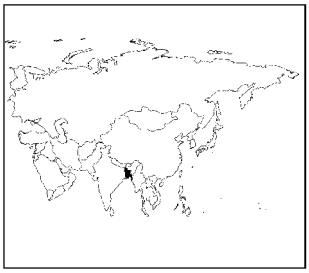

Evaluation of healthy city projects: stakeholder analysis of two projects in Bangladesh

Salma Burton

SUMMARY: *This paper describes the Healthy City projects that are underway in Chittagong and Cox's Bazar and presents the findings of a stakeholder analysis in each city. These analyses were used to demonstrate to project staff the value of evaluations and to show how such evaluations can involve the stakeholders in identifying evaluation needs and tools. The paper discusses the potential of this kind of analysis within evaluations of on-going projects, especially to primary stakeholders. It also discusses why few evaluations of Healthy City projects have been undertaken and how and why those involved in what they perceive to be "successful" projects often feel that evaluations are unnecessary.*

Salma Burton is a research assistant at South Bank University, London and is involved in the University's research on Healthy City projects in developing countries. She is also researching for a PhD on evaluation of Healthy City projects in developed and developing countries. This paper draws upon the United Kingdom Department for International Development (DFID) funded research carried out by the author in 1998 on "The Identification of Evaluation Needs and Tools for Healthy City Projects". DFID supports policies, programmes and projects to promote international development. The views and opinions expressed here are, however, those of the author alone.

Address: South Bank University, 202 Wandsworth Road, London SW8 2JZ, UK; e-mail: burtons@sbu.ac.uk

I. INTRODUCTION

THIS PAPER IS about evaluation of Healthy City projects (HCPs). As the number of these projects across the world has increased, so has interest in evaluating them. Attempts to develop criteria, approaches, methods, tools and indicators have been hindered by the context-specific, complex and process oriented nature of Healthy City projects.[1] In the field of evaluation, there is increasing interest in the involvement of stakeholders, particularly primary stakeholders. This interest is based on the argument that their involvement improves the quality and relevance of evaluations and increases the use of results.[2] By increasing the utilization of evaluations, the lessons learnt could be applied to further develop and re-direct projects.

In this paper, the importance of conducting a stakeholder analysis to understand context and to involve the stakeholders in evaluation is demonstrated through two case studies: the Chittagong Healthy City Programme and Cox's Bazar Healthy Town Programme, both in Bangladesh. While this paper is based on these two cases, the discussions are equally relevant to other types of social development and inter-sectoral projects.

Over 1,000 Healthy City projects have been started since the model was initiated and the rapid growth in their number is now perceived as a "movement".[3] Most of these projects have been implemented in high-income countries and only a few of

them are known to have been evaluated. Hence, the literature relating to their evaluation concerns mostly projects in Europe and North America.

Evaluations of Healthy City projects can be categorized into three groups:

- Evaluations of projects across countries and/or regions. A significant example of this type of evaluation is the review of the first phase of Healthy City projects (HCPs) in the World Health Organization (WHO) European Region carried out in 1990.[4]
- Evaluation of particular aspects of a selection of HCPs and use of a particular method of evaluation. The policy evaluation of the second phase of the WHO European HCPs[5] is an example of the former, while an example of the latter is the use of "...a holistic approach based on the theory of negotiated mode of action"[6] to evaluate three Healthy City initiatives in the Montreal area.
- Evaluation of individual Healthy City projects. These include evaluation of projects as a whole and, more frequently, evaluation of particular components or aspects of the projects. Examples of evaluations of projects as a whole include the Accra HCP in Ghana[7] and Noarlunga HCP in Australia.[8]

The case studies presented here fall into this third category. Descriptions of the Healthy City Programme of Chittagong and Healthy Town Programme of Cox's Bazar are followed by a stakeholder analysis of the two projects, and the paper concludes by presenting key issues related to stakeholder involvement in the identification of evaluation needs and tools in these HCPs.

II. THE TWO SPECIFIC CASES

INFORMATION FOR THE two case studies of Chittagong Healthy City Programme and Cox's Bazar Healthy Town Programme was collected by conducting:

- A review of project and evaluation documents including minutes of task force meetings and reports for funding organizations.
- Semi-structured interviews with 21 stakeholders (including six women) of Chittagong Healthy City Programme and 23 stakeholders (including six women) of Cox's Bazar Town Programme.
- Structured interviews (in the form of a questionnaire administered by interviewers) with primary beneficiaries - 32 (including 13 women) in Chittagong (18 from Jamal Khan healthy ward and 14 from other wards) and 30 (including nine women) in Cox's Bazar.
- Two focus group meetings, one with community representatives from political and social institutions (political parties, community hospitals, media, NGOs and CBOs) and another

1. Davies, J.K. and M.P. Kelly (1993), *Healthy Cities: Research and Practice*, Routledge, London; also Poland, B. (1996), "Knowledge development and evaluation in, of and for healthy community initiatives. Part I: potential content foci", *Health Promotion International* Vol.11, No.4, pages 341-349.

2. Patton, M.Q. (1997), *Utilisation-Focused Evaluation - The Century Text* (3rd edition), Sage, Thousand Oaks, CA.

3. Tsouros, A. (editor) (1990), *World Health Organization Healthy Cities Project: a Project Becomes a Movement (Review of Progress - 1987 to 1990)*, WHO/FADL, Copenhagen.

4. Draper, R., Curtice, L., Hooper, J. and M. Goumans (1993*), WHO Healthy Cities Project: Review of the First Five Years 1987-1992: a working tool and a reference framework for evaluating the project*, WHO Regional Office for Europe, Copenhagen.

5. Leeuw de, E. (1998), *A Decade of Achievement - Healthy Cities Second Phase Policy Evaluation*, WHO Collaborating Centre for Research on Healthy Cities, University of Maastricht, Maastricht.

6. Ouellet, F., Durand, D. and G. Forget (1994), "Preliminary results of an evaluation of three healthy cities initiatives in the Montreal area", *Health Promotion International* Vol.9, No.3, pages 153-159.

7. Blankers, A. (1993), *Report on the Accra Healthy Cities Project/One Year After its Initiation*, University of Limburg, Netherlands.

8. Baum, F. (1993), "Noarlunga healthy cities project: the contribution of research and evaluation" in Davis and Kelly (1993), see reference 1.

with students. In both cases, approximately 50 per cent of participants were female.
- Observation of field activities and committee meetings.

a. Chittagong Healthy City Programme

Chittagong was first established as a municipality in 1863. It is situated in the south-east of Bangladesh and is now the second largest city in the country. It has the country's main port and is a major trade centre, characteristics which have influenced the rapid increase in the urban population of the last few decades. Chittagong, which was considered a small ancient city until 1960, is now home to about 3 million people living in an area of 158 square kilometres. The city has an estimated 110 "slums" where almost 1 million people live.

The majority of the city's population face serious health problems such as diarrhoea, acute respiratory infections and malnutrition - with their direct or indirect links to contaminated water, inadequate sanitation facilities, overcrowding, poor housing and inadequate incomes. The Healthy City project was set up in 1993 with support from WHO to address these problems. The organizational framework consisted of the following:

- A steering committee, chaired by the mayor, that would coordinate major decisions.
- Seven sectoral task forces responsible for specific sectors and their respective plans of action.
- Zonal task forces for action in smaller geographical regions.
- A project office based in the Chittagong city corporation and project staff. The project was managed by staff seconded on a part-time basis by WHO and the city corporation.

The city health plan developed in 1993 at the beginning of the Chittagong HCP, was reviewed in 1995, following which the plan of action was also revised. The project was also renamed Chittagong Healthy City Programme. The justification given for making these revisions and changes was that they had been recommended by the task forces. However, no secondary stakeholders (see Table 1), except WHO, were aware of any changes other than the change in name of the project and the remits of two task forces. Neither the city health plan of 1993 nor the plan of action of 1995 were used by stakeholders in prioritizing, allocating or implementing activities.

Two key issues seem to have contributed to a shift towards the programmatic focus in the project. The first was the orientation to the Heathy City project concept received by the mayor during his study tour to Glasgow, United Kingdom in 1995. The second was the absence of a specific project budget, meaning that the concept of Healthy City could only be applied through a participatory approach to develop inter-sectoral collaboration. The decision in 1995 to select one ward, Jamal Khan ward, as a pilot project for concentrating HCP efforts also indicated a shift in the way the Chittagong HCP operated. By declaring the Jamal

Table 1: Stakeholder Analysis - Chittagong Healthy City Programme

Stakeholder	Interests	Potential project impact	Relative priorities of interest
Primary			
Slum dwellers	Improved opportunity for income generation Safe environment Development in the slums Clean city	(+) (+) (+) (+)	1
Sweepers (women)	Improved job opportunities Safe environment Education for children Clean environment	(+) (+) (+) (+)	1
Schools	Increased facilities such as sanitary latrines Status as a “healthy school”	(+) (+)	1
Rickshaw pullers	Clean, well-kept roads Increased income Improved health of the family	(+) (+) (+)	1
Hawkers	Better standard of living Increased employment Education for children Increased services (e.g. sanitary latrines and tube wells) Clean environment	(+) (+) (+) (+) (+)	1
Labourer association	Peace and harmony City development Improved work opportunities	(+) (+) (+)	1
Youth	Improved quality of education Clean environment Health services Improved planning of city activities	(+) (+) (+) (+)	1
Tenants	Clean environment Safe neighbourhood	(+) (+)	1
Secondary			
Political leaders	Ownership of project Control over resources Public support	(+/-) (+/-) (+/-)	2
Municipality staff	Job opportunities Opportunities for travel Making contacts Access to funds	(+/-) (-) (+) (-)	3
Project staff	Control over funds Status Doing a good job	(+/-) (+/-) (+)	2
Health ministry	Achieving common objectives A means of getting inter-sectoral support	(+) (+)	1
WHO	Institutional learning Achieving “Health for All” objectives Generation of additional funds	(+) (+) (+/-)	2
NGOs	Achieving common objectives Making contacts/networking	(+) (+)	1
Businessmen	Increased income Better business	(+/-) (+/-)	3
Homeowners	Higher rents Safe clean city Healthy environment	(-) (+/-) (+)	2
Medical staff	Increased awareness of public Additional health facilities Increased income	(+/-) (+/-) (-)	3
UNICEF	Achieving common objectives	(+)	2
Religious leaders	Their role in a development project Religious and social influence	(+/-) (+/-)	3

Table 2: Stakeholder Analysis - Cox's Bazar Healthy Town Programme

Stakeholder	Interests/expectations	Potential project impact	Relative priorities of interest
Primary			
Slum dwellers	Clean streets Good roads	(+) (+)	1
Migrants	Housing Land	(+/-) (+/-)	3
Hawkers	Clean environment Health awareness Education opportunities Job opportunities	(+) (+) (+) (+)	1
Rickshaw pullers	Opportunity to express views Hygiene education Attend meetings	(?) (+) (?)	1
Day labourers	Better working conditions for women labourers Sanitary latrines Rehabilitation of the poor/homeless	(+) (+) (?/-)	1
Shell sellers	Nice environment Attracting tourists	(+) (+)	1
Fishermen	Garbage-free town Pollution-free environment Mosquito control Healthy environment	(+) (+) (+) (+)	1
Stallholders	Attracting tourists	(+)	1
School children	High profile Education	(+) (+)	1
Secondary			
Political leaders	Getting rid of the slums Improve tourism	(-) (+/-)	2
Municipality staff	Additional resources/funds Opportunity for foreign travel	(-) (-)	3
Project staff	Achieving "Health for All" objectives Developing a credible programme Coordinated action Greater involvement of NGOs	(+) (+) (+) (+)	1
Regional administration	Increased services to people and slums outside the municipality	(+/-)	4
WHO	Achieving "Health for All" objectives Effective use of resources Institutional learning Continued funding of project	(+) (+) (+) (+/-)	1
NGOs	Expansion of project to areas outside the municipality Health of the slum dwellers Collaboration with government	(+/-) (+) (+)	2
Task forces	Achieving project objectives	(+)	1
Businessmen	Attracting more tourists Improving their businesses	(+/-) (-/?)	
Schools/teachers	High profile Improved facilities/services, e.g. latrines, dustbins, vitamins and de-worming medicine, and visits by doctor	(+) (+/-)	2
Tourism sector	Increased opportunities Attracting tourists	(+) (+)	2
Religious leaders	Participation in government programmes	(+)	2

Khan ward a "healthy ward", and by applying the concept of "Health for All" at the ward level, it was easier to establish credibility and support through rapid demonstration of the successes of the approach.

At present, the Healthy City activities of Chittagong fall into three main categories:

- Strategic, policy related activities within which the city corporation is able to improve coordination between itself and other sectors. Examples of this include advocacy to put health on the agenda of all other development activities in the city.
- Activities carried out by the city corporation to include in its mandate the provision of selected health and environment services; and the lead role it plays in planning and providing these in an equitable way.
- Jamal Khan healthy ward activities, which include a system of rubbish disposal that uses rickshaw vans, ward-wide awareness programmes that promote environmental safety, mosquito eradication and children's education, in particular for girls.

b. Cox's Bazar Healthy Town Programme

Cox's Bazar, situated in south-eastern Bangladesh, became a municipality in 1869.[9] The municipality occupies an area of about seven square kilometres and is divided into three wards. The sprawl beyond the urban limits includes several "slums" accommodating a large proportion of the total urban population, many of them immigrants and in-migrants. While the number of people living outside the urban limits is not known, the population of the municipality has been estimated at 70,000, which is more than double what it was at the beginning of the 1980s. This growth in population has increased demand for urban services.

9. Elite Consultants (1992), *Report III - Draft Master Plan of Cox's Bazar*, report for the Local Government Engineering Bureau, Ministry of Local Government, Government of Bangladesh.

The Cox's Bazar Healthy Town Programme was launched by several local organizations, and led by the municipality and WHO. The aim of the programme was to improve environmental and health conditions by raising public awareness and thus mobilizing community participation in service provision through partnerships with local municipal agencies and institutions. The process began in 1995 with a series of workshops, following which a coordination committee and five sectoral task forces were established. Unlike the Chittagong programme, Cox's Bazar programme receives technical support and a salaried coordinator from the United Nations Development Programme's Local Initiative Facility for the Urban Environment.

The focus of Cox's Bazar HCP is on improving awareness of the Healthy City concept, improving coordination in the implementation of the town health plan, generating NGO participation, and the school health programme. Because of limited political commitment at policy level, the project is having to put more effort into implementation rather than into coordination of activities. The profile of the project is being gradually raised by the school health activities and other health promotion and

Table 3: Matrix Classification of Stakeholders According to Importance and Influence: Chittagong Healthy City Programme

High importance

A. (high importance and low influence) * (1, 2, 3, 4, 5, 6, 7.) *8 *14	B. (high importance and high influence) *12 *13 *11 *9 *10
*16 *18 *15 *19 C. (low importance and low influence)	*17 D. (low importance and high influence)

Low importance / Low influence — High influence

Primary stakeholders
1. Slum dwellers
2. Sweepers
3. Rickshaw pullers
4. Hawkers
5. Labourers
6. Youths
7. Tenants
8. School children/schools

Secondary stakeholders
9. Political leaders
10. Municipality staff
11. Project staff
12. Health ministry
13. WHO
14. NGOs
15. Businessmen
16. Homeowners
17. Medical staff
18. UNICEF
19. Religious leaders

Table 4: Matrix Classification of Stakeholders According to Importance and Influence: Cox's Bazar Healthy Town Programme

High importance

A. (high importance and low influence) * (1, 2, 3, 4, 5, 6, 7,8.) *9 *18	B. (high importance and high influence) *12 *14 *10 *16 *13
*15 *16 *11 *19 C. (low importance and low influence)	*20 *17 D. (low importance and high influence)

Low importance/low influence — High influence

Primary stakeholders
1. Slum dwellers
2. Migrants
3. Hawkers
4. Rickshaw pullers
5. Day labourers
6. Shell sellers
7. Fishermen
8. Stallholders
9. School children

Secondary stakeholders
10. Political leaders
11. Municipality staff
12. Project staff
13. Regional administration
14. WHO
15. NGOs
16. Task forces
17. Businessmen
18. School teachers
19. Tourism sector
20. Religious leaders

environment related activities funded by WHO. The beneficiaries' view of the project and the concept of Healthy City are, however, based on visible activities such as beach-cleaning. The creation of the tourism task force in 1997 and the seminar on the development of tourism and related activities have given the project a more distinct target. All stakeholders believe that, if more tourists come to their town, this would improve their incomes and therefore the well-being of the community.

III. STAKEHOLDER ANALYSIS

THIS SECTION PRESENTS the stakeholder analysis of the two Healthy City projects which followed the guidelines provided by the Department for International Development (DFID)[10]. Being on-going projects (five years in the case of Chittagong and four in Cox's Bazar), this process had to be dynamic, with the initial identification of stakeholders from project documents being subsequently supplemented by additional information from interviews.

10. DFID (1995), *Guidance Notes on How to do a Stakeholder Analysis of Aid Projects and Programmes*, Department for International Development (formerly the Overseas Development Administration), London.

The sample of stakeholders was selected in two stages: selection of stakeholder categories followed by the selection of representatives from each category. Stakeholder categories were identified through a review of documents and semi-structured interviews with key project participants such as task force representatives and officials from government organizations as well as agencies not directly involved in the project. The second stage involved the selection of representatives from each stakeholder category for interview. Semi-structured interviews were held with elected and nominated representatives from each category while structured interviews were held with a random selection of primary beneficiaries.

Stakeholder interests in the project were identified by the stakeholders themselves in semi-structured interviews, focus group meetings and structured interviews, and these are shown in the column headed "interests" in Tables 1 and 2. The tables also show each stakeholder's potential impact on the project which was determined by the researcher, in consultation with project staff, by asking whether or not a particular interest would have a positive or negative influence on the achievement of project objectives. Relative priorities of interest in the tables are the level of priority that should be given to the stakeholder in meeting their needs. These were scored from one (the highest priority) to four (the lowest priority). The interviews and meetings also considered the "influence" stakeholders have on project processes and the "importance" actually given by the project to satisfying each stakeholder's needs and interests. Influence and importance of stakeholders, when presented in a matrix diagram, indicate relative risks and opportunities posed by specific stakeholders.

Although both HCPs had almost identical objectives and were being implemented according to the same model, there were significant differences observed in the interests, importance and influence of different stakeholders in the projects. In both cases,

the primary stakeholders comprised similar groups, being of great importance but of low influence compared to secondary stakeholders. However, when compared to Cox's Bazar, a greater proportion of the primary beneficiaries of Chittagong HCP reported that they participated in the planning of project activities, benefited from them and were able to influence project direction. This was reported to be related to the politicized nature of the project in Chittagong, where elected political representatives led the project activities and used the project as a means of patronage. These locally elected representatives were also keen to involve the primary stakeholders in order to win their votes in municipal elections. Such influences in the Chittagong HCP have moved primary stakeholders to higher levels of influence and empowerment.

Political influence and the level of importance that political leaders give to the project play an important part in the project's success. In Chittagong and Cox's Bazar, the importance of political leaders was more or less the same, however, their influence in the Chittagong project was far greater than in Cox's Bazar. At the start of the Cox's Bazar project, the political leaders were interested in the project and its potential for generating funds for urban development activities. When they realized that this was not going to happen, many political leaders lost interest in the project. Advocacy related activities need to be carried out to generate awareness amongst political leaders of the benefits of inter-sectoral action, thus increasing their level of influence. The case of Chittagong HCP demonstrates that the high influence of political leaders can be harnessed towards the achievement of project objectives. All evaluations must be aimed at identifying the ways in which the advantages of high influence can be enhanced.

The status of NGOs and their relationships with the projects were found to be distinctly different in the two cities. In the case of Cox's Bazar, most NGOs target displaced people or refugees outside the project site and, because of this, they were of limited importance to the project. In Chittagong, while the potential benefits of involving NGOs were recognized by some stakeholders, the existing coordination structure did not involve the NGOs except in reporting on their work. NGOs are important when they have common objectives to those of the project and where their work is taken into consideration by the project when planning city services. However, in both cases, the NGOs had very low influence on the projects.

These examples demonstrate the importance and influence of stakeholders in the Chittagong and Cox's Bazar HCPs. They also demonstrate that the potential for their involvement in implementation as well as evaluation can be enhanced and that the risks (ie. negative interest/high influence) they present to the project can be monitored and minimized. By comparing the projects, it has been possible to demonstrate that there are contextual differences between projects which significantly affect their success. This reconfirms DFID's recommendation to conduct a stakeholder analysis for all social development projects.

An important point to note here is that, unlike the usual

stakeholder analysis which, ideally, would be carried out at the beginning of projects, this exercise comes several years after the projects began operating. While stakeholder analysis at the beginning of a project provides pointers towards risks and assumptions, and towards ways in which participation can be made more productive, this analysis illuminated contrasting power relationships, making it an important tool for future evaluations.

IV. EVALUATION NEEDS AND TOOLS

ANALYSIS OF HCP evaluations revealed that the knowledge of and use of evaluation results varied depending on the purpose of evaluation, the choice of participants in the evaluation and whether or not evaluation results were disseminated. The Chittagong evaluation will be used to illustrate this.

Evaluations of HCPs are mostly done for funding organizations and, as a result, the findings are neither owned nor used by the project. In November 1994, WHO funded a consultant to evaluate the development of the Chittagong HCP and the findings were to be published.[11] However, neither information concerning the evaluation nor the findings of the evaluation were available at the project site. In Cox's Bazar, there were no records of any evaluations either. Moreover, in both cases, neither the staff nor the other stakeholders in the projects were aware of any evaluation of any part of the project. Nor were they aware, as claimed by evaluators, that the changes made to the project in Chittagong were based on the evaluation findings.

It is often the case in evaluations of Healthy City projects that the need for evaluation is not expressed at the implementation level. In the cases of Chittagong and Cox's Bazar, the need for evaluation was expressed only at the level of the funding organization. Moreover, the project staff regarded evaluation with a significant amount of suspicion and project managers felt that they already knew the value of the project.

The projects were viewed by stakeholders at the management level to be a complete success. In the case of Chittagong, almost all of this success was attributed, by most primary and secondary stakeholders, to the mayor of Chittagong and the commissioner of Jamal Khan ward who played leading roles in the development of the HCP. In both cases, secondary stakeholders, in general, felt that the project was heading in the right direction. However, most primary stakeholders were unaware of the project objectives and were therefore unable to comment on progress. Those primary stakeholders who were able to identify some of the activities clearly demonstrated that their knowledge of the project was based on the more visible activities such as beach-cleaning, school health and rubbish disposal.

There are many obstacles to involving stakeholders in the evaluation of HCPs. In both Chittagong and Cox's Bazar, the following problems in conducting an evaluation and, in particular, involving stakeholders in the evaluation were identified. First, in Chittagong, the activities being implemented were different from the planned activities. In Cox's Bazar, primary stakeholders

11. Werna, E. and T. Harpham (1996), "The implementation of the healthy cities project in developing countries: lessons from Chittagong", *Habitat International* Vol.20, No.2, pages 221-228.

had a limited understanding of the project concept and their low involvement in implementation limited their participation in evaluation. In both cases, any evaluation attempts require a clear understanding of the project as implemented rather than as planned.

A second issue in involving stakeholders was related to their level of awareness about evaluations. It was clear that stakeholders, particularly project staff and beneficiaries, were making judgements about the value of their activities. The following example illustrates this. During the initial months of the rubbish disposal project in Jamal Khan healthy ward (using rickshaw vans), the project staff noticed that, in certain areas, rubbish was still being dumped into the drains. Community representatives consulted local residents and discovered that it was the poorer sections of the community which did not deliver the rubbish to the rickshaw vans for fear that they would be charged for the service. Project staff addressed this by explaining to the people in those neighbourhoods that they would not be charged; rather they would be fined if they did not place their rubbish in rickshaw vans. Thereafter, project staff observed significant improvements. This is an example of an evaluation that community representatives had carried out without recognizing it as an "evaluation".

Another issue is that evaluation was seen as checking up on good intentions and as a form of criticism. In the case of a project which was widely perceived as having good results, the stakeholders found it difficult to understand why there should be an evaluation. During the research, the interviewer was asked by project staff why she asked the same question of all those interviewed. "Do you not believe us?", "The programme *is* successful" and "We *know* we are making progress" were common responses in both interviews and focus group discussions.

Even though there was limited recognition of the need for evaluation, it was evident that the capacity of both stakeholders and institutions to carry out evaluation needed to be enhanced. Even at the management level, there were statements such as "I never thought of that before I was asked by you - your questions got me thinking." The same member of staff who asked the researcher why she was repeatedly asking everyone the same question, later made the following statement: "I know what you are doing; you are looking at the table from the top, sides and underneath."

Project evaluations are dependent on whether or not funds are available and whether available funds can be allocated to evaluation rather than to routine activities. In the case of Chittagong, where the Healthy City project was a strategic approach to implementing on-going services, there were no specific funds either for specific activities or for evaluation. Any structured evaluation requires funds but what was evident, however, was that unless evaluation of activities and processes is undertaken, documented and presented, and programme success demonstrated, continued funding would not be forthcoming.

The stakeholders at the implementation and beneficiary lev-

els identified progress through observation in two distinct ways. The first was by comparing the situation before and after the activity was implemented and the other was by making comparisons between Jamal Khan healthy ward and another ward. In Cox's Bazar comparisons were made between a designated healthy school and other schools.

The extent of success was measured in percentage terms and these were derived subjectively. Success in Jamal Khan healthy ward, as specified by stakeholders, ranged from 30 to 90 per cent. Some defined these percentages as a point on a scale between what the city was like a few years ago (at one end) and the vision of what the city could be (at the other end). Others defined the percentages in terms of drains that are clean and students being educated. In focus group meetings, the stakeholders were able to agree on percentages by calculating averages.

Just as the need to involve stakeholders in evaluation is recognized, their desire and enthusiasm to be involved should also be recognized. Stakeholders in Chittagong and Cox's Bazar declared their involvement as a duty and a responsibility in their efforts to make a healthy city.

V. CONCLUSIONS

THE IMPORTANCE OF stakeholder analysis has been demonstrated in the cases of Chittagong and Cox's Bazar HCPs. In what are otherwise similar projects, there were significant differences in the importance and influence of stakeholders and the risks and opportunities posed by them. By carrying out this exercise after the projects had been in operation for several years, stakeholder analysis has been shown to be a useful tool in the evaluation of HCPs.

Evaluation needs are dependent on factors such as demand for evaluation from funding organizations, availability of additional funds for evaluation, institutional capacity to undertake evaluation, the existence of an evaluation culture and the prospects for raising more funds by proving success. The tools that are being used by stakeholders at present, such as deriving percentages based on observation (however crude that may be), would need to be modified (or sharpened) if stakeholder involvement in evaluation is desired. The tools will have to be ones that stakeholders are familiar with, appropriate and user friendly. In Chittagong and Cox's Bazar, the need for evaluation was only recognized at the funding level. The question here is whether the institutional capacity for undertaking evaluations could be strengthened and an evaluation culture established to the extent that the programmes would allocate valuable project resources for doing them.