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'Am a Man of Infrastructure and not Health'. How Understanding Multisectoral Collaboration Shapes Adoption of Health in All Policies in an Urban Local Government Setting in Ghana

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Abstract

In low-and middle-income countries (LMICs) such as Ghana, multisectoral collaboration (MSC) is essential for achieving complex development and health objectives. While national policies like Health in All Policies (HiAP) advocate for integrated approaches, municipal implementation is often stifled by structural barriers and governance issues. However, multisectoral collaboration for health improvement in most LMICs, including Ghana, is a challenge due to the multiplicity of factors, key among which is the lack of understanding and awareness among stakeholders, with some having poor, disjointed, and weak capacity, coupled with poor evidence for multisectoral collaboration at local government levels. Therefore, this study seeks to explore the understanding of multisectoral collaboration for health improvement among key stakeholders in the Ashaiman Municipality of Ghana.

Methods

This study employed an exploratory descriptive case study design to examine multisectoral collaboration within the Ashiaman municipality. Data were collected through 20 semi-structured key informant interviews with heads of decentralized departments, a systematic desk review of municipal documents created between 2018 and 2023. The findings were validated during a stakeholder workshop. Data were analyzed thematically using NVivo Version 14, with emerging themes guided by theoretical frameworks on multisectoral collaboration and the Health in All Policies (HiAP) concept.

Results

The findings revealed a significant "conceptual-operational gap." Participants demonstrated limited awareness of core MSC frameworks, with many entirely unfamiliar with HiAP, Healthy Cities, and One Health concepts. As a result, collaborative practice was minimal; the desk review found negligible evidence of inter-departmental projects or joint reporting over the five-year period. Stakeholders perceived health as a narrow clinical responsibility rather than a shared municipal mandate, leading to siloed interventions and resource duplication.

Conclusion
The lack of shared conceptual clarity among municipal-level actors serves as a critical bottleneck to effective intersectoral action. Successfully operationalizing multisectoral approaches like HiAP framework at the local level, requires more than policy directives; it demands targeted capacity building, the institutionalization of joint planning mechanisms, and clearly defined sectoral roles. These reforms are vital for transforming multisectoral collaboration from a theoretical ideal into a functional driver of urban health.

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Background

Collaboration across multiple sectors is essential for safeguarding public health especially in low- and middle-income countries (LMICs) where health outcomes are driven by a complex mix of social, political, environmental, and economic factors [1]. These countries face a dual burden of infectious diseases - such as HIV/AIDS, tuberculosis, and cholera - and a rising prevalence of non-communicable diseases like cancers, cardiovascular diseases and respiratory disorders, which are further exacerbated by high risk behaviors [1-3]. Even though vital, medical care is inadequate to singularly address these health challenges because health outcomes are predominantly shaped by social determinants like economic status, educational attainment, and environmental conditions.

Consequently, achieving sustainable health improvements requires coordinated, cross-sectoral cooperation between diverse government and community actors [4]. Such a collaboration will optimize resource utilization, fosters policy coherence, and reduces health inequities by integrating health considerations into non-health sectors [5]. This collaborative approach also called Multisectoral Collaboration (MSC) is supported by global frameworks, such as the Sustainable Development Goals (SDGs) and the Health in All Policies (HiAP) approach, which advocate for intersectoral action to mitigate the broader determinants of health [6].

In Ghana, national development strategies including the Ghana Shared Growth and Development Agenda (GSGDA) and the National Health Policy, explicitly endorse multisectoral collaboration as a means of improving health outcomes. However, a significant implementation gap remains at the local level. Municipalities frequently encounter systemic constraints, including fiscal limitations, weak institutional structures, fragmented mandates, and inadequate capacity for integrated planning [7,8].

The Ashaiman Municipality, situated within Ghana's Greater Accra Region, exemplifies these challenges. Characterized by rapid urbanization and population growth, the municipality faces overlapping issues such as inadequate housing, poor sanitation, and youth unemployment, and restricted access to health care. Addressing these multifaceted crises necessitates an integrated response that transcends traditional sectoral boundaries. Despite this need, there is a paucity of empirical data regarding how local actors in Ashaiman perceive and operationalize MSC. Understanding stakeholder awareness, institutional preparedness, and operational barriers is critical for improving governance and localized policy implementation [7]. This study therefore investigates the perceptions of key stakeholders in the Ashaiman Municipality toward

multisectoral collaboration. It is expected to provide evidence-based insights to enhance cooperative governance and coordinating regional development initiatives.

Methodology

Study Settings

The study was conducted in the Ashaiman Municipality, a major urban center within the Greater Accra Region of Ghana, located approximately five kilometers north of Tema and 30 kilometers from the capital, Accra. Ashaiman is recognized as the fastest-growing urban area in Ghana and ranks as the fifth most densely populated municipality in the country. According to the Ghana Statistical Service, the municipality has an estimated population of 302,514, characterized by a high annual growth rate of 4.6% and a significant migration rate of 61.3% [9]. With a population density of 10,489 persons /Km^2, the area faces immense pressure on its infrastructure and social services.

For the purposes of health administration and service delivery, the municipality is organized into seven sub-municipalities, namely, Amuidjor, Blakpatsona, Niiman, Gbemi, Mantseman, Maamomo, and Tsinaigber [9,10]. Despite its proximity to Ghana's primary industrial and political hubs, Ashaiman is plagued by socio-environmental conditions typical of rapid, unplanned urbanization. These include extreme congestion, pervasive urban poverty, inadequate housing, and poor sanitation infrastructure.

The public health landscape is particularly precarious; the municipality frequently contends with outbreaks of infectious diseases including measles, rabies, and avian influenza, a situation further exacerbated by poor hygiene practices. Notably, 28.9**%** of residents engage in the indiscriminate dumping of refuse, contributing to a sanitation crisis that fuels both communicable and non-communicable disease burdens (Ashaiman Municipal Health Annual Report, 2023). These intersecting challenges underscore the municipality's need for the integrated, multisectoral governance approaches explored in this study

Study Population

The study population comprised a diverse range of stakeholders involved in the governance, administration, and implementation of health-related policies within the Ashaiman Municipality. Key informants who hold formal authority within the city's local government, serving as leaders and playing various roles based on the remit of their office(s). These study participants were key stakeholders in health in the Municipality and were expected to contribute in meaningful ways to improving the population's health within the Ashaiman Municipality. The participants were drawn from the executives of the local government and from among the heads of the thirteen (13) decentralized departments in line with the Local Government Act, 2016 (Act 936). Participants who included departmental and unit heads all of whom represented various sectors of the economy. This was essential because the offices they held and the critical roles they played within the local government setting influence significantly multisectoral collaboration for population health improvement. Other study participants included civil society, community health committee members, opinion leaders, political appointees, elected assembly members, traditional authorities among others who equally play critical roles in population health improvement. This right mix and blend of not only technocrats but also persons representing various sectors of the Ghanaian economy and the study setting, with key knowledge and skills relating to the phenomenon under study. The inclusion of these varied actors ensured a comprehensive assessment of how cross-sectoral synergy is understood and operationalized across different tiers of local government and community structures and provided the necessary information and insight needed for this study.

Study Design

This study employed a qualitative research design using a multi-mode approach that integrated Key informant interviews (KII), comprehensive desk review and a stake holder validation workshop. Data collection was conducted over an eleven-month period, from July 2023 to May 2024.

Data Collection

Key Informant Interviews (KII)

A purposive sampling technique was used to select twenty (20) participants for semi-structured key informant interviews. These participants represented leadership from all thirteen (13) decentralized departments and key units within the Ashaiman Municipal Assembly. The interviews were designed to elicit in-depth insights into

stakeholder perceptions of multisectoral collaboration (MSC) and the influence of governance and leadership on health outcomes.

Desk Review

To complement the primary data, a systemic desk review of institutional documents produced between 2018 and 2023 was conducted to gather information on how MSC was understood in the different departments and units of Ashaiman municipality. This timeframe was selected to capture longitudinal trends in collaborative governance and municipal planning. A total of fifty (50) documents were retrieved from departmental and unit heads, including Annual Action Plans, Programmes of Action, Project inception reports, structure plans, project sites meeting reports, and minutes. A framework was developed to capture data for the study to help explore the following, name of document, date, source of document, name of project/ service, initiating department/unit, implementing department/unit, evidence of governance structure/ capacity, among others

The review focused on identifying evidence of cross-sectoral synergy, the impact of leadership capacity on collaborative efforts, and the specific structural barriers encountered by different sectors within the assembly.

Stakeholder Workshop

The final phase of data collection involved a consultative workshop with twenty-seven (27) stakeholders. Participants were selected based on their institutional roles and influence, including departmental heads, Assembly members, Traditional authorities, and representatives from Civil Society Organizations (CSOs) and Community Health Management Committees (CHMCs).

The workshop served two primary functions:

- Data Enrichment: To capture nuanced information that may not have surfaced during the initial interviews or desk review.
- Validation: To present preliminary findings to the stakeholders for verification, ensuring the accuracy and credibility of the study's conclusions (member checking).

Data Processing and Analysis

Interviews were conducted and transcribed in English. First, the research team immersed itself in the data by reading and re-reading the transcripts. Responses in the interview transcripts were analyzed thematically for codes (recurring words or phrases) by team members. The codes were reviewed by the research team to develop themes for the data. The research team then met to compare and contrast the themes to identify similarities and differences in participants' responses to what governance is all about.

Similarly, data extracted during the desk review process were typed into Microsoft Word and analyzed together with those collected from other sources of data.

Ethical Approval

Ethical approvals for the study were obtained from the University of Leeds School of Medicine Research Ethics Committee (MREC 22-093) and the Ghana Health Service Ethics Review Committee (GHS-ERC 004/08/23).

Results

The primary objective of this study was to explore how stakeholders in the Ashaiman Municipality understand and operationalize multisectoral collaboration (MSC) to improve population health. The findings, however, revealed a limited understanding that led to a significant implementation gap. While participants recognized the general value of working together, there was a profound lack of technical understanding regarding the specific frameworks—Health in All Policies (HiAP), Healthy Cities, and One Health—that underpin effective MSC. These three frameworks (or concepts) form the three pillars of MSC.

General Perception and Practice of MSC

The general view of MSC among the participants was working together with other stakeholders to take actions that will protect and promote the health of citizens in the municipality

*"…When we talk about multisectoral collaboration, we are talking about dealing with other agencies that is not necessarily the one providing direct health care services in order to improve on care and also to make health care accessible to the population…" (*KIIP-3).

"My understanding is that multisectoral collaboration is working with departments in the local government or departments of the assembly or in the municipality who does different kinds of activities, and you collaborate

with them in order not to duplicate resources and to come out with the best results" **(**KIIP-19**).**

Even though participants could articulate a broad definition of "working together," this rarely translated into documented practice. A review of municipal records found little evidence of structured inter-departmental collaboration in projects and interventions carried out in the years reviewed. Most reports remained siloed and did not mention any collaborative frameworks *(DR-47).*

Understanding of Health in All Policies (HiAP)

Effective MSC is theoretically anchored in the Health in All Policies (HiAP) approach, which integrates health considerations into all sector decision-making. However, the study revealed a that participants were totally ignorant of this concept. As captured in the following quote, most participants were unaware of HiAP or its application for population health improvement:
"Health in all policies. I do not have any idea about that one" (KIIP-2).

The consequence of this gap among policy makers is the calibration of health as the exclusive domain of medical professionals rather than a shared municipal responsibility.

Health in All Policies Implementation

While some cited activities like desilting drains, clearing weeds, or road safety training as "health-related," these were rarely coordinated under a unified HiAP strategy. As one participant noted:
"I do not really see health in all policies actually on the ground right now… we collaborate within some activities [but] not as a major [strategy]" (KIIP-12).

Evidence from documents reviewed contained no information on understanding of multisectoral collaboration within the Ashaiman municipality *(DR-48).*

When asked for evidence on HiAP practices, some participants mentioned health promotion and disease prevention activities, health education, desilting of drains, clearing of weeds, training of drivers on road safety, strategies to reduce traffic congestion and environmental pollution among others as some of their activities/projects and actions carried out.

"Like I was saying, we do not have a major in terms of, I do not really see health in all policies actually on the ground right now…. we collaborate within some activities….;" (KIIP-12).

Awareness of the Healthy Cities concept

The Healthy Cities Initiative—a global framework for urban health—another pillar of MSC was similarly misunderstood. Participants often confused the concept with general clinical care or specific health interventions like HIV prevention, rather than seeing it as a broad urban planning strategy.
"For healthy cities initiatives, that has to do a lot with adolescent and their health, and also HIV prevention and then making health care access easy and known to the public and the community" (KIIP-9).

This confusion led to a complete lack of targeted "Healthy Cities" programming within the Assembly. One participant admitted: *"The Assembly does not have it as a targeted activity that is coordinated so that you can say, 'okay, this is what transport is doing; this is what planning is doing specifically for it.' I do not know of anything like that" (KIIP-13).*

Understanding of One Health Concept

This segment explored participants' understanding of the One Health Concept - the multisectoral approach that recognizes the critical intersection between human, animal, and environmental health - and how projects, actions, activities, and interventions are linked to the concept. The study found a low level of awareness of the one health concept. Most participants were either entirely unfamiliar with the concept or dismissed it as irrelevant to their specific department.

One participant said: *"I have not heard of it" (KIIP-20).* Another participant said, *"I think it is an intervention" (KIIP-15).*

"I don't work with...I mean...I'm not in the...I'm not too much into health" (KIIP-2).

Participants could not identify the One Health concept in any of their activities. Even when they discussed community -based projects like CHORUS or partnerships aimed at addressing TB and HIV,

they failed to link them to the integrated One health philosophy as shown in the following quote:
"*yes, so many ways,……,we have a project with University of Ghana as CHORUS, if you ask me the full meaning, I may not be able to tell but that CHORUS project is coming on board to help us facilitate health delivery by riding on the already existing structures in the community, and the community leaders to get those items that are needed for health to be free, so that the CHO's in the community will be well equipped, so that they can give total health package to the individual in the health zones, and then apart from CHORUS, other organizations come in, like for HIV, TB, I will recall the names, they are many, and they come in and support us with different cases and sometimes supporting us in their own small way to get working tools for our CHO's" (KIIP-9).*

Discussion

This study explored the understanding of multisectoral collaboration among key stakeholders in Ashaiman Municipality and found a pervasive lack of awareness and conceptual clarity among stakeholders. This Limited understanding constitutes a major barrier to effective implementation of health -related intervention in the Municipality. The understanding-gap may also result in fragmented working approaches that reduce productivity, and ultimately diminish the impact of health interventions in the Ashaiman municipality.

Despite the increasing emphasis on intersectoral action in global health discourse, and the adoption of the Health in All Policies (HiAP) framework in national policies such as Ghana's National Health Policy, the study revealed that the high-level strategies have not effectively trickled down to the municipal level. Even though the HiAP framework adopted by Ghana provides a formal architecture for collaboration, it appears insufficient to translate the policy intents into action at the local government level. The noted disconnect between policy and implementation aligns with observations in previous studies in other low-and-middle-income (LMIC) countries where the vertical nature of health systems and the absence of effective coordination mechanisms undermine the local uptake of national strategies.

The policy-implementation disconnect reflects a lack of shared understanding and common language among stakeholders at the different strata of governance , a situation known to hinder Multisectoral collaboration (MSC) [7,11]. To address the complex public health challenges in Ashaiman and other municipalities in Ghana, it is imperative that the different sectors at the local government level, like health, education, social protection and urban planning, work collaboratively to create the necessary synergy for success.

Barriers to Institutionalizing Collaboration

The observed lack of understanding among municipal stakeholders is likely symptomatic of a system failure in capacity building. The absence of consistent sensitization workshops and intersectoral training means that local actors often view MSC as an abstract, high-level theory rather than a pragmatic tool for local governance. This echoes findings by Bennett et al. and Singh et al. who noted that in many LMICs, multisectoralism is frequently perceived as an additional administrative burden rather than a core functional requirement [7,12].

Moreover, the absence of a shared language and clear policy guidelines at the municipal level appears to limit the ability of stakeholders to identify opportunities for collaboration. Although some actors acknowledged the interdependence of their roles, there was little evidence of routine coordination mechanisms or joint planning efforts. This supports earlier literature suggesting that while policy rhetoric may promote integration, practical implementation often lags due to fragmented planning and resource constraints [7,13].

Furthermore, the study highlights a critical tension between intent and implementation. Interestingly, many stakeholders expressed a latent willingness to collaborate but cited a lack of institutional leadership and financial incentives as major deterrents. Moreover, political and institutional dynamics such as fragmented governance and competition for resources further complicate the institutionalization of collaborative practice [14]. This underscores the need for local governance reforms that foster joint ownership, budgetary alignment, and outcome-based collaboration across sectors [5].

Moving Forward: From Rhetoric to Reform

Strengthening MSC in Ashaiman and similar urban contexts requires a shift from top-down directives to bottom-up capacity building. As Matsieli and Sooryamoorthy (2022) suggest, policy rhetoric alone

cannot bridge the integration gap. Our findings underscore the need for local governance reforms that prioritize:

1. Shared Ownership: Moving beyond health-sector-led initiatives to foster joint responsibility across all municipal departments.
2. Budgetary Alignment: Creating financial mechanisms that incentivize joint planning and outcome-based collaboration [5].
3. Localized Guidelines: Developing clear, simplified policy manuals at the municipal level to demystify concepts like One Health and HiAP.

Ultimately, the Ashaiman Municipal Assembly must move beyond its role as a mere administrative body to become a proactive convener of sectors. By creating deliberate spaces for dialogue and aligning local development plans with the social determinants of health, the municipality can begin to transform MSC from a theoretical concept into a tangible driver of community well-being.

Study Limitation

The study has limitations even though it offers insightful information. The results may not apply to all local government contexts in Ghana because they are based on a single municipality. Furthermore, the study's qualitative design records opinions rather than impartial indicators of teamwork, which could affect interpretation.

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