Health for All: Towards Free Universal Health Care in Ghana

End of Campaign Evaluation Report

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All photos were provided by the Alliance for Reproductive Health Rights (ARHR).

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Abbreviations

ARHR	Alliance for Reproductive Health Rights
CBO	Community Based Organisation
CCP	Convention People's Party
CSOs	Civil Society Organisations
ESC	Essential Services Campaign
GHS	Ghana Health Service
GoG	Government of Ghana
HDI	Human Development Index
IEA	Institute of Economic Affairs
ISODEC	Integrated Social Development Centre
MDGs	Millennium Development Goals
MoH	Ministry of Health
NDC	National Democratic Party
NGO	Non-Governmental Organisation
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NPP	National Patriotic Party
Oxfam	Oxfam Great Britain
UHCC	Universal Health Care Campaign
VAT	Value Added Tax

List of boxes and figures

Executive Summary

Oxfam's global Essential Services Campaign (ESC) aims to ensure governments of both Aid donor and Aid recipient countries adhere to their pledges to meet the Millennium Development Goals by 2015. A key element of the ESC is to build evidence and arguments for free public health-care and to support advocacy partners at global, regional and national levels to capitalise on windows of opportunity in national and international policy forums, such as during political elections. In Ghana, the Essential Services Campaign, known as The Universal Health Care Campaign, was a bold, collaborative advocacy effort by civil society organisations and networks, working towards a collective vision of free, quality and accessible universal health care.

Historically Ghanaians have benefited from a welfare state that included free health-care. Following economic crisis and subsequent structural adjustment reforms, Ghana extended user fees to all public health-care services, known locally as the 'cash and carry' system. In 2003 the National Health Insurance Scheme was introduced. The scheme is funded through individual annual contributions from formal sector workers, with exceptions for some groups, such as pregnant women and those over 70 years old. Internationally the scheme gained recognition as a health insurance 'success story' owing to its substantial coverage of the Ghanaian population. For civil society groups this 'good news' story did not reconcile with what they saw on the ground, but they lacked the evidence they needed to back up their beliefs.

The objectives of the Universal Health Care Campaign were twofold. Firstly the Campaign aimed to raise awareness of the weaknesses of the health insurance scheme as a modality for financing free universal health care; and secondly, it proposed solutions, including alternative tax-based and innovative health care financing mechanisms to deliver universal health care. The Campaign was realised through activities such as public events, popular mobilisation, lobbying, and media engagement.

With the core funding ending for the project in March 2013, this independent evaluation of the Campaign was commissioned by Oxfam Great Britain as part of its commitment to continuous improvement and institutional learning, which includes annual Effectiveness Reviews of a random selection of concluding projects. The evaluation was conducted between December 2012 and March 2013 and used a pre-qualified qualitative research protocol (process tracing) to support Oxfam's piloting of the approach. The evaluation aimed to assess the Campaign's

Key messages

- The Universal Health Care Campaign was a bold collaboration between Ghanaian civil society actors united in their vision to realise free health care for all.
- The overarching aim of the Campaign was for the Government of Ghana to legislate for free, quality universal health care through the removal of all user fees to make health care free at the point of use by 2015.
- The Campaign used a combination of lobbying, popular mobilising, media, and research and policy tactics to achieve its objectives.
- The methodology used by the National Health Insurance Authority to calculate coverage in the National Health Insurance Scheme was shown by the Campaign to be flawed.
- There is strong evidence to suggest that the National Health Insurance Authority changed its methodology for calculating National Health Insurance Scheme coverage due to the actions of the Campaign.
- The Campaign has made a major contribution to building the capacity of civil society organisations within the Campaign's membership to advocate free universal health care.
- The Campaign made a moderate contribution to increasing the ability of civil society organisations to plan and work together to advocate free universal health care.
- Establishing constructive dialogue with parliamentarians and gaining political buy-in for universal health care prior to the 2012 elections was a weakness of the Campaign.
- Despite clear challenges the Campaign was successful in providing a unique platform for civil society organisations to come together and unite behind the goal of universal health in Ghana.

overall effectiveness by synthesising available evidence gathered from testimonies from key informants, assessment of project documentation and publically available information.

The evaluation documents a series of outcomes from the project, particularly in relation to the Campaign's cornerstone report, 'Achieving a Shared Goal: free universal health care in Ghana', published in March 2011. The pivotal report contained evidence that supported health campaigners' perceptions. Contrary to official reports of 67 per cent coverage by the health insurance scheme, as few as 18 per cent of Ghanaians were enrolled, according to the Campaign's report. Despite being met with widespread controversy and a vociferous backlash from the National Health Insurance Authority, some months following its publication the official coverage figures were lowered from 67 per cent to 34 per cent. The evaluation presents strong causal evidence linking the Campaign's report to changes in the way the National Health Insurance Authority calculated health insurance coverage. This sobering appraisal of the number of Ghanaians who actually benefit from access to free health care was a clear victory for the Campaign.

A key success of the Campaign was its ability to mobilise civil society organisations in the health arena around the common goal of free universal health care. The evaluation has shown that civil society was equipped with powerful data to endorse what was already recognised at the community level; that access to health care under the insurance scheme was inequitable and did not favour the most vulnerable members of society. Key informants were unanimous in their view that the Campaign was the only civil society movement calling for free universal health care in Ghana. The dissemination of the report's findings enabled civil society actors to better understand the technical nature of the universal health care discourse, supporting wider campaigning efforts.

The Campaign was not found to have made a significant contribution to stimulating political buy-in for free universal health care in the lead up to the 2012 elections. This finding is, in part, due to limitations of the evaluation in gaining access to parliamentarians. Available evidence suggests that the Campaign intensified its activities in the lead up to the elections, but missed key opportunities to influence the main parties' manifestos. Future campaigns should recognise the importance of a well thought-through advocacy plan. Lessons too have been learnt about the various roles of partners, particularly the role played by international NGOs, such as Oxfam, relative to national civil society organisations. Further campaigns that place national civil society organisations in the lead will not only help to build capacity, but ensure that the actions of campaigns are seen by government as homegrown.

The Campaign is to be commended for its determination in the face of public controversy. Despite the challenges experienced the Campaign was successful in providing a unique platform for civil society organisations to unite behind the vision of free universal health care for all Ghanaians. With renewed focus and commitment from its membership the Campaign surely has a future in realising its vision.

Summary results table

Table 1 summarises the extent to which there is evidence that the project realised its targeted outcomes in the form of a simple five-point 'traffic light' system. The key below illustrates what the various traffic lights represent.

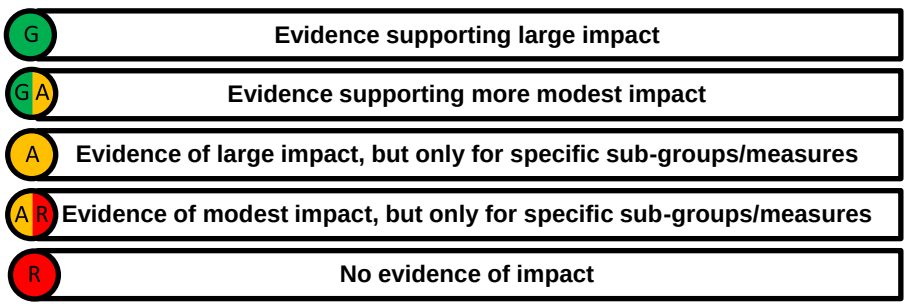

Table 1: Summary results

	Outcome	Rating	Short Commentary (including reference to other evidenced explanations as appropriate)
1	Improved coordination of civil society organisations to advocate free universal healthcare for all		• Campaign made a high contribution to building the capacity of CSOs within the Campaign's membership to advocate free universal health care. This centred on helping CSOs to understand the Campaign report's findings. • The Campaign made a moderate contribution to increasing the ability of CSOs to plan and work together to advocate free universal health care.
2	The current NHIS system is shown to be an ineffective vehicle to deliver free universal health care in Ghana		• Changes to how the NHIA calculated NHIS coverage was shown to be flawed by the Campaign. • The NHIA changed its methodology for calculating NHIS coverage because of pressure from the Campaign.
3	Increased political buy-in for free, quality and accessible universal healthcare for all		• Little evidence that the outcome was realised. • Activities of the Campaign appear to have failed to establish constructive dialogue with parliamentarians in the lead up to the elections.

Purpose and overview of the report

A component of Oxfam's global Essential Services Campaign (ESC) is to build evidence and arguments for free public health care and to support advocacy partners to capitalise on key moments in national and international policy forums, such as during political elections. Among other things, the ESC has sought to:

- Build the advocacy capacity of Southern partners and support them to speak with one voice.
- Generate debate on the delivery of quality, free health-care in Southern countries.
- Fuel the debate on delivery of health care through the Global Health Check platform.
- Ensure influential donors (e.g. the World Bank and Unicef) show measurable improvements in promoting the role of free public services.

In line with Oxfam Great Britain's (Oxfam) Global Performance Framework, samples of mature projects are randomly selected each year and their effectiveness rigorously assessed. The Essential Services Campaign in Ghana, known locally as the Universal Health Care Campaign (UHCC, also referred to in this report as the 'Campaign') was selected in this way under the policy influencing thematic area.

Oxfam wishes to rigorously assess the effectiveness of the Campaign in its aim to secure policy commitments on free universal access to health care in Ghana, as a result of

campaigning in the lead-up to the country's presidential and parliamentary elections held on the 7th and 8th December 2012. This evaluation forms part of a larger organisational undertaking by Oxfam to better capture and communicate the effectiveness of its work.

Oxfam is the intended primary audience for this report. As is Oxfam policy, this report will be made available via their website to facilitate access to its content for other interested parties, including those who participated in the Campaign.

The report is structured in six main parts as follows:

Part 1 Introduces the Campaign, its intended purpose, design and governance, and the context in which it was implemented. It focuses on describing the main actors in the Campaign and gives background information on the health system in Ghana.
Part 2 Briefly outlines the methodology used to conduct the evaluation.
Part 3 Describes the main activities implemented by the Campaign in the lead-up to the 2012 elections.
Part 4 Presents the main findings from the evaluation, exploring whether causal links are apparent between the Campaign's activities and observed outcomes.
Part 5 Presents a series of 'lessons learnt' for the Campaign to consider in future planning processes.
Part 6 Concludes with a synthesis of the main findings of the evaluation.

1 Introduction

Oxfam's Essential Services Campaign launched in 2006 – following the publication of its report 'In the public interest'[1] – and aims to ensure governments of both Aid donor and Aid recipient countries adhere to their pledges to meet the Millennium Development Goals (MDGs) by 2015. The Essential Services Campaign focuses on the attainment of health and education goals, applying pressure on governments to honour their responsibilities to their citizens, supplying them with the essential services they require to have decent health and education.

Oxfam's experience has shown that greatest change often occurs during a country's elections, making the period leading up to elections a critical time for campaigning and advocacy:

> ***'… having followed education and health quite closely, [we have] noted that most of the big steps forward have been around elections.'***
> **Key Informant, Oxfam**

Building upon existing work by the Essential Services Campaign, among other initiatives, the Voting for Justice Campaign aimed to capitalise on presidential and parliamentary elections taking place in 2012 in four West African countries: Burkina Faso, Ghana, Mali and Sierra Leone. Voting for Justice was to be a 'campaign within a campaign', working with and supporting local and national organisations to increase citizens' voices and influence political processes, while drawing on learning from recent successes in Liberia, Malawi and Zambia. In Ghana the broad aim of both the Essential Services and Voting for Justice campaigns was to secure free public health care.

1.1 Health in Ghana

The West African country has a population of approximately 24,392,000, with life expectancy at birth estimated at 57 and 64 years for males and females, respectively.[2] The Human Development Index (HDI) is a composite indicator, which combines data on life expectancy, educational attainment and income.[3] Ghana is ranked 135 out of the 187 countries and territories included in the index, placing it in the medium human development category.[4] Ghana is below average for countries in the medium development category, but above average for countries in sub-Saharan Africa.[5]

According to the MDG monitor, Ghana is off-track to meet all of the health-related MDGs.[6] Compared with countries with similar levels of income and health spending, Ghana performs below average with respect to mortality of under-fives and has fewer physicians and health workers.[7] Ghana spends approximately five per cent of its GDP on health, again below average for countries with comparable levels of income.[8]

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[1] www.oxfam.org/en/policy/in-the-public-interest
[2] www.who.int/countries/gha/en/
[3] hdrstats.undp.org/en/countries/profiles/gha.html
[4] hdrstats.undp.org/images/explanations/GHA.pdf
[5] Refer to footnote 4
[6] http://bit.ly/Ytsnt8
[7] http://bit.ly/14jlrjh
[8] Refer to footnote 7

1.2 History of health care in Ghana

Ghana was the first African nation to gain independence from colonial powers in 1957.[9] Following independence, Ghanaians benefited from a welfare state that included free health care and an expanding health care plan.[10] The country's economic crises of the 1970s and 80s however cut short this ambition. This period witnessed dramatic cuts in health investment by government and was characterised by medicine stock-outs, low health-worker morale and a freeze on health care expansion plans.[11] It was during this time that user fees for hospital services were introduced.

Following the adoption of structural adjustment reforms, in 1983 under the Rawlings administration Ghana expanded user fees to all public health care services, known locally as the 'cash and carry'[12] system.[13] Under this system, health service utilisation dropped significantly, particularly in rural areas and for people aged over 45 years.[7] Nationally, health service utilisation was estimated to have more than halved.

The 'cash and carry' system was highly unpopular and was used as political capital by the National Patriotic Party (NPP) who called for its abolition in their manifesto pledges and campaigning in the lead up to the 2000 election, with this salient issue arguably winning them the election.[14,15]

1.3 The National Health Insurance Scheme

In 2003, some years after coming to power, the NPP introduced the National Health Insurance Scheme (NHIS) with the aim of providing health care to Ghanaians through a combination of district mutual, private mutual and private commercial health insurance schemes.[10] The National Health Insurance Authority (NHIA) is responsible for regulating the scheme.

The NHIS is funded through individual annual premium payments; a value added tax (VAT) levy currently 2.5 per cent; a 2.5 per cent contribution from those in the formal sector via the Social Security and National Insurance Trust Fund; returns on investments; money allocated by the government of Ghana (GoG); donors, and other voluntary contributions.

To benefit from the NHIS and access a broad range of health care, an individual must become a member of the NHIS by registering and paying an annual premium. Exemptions apply for pregnant women; those under 18 years old (if their parents are enrolled on the scheme); those over 70 years old; pensioners under the Social Security Pension Scheme; and persons classified as indigent (means tested). In theory, therefore, only adults in the informal sector who are outside the above exemptions are required to pay the annual premium as formal sector workers are automatically covered.

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[9] http://archive.org/details/1957-03-07_A_New_Nation
[10] Apoya, P. and Marriot, A. (2011) Achieving a Shard Goal: Free Universal Health Care in Ghana. Available: www.uhcc.org.gh/Achieving%20a%20Shared%20Goal%20full%20report.pdf
[11] Refer to footnote 10
[12] This crude name aptly describes the health care realities faced by Ghanaians during this time, in that health care, including emergencies, would only be offered following payment.
[13] Blanchet, N. (2012) The Effects of Ghana's National Health Insurance Scheme on Health Care Utilisation. Ghana Medical Journal Vol. 45, No.2. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3426378/
[14] http://allafrica.com/stories/200011290267.html
[15] http://ghanaian-chronicle.com/politics-of-health-insurance/

The NHIA claimed that 67 per cent of Ghanaians were registered as members of the scheme and therefore had free access to health care. Research conducted by the Campaign presented a very different picture from the official data published by the NHIA. The Campaign's report, 'Achieving a Shared Goal', claimed that as few as 18 per cent of Ghanaians were enrolled on the scheme, only 29 per cent of which were from the poorest households.[9] The report pointed to the inequity of this situation given that all Ghanaians pay for the health system through VAT contributions, yet as few as 18 per cent benefit. This is explored further in Section 4.

1.4 The Universal Health Care Campaign

The Universal Health Care Campaign (UHCC) in its current formation is comprised of four partners: the Alliance for Reproductive Health Rights (ARHR), the Integrated Social Development Centre (ISODEC), Oxfam in Ghana and the Coalition of NGOs in Health. The combined reach of the Campaign's partners extends to over 500 organisations working on health-related issues and to all 10 regions of Ghana. See Box 1 for background information on each of the partners.

In its original conception, the Campaign was part of the Essential Services Platform of Ghana, a collective of civil society coalitions drawn from the health, education, water and sanitation sectors. Established prior to the Campaign, the rationale was to use existing structures to promote the aims of the Campaign to prevent duplication and to increase efficiency. For reasons that are discussed in Section 4.1.3 the Campaign established its own identity in mid-2011 with a full-time Campaign Coordinator, hosted by ARHR.

Box 1: Universal Health Care Campaign Partners

Alliance for Reproductive Health Rights (ARHR) Established in 2004, the Alliance for Reproductive Health Rights is a network of Ghanaian non-government organisations promoting a rights-based approach to sexual and reproductive health. The ARHR is working to ensure the sexual and reproductive health rights of all people – especially vulnerable groups, such as the poor, and marginalised women of reproductive age – are protected and fulfilled irrespective of socioeconomic status, gender or race.
Integrated Social Development Centre (ISODEC) Formed in 1987, The Integrated Social Development Centre is an indigenous non-governmental organisation committed to the promotion of human rights (especially social and economic rights) and social justice for all, especially those suffering marginalisation, injustice and powerlessness.
Oxfam in Ghana Oxfam is a global movement of people who share the belief that, in a world rich in resources, poverty isn't inevitable. It's an injustice which can, and must, be overcome. Oxfam is a confederation of 17 affiliated organisations. Oxfam GB has worked in Ghana since 1986. Oxfam aims to bring lasting solutions for quality access to water, poverty, hunger, and injustice in the extractive sector.

Coalition of NGOs in Health The Ghana Coalition of NGOs in Health is a not-for-profit Civil Society Organisation (CSO) established in 2000 as an umbrella and coordinating body of activities of all registered NGOs/CBOs in the health sector in the country.
Essential Services Platform of Ghana The Essential Services Platform of Ghana is an umbrella of coalitions in health, education, water and sanitation.

1.4.1 Aim of the Universal Health Care Campaign

The aim of the UHCC is for the government of Ghana (GoG) to legislate for free, quality and accessible health care by 2015, using new sources of funding from tax revenues and innovative financing mechanisms to realise this vision.

The Campaign used a combination of lobbying, popular mobilising, media, research and policy tactics in achievement of its stated objectives, discussed further in Section 3.

This evaluation employed a pre-qualified methodology called process tracing, discussed further in Section 2. A key component of this approach is to reconstruct the Campaign's Theory of Change or logic model to help identify a series of intermediate outcomes to frame the evaluation. This is important as advocacy and campaigning projects are often working towards longer-term aims that may take years to materialise. Without identifying intermediate outcomes along the pathway of change, evaluations of advocacy and campaigning projects are at risk of returning fairly pessimistic findings that do not sufficiently capture the range of successes or 'wins' that may have been achieved.

The Campaign developed a logic model (See Section 2.4) to establish causal links between inputs, activities, outputs and outcomes. The Evaluator led a participatory workshop with a small group of Campaign team members to revisit the logic model with the aim of arriving at three or four intermediate outcomes that the Campaign was most recently working towards. As the focus of this evaluation was the period leading up to the presidential and parliamentary elections in 2012, this was used as a lens to help identify potential targeted outcomes for that period.

Given the Campaign's aim of realising free universal health care, a central tenet of the Campaign's logic was to understand whether the NHIS was the right vehicle to deliver free universal health care in Ghana. Research published in the Campaign's report reached the conclusion that, in its current configuration, the NHIS could not deliver free universal health care. As the Campaign entered the election year, therefore, two priorities were clear. Firstly, the Campaign had to raise awareness of the weaknesses of the current NHIS as a modality for financing free universal health care; and secondly, the Campaign had to put forward solutions, including alternative health-care financing mechanisms, to deliver universal health care. These two interconnected priorities, therefore, became the focus of reconstructing the Campaign's logic model.

In order to realise the two central strands of the Campaign in 2012, the following intermediate outcomes were identified and agreed upon for the purposes of this evaluation:

1. Improved coordination of civil society to advocate free universal health care for all.
2. Showing the current NHIS system to be an ineffective vehicle to deliver free universal health care in Ghana
3. Increased political buy-in for free, quality and accessible universal health care for all.

2 Evaluating the Universal Health Care Campaign

Oxfam has adopted a Global Performance Framework. Among other things, this framework involves the random selection of samples of closing or sufficiently mature projects under six outcome areas each year and rigorously evaluates their performance. These are referred to as Effectiveness Reviews. Effectiveness Reviews carried out under the Citizen Voice and Policy Influencing thematic areas are to be informed by a research protocol based on process tracing, a qualitative research approach used by case study researchers to investigate causal inference.

Policy and Citizen Voice interventions will be working to achieve specific intermediary and final outcomes. The Evaluator's first task is to help identify the scope of the intervention, including the outcomes, or changes it is seeking (or sought) to achieve, and the activities undertaken that were intended to bring these about. The Evaluator is to then evidence the extent to which the intervention's key targeted outcomes have materialised; investigate the causal mechanisms responsible, i.e. how the observed outcome change came about; and, in light of an evidenced understanding of competing explanations, draw conclusions about the significance of the intervention's contribution.

As such, the purpose of the evaluation is not simply to narrow in on only one explanation for an observed outcome-level change. Rather, the approach is more nuanced and should accomplish three things:

1. Shortlist one or more evidenced explanations for the outcome in question (which may or may not include the intervention).
2. Rule out alternative, competing explanations incompatible with the evidence.
3. If more than one explanation is supported by the evidence, estimate the level of influence each had on bringing about the change in question.

While not intended to be a mechanical sequence of linear steps of how the research exercise should proceed, the following eight steps form the core of the research exercise's protocol.[16]

1. Undertake a process of (re)constructing the intervention's theory of change, in order to clearly define the intervention being evaluated – what is it trying to change (outcomes), how it is working to effect these changes (strategies/streams of activities) and what assumptions it is making about how it will contribute to these changes (key assumptions).
2. Work with relevant stakeholders to identify up to three intermediate and/or final outcomes considered by stakeholders to be the most significant for the evaluation to focus on (central to the intervention's theory of change, and useful for learning/forward planning).
3. Systematically assess and document what was done under the intervention to achieve the selected targeted outcomes.
4. Identify and evidence the extent to which the selected outcomes have actually materialised, as well as any relevant unintended outcomes.
5. Undertake 'process induction' to identify salient plausible causal explanations for the evidenced outcomes.

[16] Significant iteration between many of the processes is expected and, indeed, desired.

6. Gather required data and use 'process verification' to assess the extent to which each of the explanations identified in Step 5 are supported, or not supported, by the available evidence.
7. Write a narrative analytical report to document the above research processes and findings.
8. Summarise aspects of the above narrative analysis by allocating campaign 'contribution scores' for each of the targeted and/or associated outcomes. This is not expected to provide a precise measure of contribution, but rather a sense of how much the campaign was likely responsible for observed change(s).

For the full process-tracing protocol, please see Oxfam's Policy and Practice website.[17] The evaluation was conducted between December 2012 and March 2013. The evaluation approach was agreed by Oxfam following the submission by the Evaluator of an inception report in early November 2012.

Evidence for the evaluation was drawn from the following sources:

- oral testimony from key informants
- project documentation
- documentation provided by key informants
- publicly available information accessed via the internet.

2.1 Key informant interviews

Oxfam in Ghana was responsible for initial identification of key informants, guided by the Evaluator to prioritise 'information-rich' cases that were drawn from a range of key constituencies, including stakeholders from: the Campaign; advocacy targets, such as MPs and civil servants from the Ministry of Health (MoH), the Ghana Health Service (GHS) and the National Health Insurance Authority (NHIA); and academics.

A total of 21 key informant interviews were conducted both face-to-face (n=16) and by telephone (n=five). Interviews generally lasted between 30 to 60 minutes. A questionnaire was used to guide key informant interviews and contained 15 open-ended, neutral questions. Key informant interviews were digitally recorded when informed consent was granted. Audio files were then transcribed verbatim into Word document format in readiness for analysis. When informed consent was not given to record interviews, the Evaluator took notes using a laptop.

2.2 Project documentation

Documentation for the evaluation came from a variety of sources including: from the Campaign, from key informants and from internet searches. A total of 50 documents were included in the evaluation, an index of which can be viewed in Appendix 1.

2.3 Data analysis

All qualitative data, including all documentation and transcripts from key informant interviews, were systematically coded using Nvivo10[18] qualitative software, to support a rigorous and consistent approach to data analysis. Qualitative data analysis was done by coding and classifying recurring regularities in the data around particular emerging themes.

[17] bit.ly/X7XdFA
[18] http://www.qsrinternational.com/products_nvivo.aspx

During the coding process the Evaluator regularly assessed coding categories to ensure internal homogeneity and external heterogeneity (convergence and divergence).

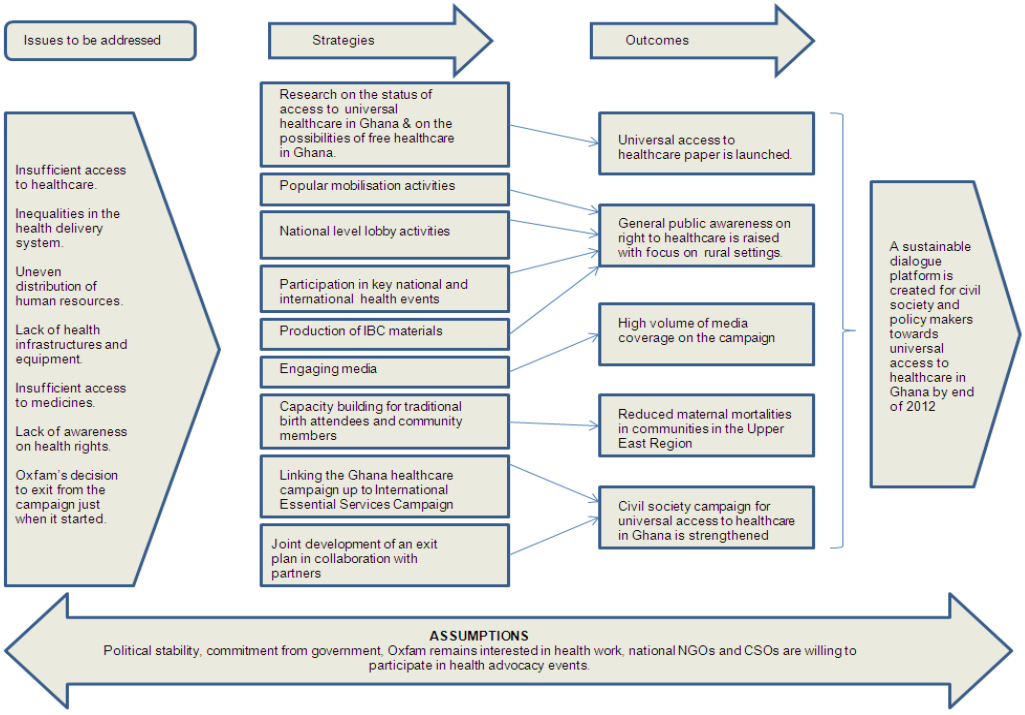
2.4 Campaign's logic model

The Process Tracing methodology required the Evaluator to work with members of the Campaign team to agree a series of intermediate outcomes the Campaign was most recently working to bring about. To facilitate this process the Evaluator led a participatory workshop to support the reconstruction of the Campaign's logic model. Four Campaign team members took part in this workshop (two from Oxfam, one from ARHR and one from the Coalition of Health NGOs). Limitations discussed in Section 2.6 were a factor in having too few Campaign team members involved in this process.

Although the Campaign had a logic model (Figure 1), this was never revised or revisited after initial drafting and was not an up-to-date representation of the aims and objectives of the Campaign strategy document. For the purposes of the workshop, therefore, the logic model of the Campaign was set aside and the Campaign strategic plan used instead.

The Evaluator used participatory techniques, writing out each of the Campaign's objectives onto individual A4 pieces of paper and called upon participants to think through some of the key changes/outcomes required prior to achievement of each objective. To assist with this process, a project timeline was created, again in a participatory manner, which helped to place the project's activities, key dates and external events/factors in an ordered sequence (see Figure 3).

This process led to the identification of three outcomes. The logic model produced at this workshop and the outcomes agreed upon are described in Section 3 of this report.



2.5 Validity of findings

To strengthen the validity of findings the evaluation has used triangulation in the following ways: using multiple data sources, using both primary and secondary data and multiple methods of data collection. Other methods of triangulation, such as using multiple evaluators and repeating observations over time have not been possible due to limitations of time and budget. The report was validated to strengthen the accuracy of its findings, including the reasonableness of its interpretations with Campaign stakeholders during the drafting phase.

2.6 Limitations

Failure to gain adequate access to key informants from within the MoH, NHIA and GHS was the most significant limitation of this evaluation. Due to bureaucratic constraints the Evaluator was dependent upon members of the Campaign team facilitating access to key informants from within these government departments. The Evaluator was supported while in the country to contact key informants, but it was not clear how much preparatory work to secure key informants from within government had occurred prior to the Evaluator's arrival in country. This, compounded with the usual challenges in securing audiences with senior level government staff, resulted in the Evaluator only having face-to-face interviews with three staff at the GHS, and one telephone interview with the Chair of the Health Select Committee.

Sub-optimal planning for the evaluation may have also affected the range and quality of key informant interviews. For example, the Evaluator did not have regular contact with someone with intimate knowledge of the Campaign who could easily facilitate access to key stakeholders as the evaluation progressed. Moreover, in some cases a lack of sufficient planning in advance of the Evaluator's arrival in the country meant that interviews were shorter than would have been optimal, as key informants struggled to accommodate the evaluation into their busy schedules.

3 Campaign description

The UHCC began sometime in 2009 and its core funding ended in March 2013. Campaign members have not come to a conclusion as yet about whether the Campaign will continue beyond this time.

The Campaign had two phases that can be described as follows:

1. Where the Campaign operated through the pre-existing Essential Services Platform of Ghana (2009–2011).
2. Where the Campaign broke away from the Platform and stood in its own right as a Campaign operated by the four Campaign Partners (2011–present) and coordinated by a full-time ARHR staff member (See Box 1).

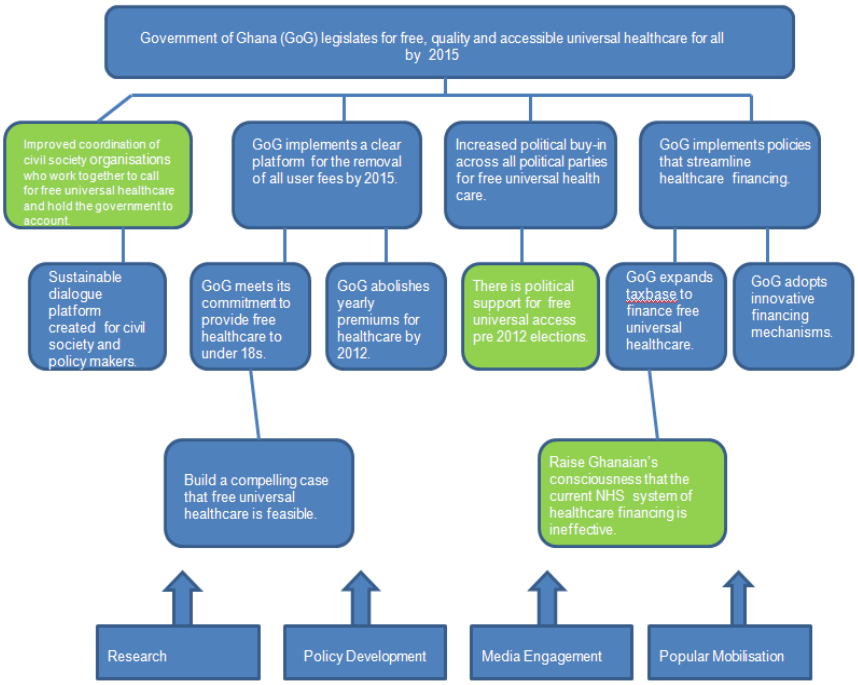
Potential reasons for the different phases of the Campaign are explored in Causal Story A.

3.1 Objectives of the campaign

The overarching aim of the Campaign is for the GoG to legislate for free, quality universal health care by 2015. In collaboration with a small subset of the Campaign team, the Evaluator reconstructed a logic model which can be seen in Figure 2. The specific objectives of the Campaign included:

1. GoG implements a clear plan for the removal of all user fees to make health care free at the point of use by 2015. The first step towards this is to ensure that the GoG meets its commitment to provide health care to under-18s regardless of their parents insurance status by the end of 2011.
2. GoG implements policies that streamline health care financing, delineating roles and responsibilities of the NHIA, GHS and MoH.
3. Politicians at national, regional and district level openly support universal access to health care pre-2012 elections
4. Civil society organisations work together to hold the GoG to account for commitments made on the provision of health care and engage 25,000 individuals to take a campaign action towards securing free universal health care with the first year of the Campaign (2011–2012).

Figure 2: Reconstructed Campaign logic model



*Outcomes shaded green were decided upon as the most reasonable to select for the evaluation.

The Campaign was guided by a three-year strategic plan, which was supplemented by a more intensive plan in the lead up to the elections in 2012. The Campaign's main activities can be categorised as follows:

1. Research and policy analysis
2. Public events and popular mobilisation
3. Lobbying
4. Media engagement.

3.2 Research and policy analysis

During 2009 and 2010, the Campaign was relatively introspective as its structure and function was established among the membership of the Essential Services Platform. This time is characterised by a period of research and analysis, agreeing operational issues among the membership and building capacity of the membership on issues such as health financing.

While the Campaign's membership was united in their vision of free universal health care, rigorous evidence to inform how to realise this vision was lacking. Furthermore, although Campaign members knew that the NHIS was unlikely to be the best vehicle to deliver free universal health care, they lacked the evidence to substantiate their views. The Campaign commissioned research to provide such evidence, which was later used to establish its advocacy strategy on a strong foundation.

The resultant report, 'Achieving a shared goal: free universal health care in Ghana', published in March 2011, is the single most important output from the Campaign. The report contained evidence that showed the numbers of people covered under the NHIS was dramatically lower than the NHIA claimed. It showed the NHIS to be inequitable and the NHIA to be inefficient.

The report contained a range of recommendations for government, civil society and donors and quickly became the cornerstone of the Campaign. The report guided all other Campaign activities, from lobbying work to media engagement.

Two policy briefings followed, which were used to engage policymakers and key-decision makers as tools to engage the media and as capacity building aides for the Campaign's own membership.

Resources
Report – Achieving a Shared Goal: Free Universal Health Care in Ghana
Policy Brief – Addressing Wastage and Inefficiencies in the Health Sector
Policy Brief – Free Universal Health Care in Ghana

3.3 Public events and popular mobilisation

During the election year, the Campaign aimed to increase its visibility by engaging Ghanaian citizens through a range of popular mobilisation activities and key events. For example, a Universal Access to Health Campaign Walk recruited 300 women to march to the political headquarters of the main political parties in Accra. The walk aimed to influence representatives from each political party to sign a Campaign pledge card committing to deliver free universal health care.

The range of activities included:

- a nationwide march held on the 6th March
- participation in public May Day events
- regional health forums.

3.4 Lobbying

Lobbying of key targets took various forms during the election year. The range of activities included:

- Meetings with the NDC, NPP and CCP to influence their manifestoes.
- The three main political parties signed Campaign pledge cards which were framed and given over to be hung in their headquarters. This was followed up with a letter sent to each presidential candidate (NDC and NPP only) thanking them for signing the Campaign's pledge.
- A live TV discussion on Joy TV with parliamentarians.
- The Campaign wrote to former President Rawlings and Kufou seeking their endorsement for universal health care.

Key targets for the Campaign included government departments, such as: MoH, GHS, NHIA, Regional Health Directorates, Ministry of Finance, Social Welfare; as well as key individuals, including the President, the Vice President, ministers, policy advisers to the President and the speaker of the House. At the regional and district levels, targets included traditional leaders, civil society organisations and members of the community.

The Campaign was invited to take part in a live televised presidential debate organised by the Institute of Economic Affairs (IEA). The Campaign was able to submit a question that was put directly to the presidential candidates by the Campaign's coordinator. The question was:

'The contribution of annual health insurance premium as a percentage of the total revenue to the NHIS has been small relative to VAT and Social Security and National Insurance Trust Levies. This means that annual premiums have not been effective in mobilising financial resources from the large informal sector. Since VAT levies (70% of total NHIS revenue) are currently the financial backbone of the NHIS, will you scrap the annual premiums and adopt 100% tax-based financing to ensure sustainable financing for the NHIS, and provide universal access to health care free at the point of use?'

This meant the presidential candidates had to respond to the issue of universal health care and adopt a position.

3.5 Media engagement

The Campaign worked hard to foster good relationships with journalists, engaging them early in the Campaign. Journalists were supported through a workshop designed to help them understand the complexity of some of the Campaign's issues. This in turn helped to ensure the Campaign received coverage and aimed to drive up the accuracy and quality of reporting. The Campaign produced press releases and appeared on radio discussion programmes and televised debates.

The Campaign invested time in using social media platforms, such as Twitter and Facebook. The Campaign is to be praised for the range of engaging content that it posted to its Facebook page in particular, making great use of video, stories in the press, promotion of relevant reports and as a space for commentary. The way the Campaign used Facebook has been useful for the Evaluator in two main ways: it acted as a central repository for a number of important pieces of evidence, allowing the Evaluator to easily access video footage, for example; and Facebook's timeline feature was useful in understanding the sequence of events the Campaign engaged in.

The effort invested by the Campaign in developing Facebook content is commendable. To improve the reach of such content for future campaigns more focus needs to be given to strategies that lead to greater dissemination of social media content. As of January 2013, 67 people had 'liked' the page and while an imperfect indicator, it does give a proxy of the total reach of the published content. More could be done to promote social media content for future campaigns. For example, the Coalition of NGOs in Health alone has over 500 organisational members and countless staff. Simply ensuring the Campaign's members had 'liked' the Campaign page would have been a great way to promote the page and its content and as a means for keeping Campaign members up to date. There are an estimated one million registered Facebook users in Ghana.[19] Clearly there is greater potential to disseminate social media content than the Campaign realised.

The Campaign used bulk SMS to bring more members of the public into the Campaign. In total, 22,500 SMSs were sent with the following message:

'No one in Ghana should die because he or she lack access to basic healthcare services, demand for Universal Health care (UHC) by texting UHC to short code 1402'

This resulted in 1,402 individuals texting the short code and thereby endorsing the Campaign's message. It is not clear what the Campaign then did with the support shown by those who chose to text the short code.

The range of activities included:

- Radio discussion on A One radio station in Bolga.
- Two radio interviews broadcast on GBC radio featuring the Health Walk, coverage of the walk was also shown on TV3.

[19] http://www.datagenetics.com/blog/august12011/index.html

- Video footage of the main political parties signing the Campaign's pledge card on its Facebook page.
- Killer facts document produced.
- Q & A for media engagement.
- Press release issued for International Women's Day.
- Media training.
- Radio discussion on Choice FM.
- Press conference held in response to a World Bank report.
- Radio discussion on 'A One' radio station in Bolga.
- Live TV discussion on TV3.
- Press release issued on tax-based financing for universal healthcare
- Press release issued calling for political parties and the general public to prioritise universal health care.
- Bulk SMS campaign.
- TV 'crawler' ads.

3.6 Campaign budget

A full budget was not provided to the Evaluator, but costs between June 2011 and July 2012 were known to have totalled GHS 326,002 (£98,438). For some key informants the budget was too modest:

'The budget allocation is limited and low, it doesn't allow for bringing people together. Bringing members together in one point wasn't funded.'
Key Informant, CSO Campaign Member

'A resourcing gap limited the campaign's effect.'
Key Informant, CSO Campaign Member

Figure 3: Campaign timeline

2009		UHCC launched by the Essential Services Platform membership
2010		Research being conducted to inform the Campaign's strategy Planning and strategising Capacity building with partners Developing materials
2011	Mar	Campaign's research report, 'Achieving a shared goal: free universal healthcare in Ghana' launched
		Campaign publishes a series of policy briefs summarising the key findings of the research report NHIA issue critical response to the Campaign's report[20] Oxfam issue a response to the NHIA[21]
	Apr	Press conference held
		Students forum on free healthcare
	Jun	World Bank holds a workshop on health financing in Ghana
	Sep	NHIA Magazine publishes a rebuttal to the *Achieving a Shared Goal* report.

[20] http://bit.ly/15ONyDh
[21] http://bit.ly/16eD3el

		Oxfam assumes a less prominent and publicly visible role within the campaign
	Oct	NHIA Publishes its Annual Report
2012	January	World Bank publishes its report, 'Health financing in Ghana'
		World Bank/NHIA Workshop
		Campaign training of regional focal persons
	February	Campaign General Meeting to brief and update members
	March	Nationwide public marches Training for health coalition's regional focal persons Campaign General Meeting held in Accra Meeting to strengthen media relations Media training provided by the Campaign for selected media personnel to deepen their understanding of universal health care
		Press release issued to mark International Women's Day
	April	Radio discussion on the topic of financing free health care in Ghana
	May	Campaign participation in regional May Day event
	June	Press Conference held in Response to World Bank Report
		Radio discussions
		Held meetings with NPP, NDC and CCP on their manifestoes
		IEA meeting to discuss presidential debate
		Pre-manifesto lunch press conference calling for prioritisation of healthcare in 2012 election.
		Live TV discussion on Joy TV
		Radio discussion on Unique FM
		Collaboration with Joy TV on manifesto digest
		National debate on healthcare financing
		Live TV discussion on TV3
		Press release calling on tax-based financing
		Press release asking political parties to prioritise universal healthcare
		National walk for universal healthcare
	Sep/Oct	Political manifestoes published
	Nov	NHIS publishes coverage figures in the press IEA presidential debates
	7–8 Dec	Presidential and parliamentary elections

4 Key findings

The main focus of this evaluation is to establish if there are reasonable causal links between the Campaign's activities and a series of defined, observable outcomes as described in the methods section of this report (Section 2). Key findings from the evaluation are framed around a series of intermediate outcomes that were identified and agreed during a participatory workshop, facilitated by the Evaluator with a small subset of the Campaign team. The following outcomes were agreed to be the most relevant for the evaluation as they represented the outcomes the campaign was most recently working towards:

1. Improved coordination of civil society to advocate free universal health care for all.
2. Showing the current NHIS system to be an ineffective vehicle to deliver free universal health care in Ghana.
3. Increased political buy-in for free, quality and accessible universal healthcare for all.

Taking each outcome in turn, this section will:

I. define the outcome the Campaign was seeking to bring about
II. assess whether there is evidence to suggest that the desired outcome actually materialised
III. given the range and intensity of the Campaign's activities and taking gathered evidence into account, identify salient causal stories to explain how the desired outcomes were realised
IV. considering other plausible, alternate factors, assess the Campaign's contribution to achievement of the observed outcome.

4.1 Outcome 1: Improved coordination of civil society organisations to advocate free universal health care for all

4.1.1 Outcome description

A desired outcome of the Campaign was to improve the coordination of civil society organisations to become effective advocates for the Campaign's cause and credible spokespersons for its key messages. This outcome is not concerned with the outright coordination of civil society organisations *per se*. The claim here is that the Campaign improved coordination of civil society organisations who were active members of the Campaign on the very specific set of issues that surround the achievement of free universal health care. An inherent aspect of the achievement of this outcome, therefore, is the effectiveness of the Campaign in building the capacity of civil society organisations to communicate about many of the technical aspects of the Campaign's policy 'asks', for example on tax-based health financing; as well as its ability to support CSOs in the Campaign to plan, work and implement activities as a collective.

4.1.2 Validation

Following Independence in 1957, civil society organisations were suppressed by the new regime and it was not until the rebirth of democracy in 1992 that civil society organisations began to flourish once more.[22]

Today, Ghana has a vibrant range of civil society organisations that have worked on a broad spectrum of social, human rights and environmental issues for decades. Of the Campaign partners, most have been engaged in advocacy on social and health-related issues for at

[22] Ghana Centre for Democratic Development (2012) *Civil Society Organisations and Political Parties' Interactions in West Africa.*

least nine years, for example: ISODEC was formed in1987; the Coalition of NGOs in Health, which currently has over 500 CSO members, was formed in 2000; and the ARHR, again a network of CSOs, was established in 2004. Evidence of CSOs' ability to organise and coordinate themselves for the purpose of health advocacy, prior to the arrival of the Campaign, is manifest in the establishment of the Essential Services Platform of Ghana; as well as the existence of coalitions of NGOs working on health.

Of the CSO key informants the Evaluator interviewed, it was evident that most of them spoke knowledgeably about the various constraints preventing the realisation of free universal health care and the policy solutions that could circumvent such constraints.

The Evaluator saw evidence of coordinated CSOs and interviewed many who are members of the Campaign, who were knowledgeable about the policy landscape and language of free universal health care. Whether the Campaign contributed to this observed outcome is discussed below.

4.1.3 Causal stories

The following causal stories were identified and are explored in detail in this section:

a) The Campaign increased member CSOs' capacity and ability to plan and work together as advocates for free universal health care.
b) CSOs as members of the Essential Services Platform already had sufficient capacity and had planned and worked together as advocates for free universal health care.

Causal story A	*The Campaign increased member CSOs' capacity and ability to plan and work together as advocates for free universal health care*

This causal story has two components, which will be assessed distinctly, namely that the Campaign 'increased CSO capacity' and that it 'supported CSOs to plan and work together' as advocates for free universal health care.

Assessing firstly the capacity of Campaign member CSOs to advocate free universal health care, oral testimony from key informants paints a clear picture. Available evidence suggests that until the Campaign, few, if any, CSOs were calling for free universal health care. While many organisations were working on health, it was usually through the lens of a particular issue, for example, mental health or reproductive health. Key informants were unanimous in their view that the Campaign was the only civil society movement calling for free universal health care in Ghana. Furthermore, key informants were of the view that until the Campaign, the ability of CSOs to engage in discourse, on, say, health financing, was quite weak.

The Evaluator was only able to interview three representatives from health-focused CSOs from outside the Campaign. While this sample is too small to draw any significant conclusions, they were not aware of any home-grown movement calling for free universal health care, other than the Campaign. A desk-based internet search using: 'universal health care & Ghana'; 'free health care & Ghana'; and 'free health services & Ghana' as search terms returned a number of hits, but all were related to the Campaign. While not an extensive review, the Evaluator is satisfied that the most visible group calling for free universal health care in Ghana in the lead up to the 2012 elections, was the Campaign.

The Campaign's ability to untangle and make sense of the complexity of the NHIS, highlighting its shortcomings and casting doubt on its ability as a mechanism to deliver free universal health care, undoubtedly built capacity – in terms of health financing policy knowledge - within the Campaign's membership. Prior to the launch of the 'Achieving a Shared Goal' report, its key findings were presented to Campaign members who were able to ask questions directly to one of the report's authors. It is reasonable to conclude that of

the CSOs who actively engaged with the Campaign, their engagement built their capacity to advocate free universal health care.

'…[the] understanding of civil society health financing issues and how to articulate them was, in itself, quite weak. So…the capacity building…on the issue of health financing was one of the major achievements of the Campaign.'
Key informant, Campaign member

'How to articulate the Campaign's messages and building the capacity of civil society organisations was a key success of the campaign. They are much more knowledgeable about the campaign's messages.'
Key informant, Campaign member

'I would say that the Campaign is the only campaign in Ghana that has actually brought Ghanaians attention to the challenges all the weaknesses of the national health insurance scheme.'
Key informant, Campaign member

The second component of this causal story assesses whether the Campaign 'supported member CSOs to plan and work together' as advocates for free universal health care. Prior to the Campaign, a coordinated body of health CSOs, known as the Essential Services Platform already existed. Available evidence has shown that until the publication of the Campaign's report there was little notable advocacy for free universal health care. It is unclear to the Evaluator whether this is associated with a lack of appropriate coordination, or whether advocacy planning was nascent at this time. Whatever the cause, the phase prior to the report's publication is characterised as a time when little publicly visible advocacy took place.

Exploring this line of enquiry further uncovered critique levelled at Oxfam in Ghana, which may have been initially detrimental to the joint planning and working of member CSOs as advocates for free universal health care. Key informants suggested that Oxfam's role at certain points in the Campaign became far too dominant. They posited that this may have prevented meaningful engagement with some CSOs, which in turn, may have caused some fragmentation of effort and withdrawal of CSOs. To help unpack this situation the Evaluator pieced together narrative from oral testimony to try and understand a possible sequence of events.

This report has stated that the Campaign could be viewed as having two phases: the first in which it operated within and through the Essential Services Platform of Ghana; and the second where the Campaign stood in its own right with a full-time coordinator (although it must be clarified that lines of communication remained active between the Campaign and the Platform throughout). For ease of reference this will be referred to as the 'first phase' and the 'second phase', respectively.

'[during the first phase] Oxfam's role was basically supporting the local organisations, so the ARHR and ISODEC were in the lead. [The first phase] provided technical support and help[ed] to fill capacity gaps and encourage local partners. But I think this sort of changed [after the first phase]. From that stage the local partners started withdrawing. [In the second phase] everything started to be sort of micromanaged within Oxfam and partners [were] no longer in the lead, in a way. It was a gradual thing that happened…but it built up to a point. Though the campaign was successful it could have been much more successful had some of these things been managed properly.'
Key informant, CSO Campaign member

Although difficult to be precise about when this perceived change occurred, several key informants articulated like-minded feelings, illustrated by the following excerpts:

'I didn't feel that we were part of the whole process. I felt used somehow, to be used just for implementation. I didn't know the arrangement with Oxfam – the plan was developed and when it was time to implement they come to us, 'you do activity a, then b'. Oxfam bring their work plan, let's say an activity to do a march. Members were confused about how the activities related to other parts of the Campaign's plan. The members didn't understand the concept fully of the whole Campaign. If they see it as a one-time activity, they are then waiting for what to do for the next time.'

Key informant, CSO Campaign member

'… it was just like the big NGOs coming together at meetings. But then they realised that they cannot do it without the people who can implement the vision and push forward. Maybe there should have been a wider scope of meetings with more NGOs involved. People didn't really feel part of it [the planning].'

Key informant, CSO Campaign member

'In the beginning we had a number of issues with Oxfam as the main player. They were seen as being too much in the front. Traditionally Oxfam works through other organisations. We felt that Oxfam was too much in the front. They have now stepped back and allowed more CSOs to be involved. Before they would plan and then dump it on others to deliver.'

Key informant, CSO Campaign member

'[In the second phase] I think they [Oxfam] was overly enthusiastic to place Oxfam first. I do not know what the motivation was. And also to run programmes by themselves, instead of continuing with the old philosophy of making it a locally driven Campaign, with support from Oxfam. This is what changed.'

Key informant, CSO Campaign member

The timing of the Campaign's report launch coincided with the period when some key informants felt Oxfam was too prominent in the Campaign. Following the Campaign's report launch, there was a tense period during which the NHIA – the main focus of the report – publicly criticised Oxfam, using imperialist undertones to attack Oxfam rather than addressing the many issues and concerns raised by the report.[23] Some key informants felt that Oxfam's overly dominant role in the Campaign, particularly during the report launch, made them an easy target for the NHIA's imperialist propaganda and demoralised some Campaign members.

'Some members of the campaign raised the[ir] concerns [about Oxfam's dominance], especially when it landed the campaign in serious issues. There was also a rush after the launch took place…to get Oxfam speaking to the press. So when the attacks started coming the NHIA was doing everything it could do to find any little thing it could pick on, to discredit the report. 'This imperialist agenda'. 'Don't mind these UK people'. It kind of demoralised some of the local actors. We pointed this out to Oxfam and then they realised because of that particularly public report, that they had to step back. From that point on, I think that they became conscious of that fact. But still the administration processes behind the scenes, were still ingrained in some of the thinking that followed. The result was the creation of a different platform instead of the initial intent of building on an existing work.'

Key informant, CSO Campaign member

[23] See for example: http://bit.ly/15ONyDh

[After the report launch] there was a need for the campaign to be restructured in such a way that we would be able to communicate about the findings of the report. This required Oxfam to be in the background and the campaign to be in the foreground. This allowed us to deal with the issues that the report brought forward.
Key informant, CSO Campaign member

At some point following the launch of the Campaign, the decision was taken for the Campaign to split from the Essential Services Platform of Ghana, to be coordinated by one of the Campaign's partners. Funds were raised to employ a full-time coordinator for a period of 18 months and this was put out to competitive application among the membership. A member of staff at ARHR was subsequently recruited as the Campaign's coordinator.

'Initially the plan was to build on existing campaigns. There was the Essential Services Platform which was already in existence, so to build the universal access to health care campaign within this existing platform. But because of the micromanagement issues [at Oxfam] a new platform had to be created. So we realised that the Essential Services Platform was, at a time divided in terms of what was going on. Usually [members of the campaign] would receive an invitation through the Essential Services Platform but now, there were times when they would receive information directly from Oxfam, to attend meetings. So it kind of created a bit of a problem.'
Key informant, CSO Campaign member

The period in the lead up to the 2012 presidential and parliamentary elections was the most intensive period of the Campaign and the best example of the Campaign partners planning and working together. The recruitment of a full-time dedicated coordinator certainly helped to drive the Campaign forward and support CSO's ability to plan and work together as advocates for free universal health care.

In summary, the first phase of the Campaign was associated with little publicly visible advocacy of free universal health care. A possible reason for this could be the nascent nature of the Campaign's planning, among others. There is a suggestion from key informants that the second phase of the Campaign experienced some challenges, particularly in relation to Oxfam's dominant role, which did not support collegiate CSO activity. Following publication of the Campaign's report, coordination was noticeably improved with the range and volume of advocacy activities increasing substantially. This improved joint working could have many explanations, including: Oxfam's decision to take a less prominent role and allow 'home grown' CSOs to take the lead, the appointment of a fulltime coordinator and the urgency to work together as the impending presidential and parliamentary elections drew closer.

Causal story B	*CSOs as members of the Essential Services Platform already had sufficient capacity and had planned and worked together as advocates for free universal health care.*

The assertion that civil society organisations were already knowledgeable on policy related to free universal health care cannot be disproved. A number of CSOs have been actively engaged in holding the GoG to account in relation to the Abuja Declaration for example, a health financing-related policy. Without a baseline to assess the health advocacy plans of CSOs prior to the Campaign, it is not possible to accept or reject this statement. It is clear, however, that the Campaign built the capacity of CSOs engaged in the Campaign in relation to the findings contained within the Campaign's report. A dearth of evidence prior to its publication made it difficult for CSOs to mount a comprehensive advocacy strategy informed by strong data. Key informants have also suggested that prior to the Campaign the ability of some CSOs to engage in health financing discourse, for example, was weak.

In relation to the ability of CSOs to plan and work together as advocates for free universal health care, evidence exists that member CSOs were already working together through their own networks and through the Essential Services Platform of Ghana. However, until the Campaign there was little publicly visible advocacy for free universal health care.

4.1.4 Contribution analysis

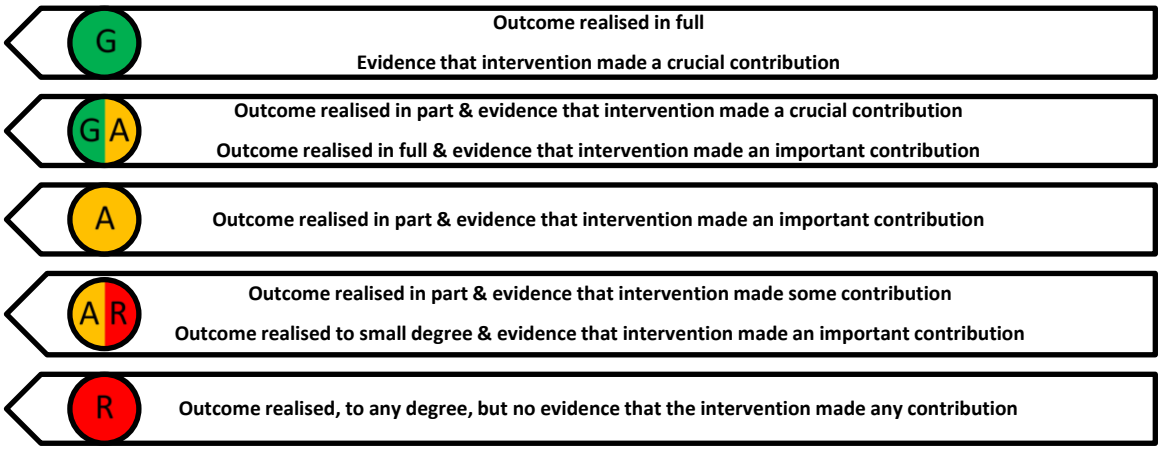
In relation to this outcome and based on available evidence, the Evaluator concludes that **the Campaign made a high contribution to building the capacity of civil society organisations within the Campaign's membership, to effectively advocate free universal health care**. This finding has been validated by the views of key informants who, prior to the Campaign, did not actively engage in advocacy on universal health care although it is acknowledged they were working on related health financing policy agendas. Until the publication of the Campaign's report there was a dearth of rigorous evidence upon which to build solid policy assertions and an effective advocacy effort, which highlighted the inappropriateness of the NHIS as a vehicle for delivering free universal health care. The Campaign worked hard to help everyone involved understand its findings, through workshops, factsheets and policy briefings.

The Campaign's contribution to improving the planning and joint working of member CSOs as advocates for free universal health care is less clear, but a contribution is apparent. The Essential Services Platform existed prior to the Campaign and many CSOs have been actively engaged in health-related advocacy for decades. However little observable advocacy on free universal health care was apparent until the Campaign began. While the original intention was for the Campaign to leverage the support of existing advocacy platforms, the decision to establish the Campaign as distinct from the Essential Services Platform, did, in the short-term, lead to confusion, with some unclear lines of communication. Oxfam's prominent role during the second phase of the Campaign may have eroded some CSOs' sense of ownership, leading to some withdrawal, albeit for a short period of time. It is possible to argue, therefore, that the Campaign may have hindered CSOs' ability to plan and work together but this was not a sustained effect.

During the Campaign's second phase CSO coordination did improve with the number of joint advocacy activities increasing markedly, particularly in the lead up to the presidential and parliamentary elections. The appointment of a fulltime coordinator and Oxfam's decision to take a less prominent role are plausible reasons associated with improved joint planning and working. **Given key informants' version of events, it is reasonable that the Campaign made a contribution towards greater joint planning and working of member CSOs as advocates for free universal health care. This effect was observed mainly in the later stages of the Campaign in the lead up to the presidential and parliamentary elections. Given some challenges faced by the Campaign which may have affected CSO joint planning and working, on balance, the Campaign's contribution to improving CSOs joint planning and working was moderate.**

Outcome	Rating	Short Commentary (including reference to other evidenced explanations as appropriate)
Improved coordination of civil society organisations to advocate free universal health care for all		– Campaign made a high contribution to building the capacity of CSOs within the Campaign's membership to advocate free universal health care. This centred on helping CSOs to understand the Campaign report's findings. – The Campaign made a moderate contribution to increasing the ability of CSOs to plan and work together to advocate free universal health care.

***Scoring Key – Specific Contribution of Intervention**



4.2 Outcome 2: The current NHIS system is shown to be an ineffective vehicle to deliver free universal health care in Ghana

4.2.1 Outcome description

Following the publication of the Campaign's report, 'Achieving a Shared Goal' Campaign key informants claim that the report was successful in showing the NHIS to be an ineffective vehicle to deliver free universal health care in Ghana. As evidence of this claim, key informants put forward the argument that the NHIA had been inaccurately reporting the number of people covered by the NHIS and that as a result of the Campaign, the NHIA was forced to revise its methodology for calculating active membership of the NHIS.

4.2.2 Validation

The NHIA's Annual Report for 2010, published around October 2011, contained language clearly demonstrating that they had revised their methodology for calculating active membership:

'The NHIA undertook a methodology and data validation exercise, during the first quarter of 2011, to ascertain the accuracy of the 2010 membership database. During the exercise, it was realised that the old methodology of calculating active membership was riddled with inherent challenges. The old methodology calculates

active membership by subtracting the number of all expired ID cards since inception of the scheme from the sum of all ID cards issued and ID cards renewed since inception of the scheme. In order to mitigate these challenges, a new and appropriate methodology was used to determine the 2010 active membership. This new approach is based on the sum of the number of new members registered for a given year and the number of renewals made for that year.'

Utilising the new methodology, the NHIA estimated that 34 per cent of the population were active members of the scheme in 2009. This compares with 67 per cent the previous year, using the old methodology.

The causal stories below assess the extent to which the Campaign contributed to this change.

4.2.3 Causal stories

The following causal stories were identified and are explored in detail in this section:

c) The NHIA revised its methodology for calculating active membership of the NHIS because of pressure created by the Campaign
d) The NHIA revised its methodology for calculating active membership of the NHIS based on its own plans and timetable to do so.

Causal story C	The NHIA revised its methodology for calculating active membership of the NHIS because of pressure created by the Campaign

Ghana has been praised internationally as a success story in implementing a national health insurance scheme that works, most prominently by the World Bank.[24] Yet, the reality on the ground for many of the CSOs engaged in this Campaign did not reconcile with this 'good news' story. CSOs knew that health care in Ghana was unequal and uneven based on their own direct experiences and observations. For example, of the community members they engaged in rural settings, few held an NHIS card, or even understood how the scheme worked. However, members of the Campaign lacked rigorous evidence to back up their beliefs. These are some of the factors which led the Campaign to commission research into the NHIS in 2010.

The most commonly cited success of the Campaign by key informants was the actions they took to show that the NHIA coverage figures were inaccurate and misleading. The evidence to substantiate these claims was contained within the Campaign's report. This new evidence was used extensively by the Campaign in media releases, Campaign slogans and policy briefings, particularly in the lead up to the 2012 elections. The 'Achieving a Shared Goal' report was the main driving force behind the Campaign, with its key messages and recommendations the clarion call to all its members.

The NHIA claimed that the NHIS covered over 67 per cent of the population.[25] The Campaign's report, using publicly available data from the NHIA, was able to demonstrate that the methodology used by the NHIA was flawed and presented an inaccurate picture of NHIS coverage. The basis of the Campaign's argument was two-fold:

[24] See page 23, Box 2: Apoya, P. and Marriot, A. (2011) *Achieving a Shard Goal: Free Universal Health Care in Ghana*. Available: http://bit.ly/X9mhNq
[25] http://www.nhis.gov.gh/

I. Firstly, the NHIA calculated the proportion of the population registered under the NHIS against population figures from 2004 rather than using more recent population data. Given population growth, the Campaign's report claimed this overinflated coverage figures.
II. Secondly, the NHIA's figures were based on the accumulated number of people who had ever registered with the NHIS, rather than the total number of valid members at any one time.

The Campaign's report recommended that coverage figures should be calculated based on the number of new members, plus those who renewed their membership in any given year, thereby giving a truer picture of 'active membership' in the NHIS. Using this methodology, the Campaign claimed that NHIS coverage was closer to 18 per cent, a dramatically lower figure than the NHIA had published. The Campaign report was also able to show that of those who were registered, 64 per cent were from richer households, with only 29 per cent of the poorest holding a valid NHIS card.[26]

The backlash from the publication of 'Achieving a Shared Goal' was intense, clearly making some Campaign members feel uneasy. For the Evaluator, this struck at an apparent tension of how the business of advocacy in Ghana is done, with key informants expressing polemic views. This point is explored further in Section 5. What is clear from the evidence is that the Campaign's report received a lot of attention, particularly in the national and regional press:

'It jostled people at the NHIA, it got them to sit up. The Minister of Health was very angry, there was controversy. But now they have revisited the stats and the NHIA is publishing more realistic figures. That is a big plus for the Campaign.'
Key informant, CSO Campaign member

'When the report came out there was a lot of noise in Ghana. It is keeping the government on its toes.'
Key informant, CSO Campaign member

'Awareness of the issues of the NHIS got a lot of publicity since the launch of the report. There was discussion in the media about the issues.'
Key informant, CSO Campaign member

'…it really brought up discussions on radio, on TV and all those things…I remember, when the report was launched I was in Senegal for a meeting on universal health care coverage. Even there I was asked to make a comment about stories in the media back in Ghana.'
Key informant, Ghana Health Service

The Evaluator was able to find numerous media articles and blogs covering the story during online searches. A small range of examples include:

- **Really Oxfam? Really?**
  http://bit.ly/14rWFxT
- **Ghana Health Insurance Scheme not Working for Many – Oxfam**
  http://bit.ly/16VcWdS
- **NHIA Tears Oxfam**
  http://bit.ly/WT3CTL
- **Oxfam Damns Health Insurance Scheme**
  http://bit.ly/X9mHU0

[26] More detail from the Campaign's report is presented in Section 1.

- **Coalition defends report on low coverage of NHIS**
  http://bit.ly/16eIeLD

These examples illustrate the very public nature of the 'confrontation' between the NHIA and the various Campaign partners and the attention the report received:

> *'They were really vicious attacks…and to me, that is a sign. Unless you make someone uncomfortable you are clearly not doing the right thing!'*
> **Key informant, Oxfam**

Following the publication of the Campaign's report on March 9th 2011, the NHIA published a statement on the March 17th from its Chief Executive. The statement addressed the unusual nature of the NHIA response to such publications, but cites the many *'factual inaccuracies, hearsay and innuendoes'*, contained within the report that warranted *'setting the record straight'*.[27] The statement from the NHIA very publicly attacks Oxfam, ignoring the fact that the report was a combined effort between a broad range of Ghanaian NGOs. It refers to Oxfam's *'blatant aversion to health insurance'*, how flawed analysis is *'Oxfam's stock in trade'*, and makes a number of remarks deliberately designed to induce indignation in the reader of an interfering international NGO meddling in the affairs of a *'home grown'* health insurance scheme.

The public fallout from the Campaign's report continued for some months between the NHIA and the Campaign's partners, particularly Oxfam. The NHIA's statement was publicly rebutted by the Campaign's partners, again most prominently by Oxfam.[28]

It is clear from ongoing blogs and media coverage that this report dominated health debates in Ghana for the latter part of 2011. In the NHIA's quarterly newsletter, published in September 2011, the front cover had the title, 'Oxfam Lies Exposed'. In the article, the attack on Oxfam continues, failing entirely to address any of the points raised by the report:

'The chickens are coming home to roost as the Oxfam-led coalition squirm in their own broth…Oxfam's wounds are self-inflicted. The humanitarian aid organisation squandered its credibility over this issue. The offensive against the NHIS was desperate and error-strewn. Oxfam frequently exploits images of desperately needy Africans and other non-white people to solicit assistance from well-meaning philanthropists. One only hopes that such resources are spent entirely on the needy rather than ideologically driven 'Don Quixotic' campaigns, such as the attack on the NHIS. And who will vouch that their willing pawns in its ill-advised campaign offered their services for charity?'

This makes what happened next all the more remarkable. In the NHIA's 2010 Annual Report, published in October 2011, the NHIA admitted that the methodology they were using was flawed and revised downwards their coverage figures from 67 per cent to 34 per cent:

'The NHIA undertook methodology and data validation exercise, during the first quarter of 2011, to ascertain the accuracy of the 2010 membership database. During the exercise, it was realised that the old methodology of calculating active membership was riddled with inherent challenges. In order to mitigate these challenges, a new and appropriate methodology was used to determine the 2010 active membership. This new approach is based on the sum of the number of new members registered for a given year and the number of renewals made for that year.'[29]

[27] The statement from the NHIA can be read in full here: http://bit.ly/15ONyDh
[28] http://bit.ly/16eD3eI
[29] http://bit.ly/Yckp5h

The above excerpt from the NHIA Annual Report indicates that revisions to their methodology took place during the first quarter of 2011, yet in their rebuttal to the Campaign's report, published on March 17th 2011, they make no indication of this, indeed, going further to reaffirm the accuracy of their methods:

'The NHIA affirms that the figures and other information it has put in the public domain are reliable within the limitations of typical data collection and statistical challenges.'[30]

The NHIA make no reference to the Campaign's report for this dramatic turnaround, but to key informants the reasons were clear:

'it [Campaign report] generated a quick response and heated debate from government around the accuracy of the figures. Eventually, they admitted that the figures were wrong. It has highlighted that the fund still has many people who are outside the scheme.'
Key informant, CSO Campaign member

'The issue has now moved away from the accuracy of the figures but the fact that large numbers of people are not covered is accepted by the health authorities.'
Key informant, CSO Campaign member

'There is nothing to convince me that without this report, the NHIA would not have revised their methodology.'
Key informant, CSO Campaign member

'Our figures hit them so much. They had to hold several meetings to look at this issue. They were using cumulative figures and not active membership in a given year. After that we saw some form of review, they set up a clinic audit unit, to check fraud from managers and providers of the scheme. Providers had found a way of beating the system, for example I could go to hospital with malaria, they would fill the forms that I have another disease, such as typhoid, and claim for more expensive treatment that was not delivered.'
Key informant, CSO Campaign member

As alluded to by the final comment above, following the NHIA's admission of a flawed methodology for calculating NHIS coverage, a clinical audit unit was used to take more strident steps to at least be seen to be doing something about corruption and inefficiency. Let us remember that Ghana was now entering an election year.

'The clinical audit unit existed before the campaign started. But the campaign's report and the intensification of the campaign…really egged them on.'
Key informant, CSO Campaign member

'it [Campaign report] put a lot of pressure on the NHIA to increase the coverage and a lot of pressure to show that it was efficient and sustainable. So that pressure has kept NHIA exploring every single mechanism to show that they are efficient and the NHIA is sustainable. So even though nothing has come yet you can see a lot of commitments a lot of pressure to actually show that the National Health Insurance Scheme works. For me it is positive in the sense that we are beginning to see the right attitudes in a public institution that is committed to results. They know that in this particular case, people are watching.'
Key informant, CSO Campaign member

[30] http://bit.ly/15ONyDh

To validate whether the Campaign's report was the causal mechanism that led the NHIA to revise its methodology, the Evaluator interviewed senior representatives from within the Ghana Health Service. While a senior NHIA representative did indicate their willingness to be interviewed for the evaluation, a suitable date and time was never secured during the evaluation window.

The key informants from the GHS agreed with the assertion that the Campaign's report had a causal link with the NHIA's decision to revise its methodology:

> *'I would say "yes", since these changes came after the campaign's report, I would agree it was one of the factors that led to the change in methodology by NHIA in how they calculate coverage of the national health insurance scheme.'*
> **Key informant, Ghana Health Service**

Of further relevance is an excerpt from a World Bank report on health financing in Ghana which stated:

'[Campaign's report] claim[s] that Ghana's NHIS covered only 18 per cent of the population in 2009; the NHIS claimed that more than 60 per cent of the population was covered. In response to these large disparities, the NHIS revised its methodology for estimating coverage. According to its 2010 annual report, the number of 'active' members was 8.16 million in 2010, or 34 per cent of the population'[31]

Finally, at a World Health Organisation and World Bank Ministerial Meeting on Universal Health Care which took place in Geneva in February 2013, the Ghana delegation provided the most compelling evidence to date of the Campaign's contribution:

> *'I'm sure you all know about what has been come to be known as "'the Oxfam Report". This report declared that coverage of the NHIS was as low as 18 per cent. This was actually very helpful and prompted us to revise our figures. We now know that 34 per cent of the population are covered, not 67 per cent as previously thought. In Ghana we are now doing a lot more to improve our monitoring and evaluation and in this way civil society is helping us.'*[32]
> **Ghana Delegation, World Health Organisation and World Bank Ministerial Meeting**

Causal story D	The NHIA revised its methodology for calculating active membership of the NHIS based on its own plans and timetable to do so.

In relation to the NHIA's decision to revise how it calculated active membership and coverage of the NHIS, the Evaluator has not been able to find any convincing evidence that this change would have occurred without the actions of the Campaign. Had the NHIA planned to make changes to its methodology, it would appear incongruent for them to so vociferously defend their position in light of the Campaign's evidence. Moreover, senior representatives from the GHS, concur that the timing of the Campaign's report, together with the subsequent revision of the NHIA's methodology, point to the Campaign as the principal causal mechanism.

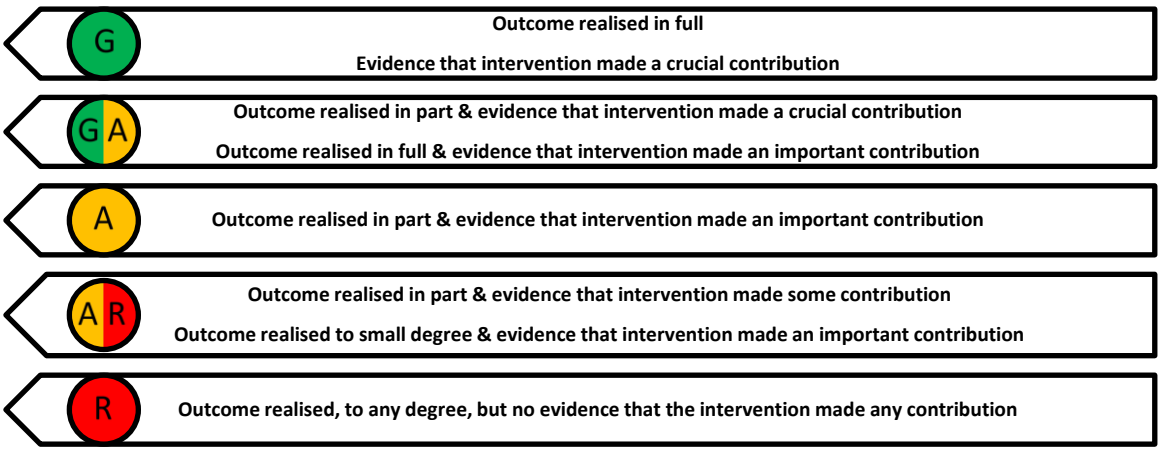
[31] http://bit.ly/14jlrjh
[32] Email correspondence

4.2.4 Contribution analysis

The evidence causally linking the Campaign's report to changes in the way the NHIA calculates NHIS coverage is strong. The Campaign's report received a lot of media attention, with the NHIA taking a particularly defensive public stance to refute the claims made by the Campaign, few of which actually addressed the evidence, instead focusing on attacking Oxfam's credibility. The incongruity of the NHIA's public rebuttal of the Campaign's evidence for months following the report's publication, with the later revision of its methodology, and lowering of the official coverage rates from 67 per cent to 34 per cent, suggests that the NHIA was pressured into making such changes because of the Campaign. This view is supported by senior representatives of the GHS and an excerpt from a World Bank report published in 2012. The most compelling evidence of the Campaign's contribution comes from a Ghana delegation attending a World Health Organisation and World Bank Ministerial Meeting on universal health care. During this meeting the Ghana delegation admitted the Campaign's report prompted the revision in the NHIA's figures. The contribution the Campaign made to this observed outcome is therefore considered to be high.

Outcome	Rating	Short commentary (including reference to other evidenced explanations as appropriate)
The current NHIS system is shown to be an ineffective vehicle to deliver free universal health care in Ghana		• Changes to how the NHIA calculated NHIS coverage was shown to be flawed by the Campaign. • The NHIA changed its methodology for calculating NHIS coverage because of pressure from the Campaign.

***Scoring Key – Specific Contribution of Intervention**



4.3 Outcome 3: Increased political buy-in for free, quality and accessible universal health care for all

4.3.1 Outcome description

In the lead up to the presidential and parliamentary elections in December 2012, the Campaign's activities sought to engage parliamentarians to secure increased political buy-in for free universal health care.

4.3.2 Validation

The Campaign orchestrated the signing of pledge cards by representatives from the three main political parties in the weeks prior to the election and engaged with parliamentarians at events and meetings, but there is little available evidence that this led to policy commitments of any kind either during the elections or subsequently. The two main political parties – NDC and NPP – did include language on health in their manifestoes, but it was weak, lacking in detail and did not include any commitment towards free universal health care.

In a review of media coverage during the election period, health was overshadowed by issues such as education and the economy. While health was included in the main parties' manifestoes, the issue of free universal health care appears to have been given little political attention. During a live televised presidential debate just weeks prior to the election, the Campaign did put a question on universal health care directly to the candidates, which necessitated the candidates formulating a position on and response to universal health care provision. While a laudable achievement by the Campaign, it is difficult to assess whether this influenced political buy-in given the limitations faced by the Evaluator in accessing parliamentarians. The Evaluator considers therefore that the outcome was realised only to a small degree.

4.3.3 Causal stories

The following causal stories were identified and are explored in detail in this section:

a) The Campaign garnered support from parliamentarians in the lead up to the 2012 elections.
b) The Campaign failed to garner support from parliamentarians in the lead up to the 2012 elections.

Causal story E	The Campaign garnered support from parliamentarians in the lead up to the 2012 elections

Based on the range of activities the Campaign undertook in the lead up to the election in December 2012, it is clear that the Campaign had some success in bringing the issue of universal health care into the public arena. The IEA televised presidential debate was the most visible demonstration of this effort. A number of representatives of the main political parties did also sign Campaign pledge cards and engage in radio and TV discussions. Evidence of broad parliamentary support, however, is not apparent.

For some key informants, this was a weakness of the Campaign. Key informants spoke about difficulties in identifying the processes for influencing the main parties' manifestoes, with the drafting process kept rather 'secretive' and publication of manifestoes occurring very close to the actual election.

Key informants also spoke of the difficulty presented by the timing of their activities. They expressed frustration in trying to engage parliamentarians who were very busy and could not offer them audiences. Timing was also an issue during public debates where representatives from the NHIA, for example, attended, but advised the Campaign that they would not be able to make any comments due to the closeness of the elections. They sat in silence throughout one such meeting.

> *'…we had invited the NHIA to a meeting, they sat down and said that they would not comment. People were asking them direct questions and they would not answer.'*
> **Key informant, CSO Campaign member**

'…we have not actually drawn much public attention to our plight. We need[ed] to target MPs and policy-makers in the region…we did try to engage our political leaders but it was hard to access them. This was less successful. Because of the election they were so busy and they didn't have the time to attend.'
Key informant, CSO Campaign member

An advocacy plan which recognised such constraints may have had more success:

'…the earlier part of the campaign was a little bit slow. More momentum could have been put into it, than just waiting for the last year.'
Key informant, CSO Campaign member

'…for the last three or four months of the campaign we never got any official replies to our messages. I am beginning to realise that, yes, maybe we should have been more strategic about timing and know what are the types of things that we can be doing in terms of mobilisation, in terms of more planning and perhaps launching the campaign.'
Key informant, CSO Campaign member

In speaking to a parliamentarian active on the Select Committee on Health, they were aware of the Campaign from the 'Achieving a Shared Goal' report, but they had no recollection of the Campaign ever having engaged with the Select Committee:

'I thought…this campaign…would have engaged the Select Committee on Health because within the past two years we did work on the Health Research Bill, we worked on the Public Health Bill, we worked on the Mental Health Bill, we worked on the National Health Insurance Bill. And I thought if you look at our country and what we were working on, we were virtually covering 90 per cent if not more of the issues concerning the health delivery system in our country. But I cannot remember [the Campaign] doing a presentation to the select committee, I can't remember [the Campaign] meeting the select committee on any of these Bills. I also cannot remember during our oversight visits to institutions outside Accra, to the regions and the districts, [seeing] the presence of [the Campaign], apart from perhaps hearing them on radio or television.'
Key informant, Member of Parliament

Remarkably, a number of CSOs who had engaged with the Select Committee on Health, effectively securing broad parliamentary support on issues such as mental health, were part of the Coalition of NGOs in Health and therefore members of the Campaign. Opportunities were missed for such CSOs to also be effective spokespeople for free universal health care, pointing to some fragmentation in planning.

In speaking with other senior government personnel, they failed to even realise that the Campaign was working on the issue of free universal health care, despite the Campaign's name. This could be a legacy of the Campaign's report:

'The caption that was given to the report was generally not understood by the recipients as a campaign for universal health care coverage. It wasn't clear that this was a campaign toward universal coverage. It was perceived as an evaluation of the national health insurance scheme.'
Key informant, Ghana Health Service

A key informant from within the Campaign put it this way:

> *'The target of our research was not the NHIA. The Ministry of Health was the target for the campaign who we expected to take the results and own them, that actually didn't happen as we had anticipated. The Ministry of Health remains neutral and let the NHIA take the burden. That was our mistake. We were just misled by the euphoria of understanding the issues, putting them into the public domain and we lost track of what our core objective should have been. We were just enjoying the technical debates, and were getting carried along by that.'*
>
> **Key informant, CSO campaign member**

Causal story F	*The Campaign failed to garner support from parliamentarians in the lead up to the 2012 elections.*

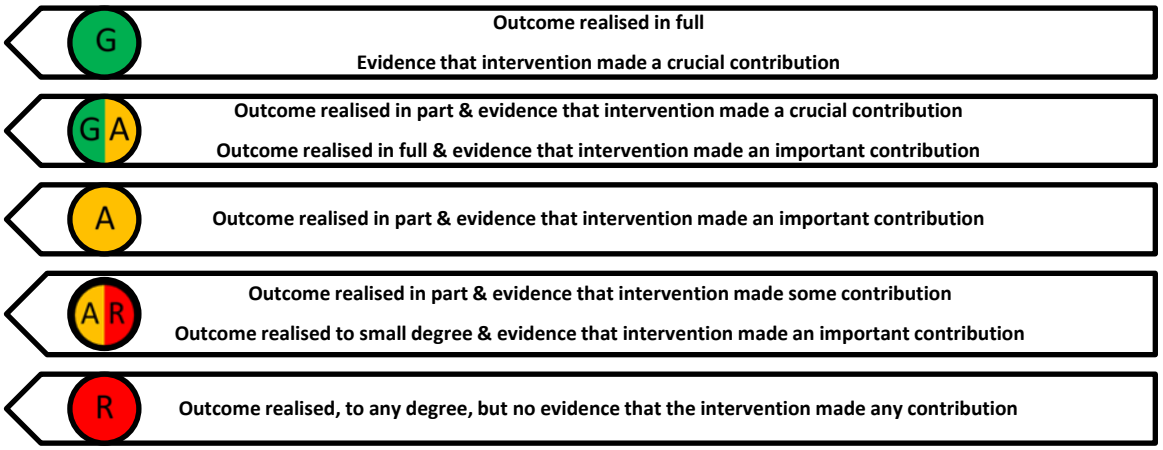
Given the lack of evidence to the contrary this causal story appears more plausible. There is little evidence of the Campaign successfully securing political buy-in through lobbying and adept political engagement. Factors such as timing of the Campaign's activities, appear to have only compounded this situation.

4.3.4 Contribution analysis

The Evaluator has seen little evidence in the period preceding the presidential and parliamentary elections of an increased political buy-in for universal health care. While health did feature in the manifestoes of the main political parties, the content was lacking in detail and did not suggest a move towards free universal health care.

Outcome	Rating	Short Commentary (including reference to other evidenced explanations as appropriate)
Increased political buy-in for free, quality and accessible universal healthcare for all		• Little evidence that the outcome was realised. • Activities of the Campaign appear to have failed to establish constructive dialogue with parliamentarians in the lead up to the elections.

***Scoring Key – Specific Contribution of Intervention**



4.4 Key points

- The Campaign is considered to have made a high contribution to building the capacity of CSOs who were members of the Campaign, to effectively advocate free universal health care. The research and publication of the Campaign's report was observed as the single biggest contributor to increasing CSOs' capacity in terms of enhancing their understanding of a broad range of issues, particularly in relation to health financing.
- The Campaign's contribution to improving the planning and joint working of member CSOs as advocates for free universal health care is less clear, but a contribution is apparent. During the Campaign's second phase CSO coordination did improve with the number of joint advocacy activities increasing markedly, particularly in the lead up to the presidential and parliamentary elections. Given some challenges faced by the Campaign in its earlier phase, which may have affected CSO joint planning and working, on balance, the Campaign's contribution to improving CSOs' joint planning and working was moderate.
- There is strong evidence linking the Campaign's report to changes in the way in which the NHIA calculates NHIS coverage.
- The ability to secure political buy-in for free universal health care appears to be the weakest area of the Campaign. There is little available evidence of increased political buy-in in the lead up to the presidential and parliamentary elections.

	Outcome	Rating	Short Commentary (including reference to other evidenced explanations as appropriate)
4	Improved coordination of civil society organisations to advocate free universal healthcare for all		• Campaign made a high contribution to building the capacity of CSOs within the Campaign's membership to advocate free universal health care. This centred on helping CSOs to understand the Campaign report's findings. • The Campaign made a moderate contribution to increasing the ability of CSOs to plan and work together to advocate free universal health care.
5	The current NHIS system is shown to be an ineffective vehicle to deliver free universal health care in Ghana		• Changes to how the NHIA calculated NHIS coverage was shown to be flawed by the Campaign. • The NHIA changed its methodology for calculating NHIS coverage because of pressure from the Campaign.
6	Increased political buy-in for free, quality and accessible universal healthcare for all		• Little evidence that the outcome was realised. • Activities of the Campaign appear to have failed to establish constructive dialogue with parliamentarians in the lead up to the elections.

5 Programme learning considerations

The following learning considerations have been synthesised from key informant interviews and from observations made by the Evaluator. Items are listed alphabetically, not in order of importance.

Advocacy in Ghana
The Evaluator noted some polemic differences of opinion in how advocacy should be done in Ghana. The publication of the Campaign's report, which generated significant controversy, probably brought these tensions to the surface. For some key informants, if you are not mobilising people to bring their plight to the attention of the political classes, demonstrating in the streets, asking difficult and challenges questions, then you are not likely to bring about change. For others, the tone of the Campaign's report was too confrontational, they did not agree with tactics, such as public marches; they would have preferred a more collaborative style of engagement with a few specific advocacy targets. For future campaigns, this tension needs to be addressed and unpacked more carefully during the planning stages to arrive at a mix of tactics that are owned by members.

Capturing people's imaginations
The Campaign did not create a slogan or strapline that both communicated clearly what the Campaign was about and captured people's imaginations. The term 'universal health care' is professionalised language that doesn't lend itself well to engaging with ordinary members of the public. The Campaign's baseline report made this point, yet this recommendation was not taken up, *'A well-crafted slogan that catches the attention of people will be a good way to nationalise a citizen led advocacy campaign.'* Future campaigns should avoid complex, professionalised language, particularly if public mobilisation and campaigning is to be an integral component.

Engaging with the media
The Campaign did engage with the media, but key informants felt more could have been done. For example by having influential people speak on behalf of the Campaign, such as well-regarded Union or religious leaders. Moreover, there is no known network of journalists working on health issues in Ghana. Had the campaign tried to establish a network of health journalists it could have fostered greater connections between journalists, helping with media penetration of the Campaign's issues.

Planning
A critique from smaller CSOs in this Campaign was that they felt left out of planning and 'used' when it came time for implementation. Greater involvement of partners during planning meetings will help to create a greater sense of cohesiveness as plans move to implementation.

Social Media
The Campaign embraced social media, particularly Facebook, and published a range of engaging content well suited to the medium. However, the Campaign failed to develop a strategy for promoting its work on social media platforms to attract larger audiences. Future campaigns should consider how to make best use of social media, including how to attract sufficient numbers to warrant the investment in staff time.

Timing of activities
During periods of political campaigning it can become difficult to engage with parliamentarians who have a number of competing agendas making them incredibly time-poor. Moreover, civil servants may be reluctant to engage in debates about issues that have become politicised, such as universal health care, close to elections. In light of these

constraints, earlier engagement with parliamentarians and civil servants should be prioritised.

Voting for Justice Campaign
During key informant interviews, no one referenced Oxfam's Voting for Justice campaign. The purpose of this campaign was to share lessons that made campaigns in Liberia, Malawi and Sierra Leone successful. It was not clear to the Evaluator whether factors that made these campaigns successful in other African countries had been shared with partners or whether an attempt was made to translate these success factors for the UHCC in Ghana. Greater and more transparent promotion of good practice should be considered for future campaigns.

6 Conclusion

The Universal Health Care Campaign was a bold, collaborative effort by civil society organisations working to bring about free universal health care for all Ghanaians. The quality of the Campaign's report, 'Achieving a Shared Goal', made its conclusions hard to ignore given how strikingly dissimilar its findings were from the official position of the National Health Insurance Authority.

This evaluation has found strong evidence causally linking the Campaign's report with an admission by the NHIA of a flawed methodology used to calculate coverage of the NHIS. Without the research presented in the Campaign's report, there is little other plausible cause that could have compelled such as dramatic revision of the NHIS' coverage data from 67 per cent to 34 per cent. The Campaign is to be congratulated for its resolve in the face of bitter controversy which it won out in the end.

While a clear success of the Campaign, focusing so much energy on the NHIA perhaps diverted its advocacy resources away from the real target of this Campaign, the Ministry of Health. The Campaign worked to uncover inaccuracies, corruption and inefficiencies in the NHIA and NHIS in order to illustrate their inappropriateness as vehicles for the realisation of free universal health care in Ghana. Having made its case the Campaign should have refocused its resources on the Ministry of Health, the government department with the policy mandate to help realise the Campaign's vision.

Following the report's publication, the Campaign was observed to lose some focus, eventually breaking away from the Essential Services Platform to become a campaign in its own right. Key informants spoke of a period in the Campaign where little happened in late 2011, only to rush through a raft of activities in the final 6–8 months of 2012.

Valuable lessons have been learnt about the timing of advocacy activities during elections, where parliamentarians have numerous competing agendas and civil servants fear speaking out on social issues because of political sensitivities. These factors have contributed to the Campaign's inability to garner broad political support for its key messages. Indeed meaningful engagement with parliamentarians has been identified as a weakness of the Campaign. It should be remembered however that gaining access to parliamentarians was a significant limitation of this evaluation.

Lessons too have been learnt about the various roles of partners, particularly the role played by international NGOs, such as Oxfam, relative to national CSOs. Placing national CSOs in the lead not only helps to build capacity, but ensures that the actions of campaigns are seen by government as home grown. The evaluation has found that despite some challenges the Campaign has made a high contribution to building the capacity of CSOs active within the

Campaign and has made a moderate contribution towards supporting CSOs to plan and work together as advocates for free universal health care.

For some Campaign partners, the time following the publication of 'Achieving a Shared Goal' was tense and fraught and evoked some introspection about which advocacy tactics are appropriate in the Ghanaian context. This has uncovered some tensions between CSO partners relative to the tone and type of tactics considered acceptable. More detailed planning for future campaigns, using approaches such as Theory of Change, can help to unpack underlying assumptions about how change occurs in particular contexts and the appropriateness of specific advocacy tactics. Partners can then choose which approaches best suit their organisational advocacy style.

Given the clear success of the Campaign's report in bringing about change within the NHIA and NHIS, Campaign members should draw confidence from what their collective action has achieved and plan the next phases of the Campaign with renewed vigour.

Appendix 1: Documentation reviewed

ID	Background Documents	ID	Background Documents	ID	Background Documents
01	Seven days until the election	22	Newspaper advert 2	43	Universal Healthcare Campaign Report 2012
02	A day after two days of voting in Ghana	23	NHIA Annual Report 2010	44	Universal Healthcare Campaign Report 2012
03	Achieving a Shared Goal full report	24	NPP Manifesto 2012	45	Voting for Justice
04	CSOs, elections and democracy in Africa	25	Oxfam CDD	46	Walk petition
05	Concept Note for Regional Forum on Universal Healthcare Campaign	26	Partners Review Meeting	47	Oxfam-Election Campaigning Concept Note 11 Jan 12
06	Effects of Ghana's Health Insurance Scheme, GMJ	27	Plaquette	48	Will the elections deliver for Ghanaians Oct 2012
07	Election Campaign Baseline Report 2012, Version 2	28	Essential Services Campaign in Ghana – Evaluation Report v1	49	Reconstructed Campaign logic Model
08	Ghana 3 year Objectives and Activity plan July 2012	29	Ghana HDI Report 2011	50	Ghana HDI Report 2011
09	Ghana health paper Q&A	30	Pledge Car		
10	Ghana Health Advocacy Programme Logic Model	31	Policy Brief, June 2012 – Addressing Inefficiencies		
11	Health Financing in GHANA (Worldbank)	32	Policy Brief, June 2012, Universal healthcare in Ghana		
12	Health Manifesto	33	Post-election strategy		
13	Health Walk Report	34	Press Release – Capitation Pilot		
14	Healthcare campaign strategy, 2nd draft	35	Press Statement June 27, 2012		

15	Killer facts	36	Report on observations and commentary on NHIS	
16	Letter to John Mahama	37	Southern Campaigning template 2	
17	Media advisory Ghana Elections Dec 2012	38	Statement at World Bank Conference, June 2012	
18	National Walk for Health – press release	39	Synopsis on health Crisis Talk 2	
19	NDC Manifesto 2012	40	Synopsis for TV Debate	
20	Newspaper advert commitments	41	UHC Programme Implementation Plan	
21	Newspaper advert 1	42	Universal access to health walk concept note final	

Appendix 2: Key informants

	Informant Name	**Affiliation**	**Designation**
01	Rev. Anna Brantus	Mission of Grace Ministries	Chair (Greater Accra), Coalition of Health NGOs
02	Dela Gle	ARHR	Programme Development Manager
03	Cecilia Senor	Hope for Future Generations	Vice-Chair Coalition of Health NGOs
04	Patricia Porekuu	Coalition of NGOs in Health	National Coordinator
05	Steve Manteaw	ISODEC	Head of Public Agenda
06	Abrham Donker	Radio Ghana	Newscaster
07	Idris Buabeng	Map International	Country Programme Manager
08	Alando Bernard	Basic Needs	Knowledge and Communications Officer
09	Dr Zakaria	ISODEC	
10	Joseph Chonia	ISODEC	

11	Clara Tigenoah	Oxfam	Health Advocacy Officer
12	Abagmbire Thomas	Coalition of Health NGOs	Upper East Secretary
13	Patrick Apoya	Skyfox Consultant	Research Consultant
14	Philip Akanzinge	Ghana Health Service	NHIS Coordinator
15	Veronica Asafo-Adejei	Ghana Health Service	NHIS Asst. Coordinator
16	Dr Afisa Zakariah	Ministry of Health	Director of Policy, Planning, Monitoring and Evaluation
17	Leonard Shang-Quartey	ISODEC	Essential Services Coordinator
18	Sidua Hor	ARHR	Campaign Coordinator
19	Mutaka Mubarak MP	NDC	Chair, Select Committee on Health
20	Rosemary Anderson	Formerly with Oxfam	Former Oxfam Staffer
21	Max Lawson	Oxfam	Head of Policy and Advocacy