

How are we doing?

Participatory evaluation in the practice of Handicap International

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Abstract

From September to November 2000, the authors carried out an evaluation of a disability support structure in Bangladesh using a participatory methodology. The subject of this article is primarily a critical look at the participatory methodology used to work with the local support structure enabling the structure's staff to analyse and identify areas for reflection and improvement.

The project under study aims at a development approach which tries to address the problem of providing services for people with disabilities in a developing country, by building the capacity of staff working in general community level organisations, to include disability awareness on the operational level into their programmes.

Participatory approach should allow all local stakeholders concerned by the evaluated project or mechanism, especially those who will have to implement the recommendations, to be involved in the evaluation process. It supposes some assumptions which must be defined and collectively clarified : evaluation must not be imposed but negotiated, all local actors must participate to its implementation, the evaluation framework must allow them to express their opinions and be heard themselves, evaluators must adopt a facilitator attitude, different from the one they have when conducting a more classical external evaluation, external look of evaluators must facilitate a better analysis and understanding of opinions and observation of local actors... Beyond their own implication and the opportunity for them to make a critical and personal analysis of their own practices, participatory approach also allows to solicit a much more important number of opinions than in classical evaluation. More than the diversity of information, it is mainly the crossing of opinions which is very interesting. However, participatory evaluation has also its own weaknesses and must not turn into a new dogma. Therefore, in the case study presented in this article, the authors underline that local actors didn't systematically follow all of the recommendations, even if they have made an important contribution in terms of their definition.

The theoretical philosophy of Community Approaches to Handicap and Development (CAHD) in a nutshell

The CAHD philosophy has been described in detail in various documents (see bibliography at the end of this article). In methodological terms, the CAHD process can be described as follows:

By using existing rural and urban Community Development Organisations (CDOs) as the implementing agent for rehabilitation activities, CAHD aims at integrating people with disabilities into the regular development activities of these CDOs and thus into mainstream life. Hence rather than create specific organisations, or even specific programmes within existing CDOs, which carries a risk of segregation of the people with disabilities community, the CAHD approach tries to include people with disabilities into functioning CDOs and their existing programmes, be they agricultural, credit, gender or any other.

Obviously, in the Bangladeshi context where the numbers of NGOs run into thousands³, this approach, in theory, seems particularly favourable. In short CAHD wants to strengthen the capacities of existing development programmes to enable people with disabilities to be included in regular community development activities, as it believes that people with disabilities belong within their communities and should not be seen as separate entities.

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³ There are said to be 27,000 local NGOs in Bangladesh, of which the majority are credit organisations (based on the approaches of the Grameen Bank and NGOs like Proshika)

From CAHD theory to CAHD practice

In order to enable the CDOs to implement this strategy, specific resource persons are to be trained among the staff of the CDOs. These are called Community Handicap and Disability Resource Persons (CHDRP) after their training, and are seen as the main agents to bring about change. A structured training course to provide the necessary training for the CHDRP is one of the main objectives of the Bangladeshi Support Structure (BSS⁴) and was the primary focus of our study.

BSS runs three CHDRP courses each year. Parallel to that core function, they organises specific courses, notably an introductory course for CDO managers, a social communication course and various short technical courses (Training of trainers, Inclusive Education, Special Seating, etc.)

The CHDRPs, once returned to their respective CDOs, will be responsible to implement the CAHD through:

1. Awareness building with their colleagues, thus enabling the inclusion of people with disabilities in the normal development activities of the CDO (micro-credit, agriculture, gender, education, etc.).
2. Direct services to people with disabilities and their families through Primary Rehabilitation Therapy and motivation of families and local communities.
3. Acting as a community resource person, informing other development actors on disability issues, as the CHDRP has now had training and acquired specific knowledge about disability.

In the CAHD philosophy this process should then continue leading ultimately to the establishment of Community Co-ordinating Committees responsible for the overall community development process which would now include People with disabilities. Finally, trained Village Handicap and Disability Resource Persons at the village level would play the role of resource persons, thus ensuring sustainability.

A participatory approach to evaluation with three phases

The CAHD approach and the BSS training programme having run for four years (11 batches of CHDRPs have been trained to date), an evaluation of both the approach and the role of BSS was felt as being essential by both BSS and the main donors.

Classically in these kind of situations, Terms of Reference were drawn up and external evaluators (one European and one from the Subcontinent both having complementary skills in community based rehabilitation and evaluation techniques) were approached.

The evaluators strongly felt that if the evaluation recommended necessary changes in approach and/or training, these would have to be implemented by BSS, their management and training staff and indirectly by the CDOs and the CHDRPs themselves. Thus the only way to ensure this would be to include staff into the evaluation process wherever possible, given the constraints of time.

To achieve this objective, we, the evaluators, realised that our role was primarily that of facilitators and hence our own attitude to the whole process needed to be an "open" one. Indeed the importance of being able to "listen" and be sensitive to the needs being voiced by all the actors in the process, and be careful not to be prescriptive or dogmatic, was crucial in this evaluation.

Therefore we tried to include all staff in the various steps of the evaluation:

- *starting from the hypothesis;*
- *identify criteria and indicators;*
- *collecting data through various techniques;*
- *analysing the findings and*
- *finally drawing conclusions.*

⁴ In order to respect the existing structure, the name of the NGO has been changed.

Discussions between the evaluators, the donors and the BSS staff led to a three-phase approach using participatory methods:

1. A first phase of 7 days with the external evaluators to understand the context and get the feel of the programme, including field visits, group discussion and interviews with CDOs, CHDRPs and disabled persons. This period was also used to start a participatory process with the staff, build a good rapport and establish trust. This was also an opportunity to initiate them into the process right from the planning stage. The objectives for the evaluation were finalised and methods of data collection agreed upon.
2. After the evaluators left, the second phase (1 month) consisted of the BSS staff carrying out their research in the field and collecting data.
3. A third phase accompanied by the evaluators (9 days) was conducted after this in order to meet other actors, conduct some independent evaluations to remove bias, and to work with the BSS staff on the analysis of their findings and possible recommendations for the future.

This approach enabled the evaluators to achieve various evaluative objectives:

1. Truly integrate staff in the evaluation process.
2. Enable staff to acquire skills to look critically at their own work and organisation.
3. Strengthen the staff's self-evaluation skills.
4. Ensure a strong sense of trust and collaboration between evaluators and the structure to be evaluated.
5. Reach out to a more important number of people than in a classical external evaluation while respecting significant numbers of direct contacts between evaluators and target-actors.
6. Base the analysis on many more field facts, while stimulating staff to formulate their own conclusions and recommendations.
7. Cover a much larger geographical area than in the case of a nation-wide programme is important.
8. Include the staff in the process to ensure that any changes proposed as a result of the evaluation would be appropriated and implemented by the BSS staff.

A methodology combining different techniques to obtain different views

In order to prevent methodological bias, a variety of techniques were used.

The following methods and techniques were used by the evaluators during the 1st phase of the evaluation:

1. Study of available documents
2. Rapid analysis of financial reports and accounts in order to be able to judge financial efficiency
3. Individual, group interviews and specific training exercises in participatory evaluation methodology with the BSS's key-actors :
 - Management Team
 - Trainers
 - Board members
4. Visit and interview of 6 CDOs and their project sites in three geographical area of the country⁵, enabling the evaluators to see:
 - CDO managers CHDRPs in the field
 - people with disabilities clients of visited CDOs
5. As two training course were going on at the time of the evaluation, the evaluators have carried out focus group discussions with:
 - CHDRP refresher course participants
 - CHDRP new trainees
 - CDO managers (11 persons)

⁵ Bogra, Dinajpur, Rajshahi

6. Group discussions (using participatory methods) were held with the BSS's team who were encouraged to participate in planning and were responsible for data collection in October. These were:
- trainers (6 persons)
 - deputy director
 - management team (6 persons)

During the second phase, the BSS staff carried out a series of interviews and visits to CDOs. They met CDO staff, some of whom had been trained by the BSS and People with disabilities in the communities that were being served by the CDOs. They collected facts, figures and life stories for analysis in the third and last phase. Notably BSS's training staff and the deputy director were in the field. For some of them this was an important field exposure and made a significant contribution towards their greater understanding of their programme.

The third phase consisted of:

7. Analysis, observation of the contents, the materials and methods of the BSS's training courses.
8. Visit to other training institutions on special needs enabling a comparison on the coherence of the BSS approach.
9. Visit of Community based rehabilitation programmes not following the CAHD approach in order to better understand methodological differences.
10. Field-visits of another five CDOs (Dhaka, Gazipur, etc.) their staff and their clients.
11. Interviews with government officials concerned.
12. Three workshops to analyse the observations and data collected by the BSS team (management, trainers, deputy director) and thus arrive at shared conclusions and recommendations for change.
13. Feed-back sessions at the end of the evaluation with the BSS's extended management team and the European donor's management team to reiterate the recommendations being made. This 'doing together' helped establish feelings of ownership for the whole evaluation.

In total the whole process took three months, of which approximately a total of 17 days were accompanied by the external experts. Methodologically speaking, this approach is standing somewhere mid-way between classical completely external evaluations and long-term anthropological studies. In terms of cost-effectiveness, obviously an important input in resources (both human and financial) is asked from the BSS, but the costs of professionals and experts are quite controlled.

Some strengths of the evaluation and the methodology used

Using a participatory methodology tries to ensure that all the actors involved benefit, in this case it was the funders, the BSS and the people who are the recipients of the services which are the CHDRPs and their clients.

An important and significant number of organisations and people involved

As mentioned, this triple phased approach and the active involvement of the BSS staff enabled the evaluators to reach well beyond the more limited numbers of a classical evaluation. The following table gives an idea of the number of persons and the different categories of actors who contributed to the evaluation and the various methods and techniques used.

Organisations/persons	Number of pers.	Methods / techniques / tools
International donor NGO staff	5	Both in Europe ,Bangladesh and Nepal
BSS's Board of Directors	2	Interviews
BSS's Management and extended management committee (EMT)	6	Direct interviews (one-to-one) Workshops Auto-research and auto-evaluation 12 special field visits by the deputy director
BSS's trainers	12	Workshops Auto-research and auto-evaluation Observation of training
CDOs and CDO managers in the field (in		Out of a total of 111 partners:

their location)	11+12	11 visited by the evaluators (10%) 12 visited by the deputy director (11%)
CDO managers in training (in the Centre)	11	Out of a 135 trained (8%) Group discussions Q-Sort
CHDRPs in the field	17+17	Out of 193 trained (18%) 17 Interviews and client visit observation by the evaluators 17 Q-Sort by the deputy director
CHDRPs on training (in the Centre)	49	Out of 193 trained (25%) 19 new trainees 17 CHDRPs on refresher course 13 CHDRPs on special seating training Group discussions Q-Sort exercise
People with disabilities in the field	55	Visits and informal talks (gender specific)
Other Disability NGOs	4	Interviews and field visits
Other partners	2	Interviews
Government authorities	1	Interview
Total	184 persons	contributions to the evaluation

Table 1 Number of persons involved in the auto-evaluation

This approach enabled the evaluators to prioritise the most significant aspects and ideas of all the actors involved in the programme. All BSS staff were involved in one way or another with the evaluation, thus it was important to obtain a similar amount of involvement from the training beneficiaries (that is the CHDRPs) and their organisations (CDOs and their managers), and thus provide a balance for the evaluation:

- More than 29% of the CDO managers were reached. Two third of them (so a significant 18%) directly by the evaluators through individual and group interviews, the other third through the participatory evaluation work done by the deputy director of the Support Structure.
- The 34 CDO managers involved directly or indirectly represent many CDOs of the 111 member network of CDOs, so a very significant 40%
- Of the total CDO network a statistically significant 10% were directly visited by the evaluators
- 43% of the trained CHDRPs have been involved, either through individual interviews (in the field) or group interviews during training. This concerns established CHDRPs (in the field or on refresher training) and new trainees. Part of these (9%) were touched upon by the evaluation work of the deputy director.
- This is statistically representative for the two main categories of CHDRPs (experienced and new CHDRPs).
- A certain number (55) of end-beneficiaries, persons with a disability themselves, have been involved.

The “assumption” methodology for participants to “become owner” of the evaluation themselves

A participatory approach cannot really be imposed on a structure's staff, either by the donor or by the management. Donor-led or management-led participatory evaluations risk to be contradictions in terms.

So the question became, in what way could the BSS staff be truly included, interested and associated into the process? What methods could evaluators use to kindle a self-critical look by the BSS at their own actions? Right from the very beginning the role of the evaluators as facilitators was critical.

One of the first observations we made in our first exchanges with the actors involved, both in Europe and in Bangladesh and from the literature available, were that the CAHD approach envisaged a systematic

approach with an internal logic. CAHD wants to be a different community based rehabilitation, or even different from community based rehabilitation. There seemed to be much projection and ideals in the approach.

We felt that there was an interesting angle of approach to be found here. We proposed an "assumption methodology", which basically meant thinking through the CAHD process together with the BSS staff and clarify the relations between the various steps, especially the "assumptions" which underpin each step.

During the workshops, staff was asked to list the various assumptions, prerequisites, working hypothesis, conditions, etc. for each step in the CAHD process. It was exciting to see how, once the accompanying evaluator wrote down the 25th assumption or so, all staff in the room sighed and said, "indeed, perhaps we ask too much". That was the moment a self-critical level was reached which is essential in participatory evaluations. The persons involved "see the point", "hear the penny drop", and it is they themselves who "discover" another level of reality or truth which will motivate the need to continue the evaluation, to make it theirs and to formulate change in which they themselves believe. In other words: to "appropriate" the evaluation in the sense of becoming the "proprietor", the owner of the evaluation themselves. A crucial moment in auto-evaluation.

Schematically, the evaluators themselves, and the persons participating in the evaluation process went through the following process.

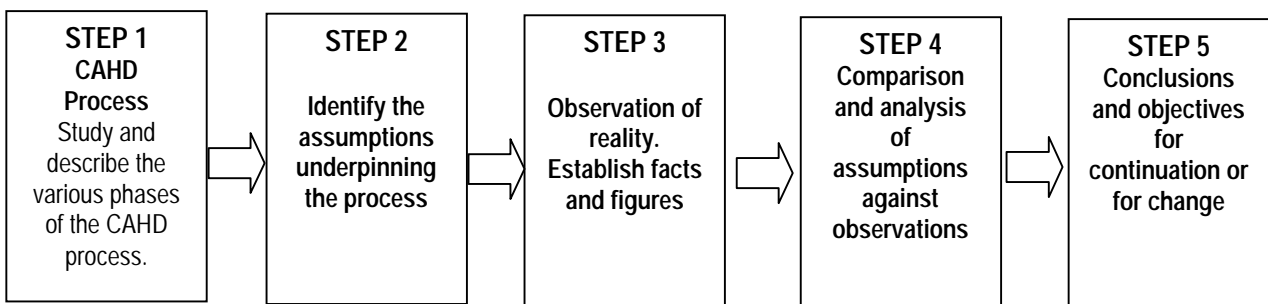


Diagram 1 : Schematic representation of the evaluation process

As an example of the application of this method, let's have a more closer look at the steps of this process:

The CAHD process in a schematic flow diagram (Step 1)

The BSS has organised the training of the CHDRPs in a comprehensive manner based on different types of activities (identification, training, follow-up, etc.). Describing this process in an explicit manner was one of the first steps in the participatory evaluation process.

"Explication", or "making explicit", of what is not said or not seen is perhaps one of the key notions in our methodology. We believe that by accompanying the actual development actors in rendering explicit hypothesis and assumptions of their "normal" way of working, helps both the evaluators and the NGO staff to look at their work in another (more objective) manner encouraging them to identify strengths and weaknesses and think-through necessary change. The advantage of this methodology being that the actors themselves, are responsible for the implementation of possible changes⁶, and will themselves formulate these necessary changes and understand their intrinsic logic.

⁶ We all know, but it won't hurt to stress again, that it is not the evaluators, nor the donors who are responsible for implementing change. They may have ideas on how to initiate a process, but they are not « doing it ».

Schematically, the CAHD approach can be represented by the following flow diagram:

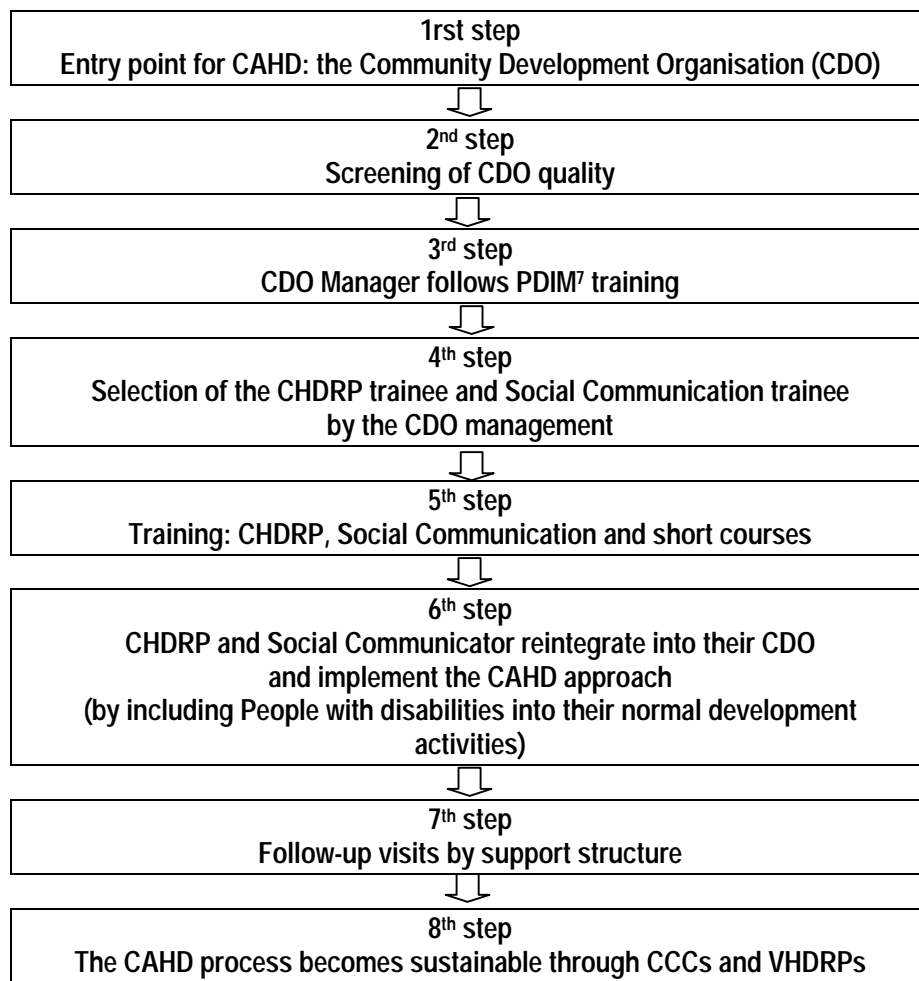


Diagram 2 : Flow-chart of the CAHD process

CHDRPs are not to be paid through a specific People with disabilities programme (or through the BSS). One of the basic principles (in the conditions of partnership between BSS and the CDO) is that the CDO selects one member from its already existing staff and pays the salary costs for the CHDRP training. Once trained the CHDRPs should be 100% available for their role as resource persons.

The preliminary PDIM training for CDO managers should ensure that the conditions under which the CAHD approach is to be implemented is clear to the management before the actual start of the Resource Person's training.

Identifying "assumptions"

In group discussion the evaluators asked the group "So in order to reach such or such objective, what are your assumptions?" Upon which the group members responded. Responses were noted down on a board and the same question asked again for each assumption (often a sub-objective).

In a way this method reminds us of Logical Framework Analysis or Prerequisite Identification as used in any logical step-by-step approach. Indeed this is the basis of the process, which could have come "naturally" to those in charge of the work. However, lack of distance, too much direct involvement, intensity of day-to-day management, often hindered the trainers (and management) to see clearly the

⁷ PDIM = Programme Design, Implementation and Management.

prerequisites they've defined (or assumed) as being fulfilled by all the participants in their training course. The presence of an outside facilitator (here the evaluators) enables all to express themselves more freely and indeed "take distance" in order to objectify as much as possible the actual situation as it appears.

As an example, of step 5 of the CAHD process, "CHDRP Training", hereunder the assumptions cited:

5th step of the CAHD process: CHDRP training

1. The trainees already possess community development skills as they come out of a functioning CDO.
2. The trainees need to be trained in technical, medical and communication skills
3. The trainees will themselves combine both type (community development and technical) of skills
4. The BSS has sufficient technical and medical skills to train CHDRPs
5. The BSS has sufficient training skills among their training staff appropriate to the trainees background and experience.

Observation of reality, observing facts and figures

Both the experts and the BSS staff went into the field to collect data and observe the actual reality of the activities.

Although participatory in nature, it was necessary for the evaluators to spent time themselves in the field in direct observation and interviews in order to establish some kind of "own or outside version" of the reality.

Indeed one of the risks of an "all participatory" approach is bias by those who are involved and who, after all, are observing the results of their own work. In order to be able to "put in perspective" the participants' observations (in phase 2) the evaluators needed this yard-stick.

The result of this observation phase 5 of the CAHD process for the CDRP Training aspect was the following:

Observation in the field for step 5 "CDRP Training

1. Trainees do not necessarily have skills/experience in the dynamics of social change (33% of CHDRPs interviewed)
2. The majority of trainees do not have technical and medical skills
3. As many trainees do not have community development skills, they will not necessarily combine both technical and social skills.
- 4a. Observation of the trainers during training sessions raise doubts on their training methods and contents.
- 4b. There is only a very limited pool of technical back -stoppers.
- 5a. Observation of the training sessions showed much rote learning of English technical definitions.
- 5b. The existing skills and experience of the trainees are not used in the training methods. They are very much seen as "students who don't know" and need to learn.

Comparing "assumptions" and "observations"

Comparing assumptions and observations leads to identification of discrepancies and offers scope for defining necessary changes. Hereunder the result of that comparison:

Assumptions underpinning this step	Observations / facts and figures from the field ⁸	Comparison "assumptions" and "observations"
<p>5th step: CHDRP training</p> <p>The trainees already possess comm. dev. skills as they come out of a functioning CDO.</p>	<p>Trainees do not necessarily have skills/experience in the dynamics of social change (33% of CHDRPs interviewed)</p>	<p>1.The assumption only partly corresponds with the observation. An important part (33%) of the trainees do not enter the course with established comm. dev. skills. The entrance level of know-how for this category of trainees has thus to be taken into account as they will encounter difficulties in understanding the contents of the course. Also the pedagogical approach is probably not adapted to this category of trainees.</p> <p>Adaptations are necessary either in the course contents or in the intake criteria.</p>
<p>The trainees need to be trained in technical, medical and communication skills</p>	<p>The majority of trainees do not have tech. and medical skills</p>	<p>2.Indeed the assumption corresponds with the observation. The contents of the training course concentrating on technical and medical skills is relevant to the trainees' situation.</p> <p>No adaptations are necessary.</p>
<p>The trainees will themselves combine both types of skills (comm. dev. on the one hand and technical on the other)</p>	<p>As many trainees do not have comm. dev. skills, they will not necessarily combine both technical and social skills.</p>	<p>3.As mentioned under 1, a fundamental problem in terms of pedagogical methodology occurs here basically questioning the very basis of the "double skill" outcome expected at the end of the training course.</p> <p>Adaptation is necessary.</p>
<p>The BSS has sufficient technical and medical skills to train CHDRPs</p>	<p>a. Observation of the trainers during training sessions raise doubts on their training methods and contents. b. There is only a very limited pool of technical back - stoppers.</p>	<p>4.The assumption does not correspond with the observation. This means recommendations have also to include the BSS training staff' technical skills.</p> <p>Adaptations are necessary.</p>
<p>The BSS has sufficient training skills among their training staff appropriate to the trainees background and experience.</p>	<p>a. Observation of the training sessions showed much rote learning of English technical definitions. b. The existing skills and experience of the trainees are not used in the training methods. They are very much seen as "pupils who don't know" and need to learn.</p>	<p>5.The assumption does not correspond with the observation. This time recommendations are necessary concerning the actual training skills.</p> <p>Adaptations are necessary.</p>

Table 2 : Comparison of "assumptions" and "observations" for CHDRP Training

⁸ These were much more quantified in the evaluation report. Here only the global issues are raised.

The comparison was made in front of the trainers themselves based on their assumptions and (a condensed version of) the observations they've made themselves. However, although the overall majority was, not all observations were made by the participants. In this particular area, for reasons easy to understand, the trainers had difficulty identifying their own shortcomings (points 4 and 5 above). Indeed, the need for a parallel "outside version" by the evaluators, as carried out during the first stay in-country, was clearly necessary and needed careful and diplomatic presentation.

Drawing conclusions from the comparison " assumptions" and "observations"

The conclusions from the comparison were elaborated through common work with participants and evaluators, basically by working through the classical three variables which come together in any adult training process: the trainees, the training (contents and method), the trainers.

The conclusions were:

Regarding trainees

1. In their future practice, CHDRPs need both global understanding of disability and tech. & medical skills. Based on the trainees intake level, both skill-areas have to come together in the course.
2. If development skills lack among a certain category of students, then there should either be a more careful selection of trainees, or a special module on community development skills has to be developed. However, such would undermine the very basis of the CAHD approach (pure training rather than built on existing skills. Stricter intake criteria should therefore be the ultimate solution.

Regarding training

3. Training contents should integrate both tech. & medical skills and general community development skills.
4. The training method should integrate the existing experiences of the trainees (used as a foundation for learning). Generally adult education principles should be used in the methodological build-up of the training course.

Regarding trainers

5. Strengthening of trainers' skills in:
 - global understanding of disability
 - tech. & medical skills
 - training methods
 - self-analysis
6. There does not seem to be a back-up system to ensure the quality of the tech. & medical contents. A professional back-stopping system with local experienced disability experts is needed.
7. It is advisable to enlarge the pool of methodological back-stoppers with adult education experts.
8. The back-stopping team does not need to meet often (once a year is enough to update the training and in between case-by-case back-stopping by individual team members)

What was taken over by the BSS?

One way to "evaluate" the impact of the participatory dimension of the evaluation is looking at the next co-funding proposal the BSS put in to a donor after the evaluation.

For this article, we went through that proposal (made several months after the evaluation) and looked at the elements included from the participatory evaluation. We can assume that those conclusions were truly shared

What was found was the following:

Included the "new" funding proposal	Not included from the participatory evaluation
<ul style="list-style-type: none"> - The fact that the evaluation was conducted is mentioned in the new proposal and indicates the need to "urgent need to improve skills" - Training of trainers in specific technical skills and disability issues. - Training of trainers in teaching methods - Training of CDO management in improved organisational management - Upgrade et redesign the contents of certain training modules using outside experts. - Improve monitoring tools so as to really assess progress. - Introduce feed-back mechanisms through the monitoring/evaluation system to improve the training (its quality, effectiveness, process, implementation, and further development) 	<ul style="list-style-type: none"> - Keep the number of 110 CDOs and work on the quality of this network, rather than its quantity (<i>BSS proposes to increase the network by 60 CDOs</i>) - Reduce during one year the three main courses to two main courses, thus liberating time for work on training of trainers and quality (<i>BSS continues the three modules per year approach</i>). - New criteria for the level of experience for the intake of new trainees (<i>no indications in the new proposal</i>).

In the end the new project proposal was not funded by the donor. What can be observed is that:

1. Issues which might have been difficult because they question the skills of staff in place (i.e. strengthening trainers, CDO managers) and thus needing a self-recognition of "lack of skills" were indeed included.
2. Working on the quality of the training is indeed recognised, but as details lack in the proposal (improve level for intake, increase practical part of the training, etc.) we cannot judge the depth of changes in the actual training programme.
3. The recommendation to work on quality of the existing network and training, rather than increase the quantity, is not taken over. This is probably the result of economic needs of the organisation (training module generates income)

A critical look at the participatory approach

1. The prerequisite to this approach is a basic trust between evaluators and the structure to be evaluated, and so a clear demand from the structure itself that it want and needs the evaluation. As one manager put it during the evaluation "*this is our evaluation*". For Northern support agencies this is an important prerequisite, which might be the object of discussion during annual visits.
2. Definitely, in this particular case, the persons involved felt very much part of the process. Their enthusiasm and their "discovery" of other ways to work other than traditional rote-learning methods, was very positive.
3. In this particular case, the "end beneficiaries", the persons with disabilities could have been more included. This would have ensured the inclusion of all groups of actors in the evaluation. In reality, however, it is extremely difficult to obtain critical information from the people with disabilities target group. The benefits (even small) of the CDOs' activities being so important to the extremely difficult situation that the people with disabilities and their families have known before the CDO's intervention, that their understandable gratitude

and enthusiasm takes the upper-hand in regards to a critical look at the CDO. Other approaches exist which can prevent such bias. For example, a more anthropological (and so more lengthy) approach would enable the evaluators to obtain more in-depth information. Unfortunately in these types of evaluations, such timeframes are not foreseen.

4. The end comparison shows that even though the approach was participatory, it does not guarantee total success. Indeed, other strategies (sometimes as basic as survival of the organisation) might get the upperhand in a funding demand, and understandably "pollute" the full inclusion of the recommendations from the participatory evaluation.

(end)

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