 2011."

45 Javanbakht et al., "Health Related Quality of Life in Patients with Type 2 Diabetes Mellitus in Iran: A National Survey."

46 Bowling, *Research Methods in Health: Investigating Health and Health Service*, 2014.

47 Klassen et al., "Health-Related Quality of Life."

48 Schweyer, "Diabetes and Quality of Life."

49 Roxburgh, "Witchcraft and Violence in Ghana: An Assessment of Contemporary Mediation Efforts."

Chapter Three

Methodology

3.1 Study Design

This study used a concurrent mixed quantitative and qualitative methodology. Quantitative research approach is used when a researcher wants to create meaning through objective measurement of the situation and presents the findings of the study numerically[50]. Qualitative research on the other hand, involves a holistic approach to research where the researcher develops a level of detail from high involvement in the actual experiences and the data presented in textural form[51]. So, a mixed methods approach to research requires the researcher to combine both quantitative and qualitative research methodologies and also present both numerical and textural data[52]. Creswell and Garrett have emphasized that a strong mixed methods design necessitates that qualitative and quantitative data hold independent research purposes, and that the qualitative and quantitative components work together to mutually strengthen the research findings from each source[53].

The quantitative component of this research included surveying all individuals accused of witchcraft and living in the four alleged witches' camps (census). Initial interaction with caretakers of the alleged witches' camps revealed that the number of people in the camps has decreased over the years. As such, the study included all the individuals who were admitted into the camps on witchcraft accusations. The qualitative study used the narrative approach where participants shared their experiences and knowledge about beliefs about witchcraft, gender dimensions and ways of protecting the human rights of people accused of being witches[54]. In conducting the qualitative approach, the study adhered to the consolidated criteria for reporting qualitative research (COREQ)[55], and acceptable practice in fieldwork, analysis, and interpretation[56].

3.2 Study Settings and Alleged Witches Camps

The study was conducted in four alleged witches' camps located in Nanumba South (Kpatinga), Yendi Municipal (Ngani), Gushiegu and East Mampusi Municipality (Gambaga) in Ghana. The projected population figure as at 2020 for the Nanumba

50 Bowling, *Research Methods in Health: Investigating Health and Health Service*, 2014.

51 Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*.

52 Creswell and Garrett, "The ' Movement ' of Mixed Methods Research and the Role of Educators"; Teddlie, C. & Tashakkori, *Overview of Contemporary Issues in Mixed Methods Esearch. In C. Teddlic & A. Tashakkori (Eds.), Handbook of Mixed Methods in Social and Behavioural Research*.

53 Creswell and Garrett, "The ' Movement ' of Mixed Methods Research and the Role of Educators."

54 Bowling, *Research Methods in Health: Investigating Health and Health Service*, 2014.

55 Tong, Sainsbury, and Craig, "Consolidated Criterio for Reporting Qualitative Research (COREQ): A 32- Item Checklist for Interviews and Focus Group."

56 Green and Thorogood, *Qualitative Methods for Health Research*.

South district is 119,003 comprising of 58,552 males and 60,451 females[57]. About 82.1% of the population lives in the rural areas compared to 17.9% in the urban areas, which implies that the district is predominantly rural. The district has twenty-six (26) health facilities providing health services to the people. They comprise of three (3) health centres situated in Wulensi, Lungni and Pudua and twenty-three (23) Community Health Planning and Services (CHPS) compounds, two (2) CHPS zones and one (1) Reproductive Health Centre (RCH)[58]. The Yendi Municipality, males constitute 48.7% and females represent 51.3% of the population. More than half (56.1%) of the population in the municipality live in rural areas. The Yendi municipality has a Government Hospital located in Yendi and four health centers located at Yendi, Bunbonayili, Ngani, and Adibo. The municipality also has four (4) Community Health and Planning Services (CHPS) compounds.

The Gushegu district is predominantly rural with a little over three quarters of the population (76.0%) residing in rural localities. The municipality has one hospital located at Gushegu in addition to two Health Centres at Kpatinga and Nabuli, one Reproductive Health Clinic at Gushegu and nine (9) Community Health Planning System (CHPS Compounds)[59]. In the East Mamprusi, males constitute 49% and females represent 51% with 67.6% being rural. The Municipality has 14 Health facilities; Hospital (1) Clinics (2), Health Centre (4) and CHPS Compounds (7). Twenty-four hours health services are provided in these facilities. The Baptist Medical Centre in Nalerigu serves as the Municipal Hospital.

Admissions to the alleged witches' camps located in the four districts may be done on daily, weekly or even monthly basis. It often starts with the person been accused (alleged witch) of using the his or her spiritual powers to cause a misfortune or an evil by another person or selected community or family members (accusers). The accusers can be men, women, youths, and children who are directly or indirectly affected by the alleged occult harm. Accusers make allegations on the grounds that they – or their relatives or friends - have suffered some misfortune – sickness, death, accidents, poor harvest, or infertility. Drawing on his studies of the witches' camps in Gambaga, Wiafe argued that alleged witches seek shelter at the alleged witches' camps to avoid being beaten and lynched by community members[60].

The alleged witches' camps are suburbs of the respective villages that accommodate them. The camps are made up of small mud huts or compounds with thatch roofs characteristic of the housing architecture in northern Ghana. A typical living compound in the camp is occupied by a minimum of one and as many as four

57 GSS, "The 2010 Population and Housing Report."

58 Nanumba South District Assembly, *The Composite Budget of the Nanumba South District for the 2021 Fiscal Year*.

59 Gushegu Municipal Assembly, *The Composite Budget of the Nanumba South District for the 2021 Fiscal Year*.

60 Wiafe, *Inter-Religious Dialogue and Cooperation among the Three Major Religions of Ghana.*

accused witches. Life is very rudimentary in the alleged witches' camps. The major economic activity in all the camps is peasant or subsistence farming. The women provide farm labour for natives in the host community in exchange for foodstuffs and sometimes money. They help villagers to plant their crops during the start of the farming season and are also called upon to provide labour when it is time for harvesting. The custodian of the camp and his family also rely on the labour of the women in exchange for the protection that is accorded them. The livelihood support packages received from family members and other external donors constitute an important coping strategy for the camp inhabitants. The major external livelihood support for residents of these alleged witches' camps often comes from benevolent individuals, churches and development non-governmental organizations (NGOs). Other residents of the camps include attendants, who are usually the granddaughters of the accused. These girls do not attend school.

In reaction to reports of exploitation, deprivation and abuse of accused persons living at these camps, the government of Ghana organised its first ever national conference on Witchcraft Accusations in Accra in December 10, 2014[61]. The government through the Ministry of Women and Children Affairs announced plans to close down the alleged witches' camps and reintegrate accused persons living in these places. This decision generated debates on the fate and future of accused persons especially in a region where accusations and banishment of alleged witches frequently take place.

3.3 Population of the Study

The population for this study included people accused of being witches and living in the alleged witches' camps, caretakers of camps and selected stakeholders where the camps are located as well as regional and national level as key informants.

3.4 Sample Size Determination and Sampling

In view of the small population for the study, a census was conducted to include all men (N=18) and women (N=259) in the four alleged witches' camps. In all 277 participants were recruited into the study in the quantitative component of the study whilst 18 stakeholders participated in the qualitative arm of the research.

3.5 Data Collection Tool

A structured questionnaire was developed for the surveys. The survey collected data on the socio-demographic characteristics, socioeconomic status, risk factors for depression and general wellbeing of the alleged witches. The survey was developed in Open Data Collection Kit (ODK) for onsite electronic data collection. The structured questionnaires were preloaded in Android Tablets and translated into two key local languages (Dagbanli and Mampruli) during data collection.

61 ActionAid, "Condemned without Trial: Women and Witchcraft in Ghana."

The prevalence of depressive disorder was assessed using Patient Health Questionnaire 8 (PHQ-8), an instrument based on Diagnostic and Statistical Manual of Mental Disorders (DSM) IV criteria, which has been shown to be valid and reliable for assessing current depressive disorder in the general population[62]. The PHQ-8 is a self-reported questionnaire which is composed of eight items, which correspond to the DSM-IV diagnostic criteria for major depressive episode excluding thoughts of death and suicide. The recall period for this scale corresponds to the previous two weeks and the response scale ranges from 0 (not at all in 14 days) to 3 (nearly every day of the 14 days), (see appendix A). The WHO health-related quality of life (WHOQOL) questionnaire was adopted for this study. The WHOQOL comprise of four domains-physical, psychological, social and environment which is assessed on a five-point Likert scale. The physical domain comprises of multiple questions (6), psychological (6 questions), social (3 questions) and environment (8 questions), (see Appendix A). A face-to-face interviews approach was used whilst maintaining physical distance and observing COVID-19 protocols.

3.6 Qualitative Research Component

This section describes the qualitative component of the study. It defines the study population, how the sampling was done and the tool that was used during data collection.

3.7 Study Population and Sampling

The study population for the qualitative component of the study were stakeholders across essential ministries, departments and institutions. These participants were identified through an initial stakeholder mapping and analysis. Once the institutions were identified, purposive sampling was used to select the actual participants. The list of people who were identified and included in the study have been summarized on Table 1.

Table 1: List of Stakeholders for Qualitative Interviews

No	Category	Number of Participants
1	Caretaker of Camps	4
2	Assemblymen	2
3	District Social Welfare Officers	2
4	Representative from CHRAJ	1
5	Representative from Ministry of Gender, Children and Social Protection	1
6	Human right lawyer	1
7	Chiefs/Representatives	2
8	National Commission for Civic education	2
9	Academia (clinical psychologist)	1

62 Arias-de la Torre et al., "Prevalence and Variability of Current Depressive Disorder in 27 European Countries: A Population-Based Study."

10	Mental Health Coordinator	1
11	Police Officer (DOVVSU)	1

3.8 Data Strategy and Collection Tool

In-depth interview guide was developed and used for data collection. The interview guide focussed on areas such human right issues, policy perspective, and how to address sigma and discrimination (see Appendix B). The topic guide also elicited information on strategies for the reintegration. In-depth interviews were conducted in English and local languages. It took between 30 to 45 minutes to complete an interview session. The interviews at the community and camps were conducted by trained research assistant with linguistic competence in the native language. Interviews at the national level were conducted in English Language by the Principal Investigator.

3.9 Training of field coordinators/interviewers

Training was organized for the three Research Assistants (RAs). The training covered the objectives of the study, consenting process, the questionnaire and interviews guide. Mock interview sessions were conducted. One woman from the alleged witches' camps and a supervisor participated in the training and were used for the mock interview sessions. These individuals were excluded from the main study.

3.10 Quality Control and Quality Assurance

Training of the research assistants was done and the data collection tools piloted. Data was collected using tablets with a software management tool called ODK. The Principal Investigator (PI) was responsible for data quality control issues, handled at three different levels.

1. The first level was the real-time logical and range checking built into the web-based data entry system.
2. The second level of quality control involved the data manager conducting real time daily checks. Checks identified complicated and less common errors.
3. The third level of quality control involved local monitoring, where data in our database was checked and if errors were identified, the Research Assistants (RA) who committed those errors was identified using the system and asked to correct them before moving to the next stage of data collection. The PI was responsible for ensuring that all study related information is collected by competent trained personnel.

Data validation workshop was organized to share the findings of the research with study participants. Post presentation discussions were incorporated into the findings of the study.

3.11 Data Management, Processes and Analysis

3.11.1 Quantitative Data Analysis

STATA version 16 was used to analyse the quantitative data. Descriptive statistical methods were first used to summarise the distribution of the data across demographic characteristics of the study participants, and prevalence of depression. In determining prevalence of depression, a PHQ-8 score was used. The PHQ-8 response set was standardized by asking the number of days in the past 2 weeks the respondent had experienced a particular depressive symptom. The modified response set was converted back to the original response set: 0 to 1 day= "not at all," 2 to 6 days= "several days," 7 to 11 days= "more than half the days," and 12 to 14 days= "nearly every day," with points (0 to 3) assigned to each category, respectively. The scores for each item were summed to produce a total score between 0 and 24 points. A total score of 0 to 4 represented no significant depressive symptoms. A total score of 5 to 9 represented mild depressive symptoms; 10 to 14, moderate; 15 to 19, moderately severe; and 20 to 24, severe[63]. Any participants who had 10 or higher was be deemed to be positive for current depressive disorder (sensitivity over 85% and specificity over 88%)[64]. Pearson's Chi Square and Fisher's Exact models were used to determine the association between socio-demographic characteristics and depression.

The study adapted the WHO Quality of Life tool (WHOQOL) with its associated score. The WHOQOL-26 questionnaire contains two items from the self-rated overall QOL and general health and 24 items of satisfaction that are divided into four domains: Physical health with 6 items (DOM1), psychological health with 6 items (DOM2), social relationships with 3 items (DOM3) and environmental health with 8 items (DOM4). Each item was rated on a 5-point Likert scale and was scored from 1 to 5 on a response scale with maximum score of 120. Domain scores were scaled in a positive direction (i.e., higher scores denote higher QOL). The following values of scores were extracted from the reviewed studies and were applied in the current study: score ≤ 45 extremely low QOL; score 46–65 low QOL; score 66–86 moderate QOL, score 87–101 relatively high QOL and score ≥102, excellent QOL[65].

The quantitative results were summarized factsheets, with diagrams (e.g., bar charts and graphs) to aid visualization and interpretation by various stakeholders.

63 Kroenke, Spitzer, and Williams, "The PHQ-9: Validity of a Brief Depression Severity Measure."

64 Moriarty et al., "Screening and Case Finding for Major Depressive Disorder Using the Patient Health Questionnaire (PHQ-9): A Meta-Analysis."; Levis et al., "Equivalency of the Diagnostic Accuracy of the PHQ-8 and PHQ-9: A Systematic Review and Individual Participant Data Meta-Analysis."

65 Burckhardt and Anderson, "The Quality of Life Scale (QOLS): Reliability , Validity , and Utilization."

3.11.2 Qualitative Data Analysis

The qualitative interviews were recorded using audio recorders and transcribed verbatim. The transcripts were reviewed to develop a codebook which served as guide for the thematic analysis[66]. The transcripts were imported into NVivo 13. Each transcript was opened in the software coded and reviewed by Principal Investigator and research assistants with expertise in qualitative data analysis. Initially, coding was done into free nodes and later as tree nodes. Double coding was done and code comparison query run in NVivo. The intercoder reliability index (Kappa Coefficient) was computed as 0.89 which indicates higher level agreement[67]. Coded sections were regrouped into relevant categories and themes for presenting the results. Direct quotations were used, where appropriate, to support the themes.

3.11.3 Data Triangulation

Data triangulation refers to the combination of two or more data collection strategies in single research[68]. Triangulation is often premised on the reasoning that no single method ever adequately solves the problem of rival or counter explanations[69], and that the weaknesses in each single method will be compensated by the counter-balancing strengths of another[70]. Since both quantitative and qualitative data were collected in this research, data triangulation strategy was employed to report the findings of this study. Triangulation techniques are helpful for cross-checking data validity and used to provide confirmation and completeness when two or more different types of research data collection strategies are used. The approach was therefore used to increase the credibility and validity of both the qualitative and quantitative results[71].

3.12 Ethical Considerations

The protocol for study was reviewed and approved by Ghana Health Service Ethics Review Committee (GHS-ERC 014/09/21, see appendix C). The implementation of the study followed all the ethical requirements in conducting research using human participants**.** We also adhered with the World Health Organization and Ghana Health Service protocols in conducting face-to-face interviews during the COVID-19 pandemic, which includes social distancing and wearing of facemask.

66 Bowling, *Research Methods in Health: Investigating Health and Health Service*, 2014.

67 Tabong et al., "Premorbid Risk Perception, Lifestyle, Adherence and Coping Strategies of People with Diabetes Mellitus: A Phenomenological Study in the Brong Ahafo Region of Ghana."

68 Yeasmin, "Triangulation Research Method as the Tool of Social Science Research."

69 Patton, *Qualitative Research and Evaluation Methods*.

70 Teddlie and Tashakkori, "Overview of Contemporary Issues in Mixed Methods Research."

71 Yeasmin, "Triangulation Research Method as the Tool of Social Science Research"; Bekhet and Zauszniewski, "Methodological Triangulation: An Approach to Understanding Data"; Fielding, "Triangulation and Mixed Methods Designs Data Integration with New Research Technologies"; Denzin, "Triangulation 2.0."

Chapter Four

Results

4.1 Socio-demographic Characteristics of Participants

Table 2 shows the socio-demographic characteristic of the study participants. From the Table, 106 (38.3%) of the participants were between the ages of 70-79 years, 259(93.5%) were females, 156 (56.3%) adhered to Islamic faith, 94 (33.9%) were Christians, 236 (85.2%) had health insurance and only 15 (5.4%) were engaged in some form of work that generates income such as farming, and petty trading.

Table 2: Socio-demographic characteristics (SDC) people accused of witchcraft in Northern and North regions in Ghana, 2021

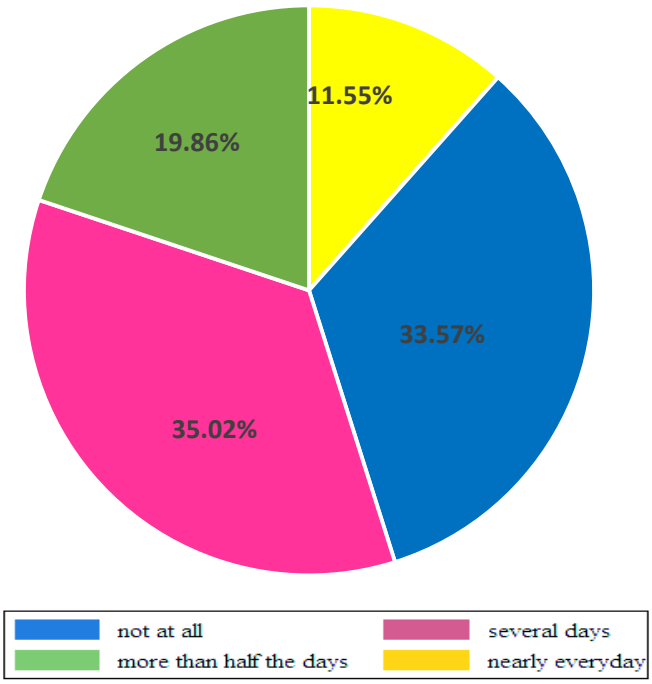
SDC	Observations	Frequency (n)	Percentage (%)
Age (in years)			
Mean age=69 years	40-49	10	3.6
	50-59	33	11.9
	60-69	70	25.3
	70-79	106	38.3
	≥80	58	20.9
Sex			
	Female	259	93.5
	Male	18	6.5
Religion			
	Islam	156	56.3
	Christianity	94	33.9
	Traditional	21	7.6
	No religion	6	2.2
NHIS Status			
	Insured (valid card)	236	85.2
	Not insured	41	14.8
Marital history			
	Ever married	268	96.8
	Never married	9	3.2
Current marital status			
	Married	40	15.0
	Separated/divorced	50	18.7
	Widowed	177	66.3
Children			
	Have biological children	255	92.1
	No biological children	22	7.9

	Child(ren) alive	249	97.6
	Child(ren) dead	6	2.4
Education			
	No formal education	274	99.0
	Primary	2	0.7
	Secondary	1	0.3
Employment			
	Not engaged in income generating work	262	94.6
	Engaged in income generating work	15	5.4
Monthly income			
	GHS 5-10	232	83.7
	GHS 11-20	39	14.1
	GHS 21-30	2	0.7

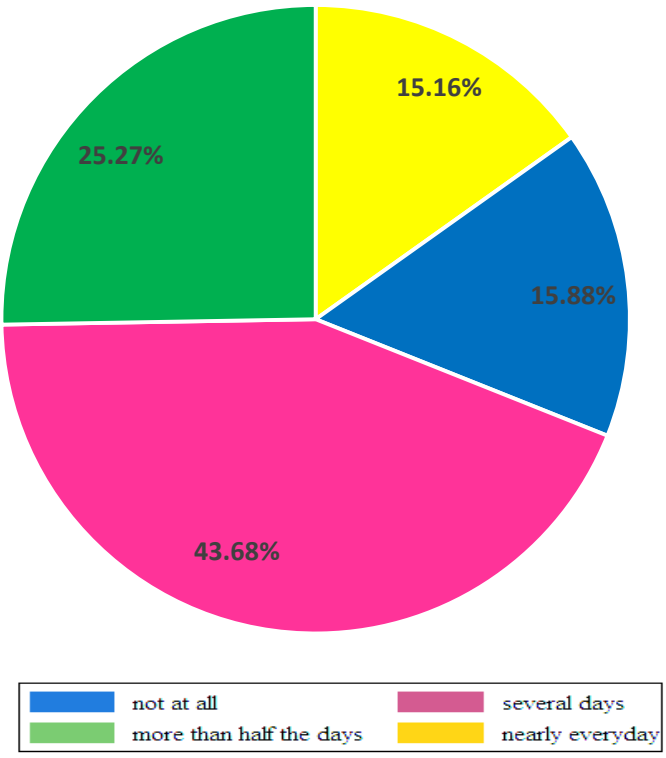
4.2 Distribution of Signs and Symptoms of Depression (PHQ-8) among Participants

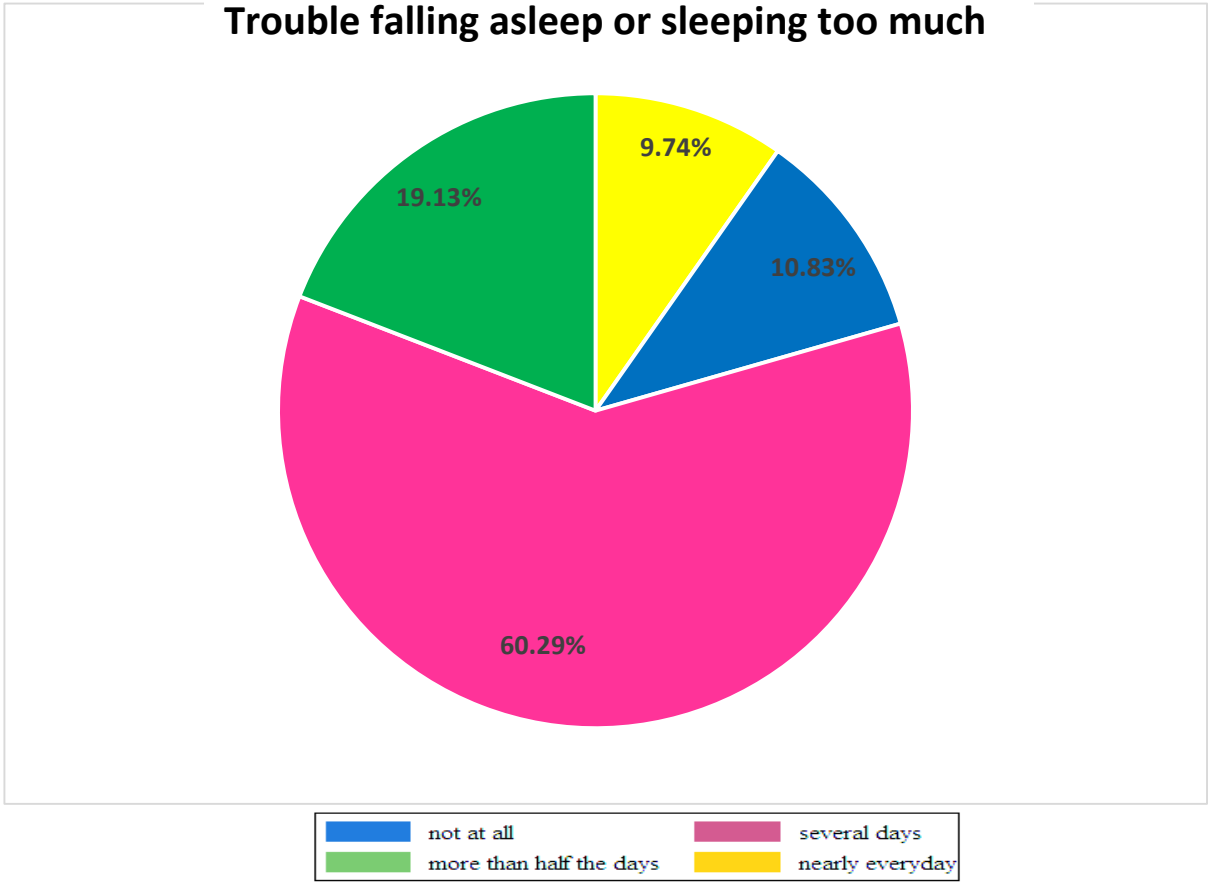
The study showed majority of the participants experienced some form of signs and symptoms of depression on daily basis. About 11.55% experienced little interest of pleasure nearly every day (12-14 days) whilst 35.0% experienced it several days in the two week (2-6 days). In addition, 43.7% and 15.2% reported the feeling of hopelessness several days in two weeks and everyday of the 14 days respectively. Participants also reported having challenges in falling asleep or sleeping too much; 60.3% experienced this several days in two weeks (2-6 days) and 19.1 % experienced this for more than half (7-11) days in two weeks. Furthermore, 39.7% and 10.1% reported feeling tired or lack energy for their daily activities several days in two weeks and nearly every day of the 14 days respectively (Figure 1)

Little interest of pleasure in doing things



Feeling of hopelessness




Trouble falling asleep or sleeping too much
9.74%
10.83%
19.13%
60.29%
not at all
several days
more than half the days
nearly everyday

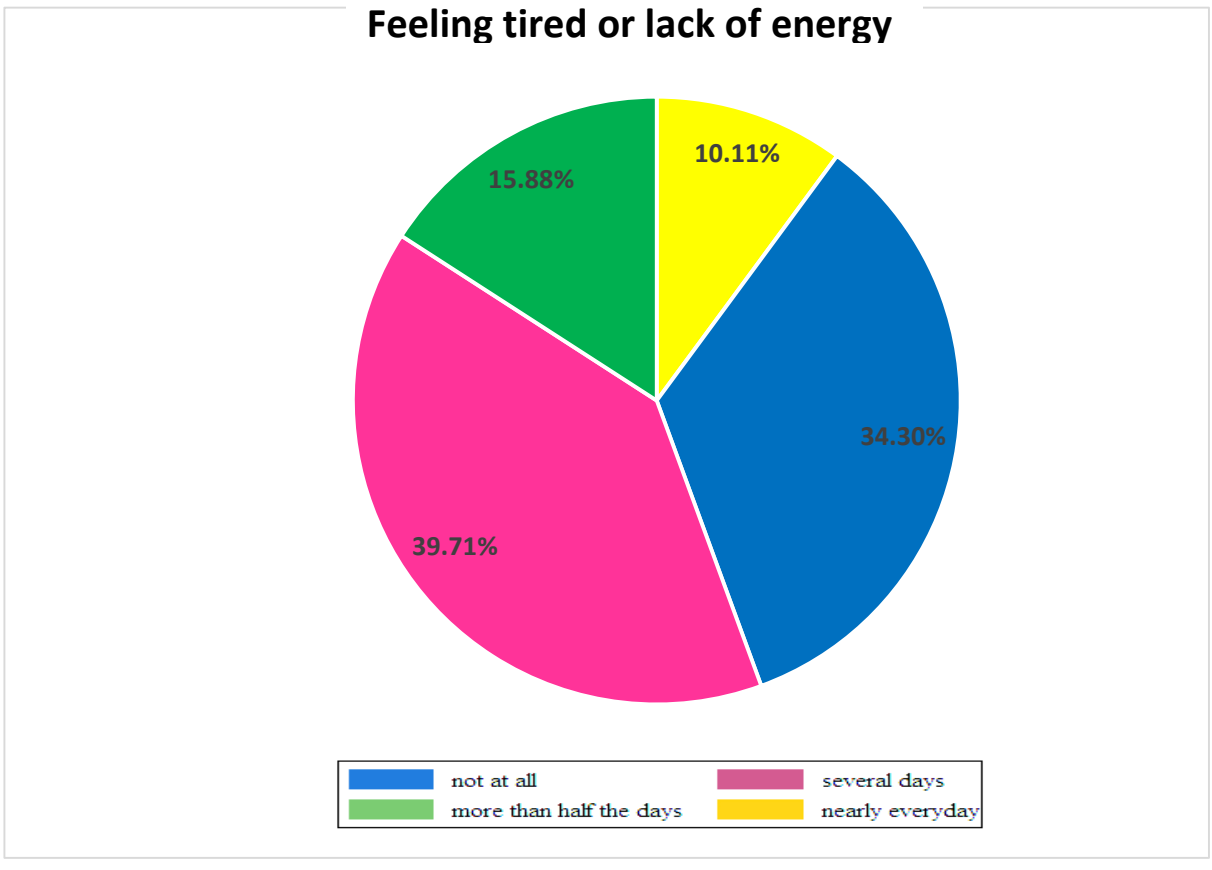
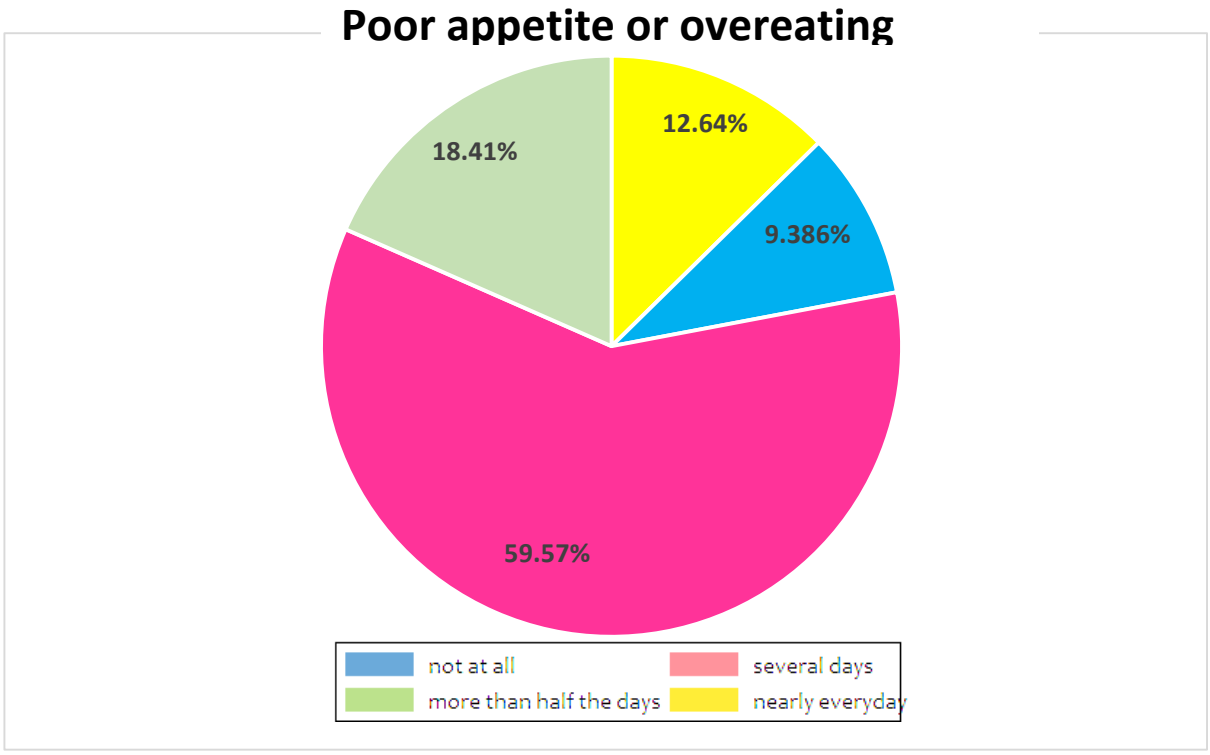
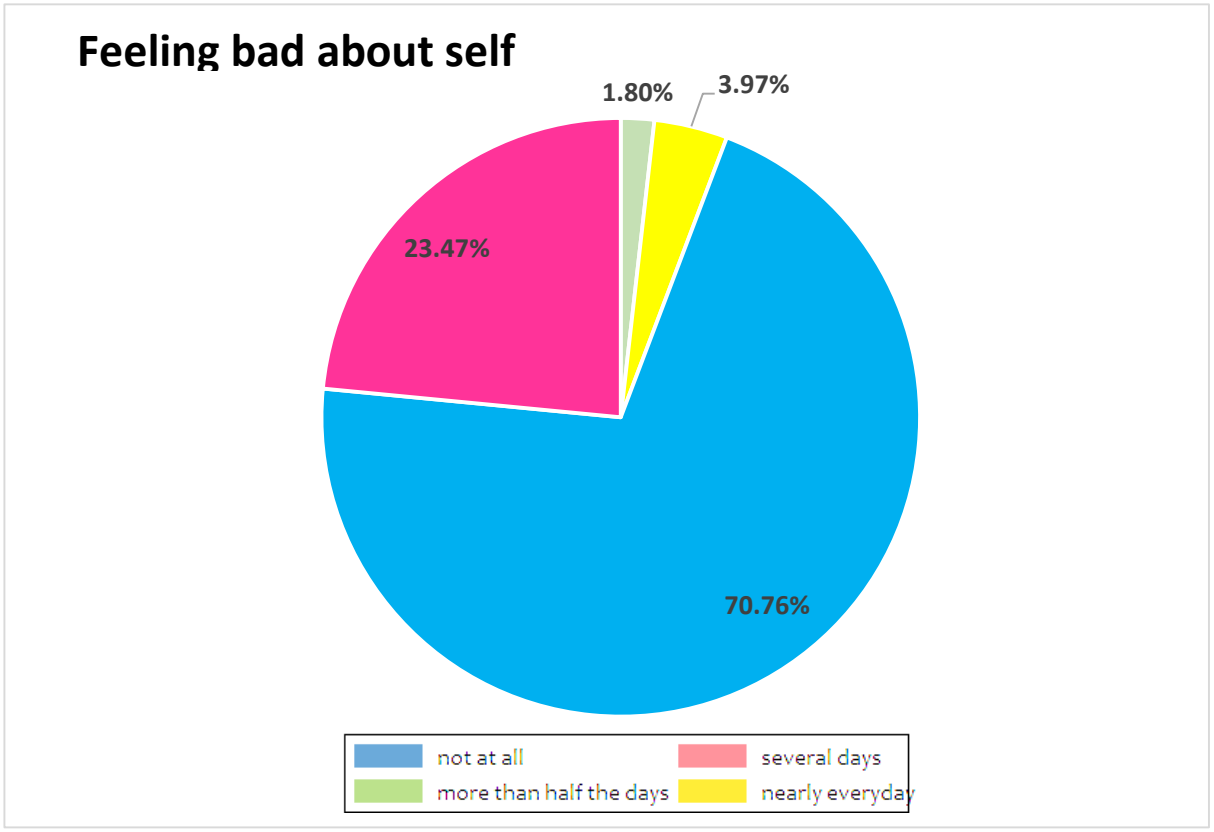
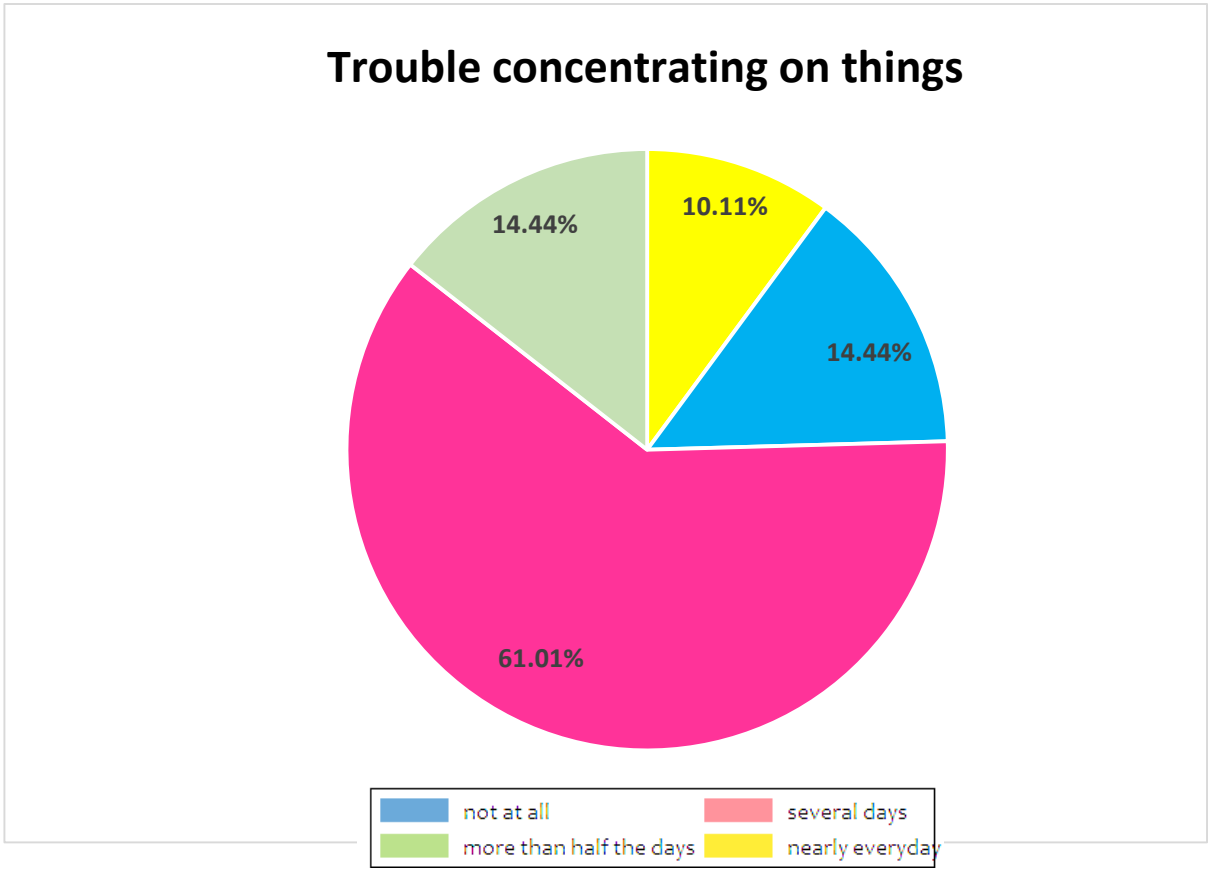

Feeling tired or lack of energy
10.11%
15.88%
34.30%
39.71%
not at all
several days
more than half the days
nearly everyday

Figure 1: Prevalence of Signs and Symptoms of Depressions among Alleged Witches, 2021

Furthermore, participants reported poor appetite as 59.6% experienced this several times in two weeks whilst 18.4% experienced this symptom more than half the days in two weeks. Having bad perception about self was also reported by 23.5%, experiencing this bad perception several days in two weeks. Again, many participants reported challenges in concentrating as well as moving and speaking slowly (Figure 2)






Trouble concentrating on things
14.44%
10.11%
14.44%
61.01%
not at all
several days
more than half the days
nearly everyday

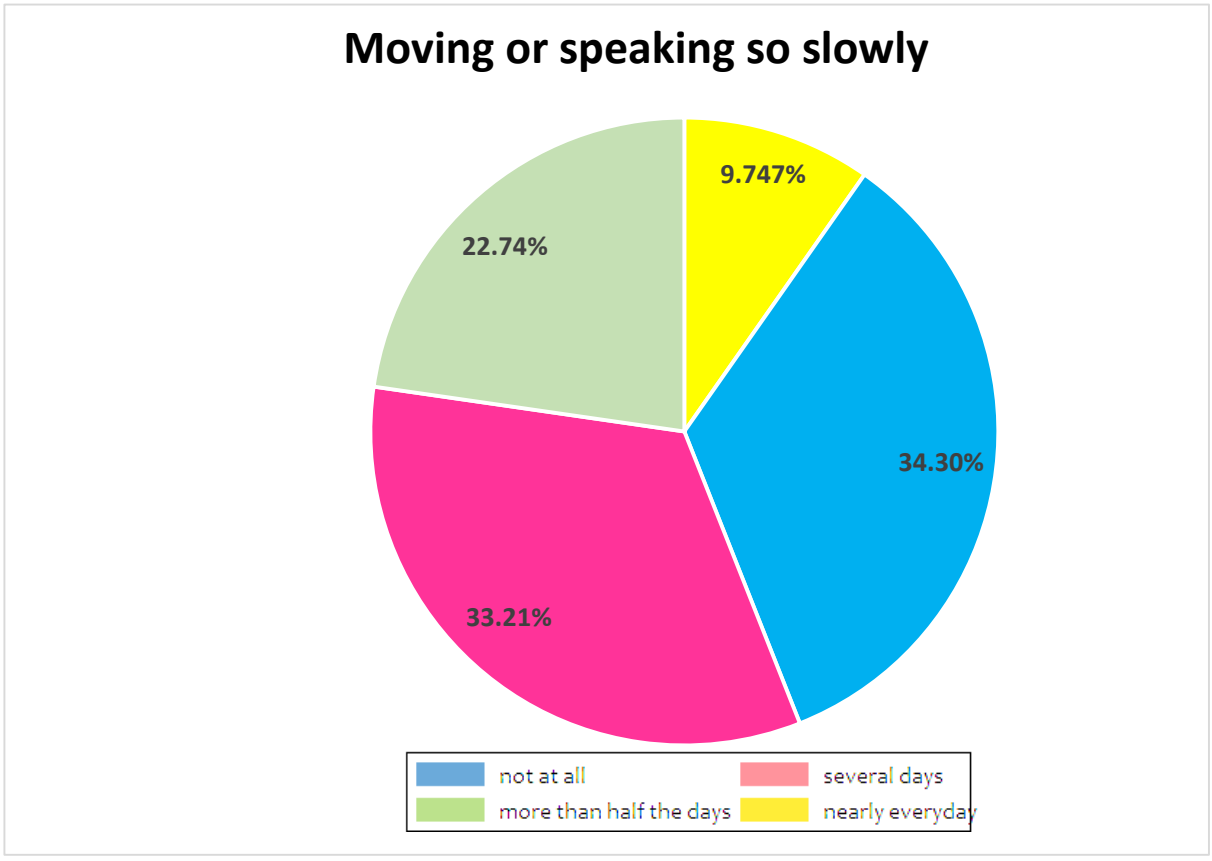

Moving or speaking so slowly
9.747%
22.74%
34.30%
33.21%
not at all
several days
more than half the days
nearly everyday

Figure 2: Prevalence of Signs and Symptoms of Depressions among Alleged Witches, 2021

4.3 Prevalence of Depression

Using a cutoff of ≥10, the prevalence of depression among the participants was 52.7% (Figure 3).

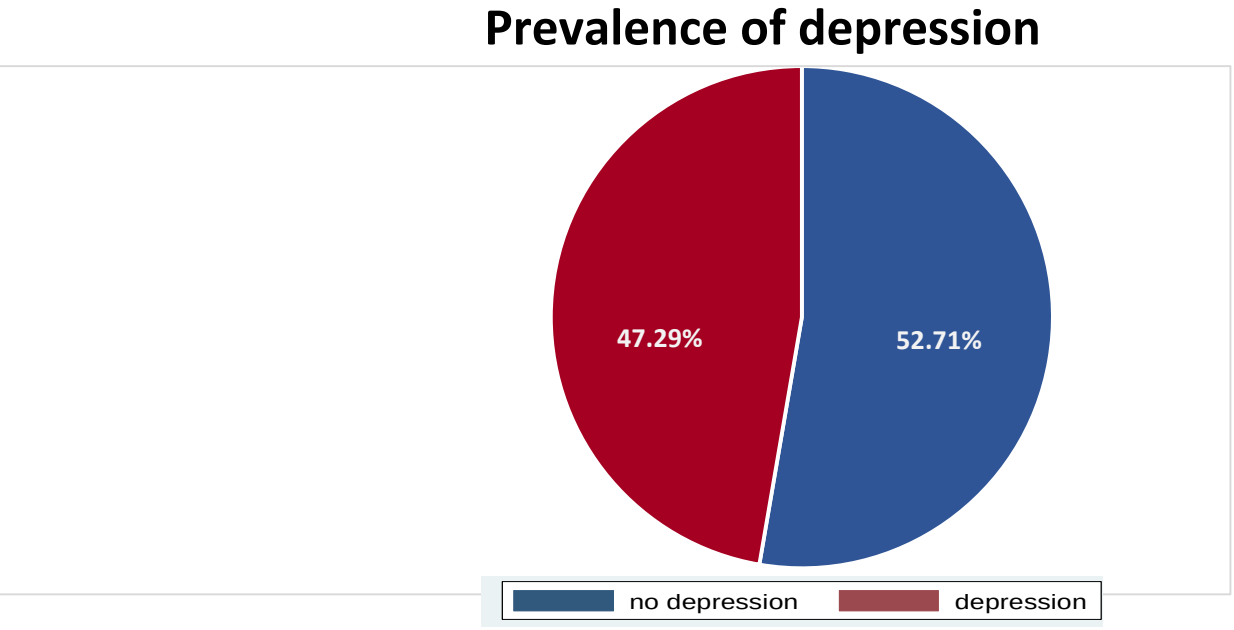


Figure 3: Prevalence of Depression among Alleged Witches (cutoff PHQ≥10), 2021

4.4 Severity of Depression among Participants

In terms of severity of the depression, 23.5% had mild depression, 37.1% had moderate depression, 7.2% had moderately severe depression whilst 2. 9% had severe depression (Figure 4)

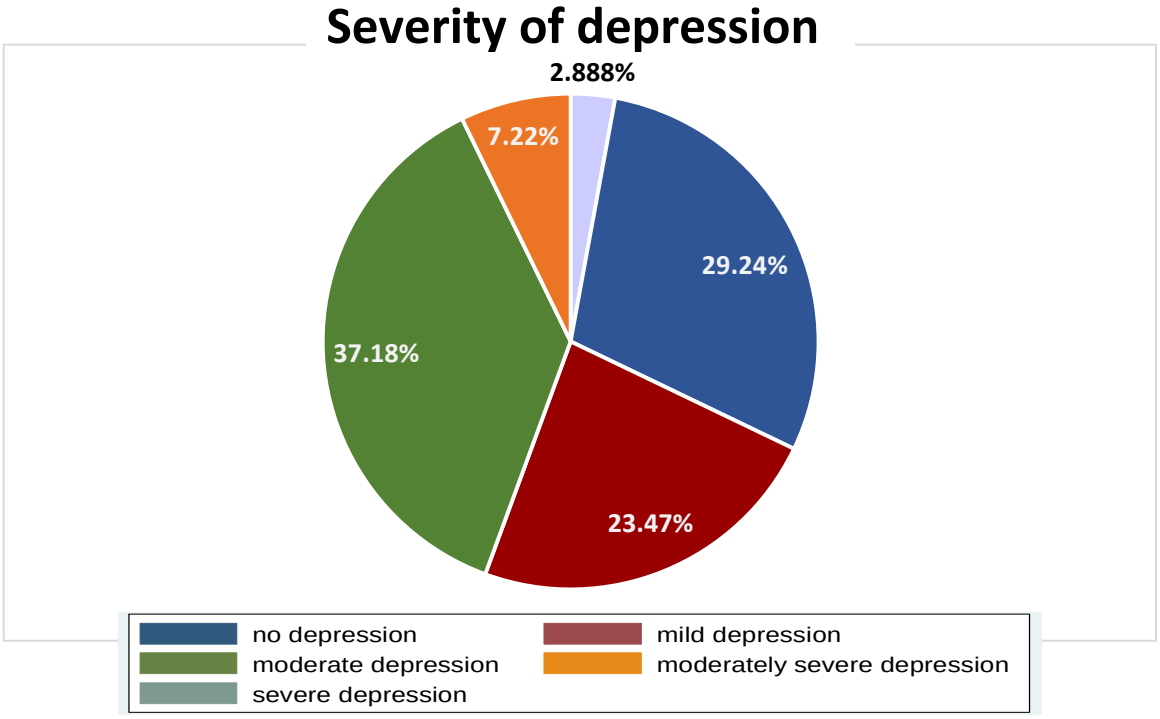


Figure 4: Severity of Depression among Alleged Witches, 2021

In interviews, participants recognised that witchcraft accusations could affect their psychosocial wellbeing. As a result, some interviewees suggested regular visits to the alleged witches' camps by health workers and other professionals to provide psychological support, screening and care as follows:

> "The stakeholders such as; the CHRAJ, Police, Social Welfare, and community development are also supposed to take up some responsibility of frequently visiting these group of people to monitor their health and provide psychological services such that they would be able to adjust quickly and to live with the stigma that they are confronted with" (Interviewee, clinical psychologist)

4.5 Association between socio-demographic characteristics and depression

Table 3 show that more females 49.4% than males 16.79% had depression and the differences was statistically significant (X^2=7.24, p=0.007). Other variables that had statistically significant association with depression are: never been married (p=0.001), widowed or separated (p=0.004) and not having biological children (p=0.004). Table 3 provides a summary of the association between socio-demographic characteristics of participants and depression. Statistically significant data are in bold.

Table 3: Association between socio-demographic characteristics and depression

SDC	No depression n (%)	Depression n (%)	X^2 (p-value)
Age			
40-49	6(60.0)	4(40.0)	
50-59	21(63.6)	12(36.3)	
60-69	35(50.0)	35(50.0)	6.96(0.138)
70-79	61(57.5)	45(42.3)	
≥80	23(39.7)	35 (60.3)	
*__Sex__			
Female	131(50.6)	128(49.4)	**7.24 (0.007)**
Male	15(83.3)	3(16.7)	
Religion			
Islam	78 (50.0)	78 (50.0)	
Christianity	51 (54.3)	43 (45.7)	
Traditional	15 (71.4)	6 (28.6)	4.40 (0.215)
No religion	2 (33.3)	4 (66.7)	
Education			
No formal education	144(52.5)	130(47.5)	0.91(0.636)
Primary	1(50.0)	1(50.0)	
Secondary	1(100)	0(0)	
*__Marital history__			
Ever married	146(54.5)	122(45.5)	**10.37(0.001)**
Never married	0(0)	9(100)	
*__Current marital status__			
Married	30 (75.0)	10(25.0)	
Separated/divorced	31 (62.0)	19(38.0)	**10.91 (0.004)**
Widowed	85 (48.0)	92(52.0)	
Children			
*Have biological children	141 (55.3)	114 (44.7)	**8.62 (0.004)**
No biological children	5 (22.7)	17 (77.3)	
Child(ren) alive	138(55.4)	3(50.0)	0.79(1.000)
Child(ren) dead	111(44.6)	3(50.0)	
Employment			
Not engaged in income generating work	136(51.9)	126(48.1)	1.23(0.299)
Engaged in income generating work	10(66.7)	5(33.3)	
Income			
GHS 5-10	128(54.2)	108(45.8)	4.15 (0.124)
GHS 11-20	16 (41.0)	23 (59.0)	
GHS 21-30	2 (0)	0(0)	

Health insurance			
Insured (valid card)	129(54.7)	107(45.3)	2.44(0.130)
Not insured	17(41.5)	24(58.5)	

*Statistically significant at p<0.05

4.6 Socio-demographic Characteristics and Severity of depression

Table 4 shows the association between socio-demographic characteristics and severity of depression using the Diagnostic and Statistical Manual (DSM IV) classification. From the table, severity of depression increases with age, having low income, widowed or divorced and not having children.

Table 4 Association between socio-demographic characteristics and severity of depression

SDC	No depression, n (%)	Mild depression, n (%)	Moderate, n (%)	Moderately severe, n (%)	Severe, n (%)	X^2 (p-value)
***Age (in years)**						
40-49	4(40.0)	2(20.0)	1(10.0)	1(10.0)	2(20.0)	
50-59	13(39.4)	8(24.2)	6(18.2)	2(6.1)	4(12.1)	
60-69	25(35.7)	10(14.3)	27(38.6)	7(10.0)	1(1.4)	**47.48(<0.0001)**
70-79	26(26.4)	33(31.1)	36(34.0)	8(7.5)	1(0.9)	
≥80	11(19.0)	12(20.7)	33(56.9)	2(3.4)	0(0)	
Sex						
Female	74(28.8)	57(22.0)	101(39.0)	19(7.3)	8(3.1)	8.37(0.066)
Male	7(38.9)	8(44.4)	2(11.1)	1(5.6)	0(0)	
***Religion**						
Islam	57(36.5)	21(13.5)	61(39.1)	12(7.7)	5(3.2)	**19.53(0.003)**
Christianity	16(17.0)	35(37.2)	33(35.1)	7(7.4)	3(3.2)	
Traditional	8(38.1)	7(33.3)	5(23.8)	1(4.8)	0(0)	
No religion	0(0)	2(33.3)	4(66.7)	0(0)	0(0)	
***Marital history**						
Ever married	81(30.2)	65(24.2)	101(37.7)	20(7.5)	1(0.4)	**186(<0.0001)**

Never married	0(0)	0(0)	2(22.2)	0(0)	7(77.8)	
***Current marital status**						
Married	17(42.5)	13(32.5)	7(17.5)	3(7.5)	-	
Separated/divorced	23(46.0)	8(16.0)	18(36.0)	1(2.0)	-	**19.7(0.002)**
Widowed	41(23.2)	44(24.9)	76(42.9)	16(9.0)	-	
***Children**						
Have biological children	79(31.0)	62(24.3)	94(36.9)	20(7.8)	0(0)	**98.84(<0.0001)**
No biological children	2(9.1)	3(13.6)	9(40.9)	0(0)	8(36.4)	
Child(ren) alive	77(30.9)	61(24.5)	91(36.5)	20(8.0)	-	0.92(0.891)
Child(ren) dead	2(33.3)	1(16.7)	3(50.0)	0(0)		
Educational attainment						
No formal education	80(29.2)	64(23.4)	103(37.6)	19(6.9)	8(2.9)	9.57(0.156)
Primary	0(0)	1(50.0)	0(0)	1(50.0)	0(0)	
Secondary	1(100)	0(0)	0(0)	0(0)	0(0)	
Employment						
Not engaged in income generating work	74(28.2)	62(23.7)	100(38.2)	18(6.9)	8(3.0)	4.27(0.327)
Engaged in income generating work	7(46.7)	3(20.0)	3(20.0)	2(13.3)	0(0)	
***Income**						
GHS 5-10	74(31.7)	54(22.9)	89(37.7)	15(6.6)	4 (1.7)	
GHS 11-20	6(15.4)	10(25.6)	14(35.9)	5(12.8)	4 (10.3)	**15.34(0.025)**
GHS 21-30	1(50.0)	1(50.0)	0(0)	0(0)	0(0)	
***Health insurance**						
Insured	74(31.4)	55(23.3)	87(36.9)	16(6.8)	4(1.7)	**10.78(0.040)**

Not insured	7(17.1)	10(24.4)	16(39.0)	4(9.8)	4(9.8)	

*Statistically significant at p<0.05

4.7 Quality of life of Alleged Witches

The quality of life has five domains with specific questions measured on a five-point Likert Scale (1=not at all, 5=suffer or experience severe form). In the physical domain of QOL, the study showed that majority of the participants feel some pain and may have to depend on medication to be able to undertake their daily activities (medication may not always be available). Psychologically, participants indicated they did not enjoy life, have a poor perception about their life as well as negative physical appearance of their body (body image). Poor social support was reported on the social domain (Table 5).

Table 5: Quality of Life of Alleged Witches, 2021

Domain	**Elements**	**Minimum**	**Maximum**	**Mean (Standard Deviation)**
Physical				
	Pain and discomfort	1	5	2.9(0.85)
	Need medication	2	5	3.4 (1.03)
	Energy and fatigue	1	5	2.2 (0.65)
	Sleep and rest	1	5	2.3(0.67)
	Perform daily activities	1	5	2.2(0.65)
	Capacity to work	1	5	1.7 (0.66)
Psychological				
	Enjoy life	1	4	2.5(0.72)
	Positive feelings	1	4	2.5(0.56)
	Concentration	1	4	2.2 (0.66)
	Self-esteem	1	4	2.7(0.55)
	Bodily image and appearance	1	4	2.9(0.58)
	Negative feelings	1	4	2.4(0.67)
Social				
	Personal relationships	1	4	2.6(1.07)
	Social support	1	4	1.6(0.64)
	Sexual activity	1	4	1.62(2.09)
Environment				
	Physical safety and security	1	5	3.2(0.75)
	Home environment	1	4	2.8 (0.74)

	Financial resources	1	4	1.6(0.69)
	Health and social care: accessibility and quality	1	4	2.2(0.68)
	Opportunities for acquiring new information and skills	1	4	1.9(0.68)
	Participation in and opportunities for recreation/ leisure activities	1	4	2.0(0.52)
	Physical environment (pollution/noise/traffic/cli-mate)	1	4	2.4(0.73)
	Transport	1	4	2.0(0.71)

In the composite score, the mean QOL score is 53.3(Standard Deviation, SD=6.23). The majority (88.8%) of the participants had total QOL score between 46-65 which means they had low quality of life. In addition, about 8.6% had extremely low QOL (score of ≤45) whilst only 2.5% had moderate QOL (score of 66-86), (Figure 5). No participant belonged to relatively high QOL (score 87-101) and excellent QOL (≥102) respectively. In summary, over 97% of alleged witches have low or extremely low quality of life. None have high or excellent quality of life.

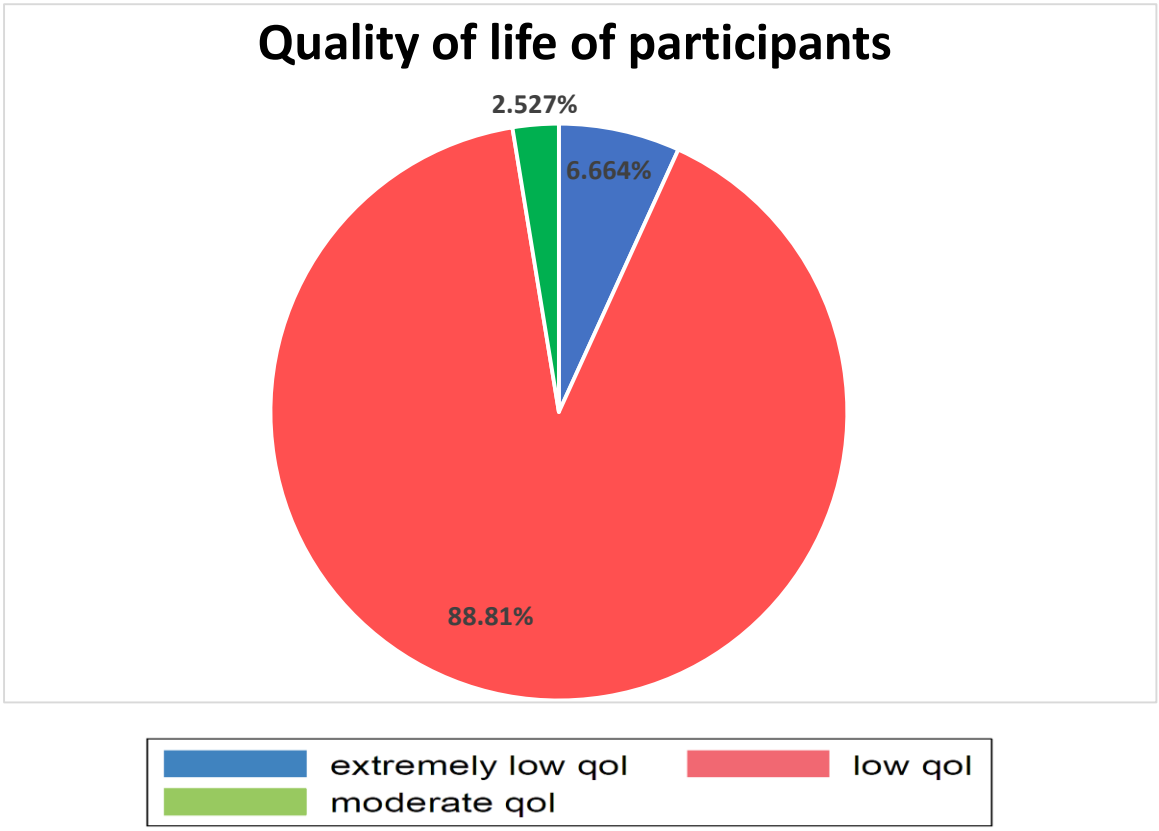


Figure 5: Quality of Life of Alleged Witches, 2021

Interviewees suggested that the district assembly should organize periodic health screening for people residing in these alleged witches' camps because of exposure to adverse health conditions as follows:

> "I expect the District Assembly to once in a while organise health screening to ensure that these old women's health is taken care of. The District Assembly can support by getting these women registered onto the National Health Insurance Scheme" (Human rights lawyer)

In addition, interviewees were of the view that the age of the residents of the alleged witches' camps and the deplorable state of the environment can negatively affect their quality of life and predispose then to many health conditions. One interviewee shared his views as follows:

> "These women are old, poor and may have poor nutrition. This therefore make them very vulnerable to several health condition, even though they appear neglected by the district assemblies" (Mental Health Coordinator)

4.8 Gender Dynamics of Witchcraft Accusation

The study found that the majority of the people accused of witchcraft in the four alleged witches' camps, were females, i.e., 259 (93.5%). Only 18 (6.5%) were males (Figure 6).

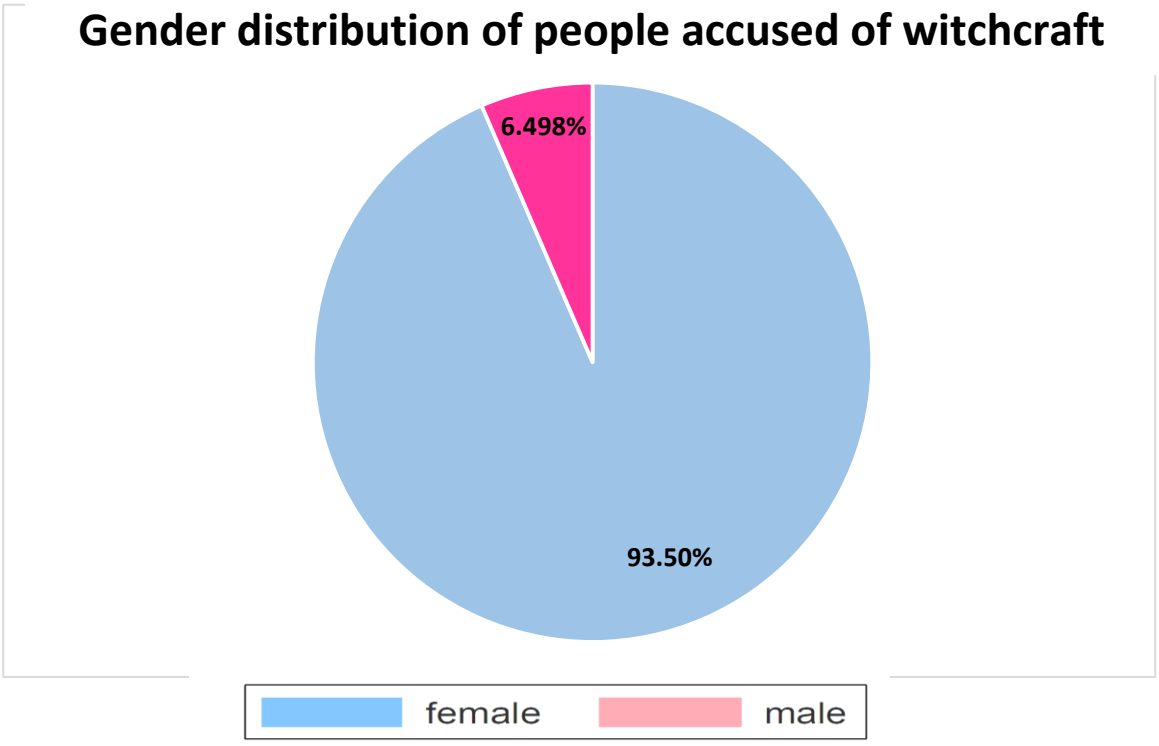


Figure 6: Gender Distribution of People Accused of Witchcraft, 2021

The study showed that whereas women who are accused of being witches were condemned and confined to camps, men with the same accusation were allowed to live in the community, So in Dalong community, the men accused of being witches are not camped but live among the community members. An opinion leader in this community shared the following in an interview:

> "There are some men here who are also accused of witchcraft. The truth is that the number of men in it is smaller than that of the women; again, the women are under the control of men, so are easily accused and banished" (Caretaker, Dalong)

> "When men are accused to witchcraft, they can negotiate with their accusers and defend themselves. However, when women are accused, the community is often fast to condemn and banish them" (Chief of community with alleged witches camp)

In qualitative interviews, interviewees cited poverty as one of the drivers of witchcraft allegations. The women who are accused largely belong to poor socioeconomic status and rely on menial works such as assisting people in farms for survival. Some women are accused because the males that engage them to work on their farms may use witchcraft allegation to avoid paying for the service delivered. One key informant with background working in human rights institutions shared his views as follows:

> "Yes, if you look at the witchcraft, I must say that it is tied to poverty issues. Because if you look at it, my experience over the last twelve (12) years with the human rights institution and working with communities showed that witchcraft incidents usually occur along human relations and engagements…if the person does not want to repay the female after harvesting, they start making such unfounded allegation" (Interviewee, NCCE)

At the intersection of economic status and witchcraft accusations, older women, who were often widows, were more vulnerable because they were most likely to be poor and dependent on neighbourly assistance. In this study, 177(66.5%) of the people accused of witchcraft were widows without a husband/male to shield them from the accusation. Interviewees held the view that poverty and lack of economic resources have often fuelled the accusation of women as witches. Largely, most accused women are often poor women without the economic power to fight for their human rights. A chief in an interview explained as follows

> "…it is only the poor and deprived women who are accused of witchcraft. The social structure in northern Ghana deprives women access to productive resources and hence are blamed for the misfortunes of other community members" (Chief in a community with witches' camp)

In addition, the patriarchal nature of the societies in the northern Ghana place women in a disadvantaged position, depriving them access to family resources. One interviewee with expertise in the practice of witchcraft explained as follows:

> "Furthermore, women in our society are structurally disadvantaged due to assigned roles and their limited role in decision making, coupled with their less access to resources and opportunities. The women are ordinarily disadvantaged and therefore vulnerable. I have never come across well empowered woman accused and or banished from any community because of allegations of witchcraft" (An academic with expertise in witchcraft research)

Furthermore, the social belief that only men should have magical powers introduces another gender dimension to witchcraft accusation. As such women who are believed to possess magical power are accused of witchcraft. Two interviewees shared their knowledge on witchcraft accusation as follows:

> "In our culture I can wear amulets and all kinds of magical symbols and decorations but women are not allowed. Therefore, magic comes for men in our societies and not women and so if a woman wears any of the magical symbols, she will be described as a witch" (Caretaker of witches' camp)

> "Whenever a woman is accused whether she is actually a witch or not, people are quick to pronounce them guilty because they are normally not heard in society. However, if the suspect is a man, they are even afraid to approach him because generally there is nothing wrong with a man possessing black magic in our society…the belief that women should have magical power also tend to fuel these accusations" (District Social Welfare Officer)

There are also gender dimensions in ways accused people are treated before they are banished. Women accused of witchcraft are usually not given a fair hearing and mostly beaten and maltreated. In a media report, Akua Denteh who was alleged to be a witch was torture for hours which lead to her death at Kafaba near Salaga. However, when men are accused, they are likely not to suffer from any mistreatment before they are admitted to the camps. One caretaker of the camp shared the following in an interview:

> "Though there are more women here as I speak, the number of men in this camp are and largely relative of women. Even for the here who were alleged to be witches and banished there was no sign of physical attack. However, all the women were beaten and maltreated before they were brought to this camp" (Caretaker, Alleged Witches Camp)

This was supported by the quantitative data as all the female alleged to be witches indicated they were beaten and had to leave the community to avoid lynching.

Some interviewees attributed the gender dynamic to low literacy rate among women in the Northern and North East regions. As such, advocacy for girl child education

was suggested as long term intervention to address this gender-related issue about witchcraft accusation. According to interviewees when women are educated and empowered, they cannot be accused witchcraft. One participant revealed that females who are educated and have educated children even when accused are not banished because such people have access to legal protection. One stakeholder shared the following in an interview:

> "Yes, if you accuse me [man] of witchcraft, we will go to court to investigate the matter. Sometimes it is the family that will accuse her and if she does not know what to do then they chase her out so if we don't send our girl child to school, witchcraft will continue until we are all dead" (Assemblyman)

> "If a woman who is educated and empowered is believed to possess magical powers, the community or family members are often afraid to accuse such individuals. So, we need to ensure that a children go to school" (Interviewee, CHRAJ)

4.9 Reintegration and Protection of Human Rights Strategies

Majority of the participants (73.3%) indicated they wanted to be reintegrated into communities and called for the closing down of the Witches camps (Figure 7). For those who did not want to be reintegrated, concerns were raised about their safety in the community. Some revealed they may be attacked and lynched if they are relocated to their community of origin.

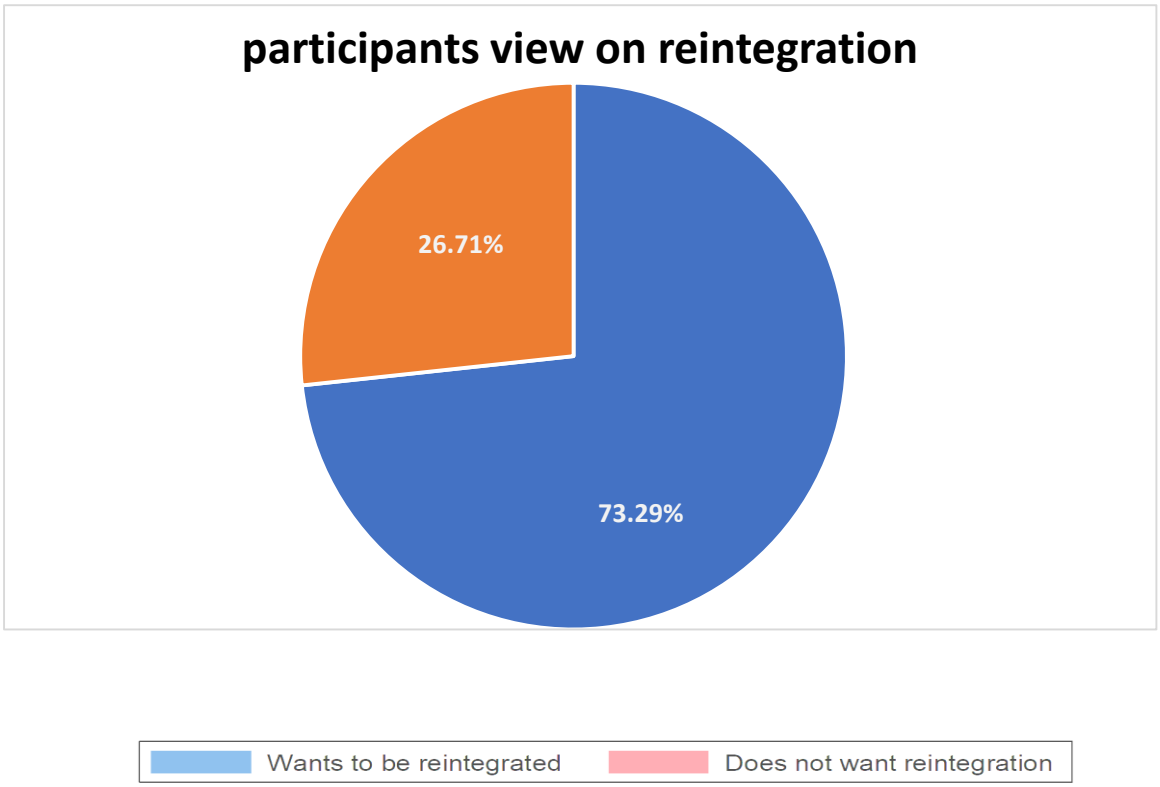


Figure 7: Participants Views of Reintegration, 2021

All participants of qualitative interviews including camp caretakers unanimously called for the closing down of the alleged witches' camps. Some interviewees revealed a collaboration between the local authorities (chiefs) and the local government institutions to ensure the human rights of the people were protected when they are reintegrated into their community of origin. Two interviewees revealed:

> "The camps should be closed down....it is important to put in place interventions to ensure that the human rights of the women are protected before reintegration" (Police Officer, DOVVSU).

> "The chiefs with support from the district assemblies and the government can collaborate to close down the camps but this would require putting in place measures to protect their human rights and lynching" (Social Welfare worker).

The reasons adduced for proposing the abolition of the camps were that all of those accused were innocent; the camps results in stigmatization and poor and inadequate facilities at the alleged witches' camps. In addition, some interviewees opined those women living in the alleged witches' camps experience loneliness and isolation, and the traditional way of adjudication and banishment violate their human rights.one interviewee shared his views on this as follows:

> "The problems in the camps are many-poor infrastructure, isolation, abuse of human right. In my opinion, the camps should be closed down" (Assemblyman)

The lack of economic opportunities at the alleged witches camp accentuates the poverty level of people resident in those camps. This was cited as one of the reasons the camps should be abolished as follows:

> "There should be in place laws to send these alleged witches back to their communities whilst protecting their lives at the same time. I strongly believe in the reintegration of these witches back into their communities because in this camp there is no means of any economic activity through which they can earn a living. Even the men in this camp have no access to farmlands on which they can farm to feed themselves and so they are suffering in this camp" (Caretaker of camp)

In suggesting ways to reintegrate the alleged witches, the alleged witches suggested sending them back to their community of origin, improving the conditions at the camps to make them more habitable or convert them to residential area, and relocating them to different communities (Figure 8).

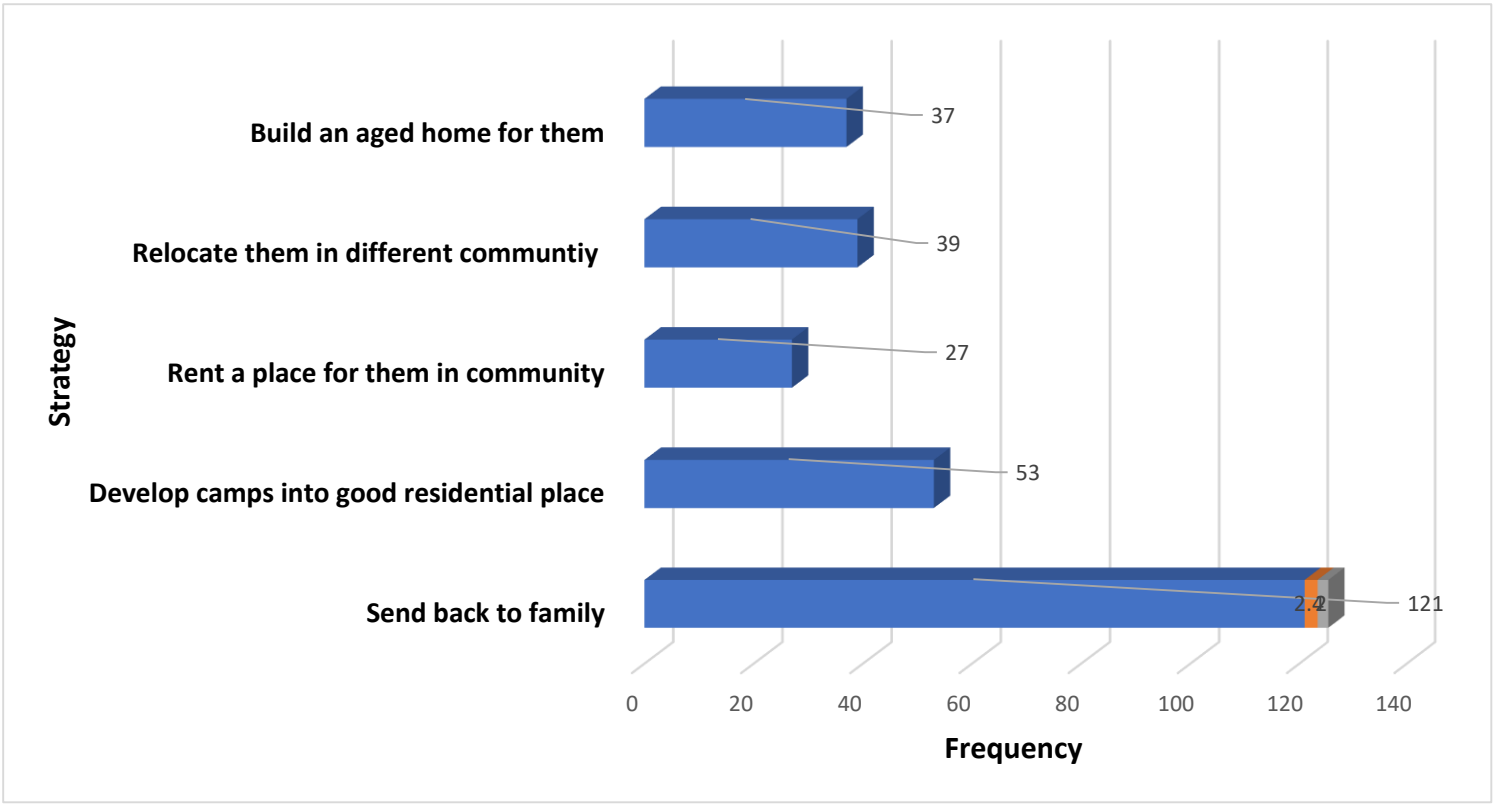


Figure 8: Strategies of Reintegration, 2021

In addition, interviewees suggested intense education of communities in the northern and north east regions on their sociocultural beliefs. This education according to interviewees, should be done with support from traditional authorities. One interviewee shared his views on the approach to health education as follows:

> "And then I believe that the education and community sensitization can be done strategically in the sense that you should execute the awareness creation using the local structure such as; traditional authority, religious authority, opinion leaders, and the youth structures since the belief has its roots in culture" (Chief of Town with Alleged Witches camp)

Interviewees also suggested good collaboration between civil society organizations, local authorities and national commission for civic education (NCCE) and information service department as follows:

> "More advocacy and more education are required, NCCE, civic society organizations that champion the right of women and gender issues to lead this process" (Interviewee, NCCE)

Some interviewees shared their experience where in the past some alleged witches were successfully reintegrated and accepted by communities and families as follows:

> "In the past that was done, and the engagements were fruitful and some of the family members of those victims in the camps were engaged thoroughly and we made them to appreciate the fact that these are just myths that are causing harm to these innocent people. Most of the family members agreed to get their people re-

> integrated. Some of them did it and the women were brought back. Even though the women had the fear that they may be lynched. But those that were re-integrated were not lynched after all" (Human rights lawyer)

Some interviewees described some alleged witches were successfully reintegrated in 2019. Through collaboration between community opinion leaders, chiefs, nongovernmental organizations (ActionAid and Songtaba Ghana) and the commission for human rights and administrative justice, the alleged witches' camp in Nabuli, a community in the Gushegu municipality was closed, reintegrating about 45 alleged witches. An interview shared her views as follows:

> "Reintegration the alleged witches involve intense community sensitization, education and collaboration with traditional leaders and government institutions. It takes a lot of time to achieve but this was successfully done in 2019" (Interviewee, CHRAJ)

The role of local authorities in the reintegration is indispensable. For example, in Dalong community, people who are accused of witchcraft are accepted into the community and given land to put up their own building. An opinion leader shared how that is done in an interview:

> "When they are banished from their communities and they come, I ask the alleged witches for their trusted family members. Then I get a room for the women and a plot for them to prepare and build a house or a room in their family member house in the community" (Assemblyman)

In the interim, there were suggestions that the district assemblies should pay attention to the health and resource needs of the residents in the camps. This according to interviewees could be achieve through the allocation of a percentage of the district assembly common fund to developing the camps as well as meet the financial needs of the residents. Some interviewees shared their views as follows:

> "The camps are neglected by the district assemblies; I will suggest the allocation of some common of places districts where these camps are located to help develop the camp. I am sure if the camps are well resourced with social amenities, the community to move to the camps and reintegration would happen naturally" (Interviewee, MGCSP)

> "So, what can be done in the perspective of the government is that the victims should fully be included in the safety-net of the social protection system that is currently implemented by the government such as the livelihood empowerment program as well as special recognition in district assembly common fund as being done for people with disability" (Interviewee, CHRAJ)

> "Government should provide hospital, good drinking water, toilets, and school for children and grandchildren in the camps" (Interviewee, NCCE)

Although the residents of the alleged witches' camps are supposed to be included as beneficiaries of the Livelihood Empowerment Against Poverty (LEAP), many of them are facing challenges accessing this social protection intervention. In Addition, interviewees also suggested inclusion of the alleged witches as beneficiaries of the 3% allocation of district assembly common for people with disability. Increasing the 3% to about 5% would be helpful to support the material and feeding needs of the alleged witches. One interviewee suggested as follows:

> "We need to advocate for the alleged witches to benefit from the 3% disability fund that goes to the districts. These people have some form of disability and mental conditions as well. So, they quality according to the law governing the common fund" (Interviewee, District Assemble Worker)

Another way to improve the welfare of the women is to provide them with capital to engage in trading. This was suggested as a way of reducing the poverty and improve their wellbeing as follows:

> "Some of them are still active to the extent that they can still engage in trade. So, if there is capital support for these women they can engage in trading in the local market, and you would be surprise some of them can even make money to the extent that they can even rent rooms where they could move back to society" (Human rights lawyer).

On issues of protecting the human rights of people accused of witchcraft, interviewees were of the view that local authorities should work with the law enforcement agencies such as the police, commission on human rights and administrative justice (CHRAJ) and the courts. People who are accused should be allowed access to the law courts and not confined to traditional (customary) trial system that exist in the communities. Some interviewees noted:

> "…the leaders must ensure that matters or allegations of witchcraft are subjected to due processes of the law. In the laws of Ghana, accuse persons remains innocent until proven guilty or plead to guilt, but that the process must be devoid of duress and undue influence, and complies with the rules of natural justice" (Interviewee, CHRAJ)

> "I think that the laws are already available and what is left is enforcement. We need action from government to put a stop to this. As a country, why do we have to allow the so-called witches camps to even exist in the first place? The enforcement of the law to disband witches' camps is long overdue. The stakeholders in our society should be seen actively engaging to put an end to the unlawful subjection of the victims to such persecution" (Police Officer, DOVVSU)

Interviewees emphasized that if the human rights of people accused of witchcraft are not protected, reintegration could be compromised. One interviewee suggested:

> "My observation is that most women accused of witchcraft are poor if not elderly so in order to ensure effective reintegration, the women should be empowered economically. Moreover, I said earlier that the government in collaboration with the chiefs should always ensure that the lives of these women are protected. It is only when these women feel their lives will be protected that they would go back to their communities" (Assemblyman)

Sometimes, alleged witches report to state institutions such as police service, CHRAJ, however, the trial of accusers and abusers take so long. As a result of the long adjudication, the alleged witches tend become frustrated and abandon the process. Two interviewees shared their experience as following:

> "…when the human rights of the women are abused, and is reported, the delays in investigation and the justice system make it frustrating…we need to put in place measure to expedite the process. In my view creating special courts in places where witchcraft allegations are common would help reduce the delays" (Human rights lawyer)

> "We have had a number of cases reported to the police, however sometimes it is difficult to investigate. You are unable to tell who abused the alleged witch…the people after beating the alleged witch abscond from the community and nobody would disclose the identity of the accusers since it is often a community action" (Police Officer, DOVVSU)

Furthermore, interviewees mentioned the lack of political willing as one of the challenges previous reintegration attempts faced. Another barrier is the opposition from the caretakers of the alleged witches' camps. The caretakers of the alleged witches' camps rely on donations and use the women as farm labour. As a result, there is the need to find an alternative livelihood for caretakers when planning to abolish the alleged witches' camps. Two interviewees explained as follows:

> "The caretakers of the camps rely on the services provided by the alleged witches and donations. So, it is source of labour and livelihood. So, some caretakers do that support the closing down of the camps" (Interviewee, CHRAJ)

> "There is lack of political will among our politicians. So, we need to get them (politicians) committed to the process of closing down the alleged witches camp" (interviewee, social welfare officer)

Nonetheless, caretakers in the current study expressed support for the abolition of the alleged witches' camps.

Chapter Five

Discussion

5.1 Depression among People Accused of Witchcraft

Using a cutoff of ≥10, the prevalence of depression among the participants is 52.7%. In terms of severity of the depression, 23.5% had mild depression, 37.3% had moderate depression, 7.2% had moderately severe depression whilst 2.9% had severe depression. The high prevalence of depression among people accused of witchcraft and living in these designated witches' camps may be due to multiple factors. Firstly, the psychological trauma that comes with this accusation and banishment makes adjustment difficult. For some people having experienced near lynching without any psychological support prior to being admitted to the camp leaves these women with chronic psychological distress. Marginalization, isolation and living in a deplorable condition has been reported to increase the risk of depression[72]. The camps are made up of small mud huts or compounds with thatch roofs and lack social amenities. A typical living compound in the camp is occupied by a minimum of one and as many as four accused witches. The lack of social amenities and poor nature of their living condition, the inability of residents to cater for the daily needs are all triggers of psychosocial distress and precursors for mental health conditions such as depression[73.]

Mental health conditions could make an individual behave in ways akin to beliefs about characteristics of an alleged witch. In many instances, depression may be treated as a consequence of witchcraft accusation and banishment. Nonetheless, mental disorders such as depression could also make an individual to behave in ways that may lead to witchcraft accusation. In particular, some societies hold the belief that people with mental health conditions and disabilities have been cursed. In Sierra Leone for example, local explanatory models for child and adolescent mental health problems are mostly spiritual and may include involvement in witchcraft[74]. A study in Nigeria reported that majority (72%) of caregivers of people with mental conditions indicated mental illness had supernatural causes [75.] In Ghana Yaro et al., in a study in three regions-Northern, Brong Ahafo and Central reported that the belief that mental health conditions could be caused by spiritual factors and a curse was common[76]. Given the wide access to mental services (treatment) gap in Ghana, it is therefore possible that some of these women could have been accused because

72 WHO, "Risks to Mental Health: An Overview of Vulneranilities and Risk Factors."

73 Yang et al., "The Effects of Psychological Stress on Depression."

74 Yoder et al., "Child Mental Health in Sierra Leone: A Survey and Exploratory Qualitative Study."

75 Igberase and Okogbenin, "Beliefs about the Cause of Schizophrenia among Caregivers in Midwestern Nigeria."

76 Yaro et al., "Stakeholders ' Perspectives about the Impact of Training and Sensitization of Traditional and Spiritual Healers on Mental Health and Illness : A Qualitative Evaluation in Ghana."

they had underlying mental conditions. Mental health conditions are also common among the elderly or aged, a critical population for witchcraft accusation.

In this study, more of the alleged witches are females (49.4%) and males (16.79%) had depression and the differences is statistically significant (X^2=7.24, p=0.007). Other variables that had statistically significant association with depression are never been married (p=0.001), widowed or separated (p=0.004) and not having biological children (p=0.004). Majority of people accused of witchcraft are women with advanced age and in their menopausal period. Generally, women also experience specific forms of depression-related illness, including premenstrual dysphoric disorder, postpartum depression and postmenopausal depression that are associated with changes in ovarian hormones and could contribute to the increased prevalence in women[77]. In addition, earlier studies have reported higher prevalence of depression among widowed and separated women. Widowhood and divorce are significantly distressing events in the life of an individual, with associated psychological ramifications. Generally, women are more likely than men to be widowed for two reasons. First, women live longer than men as highlighted by worldwide data regarding differences in life expectancies of men and women. In addition, women tend to marry older men in Ghana, although this gap has been narrowing. Because women live longer and marry older men, their odds of being widowed are much greater than men[78]. The psychological stresses that come with widowhood are further compounded among women owing to particular social and cultural aspects, which lead to increased feelings of guilt, remorse and aloofness. This underscores the need to improve social support for widows. Availability and access to self-help groups to assist with emotional management during widowhood has been reported to improve mental wellbeing and reduces risk of mental disorders such as depression. This can help counter loneliness and promote the survivor's reintegration into society[79].

5.2 Health-related Quality of Life of People Accused of Witchcraft

The overall QOL was computed using the four domains of the WHOQOL, with minimum score of 24 and maximum score 120. The average score for this study was 53.3 which is classified as low QOL. The findings show that more than 90% of the participants have low or extremely low quality of life across all the four domains- physical, psychological, social and environment- (88% had low QOL and 8.6% has extremely low QOL). None have high or excellent quality of life. The health-related quality of life of individuals living in poverty is lower than that of the general population, and the mental health dimension is most affected by poverty among

77 Albert, "Why Is Depression More Prevalent in Women?"

78 Lee et al., "Gender Differences in the Depressive Effect of Widowhood in Later Life."

79 Kanacki, Jones, and Galbraith, "Social Support and Depression in Widows and Widowers."

respondents who are middle-aged[80]. There is therefore an urgent need to develop strategies to alleviate the poverty level among the people resident in the alleged witches camps. Health creates wealth and is one of the key contributors to Sustainable Development Goals, especially for poverty reduction and the promotion of health and wellbeing.

Some of these people in the camps are still active and could be supported with financial resources to engage trading. Participant in this study have suggested novel ways of providing resources to the residents of these camp such as budgetary allocation from district assemblies common fund as is currently be done for people with disability. The inclusion of the alleged witches in the 3% disability fund portion of the district assembly common fund could potentially improve their livelihood. Again, economic empowerment of these people would not only improve their quality of life but reduce mental disorders as well. Poverty and income inequality also induce poor mental health via multiple material and psychosocial channels[81].

Furthermore, ensuring the alleged witches have access to the Livelihood Empowerment Against Poverty (LEAP) cash transfer system is critical in improving the quality of life. Although, the alleged witches qualify as beneficiaries, majority indicated they had not received this social welfare scheme and did not have the LEAP cards. This underscores the need for district assemblies and the social welfare department to ensure that women in those alleged witches camps receive their LEAP cards and benefit from this social welfare system. The LEAP Programme provides conditional cash transfers to the extreme poor with no alternative means of meeting their subsistence needs. To this end, unconditional grants are also provided to individuals with no productive capacity e.g., the elderly poor, persons with severe disabilities. Enrolling the allege witches into the LEAP scheme can invariably affect their grandchildren who are their caretakers. One of the conditions of the LEAP beneficiaries is a commitment to enrol and retain all school going age children in the household in public basic schools. Furthermore, LEAP is integrated with other social protection policies such as the National Health Insurance Scheme (NHIS). This provision allows older persons aged 65 years and above who are registered on the LEAP cash transfer programme an exemption from the payment of registration fees as premiums to access health services under the NHIS.

5.3 Addressing Gender Dynamics in Witchcraft Accusation

Clearly from this study, witchcraft accusation has gender dimensions. The workings of patriarchy, defined as historically specific ways of organizing and exercising political, legal, social, economic, and cultural power, which privilege men over women, and that has shaped witchcraft belief and processes of accusation. In Ghana, as in most societies of Sub-Saharan Africa, the belief in witchcraft

80 Li and Zhang, "Poverty and Health-Related Quality of Life: A Cross-Sectional Study in Rural China."
81 Hanandita and Tampubolon, "Does Poverty Reduce Mental Health? An Instrumental Variable Analysis."; Adler and Newman, "Socioeconomic Disparities in Health: Pathways and Policies."

accusations is pervasive and the powers possessed by the alleged witches could be used to cause a good or bad outcomes. However, according to Adinkra[82], the prevailing view about witchcraft is more negative and highly gendered. All unfortunate occurrences that are not easily explicable may be attributed to witchcraft [83]. In southern Ghana, witchcraft accusations often result in the victims being taken through some religious or cultural rituals to "deliver" or to "cleanse" them from the negative forces. The alleged witches can live within their communities once these purification acts have been conducted[84]. By contrast, in northern Ghana, alleged witches are displaced from their communities to live in designated "witch camps" and are mostly women because socio-cultural beliefs and marginalization of women in decision making.

In this economic explanation of accusation, older women, who were often widows, were more vulnerable because they were most likely to be poor and dependent on neighbourly assistance. These makes these women fit into the sociocultural perception of qualities of witches. Broadly, the classic stereotype of witches as women who are old, lame, pale, and full of wrinkles[85]. And even when men faced allegations of witchcraft, it is typically because they were somehow associated with accused women. These findings are similar to studies conducted in other parts of the world where females are mostly blamed for witchcraft. In Nigeria, it has been reported that females especially elderly women are more to be accused of witchcraft[86]. Similar findings have been reported in Gambia and Tanzania[87]. On a whole, elderly women were more likely to be accused if they lived alone or enjoyed longevity because of the suspicion in such cases that they had obtained a new soul by devouring that of a child[88].

Furthermore, state institutions have s critical role to play on protecting the human rights of people accused of witchcraft. Sometimes, the alleged witches petition the police with the hope that they could intervene either by arresting the accusers, mediating in the cases, or helping prosecute the accusing parties. In addition, lodging of complains with the state human rights agency, Commission for Human Rights and Administrative Justice (CHRAJ), expecting them to assist in the restoring their human rights. Nevertheless, the procedure in investigation and challenges in identifying the accusers and those who abused the human rights of the accuse have

82 Adinkrah, Witchcraft*, Witches and Violence in Ghana*.

83 Quarmyne, "Witchcraft: A Human Rights Conflict Between Customary/Traditional Laws and the Legal Protection of Women in Contemporary Sub-Saharan Africa."

84 Agyepong, "Pastoral and Theological Responses To The Effects Of Witchcraft Beliefs In Ghana."

85 Nukunya, *Tradition and Change*.

86 Okonkwo et al., "Gender Disparities in Witchcraft Beliefs: A Challenge to Nigerian and African Historiography."

87 Mesaki, "Witchcraft and the Law in Tanzania."

88 Tabong and Adongo, "Understanding the Social Meaning of Infertility and Childbearing: A Qualitative Study of the Perception of Childbearing and Childlessness in Northern Ghana."

often undermined the process. The state encounters witchcraft-related violence most publicly and probably most frequently through the CHRAJ. CHRAJ has the power to use court actions to enforce their resolutions on noncompliant parties. Like the police institution, CHRAJ intervenes in cases related to witchcraft accusation in cases where there are willing complainants (individuals who lodge formal complains). However, willing complainants may not immediately go to these institutions because sometimes they do not know that they exist or where their offices are located or they do not know how they operate. On a whole accused persons often contact the civil society organizations (CSOs) to assist them in filing their complaints and in taking other measures to neutralize the accusations.

In addition, the Domestic Violence and Victim Support Unit (DOVSSU) of the police service deals with cases related to witchcraft because crimes are often committed in the course of witchcraft allegation. DOVVSU investigates complaints of witchcraft accusation to establish if a crime has been committed and then prosecute the suspects. However, it is not all cases that are reported to DOVVSU that are charged to court. Though, DOVVSU is a state institution, it also works with chiefs to resolve cases of accusations through mediation. The agency compels accusers to abandon accusation, allow the accused to return to their communities or initiates prosecution. However, it is not all police interventions that lead to the neutralization of accusations. As Ghana is also signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the country would have to remain committed to take concrete steps to eliminate all forms of discrimination against women in witchcraft accusations.

Furthermore, improving girl child education in the Northern and North east regions was suggested by participants in the study to address aspects of the gender dynamics of witchcraft. From the findings of this study, these women are largely uneducated, poor and widowed. Even though Ghana has made progress in girl child education, disparities exist in the country and negatively skewed toward the northern part of Ghana[89]. More advocacy is required to address sociocultural barriers to girl child education. When more women in the northern part of the country become educated and economically empowered, it would reduce the tendency of them being accused as witches. Historically and in contemporary times, the majority of accused victims have been vulnerable women, who are aged, uneducated, widowed or divorced, and of lower socioeconomic status[90].

On a whole, it is as a result of gendered relations, not witchcraft, that women may be more vulnerable to witchcraft-related violence in the form of accusations than men. While the gendered character of accusations in some societies is an important characteristic of witchcraft-related violence, it is not a defining one. When witchcraft

89 NDPC/UN, "Ghana Millennium Development Goals, 2015 Report"; GSS, "Ghana Living Standards Survey (Round 7)."

90 Mutaru, "An Anthropological Study of 'Witch Camps' and Human Rights in Northern Ghana."

is understood as causing harm to another through supernatural means, there is no specific or inherent gender dimension therein.

5.4 Abolition of Witches Camps and Community Reintegration

In this study, majority (73%) of the participants wanted to be reintegrated into the community. However, concerns were raised about acceptance by community members and safety. In the wake of accusations and ensuing threats of violence, women accused of being witches were afraid of relocating back to their community of origin. It should, however, be noted that although there are no specific laws that explicitly address the problem of witchcraft in Ghana, the 1992 Constitution of the Republic of Ghana articulates sincere commitment on the part of government towards the protection of women's rights, including the prohibition of any cultural practices which undermine the dignity and violate the fundamental rights of women. Enforcement of the law is needed to address the deeper systemic issues of poverty and abuse, before reintegration. The findings of this study are however different from earlier research conducted in 2010 by the National Commission for Civic Education (NCCE) where 68.7% did not want to go back home for fear of their lives. In the study by NCCE, 61% of community members revealed they were unwilling to accept the alleged witches in their community[91]. Lynching of alleged witches in the community is very common in the media Ghana. The government of Ghana officially condemns the existence of the alleged witches' camps but rarely addresses the issue of witchcraft beliefs or violence directly. This approach highlights the conflict between the human rights of the accused and the criminal nature of the offences, and the state's obligation to respect, as well as the difficulty in dealing with cultural practices. The legal system is slow and protracted in responding to such violence. Criminalizing of witchcraft accusation presents the most potential for mediating and reducing witchcraft-related violence in Ghana.

The increasing life expectancy in Ghana has resulted in a demographic transition with many aged people in the community especially women. The national ageing policy which was first developed in 2003 and revised in July 2010, acknowledges the increasing number of older persons and the implications on health, and social services. This policy gives full recognition to fundamental human rights including the right to independence, active participation in society, benefit from community support and care, self-fulfillment in pursuit of educational and other opportunities and dignity, and security. The existence of these alleged witches' camps will enable the youth and community members to accuse people especially women of witchcraft unless outlawed and criminalized in the country. Nevertheless, community sensitization and advocacy are required to prepare communities before the abolition of the camps. Districts with these camps can enact bye-laws to protect the human rights of women. CSOs can advocate for the criminalization of this sociocultural practice. In doing this,

91 NCCE, "Witchcraft and Human Rights of Women in Ghana: Case Study of Witches Villages in Northern Ghana."

it is important to involve political leaders both at the local and national level. Experiences of reintegration efforts in the past should guide the process. The aged people have acquired a wealth of experience which could harness for national development after reintegration.

Furthermore, the country has policies and legislations that have made considerable provisions on gender equality and social inclusion. For example, the national Social Protection Policy recognised the need to protect people against vulnerability and poverty[92]. The national gender policy also makes provision to protect the human rights of vulnerable people, especially women. These policies drive their power from provisions in the 1992 constitution which grants access of all people resident in Ghana to all public facilities and services; respect for fundamental human rights and freedoms; and the prohibition of discrimination and prejudice on grounds of place of origin, birth circumstances, ethnic origin, gender, religion, creed and other beliefs. However, implementation of the provisions has been a challenge. This provides opportunity for advocacy by civil society organisation. It is commonly acknowledged in Ghana that politicians and civil servants are not exempt from this temptation of witchcraft accusation[93] and as such the lack of political will to abolish the camps. Ghana has been without an explicit legal framework that addresses the problem of witchcraft since its independence in 1957. This perhaps also explains why deliberations on witchcraft have been largely absent at government corridors and has received less attention. This underscores the urgent need for promulgation of a legislation that would outlaw and criminalize witchcraft allegation, human rights abuses and banishment.

92 The Ministry of Manpower Youth and Employment, "The National Social Protection Policy: Investing in People."

93 Ellis and Ter Haar, *Worlds of Power: Religious Thought and Political Practice in Africa*.

Chapter Six

Summary, Conclusion and Recommendations

6.1 Summary

This formative research was undertaken to determine the prevalence of depression among people accused of witchcraft and explore the gender dynamics in the accusation of witchcraft in northern and north east regions in Ghana. A concurrent mixed quantitative-qualitative methodology was employed. Using the listing of people in the four camps in Nanumba South, Yendi Municipal, Gushegu and East Mampusi Municipality in Ghana, two hundred and seventy-seven (277) people accused of witchcraft were interviewed using structured questionnaire designed in open data collection kit (ODK) software. In addition, eighteen (18) community, district, regional and national level stakeholders were purposively selected for an in-depth interview. The quantitative data was analyzed using STATA 16 whilst NVivo 13 software was used for coding the interview transcripts. Data triangulation techniques was used to merge the quantitative and qualitative data. The findings of the study include:

1. The prevalence of depression among the participants is high (52.7%). In terms of severity of the depression, 23.5% had mild depression, 37.2% had moderate depression, 7.2% had moderately severe depression whilst 2.9% had severe depression.
2. The sociodemographic factors that are associated with depression include gender (p=0.007), marital status (p=0.001), widowed or separated (p=0.004) and not having biological children (p=0.004).
3. Over 97% of alleged witches have low or extremely low quality of life. None have high or excellent quality of life.
4. About 8.6% had extremely low QOL whilst only 2.5% had moderate QOL. No participant belonged to relatively high QOL (score 87-101) and excellent QOL (≥102) respectively.
5. In this study, 177(66.5%) of the people accused of witchcraft are widows. Even when males are accused of witchcraft, they still live in the communities, neither maltreated nor banished.
6. Sociocultural practices, patriarchal nature of the society, lack of economic independence or opportunities, and poverty, skew witchcraft accusation towards females.
7. Majority of the participants (73.3%) indicated they wanted to be re-integrated and the closing down of the Witches camps; however, concerns were expressed about acceptance by communities of origin and safety
8. Collaboration between the local authorities (chiefs and opinion leaders and police) and the local government institutions is necessary to protect the human rights of the alleged Witches in the community and reintegration
9. Education, advocacy and enforcement of laws are required to protect the human rights of women accused of witchcraft.

6.2 Conclusions

In conclusion, majority of the women accused of witchcraft have low or extremely low quality of life with high depression. Female gender and marital status of divorced, widowed, or separated were strongly associated with depression. These two factors and quality of life synergistically contributed to depression. Although the belief in witchcraft is framed within a sociocultural context, the narrative within its practice is highly gendered with power relations, and gender agency playing a critical role. Men who are accused of witchcraft have the opportunity and power of negotiating and renegotiating their destinies and the varied outcomes of witchcraft accusations and are neither banished nor mistreated. Social norms dictate that women should not have magical powers and have no access to productive resources. The lack of resources works together with sociocultural beliefs about power to creates a fertile ground for women to be accused of witchcraft and banishment. Witchcraft accusation is therefore indicative of the marginal status of women and their subordination in societies in northern and north east regions of Ghana.

In addition, as a result of the lack of productive resources, poor living conditions and human right abuses that characterize the belief and practice of witchcraft, there is an urgent need to abolish the camps and reintegrate their residents back into their community of origin. This would however require community education, advocacy to demystify the practice of witchcraft.

6.3 Recommendations

The following are recommendations based on the findings of the research:

1. Ghana Health Service should expand mental health service and periodic screening for residents of the alleged witches camps as their living conditions and situation increases their risk of developing mental health conditions especially depression. Ghana Health Service could visit the camps with multidisciplinary teams for health screening and provision of other services;
2. The government and district assemblies should allocate funding towards improving the living conditions of the camps to make their more habitable or convert them into residential areas or relocate them to different communities. The current living conditions in the camps are deplorable and not fit for human habitation;
3. While the continued existence of the alleged witches indicates the prevalence of witchcraft accusations and the belief system(s), it is important for government to initiate processes that would lead to the abolition of these camps. This is important in order to realise the 2030 agenda of universal health coverage and sustainable development, that “leaves no one behind;
4. Intense community sensitization and education on witchcraft is required before abolition of the camps and reintegration of alleged witches. This presents an opportunity for civil society organizations and non-governmental organizations;

5. Sensitization and education of police service and government institutions involved in the human rights and social protection on witchcraft beliefs and practice should be done. This could be led by Songtaba and other non-governmental organizations;
6. The government should enact laws to criminalize witchcraft accusation to ensure that accusers are severely punished. This could be done through collaboration with human rights lawyers in Parliament through a private member's bill;
7. Civil Society Organizations (CSOs) should advocate for increase enrollment of girl child in the northern and north east regions of Ghana. Embedded in the dynamics in witchcraft accusation is high level of illiteracy and poverty among women;
8. There is the need further research on the causes of accusations, willingness of the communities to accept alleged witches to community and the challenges of reintegration.

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Appendix A: Data Collection Tool (Structured Questionnaire)

Ques No.	**Questions Response**	
Section 1 Demographics – Background information of patient		
101	Sex (Do not ask)	|___|
	1. Female	
	2. Male	
102	What is your age as at your last birthday? (in years)	|___|
	How long have been in this camp	
103	Have you ever been married	
	1. Yes	
	2. No	
104	What is your current marital status?	|___|
	1. Still Married	
	2. Divorced/ Separated	
	3. Widowed	
105	What is your religious denomination?	|___|
	1. Islam	
	2. Christianity	
	3. Traditional	
	4. No Religion	
106	What ethnic group do you belong to?	|___|
	1. Mole-Dagbani	
	2. Other	
107	How you have biological children?	
	1. Yes	
	2. No	
108	What is the se distribution of you children?	
	1. Male.....	
	2. Females.....	
109	Are your or some of your children still alive?	
	1. Yes	
	2. No	
110	How many of children are alive	
	1. Males.....	
	2. Females.....	
111	Do you have a health insurance card (inspect card to see if it is valid of not	
	1. Yes, card valid	|___|
	2. Yes, card expired	
	3. No	

Section 2 Socio-economic characteristics of patient		
201	What is your highest educational level attained?	|___|
	1. No education	
	2. Primary	
	3. Middle	
	4. JSS/JHS	
	5. Secondary/Vocational	
	6. SSS/SHS	
	7. Higher	
202	What is your employment status?	|___|
	1. Unemployed	
	2. Employed	
203	If employed, what is your occupation, that is, what kind of work do you mainly do?	|___|
205	What is your overall monthly income?	|___|

Depression PHQ Scale (301-308)

How often in the past 2 weeks were you bothered by	Not at all (0)	Several days (1)	More than half the days (2)	Nearly everyday (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				

	Poor appetite or overeating					
	Feeling bad about yourself, or that you are a failure, or have let yourself or your family down					
	Trouble concentrating on things					
	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.					

Section 3 Quality of life assessment		
General health		
401	Generally, how would you rate your quality of life?	|___|
	1. Very poor	
	2. Poor	
	3. Neither good nor poor	
	4. Good	
	5. Very good	
402	How satisfied are you with your health?	|___|

	1. Very dissatisfied	
	2. Dissatisfied	
	3. Neither dissatisfied nor satisfied	
	4. Satisfied	
	5. Very satisfied	
403	Why do you think you have this quality of health?	|___|
	01. I don't have money	
	02. Because of my condition	
	03. Cannot access healthcare services	
	04. Cannot afford medication	
	96. Others (Specify): …….....	|___|
Physical health/functioning		
404	Does physical pain prevents you from doing what you need to do?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
405	How much do you need medicines or any medical treatment to be able to go daily life about your duties in your	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
406	Do you have enough energy for everyday life?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
407	How satisfied are you with your sleep?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
408	How satisfied are you with your ability to perform your daily living activities?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	

	4. Very much	
	5. An extreme amount	
409	How satisfied are you with your capacity for work?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
410	Why do you think you have this level of physical health?	|___|
	01. I don't have money	
	02. Because of my condition	
	03. Cannot access healthcare services	
	04. Cannot afford medication	
	96. Others (Specify): …….....	|___|
Psychological functioning		
411	How much do you enjoy life?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
412	To what extent do you feel your life to be meaningful?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
413	How well are you able to concentrate?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
414	Are you able to accept your bodily appearance?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
415	How satisfied are you with yourself?	|___|
	1. Not at all	
	2. A little	

	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
416	How often do you have negative feelings such as bad mood, despair, anxiety, depression?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
417	Why do you think you have this level of psychological functioning?	|___|
	01. I don't have money	
	02. Because of my condition	
	03. Cannot access healthcare services	
	04. Cannot afford medication	
	96. Others (Specify): …….....	|___|
Social relationships		
418	How satisfied are you with your relationships with family, friends etc?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
419	How satisfied are you with your sex life?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
420	How satisfied are with the emotional and financial support you get from your friends?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
421	Why do you think you have this level of social relationships?	|___|
	01. I don't have money	
	02. Because of my condition	
	03. Cannot access healthcare services	
	96. Others (Specify): …….....	|___|
Environment		

423	How safe do you feel in your daily life?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	|___|
424	How healthy is your physical environment?	
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
425	Have you enough money to meet your needs?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
426	How available to you is the information that you need in your daily-to-day life?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
427	To what extent do you have the opportunity for leisure activities?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
428	How satisfied are you with the condition of your living place?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
429	How satisfied are you with your access to health services?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	

	5. An extreme amount	
430	How satisfied are you with your transport?	|___|
	1. Not at all	
	2. A little	
	3. A moderate amount	
	4. Very much	
	5. An extreme amount	
Views on re-integration		
511	Would you like to be re-integrated into community	
	1. Yes	
	2. No	|___|
512	What is the best strategy for you to re-integrated	
	1. Send me back to my family	
	2. Develop the camp to become more residential	
	3. Rent a place in the community for me	
	4. Send me to different community	|___|
	5. Build an aged home for people who are banished from community	

Appendix B: Data Collection Tool (In-depth Interview Guide)
FORMATIVE RESEARCH TO DETERMINE THE PREVALENCE OF DEPRESSION AND UNDERSTAND THE GENDER DIMENSIONS OF WOMEN ACCUSED OF WITCHCRAFT IN NORTHERN AND NORTH EAST REGIONS OF GHANA"

a. ***Name of interviewer:*** _____
b. ***Date:***_____
c. ***Time interview started:*** _____***Time ended:***_____
d. ***Demographic Data to be completed on a separate sheet (Age, Sex, Marital status, Number of Wives, Number of children, Educational level, professional background, how long they lived in this community, etc.)***

Let's go ahead and get started. My name is _____ Today I would like to have a conversation with you all. We are very interested in learning about how to protect the human right, health and wellbeing of vulnerable women accused of witchcraft and banished from the community to live in special camps. I will only share the information I learn today in a general way that does not reveal the identity. With your permission, I would be recording our conversation. There are no right or wrong answers.

Do you have any questions before I begin?

Ice breaker

Kindly share with me what you know about Witchcraft in Ghana.

1. ***Knowledge and Experiences of Witchcraft in Communities***
    a. Please tell me about what you know about issues concerning witchcraft in Northern and North East Region of Ghana
    b. What socio-cultural factors influence the practice of witchcraft?

2. **Gender dimension of witchcraft**
    a. Why do you think women are mostly accused of witchcraft?
    b. What societal factors results in the differential in how men and women are treated when it comes to witchcraft allegations?
    c. In your opinion, what can be done to reduce community members accusing women as being witches?
3. **Human right protection**
    a. What can be done in Ghana to protect the human rights of women accused of witchcraft
    b. How can women accused of witchcraft be protected against stigmatization and discrimination?

c. What can government do to protect the health and wellbeing of women accused of witchcraft and banished from communities

4. **Re-integration Strategy**
    a. In your opinion, what can be done to re-integration women accused of witchcraft into community
    b. What specific intervention can help ensure a sustainable re-integration plan
5. **District assembly support**
    a. What can the district assembly do to support women at the witches' camp
        i. Probe on budgetary allocations
        ii. Probe on district assembly common fund
    b. What support do witches camps get from the district assemblies

Closing: Are there any other things you will like to share with us regarding witchcraft and gender dimensions of it in Ghana?

THANK YOU FOR YOUR TIME!!!

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

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My Ref. GHS/RDD/ERC/Admin/App 121/516
Your Ref. No.

22nd November, 2021

Dr. Philip Teg-Nefaah Tabong
Department of Social and Behavioural Sciences,
School of Public Health, Post Office Box LG 13,
College of Health Sciences,
University of Ghana, Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your StudyProtocol.

GHS-ERC Number	**GHS-ERC 014/09/21**
Study Title	Formative Research to Determine the Prevalence of Depression and Understand the Gender Dimensions of Women Accused of Witchcraft Northern and Northeast Regionsof Ghana
Approval Date	22nd N ovember,2021
Expiry Date	21st November ,2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.. ..... Bannerman .....
Dr. Cynthia Bannerman
(GHS ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra