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Sida REVIEW

Staffan Engblom

SWEDISH HEALTH FORUM IN SOUTH AFRICA – FROM POINT OF VIEW OF THE SWEDISH PARTNER

Swedish Health Forum in South Africa – from point of view of the Swedish Partner

Staffan Engblom

Sida Review 2009:01

Sida

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The views and interpretations expressed in this report are the author's and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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List of Abbreviations and Acronyms

ANC	African National Congress
BNC	Bi-national Commission between SA – Sweden
CFTC	Contract-Financed Technical Cooperation (KTS in Swedish)
DoH	Department of Health, South Africa
DoT	Department of Transport, SA
HF	Health Forum
HSD	Health Systems Development
ITP	International Training Programme (Sida)
MDG	Millenium Development Goals
MFA	Ministry for Foreign Affairs
MoHSA	Ministry of Health and Social Affairs, Sweden
MoU	Memorandum of Understanding
NBoHW	National Board of Health and Welfare, Sweden
NAC	South African National Arts Council
NCCA	Swedish National Council for Cultural Affairs (Kulturrådet)
NICD	National Institute for Communicable Diseases, SA
NIPH	National Institute of Public Health, Sweden
ODA	Official Development Assistance
PGD/PGU	Policy for Global Development (Sweden)
RT	Review Team
SA	South Africa
SALA-IDA	Swedish Association of Local Authorities – Internat. Dev. Agency
SAPS	South African Police Service
SNPB	Swedish National Police Board (Rikspolisstyrelsen)
SARS	South African Revenue Service
SBU	Swedish Council on Technology Assessment in Health Care
STA	Swedish Tax Authority (Skatteverket)
SEK	Swedish Krona
Sida	Swedish International Development Cooperation Agency
SADC	Southern African Development Community
SALGA	South African Local Government Association
SMI	Swedish Institute for Infectious Disease Control
SMME	Small, Medium and Micro-enterprises
SRHR	Sexual and Reproductive Health and Human Rights
SSBF	South African Swedish Business Partnership Fund
SCB	Statistics Sweden (Statistiska Centralbyrån)
SRA	Swedish Road Administration
StatsSA	Statistics South Africa
UNDP	United Nations Development Programme
ZAR	South African Rand

Foreword

The first draft report was delayed, more than five months, due to different unlucky circumstances. Comments on the First Draft were also delayed for three months.

The Swedish consultant, in contact with Sida, had to adapt the time-schedule due to other assignments during autumn –08.

A diversion from the ToR had to be made in the sense that a *joint* report could not be produced (ToR, point 6, p. 4). The two partners, in practice, had to make separate reports. Besides this, all attempts have been made to follow the attached ToR, wherever appropriate due to circumstances. The reader is encouraged to study these ToRs, annex 1, as they form the basis for the List of Contents.

The First Draft Report of 2008-06-08 has been adjusted based on comments in writing from Sida 5th September, MoHSA 8th September and, again comments from the new Programme Officer at Sida, 11th November 2008.

As regards main Conclusions and Recommendations in the First Draft they have never been questioned by Sida or MoHSA. However, they have been further refined and re-structured in this Final Draft and some aspects more developed such as Future Collaboration and General Aspects.

All comments in writing from Sida and MoHSA, as well as comments during a meeting at Sida 5th November 2008, have now been very strictly adhered to.

Finally – MoHSA has per September 2008 submitted all requested reports to Sida as per the main Agreement/Contract between Sida and MoHSA.

/The Author/Consultant, 2009-01-19

Executive Summary

Sweden has developed deep relations with democratic South Africa and previously with ANC. Sweden supported the freedom struggle very firmly based on Democratic principles and principles on Human Rights.

As early as 1999 the Heads of the Swedish and South-African Governments established a standing Bi-National Commission, BNC. BNC is a political and unique forum and platform for dialogue on practical cooperation issues but with an emphasis on future and strategic bilateral and other relations between the two Countries.

In 2001 the Bi-National Commission decided to set up a joint Health Forum to explore possibilities to develop a “broader cooperation” within the Health Sector, and closely related sectors and issues. This approach was outside the traditional cooperation framework. In February 2002 President Mbeki and Prime Minister Persson met in Stockholm and declared their firm support for the whole idea on Health Forum.

Sida got the assignment from the Government to prepare and plan the new Programme on HF and had to do it very rapidly and under time pressure – due to the political character of the approach.

HF consisted of two important main aspects – a political aspect and a technical dimension. The two main aspects of HF, the political dimension and the technical dimension were very important and were both covered through the terminology of “Health Forum”.

A special agreement was signed between Sida and Swedish Ministry for Health and Social Affairs (MoHSA) in April 2003. This agreement made MoHSA the main planning, coordinating and responsible body on the Swedish side – the main and prime project owner and project manager. No agreement or contract was signed between MoHSA and DoH in SA.

The purpose of the Health Forum is /was, as per the Contract between Sida and MoHSA, its main enclosure 1 (documents in Swedish only) and a number of brief reports, “...to facilitate and stimulate enhanced and broad-based cooperation between South Africa and Sweden in the field of public health for the benefit of both Countries”.

The Aims (objectives) of the Health Forum, which should be facilitated through the approach, were stated in very general terms as follows:

- Policy dialogue in the area of public health
- Experience and information sharing
- Human resource development/competence development
- Knowledge transfer and exchange/transfer and sharing of know-how

In the Agreement, Sida – MoHSA, it is further stated that HF shall promote a long-term, not aid or donor financed, cooperation within the health sector. HF is not a standard international development co-operation project. HF is a piece and parcel of a new development process, “actor-driven co-operation”. Such a process would need new “practical development tools”. The Country Strategy states that “before a solid portfolio of sustainable partnerships can be established, a number of trial attempts need to be made” (p. 16 this report).

The programme secretariat has been based at MoHSA with overall and full responsibility for all planning, implementation, accounting, auditing and reporting as per the main contract, Sida-MoHSA.

It is very clear that MoHSA took on very big and heavy under-taking, with much of the character of a difficult TRIAL, based on PGU/PGD and based on the fairly vague principles of the so called “broader co-operation” – or later “actor-driven co-operation”.

MoHSA mobilised Swedish Agencies such as SMI, SRA/Stockholm Region, NIPH, SBU and NBoHW to work on the technical, health-oriented, sub-projects. These sub-projects covered a wide range of aspects, out-lined in chapters 6 and 8.

Against the back-ground of the Swedish Country Cooperation Strategy for South Africa for 2004–2008 Health Forum was a relevant project or programme in the sense that Health Forum is in line with the development of the cooperation “from Humanitarian Support to Broader Cooperation” (Strategy page 1, chapter 2). Health Forum was also partly in line with the emphasis on HIV/AIDS as pronounced in the Strategy, page 20, chapter 10.

Most/all sub-projects established have been in line with the overall internal development and strategic needs of MoHSA. It is also obvious that the different proposed and implemented sub-programmes/projects within HF, in general, are in line with Swedish MoHSA priorities as per the Swedish Policies for Public Health.

It was relevant to initiate, start and establish the Programme, firstly and foremost as a “trial” or an “experiment” on “broader co-operation”. But also as part of the bi-national health policy dialogue. This policy dialogue has been an important aspect of the Programme.

It is very difficult to evaluate or review the Programme effectiveness of HF. This is due to the fact that far too little investments were set aside for Programme preparations and for Programme planning. This is also a common understanding among all participants involved and interviewed. Most interviewees refer this understanding to the political character of the BNC and its Health Forum and to the relative political urgency to start implementation. But this point of view is hardly fully valid as the political aspect should not have hampered proper programme planning. It is impossible to find any relevant planning for HF, based on the Logical Framework Approach – LFA, or any similar method.

As regards the general and overall Aims of HF, minutes from the four HF-sessions indicate that some such information sharing and such transfer of knowledge took place. In terms of overall mutuality of HF per se the Swedish Side had a clear lead role. Most initiatives, policies and practical projects, were all taken in Sweden. Partly this is related to contractual and funding issues but also to some differences in terms of administrative capacity.

The general aims of the HF are really very general and difficult to follow-up and were not supported by any more specific objectives, purposes and expected results. Opinions among interviewees are divided as regards the policy dialogue and in principle related to positions. Based on available reporting and performed interviews the consultant make the overall judgment that the policy dialogue have been useful and that the other aims partly have facilitated the cooperation and partly have facilitated implementation of sub-projects.

Projects implemented by SMI, SRA/SweRoad and by NIPH (especially Tobacco Control) were all implemented and in fairly successful manner. These three Agencies had a good international experience and operated as driving forces. SMI and SRA/SweRoad made “by-passes” working directly with their partners but NIPH/Tobacco worked with and through DoH. Other projects were in principal a failure or, rather, did never materialise. Details are found under chapter 8.2.

Due to weak planning and reporting it is very difficult to objectively judge upon cost-effectiveness. The whole approach has to be considered as a trial in many respects.

“Value for money” is limited if you do not consider the approach as a trial.

The reporting has been very weak and not according to the Agreement between Sida and MoHSA. The main reason for this is most probably that the specifics in the Contract were not properly discussed and explained. Neither Sida nor the MoHSA fully understood and grasped the needs for training of the project management at MoHSA, as international (planning and) reporting is quite different from the standard one within Swedish Public Service.

The reporting has been very similar during the whole length of the programme and in principal the same year by year. The result-oriented reporting has not visualised and there has been limited problem-based analysis. Weaknesses were not discovered as no initial LFA Workshop took place and project monitoring obviously was very limited.

Based on all definitions of sustainability it is obvious that there is limited sustainability in this programme. Main reasons for the limited sustainability are weak initial planning, no LFA-related workshop, limited stakeholder involvement in the preparatory processes and also the fact that the concept of “broader co-operation” was not fully clarified or understood by the parties and by participating agencies.

No Contract was signed between MoHSA and DoH/the Ministry in South Africa. The very professional and clarifying Contract/Agreement on the Programme between MoHSA in Sweden and Sida was never provided to DoH in SA. This limited understanding and sustainability. Other contributing factors to the limited sustainability are severe internal and very practical communications problems within the Programme, fairly weak programme management due to limited time and training, and also the fact that the whole approach was a political order or a political decision – a top-down approach in other words.

Sida should make another, and much more developed, better planned and monitored trial based on experiences from HF, preferably with SA again or with, for example, Russian Federation (more close) as Sweden has a great number of comparative advantages within the Health Sector and in order to further develop the practical tools for actor-driven co-operation. This would benefit the Swedish (and South African) Health System and it is also proposed that the approach would cover decentralisation, health administration and management development. Therefore also Agencies and Institutions in Sweden working on “Administrative Development” within the Health Sector should be heavily involved such as some Universities, Stockholm School of Economics, Department of Medical Management at Karolinska Institute, Nordic School of Public Health in Gothenburg and probably some Consulting Firms.

Recommendations to Sida

It is evident that the PGU/PGD raises questions and problems on which institution (Sida ?) is responsible for capacity development to ensure sufficient competence and capacity within implementing organisations. If this is a Sida responsibility this organisation has to be provided with resources to carry out the task.

- “Actor-driven” co-operation needs further, very practically oriented, developments. Quite some issues have to be clarified and developed and it is obvious that the practical “tools” can not be transferred from previous, since long well established phases, of international development co-operation.
- Agreements between Sida and Swedish managing/implementing Agencies has to be well explained and discussed, if they continue to be based on principals for previous stages of international co-operation, or preferably, fully adapted to “broader co-operation” and thereby made more clear and easy to understand.
- Sida should encourage, and ensure through the main agreement, that Swedish managing Agencies (MoHSA within in HF) do sign agreements with foreign co-operation partners, based on the internal Swedish main Agreement.

- Sida should definitely clarify that English is “the language of co-operation” and that all important documents are provided in English (one example, the main Agreement Sida – MoHSA with its In-depth Assessment Memo).
- Sida should initiate, and ensure, that the LFA-approach is utilised for planning, stakeholder involvement, follow-up and evaluation purposes – both on the Swedish Side and in between co-operating international partners.
- Sida should, especially during the initial stages of “actor-driven cooperation”, increase its monitoring involvement.
- Sida should develop special training for institutions supposed to be involved in the PGU/PGD and in actor-driven cooperation (this is now also requested by MoHSA in its draft final report, pilot courses also available).
- Sida should make another, and much more developed, better planned and monitored trial based on experiences from HF, preferably with SA again or with, for example, Russian Federation (more close) as Sweden has a great number of comparative advantages within the Health Sector and in order to further develop the practical tools for actor-driven co-operation. This would benefit the Swedish (and South African) Health System and it is also proposed that the approach would cover decentralisation, health administration and management development. Therefore also Agencies and Institutions in Sweden working on “Administrative Development” within the Health Sector should be heavily involved such as some Universities, Stockholm School of Economics, Department of Medical Management at Karolinska Institute, Nordic School of Public Health in Gothenburg and probably some Consulting Firms.
- Sida should remove the procedure of double financial auditing from actor-driven cooperation as all concerned staff find the procedure frustrating and costly.
- Sida should summarise and disseminate good experiences of broader co-operation from different Agencies such as SMI, SRA, Swedish Police Authority, Swedish Statistical Office, etc, in order to further contribute to the development of PGU/PGD.

Recommendations to MoHSA

- MoHSA should finalise all its contractual reporting as per 31 December 2007.
- MoHSA should further strengthen its capacity to operate based on the PGU/PGD.
- MoHSA should contribute to further strengthen related Agencies to operate based on the PGU/PGD.
- MoHSA should participate as lead agent in the proposed future collaboration on the proposed and re-planned HF

1. Background and Introduction to Health Forum

1.1 Background

Sweden has very long-lasting and comprehensive relations with democratic South Africa and, previously, with ANC since early 1960s. Sweden firmly supported the struggle against apartheid. Mid 1990s, after the apartheid period, the humanitarian programme was transformed into a regular and broad-based development cooperation programme.

Swedish development assistance was supposed to be provided in strategic areas during a brief transition period. The main objective was to further strengthen the capacity of the new in-coming ANC government to take on responsibility for the strategic development of the Country.

Due to the solid strength of the South African economy the cooperation was supposed to be directed towards areas and objectives wherein Sweden would have strong comparative advantages, knowledge and experiences. It was felt that South Africa was very different from most other developing countries, or rather mid-income countries, in the sense that there was not a real lack of financial resources.

“Instead the Country primarily needed to deal with a severely distorted economy, an undemocratic political culture and a deep skills gap between the white minority and the historically disadvantaged black majority” (Country Strategy, July 2004–2008).

As early as 1999 the heads of the Swedish and South-African Governments established a standing Bi-National Commission, BNC. BNC is a political and unique forum and platform for dialogue on practical cooperation issues but with an emphasis on future and strategic bilateral and other relations between the two Countries. The Commission is chaired by the highest Government levels and the main purpose is to even further broaden and deepen the cooperation between the two Countries. BNC was formally launched in October 2000 by the President of South Africa and the Swedish Prime Minister.

In 2001 the Bi-National Commission decided to set up a joint Health Forum to explore possibilities to develop a “broader cooperation” within the Health Sector, and closely related sectors and issues. This approach was outside the traditional cooperation framework and a step on the road from humanitarian assistance through regular development cooperation programme to, so called, *broader cooperation*, (in Swedish “bredare samverkan”, I a based on the PGD, “Shared responsibility; Sweden’s Policy for Global Development”, in English nowadays “Actor-driven Co-operation” instead of “Broader Co-operation”).

In February 2002 President Mbeki and Prime Minister Persson met in Stockholm and President Mbeki declared on this occasion his firm support for the whole idea on Health Forum.

Sida, through the Health Division, got the assignment to prepare the new project based on internal and international standard routines and delivered a proposal in April 2002.

A preparatory meeting with Swedish and South African civil servants as participants took place in Pretoria, October 2002, and the very first Health Forum took place in South Africa, March 2003. Since then all together four sessions of the Health Forum have been carried out, one per year 2003–2006.

The latest, and last Health Forum within the frame of this project/programme, took place in Stockholm, March 2006.

In between the policy-oriented dialogue, in the frame of the annual meetings, a number of minor, but policy-wise important, technical projects were planned and implemented. Both main aspects of Health Forum, the political dimension and the technical dimension, were important.

A special agreement was signed between Sida and Swedish Ministry for Health and Social Affairs (MoHSA) in April 2003. This agreement made MoHSA the main planning, coordinating and responsible body on the Swedish side – the main and prime project owner and project manager.

The Ministry took on the overall responsibility and implementation of the Project on Health Forum on behalf of Sida/the Swedish partner (s). The first agreement (Sida – MoHSA) was valid until 2006-12-30 but was later on (2006-12-15) extended with expected implementation activities until 30 June 2007 and final reporting, latest 31 December 2007 (results-based reporting plus financial reporting plus auditing).

The prolonged agreement also stated that Health Forum would be jointly evaluated by MoHSA and Sida and in close cooperation with the South-African Department of Health (DoH). Enclosed ToRs formed the preliminary basis for this joint evaluation.

1.2 Health Forum – Aims and Start-up

Health Forum is an early started and early implemented case on the so called “broader cooperation” between Sweden and South Africa.

Other examples may be SSBF, SNPB- SAPS, NCCA- NAC, STA- SARS, SALA-IDA—SALGA, SCB- StatsSA, ITP and even more examples on broader cooperation more or less outside the frame of the, previous, standard “tool-box” for regular bilateral development cooperation (ref to List of Abbreviations, page 2, this report).

The different instruments for “broader cooperation” will be commented upon under chapter 3 on the Swedish Country Cooperation Strategy for South Africa for 2004–2008.

The purpose of the Health Forum is /was, as per the agreement between Sida and MoHSA, its main enclosure 1 (both documents in Swedish only) and a number of brief reports, “...to facilitate and stimulate enhanced and broad-based cooperation between South Africa and Sweden in the field of public health for the benefit of both Countries”.

The Forum would I.a. give Sweden opportunities to contribute to the HIV/AIDS debate in South Africa and also to influence the SA Government in this important issue through a policy dialogue. HF would give the policy dialogue continuity and clarity.

The aims of the Health Forum, which should be facilitated through the approach, were stated as follows:

- Policy dialogue in the area of public health
- Experience and information sharing
- Human resource development/competence development
- Knowledge transfer and exchange/transfer and sharing of know-how

In the Agreement, Sida – MoHSA, it is further stated that HF shall promote a long-term, not aid or donor financed, cooperation within the health sector. Aid or Sida funding would be needed to start with in order to facilitate the initial contacts but in the long run there would also be need of other sources of financing. A pre-condition for this is of course that the involved authorities, or state agencies, would

have great interest in this specific type of international cooperation and thus be prepared to contribute financially.

Initially it was clarified that the cooperation would encompass five main areas:

- HIV/AIDS, TB and Communicable Diseases
- Reproductive Health and Rights
- Health Sector Reform
- Health Promotion and Health Impact Assessment
- Injury Prevention

These five main priority areas have, according to reports and minutes, guided the cooperation during the whole life span of the project/programme and were identified in the Agreement, MoHSA – Sida, but were also technically approved by the South African DoH during preparatory meetings and during the very first session of Health Forum, March 2003.

It is important to understand, as part of the same Agreement, enclosure 1, that “Financing of projects can not take place in the frame of Health Forum”. These were obviously intended to be financed by participating Ministries and Agencies – but these contributions became in this case very limited as all sub-project costs on the Swedish Side (and for South Africa as well) were, in practice, covered through the Health Forum budget allocation by Sida of 10 MSEK (out of these, around 6,0 MSEK utilised).

In terms of working methods it was clarified that the Health Forum would consist of meetings between policy-makers (rather top politicians or government representatives) to discuss matters of mutual interest and, in connection to these meetings, of a number of technical workshops/presentations within the themes, or areas, agreed upon. These workshops would be run by specialised health agencies/bodies.

The terminology “Health Forum” has covered both political meetings/ political dialogue as well as the technical cooperation. This may have been a method to facilitate financing of the technical cooperation between Agencies and, on the other hand, the technical cooperation (between Agencies) formed the basis for the political/policy agenda.

The two dimensions of HF are important to understand and grasp. HF/The four main meetings implemented covered a political/policy agenda as well as much more technical aspects. The two dimensions were equally important and piece and parcel of the same HF.

A policy maker’s dialogue on public health, exchange of information and experiences, competence development and transfer of knowledge would thus form the very basis for the co-operation. Such discussions would draw on results emanating from the broad-based cooperation and serve to facilitate future co-operation in relevant fields. The main aim was to enhance co-operation in the field of public health with an emphasis on epidemiology (also ref to Guiding Principles of the Health Forum between South Africa and Sweden, discussed at the first Health Forum, 11 March 2003).

A detailed and fairly comprehensive Agreement was signed between Sida and MoHSA in Sweden.

However, no formal contract/agreement was signed between MoHSA and DoH in South Africa. This meant that the understanding and interpretation of the Programme, and the Programme Aims, were put into the hands of the Swedish Counterpart.

A fairly vague set of documents from the Preparatory Meeting in Pretoria 10–11 October 2002 (a very general “Memo of Understanding” plus general “Records of Proceedings”) and “Agreed Minutes of

the first Meeting of the Health Forum between South Africa and Sweden, 11–12 March 2003” plus herewith enclosed “Guiding Principles of the Health Forum between South Africa and Sweden: held in Pretoria on 11 March 2003” form the only basis for the “broader co-operation” between the Countries within Health Forum. Little was said about financial issues in these joint documents and nothing about transfer of funds (no such transfer acc. to Ms Minty, Director, North-South Co-operation, DoH, SA, see List of People met with, annex 2) and very little about planning methods, project follow-up, principles and rules for communications and project management.

The Countries, with Sweden as the main and only financier in reality, embarked on this example of “broader co-operation” without clearly defined concepts and procedures and with a very unclear practical “cooperation toolbox”. The stage was set for difficulties.

It should already here be mentioned that the Agreement on the Swedish Side between Sida and MoHSA was very clear and well developed on paper – but Sida did not in reality transfer its very comprehensive and well developed “international development toolbox” to MoHSA – and MoHSA did not ask for it. A second stage was set for difficulties, here on the Swedish Side internally.

However, even if this very well developed Sida “toolbox” for standard, previous development co-operation projects would have been properly transferred to MoHSA that toolbox was not really what MoHSA would have requested. MoHSA would have requested an up-dated toolbox from Sida adapted to “broader co-operation projects”. But at that time the box was “half-empty”.

For sake of clarity, it should be mentioned already here, that in the Sida-MoHSA Agreement it clearly says that “Financing of projects shall not take place within the frame of Health Forum” (translated from Swedish, said Agreement, Annex 1, under Purpose). Were the South Africans made fully aware of this? This is a question mark and the answer is “no” according to discussions with Director Minty, 7 March 2008.

2. Comments on Terms of References and on the Methodology of the Evaluation

The attached ToR, annex 1 to this Report, was discussed and communicated between Sida, Department of Health in South Africa and the Swedish Ministry of Health and Social Affairs during summer 2007, jointly approved, and a tender/call-off process took place in Sweden during September with dead-line 2 October.

A contract between Sida/AFRA and Institute of Public Management, IPM, was signed on 8 November 2007 and extended and prolonged per 11 March–08. IPM did of course, with a few minor oral comments later on, fully accept the ToR as a precondition to win the assignment. A consultant was thereby identified on the Swedish side.

This report follows the ToR as closely as possible – depending on circumstances mentioned in the Foreword.

The objective of the evaluation is to assess the performance of the Health Forum in accordance to the set objectives and aims. The initial results of the evaluation should serve as input for the discussions regarding the direction of the cooperation at the next Health Forum meeting. Health Forum is an important case on broader, or actor-driven, co-operation between SA and Sweden, also ref to MTR and 3.2, please.

The Scope and main issues of the Evaluation is in principle based on the Sida Evaluation Manual, “Looking Back, Moving Forward”, an international standard set-up for evaluation of general development projects. This means that I.a. these issues should be looked into:

- Relevance
- Effectiveness
- Costs
- Reporting and Documentation
- Sustainability
- Future Collaboration
- General/Other Issues and Comments

In terms of Methodology and Time Frame the following was stated (quote from ToR):

“The consultants will, in addition to studying and analysing relevant documentation relating to the Health Forum, conduct interviews with key persons on both the Swedish and the South African side. This will include the key government departments involved in the project, project members and any other agencies with which the project has been involved.

The first draft should be presented by 7 December, 2007. Comments by the Parties (Department of Health, South Africa and the Ministry for Health and Social Affairs, Sweden) should be given to the evaluators before 21 December, 2007. A final draft should be delivered by 11 January, 2008. This will serve as an input to the planned Health Forum in February, 2008.”

It is important to observe that the time schedule was approved by both Sides and that a *joint* report should be prepared.

The Swedish consultant met with Director Nadia Minty, Friday 7 March. The Swedish consultant and Ms Minty fully agreed to work on two tracks and make two separate reports due to visible practical reasons. This approach was already previously accepted by Sida/Embassy, if need would arise. This is an important diversion from the ToR that had to be made due to practical reasons.

Otherwise the methodology out-lined in the ToR has been adhered to in this report, as far as possible. Documents have been gathered, a comprehensive desk-study performed and more than 20 interviews done in Sweden. Interviews form an important part of this evaluation due to weak reporting in writing (chapter 10).

As can be seen in the ToR this is also a very small project, by South African and by Swedish standards and no transfer of funds to South Africa has ever taken place. The project was very small in terms of funding but strategically important and of great interest within the framework of “broader” or “actor-driven” co-operation.

A crucial comment is that this HF is not a standard international development co-operation project. HF is a piece and parcel of a new development process, “actor-driven co-operation”. Also new tools will have to be developed in this context as regards evaluations, monitoring processes, principles for project planning and contracts, indicators, project follow-up and reporting, results-based management, training of project managers and other participants, etc.

3. Swedish Country Cooperation Strategy for South Africa for July 2004–December 2008 – and the Mid-term Review, June 2006

3.1 Country Cooperation Strategy, 2004–2008

The Country Cooperation Strategy forms the basis for and explains the new and “broadened” character of the mutual relations – “from Humanitarian Support to Broader Cooperation” (Strategy, page 1, chapter 2).

Emphasis is also on the great importance of the “Bi-national Commission”:

“In 1999, Sweden and South Africa established a standing Bi-National Commission (BNC). This is a political forum which in a Swedish context constitutes a unique platform for dialogue on on-going and future bilateral relations. Chaired at the highest government level, the objective of the Commission is to broaden and deepen relations between the two countries. The work is shared between three committees dealing with a/ political issues, b/ economic exchange and c/ questions related to the social, cultural and academic fields. The BNC was launched in Stockholm in October 2000.

In 2001, the BNC decided to set up a joint Health Forum to explore avenues for developing broader relations in this area. Falling outside the traditional cooperation framework, the bilateral (health) forum was launched in 2003 with the aid of a small contribution from Sida (10 MSEK).

Over the last decade, Sweden’s partnership with South Africa has thus developed in three stages, from humanitarian support via regular (bilateral) development assistance to broader cooperation. While the latter still needs consolidating, it rests on a solid base thanks to the two previous stages (Strategy, p. 1–2).”

The objectives of the development cooperation programme are to promote “broader relations” and, in terms of financing of these relations, “the present development cooperation shall be transformed in to broader co-operation, based on mutuality and joint financing”. However, it is stated that the HIV/AIDS issue could be handled as previously due to the very nature of the problem.

As regards the further transformation of the cooperation during 2004–2008 it is stated, Strategy page 17, that “Swedish participation – based on South African ownership – should involve broader sections of the Swedish society in direct, mutually beneficial, relations with South African counterparts...”. This is fully in line with Sweden’s policy for Global Development, the so called PGU in Swedish.

The Health Sector in general, except as mentioned for HIV/AIDS, is not among the 10 priority areas for the Swedish –SA cooperation.

It is also stated that “before a solid portfolio of sustainable partnerships can be established, a number of trial attempts need to be made”. As regards “broader co-operation” reference is made to similar trials in Eastern Europe, Asia and Latin America related to contract-financed technical cooperation (CFTC-KTS).

The following transformation “toolbox”/instruments is out-lined:

1. CFTC/KTS
2. Financial Market Development

3. ITP/ITC, International Training Programmes
4. Twinning
5. The “fund model” (as the SSBF)
6. Regional projects and programmes in tripartite cooperation
7. Bilateral forums, such as Health Forum, Labour Market Forum and the like
8. Support to civil society

Finally – it is clarified and underlined that it is an important challenge to make these instruments well known both in Sweden and in SA. “Resources should be set aside for testing the instruments applicability and for marketing/promotion purposes”(Strategy, p. 20).

It is obvious, again, that the close relations in this context to the PGU should be acknowledged and kept in mind.

3.2 Mid-term Review, June 2006

A Mid-term Review, MTR, of the Cooperation Strategy was done and finalised, June 2006.

The “Summary Overview” and “Conclusions and Recommendations” are enclosed, annex 4.

The MTR raises a number of very pertinent issues, for both partners and for the Swedish side internally, in relation to the implementation of the Country Strategy. These relates to the implementation toolbox, the “how-issues”, important practicalities, the method of broader cooperation in general and the Swedish Policy for Global Development.

These issues will also, directly and in-directly, be commented upon and analysed in relation to implementation of Health Forum with emphasis on the internal Swedish aspects (as the SA ones is tackled by the consultant from SA).

The MTR-team “received mixed messages on the Health Forum as an appropriate, efficient and effective means of creating cooperation opportunities. It appears that the context on both sides of this partnership is complex and creates both barriers and opportunities with respect to this Forum”. This is also the opinion of the evaluation consultant engaged in this study on Health Forum.

4. Health Priorities of the Ministry of Health and Social Affairs, Sweden

The overall Swedish health priorities within public health, health and medical care and care for the elderly are all in line with different aspects of the proposed and implemented sub-projects within Health Forum. This may be confirmed through studies and reading of the “Governing Regulations” (“Regleringsbrev” in Swedish) during a couple of years during the implementation of the Health Forum through MoHSA.

There are in principle no contradictions or serious deviations in respect to the sub-projects of Health Forum outlined in chapters 6 and 8 below. This is also obvious in the sense that all implementing Swedish Agencies, except for the Swedish Road Administration (SRA), are in reality under direct control and guidance of MoHSA.

The Swedish implementing Agencies all hooked on to their own tasks, capacity and technical competence.

5. Principles and Policies for Transformation of the Traditional Development Co-operation Relationship into “Broader (institutional) Cooperation”

Principles and Policies are outlined in the following documents (all in Swedish only, translation by the consultant):

1. Government decision, 2007-12-19
2. Enclosure to Government Decision as above, “Actor-driven Cooperation for Global Development – Policy for Actor Cooperation within Development Cooperation”
3. Summary – Actor-driven Cooperation within Development Cooperation, Government Web-page, 2008-01-16
4. Paper to Sida Top Management Team, 2008-01-15, “Policy for Actor Cooperation and Divisions of Responsibilities within Sida”

Some previous principles and challenges for broader cooperation are also summarised in the MTR, June 2006.

It is evident that an overall challenge for Sweden is to develop sufficient internal clarity of purpose, method and quantity (what is the level of ambition), so that these can be discussed with South African and other partners.

Director Minty (on 7 March 2008) expressed great anxiety as regards the whole approach, with Health Forum as an example, and clearly indicated that there is big room for clarifications, for developments and common discussions.

While some see the need to maintain flexibility in defining the parameters and implementation of “actor-driven co-operation”, “there is a proportional risk that an absence of clarity heightens the transaction cost and diminishes the likelihood of South African partners making full use of the opportunities that may exist” (MTR).

“There is a founded perception in South Africa that the tools of broader cooperation – especially CFTC – are a reversal towards tied aid. It will be necessary, for example, for some policy guidelines to be developed which outline the expectations from the Swedish side on what percentage of CFTC financing is required to be spent on the Swedish resource base, what proportion can be used to hire other international expertise, and what proportion could be local. Further work is required on the operational definitions of the broader cooperation toolbox for the South African context. If these tools are not simple to use, they will not be used.

In terms of the implementation of Sweden’s PGD, the question emerges: are the equivalent state institutions in Sweden looking for opportunities of partnership, are they interested, who are they receiving information from? When Sida is no longer present in South Africa, who will make the links and who will facilitate the creation of opportunities for the achievement of mutual goals?” (MTR, p. 23–24).

A very important issue that should openly be raised here is – are different Swedish public and private institutions capable to take on such assignments without proper training? Who is responsible to look after that there is sufficient capacity? Sida – or in the case of Health Forum – Swedish MoHSA ? These are all very important and decisive questions within the frame of PGD/PGU.

6. Programme Management Role of MoHSA and Overview of Implemented and Planned Co-operation Sub-projects

6.1 Programme Management Role of MoHSA

Swedish MoHSA has been the main programme owner and programme manager in Sweden. The HF was made a piece and parcel of the international co-operation always on-going through MoHSA. All funds have been channelled from Sida to MoHSA and from the Ministry to the different Swedish implementing agencies.

The programme secretariat has thus been based at MoHSA with overall and full responsibility for all planning, implementation, accounting, auditing and reporting as per the main contract, Sida-MoHSA.

In discussions with representatives of MoHSA (previous and present staff), during the course of this assignment, it became obvious that HF should be considered as a political order, or assignment, based on political aspects that would contribute to increased Swedish-South African Health Co-operation, Swedish –South African political Co-operation in general and be based on the Swedish PGU/PGD. The whole approach was also in general fully in line with policies and technical priorities of the Ministry and its sub-agencies (see also under Relevance, please). Thus – it was partly a political programme and partly a technical one.

It is very clear that MoHSA took on very big and heavy under-taking, with much of the character of a difficult TRIAL, based on PGU/PGD and based on the fairly vague principles of the so called “broader co-operation”.

The driving forces of the whole programme has been based at MoHSA but the Ministry did not get any specific funding for this, for additional work-load or for employment of extra, temporary staff for implementation of the programme. MoHSA was according to the Agreement not even authorised to employ extra additional staff based on HF funding. Therefore, in practise, the programme became an extra assignment on top of all other duties to be performed by a very important and very busy Swedish Ministry.

As previously clarified in this report, the Ministry signed a very comprehensive and professional Agreement with Sida. Other documents related to planning and implementation are either non-existent or fairly vague, such as the Guiding Principles of the Health Forum between South Africa and Sweden (discussed at the first Health Forum 11 March 2003). No formal contract/agreement was ever signed between MoHSA and SA, DoH, and this did of course push all/most responsibilities into Swedish hands.

MoHSA did not only take on the co-ordinating role inside Sweden but also had to take on the full responsibility for the “mutuality” and for the full financing of the Swedish-SA cooperation. The “mutuality” therefore became fairly “one-sided”.

Frequent meetings, 8–10 per year, were internally organised by the Swedish Side and the Swedish project owner, MoHSA. In addition to this MoHSA took on most of the “mutual” SA-Swedish plan-

ning and “pushing” work through the business plans, that also became much of a, one-sided, Swedish undertaking. MoHSA was, in close co-operation with the Swedish Agencies and the Swedish Embassy in Pretoria, in practise the main initiator and implementer of the four (4) more formal political and professional meetings/conferences within Health Forum, 2003–March 2006.

An important issue to be discussed – was sufficient funds and resources set aside for the developmental, methodological, training and promotional aspects of the new programme approach? The answer is definitely “no”. No visible or tangible funding was set aside for these difficult processes within the frames of a new type of Co-operation as part of the Swedish Government Policy for Global Development.

MoHSA was, more or less, left alone to tackle these issues by itself, however, in close co-operation with a few Swedish Agencies with considerable and long-term experience of “standard” or previous type of development co-operation, such as the Swedish Institute for Infectious Disease Control, SRA/SweRoad and a few others.

Even-more – did Sida provide MoHSA with sufficient resources, training and methods to take on the leading and developmental role in this very difficult and demanding under-taking ? Did Sida provide MHSa with the old, well established tools or methods to lead and carry out an international development Programme of the “old/previous” type ? The answer is “no” as the Policy for Global Development assumes that this will be organised and financed by the implementing or managing Ministry. In other words – the important issue of capacity and competence development for Ministries and other Agencies participating in the new type of broader co-operation has “fallen between the chairs”. On the other hand MoHSA, should have initiated an discussion with Sida on the matter as it embarked on a new and difficult international undertaking. The Contract between Sida-MoHSA, per se, hinted at this as the Ministry was to take on an important role in the development process of “broader co-operation”.

In terms of staff stimulus for increased international co-operation the HF played an important role within MoHSA and all involved agencies, as listed and described below.

The approach has as a trial attempt contributed to increased Swedish knowledge and experience within so called actor-driven co-operation.

6.2 will give an overview of implemented and planned sub-projects.

6.2 Swedish Institute for Infectious Disease Control and National Institute for Communicable Diseases, South Africa

These headed Institutions together carried out projects within the field of HIV/AIDS, Tuberculosis and other Communicable Diseases. Projects covered research and training in epidemiology and was organised straight between the two partners but of course with approval by MoHSA as the funding agency. Involvement and ownership of DoH was limited due to practical difficulties. The following sub-projects were jointly worked upon between the two Institutions:

- Training in epidemiological surveillance (in Stockholm 2003–2005, 1 person)
- Study on antibiotic resistance in pneumocystis jirovecii (sulpha resistance)
- Security Laboratories, bilateral collaboration
- General exchange of experiences
- Participation in HF Conferences/Meetings

A couple of other projects, related to tetramer reagents and toxoplasmosis in HIV-positive patients, were discussed and planned but not implemented.

6.3 Swedish Road Administration (SRA/Stockholm Region) and Department of Transport (DoT), South Africa

SRA/Stockholm and DoT have basically been working on injury prevention and prevention on road accidents.

The cooperation on road safety was later on, as late as 2005, extended to also cover prevention on HIV/AIDS and alcohol abuse. The co-operation has practically built upon extensive networking, seminars and also Swedish consultancy inputs via SweRoad – and technical advice by SweRoad. Staff at the Swedish Embassy in Pretoria contributed extensively as local project manager.

The main co-operation has taken place in straight contacts between SRA and DoT, with very limited involvement from DoH, and has also covered general exchange of experiences and participation in HF conferences/meetings.

6.4 National Institute of Public Health, Sweden, and Department of Health, South Africa

- NIPH has been involved in a number of projects such as:
- SRHR (reproductive health incl violence against women)
- Partner notification and STI prevention
- Youth Programmes (different themes discussed incl youth clinics)
- Counselling
- Health Promotion with emphasis on Tobacco Control

Other sub-projects were also discussed and partly planned such as alcohol prevention and health impact assessments, but did not take off.

6.5 The Swedish Council on Technology Assessment in Health Care (SBU) and Department of Health, South Africa

The main and only discussed and planned project included here was on Health Technology Assessment (HTA) in order to prepare for the establishment of a Unit on HTA in SA. This Unit would work with assessments and appraisals of new health technologies (in a similar way as SBU as a very well-known international forerunner in this field).

6.6 National Board of Health and Welfare, Sweden, and Department of Health, South Africa

The discussed project idea here was on Quality Assessment within Health Services.

Some exchanges of experiences and a few seminars took place but real project implementation was post-phoned and later on cancelled.

7. Relevance of the Co-operation within Health Forum

Against the back-ground of the Swedish Country Cooperation Strategy for South Africa for 2004–2008 Health Forum was a relevant project or programme in the sense that Health Forum is in line with the development of the cooperation “from Humanitarian Support to Broader Cooperation” (Strategy page 1, chapter 2). Health Forum was also partly in line with the emphasis on HIV/AIDS as pronounced in the Country Strategy, page 20, chapter 10.

During the five-year period, according to the Country Strategy, a strategic goal shall be established, namely to promote long-term, broad relations. Health Forum is directly mentioned as an example on these proposed developments of the co-operation (Strategy, page 2, chapter 2).

The guidelines from the Swedish Government states that the “present development cooperation shall be transformed into broader cooperation, based on mutuality and joint financing”. This was also the broad intentions, broad aims and goals of Health Forum.

Health Forum should be considered as one of the many *trial attempts* that have to be carried out to develop the overall *and* the practical toolboxes. The overall toolbox reflects upon type/kind of co-operation and the practical toolbox more upon specific planning, implementation, project management, financial, auditing and follow-up mechanisms that all definitely would need considerable development to be adapted to the specific type of cooperation instrument utilised, in order to increase and share ownership, achieve real mutuality, achieve joint financing in reality and, in this very specific case as this report is dealing with, joint, mutual or otherwise common evaluation.

The programme Health Forum is also relevant from the point of view of the Swedish Government Bill 2002/3: 122, “Shared Responsibility: Sweden’s Policy for Global Development. It is stated:

“Global development policy concerns us all. Swedish Society as a whole must be involved in these efforts. In the Government Offices, the responsibility for achieving (the goal of equitable and sustainable development) will be divided among all the Ministries. Community organisations, popular movements and the private sector will be assigned a more important role.”

Health Forum should be considered as a move in this direction as several Swedish Health Agencies and Health Institutions have been involved in the process, with MoHSA as the focal organiser and main “programme manager”.

Health Forum is also in line with some models and some experiences applied among the middle income Countries in Eastern Europe, Asia and Latin America and similar approaches are under development, especially in the case of the Russian Federation.

It should also be clarified, under this heading, that broader co-operation within the Health Sector for sure is very relevant as the Sector is extremely knowledge and research intense. Both Sweden and South Africa has comparative advantages in this Sector. Sweden in the sense that Sweden is at top of most important Population Health Statistics and has advanced processes in terms of Health Systems Development and South Africa in the sense that it has a well developed Health System and a great medical research potential. The co-operation within HF related to HIV/AIDS has been very relevant and beneficial (for both main parties) also in the sense that South Africa probably is the most important Country on the Continent.

Most/all sub-projects established have been in line with the overall internal development and strategic needs of MoHSA.

It is also obvious that the different proposed and implemented sub-programmes/projects within HF, in general, are in line with Swedish MoHSA priorities as per the Swedish Policies for Public Health.

Finally, the Programme has been relevant also for some of the Swedish Agencies involved in the sense that they have benefited from the sub-projects. However, this is basically true for those Agencies with previous experience of implementation of international development cooperation projects. Other Agencies have also benefited from the programme I a in the sense that it has stimulated and encouraged their staff.

Again – the overall conclusion is that Health Forum was/is relevant in this context.

It was relevant to initiate, start and establish the Programme, firstly and foremost as a “trial” or an “experiment” on “broader co-operation”. But also as part of the bi-national health policy dialogue. This policy dialogue has been an important aspect of the Programme.

8. Effectiveness/Efficacy in terms of Programme Aims and Sub-projects

The definition of effectiveness/efficacy below is cited from Sida, Evaluation Manual, 2004:

“The extent to which the development intervention’s objectives were achieved, or are expected to be achieved, taken into account their relative importance.

Also used as an aggregate measure of, or judgement, about the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact.”

It is very difficult to evaluate or review the Programme effectiveness of HF.

This is due to the fact that far too little investments were set aside for Programme preparations and for Programme planning. This is also a common understanding among all participants involved and interviewed. Most interviewees refer this understanding to the political character of the BNC and its Health Forum and to the relative political urgency to start implementation. But this point of view is hardly fully valid as the political aspect should not have hampered proper programme planning.

It is impossible to find any relevant planning for HF, based on the Logical Framework Approach – LFA, or any similar method. The consultant has failed to retrieve such a plan or such a document as they are not available – and the reporting and monitoring is very weak. Therefore the LFA-matrixes for the whole Programme, or for the sub-projects, cannot be established afterwards by the consultant.

The chapter below will look into the effectiveness of the “aims” of HF, into the effectiveness of sub-projects implemented by different partner institutions and previously described under chapter 6 and, finally, into the effectiveness of some General Issues raised in the ToR for the assignment, provided they are not dealt with elsewhere in this report. Comments and analysis will be given on difficulties in implementation of some sub-projects.

8.1 Effectiveness as regards the Aims of HF

General aims have been established for HF and are as follows:

- Policy dialogue in the area of public health
- Experience and information sharing
- Human resource development/competence development
- Knowledge transfer and exchange/transfer and sharing of know-how

These very global and very general aims were not based on any proper situation analysis in writing, no baselines, not on any LFA workshops and on no clear programme objectives, no programme purposes, no expected results, no indicators were provided – and only a limited number of activities were described.

The weak stakeholder involvement in the weak planning and the limited preparatory investments is also the main cause of the fairly separate and vague understanding among the participants and stakeholders on the purpose of the whole undertaking. According to some participants and some representatives from different institutions interviewed they were more or less commanded to participate in HF.

Especially in the case of a “trial” it is extremely important to run a (or a couple of) proper stakeholder LFA workshop (s) (or any similar approach). This was not done in the case of HF.

This has of course also led to very different understandings, especially in relation to the SA partner, on everything from aims, objectives, purposes to procedures, funding etc, etc. The same also applies to mostl interviewees in Sweden.

There are no result indicators and these can not be recovered (or re-claimed) afterwards because there are so different understandings of the aims and purposes, etc, of the whole Programme and also of the sub-projects.

Based on what is mentioned above, the reporting is also weak in general and not suitable for any meaningful and precise follow-up or evaluation.

Within a programme based on “broader co-operation” or actor-driven co-operation, it is even more needed to plan properly as so many participating organisations and individuals are participating – and especially as the whole approach, until later on, has to be considered as a “trial”. Participants, from different organizations and countries, are also familiar with different routines, procedures and approaches. Even very minor practicalities, such as type of air tickets, have to be discussed and sorted out to avoid frustrations. Lack of planning hampered mutuality and joint ownership within HF and sub-projects.

Nowadays, and since some 10–15 years back, the standard, and very useful, planning method for international co-operation projects is LFA. Sida failed to inform MoHSA on this and also failed to equip MoHSA with this practical knowledge. On the other hand, MoHSA should have understood this based on the Contract and looked for proper assistance or competence. (It should be acknowledged that the Swedish NIPH used the LFA-approach, but fairly late in the processes but it was a good step forward).

In terms of monitoring the Sida follow-up procedures seem to have been too limited to be able to, at an early stage, discover weaknesses in the implementation and reporting by different actors, in particular by MoHSA.

Based on available reporting, but much more on interviews, the following could be concluded as regards the fulfillment of the “aims” of the overall Programme:

“Policy dialogue in the area of public health”:

This policy dialogue between Health Ministers/Vice Health Ministers, with emphasis on HIV/AIDS, TB and Communicable Diseases, has taken place during very brief initial meetings of all the four sessions of HF but also during a few separate meetings between the top programme managers from both Countries. However, the mutual influence of this policy dialogue should not be underestimated as it has contributed to clarify some viewpoints and some priorities (the what-issue only). It is important to state that this policy dialogue has also practically contributed to smoothen and facilitate programme implementation – especially to try to open doors and try to open communications channels between different actors and Agencies.

The opinions among the interviewees on the usefulness, results and impact of the policy-dialogue were sharply divided. The pattern here is a bit unclear but in principle related to the position and status of the civil servant.

It is fairly obvious that political changes of Governments, staff and manpower affect this policy dialogue. Very little has happened in this programme since March 2006 and quite some funds have not been spent. Sweden had parliamentary and municipal elections in September 2006. The previous social democratic Government had since long very established contacts with SA and ANC and the incoming Government most probably at a lesser extent. This may have affected the priorities in terms of policy relations between the two Countries.

“Human resource development (HRD)/competence development”:

In principle it should be stated that HF has contributed to HRD through discussions during all meetings and seminars. Communications and meetings between people do contribute to HRD.

One staff from SA was also trained during two years in epidemiological surveillance in Stockholm, at the Swedish Institute for Infectious Disease Control.

“Experience and information sharing” – “Knowledge transfer and exchange/transfer and sharing of know-how”:

These two aims are closely related and can hardly be clearly separated.

Minutes from the four HF-sessions indicate that such information sharing and such transfer of knowledge took place. On the other hand some interviews stated: “Limited exchange of experiences, the How-issue was seldom discussed – only What”. Also on this aspect the opinions among the interviewees were fairly divided.

In terms of overall mutuality of HF per se the Swedish Side had a clear lead role. Most initiatives, policies and practical projects, were all taken in Sweden. Partly this is related to contractual and funding issues but also to some differences in terms of administrative capacity.

In summary – the general aims of the HF are really very general and difficult to follow-up and were not supported by any more specific objectives, purposes and expected results. Opinions among interviewees are divided as regards the policy dialogue and in principle related to position/status. Based on available reporting and performed interviews the consultant make the overall judgment that the policy dialogue have been useful and that the other aims partly have facilitated the cooperation and partly have facilitated implementation of sub-projects.

8.2 Effectiveness of Sub-projects per set of Co-operation Partners

Swedish Institute for Infectious Disease Control and National Institute for Communicable Diseases, South Africa

In terms of these two institutions you talk about reasonable “mutuality” and common interests.

The sub-project “Training in epidemiological surveillance (in Stockholm 2003–2005, 1 person)” was

initiated by NICD. The cooperation has been, more or less, carried out outside the frame of DoH:s involvement in HF. The main reason for this was that communications through DoH were often severely delayed.

The cooperation related to HIV/AIDS has according to SMI been relevant and fruitful for both Institutes and both Countries. All sub-projects previously listed under chapter 6 were, directly or in-directly, related to the important HIV/AIDS issues and to connected research aspects. To achieve this, the co-operation was planned and implemented “Institute to Institute” in order to increase efficiency and effectiveness.

The HRD component related to epidemiological surveillance was successfully implemented at SMI. This training component was relevant and useful.

The access to SA patients for research and development was important for SMI.

SMI has great experience of international co-operation, and a very good institutional and own financial capacity and financial liquidity, and this was a pre-condition for the good and fruitful co-operation and to avoid red tape.

However, the co-operation will, according to the Head of SMI, most probably not continue without Sida-financing. Continued funding from Sida is a pre-condition for sustainability.

Swedish Road Administration (SRA/Stockholm Region) and Department of Transport (DoT), South Africa
SRA has a long-term experience of international development cooperation through its consultancy firm, SweRoad. SweRoad participated extensively on a consultancy basis in the SRA-DoT activities within HF and contributed a lot. (This was partly outside the main contract between Sida and MoHSA, as salaries/consultancy fees were paid.)

The Swedish Embassy in Pretoria also had to become involved as local project manager for some local HIV/AIDS-oriented, minor, health clinics (for lorry and bus drivers).

The relative success of this institutional cooperation (road safety, HIV/AIDS and health clinics for drivers) is much dependant on the fairly heavily involvement of SweRoad and SA local staff at the Swedish Embassy in Pretoria in practical project planning, project management and implementation. Another pre-condition for the progress and good results of this institutional cooperation was that it was mainly carried out as a “by-pass”, outside DoH. Swedish organisations had a lead role on this project.

The cooperation will not continue based on SRA-funding only. Sida will have to be financially involved in order to ensure future sustainability. This was clearly stated by staff interviewed at SRA/SweRoad.

National Institute of Public Health, Sweden, and Department of Health, South Africa

In principle three out of four SRHR-components were fully implemented but the Tobacco Control Project was the most successful one and was one of very few projects within the whole HF that practically involved DoH. The mutuality therefore was reasonable.

Based on several interviews the Tobacco Control Project may be stated as one project within HF that was really cultural sensitive.

MoHSA is the main Swedish Ministry responsible for international cooperation within WHO and other health-related international agencies. The cooperation MoHSA/NIPH and DoH related to Tobacco Control became in some respects very fruitful as SA is an important actor on the African Continent – and elsewhere. Positive international developments within WHO in the field of Tobacco Control were achieved thanks to increased MoHSA/NIPH-DoH co-operation within HF as a basis for joint actions and joint promotion activities within WHO.

The Swedish Council on Technology Assessment in Health Care (SBU) and Department of Health (DoH), South Africa

This Unit on HTA was discussed and planned for quite some time but real implementation did never take place due to internal uncertainty in SA on where and how to organise the HTA-Unit.

Quite some preparatory work was put into the project on the HTA-Unit in SA but due to different reasons the project did not take off – the main one outlined above. These under-lying reasons were basically related to too small investments during the very initial preparatory-and planning process on the whole HF. With a proper LFA planning process stakeholders might at an early stage have detected and understood that a HTA-Unit by that time in SA was not realistic. Red tape caused a lot of problems in SA within this sub-project.

The Swedish side “paid for everything” but even so quite some funds had to be returned from SBU to MoHSA. Funding provided to SBU for project implementation was therefore returned to MoHSA.

A positive development might have been that the whole idea on HTA was disseminated and promoted. The mutuality was in reality limited.

National Board of Health and Welfare, Sweden, and Department of Health, South Africa

As previously mentioned the discussed project idea here was on Quality Assessment within Health Services.

Some exchanges of experiences took place but at a very limited extent.

In reality the project never took off due to lack of proper basic LFA-based project planning and lack of mutual under-standing. This meant that proper communication lines were never opened and this caused frustrations. Besides this, real differences in terms of development needs may make cooperation difficult as the Health Systems are quite different in terms of structure and infra-structure. Finally – the National Board was more or less commanded to take on this assignment, was over-loaded with other assignments in Brussels, and elsewhere, and probably this is not a good basis for real involvement. Again – the whole HF was not properly planned and without proper stakeholder involvement.

Some other Project-and Methodology-oriented Issues

Based on interviews in SA and in Sweden there is a fairly wide-spread and fairly common understanding that there were several serious draw-backs in the preparatory stage of HF and in the planning of the sub-projects. This has been repeatedly discussed and will be further analysed and summarised under Conclusions. These may be listed as follows:

1. A fairly small and fairly insignificant project
2. The HF has not taken off
3. No transfer of funds to SA
4. Not sufficient project planning
5. No implementation process good enough
6. Practical tools for this kind of co-operation not yet developed and available
7. Limited under-standing of the important political aspects of the approach and of the political “order”

Conclusions on effective/less effective Sub-projects

Projects implemented by SMI, SRA/SweRoad and by NIPH (especially Tobacco Control) were all implemented and in fairly successful manner. These three Agencies had a good international experience and operated as driving forces. SMI and SRA/SweRoad made “by-passes” working directly with their partners but NIPH/Tobacco worked with and through DoH.

Other projects were in principal a failure or, rather, did never materialise.

In reality nothing has happened within HF since the latest HF-meeting in March 2006. Far from all available funding has been spent and in one sense this is good as it is not reasonable to continue to spend funds on such a in-sufficiently planned Programme with only very limited stakeholder involvement in the planning process, etc. Such a Programme can hardly succeed. With all due respect for democracy, political orders and political interference – there was really no good arguments for such a non-existent LFA-process.

Participants were not properly informed about the “trial-oriented” character of the whole HF approach within the frame of “broader” or “actor-driven” cooperation.

If you summarise positive aspects under this heading you may conclude as follows:

1. A good “trial”.
2. HF has contributed to highlight methodological problems related to “broader co-operation” and has, most probably, developed the future approach.
3. HF has facilitated the policy-dialogue within the BNC related to Health.
4. A few projects have developed positive cooperation processes, reasonable mutuality and some positive values have been added (staff encouragement and stimuli, etc) (SMI, SRA, NIPH/Tobacco).

9. Cost Effectiveness/Efficiency

Cost Efficiency is a “measure of how economically resources/inputs (funds, expertise, time, etc) are converted to results (Sida, Evaluation Manual, 2004)

This is always a difficult methodological question to answer. The bottom line will be to asses whether the MoHSA/HF used funds and expertise in a way, which is worth the cost of these services i.e. *value for money*.

For programme components which have focus on capacity building, as in most of HF, it is often difficult to measure the output in quantitative terms. In such cases the analysis need to be limited to a discussion about the reasonableness of the costs in views of resources used.

Two preliminary financial reports are attached (2 x Excel) and as well as also Comments to Financial Reporting 2003–2007 (Word, in Swedish only). Besides these the draft final report (2008-02-07) is attached as well as an explanatory e-mail dated 10 February 2008 (in Swedish).

Final Reporting, expected per 31 December 2007, has not yet been submitted in final versions as per the Contract, § 9.1–9.2, and per Contract Extension, 2006-12-15. This applies to all three of Final Result-oriented Report on Effects and Results (“Final Implementation Report”), Final Financial Reporting and Final Auditing by “Riksrevisionen”.

Out of the 10 MSEK according to the Contract/Agreement between Sida and MoHSA, the Ministry has requested maximum 7,7 MSEK from Sida. Out of these 6,085 MSEK has been transferred to different Authorities/Agencies. More than 1,0 MSEK thus remains at MoHSA and around 2,3 MSEK are still at Sida.

0,6 MSEK has been spent on the “political” branch of Health Forum and the rest, 5,5 MSEK on projects.

Type of Costs can be found in Enclosures. Some 1,5 MSEK has been spent on Training and, basically, the rest, 4 MSEK, on different Running Costs.

SRA has spent 2,4 MSEK, SMI 1,4 MSEK, NIPH 0,4 and others only insignificant amounts. SRA and SMI has obviously charged for own salaries/consultancy fees, somehow in contradiction to the Contract and the whole approach of “broader co-operation”.

Business Class-tickets were used by staff from SA as per their internal SA rules regulations.

The overall Reporting would need to be further clarified and finalised. However, there are absolutely no indications of any misdoings or falsifications. Reports just have to be straightened.

Due to weak planning and reporting it is very difficult to objectively judge upon cost-effectiveness. The whole approach has to be considered as a trial in many respects.

However, many interviewees clearly mentioned that the approach “was a waste of funds” and the consultant would partly agree upon this, based on available information. “Value for money” is limited if you do not really consider the approach as a trial.

10. Reporting and Documentation

The reporting has, as previously stated, been very weak and not according to the Agreement between Sida and MoHSA. The main reason for this is most probably that the specifics in the Contract were not properly discussed and explained.

Neither Sida nor the MoHSA fully understood and grasped the needs for training of the project management at MoHSA, as international (planning and) reporting is quite different from the standard one within Swedish Public Service.

The reporting has been very similar during the whole length of the programme and in principal the same year by year. The result-oriented reporting has not visualised and there has been limited problem-based analysis. Weaknesses were not discovered as no initial LFA Workshop took place and project monitoring obviously was very limited.

Different final reports per 2007-12-31 have not yet been provided to the consultant – or, more important, to Sida. Reports are delayed.

Too many documents and reports, such as the main contract Sida – MoHSA, have been provided in Swedish only. This has severely hampered the joint planning and preparatory work, the common understanding of the concepts of “broader cooperation” and “actor-driven cooperation”, joint reporting, etc. It has contributed to quite some misunderstandings and frustrations – one of them the obvious belief in SA that programme funds would be transferred to DoH in Pretoria.

The consultant would like to question the fairly unnecessary “double auditing processes”. MoHSA is being audited by Riksrevisionen so why should the same Audit Agency audit the HF once again ? This would only indicate extra costs that are not beneficial for programme implementation.

If the “broader co-operation” shall take hold, Sida has to look into the training needs of the Swedish and foreign Agencies expected to participate in any project. This is also clearly stated in the draft implementation project report provided to the consultant from MoHSA (page 7).

11. Sustainability

Based on all definitions of sustainability it is obvious that there is limited sustainability in this programme.

Main reasons for the limited sustainability are weak initial planning, no LFA-related workshop, limited stakeholder involvement in the preparatory processes and also the fact that the concept of “broader co-operation” was not fully clarified or understood by the parties and by participating agencies.

(In SA you may probably conclude that there was a, more or less, full misunderstanding of the concept. Otherwise no one would have asked for transfer of funds within this programme, etc.)

This oversight has led to limited or no sustainability. It would have been much better to have the concept of “broader cooperation” on the agenda during, more or less, every conference, seminar and workshop – or to set aside special resources to monitor the issue. Through this the “trial” on Health Forum would have been much more beneficial for all concerned. Limited/No visible common developments efforts on the idea of “broader co-operation” have been documented in the reporting. So in this sense HF has most probably failed to promote a long-term, not aid or donor financed, cooperation within the health sector.

No Contract was signed between MoHSA and DoH/the Ministry in South Africa. The very professional and clarifying Contract on the Programme between MoHSA in Sweden and Sida was never provided to DoH in SA. This limited understanding and sustainability.

Other contributing factors to the limited sustainability are severe internal and very practical communications problems within the Programme, fairly weak programme management due to limited time and training, and also the fact that the whole approach was a political order or a political decision – a top-down approach in other words.

A top-down approach seldom works – in Sweden, or elsewhere, as there is no genuine involvement of stakeholders. This is important to comprehend.

Nothing has happened in the programme since March 2006 – either based on Sida-funding, voluntary efforts or voluntary funding.

Even based on fairly generous spending/funding principles (salaries/fees paid, etc.) some 4 MSEK (out of 10) remains and could not be spent properly. Funding was returned from Agencies to MoHSA due to limited interest in the sub-projects and this clearly indicates limited interest in the overall Programme.

People interviewed confirmed that the whole HF idea is “impossible” without continued Sida funding. No Agency would like to participate under such conditions. This was clearly stated by all interviewees. It is important to underline that no one interviewed expressed the opinion that the different Agencies would at present continue to cooperate without Sida support and without Sida financial contributions. This also applied to those Agencies with good progress in the sub-projects.

SA is also a bit far away which makes transport costly and time consuming. Europe is much more accessible for exchange of experiences, know-how, for cooperation on policy/political issues, etc.

As a trial attempt Sida and MoHSA should probably have set aside much more time to monitor and follow-up the “experiment”, exactly as was proposed in the Country Strategy, p 20, as follows: “Resources should be set aside for testing the instruments applicability and for marketing/promotion purposes”.

It has been a slight mistake to apply standard development cooperation principles on the HF as part of the “broader cooperation”.

There have, in fact, been very limited aspects of South African ownership within this project. The same may also be said for most of the Swedish Agencies as they did not get proper training to understand the very character of the Programme.

Even if it is, due to circumstances, outside this evaluation assignment to analyse reasons for limited SA ownership, reference is made to the introductory paragraphs of this chapter. It may also be added that several sub-projects obviously “by-passed” what was considered as “red-tape” at DoH and this, of course, even further decreased the Departments interest in the Programme. DoH considered the programme as a “small and insignificant” one. Other donors contributed more substantially.

Even the evaluation per se was difficult to set in motion as it took 5 months to find and to contract a SA evaluation consultant.

12. Future Collaboration

Health Forum should be considered as an important trial to develop the policy dialogue within public health, and the health sector as a whole, and also to contribute to health systems development (HSD) in both Countries.

Issues related to HSD were covered through policy discussions but in particular through experience and information sharing, human resource development and exchange of know-how within different sub-projects as per chapters 6 and 8.

Swedish main public health indicators such as infant-and maternal mortality are excellent in international comparisons. Maternal mortality is by WHO considered as the single most important indicator on the status of any health system as being a comprehensive and crucial indicator. The Swedish Health System has a number of comparative advantages including vast experiences of HSD – or health reforms. This applies to the system per se and of course to all its supporting Agencies (participating in HF as per this report – and several others in the Country as well). The Swedish System is highly decentralised, with strong local management structures that can adapt the system to local needs, and this is an important basis for its good performance.

South Africa has a well developed health system with a good infra-structure, good research capacity but still a number of very challenging problems. South Africa has to solve the very demanding issues related to prevention and treatment of HIV/AIDS and other infectious diseases such as tuberculosis. Supply of health staff is another demanding issue – and there are others.

Based on findings in this report it should be concluded that, due to circumstances, the full potential of the idea of HF could not be utilised and/or implemented. This is a common understanding among

most/all interviewees. The main problem according to the interviewees was the limited situation analysis and insufficient preparatory and project planning activities including lack of stakeholder involvement. The key challenges are to achieve a common understanding among Swedish participating Agencies on the overall and specific objectives of the HF Programme, and of course, a common understanding in relation to the SA partners.

Sida should make another, and much more developed, better planned and monitored trial based on experiences from HF, preferably with SA again or with, for example, Russian Federation (more close) as Sweden has a great number of comparative advantages within the Health Sector and in order to further develop the practical tools for actor-driven co-operation. This would benefit the Swedish (and South African) Health System and it is also proposed that the approach would cover decentralisation, health administration and management development. Therefore also Agencies and Institutions in Sweden working on “Administrative Development” within the Health Sector should be heavily involved such as some Universities, Stockholm School of Economics, Department of Medical Management at Karolinska Institute, Nordic School of Public Health in Gothenburg and probably some Consulting Firms.

The consultant would like to propose that the Programme on HF is being re-planned and re-implemented based on previous experiences and on conclusions and recommendations in this report. This would be beneficial for the Health Sectors/HSD in both Countries, for the Policy Dialogue but also for development efforts related to Actor-driven Cooperation as the three aspects are integrated within HF.

13. Conclusions and Recommendations to Sida and MoHSA

13.1 Conclusions

The purpose of the Health Forum is /was, as per the Contract between Sida and MoHSA, its main enclosure 1 (both documents in Swedish only) and a number of brief reports, “...to facilitate and stimulate enhanced and broad-based cooperation between South Africa and Sweden in the field of public health for the benefit of both Countries”.

Health Forum would have been a new type of “broader”, or “actor-driven”, and process-oriented co-operation and it is obvious that such a development, to start with, would face a number of obstacles and hindrances. This also applies to the evaluation and summing-up phase.

This new type of “actor-driven” co-operation needs further developments. Quite some issues have to be clarified and developed. A lot of development work has to be done as the very practical “tools” are, more or less, non-existent or roughly transferred from a previous type of co-operation. Only a fairly general policy is not sufficient.

A detailed and fairly comprehensive contract, in Swedish only, was signed between Sida and MoHSA in Sweden.

No formal contract/agreement was signed between MoHSA and DoH in South Africa.

A rather vague and general set of documents from the Preparatory Meeting in Pretoria 10–11 October 2002 (a very general “Memo of Understanding” plus general “Records of Proceedings”) and “Agreed Minutes of the first Meeting of the Health Forum between South Africa and Sweden, 11–12 March 2003” plus herewith enclosed “Guiding Principles of the Health Forum between South Africa and

Sweden: held in Pretoria on 11 March 2003” form the only basis for the “broader co-operation”. Little was said about financial issues in these joint documents and very little about planning methods, project follow-up, principles and rules for communications and project management.

The Countries, with Sweden as the main and only financier in reality, embarked on this example of “broader co-operation” without clearly defined concepts and procedures and with a very unclear practical “cooperation toolbox”.

It is evident that an overall challenge for Sweden is to develop sufficient internal clarity of purpose, method and quantity (what is the level of ambition), so that these can be openly discussed with different partners.

A very important issue that should openly be raised here is – are different Swedish public and private institutions capable to take on such international cooperation assignments without proper training? Who is responsible to look after that there is sufficient capacity? Sida – or in the case of Health Forum – Swedish MoHSA ? These are all very important and decisive questions within the frame of PGD/PGU.

Swedish MoHSA has been the main project/programme owner and project/programme manager in Sweden. All funds have been channelled from Sida to MoHSA and from the Ministry to the different implementing agencies.

It is very clear that MoHSA took on very big and heavy under-taking, with much of the character of a difficult TRIAL, based on PGU/PGD and based on the fairly vague practical principles of the so called “broader co-operation”.

The general aims of the HF are really very general and difficult to follow-up and were not supported by any more specific objectives, purposes and expected results. Opinions among interviewees are divided as regards the policy dialogue and in principle related to positions and status. Based on available reporting and performed interviews the consultant make the overall judgment that the policy dialogue have been useful and that the other aims partly have facilitated the cooperation and partly have facilitated implementation of sub-projects.

Projects implemented by SMI, SRA/SweRoad and by NIPH (especially Tobacco Control) were all implemented and in fairly successful manner. Some other projects were planned but not implemented.

In reality nothing has happened within HF since March 2006. Far from all available funding has been spent and in one sense this is good – in the sense that the project should be properly re-planned.

There are a number of unclear points in the whole HF approach, related to tools for “broader cooperation”. Too limited investments were put into the HF and sub-project preparatory processes. Participants were not properly informed about the “trial-oriented” character of the whole HF approach within the frame of “broader” or “actor-driven” cooperation.

Against the back-ground of the Swedish Country Cooperation Strategy for South Africa for 2004–2008 Health Forum was/is a relevant project or programme in the sense that Health Forum is in line with the development of the cooperation “from Humanitarian Support to Broader Cooperation” (Strategy page 1, chapter 2). Health Forum is/was also in line with the emphasis on HIV/AIDS as pronounced in the Strategy, page 20, chapter 10.

The programme Health Forum is also relevant from the point of view of the Swedish Government Bill 2002/3: 122, “Shared Responsibility: Sweden’s Policy for Global Development”.

It is very difficult to evaluate or review the effectiveness in HF. This is due to the fact that far too little investments were set aside for Programme preparations and for Programme planning. This is also a common understanding among all Swedish participants involved and interviewed.

Final Reporting, expected per 31 December 2007, has not yet been submitted in final versions as per the Contract, § 9.1–9.2, and per Contract Extension, 2006-12-15. This applies to the Final Result-oriented Report on Effects and Results (“Final Implementation Report”), Final Financial Reporting and Final Auditing by “Riksrevisionen”.

Out of the 10 MSEK according to the Contract/Agreement between Sida and MoHSA, the Ministry has requested maximum 7,7 MSEK from Sida. Out of these 6,085 MSEK has been transferred to different Authorities/Agencies. More than 1,0 MSEK thus remains at MoHSA and around 2,3 MSEK are still at Sida.

0,6 MSEK has been spent on the “political” branch of Health Forum and the rest, 5,5 MSEK on projects.

Type of Costs can be found in Enclosures. Some 1,5 MSEK has been spent on Training and, basically, the rest, 4 MSEK, on different Running Costs.

SRA has spent 2,4 MSEK, SMI 1,4 MSEK, NIPH 0,4 and others only insignificant amounts. SRA and SMI has obviously charged for own salaries /consultancy fees, in contradiction to the Contract and the whole approach of “broader co-operation”.

Based on all definitions of sustainability it is obvious that there is limited sustainability in this case. Main reasons are weak initial planning, no LFA-related workshop and also the fact that the concept of “broader co-operation” was not fully clarified or understood by the parties and by participating agencies. Other contributing factors to the limited sustainability are severe internal and very practical communications problems within the Programme, fairly weak programme management due to limited time and training, and also the fact that the whole approach was a political order or a political decision – a top-down approach in other words. A top-down approach seldom works – in Sweden, or elsewhere, as there is no genuine involvement of stakeholders. This is important to comprehend.

Based on available reporting and performed interviews the consultant make the overall judgment that the policy dialogue have been useful and that the other aims of HF partly have facilitated the cooperation and partly have facilitated implementation of sub-projects. HF has fulfilled a positive role as a basis and a tool for the policy/political dialogue between Sweden and South Africa.

13.2 Recommendations to Sida

It is evident that the PGU/PGD raises questions and problems on which institution (Sida ?) is responsible for capacity development to ensure sufficient competence and capacity within implementing organisations. If this is a Sida responsibility this organisation has to be provided with resources to carry out the task.

- “Actor-driven” co-operation needs further, very practically oriented, developments. Quite some issues have to be clarified and developed and it is obvious that the practical “tools” can not be transferred from previous, since long well established phases, of international development co-operation.
- Agreements between Sida and Swedish managing/implementing Agencies has to be well explained and discussed, if they continue to be based on principals for previous stages of international co-operation, or preferably, fully adapted to “broader co-operation” and thereby made more clear and easy to understand.
- Sida should encourage, and ensure through the main agreement, that Swedish managing Agencies (MoHSA within in HF) do sign agreements with foreign co-operation partners, based on the internal Swedish main Agreement.

- Sida should definitely clarify that English is “the language of co-operation” and that all important documents are provided in English (one example, the main Agreement Sida – MoHSA with its In-depth Assessment Memo).
- Sida should initiate, and ensure, that the LFA-approach is utilised for planning, stakeholder involvement, follow-up and evaluation purposes – both on the Swedish Side and in between co-operating international partners.
- Sida should, especially during the initial stages of “actor-driven cooperation”, increase its monitoring involvement.
- Sida should develop special training for institutions supposed to be involved in the PGU/PGD and in actor-driven cooperation (this is now also requested by MoHSA in its draft final report, pilot courses also available).
- Sida should make another, and much more developed, better planned and monitored trial based on experiences from HF, preferably with SA again or with, for example, Russian Federation (more close) as Sweden has a great number of comparative advantages within the Health Sector and in order to further develop the practical tools for actor-driven co-operation. This would benefit the Swedish (and South African) Health System and it is also proposed that the approach would cover decentralisation, health administration and management development. Therefore also Agencies and Institutions in Sweden working on “Administrative Development” within the Health Sector should be heavily involved such as some Universities, Stockholm School of Economics, Department of Medical Management at Karolinska Institute, Nordic School of Public Health in Gothenburg and probably some Consulting Firms.
- Sida should remove the procedure of double financial auditing from actor-driven cooperation as all concerned staff find the procedure frustrating and costly.
- Sida should summarise and disseminate good experiences of broader co-operation from different Agencies such as SMI, SRA, Swedish Police Authority, Swedish Statistical Office, etc, in order to further contribute to the development of PGU/PGD.

13.3 Recommendations to MoHSA

- MoHSA should finalise all its contractual reporting as per 31 December 2007.
- MoHSA should further strengthen its capacity to operate based on the PGU/PGD.
- MoHSA should contribute to further strengthen related Agencies to operate based on the PGU/PGD.
- MoHSA should participate as lead agent in the proposed future collaboration on the proposed and re-planned HF

List of Annexes

1. Terms of References, September 2007 (Annex adjusted one week = in terms of time plan for the evaluation exercise)
2. List of People met with/interviewed in Sweden and South Africa
3. List of References, Reports and Literature
4. MTR June 2006, Summary Overview and Conclusions and Recommendations

Annex 1 Terms of Reference

Evaluation of the South Africa/Swedish Health Forum

1 Background

In 1999, the heads of the governments of South Africa and Sweden proposed the establishment of a Bi-national Commission (BNC) to further enhance co-operation on political, social and economic issues. In this context, public health was identified as an area of particular relevance and interest and an agreement was reached to create a Health Forum to act as a coordinating body for policy discussions and bilateral projects in the field of public health.

Formally launched in Pretoria in March 2003, the Health Forum is a collaboration between the South African National Department of Health and the Swedish Ministry of Health and Social Affairs. The objective of the programme is to facilitate and stimulate enhanced and broad-based cooperation for the mutual benefit of both countries as follows:

1. policy dialogue in the area of public health,
2. experience and information sharing,
3. human resource development, and
4. transfer and sharing of know-how.

The Forum is guided by the overall goal of Swedish development co-operation, as well as the objectives and aims of South African and Swedish policies for public health.

The cooperation agreement between the Swedish parties has been extended until 31 December 2007 and the activity period until 30 June 2007. The total Swedish contribution for the period 2003–2007 has been 10 million SEK (Swedish kronor), financed from the budget vote for the country cooperation between Sweden and South Africa by the Swedish International development Cooperation Agency (Sida).

The Health Forum comprises a number of projects in five priority areas:

1. HIV/AIDS, tuberculosis and other communicable diseases
2. reproductive health and rights
3. health sector reform
4. health promotion and health impact assessment
5. injury prevention

Since the setting up of the Health Forum the partners have met once every year, 4 times in total, to discuss existing and potential projects, including progress achieved.

2 Objective of the evaluation

The objective of the evaluation is to assess the performance of the Health Forum in accordance to the set objectives. The initial results of the evaluation should serve as input for the discussions regarding the direction of the cooperation at the next Health Forum meeting.

3 Scope of the evaluation

The consultants will, in addition to studying and analysing relevant documentation relating to the Health Forum, conduct interviews with key persons on both the Swedish and the South African side. This will include the key government departments involved in the project, project members and any other agencies with which the project has been involved.

The evaluation should cover, but not necessarily be limited to, the following issues:

General:

- Assess results achieved in relation to set objectives as described in the Agreement
- Identify, assess and give examples of areas in which the cooperation has been successful/less successful; and the reasons why and how this has been addressed;
- Identify possible areas and forms for future cooperation where mutual interest exists, as well as the key challenges and obstacles for such co-operation;
- The degree of mutuality in the specific projects so far and in the Forum as such;
- Assess to what extent the Forum has contributed to deepening the relationship between partners;
- The organisational set-up of the projects, and the communication between stakeholders.

Relevance:

Assess how and to what extent the Health Forum is and has been relevant in regards to:

- The Swedish Country Cooperation Strategy for South Africa for 2004–2008,
- Priorities of the National Department of Health, South Africa and the Ministry of Health and Social Affairs, Sweden.
- The transformation of the traditional development co-operation relationship into broader (institutional) cooperation

Effectiveness:

- Assess whether the cooperation has produced the expected outputs and achieved the immediate objectives as described in the Agreement.

Costs:

- Briefly describe the financial contributions made by Sweden and South Africa to the Forum;
- Assess whether the costs are consistent with the budget;
- Assess how the costs are related to project output and achievement of immediate objectives;
- Assess whether these costs have been reasonable and proportional in relation to project output;

Reporting and documentation:

- Assess whether reporting and documentation is satisfactory and has been done according to the Agreement.

Sustainability:

- Assess and discuss the different aspects of sustainability, including whether the cooperation is and/or has the potential to become sustainable in the longer term;
- Assess whether the cooperation can and will be sustained without continued financial support from Sida;

- Discuss the roles of the actors in a possible future cooperation.

Future collaboration:

- Recommend areas of mutual interest where the greatest potential for future cooperation exists;
- Assess possible sources of financing and organisation for the future cooperation on both the South African and Swedish side.

4 Implementation

The overall responsibility for the evaluation will be shared between the National Department of Health, South Africa and Sida/AFRA. The evaluation should be undertaken in close collaboration between the evaluators and the South African Department of Health (through the Directorate: North-South Co-operation), and the Swedish Ministry of Health and Social Affairs. Thus, it will be a joint Swedish-South African evaluation. Funds for costs associated with the Swedish partner will be made available from the Swedish project budget (i.e. Sida); and for the South African side, via the National Department of Health's funding partners.

5 Competency and expertise requirements

The evaluation will be conducted by a joint team of two consultants, one Swedish and one South African, with each consultant working in their respective countries.

The consultant(s) will be expected to have the following skills and competencies:

- A university degree in management and/ or development studies.
- Knowledge and experience of development and health policy in South Africa and Sweden
- Understanding of the donor agencies and overseas development assistance and current debates on development co-operation
- Working experience of project management.
- Ability to communicate with clients at all levels – operational and strategic
- Excellent negotiation, facilitation and presentation skills.
- Ability to work independently as well as being part of a team.
- Previous experience of conducting evaluations

6 Time frame

The approximate overall time frame for the evaluation is five weeks (25 days).

The assignment will take place in Sweden and South Africa respectively over the period of twenty days (maximum), to be followed, at the conclusion of the active phase of the evaluation, by meetings in South Africa to work on the findings and the joint report (maximum 5 days). The travel for the Swedish consultant to South Africa will be funded via the Swedish budget.

The first draft should be presented by 7 December, 2007. Comments by the Parties (Department of Health, South Africa and the Ministry for Health and Social Affairs, Sweden) should be given to the evaluators before 21 December, 2007. A final draft should be delivered by 11 January, 2008. This will serve as an input to the planned Health Forum in February, 2008.

7 Deliverables

The consultants will present the main findings, conclusions and recommendations to:

- *South Africa:* National Department of Health and National Treasury
- *Sweden:* The Swedish Ministry of Health and Social Affairs, and Sida).

The final report will be written in English and should not exceed 25 pages. The final report should be delivered to the National Department of Health (SA); and Sida/AFRA; both electronically and in hard copy.

8 Contact Persons:

Contact person at the National Department of Health is:

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Contact person at Sida/AFRA (Department for Africa) is:

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105 25 Stockholm
+46-8-698 5142 (t)
helena.vikstrom@sida.se

Contact person at The Swedish Ministry of Health and Social Affairs is:

Ulrica Lindblom
Department Secretary, Division for Public Health
+46-8-405 33 06 (t)
+46-70-329 23 06 (cell)
ulrika.lindblom@social.ministry.se

Annex 2 People Met With/Interviewed in Sweden and South Africa

- 1 Nov 2007, Helena Vikström, Country Programme Coordinator, South Africa, Sida
- 6 Nov 2007, Ulrica Lindblom, Department Secretary, Division for Public Health, Swedish Ministry of Health and Social Affairs
- 6 Nov 2007, Lovisa Strömberg, Deputy Head of Division for Public Health, Swedish Ministry of Health and Social Affairs
- 19 Nov 2007, Åsa Ekman, Desk/Programme Officer, National Board of Health and Social Welfare
- 19 Nov 2007, Gunilla Hult-Backlund, Head of Department, National Board of Health and Social Welfare
- 22 Nov 2007, Ragnar Norrby, Director General, Swedish Institute for Disease Control
- 26 Nov 2007, Gunilla Hult-Backlund, Head of Department, National Board of Health and Social Welfare
- 28 Nov 2007, Margareta Haglund, Director, Senior Adviser Tobacco Control, National Institute of Public Health
- 3 Dec 2007, Birgitta Hederstedt, Seniorkonsult, previously Head of Planning, National Board of Health and Social Welfare
- 4 Dec 2007, Katharina Andersson-Forsman, Secretary General, Swedish Medical Association, previously Head of Department at the National Board of Health and Social Welfare
- 10 December 2007, Helena Dahlgren, Deputy Director, the Swedish Council on Technology Assessment in Health Care, SBU
- 14 December 2007, Ragnar Norrby, Director General, Swedish Institute for Disease Control
- 17 December 2007, Margareta Haglund, Director, Senior Adviser Tobacco Control, National Institute of Public Health
- 20 December 2007, Ewa Persson-Göransson, Director General at the National Board of Institutional Care, previously State Secretary at Ministry of Health and Social Affairs
- 20 December 2007, Birgitta Holmström, Director of Information, Swedish National Road Administration, Stockholm Region
- 28 December 2007, Irene Nilsson-Carlsson, Head of Department of Public Health, Ministry of Health and Social Affairs
- 28 December 2007, Helena von Knorring, Desk Officer, Ministry of Health and Social Affairs (on maternity leave at present)
- 25 January 2008, Ulrika Lindblom, Department Secretary, Division for Public Health, Ministry of Health and Social Affairs, and Lovisa Strömberg, Deputy Head of Division for Public Health, Swedish Ministry of Health and Social Affairs
- 12 February 2008, Helena Vikström, Country Programme Coordinator, South Africa, Sida

6 March 2008, Jessica Olausson, Second Secretary, Swedish Embassy, Pretoria

6 March 2008, Anders Rönquist, First Secretary, Swedish Embassy, Pretoria

7 March 2008, Ms Nadia Minty, Director: North-South Co-operation, National Department of Health, Pretoria

11 March 2008, Jessica Olausson, Second Secretary, Swedish Embassy, Pretoria

11 March 2008, Anders Rönquist, First Secretary, Swedish Embassy, Pretoria

12 March 2008, Mr Peter Barron, Senior Consultant/Evaluator of HF, Cape Town, SA

Annex 3 List of References, Reports and Literature, Draft 1

(Partly in English but most docs in Swedish only. Most docs in hard-copy only.)

Contracts, etc

1. Contract in Swedish/ Överenskommelse mellan Sida och Regeringskansliet/Socialdepartementet om stöd till etablerandet av Hälsoforum mellan Sverige och Sydafrika, (One enclosure, Background and Principles, Sida)
2. Contract in Swedish/Förlängning/Extension of 1 above, per 2006-12-15, until 30 June 2007 with all reporting finalized 31 December 2007
3. Konstitutionsutskottet, Granskning av vissa förvaltningsärenden, Samarbetet mellan Sverige och Sydafrika, HF, 2005-10-07
4. List of 1–33 registered documents provided by MoHSA. Mostly communications with Agencies and with Sida, Brief Minutes, Minutes on Actions taken, Agendas and the like. All related to Health Forum.
5. Minutes from HF number 4, 26 March, 2006, in Stockholm

Reports, edited by MoHSA

- 1–4. Annual Reports on Health Forum for year 1, year 2, year 3 (2005–6), year 4 and Final (Draft)

Financial Reporting

MoHSA: Kommentarer till den ekonomiska Redovisn, 2003–2007

MoHSA, Socialdepartementet: Ekonomisk Rapport, 2003–mars 2007, excel

MoHSA, Socialdepartementet: Ekonomisk Rapport nr 2, 2003–mars 2007, excel

Country Strategy

Country Strategy July 2004–December 2008, English and Swedish

Mid-term Review, Final report, June 18, 2006

Broader Co-operation

1. Government decision, 2007-12-19
2. Enclosure to Government Decision as above, “Actordriven Cooperation for Global Development – Policy for Actor Cooperation within Development Cooperation”
3. Summary – Actor-driven Cooperation within Development Cooperation, Government Web-page, 2008-01-16
4. Paper to Sida Top Management Team, 2008-01-15, “Policy for Actor Cooperation and Divisions of Responsibilities within Sida”
5. Web-page, Swedish Government

Reports on the Cooperation with SA, etc, Sida, Swedish Embassy

BNC 2007 Reports SWE –SA:

Joint Declaration 071004

Joint Report Social Committee 071004

Report Political Committee 071004

Annual Report 2007 SA, three annexes

Documents/Business Plans/Reports/Other provided from some implementing Agencies, etc

FHI/NIPH in Sweden, Tobacco Control, 28 Documents

SBU/HTA, 3 Documents

SMI, 17 Documents

National Board of Health and Welfare, 3 Documents

SRA, 10 Documents

Other

Sweden's new Policy for Global Development, Stockholm 2005

Sida; Evaluation Manual, 2007

Annex 4 Excerpt, MTR, Mid-term Review of the Swedish Country Strategy for Development Cooperation with South Africa, Sida, 2006

Summary Overview + Conclusions and Recommendations

Sweden and South Africa maintain close relations and bilateral dialogue with high-level contacts at the South African-Swedish Bi-national commission (BNC) co-chaired by the Deputy President and the Vice Prime Minister of the respective countries. Between BNC meetings there are frequent high-level intergovernmental exchanges.

Sweden's country strategy for Development Cooperation with South Africa emphasises a transformation process (2004–2008) in which “traditional” development cooperation of grants and projects is phased out, to be increasingly replaced by “broader cooperation” based upon mutual interests and shared costs, which can continue after 2008. This process of transformation is central to the substance of this review. As such, this review considers changes that are happening on the Swedish side, and contrasts these with trends, developments and priorities communicated from the South African side. Key to this review is a Swedish move towards “shared cost” technical cooperation as a primary modality for Sida within South Africa; and in partnership with South Africa in Africa.

This review identifies as a central strategic issue, a future process in which cooperation partners are able to arrive at a shared understanding of if, where and how the “broader cooperation” instruments being promoted by Sweden can add value in future cooperation with South Africa, and with South Africa in Africa.

While the five largest donor partners in South Africa¹ appear to have longer-term plans for remaining active in the country; “a number of smaller donors are thinking about an exit strategy”; with a focus on technical cooperation as a part of that exit strategy.² The April 2006 IDC-sponsored baseline study on Aid Effectiveness in South Africa indicates the beginnings of a new phase of ODA support to South Africa in which there is an increasing focus on international joint cooperation in Africa, the AU and the region, and also an increased emphasis on technical cooperation within and outside of South Africa.

Smith et al report that the donor community recognises that while South Africa is key in future regional and African development processes, its' economic dominance means it is necessary to approach such engagements carefully. South Africa as an emerging donor and developmental champion within Africa is indicating the political will, sensitivity, and technical know-how to contribute significantly to regional and continental development. South Africa is seeking partnerships with some donors in furthering trilateral development cooperation as an increasingly important ODA modality for the region.

Sida is in the process of considering possible internal organisational locations and procedures for the delivery of a “broader cooperation” modality appropriate to engagement with middle-income countries in which there is no specific aid budget allocated. Sida is also in the process of exiting its role of a grants-based development cooperation partner in South Africa. A key challenge is to align these two processes in South Africa so that the implementation of broader cooperation has generated a sufficient threshold of momentum by the time available local Sida resources are removed. A key risk is that ‘broader cooperation’ is insufficiently organisationally rooted and procedurally defined by the time Sida

¹ EU, Germany, UK, USA and Denmark (in that order); Smith, Browne, Dube (2006).

² Smith, M.J.; Browne, P. & Dube, N. (April 2006) High Level Forum on the Harmonization for Aid Effectiveness in South Africa: Final Report April 2006. IDC South Africa.

exits South Africa. This risk is compounded in that the process of closing down the grants-based support is likely to demand full attention of available Sida resources, and will extend into the middle of 2009.

South African ambitions in assisting development processes within Africa suggest that Sida could consider the strategic value of maintaining some presence (staffing and funds) within South Africa in order to facilitate efficient and effective responses to opportunities for complementary relationships with South Africa in Africa. Such a local focal point could play a role in identification and facilitation of opportunities that result from bilateral political and economic exchanges which are likely to continue.

Ongoing uncertainty exists with respect to final timeframes for phasing out current partnerships, staffing levels at the Embassy in South Africa, resources available after 2008; and the definition of concepts and procedures within the envisaged broader cooperation “toolbox”. If Sida is to engage partners in discussions about broader cooperation within South Africa, and with South Africa in Africa, it becomes necessary that Sida staff within South Africa have more specific information to communicate in their discussions with counterparts.

Further discussions aimed at coherence and at the clarification of roles and responsibilities are also necessary amongst the main Swedish stakeholders; Sida Stockholm, the Ministry of Foreign Affairs and the Embassy of Sweden in Pretoria.

In the absence of clear information and description of possibilities, the shrinking timeframes present the Swedish side with a risk of a) not being able to adapt to the changing context and new opportunities; and b) losing momentum, social capital and networks built up during the many years of development cooperation.

A number of existing partnerships between South African and Swedish institutions already fall within the loose definition of ‘broader cooperation’.

The successful cooperation between the South African and Swedish Police and both revenue services are notable. These partnerships have emerged out of longstanding relationships and have required dedicated human and financial resources to keep them going. South Africa have indicated that cost-sharing of future partnerships is not a problem, as long as these partnerships are aligned with South African priorities, budgeted for in South Africa’s national budget (i.e. the medium-term expenditure framework) and provide opportunities for mutual ownership.

Other notable partnerships on the local level are the municipal twinning cooperation, where the one between Buffalo City and Gävle, as well as the cooperation between Port Elizabeth and Gothenburg, have developed good working relationships and partnerships. However, in the absence of direct financial support, the future potential and extent of these relationships remains uncertain in a globalised world where cities have relationships with multiple partners driven by mutually beneficial economic and cultural synergies.

It is the opinion of the review team that further significant opportunities for ‘broader cooperation’ with South Africa (internally and externally) do exist. In the event that Sida removes its entire staff from the Embassy in South Africa by the middle of 2009, a concerted focus is now needed on establishing and entrenching workable and mutually agreeable definitions and procedures to enable broader cooperation to continue.

Sweden is also considering how best to proceed in its engagement with South Africa as a development cooperation partner within SADC, the AU and Africa generally. Sida’s envisaged approach is founded upon sharing costs for the procurement of contract-financed technical cooperation (CFTC) – with a variable but apparently substantial amount of this tied to the use of Swedish resources and institutions.

IDC in South Africa have indicated the need for further clarification and understanding on the use of CFTC with specific reference to its coherence with the Paris Aid Effectiveness Agenda. There is some debate internationally around the exclusive use of donor-defined instruments for technical cooperation as working against the promotion of local ownership.³

A further consideration with respect to ‘aid effectiveness’⁴ is that the Paris Agenda has been seeking to harmonise approaches to the management of Aid with a view to reducing the relatively high administrative and process costs involved. The introduction by Sweden of a new system aimed at promoting direct institutional relationships will inevitably introduce new and additional management challenges to those partner countries choosing to engage in such cooperation.

A key challenge in this transformation process is for South Africa and Sweden to arrive at a common understanding of where in the process “broader cooperation” is no longer classified as ODA, and, subsequently, what mechanisms and forums should be used for coordinating and managing its implementation.

South Africa continues to play a championing role in the OECD DAC process on Aid Effectiveness. A 2005 meeting convened jointly by the OECD DAC and UNDP to discuss partnerships for increased aid effectiveness concluded:

- That south-south and triangular cooperation could improve aid effectiveness;
- That triangular cooperation could strengthen the delivery capacity of non-OECD countries;
- That there should be a more systematic approach to sharing experience, knowledge and best practice in the area of south-south and triangular cooperation.

The above meeting constitutes a milestone in international recognition that some technologies and development approaches emerging from within South Africa (and middle-income states generally) “may have more effective application” within Africa as compared to the “wholesale importing of technologies, practices and policies from development countries”. South Africa has indicated its interest in developing partnerships in which financial support is provided to enable South Africa to share its technologies and technical capacity with countries in Africa. “For South Africa this modality strengthens the principle of partnership for development and deepens the sense of national ownership”. (Smith et al; 2006). Future ‘tri-partite’ partnerships can take on a number of different forms, including the model put forward in the IDC Report.

Conclusions and Recommendations:

The current South African context suggests a window of opportunity exists for Sweden to play a role in developing new modes of development cooperation partnership with South Africa that are low in opportunity costs, and beneficial to mutual objectives. The longer it takes Sweden to clarify the extent of its ambition for broader cooperation with South Africa, and to further define the applicability, and implementation cost of available instruments, the higher is the chance of an opportunity lost.

Given the perceived lack of clarity on the practical implications of “broader cooperation” on the South African side it cannot yet be assumed that this approach has been embraced and will be promoted by South African counterparts responsible for the coordination of development cooperation. Further detailed discussions with the appointed South African coordinating counterparts in Treasury (IDC) are required.

³ Smith et al 2006; p.36

⁴ The question remains: at what point does CFTC and broader cooperation cease to meet the OECD definition of ‘Aid’ and then become a series of ‘preferential economic and political agreements’ between the countries?

Broader cooperation – in whatever country or context – is always going to require resources to identify, promote, facilitate and manage its implementation. Sweden needs to decide the level of ambition at which it wishes to implement a strategy of broader cooperation in South Africa – and then dedicate the appropriate resource base to enable this. Given the imminent closure of Swedish staffing support in South Africa, this decision is now urgent. South African partners are unable to provide for ‘demand-driven’ support if they are not informed of what support is available, what it entails, what effort is needed to obtain the support, and how much of it might be possible.

The existing examples of broader cooperation in South Africa have been developed under very supportive conditions, with financial support, time and human resources to promote this. The relationships developed have created ‘communities of practice’ in which both partners have come to recognise the opportunities and developed the political will to find solutions to the implementation challenges they have faced.

In the absence of a dedicated Swedish presence in the country, and allocated funds to facilitate start-up, there is a clear and evident risk of limited success in any future implementation of broader cooperation with South Africa.

Furthermore, the Swedish tool-box for broader cooperation as currently defined means increased opportunity costs in ironing out the implementation challenges in each case. First-time implementation of the options in the Swedish tool-box will take administrative effort in order to eliminate procedural and coordination challenges on both sides. If the required effort is too demanding compared to the perceived benefits, then recipient partners are likely to lose interest.

Assuming Sweden does have a sufficient level of political ambition to implement broader cooperation in South Africa, it is *recommended* that the following be further investigated:

- User friendly instruments and management are very important in this process and there remains a lot of work to be done in defining these instruments for ease of implementation. The instruments for broader cooperation are only tools – how they are used is more important – this requires alignment with South African needs and priorities and a clearer strategic direction in implementation.
- Sida should develop further clarity on the definitions of broader cooperation, including on the legal and administrative applicability (in both Sweden and South Africa) of the mechanisms/tools for broader cooperation.
- On the Swedish side there needs to be a clear definition on roles and responsibilities for the on-going transformation. This should include clarification of the division of roles and responsibilities between Sida HQ’s, the Swedish MFA and the Embassy in Pretoria (for which an internal division must also be made).
- For Sweden there is an interest in understanding the relationship between the implementing, coordinating (for the ODA) and political levels on the South African side, with a view to harmonising the on-going transformation of the bilateral cooperation with political objectives and ambitions as outlined in the BNC.
- Decisions need to be made as to where and how to institutionally anchor broader cooperation at Embassy level and in Sweden. A broader cooperation unit is planned for at Sida HQ, but the modalities are not yet clear. It is important that this unit is placed at a sufficiently strategic or high level to facilitate coordination and synergies. Depending upon South African responses, including at the Bi-national Commission, a focal point presence in South Africa could become justified.
- Sweden should determine to what extent additional budgets are available or necessary to stimulate or bridge the gap to broader cooperation beyond 2008. The future allocation to a rapid response

fund, or similar, should be considered. Current Swedish budgetary allocations to South African cooperation means there is very limited opportunity to facilitate an expansion of the broader cooperation opportunity.

- An Identification study is commissioned to investigate:
 - The feasibility (administrative, legislative and ownership) challenges to the use of the broader cooperation tools in BOTH South Africa and Sweden;
 - The scope of opportunities for use of broader cooperation tools in South Africa, and with South Africa in Africa;
 - The risks, costs and applicability of specific tools to the spectrum of potential partners in South Africa.

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SWEDISH HEALTH FORUM IN SOUTH AFRICA – FROM POINT OF VIEW OF THE SWEDISH PARTNER

The Swedish-South African Health Forum was launched in 2003 in order to facilitate and stimulate enhanced and broad-based cooperation between South Africa and Sweden in the field of public health for the benefit of both countries.

Cooperation was initiated within the priority areas HIV and AIDS, tuberculosis and other communicable diseases, reproductive health and rights, health sector reform, health promotion and health impact assessment and injury prevention.

The evaluation raises questions regarding the planning, implementation and monitoring of this early trial of actor-driven cooperation.

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