

**ENSIGN GLOBAL UNIVERSITY,
KPONG, EASTERN REGION, GHANA**

**FACULTY OF PUBLIC HEALTH
DEPARTMENT OF COMMUNITY HEALTH**

**THE ROLE OF HEALTH PROFESSIONALS IN THE COMBAT AGAINST HUMAN
TRAFFICKING: PERSPECTIVES FROM THE ADA EAST AND WEST
DISTRICTS IN GHANA**

BY

**Esther Adinorkie Lawerteh
(257100339)**

JUNE 2026

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**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH, FACULTY
OF PUBLIC HEALTH, ENSIGN GLOBAL COLLEGE IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE MASTER OF PUBLIC HEALTH DEGREE**

JUNE 2026

DECLARATION

I, **Esther Adinorkie Lawerteh**, do hereby declare that, except for cited literature, which is acknowledged, this thesis is the result of my own original research under the supervision of Dr. Alberta Teye Agudey. This work has neither in part nor in whole been presented elsewhere for any other purpose.

Esther Adinorkie Lawerteh		14-07 2026
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(Student)	Signature	Date
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257100339

Certified by:

Dr. Alberta Teye Agudey		2/07/2026
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(Supervisor)	Signature	Date
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Certified by:

Prof. Stephen Manortey		
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(Head of Academic Program)	Signature	Date
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DEDICATION

This work is dedicated to the glory of God Almighty, the one who made it possible for this program

Secondly, to my father, Mr. Ernest Narteh Lawerteh, my number one cheerleader, for his loving support and sacrifices

ACKNOWLEDGEMENT

I acknowledge the support received from faculty and staff at Ensign Global University.

My sincere gratitude to my father and siblings, especially David Tetteh Lawerteh, for the love, immense support, prayers, and care.

Not forgetting the man and uncle who continually hold my hand on every rung of the educational ladder, Reverend Samuel Buernor Lawerteh, retired. Thank you, my second father

Appreciation is also to my friends and colleagues, especially Mr. Samuel Ojo, for the support received from your end, too

I hereby acknowledge all facilities and staff in the Ada East and West districts, not forgetting their directors, for their support

Finally, I am indeed grateful to my indefatigable Supervisor, Dr. Alberta Teye Agudey, for her invaluable, meticulous, and immense contributions to this work.

LIST OF ABBREVIATIONS

AHT	Anti-Human Trafficking
ALX	African Leadership Group
BECE	Basic Education Certificate Examination
CAWI	Computer-Assisted Web Interview
CDC	Centers for Disease Control and Prevention
CHPS	Community-based Health Planning and Services
CHRAJ	Commission on Human Rights and Administrative Justice
CI	Confidence Interval
CMS	Combatting Modern Slavery
CV	Curriculum Vitae
DHIMS	District Health Information Management System
DOVVSU	Domestic Violence and Victim Support Unit
EPA	Environmental Protection Agency
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
HT	Human Trafficking
IJM	International Justice Mission
ILO	International Labor Organization
IOM	International Organization for Migration
IRB	Institutional Review Board
MA	Master of Arts

MoGCSP	Ministry of Gender, Children and Social Protection
MPH	Master of Public Health
NGO	Non-Governmental Organization
OR	Odds Ratio
PTSD	Post-Traumatic Stress Disorder
SEM	Socio-Ecological Model
SPSS	Statistical Package for the Social Sciences
STATA	Statistics and Data
STI	Sexually Transmitted Infection
TIP	Trafficking in Persons
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
VRF	Volta Resilient Foundation
WAD	Women in Democracy
WASSCE	West African Senior School Certificate Examination
WHO	World Health Organization

ABSTRACT

Background: Human trafficking is a critical public health crisis in Ghana, yet the health sector's frontline role remains underutilized due to systemic preparedness gaps. This study examined the knowledge, perceptions, and operational challenges faced by health professionals in combating human trafficking in the Ada East and West Districts.

Methodology: Employing a mixed-method cross-sectional design guided by the socio-ecological model, quantitative data were collected from 356 health professionals via structured questionnaires, complemented by five expert key informant interviews.

Result: Results revealed near-universal awareness (97.8%), but significant disparities in knowledge of trafficking forms, operational readiness to detect, refer, and respond, and legal frameworks, with only 22.5% of respondents are familiar with Ghana's Anti-Human Trafficking Act (2005). 12.9% have received any formal training on the topic, and only 13.2% report that their facility has a written protocol for managing suspected cases. Eight in ten respondents (81.2%) anticipate facing challenges if asked to handle a trafficking case, citing lack of training (61%), limited referral knowledge (52%), and fear of retaliation (35%) as the dominant barriers.

Statistical testing confirms that formal training is the single strongest correlate of practice indicators measured: ability to identify signs ($\chi^2 = 15.7$, $p < 0.001$), confidence ($\chi^2 = 24.8$, $p < 0.001$), and case encounter ($\chi^2 = 51.5$, $p < 0.001$). Significant inequities exist by facility tier and by district, with Ada East workers reporting nearly four times the training rate of Ada West workers (17.7% vs 4.6%).

While 87.6% acknowledged their professional role, only 14.3% had encountered suspected victims. Prior training was significantly associated with victim identification ($\chi^2 = 15.74$, $df = 2$, $p = 0.001$). Over three-quarters anticipated challenges, primarily citing inadequate training, unclear referral pathways, institutional constraints, and fear of retaliation.

Qualitative findings highlighted structural misalignments, including survivor exclusion from the National Health Insurance Scheme, fragmented inter-agency coordination, and weak policy

enforcement. Participants advocated mandatory capacity building, survivor-centered care models, and integrated service delivery.

Conclusion: The study finds that while health professionals are willing to intervene, systemic barriers severely limit clinical readiness. Recommendations include institutionalizing trafficking screening into health curricula, reforming insurance coverage for survivors, standardizing referral protocols, and strengthening multi-sectoral coordination. These findings provide critical evidence base for transforming Ghana's health sector from a passive contact point into an active, accountable pillar of national anti-trafficking efforts.

Keywords: Human Trafficking; Public Health; Health Systems; Clinical Readiness; Ghana; Combat; Ada East; Ada West

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Human trafficking is a grave violation of human rights and a significant public health concern globally. It involves recruitment, transportation, transfer, harboring, or receipt of persons through force, fraud, or coercion for exploitation, including forced labor and sexual exploitation (UNODC, 2022). According to the International Labor Organization (ILO), over 27 million individuals were victims of human trafficking globally in 2021 (ILO, 2022). In Ghana, trafficking affects 1.8% of Ghana's population, with 60% being women and children exploited for labor/sex trafficking (UNODC 2022) and occurs both internally and across borders, with children and women being the most vulnerable (IOM, 2020). Healthcare plays a critical role in the fight against human trafficking, particularly in the areas of prevention, identification, support for survivors, and intersectoral collaboration. Victims often face numerous health challenges, including physical injuries, sexually transmitted infections (STIs), substance abuse, malnutrition, and long-term psychological trauma (Zimmerman & Kiss, 2017). Health impacts include physical trauma, HIV, and PTSD (Zimmerman *et al.* 2011). Health professionals are frequently the first point of contact for victims and are thus uniquely positioned to identify and support them (Recknor et al., 2022).

1.2 Problem Statement/Rationale

Despite the increasing health burden of human trafficking and the intersection of trafficking and health, Ghana's formal policies involving healthcare practitioners in anti-trafficking efforts, limit understanding and integration of anti-trafficking efforts in the health sector. Many health professionals are not adequately trained to identify or assist victims, and there are systemic barriers, such as lack of guidelines and institutional support, that inhibit their potential contribution

(Baldwin et al., 2011). Other structural gaps such as limited data sharing, lack of standardized identification protocols and poor inter-agency coordination further fragment the health sector's response (Okyere et al., 2020). This lack of preparedness reduces the health sector's ability to respond to the timely identification of victims, access to survivor-centered care, and ultimately undermines the overall effectiveness of Ghana's anti-trafficking framework to trafficking and the provision of comprehensive care for survivors. Workshops have started (for example, Ensign Global/Engage Now Africa, 2025), but they remain isolated events and not systemic reforms (Peprah, 2024; Graphic Online, 2025).

People who have been trafficked, especially youth, face intractable systemic, interpersonal, and institutional barriers to care, mistrust, illegal recruitment practices, lack of awareness and referrals, bias, and poor coordination across services (Oram et al., 2019). Extensive evidence also shows long-term physical and psychological effects among trafficked survivors in Ghana, such as PTSD, depression, somatic disorders, yet the continuum of care remains inadequate due to a lack of protocols and provider readiness (Clay Warner et al., 2021; unpublished local data). Ghana's Human Trafficking Act (2005/2017) has encouraged inter-agency collaboration, but critical implementation gaps include vague definitions, inadequate financial/logistical assistance, high staff attrition, and the absence of operational protocols or reporting tools in health facilities (Ampah & Kandilige, 2023). Most studies on trafficking in Ghana focus on law enforcement, victim reintegration, or social work. There is limited scholarly evidence on the role of health professionals in the fight against human trafficking (Amissah, 2019; Mohammed, 2022).

This study addresses a critical gap in Ghana's anti-trafficking framework by examining how health professionals in the Ada East and West Districts perceive, enact, and are constrained in their frontline roles. Despite the Human Trafficking Act, 2005 (Act 694) mandating health sector

involvement, empirical evidence on clinical capacity and systemic barriers remains limited. By mapping how health professionals see their role and challenges encountered in the fight against human trafficking, this research will add to the literature on anti-human trafficking. Not only that, but the findings from this study will also inform targeted training, strengthen cross-sectoral coordination, and support policy integration of trafficking identification and trauma-informed care into routine health services (WHO, 2013).

1.3 Conceptual Model / Framework

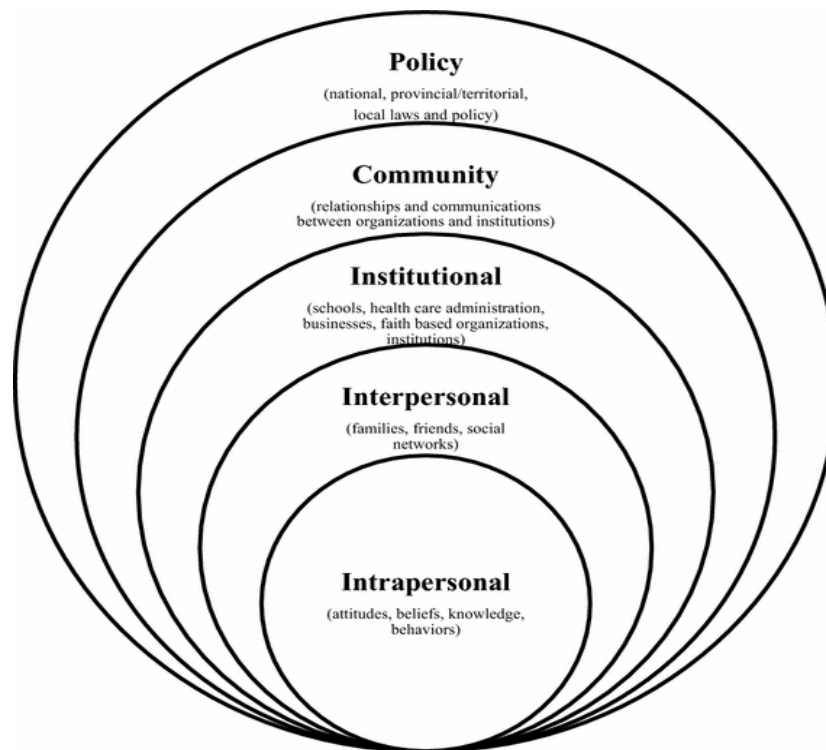


Figure 1.1: Conceptual Model / Framework

The socio-ecological model (SEM), developed by Urie Bronfenbrenner in the late 1970s, is a framework that explains how personal and environmental factors interact to influence human development (CDC,2022). The model consists of several nested levels, including the individual,

socio-cultural, socio-economic, structural, environmental, and political factors. Each level has a unique impact on human development, and changes in one level can affect other levels.

The individual level includes knowledge and skills about a subject. Socio-cultural refers to an individual's immediate environment, such as their family or school. The structural factor is the interaction between different sociocultural factors. The environmental factor is the external environment that indirectly affects an individual's growth, such as the community in which they live and work. The political factor is the broader cultural context of an individual's life, including policies in their geographic location.

In the context of the role of health professionals in the fight against human trafficking, the socio-ecological model explains how different factors at various levels can contribute to this fight. The model posits that individual behavior is influenced by interactions across various levels – individual, interpersonal, institutional, community, and policy. The hypothesis for this study is that a health professional's ability to combat human trafficking is significantly influenced by his/her knowledge, peer influence, institutional support, available policies, and intersectoral networks. Applying this model enables a systematic analysis of relationships between levels and their influence on the fight against human trafficking. It also identifies potential leverage points for intervention and policy development to improve upon the structural deficits and preparedness towards this cause in Ghana and provides a holistic approach to unravel the complexities of the role public health plays in the combat against human trafficking and its implications in the Ghanaian context.

The dependent variable for the quantitative analysis is the effectiveness of health professionals' role in combating human trafficking. This will be measured using indicators such as the frequency

of victim identification, referral accuracy, participation in rescue/reintegration, and the quality of care provided to survivors.

Table 1.1: The independent variables (factors hypothesized to influence the dependent variable) are presented in the table below.

Sn	Independent Variable	Measurement Indicators	Hypothesized Relationship
1.	Training and knowledge	Prior training received, awareness of trafficking indicators	For increased training, there will be more accurate identification of victims
2.	Resource availability	Access to trauma care tools, counseling rooms, and referral forms	Greater resource availability will lead to high-quality care
3.	Collaboration/partnership	Interaction with NGOs, police, and social workers	Stronger interagency collaboration will mean better referral and reintegration outcomes
4.	Work experience	Years of practice, previous experience with trafficking victims	More experience will also lead to increased confidence and efficiency in the trafficking response

5.	Institutional support	Policies, guidelines, protocols available	Better institutional support – improved consistency and outcome of care
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Conceptual framework design showing that each background characteristic of the health professionals in Ada East and West districts may directly influence the perceived role in the combat against human trafficking without mediation.

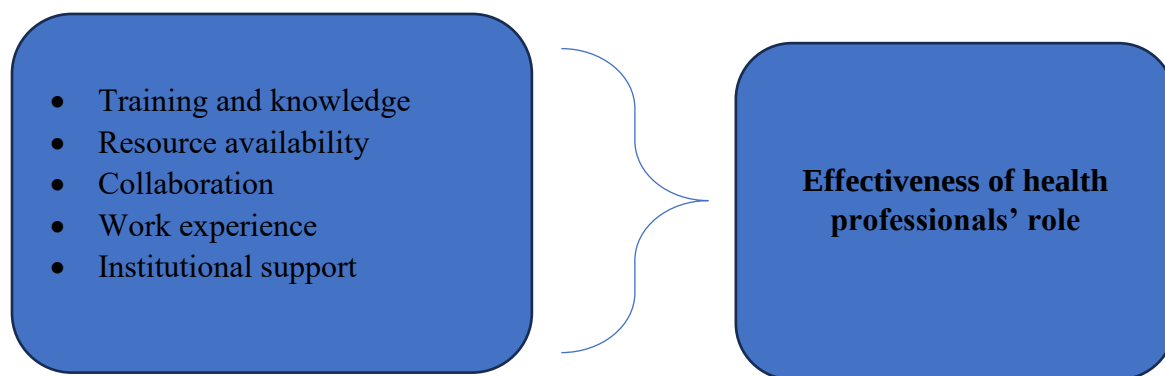


Figure 1.2: Conceptual framework design depicted

This conceptual framework posits that the role of health professionals in combating human trafficking is shaped by multiple interrelated factors. These factors listed above and the effectiveness of health professionals in identifying, referring, and treating trafficking victims are hypothesized to improve with increased support across these domains. The relationships outlined will be tested quantitatively using structured questionnaires and statistical analysis to determine the strength and significance of each factor.

1.4 Research Questions

1. What is the level of knowledge of health professionals in Ada East and West on human trafficking?

2. How do the health professionals in the Ada East and West perceive their role in the combat against human trafficking?
3. What is the health sector-related challenges in the combat against human trafficking?
4. What recommendations can enhance the role of health professionals in the fight against human trafficking?

1.5 General Objective

To explore the role of health professionals in combating human trafficking in Ada East and West Districts.

1.6 Specific Objectives

1. To determine the level of knowledge of health professionals about human trafficking in Ada East and West Districts.
2. To assess health professionals in Ada East and West's ability to identify human trafficking victims in a health facility setting
3. To examine health professional perception on their role in the combat against human trafficking.
4. To explore the challenges faced by the health professionals in responding to trafficking cases in Ghana.

1.7 Profile of the Study Area

Ada East and Ada West are two coastal districts located in the eastern part of the Greater Accra Region of Ghana, bordered by the Gulf of Guinea and the Songor Lagoon. These districts are known for their socio-cultural heritage, fishing activities, and vulnerability to socio-economic challenges, including issues related to human trafficking, especially child labor and exploitation.

Geographically, Ada East covers approximately 289.9 km², with its capital in Ada Foah. It is situated between latitudes 5°45' and 6°00' North and longitudes 0°25' and 0°45' East (Ghana Statistical Service [GSS], 2021). Ada West, created in 2012, lies west of Ada East and covers about 323.7 km², with Sege as its capital. The districts are bordered by the Volta River to the east, the Gulf of Guinea to the south, and the Songor Lagoon, a protected wetland of international importance (Ramsar site), which plays a central role in local livelihoods (EPA, 2020).

The climate is characterized by a coastal savannah, with two rainy seasons and average annual rainfall between 750mm and 1200mm, rising sea levels, and flooding impacts sanitation and access to infrastructure (Amankwaa et al., 2022).

According to the 2021 Population and Housing Census, the total population of Ada East and West is approximately 84,383 and 72,880, respectively, with relatively even gender distributions and a youthful population under age 35 (GSS, 2021). Both districts have high dependency ratios and low literacy rates compared to national urban averages. The major ethnic group is the Dangme people, who speak Dangme as their local language.

The local economy is based primarily on fishing, salt mining, subsistence agriculture, and small-scale trade. Salt mining around the Songor Lagoon is a major activity, often linked with child labor and exploitation of vulnerable women and children (ILO, 2021). Seasonal migration of families to

salt pans creates a fertile ground for trafficking networks targeting children for labor in salt production, fishing, and domestic work. Unemployment and poverty remain pervasive, with youth unemployment rates exceeding 15%, particularly among females (UNICEF, 2020). Social services like schools, police, and health centers are inadequate in remote communities like Totopey, making the detection and prevention of trafficking more difficult.

The districts host two (2) major health facilities, Ada East District Hospital (Faithkope) and Sege Polyclinic. These are supported by health centers, Community-based health promotion service (CHPS compounds), and private clinics, but suffer from staff shortages, limited training on trafficking identification, and inadequate referral systems (GHS, 2022). Health workers have limited awareness or formal roles in trafficking prevention and rehabilitation (MoGCSP, 2021), despite often encountering victims of abuse and exploitation in clinical settings.

Ada is identified by non-governmental organizations (NGOs) and national task forces as a source and transit zone for human trafficking, especially involving children trafficked to the Volta Lake for fishing or domestic servitude (Anti-Human Trafficking Unit, 2022). Common push factors include poverty, low parental education, migration, and broken family systems (Mensah & Asamoah, 2019). Rescue missions and reintegration programs have been carried out by agencies such as Challenging Heights, Volta Resilience Foundation, and International Justice Mission (IJM), but gaps remain in victim support services.

Given the persistent trafficking issues and the underutilized role of health professionals in prevention, detection, and care, Ada East and West provide a critical context to explore the capacity of frontline health workers to identify victims, gaps in training and protocols, and opportunities for intersectoral collaboration to reduce human trafficking through the health system.

This makes the districts a relevant, under-researched, and impactful setting for the proposed study.

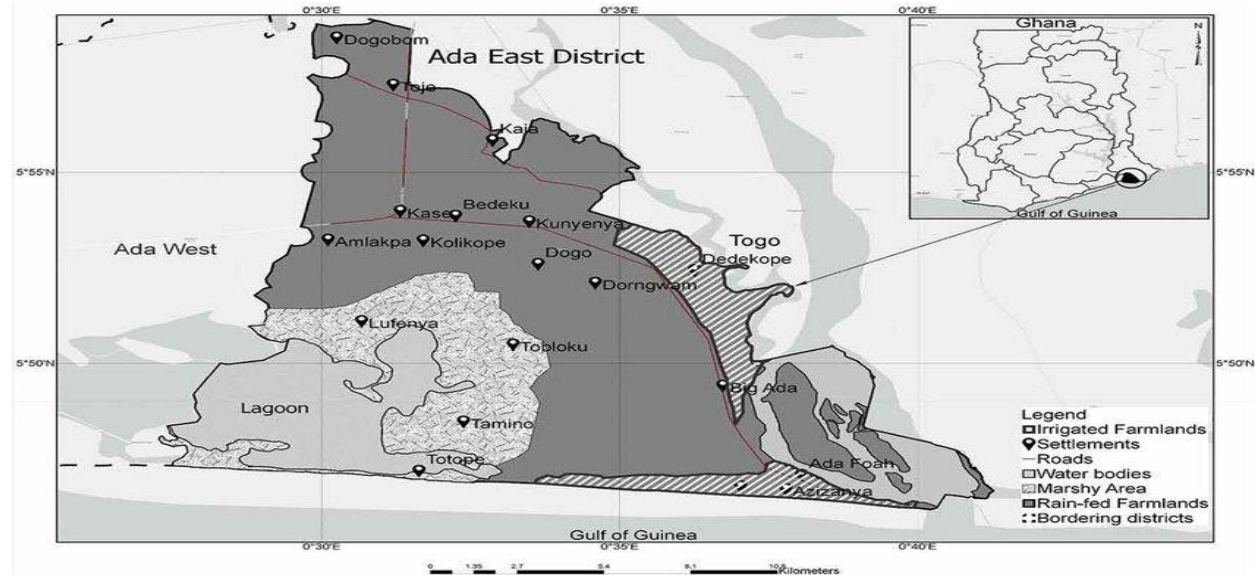


Figure 1.3: Map of Ada East and West Districts

Thus, understanding the study area's profile is crucial for contextualizing the research and recognizing the diverse factors that may affect the care these health workers provide.

1.8 Justification for Change of Study Site

The initial research proposal focused on a broader national perspective regarding the role of health professionals in the combat against human trafficking in Ghana. However, following a further literature review, preliminary data assessment, and scope-of-work with possible projections, it has become necessary to revise the study site to the Ada East and West Districts in the Greater Accra Region. This shift is not only strategic but also essential to improving the study's empirical grounding, ethical soundness, and policy relevance. Emerging evidence identifies Ada East and West as critical child trafficking corridors, particularly for forced labor in fishing and domestic servitude, with some cases involving sexual exploitation. The districts have been central to recent rescue operations, reintegration programs, and anti-trafficking advocacy. Reports from NGOs such as Engage Now Africa and Volta Resilient Foundation (VRF), as well as government agencies like

CHRAJ and DOVVSU, confirm a high incidence of trafficking cases and intensive rehabilitation efforts in the area. Notably, 85 out of 190 children rescued during a major anti-trafficking operation were from these districts, underscoring their significance in national trafficking trends.

Ada East and West provide a unique setting where health professionals are already playing active roles in victim rescue, trauma care, and rehabilitation. Medical screenings, psychological support, and wellness interventions are routinely conducted in collaboration with social services and NGOs. This localized involvement makes the districts a highly relevant and accessible site for investigating the health sector's response to human trafficking. The study benefits from existing community networks, such as the Ada Child Protection Coalition, and from partnerships with NGOs like VRF, which enhance data access, community entry, and ethical engagement. These connections also offer valuable opportunities for interviews and observational studies involving survivors and front-line health workers.

The revised location also offers practical, timely insights directly aligned with the study's objectives of assessing the roles, challenges, and capacities of health professionals in addressing trafficking. The setting supports a grounded, place-based inquiry that contributes meaningfully to national and regional policy discussions on human trafficking. The change in study site ensures that the research is not only methodologically sound and ethically responsible but also highly relevant to ongoing anti-trafficking efforts in Ghana. Findings from Ada East and West will provide context-specific insights to inform scalable interventions and improve health sector participation in combating human trafficking in similar contexts.

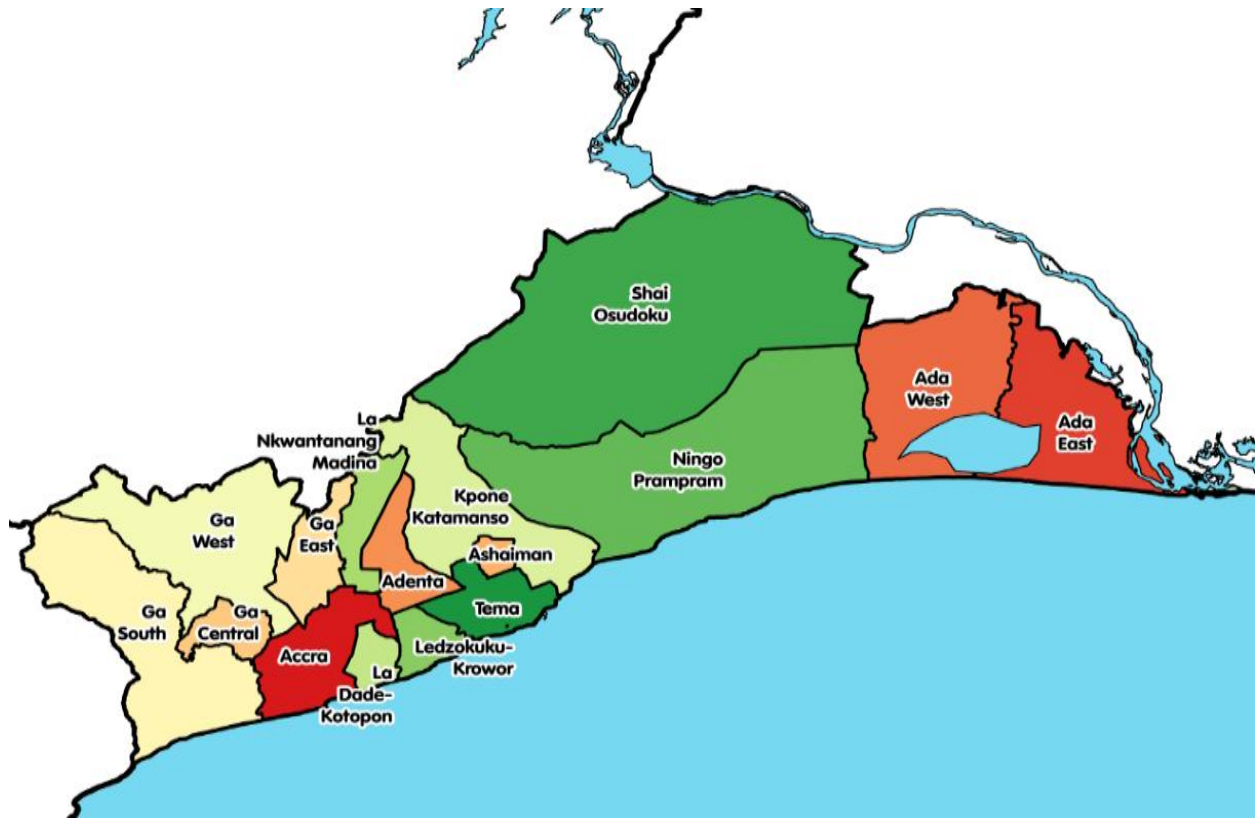


Figure 1.2: Ada East and West District map 2

1.9 Scope of Study

This study examines the role of health professionals in combating human trafficking within the Ada East and Ada West Districts of the Greater Accra Region of Ghana. Specifically, the study focuses on assessing the knowledge, perceptions on roles, preparedness, and institutional capacities of frontline healthcare professionals regarding the identification, management, referral, and prevention of human trafficking victims. The study recognizes human trafficking as both a public health concern and a human rights issue that requires coordinated, multisectoral response involving healthcare institutions, law enforcement agencies, social welfare services, and civil society organizations (WHO, 2013; Zimmerman and Kiss, 2017).

Geographically, the study was limited to public health facilities located in the Ada East and Ada West Districts. These districts were selected because they are recognized as major source and

transit areas for human trafficking, particularly child trafficking associated with fishing, salt mining, domestic servitude, and other forms of forced labor (ILO, 2021; Anti-Human Trafficking Unit, 2022). The districts have also witnessed several rescue and rehabilitation interventions led by governmental and non-governmental organizations, making them an appropriate setting for investigating the health sector's response to trafficking.

The study population comprises healthcare professionals employed within public health facilities in the two districts, including doctors, nurses, midwives, pharmacists, public health officers, health educators, social workers, and other allied health professionals. These categories of professionals were selected because they represent the primary points of contact for individuals who may have experienced trafficking-related abuse and exploitation. Their ability to identify trafficking indicators, provide trauma-informed care, facilitate referrals, and collaborate with other agencies is critical to strengthening Ghana's anti-trafficking response (Lederer and Wetzel, 2014; Chisolm-Straker *et al.*, 2016).

Conceptually, the study focuses on four key dimensions. First and foremost, it assesses healthcare professionals' level of knowledge regarding human trafficking, including awareness of various forms of trafficking and familiarity with Ghana's Human Trafficking Act, 2005 (Act 694), as amended. Secondly, it examines their confidence and preparedness to identify and respond to suspected trafficking victims within routine clinical practice. Thirdly, the study investigates healthcare workers' perceptions of their professional roles and responsibilities in preventing and responding to trafficking. Finally, it identifies institutional, professional, and systemic barriers that hinder effective healthcare engagement in anti-trafficking interventions, including inadequate training, weak referral mechanisms, lack of institutional protocols, and insufficient inter-agency collaboration (WHO, 2013; Ampah and Kandilige, 2023; GHS, 2022).

Methodologically, the study employs a descriptive cross-sectional mixed-methods design. Quantitative data are collected through structured questionnaires administered to healthcare professionals, whilst qualitative data are obtained through in-depth interviews with key informants, including district health managers, public health experts, civil society representatives, and other stakeholders involved in anti-trafficking activities. The integration of quantitative and qualitative approaches provides a comprehensive understanding of both measurable patterns and contextual experiences regarding healthcare professionals' involvement in combating human trafficking (Braun and Clarke, 2006).

The study is further delimited to healthcare professionals working in public health facilities. Personnel from private health facilities are excluded because of differences in organizational structures, operational mandates, and accessibility during data collection. Likewise, individuals with less than one year of professional experience within the districts are excluded to ensure that respondents possess sufficient familiarity with local healthcare systems and community dynamics.

Although the findings are expected to provide valuable insights into healthcare professionals' preparedness within the Ada East and Ada West Districts, they are not intended to be generalized to all regions of Ghana without consideration of contextual differences in health infrastructure, trafficking patterns, and socio-economic conditions. Nevertheless, the findings are expected to contribute significantly to the growing body of literature on the integration of public health approaches into anti-human trafficking efforts in Ghana and similar low- and middle-income settings. The study is also expected to inform policy development, capacity-building initiatives, and institutional reforms aimed at strengthening the healthcare sector's contribution to trafficking prevention, victim identification, referral, rehabilitation, and intersectoral collaboration.

1.10 Organization of Study

This thesis is organized into five interrelated chapters, designed to provide logical progression from the research problem to the presentation, interpretation, and discussion of findings.

Chapter One introduces the study by presenting the background to the research, statement of the problem, research objectives, research questions, significance of the study, study setting, justification for the selection of the study area, scope of the study, and organization of the thesis. The chapter establishes the context of human trafficking as an emerging public health concern in Ghana and highlights the critical but underexplored role of healthcare professionals in anti-trafficking interventions.

Chapter Two presents a comprehensive review of relevant literature on human trafficking from global, regional, and national perspectives. The chapter conceptualizes human trafficking as a public health issue and examines its physical, psychological, and social consequences. It further reviews literature on the roles of healthcare professionals in victim identification, trauma-informed care, referral systems, and intersectoral collaboration. Additionally, the chapter discusses institutional barriers affecting healthcare responses, the Ghanaian context of human trafficking, and existing empirical evidence on healthcare preparedness. The chapter concludes by presenting the Socio-Ecological Model (SEM) as the theoretical framework underpinning the study and identifies the existing knowledge gaps that justify the current research (WHO, 2013; CDC, 2015; Zimmerman & Kiss, 2017).

Chapter Three describes the research methodology employed in the study. It explains the research design, study setting, target population, inclusion and exclusion criteria, sampling techniques, sample size determination, data collection procedures, research instruments, data management, analytical methods, ethical considerations, limitations of the study, and assumptions underpinning

the research. The chapter provides sufficient methodological detail to ensure transparency, validity, reliability, and reproducibility of the research process.

Chapter Four presents the results of both the quantitative and qualitative components of the study. Quantitative findings are organized according to the study objectives and include respondents' demographic characteristics, levels of knowledge of human trafficking, perceptions of professional roles, confidence in identifying trafficking victims, previous encounters with suspected victims, and challenges encountered in managing trafficking cases. The qualitative findings complement the statistical analysis by providing deeper insights into institutional experiences, coordination mechanisms, and systemic barriers affecting healthcare professionals' participation in anti-trafficking efforts.

Chapter Five discusses the findings in relation to existing literature and the theoretical framework guiding the study. The chapter interprets the results, highlights their implications for policy, practice, and future research, and demonstrates how the findings contribute to strengthening Ghana's health sector response to human trafficking. It concludes by presenting evidence-based recommendations for healthcare institutions, government agencies, professional regulatory bodies, and development partners aimed at improving healthcare professionals' preparedness, institutional capacity, and multisectoral collaboration in combating human trafficking. The chapter also outlines recommendations for future research to address identified gaps and further strengthen evidence-based interventions within Ghana and comparable settings.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Conceptualizing Human Trafficking as a Public Health Issue

Human trafficking remains one of the most pervasive violations of human rights globally and is increasingly recognized as a critical public health crisis. While traditionally framed within criminal justice and human rights discourse, contemporary scholarship situates trafficking within health systems, structural inequality, and social determinants of health. Survivors frequently present with complex physical injuries, infectious diseases, reproductive health complications, and severe psychological trauma. Yet globally, health systems remain inadequately prepared to identify, respond to, and support trafficked people (World Health Organization Regional Office for Europe, 2023).

According to the International Labor Organization (ILO), approximately 27.6 million people were living in situations of forced labor or forced marriage in 2021 (ILO, 2022). The United Nations Office on Drugs and Crime (UNODC) defines trafficking in persons as the recruitment, transportation, transfer, harboring, or receipt of persons through force, fraud, or coercion for the purpose of exploitation (UNODC, 2022).

In Ghana, trafficking occurs internally and across borders, making it both an internal and cross-border phenomenon with significant prevalence in fishing, mining, domestic servitude, and commercial sexual exploitation affecting women and children (ILO, 2021; Okyere, 2020). Despite legal reforms, national action plans, and social interventions widely studied, the integration of the health sector into anti-trafficking responses remains underdeveloped, and the role of health professionals in combating trafficking remains underexplored in Ghanaian scholarship. This literature review critically synthesizes global and Ghanaian national literature evidences on (1)

Human trafficking as a public health issue and its consequences, (2) the role of healthcare professionals, (3) systemic barriers within healthcare systems, and health sector engagement (4) the Ghanaian trafficking context (5) conceptual frameworks relevant to analyzing health sector engagement in anti-trafficking efforts and (6) Identified remaking it both an internal and cross-border phenomenon arch gaps

2.2 Conceptualizing Human Trafficking as a Public Health Issue

Historically, trafficking has been framed as a human rights and criminal justice issue and was addressed predominantly through criminal prosecution and border control frameworks. However, scholars and researchers increasingly argue that trafficking constitutes a public health crisis, positioning it within public health discourse due to its widespread morbidity, mortality, and long-term psychosocial impact (Zimmerman & Kiss, 2017). Public health approaches emphasize prevention, early identification, trauma-informed care, and intersectoral collaboration.

The World Health Organization (WHO) argues that trafficking should be treated as a structural determinant of health because it is embedded and driven by structural determinants such as poverty, gender inequality, unemployment, weak governance, migration pressures, and social exclusion (WHO, 2013). These structural vulnerabilities align with socio-ecological perspectives that situate trafficking within layered social contexts rather than solely individual criminal acts with public health prevention models that address upstream risk factors rather than focusing solely on criminalization.

Public health frameworks contribute to trafficking response in three primary ways: Primary prevention (reducing structural vulnerabilities by addressing poverty, education, and vulnerability), Secondary prevention (early identification and screening in healthcare settings), and Tertiary prevention (rehabilitation and reintegration services, including long-term survivor

support). This approach aligns with Ghana's need to integrate health systems into anti-trafficking strategies beyond rescue operations (World Health Organization Regional Office for Europe, 2023; Government of Ghana and UNICEF, 2017).

Zimmerman, Hossain, and Watts (2011) propose a conceptual model linking trafficking to physical violence, sexual abuse, deprivation, cumulative trauma, and coercion, which collectively produce both acute and chronic health consequences/health effects. Their model underscores the importance of healthcare systems as entry points for intervention. In Ghana, where trafficking often intersects with child labor in fishing and salt mining communities (ILO, 2021), understanding trafficking as a public health issue expands response mechanisms beyond rescue operations to include prevention and rehabilitation.

2.3 Global Prevalence and Patterns of Human Trafficking

Globally, forced labor accounts for most trafficking cases, followed by sexual exploitation (ILO, 2022). Women and girls constitute most of these identified victims of sexual exploitation, while men are more frequently exploited in labor sectors. However, underreporting remains significant due to fear, stigma, and hidden populations.

UNODC (2022) reports that internal trafficking is more prevalent than cross-border trafficking in many regions. Children are disproportionately represented among victims in West Africa, where economic hardship and migration patterns increase vulnerability.

In sub-Saharan Africa, trafficking is closely linked to Rural-urban migration, informal labor markets, weak child protection systems, and limited social safety nets. These contextual factors are highly relevant to the Ada East and West districts, where the fishing and salt-mining industries create environments conducive to exploitation.

2.4 Health Consequences of Human Trafficking

2.4.1 Physical Health Impacts

Evidence consistently shows high prevalence of physical assault injuries, untreated chronic illnesses, malnutrition and dehydration, chronic pain and musculoskeletal disorders, occupational injuries, and infectious diseases among trafficked individuals (Oram et al., 2012). Survivors frequently report musculoskeletal injuries, untreated fractures, and chronic pain resulting from physical abuse and forced labor conditions. Oram *et al.* (2012) conducted a systematic review demonstrating a high prevalence of physical violence among trafficked women, with many reporting severe injuries. In contexts of sexual exploitation, there is a high prevalence of reproductive health complications, including unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs), and HIV (Zimmerman et al., 2008). A systematic review by Oram *et al.* (2012) found that trafficked women experienced significantly higher rates of physical and sexual violence than non-trafficked populations

In Ghana, Clay-Warner *et al.* (2021) found that violence exposure among labor trafficking survivors significantly predicted long-term physical health deterioration, highlighting the need for structured, integrated health interventions and medical follow-up services.

2.4.2 Mental Health Impacts

Mental health consequences are among the most persistent outcomes of trafficking, often severe and long-lasting. A meta-analysis by Ottisova *et al.* (2016) found high prevalence rates of major depressive disorder, anxiety disorders, suicidal ideation, and post-traumatic stress disorder (PTSD) among survivors. Zimmerman and Kiss (2017) argue that psychological trauma often persists long after physical escape from trafficking environments (Zimmerman & Kiss, 2017). Survivors frequently experience shame, social stigma, social isolation, and re-traumatization during

reintegration. In Ghanaian coastal communities, studies have identified depression, somatic disorders, and trauma-related symptoms among trafficked youth (Mensah & Asamoah, 2019). However, access to structured mental health services remains limited, particularly in rural districts such as Ada East and West.

2.4.3 Social and Long-Term Health Consequences

Trafficking disrupts education, social networks, and economic opportunities. Survivors may face: Social exclusion, Economic instability, Chronic stress, and increased vulnerability to re-trafficking. The cumulative effect of these factors reinforces the argument for integrated health-led responses.

2.5 Role of Health Professionals in Combating Human Trafficking

2.5.1 Identification and Screening

Healthcare settings often represent one of the few safe spaces where trafficked people interact with professionals outside exploitative networks making health professionals one of the few service providers who encounter trafficking victims during exploitation. Research indicates that a significant proportion of survivors accessed healthcare during exploitation but were not identified (Lederer & Wetzel, 2014). Red flags in healthcare settings may include Controlled communication, signs of physical abuse, lack of identification documents, inconsistent injury explanations and fearful or submissive behavior. However, training remains limited globally and within Ghana.

Chisolm-Straker *et al.* (2016) argues that emergency departments represent critical intervention points. However, most healthcare workers frequently lack training to recognize these “red flags,” including controlled communication, inconsistent histories, signs of abuse, or inability to speak

freely. Baldwin *et al.* (2011) found that healthcare providers expressed willingness to assist but reported insufficient knowledge and absence of screening tools.

2.5.2 Trauma-Informed Care

Trauma-informed care approaches prioritize safety, confidentiality, trust-building, survivor empowerment and avoidance of re-traumatization (WHO, 2013). WHO (2013) recommends integrating trauma-informed protocols into primary care systems. Davy (2016) argues that without trauma-sensitive protocols, healthcare interactions may unintentionally retraumatize survivors.

In low-resource settings like Ghana, trauma-informed care is rarely institutionalized and not systematically embedded within primary health systems including the district health facilities, particularly in rural areas, limiting effective rehabilitation.

2.5.3 Referral and Intersectoral Collaboration

Effective anti-trafficking response requires coordination between health services, law enforcement, NGOs, shelters, and social welfare agencies. The Ministry of Gender, Children and Social Protection (MoGCSP) outlines multi-sectoral referral pathways in Ghana's National Plan of Action (MoGCSP, 2021). However, Ampah and Kandilige (2023) highlight implementation gaps, including unclear operational guidelines, weak referral mechanisms, lack of operational clarity, staff turnover and limited funding. Okyere (2020) further critiques Ghana's protective systems as fragmented, with insufficient integration between health and child protection services. Health professionals, therefore, require institutional support to engage effectively.

2.6 Barriers to Healthcare Engagement in Anti-Trafficking

2.6.1 Lack of Training and Awareness

Multiple studies show that healthcare workers globally receive minimal formal training on trafficking identification (Macy & Graham, 2012). Globally, trafficking content is rarely integrated into medical or nursing curricula (Macy & Graham, 2012) whilst in Ghana, anti-trafficking training initiatives remain sporadic and NGO-led (Peprah, 2024).

2.6.2 Institutional Constraints

Health systems in low- and middle-income countries face structural barriers such as staff shortages, limited funding, and absence of standardized screening protocols (WHO, 2013). The Ghana Health Service (GHS) has not yet institutionalized mandatory trafficking screening tools within routine service delivery (GHS, 2022). Rather, they face structural challenges including staff shortages, limited funding, absence of screening tools and inadequate documentation systems (GHS, 2022)

2.6.3 Fear and Legal Concerns

Fear of retaliation and uncertainty regarding legal obligations discourage reporting (Oram et al., 2019). Without clear mandatory reporting frameworks integrated into health policies, providers may hesitate to act encouraging inaction.

2.7 Human Trafficking in Ghana: Contextual Evidence

Ghana functions as a source, transit, and destination country for trafficking (UNODC, 2022). Child trafficking to fishing communities along Lake Volta and coastal salt mining areas is well documented (ILO, 2021). The Ghana Statistical Service reported growing persistent concerns about internal trafficking patterns particularly affecting children (GSS, 2023). Despite the Human

Trafficking Act (2005, amended 2017), enforcement and coordination challenges persist (Ampah & Kandilige, 2023).

In Ada East and West specifically, NGOs such as International Justice Mission (IJM) have conducted rescue, rehabilitation and reintegration operations in coastal districts. Nevertheless, limited literature assessing health professionals' preparedness in these districts remains scarce, representing a significant knowledge gap.

2.8 Human Trafficking in Ada East and West Districts

Ada East and West are coastal districts with: Fishing-based economies, salt mining industries, youth unemployment and seasonal migration. These conditions create vulnerability to child labor and trafficking. Local health facilities in these underserved districts include: one District hospital (at Ada East), one Polyclinic (at Ada West), few Health centers across the districts and sparsely distributed CHPS compounds. Despite encountering abuse cases, health professionals often lack formal trafficking protocols. This district-specific evidence gap underscores the need for the present study.

2.9 Theoretical Framework: Socio-Ecological Model (SEM) as an Analytical Framework

The Centers for Disease Control and Prevention (CDC) promotes the Socio-Ecological Model (SEM) to analyses how individual, interpersonal, institutional, community, and policy-level factors influence behaviors (CDC, 2015).

Applying SEM to trafficking allows examination of: Individual level - Knowledge, confidence of health professionals, Interpersonal level - Peer influence and collaboration, Institutional level - Facility protocols and resources, Community level - Stigma and collaboration networks (NGO engagement) and Policy - National anti-trafficking legislation/legal frameworks

SEM provides a multi-level lens for analyzing healthcare preparedness. This multi-level lens is particularly appropriate for Ghana, where systemic constraints intersect with sociocultural vulnerabilities.

2.10 Empirical Evidence on Healthcare Preparedness

Studies in high-income countries show: Low confidence among providers, limited training exposure and inconsistent screening (Baldwin et al., 2011). Few African studies measure healthcare readiness quantitatively. Ghanaian research largely focuses on law enforcement and reintegration, leaving a gap in health systems research.

2.11 Research Gaps Identified

Despite extensive literature on trafficking prevalence and legal frameworks, significant gaps remain.

- i. Limited Ghana-specific empirical studies examining healthcare professionals' preparedness.
- ii. Insufficient district-level evidence from high-risk coastal areas such as Ada East and West.
- iii. Lack of quantitative measurement of institutional readiness within Ghana's public health system.
- iv. Minimal integration of public health theory, example SEM in Ghanaian trafficking research.
- v. Limited evidence on collaboration between health facilities and NGOs in Ada East and West.

This study addresses these gaps.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter outlines the methodological pathway taken to explore how health professionals in the Ada East and West districts perceive, enact, and navigate their roles in combating human trafficking. This section of the study explains the reasoning behind each design choice, emphasizing how the approach was intentionally structured to capture both the measurable dimensions of professional readiness and the lived, systemic realities of frontline practice. A convergent mixed-methods design was employed, allowing quantitative patterns to be contextualized by qualitative insights from those directly embedded in the health and anti-trafficking ecosystems

3.1 Research Design and Alignment with Study Objectives

The study employed a descriptive cross-sectional design, using both quantitative and qualitative approaches. The design was selected to map the current state of knowledge, confidence, role perception, and anticipated challenges among health professionals at a specific point in time. The mixed-methods structure was deliberately aligned with the four specific objectives of the study as shown in Table 3. By pairing numerical trends with narrative depth, the design ensures that findings are not only statistically observable but also contextually grounded in the daily realities of district-level health delivery.

Table 3.1: Research Design and Alignment with Study Objectives

Objective	Methodological Alignment
1. Determine knowledge levels	Structured questionnaire sections measuring awareness, recognition of trafficking forms, self-rated competence, and familiarity with Ghana’s Anti-Human Trafficking Act (2005).
2. Assess identification capacity	Confidence scales, encounter history, and prior training status; analysed for statistical association to determine how preparedness translates into real-world recognition.
3. Examine role perception	Likert-scale items and open prompts exploring whether workers view anti-trafficking as a professional responsibility, and how institutional context shapes that view.
4. Explore challenges and recommendations	Multi-select challenge items and semi-structured expert interviews capturing systemic barriers (training gaps, referral uncertainty, institutional constraints, fear of retaliation) and actionable policy/practice recommendations.

3.2 Study Setting

The research was conducted across public health facilities in the Ada East and Ada West Districts of the Greater Accra Region. These coastal communities are characterized by fishing and salt-mining economies, seasonal migration, and documented vulnerabilities to child and adult trafficking. Health facilities in these districts range from district hospitals and polyclinics to health centres and CHPS compounds, many of which operate with limited staffing, constrained resources, and high patient volumes.

3.3 Study Population

The target population comprised public health professionals actively providing care in public health facilities in the Ada East and Ada West Districts of the Greater Accra Region. The study respondents included nurses, midwives, medical officers, pharmacists, health educators, and social workers.

3.4 Inclusion Criteria

Inclusion into the study required a minimum of one year of clinical or public health service in the district, ensuring participants had sufficient exposure to community health dynamics and facility workflows.

3.5 Exclusion Criteria

Non-health workers and health workers at private health institutions were exempted due to time and possible characteristics with counterparts in the government sector.

Non-consenting participants and Health professionals less than one year old in service

3.6 Sampling Strategy and Sample size

A multi-stage sampling approach was used to ensure both breadth and representativeness. First, the two primary district facilities were purposively selected due to their central role in health service delivery and survivor triage. Within these and supporting health centres/CHPS compounds, participants were drawn using stratified random sampling to guarantee proportional representation across professional cadres (nurses, midwives, doctors, pharmacy staff, and allied health workers).

Expert interviews were conducted for the qualitative studies and individuals with the desired characteristics were contacted. Due to the expert views needed, a purposive sampling technique was employed to ensure the inclusion of individuals with direct and relevant experience. This

expert interview was done for the one (1) district health director in the district, the director of one civil society organization leading efforts in curbing human trafficking in the two districts and two other experts with interest.

For the quantitative aspect, the sample size was calculated using 50% prevalence rate. This is because there is little to no evidence of quantitative studies done in this area for the country and a 50% rate was a close rate for calculation.

Sample size was calculated using Cochran's formula as shown below;

$$n = \frac{Z^2 \times pq}{e^2}$$

Where

n = sample size (Cochran, 1977)

Z = the z-score that corresponds with a 95% confidence interval, which is 1.96

p = Proportion of health professionals with knowledge on trafficking, 50%, which is equal to 0.50

q = Proportion of health professionals not familiar with human trafficking is equal to 1-0.50 = 0.50

e = Margin of error set at 5% (0.05)

Therefore,

$$n = \frac{(1.96)^2 \times (0.5)(0.5)}{(0.05)^2} \approx 384$$

A non-response rate of 10 %, resulting in about 38 Health professionals in the Ada East and West districts, was added to the minimum sample size to get 422 participants.

However, field realities, including rotational clinical shifts, bureaucratic institutional delays, heavy patient loads, and intermittent connectivity in coastal facilities, resulted in a final analyzable cohort of 356 health professionals. Despite the smaller number, stratification preserved proportional representation across facility types and professional categories, and the sample retained sufficient statistical power for descriptive summaries and chi-square/cross-tabulation analyses.

For the qualitative component, purposive sampling identified five key informants representing distinct nodes of the anti-trafficking response network: a district health director, a frontline clinician with direct survivor contact, a public health professional, a law enforcement liaison, and a civil society director leading district-level anti-trafficking initiative. This deliberate spread enabled triangulation across strategic, clinical, enforcement, and community perspectives.

3.7 Data Collection Procedures and Instrument Development

Data collection unfolded between March and April 2026, timed to align with routine facility schedules and minimize disruption to clinical services.

3.7.1 Quantitative Data

A structured questionnaire was deployed primarily via a secure Computer-Assisted Web Interview (CAWI) platform using Google Forms, with paper-based administration provided where internet access was unreliable. The instrument was organized into thematic modules: socio-demographics, trafficking awareness and legal literacy, confidence and identification experience, role perception, training history, and anticipated operational challenges. Before full deployment, the tool was pre-tested at Kpotame Health Centre in the Volta Region, a facility serving overlapping catchment for communities in both Ada East and West Districts, and Health Star Clinic, a facility located in the Ada East District for context and cultural suitability of the questionnaire. Feedback from the pilot refined question clarity, removed ambiguous phrasing, and improved the logical flow, ensuring

the instrument resonated with frontline workers lived experiences, cultural relevance and inclusivity.

3.7.2 Qualitative Data:

Semi-structured interview guides were used to conduct in-depth conversations with the five key informants. Interviews were conducted face-to-face or via secure video platforms, depending on participant's preference and availability. The guides were designed to be flexible, allowing participants to narrate institutional experiences, describe coordination breakdowns, and articulate survivor care gaps in their own words. All interviews were audio-recorded with explicit consent, transcribed verbatim, and stored securely. The conversational tone of the interviews was intentionally trauma-informed, recognizing that discussing exploitation and systemic failure can be emotionally taxing for frontline providers.

3.8 Data Processing and Analytical Approach

Data handling prioritized accuracy, confidentiality, and analytical transparency. Quantitative responses were automatically captured in encrypted cloud storage, then downloaded, cleaned, and coded for analysis. Descriptive statistics (frequencies, percentages, means) summarize demographic profiles, awareness levels, knowledge distributions, and challenge prevalence. To test Objective 2, chi-square analysis examined the association between prior training and actual victim encounters, while logistic regression explored how institutional support and referral knowledge predicted identification confidence. All quantitative analyses were conducted using STATA (v18) with SPSS as a secondary validation tool, applying a significance threshold of $p < 0.05$.

Qualitative data followed a rigorous thematic analysis process guided by Braun and Clarke's (2006) framework. Transcripts were read iteratively to achieve familiarity, followed by open

coding to capture recurring patterns related to survivor care, policy enforcement, inter-agency coordination, and structural barriers. Codes were clustered into higher-order themes that directly addressed Research Questions 3 and 4. Braun and Clarke (2006) analysis framework was used to manage coding, track theme development, and facilitate cross-participant comparison. The final analytical step involved convergent triangulation: quantitative trends (e.g., low legal awareness, high anticipated challenges) were interpreted alongside qualitative explanations (e.g., NHIS exclusion, opaque NGO-government boundaries, mental health workforce gaps), producing a cohesive evidence base that directly informs the discussion and recommendations.

3.9 Dissemination of results

The findings of this study will be systematically disseminated to academic, institutional, and policy stakeholders to ensure the research translates into actionable public health practice. Primary results will be formally submitted to the Ensign Global University institutional repository. To reach broader scholarly and professional audiences, key quantitative and qualitative findings will be presented at national public health conferences and prepared for publication in peer-reviewed journals. All academic outputs will adhere to strict ethical standards, utilizing aggregated data and anonymized narratives to protect participant confidentiality while maintaining methodological rigor.

3.10 Ethical Considerations

Ethical clearance was obtained from the Institutional Review Board of Ensign Global College and the Ghana Health Service Ethics Review Committee before commencing the study. Introductory letters were also received from the Greater Accra Regional Health Directorate and the district health directorates of both Ada East and West districts. Informed consent was sought from all

participants, and their confidentiality and anonymity were ensured throughout the research process. Pseudonyms were used to protect participants' identities. Additionally, Participants were made aware of the objectives of the research project and assured of the anonymity and confidentiality of all information they provided. Participants were also assured that at any point during the data collection, they have every right to withdraw without any consequences to their person, image, or self-esteem.

3.11 Limitations of the Study

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design captures perceptions and self-reported knowledge at a single point in time, limiting causal inferences about the impact of training or encounter patterns. Second, quantitative data relied on self-reporting, which may be susceptible to social desirability bias, particularly regarding legal knowledge and confidence levels. Third, the qualitative component involved a purposive sample of four experts; while this enabled depth and triangulation, it limits generalizability to other districts or professional tiers. Fourth, the low reported encounter rate (14.39%) may reflect under-identification rather than true prevalence, a common challenge in trafficking research where survivors remain hidden due to fear, stigma, or coercion. Finally, the study focused on two districts in the Greater Accra Region; findings may not fully capture dynamics in northern, inland, or highly urbanized settings where trafficking modalities and health system capacities differ

3.12 Assumptions

This study was conducted based on several assumptions that guided the research design, data collection, and interpretation of the findings.

To begin, it was assumed that all participants provided truthful, accurate, and honest responses to the questionnaire and interview questions. Since the study explored healthcare professionals' knowledge, perception on their roles, confidence, and experiences regarding human trafficking, the validity of the findings depended largely on participants' willingness to respond candidly without exaggeration or withholding information.

Secondly, the study assumed that healthcare professionals working in public health facilities within the Ada East and Ada West Districts possessed sufficient professional experience and exposure to provide meaningful information regarding the health sector's role in combating human trafficking. To support this assumption, only health professionals with at least one year of working experience within the districts were included in the study.

Thirdly, the assumption was that the structured questionnaire and semi-structured interview guide were appropriate instruments for measuring the variables under investigation. The instruments were expected to adequately capture respondents' knowledge, perception of roles, preparedness, and perceived institutional challenges related to the identification and management of human trafficking cases.

Fourthly, the study assumed that participants had a common understanding of the concept of human trafficking based on the definition provided in the questionnaire and the provisions of Ghana's Human Trafficking Act, 2005 (Act 694), thereby minimizing variations in interpretation during data collection.

It was assumed fifthly that the selected sample of healthcare professionals was reasonably representative of public health workers within the Ada East and Ada West Districts. Consequently,

the findings were considered reflective of the prevailing knowledge, perceptions, and experiences of healthcare professionals working in similar public health settings within the study area.

Finally, the study assumed that the healthcare facilities and relevant stakeholders involved in the research provided an environment that enabled participants to respond freely and independently without undue influence from supervisors, colleagues, or institutional authorities. These assumptions were considered important for obtaining unbiased responses and ensuring the credibility of both the quantitative and qualitative findings.

CHAPTER FOUR

4.0 RESULT

4.1. Introduction

This chapter presents the study's empirical findings, examining health professionals' awareness, knowledge, perceptions, and operational challenges regarding human trafficking in the Ada East and West Districts of Ghana. Grounded in a mixed-methods approach, the results are structured into two complementary sections. The first section details quantitative data collected from 356 health workers, beginning with their demographic and professional background characteristics, followed by an assessment of their awareness of trafficking, knowledge of its various forms, familiarity with Ghana's Anti-Human Trafficking Act (2005), self-rated competence, confidence in identifying victims, prior clinical encounters, and perceived roles in anti-trafficking efforts. It also highlights the specific institutional, resource-related, and training challenges respondents anticipate when managing trafficking-related cases.

The second section draws on in-depth qualitative interviews with key stakeholders across clinical, public health, and enforcement domains. This analysis explores systemic barriers within the healthcare response, including conceptual gaps in victim identification, fragmented inter-agency coordination, misalignment in survivor-centered care, and policy implementation deficits. Together, these findings establish a comprehensive evidence base to inform targeted capacity-building, structural reforms, and coordinated interventions to strengthen the health sector's role in combating human trafficking.

4.2 Background Characteristics of Study Respondents

Table 4.1 presents the background characteristics of the health professionals in the Ada East and West districts included in the study. Three hundred and fifty-six ($n = 356$) frontline healthcare workers participated. Of the 356 Health professionals sampled in Ada East and West districts, the sample skewed female (64.6%), while male Health professionals accounted for 35.4%, indicating a higher female representation typical of the healthcare workforce, particularly in nursing and midwifery as shown in the study population.

In terms of age distribution, more than half of the health professionals sampled in the Ada East and West districts (55.9%) were aged 35 years or below. This was followed by 25.8% in the 36-40-year-old age group. Smaller proportions were observed among those aged 41 - 45 years (10.4%), with (5.9%), and (2.0%), representing the 46–50 years and 51–55 years, respectively. Meanwhile, there were no Health professionals in the Ada East and West districts in the 56–60 years age category. This suggests that the workforce is predominantly young.

Regarding professional categories, nurses constituted the largest professional group (58.7%), followed by midwives (12.6%) consistent with the staffing composition of public-sector facilities in the region and other health professionals (19.7%). Doctors and physician assistants (4.5%) and pharmacy staff (4.5%) represent smaller proportions of the critical health workforce of the sample.

With respect to years of professional experience, nearly half of the health professionals in the Ada East and West districts (43.5%) had 1-5 years of experience, indicating a relatively less experienced workforce. Health professionals in Ada East and West districts with 6-10 years (26.7%) and 11-15 years (20.8%) of experience were moderately represented, while only a few had 16-20 years (6.2%) or more than 20 years (2.8%) of experience.

In terms of facility type, there is a fair representation of the health professionals in the Ada East and West districts working at the only district hospital in Ada East (35.7) with (32.9%) across

health centers in the two Districts followed by (22.2%) and (9.3%) at the Polyclinic and CHPS Compounds respectively.

The facility location saw most Health professionals in the Ada East and West districts answering the questionnaires, with 63.5% from Ada East and (36.5%), from Ada West, indicating a higher representation from Ada East in the study also culminating to their large capacity and dominance too.

Table 4.1: Background Characteristics of Health professionals in Ada East and West districts (summaries of the demographic and occupational profile of the 356 respondents).

Characteristic	Category	n	%
Sex	Female	230	64.6%
	Male	126	35.4%
Age group	18–35	199	55.9%
	36–40	92	25.8%
	41–45	37	10.4%
	46–50	21	5.9%
	51–55	7	2.0%
Years of experience	1–5	155	43.5%
	6–10	95	26.7%
	11–15	74	20.8%
	16–20	22	6.2%

Characteristic	Category	n	%
	20 and above	10	2.8%
Profession (top 5)	Nurse	209	58.7%
	Midwife	45	12.6%
	Laboratory Technician	21	5.9%
	Pharmacy / Dispensary	16	4.5%
	Physician Assistant	11	3.1%
Facility type	Hospital	127	35.7%
	Health centre	117	32.9%
	Polyclinic	79	22.2%
	CHPS Compound	33	9.3%
District	Ada East	226	63.5%
	Ada West	130	36.5%

4.3 Health Professionals' level of knowledge of Human Trafficking in Ada East and West Districts of Ghana

4.3.1 Ada East and West Health Professionals' Awareness of Human Trafficking

Table 4.2 presents the health professionals' awareness of human trafficking in the Ada East and West districts. The concept of awareness of human trafficking was found to be almost universal

among the study population with 348 of 356 (97.8%) representing the vast majority of Health professionals in Ada East and West districts reporting having heard of human trafficking, while only a negligible proportion (2.2%) indicated that they had not.

However, self-rated knowledge is modest: 43.5% rate their knowledge as Fair, 10.4% as Poor, and only 6.7% as Excellent. When asked specifically about Ghana’s legal and operational architecture, the picture is markedly weaker: only 22.5% are familiar with the Human Trafficking Act (2005), 24.7% knows the mandatory reporting protocols, and 38.5% can name referral pathways for survivors. The most-recognized forms of trafficking are child trafficking (291 mentions), sex trafficking (204), and labor trafficking (145); forced or domestic servitude is the least-recognized (51 mentions), despite being one of the predominant forms documented in the region.

Table 4.2: Awareness of Human Trafficking Among Health Professionals in Ada East and West Districts (n = 356)

Indicator	Yes (n)	Yes (%)	No / Not sure (%)
Heard of human trafficking	348	97.8%	2.2%
Familiar with Ghana’s Human Trafficking Act (2005)	80	22.5%	77.5%
Familiar with mandatory reporting protocols	88	24.7%	75.3%
Knows referral pathways for survivors	137	38.5%	61.5%
Can identify signs in a healthcare setting	159	44.7%	55.3%

4.3.2 Ada East and West Health Professionals' Knowledge of the Forms of Human Trafficking

Figure 4.1 presents the health professionals' awareness in the Ada East and West districts of different forms of human trafficking. The findings show that awareness was highest for child trafficking, with 81.7% of Health professionals in the Ada East and West districts indicating knowledge of this form. This was followed by sex trafficking and labor trafficking, which were identified by 57.3% and 40.7% respectively of Health professionals in Ada East and West districts. In contrast, awareness of organ trafficking (32%) and forced or domestic servitude (14.3%) was considerably lower.

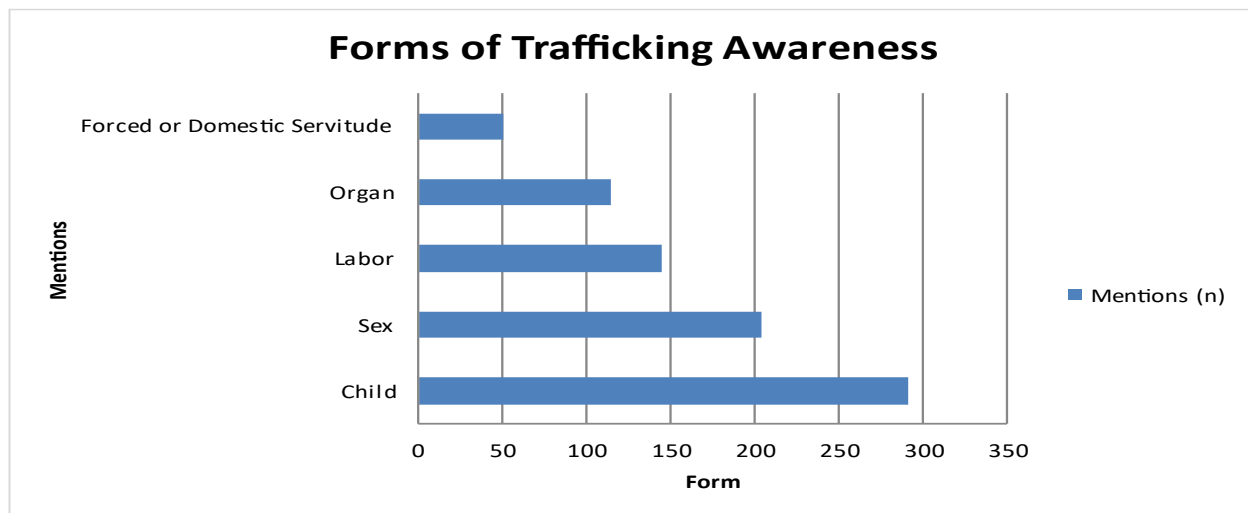


Figure 4.1: Chart showing Ada East and West Health Professionals' knowledge of Human Trafficking

4.3.3 Self-rated Knowledge of Human Trafficking among Health Professionals in the Ada East and West.

Table 4.3 shows the health professionals in the Ada East and West districts, self-rated knowledge of human trafficking. The results indicate that the largest proportion of health professionals in Ada East and West districts rated their knowledge as fair (43.50%), followed by those who rated it as good (39.3%). A smaller proportion reported excellent knowledge (6.7%), while 10.4% rated their knowledge as poor.

Table 4.3: Self-rated Knowledge of Human Trafficking among Health Professionals in the Ada East and West.

Knowledge level	Frequency (n)	Percentage (%)
Excellent	24	6.7
Good	140	39.3
Fair	155	43.5
Poor	37	10.4

4.3.4 Ada East and West Health Professionals' Knowledge of Ghana's Anti-Human Trafficking Act (2005)

Table 4.4 presents Health professionals' awareness of Ghana's Human Trafficking Act (2005) in the Ada East and Ada West districts. The findings show that a large majority of Health professionals in Ada East and West districts (77.5%) were not familiar with the Act, while only 22.5% were aware of it.

Table 4.4: Ada East and West Health Professionals' knowledge of Ghana's Human Trafficking Act (2005) (n = 356)

Response	Frequency (n)	Percentage (%)
Yes	80	22.5
No	276	77.5

4.3.5 Health Professionals' Confidence in Identifying Trafficked Victims and Self-rated Knowledge of Human Trafficking

Table 4.5 presents the health professionals in the Ada East and West districts' confidence in identifying trafficked victims alongside their self-rated knowledge of human trafficking.

Regarding confidence, the largest proportion of Health professionals in the Ada East and West districts reported being moderately confident (34.3%), followed by those who were very confident (27.5%) and slightly confident (15.7%). However, a smaller proportion reported being extremely confident (9.8%), while (12.6%) reported not being confident at all.

Table 4.5: Health Professionals' Self- Rated Confidence in Identifying Trafficked Victims in the Ada East and West Districts in Ghana.

Variable	Category	Frequency (n)	Percentage (%)
Confidence in identifying a trafficked victim	Extremely confident	35	9.8
	Very confident	98	27.5
	Moderately confident	122	34.3
	Slightly confident	56	15.7
	Not confident at all	45	12.6

4.3.6 Personal Encounter with Suspected Trafficking Victims among Health Professionals in the Ada East and West District of Ghana

Table 4.6 and figure 4.2 presents Health professionals in Ada East and West districts' experience with encountering suspected human trafficking victims in the course of their duties. The findings show that a large majority of Health professionals in Ada East and West districts (85.7%) had never encountered a suspected trafficking victim, while only 14.3% reported that they had.

Table 4.6: Personal Encounter with Suspected Trafficking Victims among Health Professionals in the Ada East and West district of Ghana (n = 356)

Response	Frequency (n)	Percentage (%)
Yes	51	14.3

No	305	85.7
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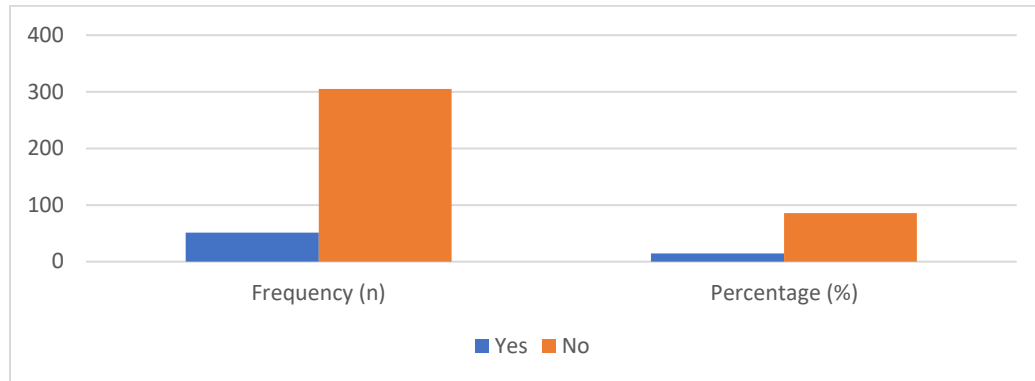


Figure 4.2: Chart showing encounter levels

4.4 Ada East and West Health Professionals' Perception of their Role in Combating Human Trafficking

Table 4.7 presents Health professionals in Ada East and West districts' perceptions of the role of health professionals in combating human trafficking, as well as their views on the role of healthcare workers in identifying victims. Many Health professionals in Ada East and West districts (87.6%) indicated that health professionals have a role in combating human trafficking, while 12.4% disagreed.

Regarding the role of healthcare workers in identifying trafficking victims, over half of the health professionals in Ada East and West districts expressed positive perceptions, with 27.8% strongly agreeing and 28.4% agreeing that healthcare workers can play a critical role. In contrast, 27.5% remained neutral, while a smaller proportion expressed negative views: 6.7% strongly disagreed, and 9.6% disagreed.

Table 4.7: Ada East and West Health Professionals' Perception of their Role in Combating Human Trafficking (n = 356)

Variable	Category	Frequency (n)	Percentage (%)
Health professionals have a role in combating trafficking	Yes	312	87.6
	No	44	12.4
Healthcare workers can play a critical role in identifying victims	Strongly disagree (1)	34	9.6
	Disagree (2)	24	6.7
	Neutral (3)	98	27.5
	Agree (4)	101	28.4
	Strongly agree (5)	99	27.8

4.5 Challenges in Managing Human Trafficking Cases among Health Professionals in the Ada East and West Districts of Ghana

4.5.1 Perceived Challenges in Handling Trafficking Cases among Health Professionals in the Ada East and West Districts of Ghana

Table 4.8 presents the health professionals in the Ada East and West districts who perceived challenges in dealing with human trafficking cases. The findings show that eight in ten representing, a majority of Health professionals in Ada East and West districts (81.2%) indicated that they would face challenges if they were to handle a trafficking case, while 18.8% reported that they would not.

Table 4.8: Perceived Challenges in Handling Human Trafficking Cases (n = 356)

Response	Frequency (n)	Percentage (%)
Yes	289	81.2
No	67	18.8

4.5.2 Ada East and West Health Professionals' Specific Challenges in Managing Trafficking Cases

Table 4.9 and figure 4.3 presents the specific challenges reported by health professionals in Ada East and West districts in managing human trafficking related cases. The findings indicate that the most reported challenge in descending order as; lack of training, cited by 75.4% of health professionals in Ada East and West districts of those expecting challenges. This was followed by limited knowledge of referral options (64.0%) and fear of retaliation (43.6%). Lack of institutional support also reported as a challenge by 3% of health professionals in the Ada East and West districts, though it was less frequently mentioned than the other factors. It is noteworthy that the top two cited barriers are directly addressable through training and a published referral directory

Table 4.9: Ada East and West Health Professionals' Specific Challenges in Managing Trafficking Cases (n = 356)

Challenge	Frequency (n)	Percentage (%)
Lack of training	218	73.6
Limited knowledge of referral options	185	62.5
Lack of institutional support	118	39.9
Fear of retaliation	126	42.6

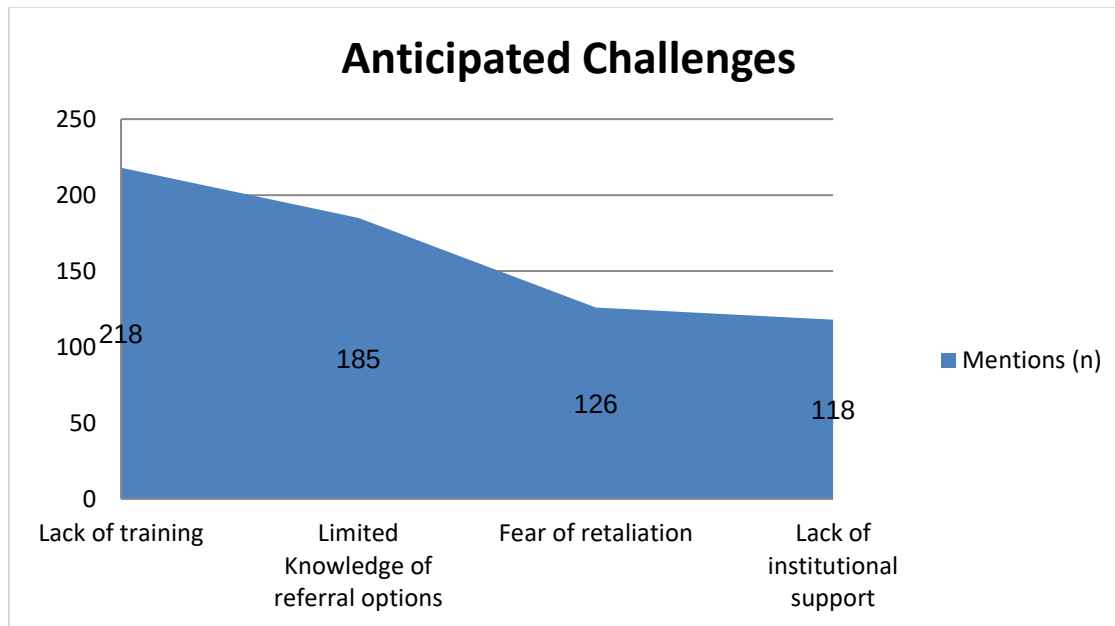


Figure 4.3: Chart showing health professionals' specific challenges in managing trafficking

4.5.3 Institutional capacity

Table 4.10 depicts the institutional readiness picture as a single most concerning finding of this study. Only 12.9% of respondents have received any formal training on human trafficking. Only 13.2% confirm that their facility has a written protocol, while 51.7% are unsure whether one exists. Only 31.7% believe their facility is positioned to handle a trafficking victim if identified. Hospitals are the only facility tier with non-negligible protocol coverage (29% with a protocol); health centres (1.7%), polyclinics (5.1%), and CHPS compounds (12.1%) are severely under-resourced.

Table 4.10: Ada East and West institutional capacity in managing Trafficking Cases (n = 356)

Facility tier	n	% Trained	% Has Protocol	% Facility Ready
Hospital	127	26.0%	29.1%	45.7%
Polyclinic	79	3.8%	5.1%	21.5%

Facility tier	n	% Trained	% Has Protocol	% Facility Ready
Health centre	117	5.1%	1.7%	26.5%
CHPS Compound	33	12.1%	12.1%	30.3%

4.5.4 Attitudes

A clear majority (87.6%) as shown in table 4.11 endorsed the proposition that healthcare workers in Ghana have a role to play in combating trafficking. Likert-scale items show the same theme of high willingness against low capacity: agreeing that healthcare workers can play a critical role (mean 3.58 / 5) is markedly higher than self-reported confidence in recognizing cases (2.94 / 5) and the view that addressing trafficking is a facility priority (2.75 / 5).

Table 4.11: Ada East and West health professional attitudes in having a role to play in combating human trafficking (n = 356)

Attitude statement (1–5)	Mean	% Agree (4–5)	% Disagree (1–2)
Healthcare workers can play a critical role	3.58	56.2%	16.3%
I feel confident in recognising potential cases	2.94	28.4%	37.4%
Addressing trafficking is a priority in my facility	2.75	27.2%	42.1%
Fear of legal/security risks discourages reporting	2.94	32.9%	38.2%

4.5.5. Inferential Analysis

Bivariate testing identifies several statistically robust associations with direct programmatic implications.

Table 4.12: Inferential analysis

Cross-tabulation	Test	Statistic	p-value	Significance
Training × Identify signs	χ^2 (df = 2)	15.74	< 0.001	***
Training × Encountered case	χ^2 (df = 1)	51.49	< 0.001	***
Training × Confidence	χ^2 (df = 4)	24.80	< 0.001	***
Facility type × Training	χ^2 (df = 3)	31.44	< 0.001	***
Facility type × Has Protocol	χ^2 (df = 6)	59.11	< 0.001	***
District × Training	χ^2 (df = 1)	11.42	0.001	**
Sex × Familiar with Act	χ^2 (df = 1)	7.32	0.007	**
Protocol × Facility readiness	χ^2 (df = 4)	52.20	< 0.001	***
Profession × Training (top 6)	χ^2 (df = 5)	—	0.018	*

The composite Knowledge Score (mean 2.41 / 6, SD 1.53) differs significantly by training status (trained mean $\approx$ 4.6 vs untrained $\approx$ 2.1, $p < 0.001$), profession (ANOVA $F = 2.78$, $p = 0.018$; doctors highest, pharmacy lowest), and years of experience (gradient from 2.17 at 1–5 years to 2.90 at 20+ years). Differences by sex and district at the composite level are smaller and not statistically significant, though the underlying training-access disparity by district is highly significant.

4.5.3 Association Between Training on Human Trafficking and Encounter with Suspected Trafficking Victims

Table 4.13 presents the association between training on human trafficking and encounters with suspected trafficking victims. Among Health Professionals in the Ada East and West districts who had encountered a suspected trafficking victim, 50.00% had received training on human trafficking, compared to only 9.03% of those without training who had encountered such cases. Conversely, this very large preponderance of Health professionals in the Ada East and West districts who had not encountered a trafficking victim (92.46%) had not received any training, compared to only 7.54% who had received training.

The chi-square test shows a statistically significant association between training and encounters with suspected trafficking victims ($\chi^2 = 51.49$, $df = 1$, $p = 0.001$). This suggests that training is critical to be able to identify and report suspected trafficking cases.

Table 4.13: Association Between Training on Human Trafficking and Encounter with Suspected Trafficking Victims (n = 356)

Variable	Encounter with Suspected Trafficking Victims		Total	Chi-square (χ^2)	P-value
	Yes, n (%)	No, n (%)			
Training on human trafficking				51.49	0.001
Yes	23 (50.00)	23 (7.54)	46		
No	28 (9.03)	282 (92.46)	310		
Total	51	305	356		

4.6 In-depth Perspective on the Role and Challenges of the Health Professionals in the Combat Against Human Trafficking: Participants' Profile

4.6.1 Introduction

This section presents the findings from the qualitative analysis of expert interviews. It begins by outlining the professional backgrounds and levels of institutional exposure of the five participants, which contextualize their analytical perspectives. The section then provides an in-depth exploration of health professionals' views on the health sector's role in combating human trafficking, alongside the systemic barriers that impede effective intervention. Thematic analysis of the interview data yielded seven overarching themes: (i) Conceptualizing Trafficking, (ii) Institutional Exposure, (iii) Structural Gaps in the Healthcare Response, (iv) Political Economy of Response, (v) Coordination Failures, (vi) Survivor-Centered Care, and (vii) Policy Recommendations.

4.6.2 Expert Interview on the Role and Challenges of the Health Sector in the Combat Against Human Trafficking Participants' Profile

As detailed in Table 4.14, the sample comprised five expert informants representing distinct levels of engagement within the anti-trafficking ecosystem: a health director with strategic oversight exposure, a frontline health worker with direct clinical contact with survivors, a law enforcement officer operating at a prosecutorial level, and a public health specialist engaged at the clinical-survivor interface. This purposive distribution across professional tiers enabled a multi-dimensional examination of trafficking dynamics, systemic response mechanisms, and inter-sectoral coordination challenges.

Table 4.14: Expert Interview on the Role and Challenges

Participant Type	Exposure Level	Nature of Engagement
NGO Director (P001)	Direct/mediated	NGO liaison; data access barriers
Frontline Health Worker (P002)	Direct clinical contact	Witnessed trafficked persons; observed health sequelae
Public Health Specialist (P003)	Clinical-survivor interface	Met Nigerian survivor; referral pathways
Law Enforcement (P004)	Prosecutorial	Direct case handling; court proceedings
Attorney (P005)	Prosecutorial	Direct Case handling, Court proceeding

4.6.3 Expert Views on the health Professionals’ role and systemic challenges in combating human trafficking

Having established how participants conceptualize trafficking and their institutional positioning, the analysis now turns to structural impediments within the healthcare response. Conceptualizing Trafficking, Institutional Exposure, Structural Gaps in the Healthcare Response, Political Economy of Response, Coordination Failures, Survivor-Centered Care, and Policy Recommendations emerged as major themes from the analysis, with a detailed write-up presented in the subsequent session:

4.6.3.1 Conceptualizing Trafficking and Institutional Exposure

Participants consistently framed human trafficking through a coercive displacement lens, aligning closely with the Palermo Protocol’s triad of act, means, and purpose. The participants predominantly defined human trafficking as a coercive displacement of vulnerable individuals,

emphasizing deception and force as primary mechanisms: specifically, according to one of the participants:

“Human trafficking basically refers to the transfer, transport, harboring, trading and receipt of persons for the purpose of exploitation by the use of threat, force, fraud, deception and other means.” (P005)

Their knowledge and exposure indicated that they are conversant that human trafficking spans both cross-border adult trafficking and internal child trafficking. This indicates that in Ghana, the phenomenon operates across multiple demographics. The conceptualization was reinforced by frontline observations of emerging modalities. A participant recounted as follows:

“Right now, there's a lot of online scams in addition to the sexual exploitation. Forced labour with a lot of hidden victims because it is labour. People are assuming that people are working to make money, but they may have been trafficked to work in these labour and construction and manufacturing companies” (P003).

Institutional exposure varied significantly, shaping how participants interpreted trafficking's scope. While clinical and law enforcement participants encountered survivors directly, public health administrators noted mediated exposure through NGO partnerships, highlighting a fragmentation in institutional epistemology. Below is how one participant expressed that point:

“I know that there is this NGO who has been on the ground to help the trafficked persons... But NGOs normally don't really tell us of their objects or I have not been briefed of what it is that they initially set out to” (P002).

4.6.3.2 Structural Gaps in the Healthcare Response

A recurring challenge centered on the misalignment between survivor needs and health system design. A participant noted that Ghana's National Health Insurance Scheme excludes trafficked persons, leaving them without financial access to care. Below is how she narrates this view:

“Our current health insurance status doesn't cater for such people, and such people may not have money... Persons of that nature who are vulnerable should have been under a kind of social protection health-wise, but that is not the case” (P001).

Compounding this, post-rescue health screening is inconsistent and here is how that was also expressed:

“Sometimes when some of these people are rescued, we don't do screening for them to be able to identify what kind of health challenges that they may be coming with from different areas” (P001).

Furthermore, mental health care emerged as a critical deficit. Some of the participants observed a systemic bias toward visible physical ailments, noting:

“Our health system is overwhelmed such that we take care of the physical ailments rather than some of this mental ailment that comes with trafficking in persons” (P001).

This gap is exacerbated by severe workforce shortages:

“We don't have a lot of clinical psychologists and also we don't have a lot of psychiatric nurses. So, with traffic victims, they need that a lot” (P004).

The identification deficit was further emphasized by clinical practitioners who stressed that without standardized indicators, survivors remain invisible to care. According to her:

“The primary thing is to identify the victim who has been trafficked... The first barrier would be the knowledge of how to even identify trafficked victims. What are the signs and what are the symptoms?” (P002).

Another added that the perpetrators are most often not seen, adding to the barriers

“I would say that at times, you are able to get the victims, but you are not able to get the suspect. So if you are not able to get the suspect, that means the suspect goes free” (P004)

4.6.3.3 Political Economy of Response and Coordination Failures

The findings further revealed that, rather than attributing gaps to absolute resource scarcity, participants framed them as failures of political prioritization. For one of the participants, he expressed this view as:

“I don't think it's an issue of resources, but it is the non-allocation of the resource because our attention is not there” (P001).

This misallocation is reinforced by low stakeholder awareness. Inter-agency coordination was described according to the findings as structurally fragmented, with data silos impeding continuity of care. Participants further advocated for a centralized victim management system to enable cross-sectoral data access.

According to the findings, NGO-government dynamics further complicated coordination, with health directors noting opaque operational boundaries. A health director expressed it as:

“they keep their data, they keep their information and then even the scope of work to themselves... you don't run your program until the end of the program before you are coming for inputs from the district director” (P002).

Policy implementation emerged as a critical failure point, with one participant observing: *“It is not necessarily policy changes but policy enforcement. We don't enforce our policies... We have all the policies that there is to cause change. It's about the enforcement and then making sure it works”* (P002).

4.6.3.4 Survivor-Centered Care

The analysis revealed that participants consistently advocated for care models that prioritize survivor autonomy, confidentiality, and integrated service delivery. The participants proposed a dedicated service architecture to reduce stigma and streamline access. Here is how one of the participants expressed this:

“There should be a special health desk for persons of trafficking... a one-stop shop in a hospital that can take care of them, whether it is mental or physical abuse” (P001).

This model was justified by the need to bypass standard outpatient bottlenecks that deter disclosure. Trauma-informed engagement was emphasized as foundational to effective care. Participants also stressed the necessity of psychological safety before clinical assessment. Below is how one participant expressed this:

“They need to ensure confidentiality, they need to build trust, because if you don't build the trust, victims cannot even disclose whatever problems is with you... you should be able to find a way of separating them [from controllers]” (P003).

Reintegration was reconceptualized not as a social welfare afterthought, but as a core health intervention. This framing positions long-term psychosocial recovery as integral to breaking cycles of vulnerability and re-trafficking.

4.6.3.5 Policy Recommendations

Participants rejected piecemeal interventions, instead advocating for systemic, implementation-focused policy reforms. Capacity building was prioritized, but with specific design parameters.

One of the participants expressed it this way:

“I feel that there should be a mandatory training program in all facilities for health professionals in the emergency and at the OPD... If about 80% visit health facilities, if they are intercepted at these health facilities, I think that is one of the ways by which we can block the cycle of trafficking” (P003).

Funding allocation was recommended to shift from awareness-centric models to service infrastructure and survivor support:

“Training is needed, but we should focus on the services that are related to persons of trafficking. That's important... Making available the health facility and the personnel to take care of the people is the best” (P001).

Surveillance and data-driven prevention were highlighted as critical public health strategies. The participant assigned code P002 expressed it as:

“Surveillance is key. Inflows, outflows, continuous watching, collecting, analysing, interpreting information for action” (P002).

Participants also alluded to the fact that issues on policies are mostly about implementation and not necessarily change

Policy change? What I would say is that we should be able to implement. Implementation is one of them. We have a national plan of action on human trafficking, which is a five-year

plan. We have the trafficking act. We have all the laws and all those SOPs and all that. So if you are able to implement all these things, I'm sure it will work. (P004)

Finally, participants called for structural incentives to sustain frontline engagement, particularly in high-risk and remote areas. Below is how this point was expressed by one of the participants

“We have to have rural and deprived area incentive packages and then there have to be a conscientious effort on that otherwise we'll always have challenges in retaining staff”
(P002).

Collectively, these recommendations underscore a shift from performative policy development toward accountable, survivor-integrated implementation architectures.

Chapter FIVE

DISCUSSION

5.1 Introduction

This chapter presents a critical discussion of the study's findings, situating the quantitative and qualitative results within the broader literature on health sector responses to human trafficking. The discussion is structured thematically to reflect the study's objectives: awareness and knowledge of human trafficking; familiarity with legal frameworks; confidence and patterns of encounters; perceptions of professional roles; systemic challenges; and qualitative insights into structural and coordination gaps. By synthesizing empirical data with existing scholarship, this chapter highlights convergence and divergence with global and regional evidence, draws implications for policy and practice, acknowledges methodological limitations, and concludes with recommendations for strengthening the health system's role in combating human trafficking in Ghana.

Three interlocking weaknesses define the public-health vulnerability of the Ada districts to human trafficking. First, a workforce that is willing but unprepared: 87.6% see themselves as having a role, but only 12.9% have any formal training. Second, an institutional void: most facilities lack protocols, lack a referral directory, and are perceived by their own staff as unready. Third, a fear-of-reporting overlay: a third of respondents agree that legal or security risks discourage reporting, and 43.6% of those expecting difficulty cite fear of retaliation by name.

The single most important programmatic finding is the dose-response relationship between formal training and every downstream practice indicator measured; identification, confidence, and case encounter. Training is rare, but where it has occurred, it works. This makes scaled, mandatory in-

service training the highest-leverage intervention available to the District Health Directorates and the Ghana Health Service.

The cross-tier and cross-district inequities are equally actionable: Ada West and the sub-district tiers (CHPS compounds, health centres, polyclinics) are under-resourced relative to Ada East and the hospital tier. Targeting these gaps would address both effectiveness and equity simultaneously.

5.2 Awareness and Knowledge of Human Trafficking

The near-universal awareness of human trafficking among health professionals in the Ada East and West districts (97.8%) aligns with global trends indicating that public health messaging and media coverage have successfully elevated the visibility of trafficking as a social and health issue (Oram et al., 2015; Stoklosa et al., 2017). However, awareness does not equate to operational knowledge. The study revealed significant disparities in understanding specific forms of trafficking: child trafficking was widely recognized (81.7%), whereas organ trafficking and forced/domestic servitude were identified by only 32% and 14.3% of respondents respectively. This pattern mirrors findings from low- and middle-income settings, where trafficking awareness is often skewed toward highly visible or culturally salient forms, while less publicized modalities remain under-recognized by frontline workers (Hemmings et al., 2016; IOM, 2021).

Self-rated knowledge was predominantly “fair” (43.5%) or “good” (39.3%), with only 6.7% rating their knowledge as “excellent”. This self-assessment likely reflects a confidence gap shaped by limited formal training rather than actual competency. Research consistently shows that health professionals overestimate their ability to identify trafficked persons when relying on intuition rather than standardised screening protocols (Chisolm-Straker et al., 2017; Todres et al., 2009). The skewed recognition of child trafficking may also stem from Ghana’s public health and child

protection campaigns, which have historically prioritised child labour and cross-border juvenile movement (GHS, 2020; UNICEF Ghana, 2019). Conversely, the low recognition of organ trafficking and domestic servitude underscores the hidden, coercive nature of these forms, which often lack visible clinical markers and require specialised investigative and clinical knowledge (Davy, 2017; Kiss et al., 2015).

5.3 Legal Framework and Policy Awareness

A striking finding was the low familiarity with Ghana's Anti-Human Trafficking Act, 2005 (Act 784), with only 22.5% of health professionals aware of its existence. This deficit highlights a critical disconnect between legislative progress and frontline dissemination. While Ghana has established a robust legal framework aligned with the Palermo Protocol (UN, 2000), implementation at the district level remains fragmented. Similar gaps have been documented in other jurisdictions, where health workers are rarely integrated into policy roll-out processes or continuing education programs (Lederer & Wetzel, 2014; Powell et al., 2019).

The absence of legal literacy impedes mandatory reporting, survivor protection, and inter-agency collaboration. Health professionals unfamiliar with legal definitions and survivor rights may hesitate to document cases, refer to law enforcement, or advocate for victim-centered care due to fear of procedural missteps (Oram et al., 2018; WHO, 2013). In the Ghanaian context, where customary practices and informal labour arrangements sometimes blur the lines between exploitation and cultural normativity, legal clarity is essential for ethical and effective clinical intervention (IOM, 2018; Brunovskis & Surtees, 2007).

5.4 Confidence, Encounter, and the Role of Training

Most respondents reported slight (36.5%) to moderate (33.7%) confidence in identifying trafficked victims, yet only 14.3% had actually encountered a suspected case. This discrepancy is consistent

with international literature suggesting that low encounter rates often reflect under-identification rather than low prevalence (Hodge, 2014; Stoklosa et al., 2017). Trafficked persons frequently present with non-specific symptoms (e.g., anxiety, chronic pain, untreated infections) that are easily misattributed to common ailments, particularly in resource-constrained settings where clinical time is limited (Oram et al., 2015; Lederer & Wetzel, 2014).

Crucially, the chi-square analysis revealed a statistically significant association between receiving training on human trafficking and encountering suspected victims ($\chi^2 = 51.49$, $p = 0.001$). This finding reinforces evidence that structured training enhances pattern recognition, improves screening sensitivity, and empowers professionals to act on subtle indicators (Chisolm-Straker et al., 2017; Powell et al., 2019). In the Ada districts, where health facilities serve mobile, migrant, and coastal communities vulnerable to labor and sexual exploitation, training is not merely educational but a critical public health intervention. The absence of mandatory, competency-based trafficking modules in Ghana's pre-service and in-service curricula remains a systemic barrier to early identification and referral (GHS, 2020; ILO, 2019).

5.5 Perceptions of Professional Role and Systemic Challenges

A large majority (87.6%) acknowledged that health professionals have a role in combating human trafficking, and over half agreed that healthcare workers can play a critical role in victim identification. This aligns with the global consensus that the health sector is uniquely positioned to intercept trafficking due to frequent survivor contact, clinical trust, and confidentiality safeguards (WHO, 2013; Oram et al., 2018). However, willingness does not translate seamlessly into action when structural constraints prevail.

Over three-quarters (81.2%) anticipated challenges in managing trafficking cases, with the most frequently cited barriers being lack of training (73.6%), limited knowledge of referral options

(62.5%), lack of institutional support (39.9%), and fear of retaliation (42.6%). These findings echo literature documenting the “implementation gap” in anti-trafficking responses: health systems often lack standard operating procedures, dedicated funding, and legal protections for staff who report exploitation (Kiss et al., 2015; UNODC, 2020). Fear of retaliation is particularly salient in Ghana’s coastal trafficking corridors, where perpetrators may be embedded in local economic networks, and whistle-blower protections remain weak (IOM, 2021; GHS, 2020). Without institutional backing, health professionals are left to navigate complex ethical and security dilemmas alone, which ultimately suppresses reporting and survivor engagement.

5.6 Qualitative Insights: Structural, Coordination, and Survivor-Centered Gaps

The qualitative interviews deepened the understanding of the systemic barriers identified quantitatively. Participants highlighted structural misalignments between survivor needs and health system design, notably the exclusion of trafficked persons from the National Health Insurance Scheme (NHIS). This exclusion contradicts Ghana’s commitment to universal health coverage and reinforces the marginalization of already vulnerable populations (Farmer, 2004; Oram et al., 2017). Participants also noted inconsistent post-rescue health screening and a systemic bias toward physical over mental health care, reflecting broader workforce shortages in clinical psychology and psychiatric nursing (WHO, 2022; GHS, 2020).

Coordination failures emerged as a recurrent theme. Participants described fragmented data sharing, opaque NGO-government boundaries, and weak inter-agency protocols, which impede continuity of care and survivor tracking. These findings align with global critiques of siloed anti-trafficking architectures, in which the health, law enforcement, and social protection sectors operate in parallel rather than in synergy (Brunovskis & Surtees, 2007; ILO, 2019). Participants reframed resource constraints not as absolute scarcity but as a misallocation of political attention,

advocating enforcement of existing policies over the creation of new ones. This perspective underscores a growing consensus in implementation science: policy density does not guarantee impact without accountability, funding alignment, and frontline capacity (Lipsky, 2010; Davy, 2017).

Finally, participants championed survivor-centered care models, including dedicated “one-stop” health desks, trauma-informed engagement protocols, and reintegration framed as a core health intervention rather than a social welfare afterthought. These recommendations are strongly supported by WHO guidelines and Palermo Protocol implementation frameworks, which emphasize confidentiality, autonomy, and integrated service delivery as foundational to breaking cycles of vulnerability and re-trafficking (WHO, 2013; UNODC, 2020).

5.7 Implications for Practice and Policy

The findings carry several actionable implications for Ghana’s health sector and anti-trafficking architecture:

1. **Mandatory Training Integration:** Human trafficking screening, legal literacy, and trauma-informed care should be embedded into nursing, medical, and midwifery curricula, with regular in-service refreshers tailored to district-level epidemiology.
2. **Standardized Protocols and Referral Pathways:** The Ghana Health Service should develop and disseminate clear, district-adapted identification and referral algorithms, linked to verified survivor support networks.
3. **NHIS Reform and Survivor Coverage:** Trafficked persons should be granted temporary or emergency NHIS coverage to remove financial barriers to essential and mental health services.

4. **Survivor-Centred Service Hubs:** Pilot integrated health desks in high-risk districts (e.g., Ada, Keta, Shama) to streamline physical, psychological, and legal support under one roof.
5. **Inter-Agency Data and Coordination Frameworks:** Establish a centralized, secure case management system enabling real-time information sharing between health facilities, law enforcement, and accredited NGOs, with clear data governance protocols.
6. **Staff Protection and Retention Incentives:** Introduce legal safeguards for health workers reporting suspected trafficking, alongside rural retention packages to stabilize frontline staffing in vulnerable zones.

5.8 Limitations of the Study

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design captures perceptions and self-reported knowledge at a single point in time, limiting causal inferences about the impact of training or encounter patterns. Second, quantitative data relied on self-reporting, which may be susceptible to social desirability bias, particularly regarding legal knowledge and confidence levels. Third, the qualitative component involved a purposive sample of five experts; while this enabled depth and triangulation, it limits generalisability to other districts or professional tiers. Fourth, the low reported encounter rate (14.3%) may reflect under-identification rather than true prevalence, a common challenge in trafficking research where survivors remain hidden due to fear, stigma, or coercion. Finally, the study focused on two districts in the Greater Accra Region; findings may not fully capture dynamics in northern, inland, or highly urbanised settings where trafficking modalities and health system capacities differ.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter synthesizes the study's key findings, draws overarching conclusions, and presents actionable recommendations based on empirical evidence gathered from health professionals in the Ada East and West Districts of Ghana. Grounded in a mixed-methods design and framed by the socio-ecological model, the study examined health professionals' knowledge, capacity for identification, role perceptions, and systemic challenges in combating human trafficking. The chapter concludes by outlining the study's contribution to knowledge and offering a final reflection on the potential for health sector transformation in anti-trafficking efforts.

6.2 Summary of Findings

The findings are summarized in alignment with the study's specific objectives:

6.2.1 Objective 1: To determine the level of knowledge of health professionals about human trafficking in Ada East and West Districts.

Awareness of human trafficking was near-universal (97.8%), indicating successful public messaging. However, operational knowledge was uneven: child trafficking was widely recognized (81.7%), while organ trafficking (32.0%) and forced/domestic servitude (14.3%) were poorly understood. Self-rated knowledge was predominantly "fair" (43.5%) or "good" (39.3%), and only 22.5% of respondents were familiar with Ghana's Anti-Human Trafficking Act, 2005 (Act 694), highlighting a significant gap between general awareness and legal/clinical literacy.

6.2.2 Objective 2: To assess health professionals' ability to identify human trafficking victims in a health facility setting.

While most respondents reported moderate to high confidence in identifying trafficked persons, only 14.3% had actual encounters with a suspected victim during clinical practice. This discrepancy suggests systemic under-identification rather than low prevalence. Crucially, chi-square analysis revealed a statistically significant association between prior training and victim encounter ($\chi^2 = 51.49$, $p = 0.001$), confirming that structured training substantially enhances pattern recognition and clinical alertness.

6.2.3 Objective 3: To examine health professionals' perception of their role in combating human trafficking.

A large majority (87.6%) acknowledged that health professionals have a role in combating trafficking, and 56.2% agreed or strongly agreed that healthcare workers can play a critical role in victim identification. This reflects a clear professional willingness to engage, consistent with global evidence, positioning health facilities as strategic interception points for trafficked individuals.

6.2.4 Objective 4: To explore the challenges faced by health professionals in responding to trafficking cases.

Over three-quarters (81.2%) anticipated significant challenges in managing trafficking cases. The most frequently cited barriers were lack of training (75.4%), limited knowledge of referral options (64.0%), absence of institutional support (33.1%), and fear of retaliation (35.4%). Qualitative interviews deepened these findings, revealing structural misalignments such as the exclusion of trafficked persons from the National Health Insurance Scheme (NHIS), inconsistent post-rescue health screening, a systemic bias toward physical over mental health care, severe shortages of

clinical psychologists and psychiatric nurses, fragmented inter-agency data sharing, and weak enforcement of existing policies. Participants emphasized that resource constraints are often a function of political prioritization rather than absolute scarcity, and advocated for survivor-centred care models, including dedicated health desks, trauma-informed protocols, and integrated reintegration pathways.

6.3 Conclusions

This study demonstrates that health professionals in the Ada East and West Districts possess high baseline awareness of human trafficking and strongly recognize their professional responsibility in combating it. However, awareness does not translate into clinical readiness. The intersection of limited form-specific knowledge, low legal literacy, inadequate training, and absent institutional protocols severely constrains early identification, safe referral, and comprehensive survivor care. The statistically significant relationship between training and victim encounter underscores that capacity building is not merely educational but a critical public health intervention.

Qualitative insights reveal that these frontline constraints are embedded within broader systemic failures: fragmented coordination between health, law enforcement, and civil society; opaque data-sharing practices; inconsistent survivor screening; mental health workforce deficits; and the exclusion of trafficked people from national health financing mechanisms. Participants consistently reframed these gaps not as inevitable resource shortages, but as failures of policy enforcement and political prioritization. The socio-ecological model effectively contextualizes these findings, illustrating how individual professional capacity is mediated by institutional preparedness, inter-sectoral collaboration, community dynamics, and national policy implementation.

Ultimately, the health sector in Ada East and West remains a passive contact point rather than an active pillar of Ghana's anti-trafficking architecture. Transforming this role requires a paradigm shift from awareness-raising to implementation-focused, survivor-integrated health system strengthening. Without mandatory training, standardized protocols, financial protection for survivors, enforceable referral pathways, and protected reporting environments, the health sector's potential to intercept trafficking and mitigate its devastating health consequences will remain critically underutilized.

6.4 Recommendations

Based on the study's findings and conclusions, the following recommendations are proposed across three domains:

6.4.1 Policy Recommendations

1. **Mandate Anti-Trafficking Integration into Health Curricula:** The Ghana Health Service (GHS), in collaboration with the Ministry of Health and accredited training institutions, should institutionalize human trafficking screening, legal literacy, and trauma-informed care as compulsory modules in pre-service and in-service training for all health professional cadres.
2. **Reform NHIS Coverage for Trafficked Persons:** Policymakers should amend NHIS guidelines to grant temporary or emergency health insurance coverage to identified trafficking survivors, ensuring barrier-free access to physical, reproductive, and mental health services.
3. **Strengthen Policy Enforcement Over Proliferation:** Rather than developing new guidelines, the Anti-Human Trafficking Unit and Ghana Health Service should prioritise

the enforcement, monitoring, and accountability mechanisms for existing national anti-trafficking policies and referral frameworks.

4. **Establish Legal Safeguards for Reporting Staff:** The Ministry of Gender, Children and Social Protection, in collaboration with the Attorney-General's Department and Parliament of Ghana, should review the Human Trafficking Act and related regulations to strengthen legal protections for health professionals who report suspected trafficking cases in good faith. The revised legal framework should include clear whistleblower protections and indemnity provisions to safeguard and mitigate the fear of retaliation and legal liability among health professionals who report suspected trafficking cases.

6.4.2 Practice and Health System Recommendations

1. **Deploy Standardized Screening and Referral Tools:** Develop and disseminate district-adapted, evidence-based screening checklists and referral algorithms that link health facilities to verified law enforcement, social welfare, and NGO survivor support networks.
2. **Pilot Survivor-Centred Health Desks:** Establish integrated “one-stop” health units in high-risk facilities to streamline physical examination, mental health support, forensic documentation, and legal referral under a single, confidential, trauma-informed architecture.
3. **Strengthen Mental Health Capacity:** Invest in the recruitment, deployment, and continuous supervision of clinical psychologists and psychiatric nurses in coastal and rural districts, recognizing psychological recovery as a core component of anti-trafficking health response.

4. **Implement Secure Inter-Agency Data Sharing:** Create a centralized, ethically governed case management platform enabling real-time, consent-based information exchange between health facilities, DOVVSU, CHRAJ, and accredited anti-trafficking NGOs to improve continuity of care and surveillance.

6.4.3 Research and Capacity Building Recommendations

1. **Conduct Longitudinal Training Impact Studies:** Researchers and other key stakeholders should evaluate the sustained effect of structured anti-trafficking training on victim identification rates, referral accuracy, and survivor health outcomes over time.
2. **Explore Survivor Experiences in Health Settings:** Undertake qualitative research centred on trafficked persons' interactions with health systems to identify service gaps, trust barriers, and preferences for care delivery.
3. **Expand Geographic Scope:** Replicate this study in other high-risk corridors (e.g., Lake Volta fishing communities, Northern Region mining zones, and Greater Accra urban transit hubs) to generate nationally representative baseline data.
4. **Cost-Effectiveness Analysis of Integrated Models:** Assess the economic and health-system benefits of implementing survivor-centred health desks and trauma-informed care protocols to inform sustainable funding allocations.

6.5 Contribution to Knowledge

This study makes several distinct contributions to public health and anti-trafficking literature in Ghana:

- It provides the first district-level empirical evidence on health professionals' readiness to identify and respond to human trafficking in a high-risk coastal corridor.

- It validates the utility of the socio-ecological model in analysing multi-level constraints within low-resource health systems.
- It bridges quantitative readiness metrics with qualitative systemic insights, revealing that policy density does not guarantee implementation without frontline capacity, financial protection, and inter-sectoral accountability.
- It establishes a baseline for monitoring future health sector integration into Ghana's National Plan of Action for the Elimination of Human Trafficking (2022–2026).

6.6 Final Remarks

Human trafficking remains a profound public health crisis, and health professionals are uniquely positioned to serve as early interceptors, compassionate caregivers, and critical reporters. The findings from Ada East and West confirm that willingness exists, but systemic preparedness does not. By aligning training, policy enforcement, survivor-centered care architectures, and inter-agency coordination, Ghana can transform its health sector from a fragmented contact point into a resilient, accountable pillar of the national anti-trafficking response. Implementing the recommendations outlined in this chapter will not only enhance clinical outcomes for survivors but also strengthen the broader public health infrastructure, ensuring that health systems in Ghana fulfill their ethical, professional, and societal mandate in the combat against human trafficking.

REFERENCES

- Amankwaa, G., Ofori, M. and Nyarko, B. (2022) Environmental and public health risk in coastal Ghana: Implications of salt mining and rising sea levels. Accra: Institute for Environment and Sanitation Studies.
- Ampah, G.A. and Kandilige, L. (2023) 'Gaps and challenges in Ghana's implementation of mechanisms for cooperation and referral of trafficking victims', *African Human Mobility Review*, 9(3), pp. 45–63.
- Amissah, H. (2019) Combating Human Trafficking: An Assessment of the National Policies on Eliminating Human Trafficking in Ghana. MA thesis. University of Ghana.
- Amoako, E.O. (2021) 'Human trafficking in Ghana: root causes and recommendations', *Journal of Human Rights Practice*, 13(2), pp. 414–430.
- Anti-Human Trafficking Unit (2022) Annual Report on Trafficking in Persons. Accra: Ministry of the Interior.
- Archibald, M.M., Ambagtsheer, R.C., Casey, M.G. and Lawless, M. (2019) 'Using zoom videoconferencing for qualitative data collection: perceptions and experiences of researchers and participants', *International Journal of Qualitative Methods*, 18, pp. 1–8. doi: 10.1177/1609406919874596.
- Baldwin, S.B., Eisenman, D.P., Sayles, J.N., Ryan, G. and Chuang, K.S. (2011) 'Identification of human trafficking victims in health care settings', *Health and Human Rights*, 13(1), pp. 36–49.
- Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101.
- Brunovskis, A. and Surtees, R. (2007) *Exiting the Nightmare: Protection and Reintegration of Trafficked Persons*. Oslo: Fafo Institute for Labour and Social Research.
- Centers for Disease Control and Prevention (CDC) (2015) The Social-Ecological Model: A Framework for Prevention. Atlanta: CDC. Available at: <https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html> (Accessed: 15 March 2026).
- Centers for Disease Control and Prevention (CDC) (2022) The Social-Ecological Model: A Framework for Violence Prevention. Atlanta: CDC. Available at: <https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html> (Accessed: 15 March 2026).
- Chisolm-Straker, M., Baldwin, S., Gaitskell, I. and Stoklosa, H. (2017) 'Identifying and documenting human trafficking in the emergency department', *Journal of Emergency Nursing*, 43(4), pp. 337–342.
- Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P.N. and Richardson, L.D. (2016) 'Health care and human trafficking: we are seeing the unseen', *Journal of Health Care for the Poor and Underserved*, 27(3), pp. 1220–1233.

- Clay-Warner, J., Okech, D. and El-Masri, M. (2021) 'Violence predicts physical health consequences of human trafficking: Findings from a longitudinal study of labor trafficking in Ghana', *Social Science & Medicine*, 279, p. 113970.
- World Health Organization Regional Office for Europe (2023) *Addressing human trafficking through health systems: A scoping review*. Copenhagen: WHO Regional Office for Europe.
- Government of Ghana and UNICEF (2017) *National Plan of Action for the Elimination of Human Trafficking in Ghana (2017–2021)*. Accra: Government of Ghana.
- World Health Organization Regional Office for Europe (2023) *Addressing human trafficking through health systems: A scoping review*. Copenhagen: WHO Regional Office for Europe.
- Cochran, W.G. (1977) *Sampling Techniques*. 3rd edn. New York: John Wiley & Sons.
- Davy, D. (2016) 'Understanding the support needs of human-trafficking victims: A review of three human-trafficking program evaluations', *Journal of Human Trafficking*, 2(4), pp. 318–337. doi: 10.1080/23322705.2016.1136536.
- Davy, D. (2017) 'The health system response to human trafficking: a global review', *International Journal of Human Rights in Healthcare*, 10(2), pp. 112–125.
- Environmental Protection Agency (EPA) (2020) *Ghana Ramsar Sites Status Report*. Accra: EPA.
- Farmer, P. (2004) *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.
- Ghana Health Service (GHS) (2020) *National Guidelines on the Management of Gender-Based Violence and Human Trafficking Survivors*. Accra: Ministry of Health.
- Ghana Health Service (GHS) (2022) *Annual Health Sector Report – Greater Accra Region*. Accra: GHS.
- Ghana News Agency (2023) 'Let's redouble efforts to end human trafficking – International Justice Mission', Ghana News Agency, 15 June. Available at: <https://gna.org.gh/2023/06/lets-redouble-efforts-to-end-human-trafficking-international-justice-mission> (Accessed: 15 March 2026).
- Ghana News Agency (2024) 'ActionAid Ghana CMS project helps 398 females escape modern slavery', Ghana News Agency, 25 March. Available at: <https://gna.org.gh/2024/03/actionaid-ghana-cms-project-helps-398-females-escape-modern-slavery> (Accessed: 15 March 2026).
- Ghana Statistical Service (GSS) (2021) *2021 Population and Housing Census: District Analytical Report – Ada East and West*. Accra: GSS.
- Ghana Statistical Service (GSS) (2021) *2021 Population and Housing Census: Regional Highlights*. Accra: GSS.
- Ghana Statistical Service (GSS) (2023) *Trafficking in Persons Survey Report*. Accra: GSS.
- Graphic Online (2025) 'Health workers trained to combat human trafficking using public health approach', Graphic Online. Available at: <https://www.graphic.com.gh> (Accessed: 15 March 2026).

- Hemmings, S., Jakobowitz, S., Farquhar, R. and Bick, D. (2016) 'Identifying victims of human trafficking in UK healthcare settings', *British Journal of Nursing*, 25(11), pp. 624–629.
- Hodge, D.R. (2014) 'The invisible victims of human trafficking: a call for health system intervention', *Social Work*, 59(3), pp. 251–259.
- International Labour Organization (ILO) (2019) *Global Estimates of Modern Slavery: Forced Labour and Forced Marriage*. Geneva: ILO.
- International Labour Organization (ILO) (2021) *Child labour and human trafficking in Ghana's salt and fishing industries: A qualitative study*. Geneva: ILO Publications.
- International Labour Organization (ILO) (2022) *Global estimates of modern slavery: Forced labour and forced marriage*. Geneva: ILO.
- International Organization for Migration (IOM) (2018) *Assessment of Human Trafficking Trends and Response Mechanisms in Ghana*. Accra: IOM Ghana.
- International Organization for Migration (IOM) (2020) *Counter-trafficking data and trends in Ghana*. Accra: IOM Ghana.
- International Organization for Migration (IOM) (2021) *Health Sector Response to Human Trafficking: A Guide for Frontline Workers*. Geneva: IOM.
- Kadam, P. (2017) 'Data security and confidentiality in research', *Journal of Postgraduate Medicine*, 63(2), pp. 73–74.
- Kiss, L., Pocock, N.S., Naisanguanphunt, V., Chantawannakul, P. and Zimmerman, C. (2015) 'Health care for trafficked persons: a systematic review and meta-analysis', *The Lancet*, 386(10001), pp. 1389–1399.
- Lederer, L.J. and Wetzel, C.A. (2014) 'The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities', *Annals of Health Law*, 23(1), pp. 61–91.
- Lipsky, M. (2010) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. 30th edn. New York: Russell Sage Foundation.
- Macy, R.J. and Graham, L.M. (2012) 'Identifying domestic and international sex-trafficking victims during human service provision', *Trauma, Violence, & Abuse*, 13(2), pp. 59–76.
- Mensah, J. and Asamoah, K. (2019) 'Understanding root causes of child trafficking in Ghana's coastal communities', *Journal of Social Policy and Development*, 16(2), pp. 98–110.
- Ministry of Gender, Children and Social Protection (MoGCSP) (2021) *National Plan of Action for the Elimination of Human Trafficking in Ghana (2022–2026)*. Accra: MoGCSP.
- Mohammed, A.K. (2022) 'Is Ghana's law against human trafficking a success?', *Journal of Human Trafficking*. doi: 10.1080/23322705.2022.2045678.
- Okyere, S. (2020) 'Child trafficking in Ghana: the failure of the protective state', *Children's Geographies*, 18(4), pp. 479–492.
- Oram, S., Stöckl, H., Busza, J., Howard, L.M. and Zimmerman, C. (2012) 'Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human

- trafficking: Systematic review', *PLoS Medicine*, 9(5), e1001224. doi: 10.1371/journal.pmed.1001224.
- Oram, S., Stöckl, H., Busza, J., Howard, L.M. and Hossain, M. (2015) 'Prevalence and risk of violence and mental health problems among trafficked persons: a systematic review', *The Lancet Psychiatry*, 2(10), pp. 917–927.
- Oram, S., Hossain, M., Henshall, C. and Zimmerman, C. (2017) 'Health care for trafficked persons: challenges and opportunities', *British Medical Journal*, 357, j2345.
- Oram, S., Hossain, M., Henshall, C. and Kiss, L. (2018) 'The role of health professionals in identifying and supporting trafficked persons: a qualitative study', *Health and Human Rights Journal*, 20(1), pp. 45–56.
- Oram, S., Zimmerman, C., Howard, L.M. and Hossain, M. (2019) 'Barriers to the access and utilization of healthcare for trafficked youth: A systematic review', *Child Abuse & Neglect*, 100, p. 104137.
- Ottisova, L., Hemmings, S., Howard, L.M., Zimmerman, C. and Oram, S. (2016) 'Prevalence and risk of mental disorders in survivors of human trafficking: A systematic review and meta-analysis', *The Lancet Psychiatry*, 3(4), pp. 320–329. doi: 10.1016/S2215-0366(16)00070-3.
- Peprah, D. (2024) 'Advocates call for integration of anti-human trafficking into health training curricula', *Ghana News Agency*. Available at: <https://gna.org.gh> (Accessed: 15 March 2026).
- Powell, K., Chisolm-Straker, M. and Stoklosa, H. (2019) 'Training healthcare providers to identify human trafficking: a systematic review', *Journal of Human Trafficking*, 5(3), pp. 231–248.
- Recknor, F., Macy, R.J. and Graham, L.M. (2022) 'Healthcare provider responses to human trafficking: A scoping review', *Trauma, Violence, & Abuse*, 23(2), pp. 456–470.
- Riger, S. and Sigurvinsdottir, R. (2016) 'Qualitative research methods in psychology: Combining core principles with applied practice', *American Psychologist*, 71(4), pp. 263–273.
- Stoklosa, H., Chisolm-Straker, M. and Baldwin, S. (2017) 'Medical education on human trafficking: a call to action', *Academic Medicine*, 92(5), pp. 612–614.
- Sundler, A.J., Lindberg, E., Nilsson, C. and Palmér, L. (2019) 'Qualitative thematic analysis based on descriptive phenomenology', *Nursing Open*, 6(3), pp. 733–739.
- Todres, M.T., DiGangi, J. and Hynes, M.E. (2009) 'Health care providers' awareness of human trafficking: a survey', *Journal of Health Care for the Poor and Underserved*, 20(4), pp. 1021–1032.
- UNICEF (2020) *Situation Analysis of Children and Women in Ghana: Greater Accra Region*. Accra: UNICEF Ghana.
- UNICEF Ghana (2019) *Child Trafficking and Labour Exploitation in Coastal Ghana: Situational Analysis*. Accra: UNICEF.
- United Nations (UN) (2000) *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (Palermo Protocol)*. New York: UN Office on Drugs and Crime.

- United Nations Office on Drugs and Crime (UNODC) (2020) Global Report on Trafficking in Persons 2020. Vienna: UNODC.
- United Nations Office on Drugs and Crime (UNODC) (2022) Global report on trafficking in persons. New York: UNODC.
- Vasileiou, K., Barnett, J., Thorpe, S. and Young, T. (2018) 'Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period', *BMC Medical Research Methodology*, 18(1), p. 148. doi: 10.1186/s12874-018-0594-7.
- World Health Organization (WHO) (2013) Strengthening the health system response to human trafficking. Geneva: WHO.
- World Health Organization (WHO) (2022) Mental Health Atlas 2022: Ghana Country Profile. Geneva: WHO.
- Zimmerman, C., Hossain, M. and Watts, C. (2008) 'Human trafficking and health: A conceptual model to inform policy, intervention and research', *Social Science & Medicine*, 66(6), pp. 1224–1235.
- Zimmerman, C., Hossain, M. and Watts, C. (2011) 'Human trafficking and health: a conceptual model', *Social Science & Medicine*, 73(2), pp. 327–335.
- Zimmerman, C., Hossain, M., Yun, K., Gajdadziev, V., Guzun, N., Tchomarova, M., Ciarrocchi, P., Johannsson, A., Katsakou, Z., Mehmood, S. and Watts, C. (2008) 'The health of trafficked women: A survey of women entering post-trafficking services in Europe', *American Journal of Public Health*, 98(1), pp. 55–59. doi: 10.2105/AJPH.2006.108357.
- Zimmerman, C. and Kiss, L. (2017) 'Human trafficking and exploitation: A global health concern', *PLoS Medicine*, 14(11), e1002437.

APPENDICES

1. PARTICIPANTS INFORMATION SHEET

Title of Study: The role of health professionals in the combat against human trafficking in Ada East and West Districts of the Greater Accra Region, Ghana

Dear Participant,

I, Esther Adinorkie Lawerteh, a Master of Public Health Student at Ensign Global University, Kpong, am researching “The role of health professionals in the combat against human trafficking in Ada East and West Districts of the Greater Accra Region, Ghana.” I can be always contacted on 0248287418/0208495992, esther.lawerteh@st.ensign.edu.gh, Box 32, Kasseh Ada.

Background and Purpose of research: This survey aims to explore how public health systems can better address human trafficking in the district and the country by understanding healthcare workers' knowledge, attitudes, and practices. It forms part of my academic work and may also help inform future health policies

Nature of research: You will be asked questions relating to your knowledge and experience in human trafficking. A sample of 422 participants across all cadres of health professionals in facilities in the two districts will be contacted for the study answering online survey questionnaires with 4 expect interviews including the two District Health Directors.

Participants’ involvement:

- Duration /what is involved: you are required to answer the questions with clarity and truthfully. Approximately 20-30minutes will be needed for each survey.

- **Potential Risks:** This survey might require you to give very personal details about yourself and your facility. Please note that your participation is entirely voluntary. You are not required to explain your reasons if you choose not to take part in the study.
- **Benefits:** Please note that there are no direct material or financial benefits for participating in this study. However, your participation will assist us in identifying factors that influence health professionals' roles in the combat against human trafficking.
- **Costs:** There will be no costs whatsoever to you or your facility in participating in this study
- **Compensation:** There are no compensation directly to benefit you or your facility however a token of data will be sent to you at your discretion.
- **Confidentiality:** Your name will not appear on the questionnaire. All responses will be kept confidential, anonymized, and used only for research purposes. You may skip any question or pause at any time
- **Voluntary participation/withdrawal:** This study will involve some questions about your perception and experiences related to Human trafficking and might take about 20 to 30 minutes to complete. Participation is completely voluntary, and you're not obliged to answer any or all questions. Again, you are free to withdraw and discontinue this interview at any time without providing any reason.
- **Outcome and Feedback:** All data collected in this study will be used solely for research purposes, including analysis, reporting, and dissemination in academic or professional formats (e.g. reports, publications, presentations). Data will be analyzed in aggregated form to ensure that individual participants cannot be identified. Participants will not be individually identifiable in any reports or publications arising from this study. A summary

of overall study findings may be made available to participants upon request or shared via a general report or presentation at the conclusion of the study.

- **Appropriate alternative Procedures and Treatment:** Participation in this study is entirely voluntary. Non-participation will not result in any penalty, loss of benefits, or access to services. As this study is observational/educational in nature (and does not involve clinical intervention), there are no alternative procedures or treatments required as substitutes for participation. Participants who choose not to take part may seek information, support, or services related to the study topic through existing healthcare providers, wellness programs, or publicly available educational resources.
- **Feedback to participant:** Participants will be provided with general feedback on the study findings in the form of a summary report or presentation, which will outline key themes and aggregated results. No individual-level data or personalized feedback will be provided. Participants will be informed at the time of consent how and when this feedback will be made available
- **Declaration of conflict of interest:** I declare that there is no conflict of interest associated with this study. There are no financial, professional, or personal relationships that could influence the conduct, analysis, or reporting of the research.
- **Data storage and duration, data ownership:** All data collected will be stored securely in password-protected electronic files and/or locked physical storage accessible only to the principal investigator(s) and authorized research team members. Identifiable data (if any) will be separated from research data and replaced with unique study codes. Data will be retained for a period of 5 years in accordance with institutional and ethical guidelines, after which it will be securely destroyed. The data generated from this study will be owned by

the principal investigator(s) and the host institution, in line with institutional research governance policies.

- Funding information: This study is self-funded / institutionally funded.
- Sharing of participants Information/Data: The data generated from this study will be owned by the principal investigator. Individual-level data will not be shared with third parties. Only de-identified, aggregated data may be used for academic publications or presentations. No data will be shared with other organizations or individuals outside the research institution without additional ethical approval. All data use will comply with applicable data protection and confidentiality regulations.

Who to Contact for Further Clarification/Questions: By completing this survey, you are giving consent to participate. If you have any questions, contact Esther Adinorkie Lawerteh at esther.lawerteh@st.ensign.edu.gh or 0248287418/0208495992. You can equally contact the Ghana Health Service Ethics Review Committee Administrator's on (0503539896 or 0559886678, ethics.research@ghs.gov.gh) for further clarification on ethical issues and your rights as participants if need be.

Thank you for participating. Your input will directly inform public health strategies to combat human trafficking in Ghana.

Date:

Kindly click yes to continue or no to decline

Thank you

2. CONSENT FORM

2.1 STUDY TITLE: The Role of Health Professionals in the Combat Against Human Trafficking

2.2 PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand (English/Dangme). I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name of Participant.....

Participants' Signature OR Thumb Print.....

Date.....

2.3 INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (English/Dangme) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter.....

Signature of Interpreter..... OR Thumb Print

Date:.....

2.4 STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood English/Dangme)

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name.....

Signature..... OR Thumb Print

Date:.....

2.5 INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name.....

Signature

3. HEALTHCARE WORKER SURVEY QUESTIONNAIRE

3.1 INFORMED CONSENT

The role of health professionals in the combat against human trafficking in Ada East and West Districts of the Greater Accra Region, Ghana

Dear Participant,

I, Esther Adinorkie Lawerteh, a Master of Public Health Student at Ensign Global University, Kpong, am researching “The role of health professionals in the combat against human trafficking in Ada East and West Districts of the Greater Accra Region, Ghana.”

This survey aims to explore how public health systems can better address human trafficking in the district and the country by understanding healthcare workers' knowledge, attitudes, and practices. It forms part of my academic work and may also help inform future health policies

3.1.1 Confidentiality

Your name will not appear in the questionnaire. All responses will be kept confidential, anonymized, and used only for research purposes. You may skip any question or pause at any time

3.1.2 Risks

This survey might require you to give very personal details about yourself and your facility. Please note that your participation is entirely voluntary. You are not required to explain your reasons if you choose not to take part in the study.

3.1.3 Benefits

Please note that there are no direct material or financial benefits for participating in this study. However, your participation will assist us in identifying factors that influence health professionals' roles in the combat against human trafficking.

3.1.4 Voluntary Withdrawal

This study will involve some questions about your perception and experiences related to Human trafficking and might take about 20 to 30 minutes to complete. Participation is completely voluntary, and you're not obliged to answer any or all the questions. Again, you are free to withdraw and discontinue this interview at any time without providing any reason.

By completing this survey, you are giving consent to participate. If you have any questions, contact Esther Adinorkie Lawerteh at esther.lawerteh@st.ensign.edu.gh or 0248287418/0208495992.

Thank you for participating. Your input will directly inform public health strategies to combat human trafficking in Ghana.

Date:

Kindly click yes to continue or no to decline

Thank you

4. Questionnaire

4.1 Quantitative Questionnaire

4.1.1 Socio-Demographic Information

1. Sex: ☐ Male ☐ Female ☐ Other
2. Age: _____ years : ☐ 18-35, ☐ 36-40, ☐ 41-45, ☐ 46-50, ☐ 51-55, ☐ 56-60,

3. Profession: ☐ Doctor ☐ Physician Assistant ☐ Midwife ☐ Nurse ☐ Laboratory Technician ☐ Pharmacy/Dispensary ☐ Other (specify): _____
4. Years of Experience: _____ ☐ 1-5, ☐ 6-10, ☐ 11-15, ☐ 16-20, ☐ 20+
5. Type of facility: CHPS Compound ☐ Health Centre ☐ Poly-Clinic ☐ Hospital
6. Facility Location: _____/_____

4.1.2 Knowledge Assessment (Awareness and Knowledge of Human Trafficking)

7. Have you ever heard of human trafficking? ☐ Yes ☐ No
8. Which of the following forms of trafficking are you aware of? (☐ Sex, ☐ Labor, ☐ Organ, ☐ Child, ☐ Other)
9. How confident are you in identifying a trafficking victim? ☐ Extremely Confident ☐ Confident ☐ Moderately Confident ☐ Slightly Confident ☐ Not Confident at all
10. How would you rate your knowledge of human trafficking? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Knowledge on Red Flags
11. Can you identify signs of a potential trafficking victim in a healthcare setting? ☐ Yes ☐ No ☐ Not sure

4.1.3 Knowledge on AHT Laws/Rules and regulations

12. Are you familiar with Ghana's Human Trafficking Act (2005) ☐ Yes ☐ No
13. Are you familiar with the mandatory reporting protocols for HT: ☐ Yes ☐ No
14. Do you know any referral pathways for HT survivors (e.g., social services, shelters): ☐ Yes ☐ No

4.1.4 Current Practices

15. Have you ever encountered a suspected trafficking victim in your line of duty? ☐ Yes ☐ No
16. What specific actions have you taken when you suspected a case of trafficking? ☐ Followed Internal Reporting Procedures ☐ Contacted Appropriate Authorities ☐ Observed and Gathered

non-intrusive Information ☐ Consulted a supervisor or trained specialist ☐ Ensured Immediate safety ☐ Maintained Confidentiality ☐ Referred individual for support services

17. Have you referred a suspected trafficking victim to any service provider? ☐ Yes ☐ No

18. In your view, do public health professionals have a role in combating trafficking? (Yes/No)

19. Have you ever received any formal training on human trafficking? (Yes/No)

20. Does your facility have a protocol/guideline for handling suspected trafficking cases? ☐ Yes ☐ No ☐ Not sure

21. In your view, is your facility in a position to handle any HT victim if identified? ☐ Yes ☐ No ☐ Not sure

4.1.5 Attitudes Assessment (Agree/Disagree (1 = Strongly Disagree, 5 = Strongly Agree))

22. "Healthcare workers in Ghana can play a critical role in identifying HT victims." [1] [2] [3] [4] [5]

23. "I feel confident in recognizing potential HT cases." [1] [2] [3] [4] [5]

24. "Addressing HT is a priority in my facility." [1] [2] [3] [4] [5]

25. "Fear of legal/security risks discourages HT reporting." [1] [2] [3] [4] [5]

4.1.6 Challenges

26. Would you face any challenge if you were to deal with any trafficking case? Yes No

27. If yes to 25, what would that challenge be? (Select all that apply) ☐ Lack Of Training, ☐ Fear Of Retaliation, ☐ Lack Of Institutional Support, ☐ Limited Knowledge Of Referral Options, ☐ Other:

NB: HT-Human Trafficking AHT-Anti Human Trafficking

4.2 SEMI-STRUCTURED INTERVIEW GUIDE (Qualitative Tool) for Expert Interview

4.2.1 Participant Information (To be completed pre-interview)

1. Participant ID: _____
2. Role: a. Policymaker (Ministry/GHS) b. Healthcare Administrator c. others (specify)
3. Region/Facility: _____
4. Interview Language: ☐ English ☐ Dangme ☐ Twi ☐ Other: _____

4.2.2 Systemic Challenges

5. Can tell me a little about your understanding of human trafficking? (Probe: understanding on definition if possible, description etc).
6. Have you ever had any experience related to human trafficking? (Probe: observation, personal experience, news, known experiences of others etc).
7. In your view do you think trafficking can be addressed in Ghana? (Probe: ideas on addressing human trafficking problems in Ghana)
8. From your perspective, what are the biggest weaknesses in Ghana's healthcare response to human trafficking?" (Probe: Resource constraints, staff training, data sharing, survivor support)
9. What barriers do you face in identifying or responding to such cases?
10. What are the biggest gaps in healthcare support for Human Trafficking survivors?" "How do resource constraints impact anti-trafficking efforts?"
11. What support do you receive from your institution or government in relation to handling human trafficking related cases?

4.2.3 Policy

12. What are your thoughts on the role of public health addressing human trafficking and what recommendations would you make to improve public health efforts?
13. What policy changes would strengthen Ghana's Human Trafficking response?"
14. "How would you describe coordination between health services, law enforcement, and NGOs on trafficking cases?" (Probe: Examples of successes/failures; trust issues?)
15. "What public health strategies (Probe: screening protocols, community outreach) could most effectively reduce trafficking vulnerability?"
16. "Where should funding be focused to maximize health-led prevention (e.g., training, shelters, hotlines)?"
17. How can healthcare systems better address survivors' physical/mental health needs?"
18. Is there anything we haven't discussed that you would like to add?

5. Transcript of Qualitative Interview of participant P001

Interviewer: Thank you for the opportunity to do this interview with you. Can you tell me a little about your understanding of human trafficking?

Participant: *Human trafficking is a practice where individuals, vulnerable people, are taken off from where they stay to another place, unwillfully or without their will. Sometimes through deception and sometimes it may even be through force. So whilst a person is transported or taken from one place to the other, maybe for purposes that may be work or other things, which is not according to the will and desire of the person, that person is said to have been trafficked.*

Interviewer Thank you. Have you ever had any experience related to human trafficking, as in observation or personal experience?

Participant: *No, personally, but observation. Our work area, we've come across different people that have been trafficked. Some adults trafficked outside the country, others trafficked, children trafficked within the country. So I've experienced, or let me say, I've witnessed people and I've come in touch with people who have been trafficked.*

Interviewer : In your view, do you think human trafficking can be addressed in Ghana?

Participant: *Of course, there is no issue that cannot be addressed. When it comes to human trafficking, just like other issues, it can be addressed, but it needs a conscientious effort. States, the states, and then individuals and all stakeholders have to just make up their mind and put in the effort to stop it. So just like any social issue, once we are determined to stop it, we can nib it in the bud.*

Interviewer: Okay, thank you. So virtually we have talked about some of the ideas as to how we can address it. As a social issue, we have to address it today. So from your perspective, what are the biggest weaknesses in Ghana's health care response to human trafficking?

Participant: *When it comes to health care response, you know, persons that are trafficked, sometimes because of the change of environment may attract certain diseases and even the circumstances or conditions that it goes through. But our current health insurance status doesn't cater for such people, and such people may not have money. And so I think there is a gap over there. Persons of that nature who are vulnerable should have been under a kind of social protection health-wise, but that is not the case. Also, I think that sometimes when some of these people are rescued, we don't do screening for them to be able to identify what kind of health*

challenges that they may be coming with from different areas. I think that's a little bit of a gap, if I really understand your question.

Interviewer : So would you also talk about , will you say some of the weaknesses, as in the biggest weaknesses in Ghana's health care response to human trafficking can be resource constraints or staff training and data sharing or all of these trafficking issues that come about?

Participant: *Well, resource, but it is because we've not made allocation. If we really want to make allocation for that, because such people are vulnerable people, and they also need health care anyway. But it looks like we don't give so much attention to the human trafficking issue and how related it is to health.*

Interviewer: how related to

Participant: *sometimes, we just look at it from freeing the person, but not looking at some of the underlying conditions that a trafficked person may come with. So our attention has not been tilted towards that. And every day we will try to make some room or more or less reservation for that. So I don't think it's an issue of resources, but it is the non-allocation of the resource because our attention is not there.*

Interviewer: the none allocation of resources, So what barriers do you face in identifying or responding to such cases?

Participant: *Which cases?*

Interviewer: The cases of the biggest weaknesses in Ghana's health care.

Participant: *Please, can we go again?*

Interviewer: So what barriers do you face in identifying or responding to such cases of the biggest weaknesses in Ghana's health care response?

Participant: *Well, so it is, I think, one, the biggest challenge is causing people to come to the same level of understanding that there is an issue here. Because if the person doesn't understand that there is an issue, there is a challenge, the person will not have to resolve it. So for instance, there is a gap that we've spoken about, that there is a gap of health, that they are not insured, they don't have the hospital or health system that's going to take care of them. But a lot of people don't see that it's a challenge. So once people don't see it as a challenge, it will be difficult to even start resolving it in the first place. So the biggest challenge is the part that we don't even see it to be an issue. The second also is that sometimes to... Our health system is already overwhelmed when it comes to personnel. So sometimes when some of these people go, health-wise, to have time for them and be able to take them through psychological counseling and the rest, we think that once the person is not showing any physical signs of ailment, the person is not ill. But some of those things, what they go through is trauma. And this kind of trauma, you might not necessarily see it physically. So our health system is overwhelmed such that we take care of the physical ailments rather than some of this mental ailment that comes with trafficking in persons.*

Interviewer: So what are the biggest gaps in healthcare support for human trafficking survivors? How do the resource constraints impact anti-trafficking efforts?

Participant: *Well, we don't have a lot of clinical psychologists and also we don't have a lot of psychiatric nurses. So with traffic victims, they need that a lot. That's in the clinical psychologists?*

Interviewer: As in the clinical psychologist

Participant: *Exactly. And then the... Yeah, they need that a lot. That's an underline of most of their ailments and their issues. So once you have a lot of these people around and are available, they can be, I mean, attending to these people. So I think that one of the major things is the unavailability or the number, the less number of clinical psychologists.*

Interviewer: That's good. That's well noted. So what support do you receive from your institution or government in relation to handling human trafficking-related cases?

Participant: *That support has got to do more with the police, the institutions trying to support you to arrest the perpetrators and also the social welfare trying, coming in as supporting or helping those who have been trafficked. But apart from that, there isn't any much of support coming from state institutions.*

Interviewer: What are your thoughts on the role of public health in addressing human trafficking? And what recommendations would you make to improve public health efforts?

Participant: *Well, public health has a role to play in the sense that they could put their expertise at the disposal of some of these victims. Yeah, or let's say survivors. But the issue is we don't also have a lot of those public health nurses or health personnel available. The gap I see is the numbers. The gap I see is the numbers. Though sometimes they are very important and they could help. And even sometimes observing the behavior and actions of the people and even suggest some medical treatment, they are not enough in the system. So once they are not enough, you will not be able to get the benefits that you need to get from a public health official.*

Interviewer: So what recommendations would you make to that effect?

Participant: *I think government needs to ensure that more are trained. Not just trained, but ensure that they are also recruited. Because there are situations where a lot of serving personnel have been trained but they've not been recruited for them to perform their role. So training and recruiting them and ensuring that they help in the public health system of Ghana is going to be very critical.*

Interviewer: Thank you. What policy changes will strengthen Ghana's human trafficking responses?

Participant: *I think our human trafficking responses have for a very long time been dependent on arrests and prosecution. Arrests and prosecution. You arrest the victims and you prosecute the perpetrators. But after arresting the perpetrators and maybe prosecuting them, we forget about the victims themselves. So we need to also focus a little bit on the victims of trafficking and how we are able to support them health-wise and social-wise. How to reintegrate them back into the society. So our human trafficking efforts is just in that we are arresting those people and freeing persons that have been trafficked. What about the welfare of the victims themselves? So we need to focus on the welfare of the victims as well.*

Interviewer: How would you describe the coordination between health services, law enforcement and NGOs on trafficking cases?

Participant: *Very poor. Very poor.*

Interviewer: Any examples?

Participant: *Very poor coordination. Very poor coordination in a sense that even when data is available, even government institutions find it difficult sharing data. And for a very long time, you realize that it is the non-profits, organizations that do a lot of the rescuing. And some of the*

government agencies come to them for the data. But when they come for the data, they don't share it. They don't share it with health institutions and the rest. So what we need to do is to have a centralized system where this centralized system takes care of the victims so that their data and everything is available to health officials and the various government agencies that will need it. If we have a single system that all this data and information is kept, I think health officials will also go for it and other government agencies or departments will also go for that. But currently, there is no proper coordination among the government agencies.

Interviewer: I see. That's insightful. What public health strategies could most effectively reduce trafficking vulnerability? As in maybe the screening protocols, community outreach, or any other thing that could most effectively reduce trafficking vulnerability?

Participant: *Sometimes, people are trafficked for various reasons. So once people are trafficked for various reasons, public health has a role. One, there are people who have the perception that they need to travel to certain places, but they don't know that there is what we call this organ trafficking. Okay? So people are trafficking them basically because of their organs. So if people are aware and they know that even if you are healthy, you are a target for traffickers because when they traffic you, they could remove any of your, what do you call it, your parts, your body parts, and use it. Some of those things could help curb it. People feel that, oh, anybody that want to travel with me or take me outside the country, why not? Secondly also, I think that public health, people may run or may run away or may fall victims of trafficking if they lack the resources to take care of their health. So for instance, people do things for various reasons. So if there is availability of public health, a very working or crucial public health system, I think it could be of support to people who need some little bit of public education on certain things that they are doing and by extension, we hope to reduce trafficking in a way.*

Interviewer: Where should funding be focused to maximize health-led prevention? Should it be on trainings, shelters, health lines, or any other thing?

Participant: *Well, trainings are good, but I think that the training should be focused on how to identify such persons and also the kind of referral system that is available. But upon all, training should not take majority of those resources. Making available the health facility and the personnel to take care of the people is the best. The training is needed, but we should focus on the services that are related to persons of trafficking. That's important.*

Interviewer: That's the way you think it should be focused. The services that are supposed to be given to them.

Participant: *The funding should be focused.*

Interviewer: How can healthcare systems better address survivors? That is, survivors' physical or mental health needs.

Participant: *There should be a special health desk for persons of trafficking. It could be an existing health desk that is doing something else that you can attach to their mental health. So that when persons are victims of trafficking, they know that there is a one-stop shop in a hospital that can take care of them, whether it is mental or physical abuse. They know there is a one-stop shop. For instance, when you go to a hospital, you know there is a one-stop shop for HIV patients. There is a one-stop shop for pregnant women. There are those kinds of things. And even for mothers, those one-stop shops are okay. Because when people are victims of trafficking, they may not necessarily want to say it because of the stigma associated with some of them. But if in a hospital, this outpatient department or this desk is meant for persons of trafficking and also any other thing, people can work straight there and they will be given treatment. Because you cannot*

allow such a person to go through the normal out-of-patient process and expect a person to be able to see a doctor and speak and say what is worrying him or her. But immediately the person knows there is a desk. When a person gets there, they know the kind of questions to ask the person, which is not general health issues, but they know what to specifically tackle.

Interviewer: This has been an insightful conversation so far. Finally, is there anything you haven't discussed that you would like to add?

Participant: *Not really, but I think that there is a gap between health and human trafficking. Sometimes funders do not seem to think about the health aspect of trafficked victims. Because with my experience, the victims of trafficking have a lot of underlying mental issues. Even if you cannot find physical issues, you have a lot of mental issues. We have children that have suffered from bilharzia. We have children that have suffered from what you call it, body pains out of trafficking and the rest. But sometimes their funding is directed towards rescuing them. But in the process of reintegrating them, they need also this kind of health support to be able to come back into society. So a lot of funders do not really take a look at that. I think it's one of the areas that funding needs to take care of.*

Interviewer: Thank you for taking time out of your busy schedules for this conversation. I'm grateful for your time.

Participant: *you welcome*

Interviewer: Okay

6. Ethical Clearance and Letters of Introduction



**GHANA
HEALTH
SERVICE
ETHICS REVIEW COMMITTEE**

Research & Development Division
Ghana Health Service
P. O. Box MH 190
Accra,
Digital Address: GA-950-3303

Quote this number and date on all correspondence

My Ref No: GHS-26/112

Your Ref No:

Date: 16th March 2026

Esther Adinorkie Lawrenteh
Ensign Global University
C/O P.O. Box 32,
Kasheh Ada

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

GHS-ERC Number	GHS-ERC: 031/01/26
Study Title	The Role of Health Professionals in the Combat against Human Trafficking in the Ada East and West Districts of the Greater Accra Region, Ghana
Approval Date	16 th March 2026
Expiry Date	15 th March 2027
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ghana Health Service Ethics Review Committee (GHS 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 GHS ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing GHS ERC if study cannot be implemented or is discontinued and reasons why
- Informing the GHS ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without GHS ERC approval of the amendment is invalid.
- The GHS 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
- Please note that in the event where samples will be shipped outside Ghana, a signed Material Transfer Agreement should be submitted to the GHS ERC for approval.
- Please note that future use of biological samples will require GHS ERC approval and the samples cannot be used for commercial purposes.

SIGNED.....
Mr. Kofi Wellington
(GHS ERC Chairperson)

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

Tel: +233-302-960628
Mob: +233-50-7139836
Email: ethics.research@ghs.gov.gh
Website: www.ghs.gov.gh

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CamScanner

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



District Health Directorate
Ada East District
Ghana Health Service
P. O. Box AF 18,
Ada – Foah.
Email; adaeastdhd1@gmail.com

My Ref. No.
GHS/GA/AE/DHD/ADM/R0126
Your Ref. No.....

Tel: 233209049227

31st March, 2026

ALL FACILITY HEADS

RE- LETTER OF INTRODUCTION

We forward herewith the attached letter from the Regional Director of Health Services dated 25th March 2025 and referenced **GHS/GAR/RHD/ORD/2026** in respect of the above-named officer for your attention and necessary action please,

Kindly accord the officer the needed support.

Thank you.

DR. HUBERT D.K HOUNKPATIN
DISTRICT DIRECTOR OF HEALTH SERVICE
ADA EAST.

ADMINISTRATION | ADA EAST DISTRICT HEALTH DIRECTORATE **Tel: 233209049227**



**GHANA
HEALTH
SERVICE
ETHICS REVIEW COMMITTEE**

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra.
Digital Address: GA-050-3303

Quote this number and date on all correspondence

My Ref No: GHS/26/112

Your Ref No:

Date: 16th March 2026

Esther Adinorkie Luvetteh
Ensign Global University
C/O P.O. Box 32,
Kasheh Ada

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- Please note that future use of biological samples will require GHS ERC approval and the samples cannot be used for commercial purposes.

SIGNED.....

Mr. Kofi Wellington
(GHS ERC Chairperson)

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

Tel: +233-302-960638
Mob: +233-50-5539936
Email: ethics_research@ghs.gov.gh
Website: www.ghs.gov.gh

Administrative Manager
Ada East Health District
REC'D

Scanned with
CamScanner



**GHANA
HEALTH
SERVICE**

DISTRICT HEALTH
DIRECTORATE
ADA WEST

P. O. Box AF, Sege - Ada
Digital Address: GX- 0000- 4582

Quote this number and date on all correspondence

My Ref No: GHS/ADW/DHD/ADMIN/131/26

Your Ref No: _____

Date: 31st March, 2026

THE MEDICAL SUPERINTENDENT, SEGE POLYCLINIC
THE PRINCIPAL PHYSICIAN ASSISTANT IN-CHARGE, ANYAMAM HEALTH CENTRE
THE PRINCIPAL PHYSICIAN ASSISTANT IN-CHARGE, BORNIKOPE HEALTH CENTRE
ALL CHPS COMPOUND FACILITY IN-CHARGES
ALL CORE DHMT MEMEBRS, ADA WEST

LETTER OF INTRODUCTION

MS. ESTHER ADINORKIE LAWERTEH - MASTER OF PUBLIC HEALTH STUDENT, ENSIGN GLOBAL UNIVERSITY.

RESEARCH TOPIC: THE ROLE OF HEALTH PROFESSIONALS IN THE COMBAT AGAINST HUMAN TRAFFICKING IN THE ADA EAST AND WEST DISTRICTS OF GHANA.

The Ada West District Health Directorate writes in pursuance and in acknowledgement of the receipt of the letter with reference number *GHS/GAR/RHD/ORG/2026* dated *25th March, 2026* with the subject, "*Request For Data On The Location Of Health Facilities.*" emanating from the Greater Accra Regional Health Directorate (GARHD) in respect to the above subject matter. Management of the Ada West District Health Directorate with approval from the GARHD has granted approval to the above-named officer to carry out research in your outfit. The above-named officer with her team of researchers will be paying a working visit to your facility to grant interview to both staff and clients. The date and time will be communicated to you in due course.

You can kindly reach the team lead *Ms. Esther Adinorkie Lawerteh* on *0248287418* for any further discussion. Please accord them all the necessary support for a successful exercise.

Kindly find a copy of the letter from the Regional Health Directorate for your attention and required action.

Thank you.


DR. MAXWELL W. ONASSIS-FIADJOE
AG. DISTRICT DIRECTOR OF
HEALTH SERVICES
ADA WEST DISTRICT

**DR. MAXWELL W. ONASSIS-FIADJOE
AG. DISTRICT DIRECTOR OF HEALTH SERVICES
ADA WEST DISTRICT**

Cc: Ms. Esther Adinorkie Lawerteh - Master Of Public Health Student, Ensign Global University. ✓

Tel: + 233 (0) 249402771
Email: adawest.dhdgar@ghs.gov
Website:



GHANA
HEALTH
SERVICE
REGIONAL HEALTH DIRECTORATE,
GREATER ACCRA

P.O. BOX 184
ACCRA - GREATER ACCRA
Email Address: GHS-075-0430
Note: My health and life are at risk - urgent
My Ref: GHS/GAR/RHD/085/2026
Your Ref:
Date: 25th March, 2026

THE DISTRICT DIRECTORS OF HEALTH SERVICE
- ADA EAST
- ADA WEST

26/03/2026

RE: LETTER OF INTRODUCTION

Kindly find attached a letter with Reference No. ENSIGN/IRB/EL/5N-339-003 dated 16th January 2026 from the Registrar, Ensign Global University on the above subject matter for your information and necessary support.

Approval is hereby granted for the conduct of the research at your facilities.

Thank you

DR. ROBERT AMESIYA
Ag. REGIONAL DIRECTOR OF HEALTH SERVICE
GREATER ACCRA

Cc: The Ag. Deputy Director, Clinical Care

Email: rths.gar@ghs.gov.gh
Tel: 0302248997

② Admin
Let's kindly work to facilitate
heads to accord the media
copies as approved by RHD
Thank you

31/03/26

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ENSIGN GLOBAL
UNIVERSITY

OUR REF: ENSIGN/IRB/EL/SN-339-003
YOUR REF:

Friday, January 16, 2026

The Chairperson
Ghana Health Service Ethics Review Committee
Research and Development Division
P.O. Box MB 190
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION

We respectfully write to introduce to you Esther Adinorkie LAWERTEH (**Student Identification Number 257100339**) a student of the Master of Public Health (MPH) degree program of the University.

As part of her graduation requirements, she is writing a thesis on the topic; **"The Role of Health Professionals in the Combat Against Human Trafficking in Ada East and West Districts of Ghana"** and would like to obtain data from your outfit.

We would be grateful if you kindly accede her any assistance she may require in the collection of this data in your unit for her thesis.

Thank you.

Faithfully yours,



MICHAEL BOATENG DARKO
ASSISTANT REGISTRAR
FOR: REGISTRAR

P. O. Box AK 136 | Tema-Akosombo Highway, Kpong, Eastern Region, Ghana |
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mobile.ghanaweb.live

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3

Festus Anane Mensah, Sukesh Kumar Bartarya. "Study of Salinization in Shallow Aquifer in the Ada East-West Districts of Ghana", World Environmental and Water Resources Congress 2014, 2014

Publication

4

mx24online.com

Internet Source

5

damaacademia.com

Internet Source

6

Rebecca Sarku. "Farmers' perspectives on water availability in the lower Volta Delta region in Ghana", Regional Environmental Change, 2023

Publication

7

dokumen.pub

Internet Source

8

Submitted to Southern New Hampshire University - Continuing Education

Student Paper

9

justiceandcare.org

Internet Source

10

Emmanuel Tetteh Jumpah, Abdulai Adams, Selorm Ayeduvor. "Estimating Yield and Income Effects of Formal Credit-Based Programme among Tomato Farmers in the Greater Accra Region of Ghana", Scientific African, 2020

Publication

11

blog.urbanegallant.com

Internet Source

12

ojs.journalsdg.org

Internet Source

13

ir-library.ku.ac.ke

Internet Source

14 ir.ucc.edu.gh
Internet Source

15 Slaughter-Cooper, Ann Michelle. "A Study on the Influence of Divine Nine Sorority Membership on Retention at an HBCU: Insights from Members' Perspectives.", Alabam. State University
Publication

16 F. A. Mensah, S. K. Bartarya, T. A. Tagbor. "Chapter 11 Hydrogeochemical Study of Shall Coastal Aquifer as a Complement to Integrated Water Resources Management in Ghan Springer Science and Business Media LLC, 2026
Publication

17 cdn.fortunejournals.com
Internet Source

18 en.wikipedia.org
Internet Source

19 Submitted to Colorado Technical University Online
Student Paper

20 Submitted to Saint Leo University
Student Paper

21 repository.aaup.edu
Internet Source

22 repository.seku.ac.ke
Internet Source

23 Brown, Samuel Wilber, Jr.. "Integrating AI-Driven Clinical Decision Support Systems to Improve Diagnostic Accuracy and Treatment Planning in Healthcare.", National Univers
Publication

24 britsoc.co.uk
Internet Source

25 openhub.spu.ac.za
Internet Source

26 apps.who.int
Internet Source

27 documents1.worldbank.org
Internet Source

28 ugspace.ug.edu.gh
Internet Source

29 www.opastpublishers.com

30

www.scirp.org

Internet Source

31

Submitted to Georgia State University

Student Paper

32

Submitted to University of Northampton

Student Paper

33

Submitted to Zambia Centre for Accountancy Studies

Student Paper

34

Eric Tamatey Lawer, Kofi Takyi Asante. "Inclusive proletarianisation? Salt mining, outgrower schemes and the politics of dispossession", *The Extractive Industries and Society*, 2026

Publication

35

Submitted to Universität Bayreuth

Student Paper

36

www.africa-newsroom.com

Internet Source

37

www.fjitime.com

Internet Source

38

www.grafiati.com

Internet Source

39

Mwenda, Rosalia Batista. "Evaluation of Knowledge and Skills in the Assessment of Critically Ill Patients Among Nursing Students in Dodoma Region: A Cross-Section Study University of Dodoma (Tanzania)

Publication

40

archpublichealth.biomedcentral.com

Internet Source

41

bmjpublichealth.bmj.com

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42

hireawriter.iproject.com.ng

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