HIV PREVENTION CAPACITY BUILDING

2005

A FRAMEWORK FOR STRENGTHENING AND SUSTAINING HIV PREVENTION PROGRAMS

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HIV PREVENTION CAPACITY BUILDING

A framework for strengthening and sustaining HIV prevention programs

ACKNOWLEDGMENTS

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INTRODUCTION

To combat the HIV epidemic, health service providers and public health professionals must use the best possible science and proven program models to reach and influence HIV-positive individuals and others at high risk of becoming infected. The large number and complexity of approaches that are necessary to institute and maintain HIV prevention programs make capacity-building for effective positive health outcomes essential.

Capacity-building is a dynamic and informative process intended to improve the skills of individuals, organizations, and communities. It focuses on strengthening the knowledge and skill sets of both providers and recipients of health services. Capacity-building may also lead to the development of systems, such as communities or organizations, that are better able to address health problems, and in particular, problems that arise out of social inequity and social exclusion.[1]

This document explores the ways in which capacity-building can be applied to health promotion and disease prevention programs that focus on HIV by addressing the following questions.

- What is HIV prevention capacity-building?
- Why build capacity?
- What is distinctive about capacity-building?
- Why invest in capacity-building?
- Will building capacity make a difference?
- How does capacity-building affect sustainability?

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[1] Leeder, S. Challenges for Capacity Building. NSW Health Department. Sydney, Australia: 2003.

What is Capacity Building?

Capacity building is defined as: a planned, structured process by which individuals, organizations, and communities develop skills and abilities to enhance and sustain HIV prevention efforts. The goal of capacity building, which may include training, technical assistance, and infrastructure development activities, is to foster self-sufficiency and the self-sustaining ability to improve HIV prevention processes, programs, and interventions.

Capacity-building services and technical assistance are sometimes confused and many people use the two terms interchangeably. Technical assistance is the provision of direct or indirect support to build the capacity of individuals or groups to carry out programmatic and management responsibilities with respect to HIV prevention. Capacity-building services differs from technical assistance in that it is a process achieved in stages, while technical assistance is often a single episode and used to support the development or accomplishment of a specific task or activity.

Capacity building involves diverse activities, such as developing organizations, conducting evidence-based interventions, managing programs, and providing direct services. It can have a far-reaching impact by changing program policies and increasing access to services. In the public health system, it enhances the ability of individuals, organizations, and communities to adequately address a community's health needs and issues.

Figure 1: Spheres of Capacity Building
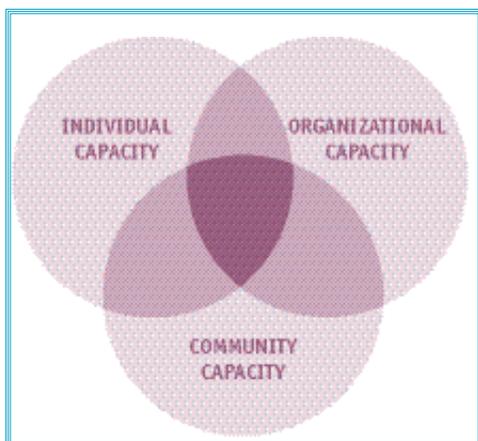
An Overview of Approaches to Capacity Building

Capacity building encourages independence, supports sustainability, and prepares service providers and their organizations to meet future challenges to delivering health services.[2] It can improve the ability of individuals (including staff and boards of directors), organizations, and communities to provide effective HIV prevention services.

[2] NSW Health. *A Framework for Building Capacity to Improve Health*. NSW Health Department. Sydney, Australia: 2001. Washington, DC: 1996.

Because individuals, organizations, and communities interact with a range of HIV prevention and health promotion activities, capacity-building requires significant collaboration and the cultivation of partnerships. Increasing the capacity of one segment strengthens the others. Appropriate capacity-building support can result in the development of a robust and integrated system to improve the health and well being of a community. Figure 1 illustrates the overlapping relationship of these three spheres.

The following section briefly describes capacity building at individual, organizational, and community levels.

Building Capacity on the Individual Level

When focusing specifically on individuals, two approaches have shown to be effective. The first is a **bottom-up approach** that provides staff of an organization with information and skills that benefit them and their organization. Examples of this approach include further training in HIV counseling and testing for health practitioners or broadening the skills and knowledge base of HIV prevention outreach workers. With this approach, the organization involved must be committed to continuous learning and investment in the development and advancement of the staff.

The second approach focusing on individuals is a **community approach** that aims to transform individuals from passive recipients of services to active participants in a process of improve the community's health. This includes programs that highlight community mobilization, board of director recruitment and diversification, and staff development and training. The approach targets individuals within an agency or community to engage and mobilize them for action and change. HIV prevention community planning is an example of this approach.

Building Capacity on the Organizational Level

A **top-down approach** focuses on an organization's capacity to be more responsive to existing and emerging health challenges. Organizational capacity can be transformed by a variety of activities, including organizational restructuring, redevelopment or implementation of protocols and policies, and coordination and planning to ensure that staff, facilities, equipment, and other resources can be mobilized as needed. The top-down organizational approach includes an organization's board of directors, since the board members play a vital role in the functioning of the organization. Examples of this approach include: training of board members, organizational development, strategic planning, staff development, and quality assurance activities.

Building Capacity at the Community Level

At the community level, capacity can be built through a **partnership development approach** involving organizations or organized groups of people. This is based on the premise that a two-way flow of knowledge can lead to partnerships through which the resources required to plan and implement health programs may emerge. Partnerships can be fostered between community members and local practitioners, members of the same community, or two or more organizations in a given community. This approach is an integral part of the HIV prevention community planning process. Figure 2 illustrates the way in which effective systems (or programs) are built on the capacities of individuals, teams, organizations, and communities that comprise them.

Building Capacity at the Community Level

This document was written for community-based organizations and their consultants, Centers for Disease Control and Prevention (CDC) project officers, capacity-building service providers and recipients, trainers,

Figure 2: Importance of Capacity at Various Levels
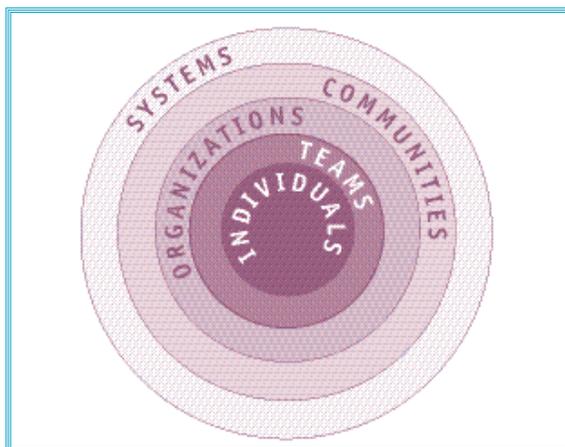
Source: *Capacity Building for Health Promotion; More than Bricks and Mortar.* Ontario Prevention Clearinghouse, Spring 2002.

and state and local health departments. It was developed to support both the providers and recipients of capacity-building services. The document is not intended as a set of rules for providing capacity-building services, but rather, as a framework for understanding the benefits and possible outcomes of capacity building. By setting forth a framework and a common language around capacity-building activities, CDC can ideally provide the HIV prevention community with a more comprehensive, integrated approach to HIV prevention. The document should be used as a tool to find the information needed for understanding, carrying out, and evaluating HIV prevention capacity building. It is not meant to be exhaustive.

The document is organized in 9 chapters, which are listed below.

Chapter 1   Introduces CDC's position on capacity building in HIV prevention in relation to their overall mission and the goals of capacity building on the Divisions of HIV/AIDS Prevention level.

Chapter 2   Addresses the multi-dimensional aspects of the capacity-building process and includes a discussion of community capital, dissemination and diffusion, and the role of cultural competency in capacity building.

Chapter 3   Highlights capacity-building and its role in current CDC programming. Specifically, it describes the new CDC initiative *Advancing HIV Prevention: New Strategies for a Changing Epidemic* and explains the CDC's capacity-building assistance framework.

Chapter 4   Offers providers and recipients of capacity-building services guidance for participating effectively in the HIV prevention capacity-building process and describes roles and responsibilities for all parties involved in the process.

Chapter 5   Explains why assessment is the first step in providing capacity-building services and describes techniques that can be used to assess needs that can be met by increasing capacity on the individual, organizational, and community/environmental levels.

PREFACE

HIV/AIDS is a crisis that deeply affects individuals, institutions, and communities. The urgent need to address the epidemic, however, has not allowed many institutions the time to focus on their capacity to ensure sustained, effective programs. For many, efforts to integrate programs into existing agency structures and philosophies (institutionalization) are contrary to the hope for an immediate end to the AIDS epidemic.

Balancing the competing needs of immediate action against institutionalization is not easy. However, taking action to respond to immediate HIV prevention program needs does not have to preclude efforts over the long term to enhance the capacity of organizations to successfully support HIV prevention services. Building program service capacity and developing infrastructures have become important topics in public health and are included as key goals of *Healthy People 2010*, a set of federal health objectives to be used by states, communities, professional organizations, and others to achieve improved health outcomes by the year 2010. For the first time, *Healthy People 2010* includes the focus area of infrastructure, with the goal of ensuring capacity to provide essential public health services at federal, state, and local levels. The infrastructure objectives do not target specific health outcomes, but focus on building increased capacity to deliver public health services.

Capacity building is holistic and developmental by nature. A competent and capable individual, organization, or community depends upon many different systems or aspects operating together effectively. Capacity building is achieved in stages, from individual to organization to community. If the capacity of an individual is increased, he or she will be more capable and valuable to the organization. If the value of the organization is increased, the community will benefit directly. If the community has strong capacity for providing HIV prevention services or care, then people at risk for HIV infection, or already infected, will have access to better health services.

This guide, *HIV Prevention Capacity Building*, **was developed by the Academy for Educational Development to document the core principles and rationale of the Centers for Disease Control and Prevention's Divisions of HIV/AIDS Prevention's capacity-building efforts.** It is designed to provide communities and organizations with core information on the need for strengthened capacity for organizations to offer more effective and sustainable HIV prevention services. Although it is intended primarily for agencies and organizations that are funded directly or indirectly by CDC, the processes described may be useful to HIV prevention programs supported by other funding sources. The tools provided in the guide also may apply to public health issues other than HIV/AIDS.

OVERVIEW OF
HIV PREVENTION
CAPACITY BUILDING AT CDC

Chapter 1 introduces the Centers for Disease Control and Prevention's (CDC) approach to capacity building in HIV prevention in relation to its overall mission and goals. This chapter will focus specifically on providing an overview of:

- The seven operating principles of capacity building at CDC;
- CDC's Capacity Building Goals;
- Capacity Building Assistance and CDC (establishment of the Capacity Building Assistance strategy);
- *Healthy People 2010* and capacity building; and
- Cost effectiveness and capacity building.

To be effective, HIV prevention-related capacity-building efforts must be based in behavioral science and research. Although new methodologies and approaches often can be adapted to the needs of a target community or audience, certain core elements that are based in science must be present if the integrity of a scientifically sound program or intervention is to be maintained.

As the nation's leading disease control and prevention agency, CDC's primary mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC seeks to accomplish its mission by working with partners throughout the nation and the world to monitor, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

The CDC Divisions of HIV/AIDS Prevention (DHAP) plan, monitor, and execute scientific and programmatic HIV/AIDS prevention activities across CDC's six mission categories:

- Surveillance;
- Research;
- Intervention and Program Implementation;
- Technical Assistance;
- Program Evaluation; and
- Policy Development.

Although capacity building is not explicitly one of the six mission categories, it is integral to CDC's overall mission and to its ability to implement each of these mission categories. For example, capacity building is now the main approach that CDC uses to provide technical assistance to grantees on surveillance, intervention, and program implementation. To achieve this goal, CDC supports a national system of organizations and individuals to provide capacity-building assistance to grantees. CDC also has embarked on a multi-year process to develop the capacity of state and local health departments and community-based organization (CBO) grantees to conduct systematic program evaluation for HIV prevention programs.

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[1] Centers for Disease Control and Prevention (CDC). "CDC's Mission." http://www.cdc.gov/aboutcdc.htm. (last updated October 2003).

Capacity building is most effective when approaches are tailored to meet the specific needs of the recipient. Many different capacity-building techniques are employed by CDC to address identified needs and use existing resources and assets in the targeted communities and populations. In this process, it is essential that recipients participate in identifying needs and locating community and organizational resources that can be used to increase local capacity.

Although capacity building is a fluid process, capacity is often developed in stages and assembled as building blocks. The most basic level of capacity occurs among individuals, which, in turn, leads to the building of capacity among organizations and communities. For example, if the capacity of an individual is increased, he or she will be more capable and valuable to the organization. If the capacity of an organization is increased, the community will benefit directly. Though a capacity-building provider may not be responsible for every level, success in capacity building at any specific level is dependent on the existence of capacity in the preceding levels.

Collaboration, coordination, and cooperation on multiple levels are required for effective and self-sustaining development of capacity. For instance, capacity building may focus on activities, such as a staff development workshop, that strengthen an organization's overall ability to deliver effective HIV prevention or care services. As a result of identifying needs, a capacity-building provider may provide an organization with technical assistance on cultural competency, financial management, or program implementation. However, training alone does not ensure that capacity will be developed. Evaluation of the capacity-building training and processes is necessary, as is monitoring and evaluation of skill use and efficacy.

Seven Operating Principles of CDC DHAP's Capacity-Building Activities

The seven key operating principles listed below should be integrated into capacity-building activities. The principles are based on a detailed review of the literature, program experience, and program evaluation.

• **Operating Principle 1**

Capacity building is targeted at the level at which impact is desired. Capacity-building activities may be applied to different levels of recipients—individuals, organizations, and communities/environments.

• **Operating Principle 2**

Capacity building occurs in stages. It is not feasible to focus on building the capacity of a community if competent organizations or structures that serve the community do not exist. Likewise, it is impossible to build the capacity of an organization without focusing first on developing and investing in capable individuals.

• **Operating Principle 3**

Capacity building focuses on appropriate responses to both the recipient of capacity-building services and the recipient's environment. By addressing the individual and his/her environment, capacity building will result in increased self-sufficiency and enhanced abilities to address HIV prevention issues. As a result, it can lead to a sense of empowerment and confidence for sustained implementation.

• **Operating Principle 4**

Empowerment to act is at the core of successful capacity building. Capacity-building providers strive to foster skills among individuals, organizations, and communities to build self-sufficiency. Rather than fostering a dependent relationship in which recipients are reliant on others, capacity-building providers should focus on imparting techniques and skills for recipients to independently achieve their goals and objectives. Capacity building should not be didactic— it requires an exchange of information and ideas between the provider and the recipient.

• **Operating Principle 5**

Capacity building results in a procedural change on an individual, organizational, or community/environmental level. The changed process is the altered and enhanced functions that recipients are able to independently sustain after the capacity-building activity is completed.

- **Operating Principle 6**
  Capacity building is dependent upon a two-way partnership between the provider and the recipient. Both parties must be committed and engaged in the process and communication must be bi-directional, respectful, and dynamic with a mutual agreement on the process and the intended outcomes.

- **Operating Principle 7**
  Capacity building is based on providing customized approaches to foster ability. Capacity-building techniques are not a set of pre-packaged technical approaches or interventions intended to bring about a pre-defined outcome. The needs and objectives of all parties involved in capacity building must be acknowledged and respected to increase capacity and sustain it.

An Overview of Capacity Building and HIV Prevention

The AIDS epidemic is perhaps the most significant health-related event of the 21st century, creating a great burden across all society and demands on both the government and non-governmental sectors to respond. Since the first reported case of AIDS in the early 1980s, the response to the epidemic has grown exponentially. What began in the United States as a concern among gay white men in major urban centers has grown to include communities of color, gay and bisexual men, injection drug users, and women. Over the course of the epidemic, prevention programs have traditionally focused on helping uninfected individuals avoid infection. While continuing to recognize the importance of prevention among HIV-negative individuals, increased attention is being placed on prevention with HIV-positive individuals. The initial cadre of service providers has grown from local foundations and AIDS service organizations to the active engagement of numerous federal agencies; state, territorial, and local health departments; non-governmental organizations (NGOs); AIDS-focused and multi-service CBOs; faith-based organizations; business groups; and others committed to fighting the epidemic.

Capacity building is critical to creating infrastructure for HIV prevention in traditional health service settings as well as in non-traditional programs. Since traditional health service infrastructures often

cannot reach those most at risk and many individuals are unaware of their HIV status, the capacity of both traditional and non-traditional HIV prevention service providers must be increased. Building capacity in both arenas will ensure that HIV prevention services more efficiently reach HIV-positive individuals through HIV counseling and testing, partner counseling and referral services, prevention case management, secondary prevention, and referral to treatment. Prevention messages must also target high-risk, HIV-negative individuals through counseling and testing, primary prevention, targeted behavioral interventions and health education, partner counseling and referral, and prevention case management.

The importance of NGOs and non-traditional providers in offering services and making HIV prevention systems more effective is often overlooked even though they are vital components of the U.S. public health workforce. The public health workforce must have timely and relevant information, skills, and perspectives to deliver services effectively and carry out the core functions of assessment, policy development, and assurance of services to those most in need of services. Strong CBOs—in partnership with state, local, federal, and tribal agencies—are essential to an effective public health system.

HIV prevention approaches must be strategically focused on avoiding new infections on the primary, secondary, and tertiary levels. This is the ultimate goal of all HIV prevention programs, whether targeting HIV-positive or high-risk negative individuals. However, implementing and sustaining effective HIV prevention services is a significant challenge due to a myriad of complicating factors including: an evolving epidemic and regional variations; complex program models; a lack of data and tailored interventions for specific target populations; mixed messages regarding prevention in a time of highly effective treatments; high staff turnover in health departments and CBOs; and stigma and discrimination.

Since 1989, CDC has supported HIV prevention capacity-building efforts in the United States. The overall intent of CDC's HIV prevention capacity-building efforts is threefold:

- To ensure that targeted HIV prevention resources are used effectively to prevent HIV transmission;
- To improve the scientific basis of program design, service implementation, and evaluation; and
- To increase the ability of HIV prevention services to reach HIV-positive individuals and HIV-negative individuals at high risk of infection.

CDC's Capacity Building Goals

It is CDC's position that successful and sustainable health promotion programs must be built on strong foundations. Individual, organizational, and community-wide capacities must be systematically developed to maximize planning, staff, and resources. A strategic approach and a sound theoretical basis are essential when creating and evaluating effective public health programs. By building capacity in these areas, CDC is working to ensure that policy makers, program leaders, and all partners involved are developing the skills and maximizing the resources needed to increase their chances of long-term success. CDC has identified four critical goals of capacity building for HIV prevention.

Goal 1: Capacity building must strengthen existing activities and capacity in communities with the greatest needs.

In the case of HIV/AIDS in the U.S. today, this requires a major concentration on building competency of existing resources in communities of color. It is essential that this be done by incorporating cultural competency, using practitioners with key competencies, and supporting a host of strategies and models.[2]

Goal 2: Capacity building must occur in four focus areas.

These areas are: strengthening organizational infrastructure for HIV prevention; strengthening interventions for HIV prevention; strengthening community access to and use of HIV prevention services; and strengthening community planning for HIV prevention[3].

Goal 3: Capacity-building strategies must emphasize regionally and locally structured approaches.

These approaches must be effectively coordinated among health departments, individuals and organizations that provide capacity building assistance), service providers, medical providers, and the consumer-at-large.

[2] Taveras, S. Consultation on Capacity Building Assistance for HIV Prevention Programs report. Capacity Building Branch, CDC. Buckhead, GA: August 25-26 2003.
[3] Taveras, S. Consultation on Capacity Building Assistance for HIV Prevention Programs report. Capacity Building Branch, CDC. Buckhead, GA: August 25-26 2003.

Goal 4: Assistance to build capacity must be timely, culturally competent, and technically proficient.

These characteristics are essential to meet the needs of the recipient and to foster complementary modalities and activities that can ensure the new capacity is sustainable and can be adapted to meet future challenges.

CDC's capacity building program activities are intended to have measurable outcomes that align with one or more of the performance goal(s) for CDC's National Center for HIV, STD, and TB Prevention:

- To strengthen the capacity to develop and implement effective HIV prevention interventions;
- To increase the proportion of HIV-positive individuals who know they are infected;
- To increase the proportion of HIV-positive people who are linked to appropriate prevention, care, and treatment services; and
- To decrease the number of persons at high risk for acquiring or transmitting HIV infection.

Capacity Building Assistance and CDC

CDC established a capacity building assistance strategy within DHAP's Capacity Building Branch. This strategy is designed to help individuals, organizations, and communities improve core competencies that are essential in delivering and sustaining effective HIV prevention interventions and services.

CDC's capacity-building strategy involves the use of six key delivery mechanisms:

1. **Information transfer.** A capacity-building mechanism in which the provider collects, packages, and disseminates information to a recipient.
2. **Skills building.** Capacity-building activities that focus on developing and increasing skills and abilities to provide HIV prevention services.
3. **Technical consultation.** The delivery or provision of advice to key personnel on how to accomplish a task or series of tasks with the intent that the task(s) will be carried out by the recipient.
4. **Technical services.** Guidance on programmatic and policy-related issues necessary for an effective approach to HIV/AIDS prevention.

5. **Delivery and provision.** The implementation of technical assistance programs including conferences, trainings, and advisory sessions.

6. **Technology transfer.** The process of facilitating access to products, methodologies, or techniques to increase capacity. Technology transfer focuses on transferring skills and developing the ability to locate/identify pertinent data to evaluate and implement programs.

Of critical importance to the success of HIV prevention-realted capacity building are four broad components that must be integrated in planning and capacity-building activities. These include: cultural competence, problem identification, strategy development and implementation, and monitoring and evaluation.

What is "Cultural Competence?"

Cultural competence is the demonstration of sensitivity, knowledge, and skills around cultural issues. It ensures effective communication, trust, and credibility of the provider with the consumer. It also ensures that services are provided in an accessible and acceptable manner, and that outcomes are based on considerations of cultural facilitators and barriers which can be personal, interpersonal, institutional, or environmental.

What is "Problem Identification?"

Properly identifying the problem depends heavily on the capacity-building assistance provider as well as the recipient of the services. Problems can be identified by various stakeholders such as the capactiy-building assistance provider, the CDC project officer, or a recipient organization's executive director and staff, consumers, and advisory boards. The effectiveness of the services provided depends on the problem assessment as well as the quality and quantity of the information provided by the recipient. Methods of identifying and assessing the needs and problems of a community most often entail conducting a needs assessment and analyzing epidemiological data.

What is "Strategy Development and Implementation?"

This is most often approached by developing a capacity-building program logic model that describes the main elements of an overall capacity-building strategy and how these work together to build the capacity of the intended organizations or communities. The model consists of sequential steps leading to desired outcomes. Other critical aspects of strategy development and implementation in

the context of the CDC capacity-building assistance framework are curriculum development, general materials development, skills building, maximizing effective communication, and developing performance indicators.

What is "Monitoring and Evaluation?"

Monitoring and evaluation are activities used to determine if a program is producing the desired results, and if the results are equally valuable to the capacity-bulidng assistance provider, the recipient organization, and CDC. For an organization to assess the success of its programs and related programmatic activities, it is critical that monitoring and evaluation mechanisms are in place from the planning phase to the outcomes. Each evaluation component is designed to answer specific programmatic questions.

As part of the capacity-building strategy, CDC-funded assistance must support CDC's HIV prevention performance goals and existing prevention infrastructure and interventions. CDC plays a pivotal role in providing coordination, guidance, and training to ensure consistency of content and quality of service.

- Diffusion of Effective Behavioral Interventions for HIV Prevention (DEBI);
- Technical assistance across a range of issues, such as HIV prevention community planning, programs for injection drug users, and program evaluations; and
- Training programs for health professionals, health departments, CBOs, and other service providers and practitioners.

Healthy People 2010 and Capacity Building

Building program service capacity is a goal of Healthy People 2010 as laid out by the U.S. Department of Health and Human Services (DHHS). For the first time, *Healthy People 2010*—a set of federal health objectives to be used by states, communities, professional organizations, and others to achieve improved health outcomes by 2010—has targeted infrastructure to ensure capacity to provide essential public health services at federal, state, and local levels. The infrastructure objectives do not target specific health outcomes; instead they focus on building increased capacity to deliver public health services.

Healthy People 2010 documents the importance of program service capacity and infrastructure. HIV prevention and care services require professionals who are skilled in cross-cutting and highly technical specialties; public health agencies that have the capacity to assess and respond to community needs; and community service providers who are competent in proven outreach, intervention, and evaluation approaches. The public health infrastructure includes public health organizations, workforce, data, information systems, and research that identify opportunities to improve health, strengthen information systems and organizations, and make more effective and efficient use of resources.[4]

Cost Effectiveness and Capacity Building

DHHS reports that nearly 10% of their total HIV/AIDS spending is devoted to prevention because investing in prevention pays. Researchers estimate that the cost of lifetime treatment for a person with HIV now averages about $155,000. Estimates are that 40,000 people are infected yearly, resulting in an annualized cost of more than $6 billion. The cumulative cost of lifetime treatment increases by more than $6 billion yearly if the number of infections stays steady, as it has over the last decade. In the last five years alone, an estimated 200,000 people have been infected with HIV. Treating them over the course of the rest of their lives will cost the nation $31 billion. At CDC's current budget level, only 4,000 infections must be prevented annually to actually result in cost savings, and only 1,300 must be prevented for the investment to be cost-effective. Most researchers agree that the number of infections actually prevented every year far exceeds the cost-savings level.[5]

[4] U.S. Department of Heath and Human Services. "With Understandin and Improving Health and Objectives for Improving Health." Healthy People 2010. 2nd ed, 2 vols. U.S. Government printing Office. Washington, DC: November 2000
[5] Centers for Disease Control and Prevention (CDC). *HIV Prevention Strategic Plan Through 2005*. CDC. Washington, DC: 2001.

HIV Prevention: A Sound Investment

Prevention accounted for $820 million of DHHS' total fiscal year 2000 HIV/AIDS budget of nearly $8.5 billion. Treatment accounted for the majority of DHHS' total HIV/AIDS spending. Together, the Centers for Medicare & Medicaid Services and the Health Resources Services Administration , which funds the Ryan White CARE Act, accounted for 65% of the annual budget. The next largest item was the National Institutes of Health's research budget at just over $ 2 billion —or roughly a quarter of DHHS's total HIV/AIDS budget. Clearly, prevention and research can contribute significantly to reducing the annual outlay for care and treatment. "Prevention investments make sound fiscal sense."

To date, the investment in prevention has mostly targeted communities hardest hit by the epidemic. Several of these communities and their institutions (many of which are younger than the AIDS epidemic itself) are receiving increased funding to help them in the fight against AIDS. However, funding alone does not ensure that at-risk or HIV-positive individuals receive all the services they need. As funding increases, so too does the need for assistance in basic processes to ensure that funds are used effectively and HIV prevention interventions are conducted effectively. Many organizations that are working to quickly institute HIV prevention services need to balance this urgent need against the need to build and sustain capacity that will allow them to meet a host of organizational challenges. For example, organizations that once existed solely on a volunteer basis, with minimal financial support, or as a secondary arm of another project may now have to deal with all of the processes and functions characteristic of larger organizations, such as human resources, finance management, organizational governance, fundraising, and public relations.

A key CDC program, which has funded CBOs directly or through health departments since 1990, provides a good illustration of how the level of funding and capacity are not always correlated. From 1989-1997, the odds of CBOs continuing to receive CDC funding over the 10-year period were less than 1 in 10. The odds of a CBO being selected in any competitive cycle range ranged from 1 in 3 in 1990, to approximately 1 in 5 in 1997. Sixty-seven organizations originally funded in 1989 did not successfully compete for funding—15 of these are no longer listed in telephone assistance directories, and are likely closed. Of those still operating, most have had to substantially reduce services and some no longer provide any HIV/AIDS services.[7]

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[6] Ibid
[7] West, G.R., et al. Building, Stengthening, and Sustaining Community Infrastructure and Organizational Capacities for HIV Prevention

Parties Involved in Capactiy Building and HIV Prevention

Although CDC is the lead federal agency charged with preventing HIV infection, no single agency can accomplish the task alone. CDC continues to work collaboratively with other agencies and organizations to enhance the effect of their collective work and to avoid duplication of effort. Many elements of effective capacity building are already being addressed through complementary agencies and resources that are vital to building capacity to prevent HIV transmission on the individual, organizational, and community levels. To accomplish that mission, and to meet other national goals for public health, such as those included in *Healthy People 2010*, CDC works with an array of domestic partners. Partners within DHHS are listed below.

- **Health Resources and Services Administration (HRSA).** HRSA provides health resources for medically underserved populations, works to reduce disparities in health status and outcomes, supports a nationwide network of community and migrant health centers and primary care programs for the homeless and residents of public housing, builds the health care workforce and provides AIDS training for health care providers through the AIDS Education and Training Centers (AETCs) throughout the United States, and provides services to people living with HIV/AIDS through Ryan White CARE Act programs.
- **Indian Health Services (IHS).** IHS provides services, including HIV/AIDS prevention, care, and treatment, to nearly 1.5 million American Indians and Alaskan Natives.
- **Office of Minority Health (OMH).** OMH's mission is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. It coordinates the DHHS Minority HIV/AIDS Initiative, which provides funds to CBOs, faith-based groups, research institutions, minority-serving colleges and universities, health care organizations, state and local health departments, and correctional institutions to help them address the HIV/AIDS epidemic within the minority populations they serve.
- **Substance Abuse and Mental Health Services Administration (SAMHSA).** SAMHSA addresses capacity-building needs related to substance abuse prevention, addiction treatment, and mental health services.

In addition to the federal partners mentioned above, CDC works numerous partners at the state and local level. These partners include:

- State and local health and education departments;
- HIV prevention community planning groups;
- Community-based organizations;
- Professional organizations of health care providers;
- Academic Institutions;
- The private sector;
- Faith-based groups;
- Foundations; and
- Not-for-profit groups.

Many of these organizations receive funding from CDC to carry out various activities. For example, CBOs, and faith-based and not-for profit groups are funded to carry out interventions targeting specific populations. In the past, CDC worked with the private sector to promote the adoption of workplace policies relating to HIV and to encourage employee education programs addressing HIV. Professional organizations have been instrumental in educating their members about HIV, from basic information about HIV/AIDS to information on preventing occupational HIV transmission and training to enhance the provision of HIV-related services.

State and territorial health departments have an especially important role in the nation's response to HIV. State health department HIV/AIDS programs have programmatic responsibility for administering HIV/AIDS health care, prevention, education, and supportive services programs funded by state and federal governments. Since 1988, CDC has provided HIV prevention resources to the 50 states, the District of Columbia, eight U.S. territories, and six directly funded cities. The health departments in each of these 65 jurisdictions implement comprehensive HIV prevention programs including counseling, testing, partner counseling, and referral services; health education and risk reduction services; community planning; capacity building; public information programs; and prevention research and program evaluation. State health agencies also conduct HIV/AIDS epidemiology, surveillance, and seroprevalence activities, which provide data critical to targeting the delivery of HIV prevention, care, and treatment.

Local health departments are also vital to the nation's response to the HIV epidemic. Many receive federal and state funding to conduct HIV prevention activities. They also help to coordinate and strengthen activities carried out by other entities at the local level.

A MULTI-DIMENSIONAL APPROACH
TO CAPACITY BUILDING

Chapter 2 addresses the multi-dimensional aspects of the capacity-building process and includes a discussion of community capital, dissemination and diffusion, and the role of cultural competency in capacity building. This chapter provides an overview of:

- Elements of capacity building;
- Dissemination, diffusion, and capacity building;
- Evaluation capacity building;
- Cultural competency; and
- An overview of the parties involved in capacity building and HIV prevention.

Elements of Capacity Building

"Capacity building" is a term that has been used in various professional arenas for some time, but it began to be applied to public health and HIV prevention efforts only in the 1990s. It has now become a "buzzword" used by many individuals and agencies involved in HIV prevention efforts domestically and around the world. In the field of health promotion, capacity building refers to enhancing the ability of an individual, organization, or a community/environment to address their health issues and concerns.

Capacity building is most effective when approaches are tailored to meet the specific needs of the recipient. Many different capacity-building techniques may be used over a period of time to meet the recipient's needs. Both the techniques used and the time it takes to successfully complete the process are dependent on the intended outcome(s). It is essential that recipients of capacity building participate in identifying these needs.

Capacity building is a critical component of the larger imperative that HIV prevention programs be grounded in a robust, scientific basis. The need to improve HIV prevention's scientific foundation by incorporating a broader range of theoretical approaches and models was first raised by the National Commission on AIDS in its 1993 review of behavioral theories, and it has become increasingly clearer since. In its 2001 report, *No Time to Lose: Getting More from HIV Prevention*, the Institute of Medicine stated that there is a link between the effectiveness of prevention efforts and the capacity of service providers.

A major tenet of the Centers for CDC's HIV prevention capacity-building efforts is to improve the scientific basis of program design, implementation, and service provision. The remainder of this chapter examines how various types of capacity-building activities can improve the scientific basis of prevention programs. Due to a dearth of research and scientific evidence surrounding capacity building and HIV prevention activities, this document will provide insight on three areas fundamental to the successful implementation of capacity building at the individual, organizational, and community/environmental levels:

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[1] Hawe, P., Noort M., King L., Jordens C. Multiplying Health Gains: The Critical Role of Capacity-Building within Health Promotion Programs. *Health Policy*. 1997 Jan; 39 (1): 29-42

1. Dissemination and diffusion, including technology transfer and training;
2. Evaluation and outcome indicators; and
3. Cultural competency and health promotion.

Dissemination, Diffusion, and Building Capacity

Building the capacity of communities to adopt and implement HIV prevention innovations (e.g., best practices, evidence-based prevention interventions) is critical. Dissemination and diffusion of innovations in HIV prevention refer to the process by which an innovation is transferred through specified communication channels among members of a social system that can include CBOs. [2, 3] Although the terms "dissemination" and "diffusion" are often used interchangeably, dissemination is generally considered to refer to relatively limited activities that include providing information and persuading others about the value of an innovation. Diffusion is a broader concept. The science of diffusion of innovations incorporates a five-stage, step-by-step process to guide and build the capacity of communities to adopt and implement innovative, more effective prevention programs.[4]

Stage 1. Communities become aware of and learn about the innovation.

This can occur through various promotional activities (e.g., satellite broadcast, dissemination of fact sheets, conference presentations). Community organizations also need to acquire "how-to" and "principles" knowledge, in which they learn how to use the innovation correctly. "How-to" knowledge capacity can be built through providing well-designed trainings that guide community organizations through the content and necessary skills of the innovation. "Principles" knowledge concerns the underlying principles and/or theory of the innovation, and communities need this knowledge to appropriately adapt or tailor the innovation to their own needs. Both training and technical assistance can develop capacity to apply principles and knowledge by having communities explore how to apply a prevention innovation to their unique context.

Stage 2. Communities build capacity by addressing the affective domain.
During this stage, known as persuasion, communities may need support and guidance in considering the extent to which the innovation is more advantageous (e.g., financially, convenient in

[2] Rogers, E. M. "Diffusion Theory: A Theoretical Approach to Promote Community-level Change" in J. L. Peterson & R. J. DiClemente (eds) Handbook of HIV Prevention. Kluwer Academic Press. New York: 2000.
[3] King, L., Hawe, P., & Wise, M. From Research into Practice in Health Promotion: A Review of the Literature on Dissemination. National Centre for Health Promotion. Australia: 1996.
[4] Rogers, E. M. Diffusion of Innovations, 4th ed. The Free Press. New York: 1995.

practice) than current programs. Communities also need to consider whether the innovation is compatible with existing values, needs, past and current experiences; can be understood and is not overly complex; and can be tried out on a limited basis. Finally, communities need to understand that results from using the innovation will be observable.

Stage 3. Communities decide whether or not to adopt the innovation. At this point, capacity building could help communities engage stakeholders to consider the innovation's advantages and any disadvantages as well as operational issues. If the innovation is adopted, the community moves to carry out the innovation.

Stage 4. Communities try out the innovation. Integrating the innovation into existing services and program operations may be a particular concern.[5] The adopting organization may need guidance on how to confirm that the innovation is appropriate and working effectively.[6]

Stage 5. Communities continue to pursue the innovation through "adoption."   Building capacity to maintain the innovation becomes of paramount importance at this point. The adopting organization will likely need support and technical guidance to institutionalize the innovation within their mission and goals, standard operations procedures, staffing, and budget. They may also need help with adapting the innovation to suit their unique circumstances and needs. Community mobilization (e.g., leadership development, coalition building) and enhancement of current prevention services may need to occur. Support from an organizational "champion" of the innovation and administrators will help ensure the opportunities to sustain the innovation.[7]

Building the capacity of local communities to adopt and use HIV prevention innovations may pose unique challenges. The prevention innovation needs to be accessible, which means that necessary materials must be available in a user-friendly format for communities. The financial constraints of many HIV prevention community organizations must be accommodated, perhaps by providing training and technical assistance at low or no cost to them.

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[5] O'Donnell, L., et al. "The Role of Technical Assistance in the Replication of Effective HIV Interventions." AIDS Education and Prevention 12, supplement A. 2000.

[6] Rogers, E. M. Diffusion of Innovations, 4th ed. The Free Press. New York: 1995

[7] Kraft, J. M., et al. A Technology Transfer Model for Effective HIV/AIDS Interventions: Science and Practice. 2000

Many staff members at CBOs are likely to require substantial help to develop the skills necessary to institute and manage prevention innovations that are often more complex and resource-demanding than their current programs. This need can be addressed with well-designed, comprehensive training and the provision of individualized technical assistance that can be targeted to specific diffusion stages and processes. Staff resistance may occur, based on concerns about the credibility of the innovation or from discomfort in using an unfamiliar set of practices (i.e., the innovation). Thus, organizational attitudes and perceptions need to be examined and addressed. Securing buy-in and support from senior staff within a CBO and from key stakeholders is important in ensuring that capacity-building activities are effective. Communities may require support and guidance to address public attitudes (the external environment) about an HIV prevention innovation, especially if it is explicit in content and targets marginalized or most at risk populations (e.g., commercial sex workers, drug users, men who have sex with men).[8]

Although training and technical assistance represent central and potentially powerful capacity-building strategies, other strategies also should be considered. These can include:

- Communicating about the innovation through print resources (e.g., promotional fact sheets, newsletters);
- Using information technologies (e.g., video presentations, websites);
- Developing or revising policies to support new, more effective prevention programs and other innovations;
- Creating administrative arrangements within an organization or across organizations; and
- Funding incentives by federal, state, and other organizations.

Evaluation Capacity Building

Building the capacity of communities to evaluate their HIV prevention programs is critical. CBOs are increasingly being expected to justify their program practices and demonstrate that their programs produce positive results. The existing evaluation capacity of community programs is generally perceived to be low.

[8] Valdiserri, R. O. "Technology Transfer: Achieving the Promise of HIV Prevention" in J. L. Peterson & R. J. DiClemente (eds) Handbook of HIV Prevention. Kluwer Academic Press. New York: 2000.

Evaluation capacity building is a context-dependent, intentional system of guided processes and practices. These practices are intended to generate and sustain quality program evaluation and program practices.[9] The goal of evaluation capacity building within HIV prevention is for local communities to acquire the knowledge, skills, commitment, and human and technical resources to plan and implement program evaluation. Ideally, these evaluations would provide accurate, practical, and program-relevant information from which meaningful program improvement efforts can be made.

Building the evaluation capacity of communities can provide many benefits, some of which are outlined below.

- **Evaluation can be used to maximize effectiveness of community HIV programs.** Formative evaluation can be used by communities to more effectively design prevention programs and materials, including pilot testing programs. Process evaluation and monitoring can be used to track program operations, from which well-informed adjustments to program processes can be made. Outcome monitoring and evaluation can then be used to acquire information on initial, intermediate, or even long-term program outcomes. Linking formative, process, and outcome evaluation can provide program personnel with a continuous feedback loop of information that leads to continuous program improvement.

- **Evaluation increases knowledge and practical understanding about program operations and effects.** This, in turn, increases program personnel's feelings, attitudes, and perceptions of mastery and efficacy in addressing HIV/AIDS prevention, improving work product and promoting a more positive work environment.

- **Increased evaluation capacity can be used to satisfy the reporting requirements of funders, and to acquire additional funding.** Community programs that can demonstrate an established, effective evaluation infrastructure that systematically and routinely provides data from which good program decisions are made are likely to be viewed positively by funders.

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[9] Stockdill, S. H., Baizerman, M., & Compton, D. W. "Toward a Definition of the Evaluation Capacity Building Process: A Conversation with the Evaluation Capacity Building Literature." New Directions for Evaluation, 93, 7-25. 2002.

- **Communities with evaluation capacity are well-positioned to disseminate information to the general public and interested stakeholders about their HIV prevention programs.** The capacity to provide such information is likely to enhance the visibility, status, and reach of the community's prevention efforts, and demonstrate program effectiveness and support for continued funding and resources.[10, 11]

Efforts to build and support evaluation capacity can be greatly facilitated by grounding the work in theoretically accepted, practical, and program-relevant approaches, such as utilization-focused evaluation, participatory evaluation, and empowerment evaluation.[12, 13] HIV prevention program staff should be fully involved and take ownership in all aspects of the evaluation, from identifying evaluation questions to formulating the evaluation design, developing measures, collecting and analyzing data and, perhaps most importantly, interpreting results and articulating implications for programs.

From an operational perspective, evaluation capacity building should consider the *CDC Framework for Program Evaluation in Public Health*.[14] This framework provides a step-by-step process and a set of standards from which prevention programs can plan and conduct evaluations. Adhering to the framework's process and standards can ensure that opportunities exist to improve the evaluation component of prevention programs, and specific framework steps have been cited in the literature as necessary to sustain evaluation.

The CDC framework also stresses that multiple evaluation methods and sources of information should be considered by program personnel. Efforts to build programs' capacities can ensure that local programs use readily available sources of evidence (e.g., key informants, non-participants, surveillance summaries) as well as adopt and use other data collection methods (e.g., semi-structured interviews, structured discussion groups which reflect focus group methods) that can be inserted into existing program operations without much additional burden.

[10] National Community AIDS Partnership. Evaluating HIV/AIDS Prevention Programs in Community-Based Organizations. National Community AIDS Partnership. Washington, DC: 1993.
[11] Windsor, R., et al. Evaluation of Health Promotion, Health Education, and Disease Prevention Programs, 2nd edition. Mayfield Publishing. Mountain View, CA: 1994.
[12] Patton, M. Q. Utilization-Focused Evaluation, 3rd edition. Sage Publications. Thousand Oaks, CA: 1997.
[13] Fetterman, D. M., Kaftarian, S. J., & Wandersman, A. Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability. Sage Publications. Thousand Oaks, CA: 1996.
[14] Centers for Disease Control and Prevention (CDC). Framework for Program Evaluation in Public Health. MMWR 1999; 48 (No. RR-11).

Evaluation capacity building occurs often with the involvement of personnel who possess a high level of training and expertise in evaluation and research methods. Those with such expertise need to act as facilitators, collaborators, and resources, rather than as personnel who impose and control an evaluation process. They should reflect the utilization-focused, participatory, and empowering evaluation principles described above. Direct personal experience and a solid understanding of prevention programs at the community level, including the realities of how programs operate and constraints under which programs function, are highly desirable.

Strong interpersonal skills, a sincere desire to work with program staff and to make a difference in HIV prevention, and an eagerness to educate and help communities with a non-judgmental, patient approach are attributes that can add greatly to evaluation capacity-building efforts. Personnel charged with building evaluation capacity also can design and use tools that facilitate program staff to develop, implement, and analyze evaluation of services provided. Furthermore, capacity building should include workshops and training sessions that use Adult Learning Principles, and a highly organized set of learning activities to guide program personnel through the process of planning their own evaluations.

A set of indicators can be used to assess the extent to which local prevention programs have attained the capacity to adequately evaluate their programs. Some possible indicators are listed below.

- **Allocation of funds.** Program budgets reflect designation of specific funds to cover the costs of evaluation. At least 5% of total funds, and more realistically a percentage between 10% to 20%, is allocated to effectively address evaluation needs.

- **Inclusion in an organization's operating principles.** The organization's mission statement, policies, and/or programmatic goals include evaluation as a key, necessary program component.

- **Integration within program operations.** Most of the organization's programs include and integrate evaluation processes, both in written program descriptions and in actual practice.

- **Involvement of stakeholders.** Key stakeholders, including various program staff, are involved in evaluation planning and selected implementation activities (i.e., program staff would not necessarily be expected to implement every evaluation methodology, but would assist, support, and comply with specific protocols).

- **Attitudes and perceptions.** Program personnel's attitudes, feelings, and perceptions about the value of evaluation will ideally be positive and constructive. A willingness and openness to accept and use both positive and less positive evaluation results are part of the process.

- **Access to evaluation expertise.** The program should already have access to evaluation personnel, either within or outside of the organization, that understand the organization's prevention programs, possess a personal style that engages easily with program personnel, and employ a participatory, utilization-focused evaluation approach.

The extent to which an organization's programs reflect the presence of these indicators will vary, and will need to be assessed in-depth. For example, an organization may integrate evaluation with program operations (Indicator 3) only with process monitoring, while another organization might employ both process and outcome evaluation methods. Thus, not only can organizations use the indicators as a measure to assess their current evaluation capacity, but also as a tool to guide their ongoing evaluation capacity-building efforts.

Cultural Competency—A Critical Capacity

Simply put, cultural competency is the development of sensitivity, knowledge, and skills around cultural issues. Becoming culturally competent is a journey, and understanding a culture enables one to help people relate to each other as individuals. It is important to remember that cultural competency is not a panacea. Rather, being culturally competent means having a set of skills and a body of knowledge that allows effective communication with recipients of capacity building assistance and other key stakeholders, by bridging cultural differences and understanding them.

> According to *Merriam Webster's Dictionary*, culture is "the integrated pattern of human knowledge, belief, and behavior that depends upon man's capacity for learning and transmitting knowledge to succeeding generations," or "the customary beliefs, social forms, and material traits of a racial, religious, or social group."

One way to understand cultural identity is by looking at the age, gender, religion, physical and mental abilities and qualities, geography, race, ethnicity, and sexual orientation of a person or group—these are the attributes that define a core cultural identity. But culture is defined by more than these demographic factors. A person is also defined by the values, traditions, and norms he or she shares with others, as well as by shared customs, arts, history, folklore, and institutions. These factors determine how people experience their world. Marital status, parental status, work experience, and socioeconomic status also influence a person as a cultural being.

Building capacity around cultural competency takes time and is a dynamic process. A one-day training program in cultural competence simply will not be effective because the process of becoming culturally competent requires learning many new skills. To become culturally competent, service providers must:

- Learn to value the diversity of a community or group;
- Have the capacity for cultural self-assessment;
- Be conscious of the dynamics inherent in the interaction between cultures;
- Recognize institutionalized cultural knowledge; and
- Be willing to adapt service delivery to reflect an understanding of cultural diversity.

To successfully achieve HIV prevention goals and other health care outcomes in a culturally competent way, successful health care organizations and other HIV prevention programs must be able to:

- Understand the diverse cultures represented in the communities they serve;
- Recognize the social, political, and economic climates of communities within a cultural context;

- Honor the inherent ability of communities to recognize their own problems and intervene appropriately on their own behalf;
- Establish and maintain trust among community partners when a history of adversarial relationships may exist;
- Effectively and equitably share limited resources among competing needs;
- Share power and ensure that the contributions of community partners are valued and respected; and
- Use various communications modalities and technologies to provide community partners with full and timely access to information.

Becoming culturally competent enables those who receive capacity building assistance to provide high-quality HIV prevention services and improve outcomes of those critical activities. As with all capacity-building support, the journey to cultural competence has no single path. Individuals and organizations embark on the journey at different points of departure and have different estimated times of arrival for achieving their goals. Most service organizations and their personnel are at various levels of awareness and stages along the cultural competency continuum. The conceptual framework of the cultural competence model that is used by the National Center for Cultural Competence embraces the following tenets.

Tenet 1: A defined set of values, principles, structures, attitudes, and practices is inherent in a culturally competent system of care.

Tenet 2: Cultural competence at both the organizational and individual levels is an ongoing developmental process.

Tenet 3: Cultural competence must be incorporated systematically at every level of an organization.

The next two pages provide a checklist that may be used, or adapted, to help consider incorporating culturally competent practices into an organization and—eventually—institutionalizing them.
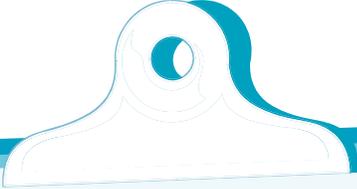
CULTURALLY COMPETENT PRACTICES:
a checklist of
things to consider

☐ Convene a cultural competence committee, work group, or task force within your organization. This group should include members who represent the policy making, administration, service delivery, and consumer levels within the organization and the community-at-large, and should reflect the diversity of the organization. This group will serve as the primary body for planning, implementing, and evaluating organizational cultural competence initiatives.

☐ Under the guidance of this work group, ensure that the organization's mission statement commits to cultural competence as an integral component of all HIV prevention activities. The mission statement should include language identifying the principles, rationale, and values for culturally competent health care service delivery.

☐ Identify the racially, ethnically, culturally, and linguistically diverse groups that are served by your organization or in your community. Assess the degree to which your programs are accessible to members of these groups and the level of satisfaction with the services received.

☐ Develop collaborations with consumers, CBOs, faith-based organizations, and informal networks of support to develop approaches for delivering HIV prevention health messages in a culturally-competent way. This process can help you identify adaptations you need to make to provide services that are responsive to the specific needs of your consumers.

☐ Conduct a comprehensive organizational cultural competence self-assessment. Determine which approaches will best match the needs of your organization. Use the results to begin development of a long-term plan, with measurable goals and objectives. This plan should incorporate cultural competence into all aspects of the program.

☐ Conduct a staff assessment to determine what training they need to provide HIV prevention-related services in a culturally competent manner.
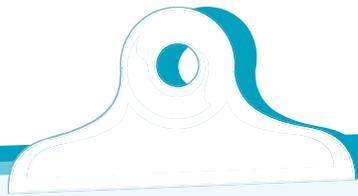
CULTURALLY COMPETENT PRACTICES:
a checklist of
things to consider... continued

☐ Convene focus groups, or use other approaches, to solicit consumer input on professional or staff development needs related to the provision of culturally competent care.

☐ Establish a dialogue or means of networking with other organizations that are also concerned with HIV prevention and related health issues and that have started to make the journey toward cultural competence. Adapt their processes, policies, and procedures to meet your organization's needs. Encourage partnerships and establish mechanisms to share training and resources at the local, state, and regional levels.

☐ Convene informal brown-bag lunches or other facilitated forums to engage staff in discussions and activities that allow them to explore their attitudes, beliefs, and values related to cultural diversity and cultural competence.

☐ Identify and include budgetary expenditures in each fiscal year for resource and professional development, through staff participation in conferences, workshops, colloquia, and seminars on cultural competence, ideally in the fields of HIV prevention and public health.

☐ Gather and categorize a library of resource materials related to HIV prevention, cultural diversity, cultural competence, and capacity building.

☐ Develop a network of natural helpers, community leaders, and others who have knowledge of the culturally diverse groups served by your organization.

☐ Establish relationships with advocacy organizations concerned with HIV prevention and related issues. Solicit their involvement in the design, implementation, and evaluation of primary and community-based health care service delivery initiatives at the local, state, regional, and national levels.

HIV PREVENTION
CAPACITY BUILDING PROGRAMS AT CDC

3

Chapter 3 highlights the Centers for Disease Control and Prevention's (CDC) initiative, Advancing HIV Prevention: *New Strategies for a Changing Epidemic*, and its relationship to capactiy building. This chapter will focus specifically on providing an overview of:

- The Advancing HIV Prevention initiative;
- The Advancing HIV Prevention (AHP) initiative;
- Strategies of the AHP initiative; and
- The relationship between the Advancing HIV Prevention initiative and capacity building.

Advancing HIV Prevention

An estimated 850,000 to 950,000 people are living with HIV in the U.S. and a quarter of these people are unaware of their HIV status. Although the annual number of AIDS cases declined by 38% between 1995 and 1998 and deaths from AIDS declined by 63%, since 1998, the number of reported AIDS cases and AIDS-related deaths have remained stable. As a result, CDC is refocusing part of its HIV prevention activities in an effort to meet its overarching HIV prevention strategic plan national goal to reduce the number of new HIV infections in the U.S. from an estimated 40,000 to 20,000 per year by 2005, particularly focusing on racial and ethnic disparities in new infections.

On April 17, 2003, CDC, in partnership with other DHHS agencies, other government agencies, and NGOs, announced a new approach to HIV prevention strategies in the United States. The AHP initiative emphasizes the importance of helping individuals who are HIV-positive but unaware of their serostatus to learn their HIV status and get into appropriate care and prevention services. The initiative was outlined in the April 18, 2003 *Morbidity and Mortality Weekly Report* (MMWR) and activities began in the fall of 2003. [1]

The AHP initiative is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for those living with HIV.[2] The initiative emphasizes the use of proven public health approaches to reduce the incidence and the spread of disease. Principles commonly applied to health promotion and disease prevention will be used, including routine screening, identification of new cases, partner notification, and an increase in the availability of sustained treatment and prevention services for those people who are infected.[3]

[1] Centers for Disease Control and Prevention (CDC). 2003. Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States, 2003. MMWR.
[2] Janssen, R.S., Holtgrave, D.R., et al. 2001. Advancing HIV Prevention: New Strategies for a Changing Epidemic. Slide Presentation, April 17, 2003.

A variety of catalysts led CDC to reassess and refocus its HIV prevention activities and launch AHP. These include:

- A stabilization of HIV-related morbidity and mortality;
- Concerns about possible increases in HIV incidence;
- A dearth of comprehensive data to measure transmission within the U.S. population;
- Large numbers of people who are living with HIV (180,000-280,000 people) who do not know they are infected;
- Evidence suggesting that people reduce their risky behaviors when they learn they are infected; and
- The effect of rapid HIV diagnostic technology on testing behaviors.[4]

Studies have shown that an emphasis on improving access to testing and providing prevention and care services for persons infected with HIV can reduce new infections and lead to a reduction in HIV-associated morbidity and mortality.[5] In addition, simplifying perinatal and other testing procedures also can lead to a more effective use of resources provided by CDC to prevent perinatal and other HIV transmission.[6]

Advancing HIV Prevention Initiative Strategies

The AHP initiative consists of 4 key strategies.

Strategy 1. Make voluntary HIV testing a routine part of medical care.

CDC is working with professional medical associations and other partners to ensure that all health care providers include HIV testing, when indicated, as part of routine medical care on the same voluntary

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[3] Centers for Disease Control and Prevention (CDC). 2003. Advancing HIV Prevention: New Strategies for a Changing Epidemic-United States, 2003. MMWR.

[4] Ibid.

[5] Centers for Disease Control and Prevention (CDC). Adoption of Protective Behaviors among Persons with Recent HIV Infection and Diagnosis-Alabama, New Jersey, and Tennessee, 1997-1998, MMWR vol 49 (2000). HIV Prevention Strategic Plan Through 2005. Advancing HIV Prevention: New Strategies for a Changing Epidemic, MMWR (2003). Late Versus Early Testing of HIV -1-6 Sites, MMWR (2002-2003).

[6] Ibid.

basis as other diagnostic and screening tests. CDC will promote the adoption of simplified voluntary testing procedures that do not require prevention counseling before testing, and will fund demonstration projects in health care settings that have high HIV prevalence.

Strategy 2. Implement new models for diagnosing HIV infections outside medical settings.
With CDC funding, CBOs will pilot new models of counseling, testing, and referral (CTR), particularly in non-medical settings, for diagnosing and referring individuals for treatment and prevention services. Because 8-39% of partners tested in studies of partner counseling and referral services (PCRS) have been found to have previously undiagnosed HIV infection, CDC also will increase its emphasis on PCRS.[7] CDC will institute these new models through health departments and CBOs.

Strategy 3. Prevent new infections by working with individuals diagnosed with HIV and their partners.
On July 18, 2003, in collaboration with Health Resources and Services Administration, the National Institutes of Health, the HIV Medical Association, and the Infectious Diseases Society of America, CDC published *Recommendations for HIV Prevention in Care Settings*. CDC is working with professional associations to disseminate these new recommendations to primary care providers and infectious disease specialists and will assess their integration into medical practice. CDC will also conduct demonstration projects with state and local health departments to provide HIV prevention case management (PCM) to their clients. PCM is conducted when HIV-positive individuals are offered targeted prevention services to reduce the transmission of HIV to HIV-negative, drug-using and sexual partners. Finally, CDC will increase emphasis on partner notification and will support proven models of partner notification, including offering rapid HIV testing to partners, and using peers to conduct partner prevention counseling and referral.

Strategy 4. Decrease perinatal HIV transmission rates.
CDC will work with existing and newly identified partners to promote routine, voluntary prenatal testing, with the right of refusal. Guidance for using rapid tests during labor and delivery, or postpartum, has been developed, and CDC will promote recommendations for routine HIV testing of all pregnant women. As

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[7] Golden, M.R. HIV Partner Notification: A Neglected Prevention Intervention [editorial]. Sex Transm Dis 2002;29:472-5.

an extra precaution, CDC also will promote the routine screening of any infant whose mother was not previously tested or her serostatus is unknown. CDC will monitor the integration of routine prenatal testing into medical practice.[8]

CDC allocated $35 million to the AHP initiative in FY 2003. This included $13 million that had been appropriated for domestic HIV prevention. Nearly 90% of the funds will be directed to new activities at state and local health departments and CBOs. Additionally, $97 million of the monies provided to state health departments and $13 million provided to CBOs for HIV diagnosis and referral for medical and preventive care services will support AHP activities. In total, $145 million of the $802 million that CDC directs to domestic HIV prevention will support AHP activities.[9]

Advancing HIV Prevention Initiative and Capacity Building

Since the introduction of the AHP initiative, questions have been raised about what new capacities providers and recipients will need to develop. The new CDC initiative requires changes in program activities, partners, and target populations. The changes will occur at levels that affect the community planning groups (CPGs), CBOs, national and regional organizations, as well as state and local health departments. In addition, new individuals and organizations must be identified to assist with capacity-building endeavors.

Through the AHP initiative, HIV prevention capacity-building efforts are being directed to CBOs that are directly funded by CDC and that work with four primary populations:

1. Persons who are HIV-positive;
2. Sex and needle-sharing partners of persons who are HIV positive;
3. Persons who are at high risk of HIV infection; and
4. Individuals unaware of their HIV serostatus.

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[8] Centers for Disease Control and Prevention (CDC). 2003. Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States, 2003. MMWR.
[9] Centers for Disease Control and Prevention (CDC). 2003. Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States, 2003. MMWR.

Critical segments of these populations are people of color, men who have sex with men, youth, women, incarcerated populations, migrant workers, and others at increased risk for HIV infection.

Within the framework of AHP, capacity building must be comprehensive and requires conducting a needs assessment, community mapping, and strategic planning to identify the needs of a community and the best way to meet them. Community stakeholders, such as agency staff, boards of directors, community leaders, policy makers, funders, and others who represent people infected and affected by the HIV/AIDS epidemic, play a vital role in the development of capacity on the local, state, and federal levels. CDC promotes the inclusion of community stakeholders in AHP by conducting needs assessments, building consensus, and conducting outreach. Involving these groups will help to ensure that community members are invested in AHP and that sustainable capacity has been developed.

CDC has made a commitment to develop and support a cadre of experts and specialized agencies to assist in building grantee capacity. This group, assembled by CDC, can be accessed to help formulate a strategic planning process and build capacity on a variety of levels to complement the AHP goals and can be advantageous for several reasons:

- They have no stake in the organization and are thus able to analyze its status realistically;
- They are experts in their field and they know what pitfalls to expect and at which point in the process to expect them;
- They can provide a neutral view on political issues or decisions;
- They can devote themselves to the strategic planning effort for the period of time that they are needed;
- They have the experience and expertise to articulate desired outcomes, and then measure them to ensure further funding and program execution; and
- They can be members of the community, which enhances their understanding of the strengths, weaknesses, and needs of the local community being served.

The goal of building and sustaining HIV prevention service capacity will exist until the end of the HIV/AIDS epidemic. Although the AHP initiative is refocusing many HIV prevention services, and as a result, forcing HIV prevention service providers to alter their programs, this initiative, and future CDC initiatives, are building on the outcomes of effective HIV prevention capacity-building efforts. The need for competencies in specific programmatic areas may change as the epidemic continues to change. However, overall capacity-building efforts do not depend on specific CDC initiatives or program announcements. As previously stated, capacity building encourages independence, supports sustainability, and prepares service providers and their organizations for future challenges to delivering health care. Strategic planning and a constant review of effective approaches must be cornerstones of capacity-building efforts. HIV prevention service providers have an ever-changing need to develop core strengths and capacity for more effective programs while also identifying and strengthening existing assets in the battle against HIV/AIDS.

Following is a checklist that individuals, organizations, and communities might use to promote discussion and planning activities around AHP and new capacities that may be necessary as a result.
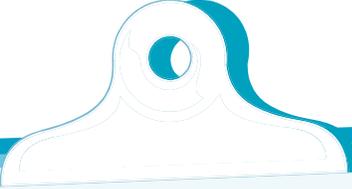
CAPACITY BUILDING AND THE NEW AHP INITIATIVE
a checklist

DIRECTIONS
1. Place a check mark next to the items in which you would like to build capacity.
2. Add your own topics and items to the list using the space provided.
3. Prioritize the new capacities that you, your organization, or community would work on first. It may be easier to rank them as high, medium, or low priority.
4. On a separate piece of paper describe your first step(s) in meeting one of your top priorities.

CHECK Priority (High/Medium/Low OR H/M/L)

____ Build a general understanding of rapid testing: how it works, what it costs, issues of reliability, confirmation of HIV infection status.

____ Build a strong understanding of AHP among staff so that all can reply to constituencies and stakeholders with state-of-the-art, science-based information.

____ Build capacity to reach out to and communicate with traditional medical doctors/health care workers.

____ Build capacity to reach out to and recruit pregnant women and their care providers, including midwives.

____ Build public relations capacity about AHP and what it means to the local community, including building skills on talking to the press about the initiative.

____ Assess or reassess the organization's involvement and commitment to prevention case management (PCM). Is a refresher course needed on prevention case management?

____ Assess or reassess the organization's commitment to testing and counseling services. Is a refresher course needed on testing and counseling?

____ Build capacity to identify new sources for treatment so that clients can be referred to treatment.

____ Assess or reassess the organization's involvement and commitment to case management. Is a refresher course needed on case management?

____ Assess AHP impact on staffing. Do more staff need to be hired? Should the hours of operation be changed?

A Model for the Design, Implementation, and Evaluation of NGO HIV Prevention Capacity-Building Activities

Define Community At Risk

A community at risk consists of a population defined by:
- HIV transmission route: heterosexual, male-to male, injection drug use, prerinatal
- Geography: Neighborhood, town, section of city, city, or region
- Gender
- May also be defined by race/ethnicity, perceived identity and age

Assess Community Risk

Assessment should be done to determine:
- Characteristics of community memebers who are at highest risk for HIV transmission or exposure
- Factors that contribute to risk for transmission of HIV
- Context within which risk for transmission of HIV occurs

Identify Community NGOs

Characteristics of NGOs should include:
- Adequate resources to conduct HIV intervention activity
- Existing organizatonal infrastructure
- Peer-based
- Credibility within community
- Experience in providing Services to community
- Experience in health education, preferably related to HIV prevention

Assess NGO Capacity Needs

Collaborate with NGO to assess infrastructure capacity for:
- Organizational governance
- Resource development
- Strategic planning
- Personnel management
- Fiscal management
- Information management
- Development of collaborations and partnerships

Collaborate with NGO to assess HIV intervention capacity needs for
- Assessment of community HIV prevention needs
- HIV interventions planning
- Use of sound principles of behavior change in intervention design
- Development of culturally appropriate health education/risk reduction message
- Development of protocols and curricula
- Design and implementaion of ongoing monitoring and evaluation
- Development of linkages with other services

Develop NGO Capacity Building Strategy

→

Implement Capacity Building Strategy

→

Evaluate Capacity Building Strategy

→

Increased Capacity for HIV Prevention

Develop consensus with NGO on a strategy that describes:
- Capacity conditions (knowledge and skills to be addressed through the strategy
- Key personnel who will be recipients of the assistance
- Intended changes in knowledge and skills of key personnel to take place
- Specific information or activities that will increase capacity
- The capacity building (information transfer, technical consultation, skills building, technical service, and technology transfer) mechanisms that will be used to deliver the services

- Select providers with demonstrated ability to deliver capacity building assistance.
- Assure delivery of capacity building assistance using one or more capacity building mechanisms.
- Work with NGO staff to monitor capacity building activities to assure that they are delivered in a way that is consistent with the strategy.
- Follow up delivery of capacity building assistance to assess need for additional assistance.

- Collect and analyze process data to determine if the strategy was implemented as proposed.
- Revise implementation if inconsistent with strategy
- Collect and analyze outcome data to determine if the intended outcomes followed the delivery of the capacity building activities.
- Revise capacity buildng strategy to increase effectiveness.

LINKING OPERATING PRINCIPLES
TO PROCESSES

4

Chapter 4 offers providers and recipients of capacity-building services guidance for participating effectively in the HIV prevention capacity-building process. It describes roles and responsibilities for all parties involved in capacity building. This chapter focuses specifically on providing an overview of:

- The fundamentals of receiving and providing capacity-building services; and
- Identifying and understanding roles and responsibilities in capacity building.

The Fundamentals of Receiving and Providing Capacity-Building Services

This chapter explains the interrelationships between the fundamental operating principles laid out in Chapter 1 and the processes of capacity building. Considering that one of the key principles of capacity building is the importance of a two-way partnership between the provider and the recipient, the roles and responsibilities of each—provider and recipient—are described in detail.

The capacity-building needs of recipients can vary greatly, both in terms of content and appropriate mechanisms of capacity-building. Nonetheless, certain basic fundamental key processes will remain constant across the various content areas that may be addressed. These fundamental processes are described below.

Fundamental 1. Capacity Building does not happen in a vacuum. Many people contribute to and invest in the process to influence the right capacities at the appropriate level, whether that level be individual, organizational, or community/environmental. Although each level is dependent on the others, it is important to differentiate the primary level at which impact is sought. For example, though capacity building may be provided through exchanges among **individuals**, it may be that the primary intention is to affect the capacity of the **organization**. As such, policy, systems, and multiple individuals must be affected if capacity is to be improved at the organizational level. Similarly, capacity building at a community level cannot depend only on changing one organization or a few individuals.

Fundamental 2. Establishing trust is a must. An established, trusting relationship between the provider and recipient ensures the effective provision of capacity-building services. It is important for the capacity-building provider to develop trusting relationships with the recipient, whether it be individual, organizational (including key staff and stakeholders), or community/environmental (including organizations, stakeholders, leaders). These relationships will enhance the ability of capacity-building providers to effectively communicate with recipients, understand the recipients' background, and offer services.

It takes time and energy to gain trust, and it can be easily and quickly lost. In *Reflections on Capacity Building*, the California Wellness Foundation offers the following recommendation for capacity-building provider on how to build and maintain trust with recipients.[1]

Avoid making assumptions about recipients. Capacity-building providers should not rely solely on past interactions with recipients or their perception of recipients, funders, or other external parties as the method by which to decide a course of action. It is important that the capacity-building provider does not assume knowledge of a recipient's values, but instead, works with the recipient to clarify both the provider's and recipient's values as they relate to the area in which capacity is to be fostered.

Take time to build relationships. The success of any capacity-building episode will depend on the relationship established between the provider and the recipient. It is crucial that providers take time to learn more about recipients than simply the area in which they require assistance, and likewise, to allow the recipient to learn about the provider.

Demonstrate understanding of, and support for, the recipient's mission. It is much easier for a recipient to feel trust if the provider understands and supports the recipient's mission and project goals. There may be times when a request is put forward to a provider for assistance in which the provider does not agree with the mission and values of the requester. In such instances, the provider should clarify the difference of opinions and work with the recipient to determine the most appropriate provider.

Fundamental 3. Capacity building is a two-way relationship.

Capacity building is a two-way relationship. Capacity building requires the active involvement of both the provider and recipient. It cannot be a process that is done to a community, organization, or individual, but rather, it must be a process that is done with a community, organization, or individual.

Each capacity-building activity has some general principles that both providers and recipients should agree to respect. Even though it may be difficult at times, both parties should:

[1] The California Wellness Foundation. *Reflections on Capacity Building*. 2001

- Be open to tapping into new resources to build capacity;
- Support a thorough initial assessment to fully identify or clarify needs; and
- Act as a full partner in the capacity-building process.

In addition, both parties need to:

- Concur with identified needs before engaging in any capacity-building activities;
- Provide access to resources and information (e.g., sharing evaluation reports and data, program budgets, reviews, and other information);
- Communicate with staff and other stakeholders about what happens during the process;
- Discuss the need for confidentiality so that it is understood and agreed upon;
- Use epidemiologic data, needs assessments, and prioritization of target audiences and interventions to design program activities;
- Develop a work plan and activities consistent with state and local comprehensive HIV prevention plans; and
- Compile lessons learned.

Identifying and Understanding Roles and Responsibilities (R&R) in Capacity Building

When roles and responsibilities are clearly spelled out, the capacity-building process becomes more efficient, with fewer surprises and misunderstandings. Because capacity-building activities involve partnerships, requires trust, and affects individuals and processes, it is very important that the roles and responsibilities for all parties be clearly defined. This next section focuses on the basic roles and responsibilities of providers and recipients in capacity-building activities.

R&R 1. Recipients need to be aware of provider services and other resources.

Recipients should be knowledgeable about how to access capacity-building services and how to complete a protocol for requesting assistance. Because no single provider of capacity-building services will be able to address all capacity-building needs, it is important that recipients become knowledgeable about the services that providers offer, as well as their limitations, thus allowing for informed decisions as to which consultant will best fit identified needs. In addition, both parties should be aware of additional capacity-building resources and knowledgeable about how to contact and contract for them. Providers should be efficient and timely in responding to requests from the recipient and in establishing an effective working relationship.

R&R 2. Both parties have active roles in, and responsibility to, the assessment process.

Soon after a capacity-building provider and recipient begin to work together, they must conduct an assessment process to identify and measure the needs of the organization. It is often difficult for recipients to discuss with external providers their weaknesses or areas that need improvement. However, identifying these needs will allow the provider to work with the recipient to address areas of concern and to focus capacity-building efforts.

Remember that assessment activities should be conducted in partnership with recipients, so it is important that they understand the assessment process and its outcomes. The assessment process allows recipients to assess their own issues and needs and enables providers to develop a more accurate work plan to effectively meet those needs and build capacity to strengthen programs and systems. Once an assessment is completed, recipients should work with providers to develop a clear, realistic plan of action for addressing the identified needs, including key activities and a timeline.

> See the Tool Box for samples of assessment tools. Providers of capacity-building services also are encouraged to develop their own assessment tools to best address the types of assistance they are able to provide.

R&R 3. Both parties are responsible for establishing points of contact.

In establishing a working relationship, providers and recipients should be available to each other, and provide a back-up contact, when needed. Even though an organization may be funded to provide

assistance, an individual or specific individuals within an organization will need to serve as the contact. Clearly designated contact people will allow providers and recipients to know specifically with whom to discuss needs, questions, and assistance.

R&R 4. Providers are responsible for tracking and documentation.

Providers of capacity-building services should establish and document a clear process for tracking and recording all activities related to providing capacity-building services and support. The recipient should monitor and review the provider's established tracking systems to be actively engaged in the process and knowledgeable about all activities related to capacity building.

R&R 5. Both parties are responsible for reporting and sharing information.

Reporting responsibilities should be delineated at the beginning of each capacity-building episode. It is critical to establish trust as well as ensure a recipient's willingness to obtain help. It is equally important that recipients are informed at the beginning of the episode as to the kind of information that will be shared with other parties, such as CDC project officers, health departments, etc. It is understood that some information will remain confidential and that other information will be provided to external parties. However, recipients should be told how any shared information will be used so that they can make an informed decision about the types of information they will provide.

R&R 6. Both parties are responsible for spelling out the resources and time available to address capacity-building needs.
For example, if travel, staff time, and expertise limit the assistance that a capacity-building provider can offer, it is critical that these limitations be delineated in advance so that recipients do not develop unreasonable expectations. Similarly, recipients should quantify their resources, staff, and time available to assist in the development and implementation of the capacity-building work plan.

R&R 7. The provider is responsible for responding to inquiries for assistance in a timely fashion.
Timely responses and interactions throughout a capacity-building episode can play an important role in the recipient's perceived satisfaction with services provided, and they can foster a willingness to seek future help. It is important that capacity-building providers and recipients agree on reasonable time frames for providers to respond to recipients' requests, questions, and inquiries.

R&R 8. Providers should clearly define the scope of services that can be addressed with the recipient. As previously stated, recipients have diverse needs, and when searching for the appropriate match between capacity-building provider and recipient, it is important for providers to explain to recipients the range of services that are available, as well as the limitations. This includes providing clarity on content areas and processes that are not necessarily areas of expertise for the capacity-building provider.

R&R 9. The recipient should provide written feedback to the provider and funder, evaluating the capacity-building experience. Capacity-building providers should be evaluated in terms of both process and outcome. This feedback is important to overall funders, the capacity-building provider, and the recipient because it helps all parties understand what worked and what did not. Feedback also helps providers and recipients maintain their newly acquired capacity and supports future capacity-building activities.

UNDERSTANDING YOUR PROGRAM
FOR BUILDING CAPACITY

Chapter 5 explains why assessment is the first step of capacity building services and describes techniques that can be used to assess needs that can be met by increasing capacity on the individual, organization, and community/environmental levels. This chapter will provide an overview of:

- Methodologies for collecting needs assessment data;
- Resource inventory and gap analysis;
- Identifying the target level for capacity-building activities;
- Identifying specific capacities for enhancement; and
- Mechanisms for building capacity.

Capacity Building and Needs Assessment

Conducting a needs assessment is the process of obtaining and analyzing information to determine the current status and service needs of a defined population and/or geographic area. Needs assessments can be used to obtain information about current conditions in a defined population, including problems or service needs and the resources and approaches being used to address them. They are also used to determine met and unmet service needs among specific target populations involved in the success of an HIV prevention program and in examining health and HIV prevention for the overall service area or community.

The needs assessment is a powerful tool for assigning priority to service needs and developing strategies to effectively increase capacity on individual, organizational, or community levels. Following are the characteristics of a comprehensive needs assessment to increase capacity:

- Targets affected populations identified in the epidemiologic profile;
- Describes the health needs of targeted populations;
- Furnishes an inventory of existing community resources;
- Includes a gap analysis of the met and unmet needs within targeted populations;
- Presents results in formats useful for priority setting, program planning, and other planning and decision-making activities (it can include a quality assurance component); and
- Provides data that inform a quality assurance approach.

The needs assessment process is closely tied to the organization's scope of work, and what they have actually been funded to accomplish. It is critical for those involved in building capacity to be familiar with the organization's scope of work before conducting a needs assessment. Priorities, decisions, and redirection of resources are based on the outcome of the needs assessment. Once a need has been identified, planning tools can be used, including the logic model.

STEPS IN DESIGNING THE NEEDS ASSESSMENT

Step 1. Determine purpose and objectives of the needs assessment.
Step 2. Identify available resources.
Step 3. Understand and agree upon roles and responsibilities.
Step 4. Determine the research questions to be answered.
Step 5. Develop the methodology for collecting and analyzing data.
Step 6. Establish a realistic timeline and work plan.

To begin the process of improving individual, organizational, or community-wide capacities to deliver HIV prevention services, a recipient needs to select a provider with a demonstrated ability to deliver capacity-building services. The provider may be a local or national provider or CDC staff person. Once an appropriate capacity-building provider has been identified and agreed upon, an assessment should be completed in partnership between the two. This assessment is done to match a recipient's needs and a provider's skills

Assessment occurs through three sequential processes.
1. Identifying the level at which capacity building will be focused (i.e., individual, organizational, community/environment);
2. Identifying the specific capacities that need to be enhanced; and
3. Developing a capacity-building plan that includes measurable objectives, activities, and methods for evaluating capacity-building services and outcomes.

Both parties need to agree on the actual assessment. For example, if a capacity-building service provider has assessed and determined that a recipient agency needs to build or enhance its capacity in cultural competency, yet the recipient does not recognize or understand why the need was identified, the processes necessary for capacity building will not be able to move forward.

In addition to a shared understanding on the outcome of the assessment, it is critical that the recipient and provider share an understanding of how the conclusions of the assessment are reached. This process assures a level of future self-sufficiency in identifying and understanding barriers to capacity and fosters accountability for outcomes.

Needs Assessment Data

Various types of data are generated in a needs assessment and contribute to the soundness of the findings and the conclusions that inform the program development. These include primary and secondary data, which can be qualitative or quantitative.

Primary data are data that are collected and analyzed directly by those responsible for the needs assessment (e.g., data from a local stakeholder meeting or results of surveys of agency clients).

Secondary data are data that were collected by someone else outside the scope of your program, but that can be analyzed or re-analyzed by those responsible for conducting the needs assessment. Secondary data may be available in "raw" (un-analyzed) or analyzed form (e.g., STD clinic chart data or census data).

Qualitative Data are presented in narrative form that generally cannot be expressed numerically, but rather are used to measure and evaluate less tangible items such as opinions, feelings, experience, and other variables that are not quantifiable by numbers. Following are descriptions of various methods of collecting qualitative data.

Focus groups are in-depth discussions among a group of six to ten people guided by a trained moderator. These groups address a pre-identified research question and explore beliefs or attitudes about an issue, a type of service, or a program. The advantage to data provided by focus groups is that they can be assumed to be truthful because they are ideally provided in a friendly environment in which people feel comfortable speaking their minds. However, the group setting can sometimes have the opposite effect on individuals, making them less likely to be forthcoming. Participants' comfort levels will vary depending on the topic. Focus groups are not always the best for sensitive topics. Focus groups are valuable for piloting new ideas, materials, and messages, and for developing quantitative research.

In-depth and key informant interviews involve a one-on-one conversation between a trained interviewer and a member of a target population. Interviews may be open-ended, semi-structured, or structured and they are useful for collecting specific information about each participant in a program or gathering information on a sensitive topic. A thoughtful interviewer should strive to develop rapport with the interviewee to make sure he or she is comfortable enough to share accurate information.

Document review entails reading and analyzing program documents and records in order to get a complete "behind-the-scenes" view of how a program is operating. This method generates information that is often difficult to obtain from any other source. However, records cannot always be assumed to be accurate, and data should be corroborated by other methods, whenever possible.

Observational studies require one or more trained observers who systematically watch and record what is happening in a community, agency, or program. Observational studies are useful in obtaining data on current activities and in verifying data obtained through other methods.

Community forums and public meetings provide the opportunity to collect qualitative information from the audience. Capturing the key points of the discussion and recording comments from the audience can be useful in generating an understanding of the opinions and views of community members and if they are in agreement or disagreement with each other.

Quantitative Data are those that can be presented in numerical terms. They provide the information necessary for statistical analysis and for conducting outcome evaluation. Several methods are commonly used to collect quantitative data.

- **Survey data collection** requires obtaining information from a large number of individuals or a sample of a specific population. Participants are asked close-ended questions, and their answers are numerically coded and analyzed using statistical and/or database software. Surveys may be conducted once or repeated in order to measure changes over time. One of the most commonly used survey instruments is the Knowledge, Attitudes, and Behavior Practices (KABP) survey tool.

- **Record abstraction** involves reviewing and extracting data from records that organizations (e.g., CBOs, health departments, local county extension services, or local universities) may have collected. This approach is useful in determining whether or not a program has had a measurable effect, but it can be a time-consuming and costly process.

Analyzing quantitative data can be extremely complicated and time consuming. For quantitative data analysis, outside resources with experience in data collection and analysis often can be valuable partners. These resources include local universities and schools of public health, social work, education, nursing, business, economics, sociology, and psychology; county extension services; local foundations; local evaluator associations; and statisticians at local government agencies; and CDC staff.

Resource Inventory and Gap Analysis

Resource inventory and gap analysis are also part of a comprehensive needs assessment. The resource inventory describes existing community capacity for services by identifying and describing current and related resources and activities in the community, regardless of the funding source. The resource inventory will identify what services already exist to meet the identified needs. Any needs that are outstanding or cannot be met by existing services are gaps that must be addressed. A gap analysis involves examining the difference between what is available and what will be needed to achieve program goals over a certain period of time.

Organizations or groups conducting a resource inventory will need to collect the following information on each community resource or activity:

- Contact information;
- Funding amount and sources (private, public, fee-for-service);
- Geographic area(s) served;
- Targeted population(s);
- Race/ethnicity of target population(s);
- Program focus and intended audiences;
- Strategies or interventions used;

- Service capacity; and
- Accessibility and appropriateness for targeted populations.

A gap analysis identifies missing programs, resources, and contacts in a community that could potentially obstruct the effect of a long-term capacity-building program. It brings together:

- Data about specific populations identified from epidemiologic profiles and reports;
- Findings about met and unmet needs from the needs assessment;
- Information about existing prevention services and resources, funding, and populations served from the resource inventory; and
- Secondary data about availability, accessibility, and appropriateness of existing services for the target population.

By conducting a needs assessment, implementing a gap analysis, and developing a resource inventory, the specific capacities being targeted will be very well understood within the context of the community and the local HIV epidemic. Doing all of this research in the beginning of the capacity-building process can be time-consuming, labor intensive, and require specialized knowledge. However, by accessing direction, input, and feedback from CBA providers, local health department staff, local partners, or schools of public health in your community, the process can be done so that it is efficient, cost-effective, and successful.

Identifying the Target Level for Capacity-Building Activities

As outlined in Chapter 1, capacity building, for the purposes of this document, is focused at one of three levels: individual, organization, and community/environment. Each level has a series of core processes that may be addressed to foster increased capacity.

Determining the appropriate level to address is important because it helps to define the outcomes. For example, capacity-building activities focused on an individual may include training staff on how to appropriately follow updated counseling, testing, and referral (CTR) protocol. By concentrating on

this individual-level capacity, it will impact the organization because the CTR services provided will be state-of-the-art and will be consistent with comprehensive care on the community level.

It is important to note that capacity at any one level affects capacity at the other levels. For example, the capacity-building service provider and recipient may decide to focus their efforts initially at the organization level because the recipient wants to focus on developing organizational capacity to evaluate outreach effectiveness. However, if individual staff members are not capable of conducting such evaluation activities, then the initial decision about level may not have been correct, and the outcome—enhanced evaluation capacity—may not be fully attainable.

Identifying Specific Capacities for Enhancement

There are specific capacities that are targeted on each level –individual, organizational, and community-wide. Capacity building strengthens an individual's own ability and capacity as well as the individual's ability to perform and carry out programs. Capacity building on an organizational level strengthens both service delivery and the ability to sustain programs, including a multitude of administrative processes. Finally, capacity building strengthens a community or environment's ability to respond effectively to developments in the HIV/AIDS epidemic. Below are three lists of the specific capacities that are targeted on each level.

Individual: Capacity building for individuals may involve assessing and addressing:

- Critical thought;
- Self actualization;
- Increase in knowledge base;
- Professional development;
- Conflict resolution; and
- Leadership development and supervision.

Organizational: Capacity building for organizations may involve assessing and addressing:

- Cultural competency;
- Human resources/personnel;
- Finance management;
- Governance;
- Program policy;
- Program development;
- Program delivery;
- Program evaluation;
- Communications;
- Strategic planning;
- Community engagement; and
- Quality assurance.

Community/ Environmental: Capacity building for communities/environments may assess and address:

- Access to resources;
- Establishing and sustaining coalitions;
- Economic resources or limitations;
- Governance of the community;
- Community planning effectiveness;
- Community leadership development;
- Community organizing;
- Community mobilization;
- Community responsibility; and
- Local laws.

Mechanisms for Building Capacity

In addition to using assessment tools to identify the specific capacities that need to be enhanced, the provider and recipient will also need to discuss the most appropriate mechanism to build the capacity. Many mechanisms can be used. However, simply employing these mechanisms and activities does not necessarily mean that the recipients' capabilities will be improved. The approach must be comprehensive in scope and move toward building self-sufficiency through empowerment. This section describes the types of mechanisms used to support capacity building, self-sufficiency, and interdependence with other resources/providers.

A common understanding of the various capacity-building mechanisms is necessary to ensure that recipients and providers are all speaking a common language. The capacity-building mechanisms used by the Capacity Building Branch at CDC are described below. Capacity-building mechanisms can occur on one or more of the three recipient levels. This list reflects some of the most common mechanisms that have been used in HIV prevention communities over the last two decades.

Coaching is a process and system of specific conversations directed by a highly trained professional or peer. Coaching uses a process of inquiry and personal discovery to build a capacity-building service recipient's level of awareness and responsibility, and provides structure, support, and feedback. Coaching is a form of consulting, but the coach maintains a relationship with the recipient to help institute new skills, changes, and goals to ensure efficacy. Coaches do not try to "fix" a recipient—it is entirely up to the recipient to carry out the changes. Coaching takes place in several sessions and is time bound. When the stated goals are reached, the coaching will end. Coaching always leads to the reconstruction and/or enhancement of recipient self-efficacy.

Facilitating community discourse is a process of bringing together organizations, key stakeholders, and other community representatives to foster community-wide approaches to addressing critical issues. An example of this approach for capacity building at the community level is the process of HIV prevention community planning developed and implemented by CDC. This process brings together health departments and community leaders, representatives, and policy makers to assure the most comprehensive and appropriate HIV prevention plan for a jurisdiction.

Community mobilization Community mobilization is the process by which individuals in a community take active roles in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.

Community organizing is the process by which groups of individuals or organizations within a community are identified and informed to address common problems and issues, formulate joint goals or solutions, and work in a collaborative fashion to move toward the goals and solutions. In this process, roles and responsibilities for involved parties are identified and maintained.

Information transfer is a mechanism from which everyone has probably benefited at some time. Providers collect, package, and disseminate information to recipients. Information transfer can occur orally or through lectures, newsletters, technical reports, web sites, electronic listservs, conference announcements, faxes, or hotlines.

Job aids contain information or approaches that support individual job performance. A job aid is not designed to improve long-term knowledge or skills. Job aids are most effective when they are designed to provide information for an activity or process when an individual needs it. For example, an individual may be knowledgeable and trained on how to carry out client-centered counseling, but may not remember the specific questions that need to be asked in a specified session. A job aid that might be designed for this situation would be a poster for the counseling site with the specific questions. Another example is a laminated algorithm that a medical provider could use when assessing a person's risk and determining the need for HIV testing.

Mentoring consists of peer-to-peer capacity building to promote networking and collaboration between or among agencies and/or individuals. Mentoring focuses on building expertise and knowledge. Just as strategic planning promotes systematic organizational development, mentoring supports collaborative empowerment for systematic societal change.

Policy development is a process by which public health organizations formulate policies and plans to address health issues for the populations they serve. Advocating for the adoption and implementation of these policies by legislative and regulatory bodies and by private-sector institutions is also an important part of this process. Policy development processes typically involve planning and priority-setting efforts that include broad participation by community members as well as health professionals and institutions.

Providing resources is a tool used to develop and build capacity within individuals, organizations, and communities. It includes providing information and materials to facilitate the implementation of HIV prevention activities, including articles and reports, data, computer searches, health education materials, and referral to content experts. Resource provision also involves establishing links between health educators and individuals and groups conducting similar projects in other cities, states, or counties.

Technical assistance (TA) is the delivery of expert programmatic, scientific, and technical support to agencies and organizations in the design, implementation, and evaluation of HIV prevention interventions and programs. TA can be used to provide a recipient with assistance in all phases of HIV prevention programs, including project proposals, evaluation protocols, survey instruments, program design, intervention materials, or implementation plans. As a capacity-building tool, TA is often used to support the development or accomplishment of a specific task or activity (e.g., development of needs assessment tools, design of evaluation surveys or qualitative instruments, or designing program work plans or development plans).

Technical consultation is the delivery or provision of advice to key personnel on how to accomplish a task or series of tasks with the intent that the task(s) will be carried out by the recipient. Technical consultation can occur on the telephone, on-site, electronically, or through written documents.

Technology transfer facilitates access to products, methodologies, or techniques to increase capacity. However, simply transferring information is not the focus of this process. Rather, it emphasizes transferring skills and developing the ability to locate/identify pertinent data to evaluate and implement HIV prevention programs. The provider and recipient may collaborate to adapt technology to fit local culture and conditions. Technology transfer may be accompanied by information exchange, skills building, technical consultation, or technical services.

Training consists of comprehensive instruction to enhance program planning, education materials development, program evaluation, grant writing, and other skills applicable to conducting primary prevention activities in the community. Training is a capacity building tool and is distinguishable from TA in that training imparts specific information and develops/builds skills, while TA provides short-term help and support with problem-solving on a specific issue and/or concern. Training will often be identified in discussions of skills building or skill sets. For the purpose of this document and HIV prevention, training can be offered to staff, board members, volunteers, or trainers.

Twinning is a process that requires the involvement of two separate organizations or agencies. Both organizations benefit from the collaboration and learn from each other. This two-way transfer of skills and knowledge can lead to building the capacity of both organizations. When used in HIV prevention, twinning usually involves a formal, substantive collaboration between two organizations.

Most of these mechanisms are related to working at individual or organizational levels, as these will most often be the level at which capacity building will occur. For example, while the desire of a CBA provider may be to increase a community's ability to prevent HIV, the focus of the capacity building may be on enhancing organizations, opinion leaders, and/or community representatives who would thereby catalyze efforts to mobilize community efforts.

Table 1. A comparison of capacity-building mechanisms and recipient levels

Capacity Building Mechanisms	Individual Level	Organization Level	Community Level
Coaching	X		
Community Discourse			X
Community Mobilization			X
Community Organizing			X
Information Transfer	X	X	X
Job Aids	X	X	
Mentoring	X	X	
Policy Development			X
Providing Resources	X		X
Technical Assistance	X	X	X
Technical Consultation		X	
Technology Transfer	X	X	
Training	X	X	X
Twinning		X	

PLANNING, MONITORING, AND EVALUATING
CAPACITY-BUILDING PROGRAMS

Chapter 6 provides an overview of planning, monitoring, and evaluating HIV prevention capacity-building activities on the individual, organizational, and community/environmental levels, and provides guidance and indicators that can be applied to this process. This chapter will focus on:

- Program design and logic model in capacity building;
- Elements of a logic model;
- Process evaluation and capacity building;
- Outcome evaluation of capacity-building activities;
- Identifying indicators and measurable outcomes; and
- Closing out a capacity-building episode.

Program Design and the Logic Model in Capacity Building

An effective logic model is an essential aspect of the planning and evaluation process. A sound logic model describes the main elements of an overall capacity-building strategy and how these work together to build the capacity of the intended organizations or communities. A logic model covers:

- Problems to address;
- Suitable interventions;
- Required resources (human, fiscal, technical);
- Measurable outcomes and effects; and
- Outcome and process evaluation that is integrated into the capacity-building program from its inception.

The logic model is a program design tool that provides a clear path from idea to action. It begins with the ideals that drive public health and ends with measurable effects of a program on the individual, organization, or community of interest. Every step in a logic model has to be connected to the points before and after. Logic models provide a snapshot for program planning to see where deficiencies may exist. Constructing and employing a logic model can help in several ways, particularly in identifying gaps and programmatic weaknesses that will need to be addressed to conduct effective capacity-building activities.

Benefits of a HIV Prevention Capacity Building Logic Model

- Demonstrates the internal logical consistency of the capacity-building strategy and helps to identify gaps in the strategy.
- Makes the intended outcomes of the strategy clear to ensure that activities are appropriate and realistic.
- Assists in monitoring the progress of programs to build capacity.
- Assists with identifying appropriate evaluation questions, indicators, and outcomes.
- Promotes communication about capacity building among planners, managers, line staff, funders, community members, and others.
- Provides a process for involving a team in planning a capacity-building strategy.

Elements of a Logic Model

The first step in developing a logic model for HIV prevention capacity building is to write a condition statement. A condition statement for an HIV prevention model would highlight conditions that may place a population at risk for contracting HIV, such as what they know about prevention, attitudes, beliefs, behaviors, skills, and environmental conditions. Additionally, before beginning the logic modeling process, capacity-building service providers and stakeholders from the community must develop profiles of each population that the activities intend to target. Establishing a profile of the target audiences' relevant descriptives and demographics must be considered and factored into all capacity-building planning and execution. Relevant variables to consider can include risk behaviors, risk determinants, gender, age range, and culture, among others.

Providers and recipients should then identify the desired overall impact on capacity. It is good to begin broad and then work in a reverse direction to become more specific about the details of reaching the program's goal of increased capacity or sustainability. Without the long-term impact in mind, it is difficult to stay on track, particularly when unanticipated obstacles arise that might derail a capacity-building program or change its direction.

As you will see in the design below, the set of inputs and activities created should result in products and services, or outputs, which will bring about changes in the population, or have an effect. The effect will contribute to the larger impact on the population. It is imperative that when designing a program you start with the impact and work in the reverse direction. Begin broad, and get more specific as you figure out the details of how you attain your goal.

> ### SAMPLE CONDITION STATEMENTS
>
> There is a need for stronger focus on supporting capacity of organizations to successfully support HIV prevention services. Successful and sustainable health promotion programs must be built on strong foundations.
>
> Organizational, project, and individual capacities must be systematically developed to maximize planning, staff, and resources. A strategic approach and a sound theoretical basis are also essential when creating and evaluating effective public health programs.
>
> Creating collaboratives and gaining support of the people who are involved is essential when creating public health prevention programs. By building capacity in these areas, policy makers and program leaders can ensure that all partners involved are developing the skills and maximizing the resources needed to increase their chances of long-term success.

Impact

Impact refers to the long-term change in the health, social, or economic status of the population of interest that results from carrying out a capacity-building strategy. Examples include changes in organizational effectiveness or community involvement in HIV prevention. The impact is the big picture. It is something that cannot necessarily be measured directly and is described with words such as "empowerment" and "elimination." It also may be a potentially measurable but extremely difficult goal to attain.

> **EXAMPLES OF IMPACTS INCLUDE:**
> - Elimination of ethnic and minority health disparities;
> - Elimination of HIV/AIDS transmission and related morbidity and mortality; and
> - Universal access to adequate information and services to protect themselves from HIV transmission.

Outcomes

Short-term outcomes are the immediate results of capacity-building activities, such as changes in knowledge, attitudes, beliefs, and skills. Intermediate outcomes are results of capacity-building activities that occur some time after capacity-building activities are completed, such as behavior change among key persons and changes in organizational conditions.

Activities and Outputs

All capacity-building activities, ranging from board development to community education, require strategically selected activities and outputs. Activities are the actual steps taken—the technical and support tasks required to produce the outputs. Examples include outreach at local venues, trainings for community planning groups (CPGs), or revisions to an agency mission statement. Outputs are the results of those activities—the products and services that must be in place for the outcomes and impact to occur. Examples include enhanced outreach at local venues, improved community collaboration, increased numbers of CPG members trained on specific issues, and an updated agency mission statement that more fully addresses the community's needs.

Creating Output Objectives

Output objectives are defined as the products and services that must be in place for the outcomes and impact to occur, and are measurable as well. Though less of an indicator of the impact on the target population, they are useful to track the results of activities and are foundations for the effects and impact. The formula to create measurable outputs objectives is:

We plan to [deliver] a [specific product or service] by [workers or system] to [specific population] by [timeframe].

Inputs

Inputs are defined as the resources needed to support the activities. Even though the planning process begins with identifying the impact, it is critical to have the inputs, or resources, to actually achieve it in the initial planning phases. Inputs are the basic resources that are necessary for any project, such as funding, infrastructure, staff, technology, and expertise.

Process Evaluation and Capacity Building

An essential component of capacity-building assistance is evaluation because it provides vital information about the effectiveness of the capacity-building strategy, its execution, and its impact. Capacity building assistance can be evaluated through multiple methods and strategies, including formative evaluation, process monitoring and evaluation, and outcome monitoring. CDC requires that all CDC-funded capacity-building assistance providers implement an evaluation monitoring plan for collecting, analyzing, interpreting, and reporting process and outcome monitoring data.

Uses of Process Evaluation

Process evaluation, also known as implementation evaluation, is designed to answer the questions of what is done, when it is done, by whom, and to whom. If conducted correctly, process evaluation can:

- Provide information that can be used to enhance the quality of a capacity-building program;
- Ensure that the total quality of the program is captured; and
- Help the program be accountable to various stakeholders, including sponsors, donors, client groups, administrators, staff, and other community members.

Process evaluation can provide answers to three important questions. Answering these three questions provides information to describe the capacity-building services and monitor how well they are being received.

Question 1
"Why was this capacity-building program developed?"

This question is simple yet critical to justify continuing, changing, or ending a program. This question is often asked by funders and policy makers and it is important to be able to answer with accuracy and conviction to enable further activity.

Question 2
"How is this capacity-building program operated?"

The answers to this question are necessary to guide any attempts at program replication and to analyze activities that cannot be easily quantified. The answers will address:
- How, why and by whom program decisions are made;
- The types of resources needed to run the program;
- The conditions (social, legal, economic, cultural) in which the program operates; and
- Unexpected challenges, opportunities, and barriers encountered in running the program.

Question 3
"Is the capacity-building program operating as intended?"

This question is often raised by funders who want to ensure that their money is being used as intended and is critical to understanding why quality outcomes were or were not achieved. The answer to this question may be used to justify a change in program focus, delivery process, staffing, or resources to improve quality.

Process Evaluation Methodology and Data Sources

Process evaluation can be conducted on an ongoing basis or at a single time and can be conducted using qualitative or quantitative data collection methods. The advantage to ongoing process evaluation is that information will always be readily available. A disadvantage is that it involves a significant investment of time and resources. Although conducting process evaluation at a specific point can minimize the time and effort involved and provide tailored evaluations, up-to-date information will not always be available.

Once a method for conducting process evaluation is selected, the next step involves considering which data sources should be used. In conducting process evaluation, it is important to use data that are already available and to consider adding additional data sources only if researchers know exactly what additional questions to ask and from what perspective—that of the funder, the client, or the staff. Audiences for the process evaluation investigation must also be identified. External audiences for process evaluation results include CPG members, CDC staff, funders, clients and community advocates. Audiences for internal process evaluation include community-based organization program staff, health department staff, managers, and the board of directors.

Data Sources for Process Evaluation
- Meeting minutes
- Planning documents
- Funding proposals
- Program policies and manuals
- Program logs
- Observations
- Client records
- Interviews
- Needs assessment findings
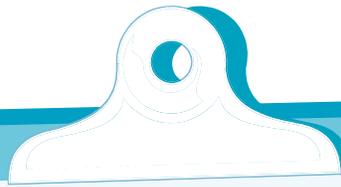
TIPS FOR DATA COLLECTION FOR PROCESS AND OUTCOME MEASUREMENT

- Determine what data are needed and the methodology for collecting the data.
- Set a routine for collecting data and stick to it.
- Divide tasks and assign individuals to each task.
- Pick one or two people to be in charge of data collection—don't spread the responsibility around.
- Keep the evaluation focused and answer only questions of interest.
- Collect only as much data as are needed.
- Periodically review research instruments to make sure that they are still useful.

DATA COLLECTION PLAN CHECKLIST

☐ Decide what data you will collect.
☐ Determine the skills needed to conduct the evaluation.
  If necessary, hire a consultant to complement the existing skill set.
☐ Determine what types of information will be most useful.
☐ Prepare the questionnaire or the interview guide.
☐ Test the tool with a small sample to make sure that it works.
☐ Solicit the support of staff.
☐ Refine the tool according to what has been learned in the small sample.

☐ Develop an implementation strategy and follow it.
☐ Conduct random or planned checks, as the data collection is under way to ensure that the process is running smoothly.
☐ Examine the data for trends and patterns.
☐ Develop a plan for preparing a written report that will help others understand the data.

Outcome Evaluation of Capacity-Building Activities

Outcome evaluation is a critical function of any capacity-building activity. It ensures accountability of leaders, provides a management tool, and documents successes for potential funders and clients. Outcome evaluation measures the ultimate effectiveness of a program and can be conducted through both qualitative and quantitative data collection methods. Outcome evaluations are used to answer the following questions:

- Did the capacity-building program have the desired outcome?
- How satisfied was the recipient?
- What was the average cost to achieve the desired outcome?

Identifying Indicators and Measurable Outcomes

Measuring performance means setting performance indicators, collecting actual performance data, and using these data to continuously improve processes. Ideally, both baseline measures and subsequent performance data should be collected for all indicators. The baseline measure indicates the current status of the organization and provides a gauge by which future performance can be measured. To accurately determine the baseline, the organization should:

- Use data for recommended data sources;
- Ideally, use at least three years of data so that a trend can be established; and
- Obtain consensus among stakeholders about the meaning of the trend and the baseline determined from the data.

A program performance indicator is comprised of information, facts, and statistics that provide insight into the performance of a capacity-building activity. It helps evaluators understand progress toward specified outcomes and it illustrates the capacity-building service provider's competence and success. Performance indicators are important for three reasons:

- They reflect the competence of the management;
- They measure performance while emphasizing results; and
- They define and link what measures are used to quantify a program's success.

Performance measurements help organizations focus on what is important to achieving a desired impact. By comparing actual results with expected results, stakeholders can evaluate progress toward goals and objectives. A successful strategic and operational planning process builds in accountability for results. Performance indicators are the tools used to measure performance and evaluate progress on these plans.

As capacity-building service providers and recipients work together to establish specific indicators of capacity building they may want to consider a few simple rules for selecting indicators.

Be motivational. When indicators provide useful information, the information can motivate changes in behavior—either individually or organizationally.

Be selective. Some capacity-building results are more important than others, so it is important to prioritize those that are more critical to achieving outcomes.

Be inclusive. Ownership is critical to capacity building. Infected and affected parties must have ownership over the capacity-building process. Shared responsibility for individual or institutional performance should foster decision-making on indicators.

Be concise and focused. Organizations often start with too many indicators to deal with realistically. It is important to concentrate on a few specific indicators for key program outcomes and impact.

Be driven by data. Think of indicators as data. What are the sources of the data and how have the data changed? Sources of data in HIV prevention programs might include: It is important to acknowledge that capacity building at the individual, organizational, and community levels will directly lead to outcomes at those targeted levels. Capacity building should be targeted at the level where the impact is most needed. In addition, it is essential that capacity-building activities are sustainable to increase the likelihood of attaining desired outcomes. In contrast to episodic technical assistance, capacity building fosters long-term change.

The questions listed below are intended to evoke innovative thinking about measuring and analyzing outcomes at the individual, organizational, and community levels. records, numbers, logs, staffing ratios, reports, observations, accounting records, training rosters, client satisfaction surveys, telephone referral logs, number of volunteers, and national or regional data sets.

Be aware. Note changes in attitudes, knowledge, skills, intention and/or behavior, and collect baseline data to which program outcomes can be compared.

Measuring Outcomes at Various Levels

It is important to acknowledge that capacity building at the individual, organizational, and community levels will directly lead to outcomes at those targeted levels. Capacity building should be targeted at the level where the impact is most needed. In addition, it is essential that capacity-building activities are sustainable to increase the likelihood of attaining desired outcomes. In contrast to episodic technical assistance, capacity building fosters long-term change.

The questions listed below are intended to evoke innovative thinking about measuring and analyzing outcomes at the individual, organizational, and community levels.

Looking for changes at the individual level?
- In what area(s) was capacity increased or built?
- How were the skill levels of individuals increased?
- How were current skills improved or mastered?
- What new skills were introduced?
- What mechanisms were used to increase skill levels? For example, was training, mentoring, or technical assistance used?
- How were the delivery mechanisms tailored to meet the needs of the individuals?
- Were changes sustained after the capacity-building episode ended? Describe.
- What multiplier effects should be monitored?
- How was the ability to deliver effective HIV prevention or HIV care services improved?

A **multiplier effect** refers to changes in a level of activity that lead to further changes in the level of other activities. In HIV prevention terms, a multiplier effect relates to prevention of infection among individuals with the highest numbers of sexual or needle-sharing partners. Prevention among these individuals will avert a greater number of future infections than prevention efforts directed at low-risk individuals.

Looking for changes at the organizational level?

- In what area(s) was capacity increased or built?
- How were the skills of the organization increased?
- What processes changed as a result of capacity building?
- What functions were enhanced or changed as a result of capacity building?
- Were changes sustained after the capacity-building episode ended? Describe.
- What multiplier effect(s) should be monitored?
- How was the ability to deliver effective HIV prevention or HIV care services improved?

Looking for changes at the community/environment level?

- In what area(s) was capacity increased or built?
- How were the skills of the community/environment increased?
- What multiplier effects should be monitored?
- How was the ability to deliver effective HIV prevention or HIV care services improved?
- Were changes sustained after the capacity-building provider left the community/environment? Describe.

Closing Out a Capacity-Building Episode

THE CLOSE-OUT PROCESS
(The transition to self-sufficiency)

Provider and Recipient
- Jointly develop a close-out plan that addresses any needs that the recipient still has.

Provider
- Write summary report .
- Develop follow-up action plan.
- Write follow-up letter.
- Documents should be sent to the funder and the recipient.

Recipient
- Write and submit a summary report to the provider and funder; submit the report before developing the close-out plan.
- Continue work on accomplishing stated goals.
- Receive follow-up guidance and support as needed.
- Demonstrate enhanced skills and improved self-sufficiency.

Capacity building assistance (CBA) often takes weeks or months of sustained, on- and off-site services. It cannot be done in a single day or during a one-shot visit. Remember, capacity building is an ongoing process.

If after weeks or months of assistance, the goals and objectives have been reached and the outcomes measured, it is most likely time for the capacity-building episode to end. This chapter describes how to close out a specific capacity-building episode and the importance of follow up, a distinct characteristic of CBA.

Capacity building assistance is designed to help individuals, organizations, and communities improve their ability to provide HIV prevention programs and services. A fundamental objective in this process is to create a smooth transition from a state of needing help to a state of self-sufficiency and empowerment. This objective must permeate all stages of the process. For example, clear timeframes and reasonable deadlines for both the recipient and the provider should be discussed when developing the initial work plan. Midway through the capacity-building episode, the provider should begin to foster greater independence in the recipient so that the recipient is prepared and less anxious when the services come to an end.

To accomplish this, the recipient and the provider should develop a close-out plan that will meet the recipient's needs, as well as allow the recipient to work further to accomplish stated objectives. The close-out plan should cover:

- Key findings;
- Summary of capacity-building services provided; and
- Expectations agreed upon for follow up, including referrals, and   any other activities.

When services are completed, the capacity-building service provider should submit a summary report and follow-up action plan to the recipient and funder/CDC. The summary report, which should be completed within seven business days of the close out, should present a concise record of actions taken and issues identified during the provision and delivery of capacity-building services, and summarize key points that emerged. The summary report, follow-up action plan, and any notes recorded during the capacity-building episode should be used as the basis for further discussions with the recipient about referrals and the need for any additional follow up. The follow-up action plan should include specific recommendations—who will do what by when, where and how will they do it, and how it will be monitored and documented.

The capacity-building service provider also should submit a follow-up letter to the recipient and to the funder/CDC. The letter should reiterate key findings and expectations agreed upon for follow up, referrals, and activities listed in the close-out plan and who will perform the activities..

The recipient should complete and submit a summary report on the capacity-building episode to the provider and funder/CDC. The recipient's summary report should provide evaluative information on the capacity-building experience, the capacity-building service provider, initial objectives, final objectives achieved (including outcomes), and any unmet needs. The recipient's summary should be submitted to the provider and funder/CDC before their close-out plan is completed.

Together, the capacity-building service provider and recipient should decide upon a timeframe for the next follow-up contact. To obtain an accurate assessment of the development of capacity, and to support the newly developed skills of the recipient, the provider should follow up with the recipient at least three months, six months, and twelve months after the initial capacity-building service has been provided. The provider should begin follow-up activities by analyzing all information collected.

If referrals are made to additional capacity-building service providers or consultants, it is important that the capacity-building service provider follow up to ensure that the recipient's needs are being met with the referral.

Being Supportive Between Capacity-Building Episodes

The following activities can help capacity-building service providers support recipients between capacity-building episodes.

- **Stay knowledgeable about the social, political, and cultural context of each recipient.** Providers are not expected to know everything about every recipient, but understanding each recipient's culture and climate will positively affect the provider's continued ability to work with a recipient. This understanding will give a provider greater insight into potential program strengths and challenges, foster a better working relationship with recipients, and help to alleviate potential problems.

- **Know the facts.** It's not enough to maintain contact. It is important to keep abreast of developments in a recipient's program activities. Providers also should keep up-to-date on issues that might affect recipients, such as cutting-edge research on prevention, treatment, and care; innovative application of science-based interventions; the changing face of the pandemic; new funding streams; and legislative developments that will affect CDC, other funders, recipients, and other systems.

- **Stay in touch.** CBA providers should maintain an ongoing, open relationship by regularly communicating with recipients. Regular communication is paramount in building effective working relationships. Ongoing communication can take many forms, and capacity-building service providers and recipients should choose whatever form is most comfortable for them—short telephone conversations, e-mail correspondence, or letter or fax correspondence. Providers should also use creative communication solutions, such as websites, e-rooms, and listservs to share effective program models, best practices, information on funding or technical assistance opportunities, up-to-date information from CDC and other federal agencies, and other information of interest.

- **Be available and accessible.** Recipients may need to be able to get in touch with their capacity-building service provider should they have an urgent question or concern. Providers should strive for a 48-hour turnaround time to respond to recipient phone or e-mail inquiries. A quick response time assures recipients that providers are concerned about their needs and view their relationship as a collaborative partnership.

- **Identify a secondary contact.** If a specific individual capacity-building service provider (either a staff person or a consultant) is not available, the recipient should know whom to contact. If the capacity-building service provider is an individual, and not an organization, the provider should provide multiple modes of access and should communicate with the recipient regularly about schedules and availability. If the capacity-building service provider is an organization, it should explain to recipients which staff members are available and accessible. Recipients also should supply CBA providers with a secondary contact in case the main point of contact is not available.

- **Commit to follow through.** In communications with the recipient, if a capacity-building service provider has committed to follow-up activities (e.g., identifying and/or distributing materials, providing referrals, responding to inquiries), the commitment should be clearly stated, and all follow-up activities should be documented. Between capacity-building episodes, capacity-building service providers should contact recipients to ensure that these activities are completed.

- **Strive to improve, not criticize.** Keep in mind that the ultimate purpose of capacity-building data collection and analysis is to assess progress and improve HIV prevention activities. Capacity-building support should never be viewed as punitive. Recipients should not consider needs or identified weaknesses as negative evaluation. Instead, the recipient should embrace findings and strive to work with the capacity-building service provider to turn weaknesses or areas for improvement into strengths. Moreover, capacity building should never be coercive. If capacity building is not developed through a collaborative process, then the development is "corrective action," not capacity building.

- **Make transitions as smooth as possible.** Rapid turnover is difficult for everyone. Shifts in staffing can be frustrating because it may mean that the recipient and provider essentially have to start over. Communicating and sharing information can help to manage change effectively. Recipients and capacity-building service providers should be open to sharing information with each other about project staff changes.

MOVING BEYOND
THE THEORETICAL FRAMEWORK:
REAL EXAMPLES OF CAPACITY BUILDING

Chapter 7 illustrates capacity-building activities through case studies of current programs occurring throughout the United States. This chapter will focus specifically on the following programs*:

- Capacity Building, Training, & Technical Support Unit, Chicago Department of Public Health;
- Technical Assistance and Training Program, Colorado Department of Public Health and Environment;
- Capacity Building Initiative for the HIV/AIDS Non-profit Sector, Los Angeles Office of AIDS Programs and Policy;
- Organizing for Community Development, New Jersey Department of Public Health; HIV/STD Prevention and Care Branch, Prevention and Community Planning Unit, North Carolina Department of Health and Human Services; and
- Initiatives for Human Development: Project REACH (Relating, Exchanging, and Capacity Building for HIV Prevention).

*Note: These summaries were initially completed in 2001-2002; and revised in 2004

I. Chicago

As mentioned throughout this document, capacity building may take many forms and may be applied to numerous content areas. While, no single example of a capacity-building program can capture the complete spectrum of activities that may be conducted, the examples provided in this chapter can help the reader think about the realm of possibilities. The six programs profiled include state, county, and city-level programs that are either carried out by, or on behalf of a state, county, or city health department.

Program Name:
Capacity Building, Training, and Technical Support Unit, Chicago Department of Public Health (CDPH).

Relationship to Community Planning Group (CPG):
The Capacity Building Unit participates in all of the CPG's full-group and subcommittee meetings. The Unit provides monthly updates on the capacity-building services it provides to the community, and works to follow up on any additional services suggested by the CPG.

Full-time Employees:
10

Services Provided:
Individual—Trains individuals to provide effective HIV interventions.
Organization—Conducts organizational development workshops for CBOs that provide HIV prevention services.
Community—Facilitates collaboration and coordination of and among CBOs.

Recipients of Services:
Organizations that provide HIV/AIDS prevention or care services and that have non-profit status or are attempting to achieve non-profit status.

Process for Accessing Services:
Recipients obtain technical support services by telephoning or by sending in a written request (mail, fax, or e-mail). All requests are assessed by staff of the unit over the telephone or in person within 21 days of submission.

Exemplary Practices:

1. Work plan is signed by the city, the agency, and the consultant.
2. Uses a pool of consultants, which allows recipients to work with external capacity-building assistance (CBA) providers.
3. Provides 30-50 hours of CBA for the initial request and allows one additional request per fiscal year.

Program Summary

The mission of the CDPH is to work in partnership with the community to use the best public health practices to prevent and treat HIV and sexually transmitted diseases (STD), and to promote the highest-quality services for the health and well being of those living with and affected by STDs, HIV, and AIDS. Funded agencies are viewed by CDPH as an extension of their mission. Together they serve the people of Chicago.

The CDPH's Capacity Building, Training and Technical Support Unit was created to examine emerging issues and provide critically needed human resources for the health department's community partners. It is committed to finding the most effective and cost-effective means to address the needs of the community. Its programs consist of the Technical Assistance Project (TAP), HIV/AIDS Training Unit (HATU), the Education and Resource Information Center (ERIC), Coalition Development Project, and Regional Coordination Initiative. Every year, the unit conducts several workshops, distributes 1,000 monthly capacity-building newsletters, and provides technical assistance (TA) to approximately 50 CBOs.

The unit has been able to focus on several critical categories based on HIV/AIDS service providers' needs. Technical support services are available through CDPH staff, consultants, or organizational development workshops. These various formats allow agencies to receive CBA in a one-on-one setting with a CDPH staff member or an assigned consultant, or through a skills-building workshop within a group setting.

Technical Assistance

Project TAP—This project is designed to help organizations develop and improve their service delivery systems as they strive for program excellence. Its CBA services include individual TA, workshops, community capacity building (newsletter), mass mailings, and e-newsletters. The

assistance they provide encompasses a broad range of activities such as helping with drafting a strategic plan or writing job descriptions, training board members, managing human resources and developing financial procedures, or developing a fundraising plan. To support this work, the CDPH offers funded agencies the opportunity to select a technical consultant who will work with the agency's leadership in both small group and individual sessions to provide assistance that helps the organization grow. The organizational development training/workshops is open to CDPH-funded agencies as well as other-funded groups. Consultants who have extensive expertise in organizational development and training conduct these workshops.

HATU and ERIC—These initiatives provide training, education, and technical assistance to make new science applicable through local and national collaborations with providers. ERIC provides CBOs access to current brochures, videos, and other resources; facilitates condom distribution to funded and non-funded agencies; and monitors the utility of resources for CBOs.

Chicago Community Coalitions Project—In 1998, the Centers for Disease Control and Prevention (CDC) announced the availability of funds to expand and enhance STD/HIV/AIDS/tuberculosis (TB)/substance abuse prevention and treatment, and care services for racial/ethnic minorities disproportionately affected by HIV/AIDS and associated illnesses. Three Chicago groups received Community Coalitions grants: West Town Humboldt Park HIV/AIDS Providers Association (WHAPA), West Side HIV/AIDS Regional Planning Group (WHARP), and North Side HIV Health Coalition (NHHC). Each coalition was assigned a consultant to assist them in developing a viable infrastructure. This involved helping the coalitions with facilitation and decision-making. The consultants also helped the groups develop evaluation plans to measure their outcomes of their prevention, treatment, and care services. Although the capacity-building needs varied greatly for each coalition, they did share some common needs:

- Membership Recruitment/Retention;
- Government Structure;
- By-laws Development;
- Integration/Role of Consumers;
- Conflict Resolution/Mediation; and
- Group Facilitation.

A Snapshot of Capacity Building　　　CHICAGO

Chicago Department of Health
Capacity Building, Training, and Technical Assistance Conference

From January to June 2004, CDPH conducted 36 workshops and trainings covering 17 different topics. A total of 576 individuals participated in these workshops and trainings. A summary of one of these trainings is provided here:

On March 11, 2004, CPDH, in conjunction with local stakeholders and agencies, hosted a Capacity Building, Training and Technical Assistance Conference at the South Shore Cultural Center with funds awarded under CDC program announcement 03002. This intensive all-day conference brought together more than 200 individuals from CBOs that provide HIV/AIDS prevention and care, substance abuse, mental health, and ancillary services. Its purpose was to provide a forum for service providers and consumers to discuss and share successful and innovative strategies for delivery. Importantly, participants included a large number of people living with HIV/AIDS and other consumers who provided crucial insights on service delivery from their unique positions. The conference was structured to allow individuals to chose from a selection of sessions covering topics such as medical adherence (from both the client and provider perspectives), bilingual prevention programs, HIV/AIDS primary care services, HIV prevention in correctional settings, coalition development as a method for improving collaborative planning, intervention implementation, and coordinated service delivery.

II. Colorado

Program Name:
Colorado Department of Public Health and Environment (CDPHE), Technical Assistance and Training Program.

Relationship to Community Planning Group (CPG):
The community planning process helps to define the purpose and activities of the Capacity Building unit.

Full-time Employees:
6

Services Provided:
Curriculum development, training, scholarship program, certification program, CB net (an electronic in-house tool for tracking CBA resources).

Process for Accessing Services:
Recipients request services by contacting CDPHE by telephone, fax, or email.

Process for Assessing Services:
The Unit assesses the capacity of HIV prevention service providers through tools that determine how well the providers comply with contract standards, general standards, organizational viability measurements, and service delivery standards.

Exemplary Practices:
Certification in HIV Prevention, Capacity Building Activity Scholarship Program.

Program Summary
In 1994, Colorado's CPG asked that the "playing field be leveled" so that all organizations would have similar abilities to address HIV prevention priorities. This request led the CDPHE to initiate its capacity-building activities. According to CDPHE, the key to successful capacity-building assistance is bringing it to the community level. Bapacity-building, like community planning, will only work if the long-term investment is made in truly trying to make the system work. Capacity building is not

an intervention, but rather cuts across to make interventions higher functioning. Collaboration and follow through are key defining elements of capacity-building activities.

Colorado's capacity-building activities are housed within the Department's Technical Assistance and Training program. The program is divided into two units – the Contract Monitoring Unit and the Capacity Building Unit. Though both units are viewed as integral components of capacity development, the Contract Monitoring Unit generally focuses on identifying the needs for assistance, whereas the Capacity Building Unit actually provides the capacity-building services. The Capacity Building Unit's services consist of planned, structured activities that may include training, consulting, technical assistance, and mentoring activities. These activities are designed to meet recipient's needs, and provide continuous support for the process of building capacity. CDPHE staff provide their services in partnership with contractors.

Capacity-building services are provided to target groups in the following order of priority:
- Health department grantees/contractors;
- Organizations and individuals providing HIV prevention services but who are not funded to do so; and
- Communities and organizations that need to be engaged in providing HIV prevention services.

The program's services are provided at no charge to the agency or organization. All funded organizations are required to participate in the development of a capacity-building plan for their agency and carry out that plan by obtaining capacity-building services, as needed. Organizations needing capacity-building services beyond what is available from CDPHE may request funds to defray the costs of obtaining the services.

Technical Assistance

Community Mobilization Initiative—The community mobilization initiative is a compilation of resources that are used to build connections among grassroots organizations. These resources (technical assistance and training) are used to strengthen grassroots organizations so that they are able to provide adequate services to the community. Through the community mobilization initiative, these grassroots organizations receive services that provide them with the skills to compete for local and federal funding.

Cultural Competence Initiative—This initiative is based on the premise that culturally competent programs and services can only be designed by culturally competent individuals. The goal of this initiative is to explore a practical mechanism for moving service delivery toward cultural competence and cultural proficiency. An extensive multi-part interview is administered and completed by participants to assess and explore their own levels of cultural competence. The interview includes demographics, training, policy setting, program design, obstacles encountered, and language capacity. Upon completing the interview, Initiative staff provide a number of step-by-step models to determine the client's needs, the application of appropriate strategies, and the identification of cultural barriers to the participants.

Certification Program—CDPHE is currently developing a certification program for people who provide HIV/AIDS prevention services in Colorado. The goal of the certification program is to build and maintain a highly qualified HIV prevention workforce. In order to develop a comprehensive and inclusive program, CDPHE will recruit people who are affected by or infected with HIV and persons from diverse communities to participate in the development of the criteria and mechanism of certification.

Scholarship Program—In addition to offering a large number of trainings and a network of providers from which to choose, CDPHE provides scholarship opportunities to recipients to attend trainings or workshops not offered by CDPHE or consultants. CDPHE also provides funding to bring out-of-state consultants to the area and to allow recipients to travel to a training, workshop, or conference out of the area. The only stipulation is that the event must be related to capacity building.

A Snapshot of Capacity Building   COLORADO

Colorado State Technical Assistance and Training Program (TATP)

Colorado's Technical Assistance and Training Program (TATP) carries out an innovative, multi-faceted, individualized HIV prevention capacity-building program. To assess and meet the training needs of contracted agencies, TATP has implemented a 6-step process that begins with tailoring capacity-building efforts according to the specific needs of the recipient agency at a given time, ensuring a comprehensive understanding of the consumers, targets, goals, resources, and challenges existing within each agency.

Subsequent steps involve performance assessment, problem definition, training needs analysis, delivery of the tailored capacity-building program, and evaluation. This final step allows new challenges to be identified and confronted so capacity can be improved on an ongoing basis.

To build and maintain a highly qualified HIV prevention workforce, an HIV/AIDS/STD Prevention Worker Certification Program is in the final phases of development. This program is intended to maximize the success of the participant at every stage of learning and assessment and will contribute to creating a consistent standard of care in the HIV prevention profession.

III. County of Los Angeles

Program Name:
Office of AIDS Programs and Policy, Capacity Building Initiative for the HIV/AIDS Non-profit Sector

Full-time Employees:
3

Services Provided:
The Capacity Building Initiative is responsible for managing and providing services to community providers. It focuses particularly on the infrastructure and management needs of CBOs. The Office of AIDS Programs and Policy's (OAPP) Educational Services provides other capacity-building TA as well, through training, certification, symposia, prevention services, care services, and financial services. Educational Services also provides TA in information systems (including training, technical assistance, and systems development) and in planning and development (including training and skills-building activities.) Educational Services distributes a yearly OAPP Training Resource Calendar so that OAPP-funded CBOs can schedule staff training well in advance.

Recipients of Services:
Providers (including contractual and service modalities), CBOs, providers in communities of color, and CPG organizations with HIV/AIDS budgets of less than $5 million annually. Organizations that can show a demonstrated link between capacity assistance and improved services are targeted to receive services. All contractual agencies are provided with capacity-building support as needed and appropriate.

Process for Accessing Services:
Organizations can obtain services by contacting OAPP by telephone or in writing (mail, fax, or e-mail). OAPP program managers can recommend and refer agencies for capacity-building support. Trainings and technical assistance requests can be made for specific topics.

The Innovative Leadership Forums and other series may be attended several times throughout the calendar year. There are Internet follow-up sessions after each forum.

Recipients of capacity-building services are required to complete a 3-page assessment every year, which is used to plan capacity building and allows the capacity-building service provider to become familiar with the recipients. This organizational survey is administered to the 65 provider programs serving communities of color Program indicators for effectiveness of the Capacity Building Initiative include:

- Fiscal fitness;
- Timeliness of contract compliance;
- Agency budget growth;
- Ratio of OAPP funds to non-OAPP funds;
- Ratio of government funds to private funds;
- First time fund raising events; and
- Completion of contract mapping.

Exemplary Practices:

1. The Capacity Building Initiative identified a philosophy and principles that would help make capacity-building services well received by HIV/AIDS service leaders and agencies in communities, especially those communities that are most acutely challenged to respond to the epidemic.
2. Capturing and disseminating lessons learned over the past 4 years has enabled others to learn about and participate in the Capacity Building Initiative.
3. Focus on public/private partnerships. The OAPP initiated a Funders Council that is comprised of representatives from private foundations, community relations departments of for-profit entities, management support centers, and non-profit subject matter experts. The Council is used to help provide resources in the community to enhance capacity-building activities. OAPP believes it is especially important to link communities of color to these private dollars and to build capacity for navigating the world of private funding. OAPP is a supporter of public/private partnerships and is interested in expanding the role of public/private dollars in HIV/AIDS services. Senior managerial staff work directly with local, regional, and national funders to educate them on the needs and work of HIV/AIDS communities and to encourage their support of local agencies.

Program Summary

OAPP directs the Department of Health Services' overall response to the HIV/AIDS epidemic in Los Angeles County. The Los Angeles County jurisdiction has the second highest number of AIDS cases in the United States. With an annual budget of more than $92 million, OAPP coordinates the dissemination of funds and the implementation of programs for HIV primary medical care, support services, HIV counseling, testing, and prevention services in partnership with more than 115 providers. Of these providers, 108 are community based and 65 work in communities of color.

In 1999, OAPP implemented a Capacity Building Initiative. Now in its fourth year, the Initiative has provided $8.2 million in capacity-building funding to more than 50 of its contracting agencies. The Initiative's overall goal is to build and develop the organizational infrastructure and capacity of service leaders and agencies to deliver and sustain more effective, high-quality HIV/AIDS services. The Initiative supports leadership development, facilitates learning and understanding of non-profit management standards and best practices by agency management, identifies strategies to integrate programs for greater efficiency, and increases overall accountability.

The Capacity Building Initiative aims to accomplish specific objectives including:

- Region-wide organizational planning;
- Increased capacity to raise and leverage private funds;
- Trained boards of directors and staff;
- Upgraded bookkeeping systems and fiscal controls;
- Improved staff retention; and
- Increased numbers of clients retained in HIV/AIDS prevention, care, and treatment services.

The Capacity Building Initiative is built on the idea that there can be continuous improvement through continuous leadership, relationships, and resource development. On behalf of those who lived and died working to establish HIV/AIDS services, the Capacity Building Initiative emphasizes life, health, and well-being for populations and communities needing HIV services and support.

The Initiative acknowledges and celebrates the fact that:

- Leaders with the desire, will, and intent to further establish and sustain viable and competent services are available in the community.
- Leaders and service agencies deserve respect;
- Organizational cultures should be relevant and responsive to the needs of the people served in their communities; and
- Community service leaders and agencies respond well to trust, commitments sustained over time, and challenges framed within a context of community and population improvements.

Program Statement of Need

Without infrastructure support, the ability of service leaders and agencies to deliver and sustain effective care and prevention programs is severely compromised. Funding to support costs associated with organizational infrastructure (e.g., fiscal management, information systems, program development, evaluation and quality assurance, development, training for staff) is limited and difficult to secure. Yet HIV/AIDS service agencies often lack the organizational infrastructure to sustain effective HIV/AIDS services, especially in communities of color and undeserved communities.

Technical Assistance

A specialized staff manages the daily operation of the Capacity Building Initiative and develops and manages a cadre of external consultants who work directly with agencies. The overall program consists of the following major components.

Direct Community-Based Organizational Support—This component provides limited amounts of one-time only funding to support improvements to infrastructure and capacity, such as upgrades to information or telephone systems.

Organizational Survey—This survey, which is designed to examine almost every aspect of local service provider agencies, provides comparative and detailed base information on leaders and agencies. The survey also has been a useful way to gather information on agencies' vendors, financial institutions, and audit firms.

Executive Director Forum Series—This forum series is funded by a grant from the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services and CDC. The Forum is designed to give service providers a unique opportunity to obtain valuable information on a variety of subjects, including executive director and board of director partnerships, financial resource development, program integration, human resources, and communications. Series participants also can log onto the Extranet to ask follow-up questions. This specialized series is designed to enhance the abilities of agency leadership, identify resources, and provide highly focused tools for achieving organization goals. Though provided to all agencies, the series focuses on assisting organizations to meet the needs of undeserved populations and communities of color. The series schedules 6 sessions per year plus additional workshops as needed. The sessions have been most effective when local and national corporate and foundation funders participate as panelists and sponsors.

New Leadership Orientation—This curriculum-based orientation session helps ensure a smooth transition when agencies hire new managers. New hires are invited to participate in a one-on-one session that helps them "hit the ground running." They learn how OAPP functions and how to navigate it. They also participate in a contract review that covers the history and current status of OAPP's contract programs, rules, regulation, and compliance. Use of data and financial requirements are also included in the orientation, as is an overview of the administrative agency structure of OAPP.

Resource Center—The library contains both electronic and hard copy materials on compliance, fundraising activities, and funding information. Within the resource center an "Extranet" has been developed as a private website so that CBOs and managers can engage in on-line discussions with other CBO directors and non-profit management experts. The Resource Center also links CBOs to other special libraries and collections.

Private Funders Council—This council, described earlier, is comprised of representatives from private foundations, community relations department of for-profit entities, management support centers, and other non-profit subject matter experts. The council is used to assist in the provision of resources in the community to enhance capacity-building activities.

Audience-Specific Educational Outreach—This initiative helps agencies identify different audiences for their programs and develop communications and messages in languages and formats that the audiences understand.

Broadening Private Funding Support—OAPP supports public/private partnerships and is interested in increasing public/private support for HIV/AIDS services. Senior managerial staff works directly with local, regional, and national funders to educate them on the HIV/AIDS needs of communities and to encourage their support of local agencies.

Technological Infrastructure—In this key component of capacity building to improve agencies' organizational infrastructure, OAPP works to modernize the technological capabilities of CBOs.

A Snapshot of Capacity Building　　　　LOS ANGELES

Los Angeles Executive Forums

The Los Angeles County Department of Health Services, Office of AIDS Programs and Policy's ongoing Executive Director Forums were praised in the CDC's 2003 Technical Review as "outstanding" and noted as "one of the most effective and well-supported capacity-building initiatives available." The Executive Director Forum series brings together key executive leaders of CBOs that provide HIV/AIDS services. Together, executive directors and other key leadership personnel engage in specific training opportunities that are designed to increase their knowledge about a range of important non-profit management issues. Some of the topics addressed at forums include:

- Creating high levels of performance;
- Preparing for financial audits;
- Enhancing the effectiveness of boards of directors;
- Integrating programs to enhance agency performance;
- Communicating with communities; and
- Raising funds.

Attendee survey results indicate the most frequently reported strengths of the forums have been: the clarity of the speaker/panelist, skill-building exercises; interactive discussions; and opportunities for networking. Consistent attendance and participation by key leadership staff of CBOs support the need and utility of the Forums, and they are repeatedly rated as extremely useful.

IV. New Jersey

Program Name:
Organizing for Community Development (OCD)

Relationship to Community Planning:
The OCD works to encourage community members to actively participate in the New Jersey HIV Prevention Community Planning Group.

Full-time Employees:
45

Services Provided:
Grant writing workshops, technical assistance, support for local HIV prevention task forces, and information sharing are provided.

Recipients of Services:
Executive directors; health educators; program coordinators; program directors; program developers; social workers; churches; drug treatment centers; local health departments; schools/colleges/universities; AIDS service organizations; and CBOs.

Process for Accessing Services:
Recipients request services by contacting OCD by telephone, fax, or e-mail, or by participating in trainings.

Process for Assessing Services:
OCD evaluates the organizations' performance and their ability to reach and complete target deliverables. An increase in the number of grants was observed.

Exemplary Practices:
Grassroots School of Grant writing

Program Summary

Organizing for Community Development was created in response to the New Jersey HIV Prevention CPG's recommendation that technical assistance be provided to grassroots CBOs to increase their capacity to provide HIV/AIDS prevention services. The OCD is a 501(c) (3) directly funded by the health department. Its primary mission is to reduce the incidence of HIV infection in New Jersey through providing capacity-building skills to CBOs. OCD's objectives include:

- Promote the growth of HIV prevention capabilities in New Jersey's communities by providing technical assistance and training to non-profit organizations in developing, implementing, and evaluating local HIV prevention programs;
- Increase the impact of the New Jersey HIV Prevention CPG by helping the members take active leadership roles in the HIV prevention community planning process in their communities;
- Support the development of local HIV prevention task forces throughout New Jersey; and
- Serve as a resource to CBOs in identifying private funding to continue their local HIV prevention efforts.

In addition to its four full-time positions, OCD has 1 part-time administrative position and two in-kind positions (principal investigator and a business manager). The OCD offers services that assist recipients with:

- Writing proposals;
- Conducting programs within the community,
- Addressing emerging issues;
- Obtaining funding; and
- Developing effective community-driven processes (linking primary services to secondary services).

These services are provided through workshops, one-on-one and group technical assistance episodes, client empowerment training, websites, and retreats.

Technical Assistance (TA)

The Grassroots School of Grant writing (GSG)—This effort is subsidized with funding from the New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control in partnership with Rutgers University Health Services, and Department of Health Education. The GSG was developed for individuals who want to:

- Develop competitive proposals for resources to reduce HIV infection, provide HIV care and treatment, and address other community-related health challenges;
- Enhance their skills at writing grant proposals;
- Increase their ability to monitor and evaluate their own programs by understanding the grant proposal process; and
- Increase the fiscal strength of their CBOs, AIDS service organizations, local health departments, and the interfaith community.

For the past five years, CBOs and local health departments throughout New Jersey have benefited from the GSG, which is specifically tailored to meet the needs of small, non-profit organizations. Participants have become more involved in HIV prevention and have demonstrated an increased ability to develop and conduct creative, effective programs. OCD has trained more than 200 participants with the following results:

- More than $800,000 in funding for the development of housing for people living with HIV/AIDS in Essex and Monmouth Counties;
- $250,000 a year in funding to the interfaith community in Newark;
- More than $550,000 in funding for HIV prevention in Hudson County;
- More than $300,000 in funding for HIV care and treatment in Bergen County; and
- $1 million for HIV prevention and drug treatment in Essex County.

In a typical eight-session GSG, the participants are divided into teams. Each team creates a fictitious organization, and then writes a grant proposal according to a request for proposals. Each session focuses on specific aspects of the proposal-writing process, including:

- Planning to write a proposal;
- Assessing the needs in a target geographic area;
- Working with data to improve the competitiveness of a proposal;
- Behavior change;
- Incorporating findings from needs assessments;
- Developing a proposal narrative that effectively bridges the gap between problems and proposed solutions;
- Translating community needs into sound programmatic concepts;
- Looking at programmatic outcomes and measuring impact to demonstrate the effectiveness of proposed efforts; and
- Budgeting for success.

V. North Carolina

Program Name:
HIV/STD Prevention and Care Branch, Prevention and Community Planning (PCP) Unit

Relationship to Community Planning Group (CPG):
The Community Planning Unit works to ensure participation by affected individuals and communities in the planning, development, and evaluation of HIV/STD prevention efforts. When North Carolina established its HIV Prevention Community Planning process in 1994, it decided to use a regional/statewide approach to achieve both a local and statewide perspective in developing HIV prevention efforts. Seven regional and a statewide CPG were formed to carry out community planning.

Full-time Employees:
8

Services Provided:
Information transfer, skills building, technical consultation, technical services, and technology transfer.

Recipients of Services:
All CBOs and county health departments in the state.

Process for Accessing Services:
Recipients request services by contacting the Prevention and Care Branch by telephone, fax, or e-mail.

Process for Assessing Services:
The Prevention and Care Branch measures the effectiveness of its capacity-building services through data submitted from funded programs and from evaluations completed at specific programs and site visits.

Exemplary Practices:
With the incubation project, capacity-building service providers actively seek CBOs that traditionally do not respond to requests for proposals and provide them with training in grant writing and organizational infrastructure so that they are able to compete for federal funding.

Program Summary

The goal of the HIV/STD Prevention and Care Branch is to provide consultation, training, educational materials, and financial assistance to CBOs and county health departments that provide HIV/STD education and risk reduction programs. The PCP Unit has developed a capacity-building plan focusing on both the organizational and community levels. This plan helps key personnel increase their ability to plan and conduct interventions and maintain the infrastructure systems and resources necessary to support activities and mobilize stakeholders.

Technical Assistance

Academies—These workshops focus on specific topics that meet the needs of the recipients and have been identified from needs assessments and evaluations. For example, academies have trained agencies in evaluation by examining what evaluation means, describing how to link objectives to evaluation methodology and outcomes, and training staff in how to conduct program evaluations.

Group Initial Site Visit (GISV)—These visits occur once a year and are mandatory for CBOs with established funding as well as those that are newly funded. The current innovative format evolved from a more traditional approach in which the Prevention and Care Branch would make initial site visits to new projects and routine site visits to old projects at the beginning of each year. The Branch found that all of the funded agencies were asking similar types of questions. As a result, health department staff began to hold site visits in a group setting with participants from both established and newly funded projects. This approach has allowed new projects to learn from established projects, and established projects to be exposed to new approaches and ideas from new projects.

Incubation Project—A large number of local agencies in the eastern part of North Carolina do not have the funding to sustain strong HIV prevention programs and projects. The Prevention and Care Branch is working with them to develop a capacity-building framework to help them receive funds to implement peer-to-peer training. Once identified, these CBOs will receive capacity-building services and training in organizational infrastructure, fund development, grant writing, and skills building.

Safety Net Project—This project observes and evaluates the gaps in services for people who are affected or infected with HIV/AIDS. The project fosters collaborations among regional agencies, such as health departments, and local agencies, so that they can develop best practices to ensure that the needs of clients are met.

African American Faith Initiative—This initiative was originally designed to empower and educate clergy who would, in turn, educate and mobilize their congregations and the community. Raleigh/Durham was one of the sites chosen to replicate the week of prayer started by the Balm in Gilead. Faith revivals, which are services that incorporate HIV/AIDS prevention messages, are held throughout the year. Any church, denomination, or place of worship can offer a faith revival with support from the Prevention and Care Branch. Support includes:

• Technical assistance;
• Speaker panels, including HIV-positive clergy and other activist clergy,
• Materials(a manual has been developed on setting up a revival); and
• Conferences.

Rapid Intervention Outreach Teams (R.I.O.T.)—The Prevention and Care branch recognizes that capacity building requires an investment of time. Although capacity building may be directed toward building future efforts, sometimes a gap in programs or services needs to be addressed immediately. The branch established Rapid Intervention Outreach Teams (R.I.O.T.) to answer one such immediate need. R.I.O.T. coordinates efforts between local health departments, CBOs, and the state HIV/STD Control Chapter to increase outreach education, screening, diagnostic services, treatment, and partner notification activities in a given area. Community-based outreach workers and disease intervention specialists from around the state come into an area to work together as prevention partners. This enables the local community to offer one-on-one outreach, risk reduction education, and HIV counseling and testing during non-traditional hours to people who have questions about HIV/AIDS and STDs.

NC Outreach Network—This network was established in 1992 to develop and promote the role of outreach workers. The participants meet quarterly to receive training on effective outreach interventions. The network developed a strategy manual in 1994. In addition, members participate in R.I.O.T. activities and receive a certificate from each outreach meeting attended.

A Snapshot of Capacity Building   NORTH CAROLINA

A Variety of Workshops

The Statewide CPG and the Prevention and Care Branch developed a capacity-building timeline to map its continuing technical assistance and educational trainings and workshops, such as:

- The Prevention and Community Planning Leadership School;
- Trainings and in-service sessions for Ryan White Consortia; and
- Capacity-building trainings for local health departments.

The CPG plans to enforce a mandate that funded agencies will be required to attend at least one capacity-building session per year.

Prevention funds were awarded through a competitive application process. The Community Planning Unit conducted workshops for potential applicants to review the application, discuss epidemiological data that needed to be included in the application, and review statewide HIV prevention priorities. The Unit also held a one-day writing workshop for providers, advocates, and citizens who were interested in learning more about writing grant proposals. This workshop included practice sessions on writing clear and measurable goals and objectives, discussed evaluation techniques, and provided ideas on how participants could monitor their progress. Other capacity-building activities included the Group Initial Site Visits, sessions on the Dissemination of Effective Behavioral Intervention (DEBI) projects, and working with men of color who have sex with other men.

VI. Rhode Island

Program Name:
Initiatives for Human Development (IHD): Project REACH (Relating, Exchanging, and Capacity Building for HIV Prevention)

Relationship to Community Planning Group (CPG):
The REACH planning committee is a subcommittee of the CPG. REACH is responsible for identifying and addressing the programmatic issues of the CBOs who serve the priority populations and develops programs, training sessions, and technical assistance to address these issues.

Full-time Employees:
3.5

Services Provided:
Curriculum training sessions, TA, networking, workshops, ongoing support, and internships.

Recipients of Services:
Agencies receiving services included those serving communities of color and special populations (e.g. men who have sex with men, injecting drug users, youth) who are at high risk of HIV infection.

Process for Accessing Services:
Recipients submit requests for services by contacting Project REACH via telephone, fax, or e-mail.

Process for Assessing Services:
Participants complete evaluations at the end of each workshop session and training. In addition, Project REACH has conducted three extensive needs assessments in their four-year history. REACH staff also receive informal verbal evaluations from recipients.

Exemplary Practices:
Grants from the health department include built-ins for capacity-building services. The Certified Capacity Building Institute is offered to prevention professionals.

Program Summary

Developed in response to needs identified by the Rhode Island HIV Prevention CPG, Project REACH is a project of the non-profit Initiatives for Human Development and is supported by a capacity-building grant from CDC awarded to the Rhode Island Department of Health Office of AIDS/STD.

The goals of Project REACH are to:
- Enhance the capacity of community-based minority agencies;
- Provide the most effective prevention programs and services to populations at high risk of HIV by involving a wide range of participants; and
- Focus on CBOs that work with communities of color, so that cultural sensitivity and appropriateness are built into capacity building.

An advisory panel, established by Project REACH, helps to encourage community buy-in and participation. Based on a comprehensive community development model, REACH looks at both HIV providers and non-HIV providers to enhance the CPG strategy. REACH combines didactic and experiential approaches to adult learning to provide effective services to recipients to nurture existing indigenous resources that are available on the local level. Project REACH, and capacity building in general, are viewed as integrally related to community planning.

From its inception, REACH has always developed its programming according to the needs, priorities, and populations identified by the CPG's Comprehensive Plan. This is partly due to the design of the capacity-building program and to the fact that IHD holds a contract to support the CPG process. A direct line is drawn between the CPG's recommendations, the vendors funded by the health department, and the programming REACH provides. This link allows the project to provide intensive outreach to CBOs that serve populations at high risk. These CBOs are provided with newsletters, workshops, intensive training, internships, seed grants, retreats, and one-on-one consultation.

Technical Assistance

Certified Capacity Building Institute—The Certified Capacity Building Institute is a 36 hour intensive training designed to maximize the skills of staff persons in CBOs serving communities of color and other HIV/AIDS priority populations. Completing an institute enhances the abilities of these professionals to plan, implement, and facilitate highly effective HIV/AIDS prevention services as well as to train and mentor others in these areas. The institute that focuses on training trainers provides proven techniques and strategies to best enable the participants to share their knowledge and experience within their organizations and in workshop settings.

A Snapshot of Capacity Building   RHODE ISLAND

Project REACH

Project REACH focuses on the comprehensive notion of community development and seeks to develop standards of HIV prevention in conjunction with community partners. Since its inception in 1996, REACH has trained hundreds of individuals and has consulted with numerous CBOs in Rhode Island.

The core of REACH's capacity building is its annual catalog of trainings. These trainings are based in sound theoretical models and best practices of HIV prevention service delivery, considering both the program interventions and the technical tools appropriate for target populations. Training components include needs assessments, focus groups, and materials. Topics are generated through a bi-annual, community-wide survey of prevention practitioners, consumers, and members of Rhode Island's targeted prevention populations.

REACH delivers a minimum of 25 training days per calendar year on topics ranging from generating culturally, linguistically, and developmentally appropriate materials to writing effective grant applications. All courses are available free of charge to all community members, with a priority on current staff members of HIV prevention organizations. Consistent attendance, the breadth of participating agencies, and the satisfaction noted on evaluation forms signify the success of these trainings. Participants cite the knowledge and diversity of trainers, the relevance of training topics, and the quality of information presented as the most common reasons for ongoing participation in REACH trainings.

REACH also offers one-on-one technical assistance on grant writing and program implementation, and works with the Rhode Island CPG members to expand and improve their capacity to participate effectively in community planning.

NOTE: Information on all of the above case studies was collected in 2001, 2002, and 2004 by key informant interviews conducted in the field.

TOOLBOX

TOOL 1

Core Competencies of HIV Prevention Capacity Building

The core competencies of HIV prevention capacity building are capabilities that are critical to an organization working to fulfill its mission and achieve its diverse goals.   This tool provides an overview of the competencies that have been identified as vital to a well-functioning organization. The overview includes six main focus areas: Human Resource/Personnel Management; Finance Management; Development; Program Design and Implementation; Collaboration; Governance; and Monitoring and Evaluation. Sub-topics are listed underneath each focus area. Tool #1 provides a preview of the issues that will be examined in greater detail in Tools #2 through #6.

Human Resource/Personnel Management
- Organizational structure and service
- Staffing: recruitment and retention
- Training/staff development (capacity building)
- Employee performance
- Management and supervisory practices
- Information sharing

Finance Management
- Accounting system
- Timekeeping
- Personnel
- Indirect expenses
- Budgetary controls
- Procurement
- Property management and equipment
- Consultants/subcontractors
- Travel
- Financial condition
- Financial management

Development

- Financial reports
- Constituencies
- Innovative linkages
- Diversification of support
- Donors

Program Design and Implementation

- Stakeholders
- Project areas
- Information sharing

Collaboration

- Networks

Governance

- Strategic planning
- Board roles and responsibilities

Monitoring and Evaluation

When reviewing this tool and those that follow, it is important to recognize that while the tools provide information that can be helpful in assessing many of the core procedures that need to be in place for an organization to operate at full capacity, no single tool can adequately meet all of the needs of all organizations. Please note that not all of the information provided is appropriate for all organizations. Also note that administering the tools requires a basic understanding of non-profit management. As such, the tools in this toolkit should be utilized in partnership between organizational representatives, management consultants, and/or capacity building assistance providers.

TOOL 2 Human Resources and Personnel Diagnostic Tool

The processes of recruiting, managing, and retaining competent staff members can be approached from myriad directions. Human resources (HR) and personnel policies and practices may vary significantly from organization to organization depending on factors including staff size and organizational culture. As such, no single assessment tool can accurately address the needs of all organizations in regards to human resources and personnel systems.

Recognizing the variations among organizational practices/policies, this tool does not provide solutions to specific human resource and personnel-related issues. However, the questions posed will help readers to develop frameworks for thinking about the many topics that must be addressed to ensure that staff members are capable and committed to the organization.

Please note, not all questions are appropriate for all organizations. Also, administering this tool requires a basic understanding of non-profit human resource and personnel management, as appreciation of the implications of the questions posed and answers provided is key to the success of the activity. This tool should be utilized in partnership between organizational representatives, financial management consultants, and/or capacity building assistance providers.

PERSONNEL

- Is adequate HR planning occurring? How does the organization forecast, recruit, and select human resources?
- Is there a comprehensive written HR policy that has been reviewed and updated within the last two years?
- Does the organization keep personnel records?
- Are there established personnel policies? How are these personnel policies established and implemented within the organization? How often are they revised?
- How is the scope of personnel activities defined?
- How is staff trained on the personnel policies and how are policies made available to them?

MANAGEMENT

- Is equity dealt with appropriately, particularly as relates to issues of selection and promotion?
- What are the communication mechanisms within and across the organization?
- Does the staff diversity reflect the diversity of the population served? What is the ethnicity percentage of staff compared to the population served?
- Are there regularly scheduled staff meetings? How often do staff meetings occur?
- What is the formal process for grievances? How are staff members made aware of the grievance process?
- Is there a formal process for evaluation of employees? If so, are employees provided with feedback? How often are evaluations of employees conducted? How are these evaluations utilized for the professional development of the individual and the development of the organization?
- Are salaries competitive? If not, are other incentives implemented (i.e. comp time, educational benefits, or educational leave)?
- Are there clear rules and boundaries for interactions between staff and clients? How is staff made aware of these rules and boundaries?
- How is the time of employees tracked and managed?
- Are there means for effective communication between management and staff? Is there an established protocol for communication between management and staff?
- Is there enough staff to provide services?
- Are there any vacancies that need to be filled? If so, how many and what percentage of the overall staff is vacant?
- Is the organization able to hire staff? If not, why not?
- Over the last 12 months, to what degree have the personnel and management practices listed below influenced the performance of new hires and veteran employees?

    - Recruitment
    - Compensation (salary and benefits)
    - Personnel evaluation
    - Promotion (professional advancement)
    - Grievance and conflict resolution policy
    - Staff (allocation of tasks and responsibilities)
    - Supervision

- Give examples of instances in which the practices listed below either contributed to or detracted from employee performance.

  - Recruitment
  - Compensation (salary and benefits)
  - Personnel evaluation
  - Promotion (professional advancement)
  - Grievance and conflict resolution policy
  - Staff (allocation of tasks and responsibilities)
  - Supervision

- Over the last 12 months, to what extent has the organization experienced loss of competent staff?
- What factors contributed to this loss?
- For the same time period, what examples does the organization have of practices listed below that directly contributed to retention of competent staff?

  - Recruitment
  - Compensation (salary and benefits)
  - Personnel evaluation
  - Promotion (professional advancement)
  - Grievance and conflict resolution policy
  - Staff (allocation of tasks and responsibilities)
  - Supervision

- Does the supervisory practices of the organization enhance the staff's capacity to meet the organization's objectives?

- What is the organization's plan for recruiting and retaining employees? Please describe.

- Is there a high turnover rate among staff members?

- Does the HR department conduct exit interviews with departing staff members?

TRAINING/STAFF DEVELOPMENT/CAPACITY BUILDING

- Does the organization's staff have the skills necessary to achieve the organizational mission?
- What is the organizational plan for staff development and capacity building?
- What training or technical assistance (TA) needs for staff have been identified?
- How is training and TA provided?
- Are there opportunities for employee training and advancement?
- Are supervisors and managers adequately trained on leadership roles and building staff morale?
- Do all new employees receive a general orientation and specific training for their positions?
- How often does the organization provide staff training events?
- Based on the 3 most recent staff training events, what evidence is there that they strengthened staff capacity and performance?
- To what extent were the areas of improved staff capacity relevant to the organization's HR needs?
- To what degree did these training events prepare staff to respond to the organization's strategic objectives?
- What are three primary, ongoing functions (e.g., monitoring and evaluation, proposal writing, resource mobilization) that are carried out to achieve the organization's mission?
- To what extent does staff, as a group, have the requisite skills to carry out these functions?
- To what extent is the number of employees carrying out these functions commensurate with work demands?

COMMUNICATION

- What are the communication mechanisms within and across the organization?
- Are there means for effective communication between management and staff? Is there an established protocol for communication between management and staff?
- What information has flowed between senior management at headquarters and non-supervisory staff (including field staff) over the past month? Typically, who initiated these communications?
- Is the prevailing flow of information top-down or bottom-up? Is information exchanged horizontally (e.g. between field offices)?
- Over the last 12 months, what have been the organizational priorities? What information did the organization utilize to develop or address organizational priorities?
- To what degree was the information useful in achieving the organizational objectives?
- How typical are these examples of informational resources within the organization in terms of content and timelines?

ASSESSING INFRASTRUCTURE

- Is there an organizational structure in place? How is the organizational structure explained and provided to all employees?
- Does the organizational strategy identify the opportunities and constraints regarding the organizational infrastructure?
- Are the buildings and internal services (e.g. water, electricity) adequate to support and facilitate daily work?
- Is there adequate transportation to and from work for employees?
- Are communications systems (hardware) functioning at the level required?
- Are there adequate maintenance systems and procedures that are supported by a maintenance budget?
- Is building and equipment maintenance being managed? How is the organizational infrastructure managed?
- Does the organization have a planning process to address infrastructure concerns?
- What individual or group is responsible for addressing the organizational infrastructure concerns?

The questions in this tool provide a framework from which to analyze the personnel issues, management styles, training/staff development activities, communications, and infrastructure of an organization in some detail.   When an analysis of these areas has been conducted, it becomes easier to meet HR and personnel needs and ensure the recruitment, proper management, and retention of skilled and committed employees.

TOOL 3 Financial Management Diagnostic Tool

A healthy financial management system may look substantially different from organization to organization (depending on funding sources, organizational budget size, and staff size). For example, just as one would not expect an external audit for an organization with a budget of less than $10,000, it is mandatory that organizations expending $300,000 per year or more in federal awards obtain an annual single audit. As such, no single assessment tool can adequately meet the needs of all organizations in regards to financial systems.

Tool #3 provides a menu of questions that can be helpful in assessing many of the core procedures that need to be in place for a financial system to operate at optimal capacity. Please note, not all questions are appropriate for all organizations. In addition, this tool does not provide procedures or solutions to problems with an organization's financial system; the questions are provided merely to suggest the broad range of items that must be addressed for a well-functioning financial system to be in place.

Finally, administering this tool requires a basic understanding of non-profit financial management, as an understanding of the implications of the questions posed and answers provided is key to the success of the activity. As such, this tool should be utilized in partnership between organizational representatives, financial management consultants, and/or capacity building assistance providers.

GENERAL INFORMATION

- Has an external audit report been issued on this organization? If yes, examine prior year audits for internal control problems that may still exist as well as any indications of financial instability.
- Has the organization had a recent audit by either another government agency or independent public accountant? If yes, what were the outcomes of the audit?
- What is the organization currently working on to meet the recommendations in the audit report?
- Does the organization have fidelity bond coverage for responsible officials? (Indicate the official covered and the amounts of coverage.) If not, what is the organization's plan to incorporate fidelity bond coverage within the organization?
- Does the organization have a set of accounting policies that are updated on an annual basis and are utilized to regulate all financial aspects of the organization?

FUNDING SOURCES

- Is the organization dependent on any single funding source/award for more than two-thirds of its entire budget?
- Is there a development (fundraising) plan in place for long-term sustainability of the organization?
- Are all grants, cooperative agreements, and contracts clearly tracked to assure complete progress reports, final reports, and renewal applications are submitted on time?

ACCOUNTING SYSTEM

- Does the organization maintain a manual or an automated accounting system? What type of accounting system does the organization utilize?
- Do controls or systems exist that limit the roles of individuals within the financial system, so that no single individual is responsible for all oversight aspects?
- Is there a general ledger? If yes, what is the protocol for entering information into the general ledger? Who has access to the general ledger?
- Is there a chart of accounts? If yes, how are the accounts tracked and managed? Who is responsible for completing this function? How often are the account charts reviewed and updated?
- Does the organization have written accounting policies and procedures? If yes, how often are the policies and procedures updated? Do all of the board members receive a copy of the policies and procedures?
- If applicable, does the organization's accounting system provide for the proper segregation of direct costs from indirect costs?
- Can the organization's accounting system identify sources and application of funds? (Commonly referred to as a fund accounting system).
- Can the fund accounting records be reconciled to the general ledger? If not, what is the organization's plan for addressing the reconciliation?
- Does the organization maintain its accounting records on a monthly basis? If not, how often does the organization maintain accounting records? How does the organization decide how often to review the accounting records?
- If applicable, does the organization have a logical and consistent method for the allocation of indirect costs to grants and contracts?

- Does the organization have or plan to hire a bookkeeper or an accountant? If not, who is in charge of the accounting? What qualities should the candidate have to meet the accounting needs of the organization? Will the candidate fulfill more than one employment role; meaning, will the candidate also complete payroll duties, development duties, etc.?
- Does the organization prepare financial statements at least annually? If not, how often? (Obtain copy of latest statement.) Is the statement easy to read and understand?
- Has an independent public accountant audited the financial statements within the last two years? If not, when will the next audit take place? How often does the organization undergo audits? Who decides the frequency of audits?
- Does the organization maintain cash-flows? If yes, how often are they updated and how far in advance do they project?

TIMEKEEPING

- Does the organization require employees to complete a personnel activity report (e.g. time card or time sheet)? Please explain.
- If time cards and time sheets are used, are there written timekeeping procedures in place requiring employees to:

  - Record time on a daily basis? If not, how often?
  - Record time on time cards in ink?
  - Correctly distribute their time by project numbers, grant name, or other identifiers for a particular program?
  - Make proper time card corrections by lining through all changes and initialing the change made?
  - Record all hours worked whether paid or not?
  - Sign the time card at the end of each pay period?

- Do the written timekeeping procedures require supervisor's to approve and co-sign all time cards?
- Does the organization maintain documented payroll information that has been approved by a responsible official of the organization?
- Is there adequate segregation of responsibilities for program activities (e.g. responsibilities for timekeeping should be separate from payroll accounting)?
- Do the timekeeping procedures prevent a supervisor from completing an employee's time card except in extenuating circumstances?

- Is there adequate timekeeping training given to all employees? The training should state that the accurate and complete preparation of time cards is a part of the employee's job.
- Can the payroll be reconciled to the time sheet?

INDIRECT EXPENSES

- Has the organization developed an indirect expense rate to distribute indirect expenses to all grants/contracts? If not, does the organization charge all expenses direct to projects?

BUDGETARY CONTROLS

- Does the organization use a budget to control program funds?
- Are persons in the organization who approve budget amendments authorized to do so by the board of directors or top management?
- Are there budgetary controls in effect (e.g. comparison of budget with actual expenditures on a monthly basis)?
- What practices and procedures are in place to help the organization avoid deficits?
- How often does the organization employ these practices and procedures?
- What are the organizational objectives this fiscal year and to what extent are these mirrored in the organization's current budget? Are these objectives included in the strategic plan for the organization?
- Over the past year, has the organization had any problems regarding delayed transfer of funds to the field or partner organizations?
- What mechanisms are in place to ensure that money flows to the field or partner organizations in a timely manner?
- Do the organization's cash management procedures lead to the timely disbursement of funds?
- How often does the organization review the level of reserves in relation to the annual operating budget?
- Amount of operating budget_____   Amount of reserves _____
- For how many months could the organization maintain the current level of operations if solely dependent on the reserves currently on hand?
- What concrete measures are the organization currently taking to enhance the reserves?
- Does the organization work to establish cash reserves equivalent to 25% of the annual operating budget? How does the organization work toward meeting this goal?

PROCUREMENT

- Does the organization have written purchasing procedures?
- Do the written procurement procedures meet the requirements per 45 CFR 74?

PROPERTY MANAGEMENT/EQUIPMENT

- Does the organization have written procedures over property management/equipment?
- Do the written property management/equipment procedures meet the requirements per 45 CFR 74?

CONSULTANTS/SUBCONTRACTS

- Does the organization have written procedures over the use of Consultants/Subcontractors?
- Do the written procedures meet the requirements per 45 CFR 74?

TRAVEL

- Does the organization have written travel procedures?
- Do the written travel procedures meet the requirements per the applicable Office of Management and Budget (OMB) circular?

FINANCIAL CONDITION

- Is the current ratio (Current Assets/Current Liabilities) acceptable?

BUDGET DEVELOPMENT AND MANAGEMENT

- Is there a budget planning process?
- Are funded activities actually occurring as described?
- What specific steps of this year's budget-planning process facilitated consideration of mission and programmatic priorities?
- Does the budgeting process lead the organization to allocate funds in a way that closely reflects the organizational priorities?
- How accurate were last year's financial projections in relation to actuals?
- How timely is the distribution of reports on financial projections versus actuals?
- Does the organization have contingency measures currently in place if projected revenue fails to materialize?
- Do the organization's financial management practices lead to accurate financial projections?
- Does the organization regularly modify the program expenditures based on findings presented in the internal financial reports?
- Do the organization's financial contingency measures prevent operational disruptions?

The broad range of items covered in this tool must be addressed for a well-functioning financial system to be in place. Once an organization's financial management system has been established, the assurance of financial security and sustainability through development can be addressed.

TOOL 4 Development Diagnostic Tool

Organizations may take many different routes in assuring their financial security and sustainability. Some organizations may rely solely on government contracts and cooperative agreements while others look to foundations and individuals for financial support. Some non-profits generate revenue directly from programs while others rely on third-party reimbursements.

While there is no one way to successfully fund a non-profit, there are certain principles and processes, regardless of funding streams, which are important in assuring an organization's stability related to funding. This tool provides a detailed look at some of the questions that should be asked of any development system. Please note, not all questions are appropriate for all organizations. In addition, this tool does not provide answers or solutions to address problems within organizations' development systems, rather the questions are provided merely to suggest the broad range of items that must be attended to if a well-functioning organization is to exist.

Finally, administering this tool requires a basic understanding of non-profit new business development/fundraising, as an understanding of the implications of the questions posed and answers provided is key to the success of the activity. As such, this tool should be utilized in partnership between organizational representatives, fund-raising consultants, and/or capacity building assistance providers.

DEVELOPMENT PLANNING

- What are the organization's financial needs? What is the organization's long-term plan for addressing financial needs?
- Does the organization have a well-developed grant-seeking schedule and approach?
- What is the strategy for identifying donors? What is the strategy for establishing linkages with these donors?

FUNDING

- What is the approximate number of current funders in each of the categories listed below? Is there a strategy in place to increase the number of funders?

  - Private Individuals
  - Corporations
  - Foundations
  - Public Sector/Government
  - Multilaterals

- Has the number of funders been increased from the previous year? What can be done to increase the number of current funders for the upcoming year?
- What is the size of the average contribution made by current funders in each of the categories listed above?
- How do these averages compare to those of last year? What can be done differently this year to increase the contributions made by current funders?
- To what degree is the organizational viability dependent upon the continued support of just a few large donors?
- What concrete measures have the organization taken over the last 12 months to diversify funding (support from more than one donor; meaning that if one of the donors decreased funding, the agency would still function)?
- Does the organization have a strategic plan to address the diversification of funding?
- What is being spent this year to raise one dollar of private support?
- How does this cost compare to what was spent last year?

DONOR COMMUNICATIONS

- What types of communication do the donors receive outside of direct solicitations?
- How frequently are donors recognized and thanked in a timely manner?
- Are required reports (e.g. annual, quarterly) submitted as requested per the funding letter?
- Over the last 12 months, to what kinds of donors (e.g. bilateral, major foundations, corporations) has the organization submitted narrative and financial reports?

- What is the quality of the information provided in these reports? How can the quality of the information provided in reports be improved?
- To what degree have these reports increased donor confidence in the organization's work? What can be done to increase donor confidence in the organization's work?
- Over the past 12 months, what feedback on performance has been gathered from donors?
- What are some concrete examples of changes that have occurred on the basis of this feedback?
- Over the last 12 months, what kinds of information about the organization's completed work has the organization shared with supporters and donors? If the organization has not shared; what information should be shared?
- In terms of all the information presented to the organization's donors, what relative priority has been give to information about the organization's impact?
- Does the organization routinely share information on its progress toward achieving its mission through communications with donors and the general public?
- If individual fundraising is conducted, do individual donors hear from the organization for reasons other than soliciting donations?
- Are mechanisms and/or processes utilized to recognize donors?

POLICY MAKERS

- Over the past 12 months, what has been the frequency and nature of the organizational contacts with policy makers? How frequently does the organization need to contact policy makers? Who are the policy makers?
- To what degree are these contacts part of an ongoing communication strategy? What should be included in an ongoing communication strategy? Why is the communication strategy important for the development of the organization?
- Does the organization regularly engage relevant policy makers and institutions in dialogue related to the organizational mission?
- Over the past 12 months, what feedback on performance has been gathered from policy makers?
- What are some concrete examples of changes that have occurred on the basis of this feedback?

LINKAGES

- Does the organization have linkages with foundations, organizations, and government contacts to secure diversified funding? If yes, how effective have these measures been?

- Over the past 12 months, what specific linkages has been established or maintained with the private business sector? What linkages should be established or maintained with the private business sector? What strategies are in place to establish these linkages?
- During the same period, to what degree has the organization offered companies the opportunity to assume a role other than that of donor? What additional roles could these companies serve for the organization?
- Does the organization forge innovative linkages with the private business sector?

An assessment of donor communications practices, relationships with policy makers, linkages with other entities, funding mechanisms and approaches to continued funding, and existing/proposed development plans will help organizations decide which route they would like to take in assuring their financial security and sustainability. Financial stability will allow organizations to continue their programming and design and implement additional programs that serve their communities.

TOOL 5 Program Diagnostic Tool

Program activities vary greatly between and within organizations. Different communities and diverse needs warrant varied approaches to the challenges faced by the populations that an organization serves. As such, no single assessment tool can adequately meet the needs of all organizations in regards to financial systems.

The questions provided in this tool can be helpful in assessing many of the core procedures that need to be in place for a program to operate at optimal capacity. Please note, not all questions are appropriate for all organizations. In addition, this tool does not provide procedures or solutions to address problems with an organization; the questions are provided merely to suggest the broad range of items that must be attended to if a well-functioning system is in place.

Finally, administering this tool requires a basic understanding of non-profit program management as an understanding of the implications of the questions posed and answers provided is key to the success of the activity. As such, this tool should be utilized in partnership between organizational representatives, program management consultants, and/or capacity building assistance providers.

PROGRAM/STAKEHOLDERS

- What is the scope of the organization's programmatic activities?
- How are new programs developed (i.e. is there a process for assessing program needs)?
- How do program objectives and activities fit within agency values and organizational mission?
- Who is the target population for the program?
- Are programs well publicized and/or advertised? Is the target population for whom the services are developed and offered aware of the program?
- What services are offered by the program, and how do these services benefit the target population?
- What is the overall goal/objective of the program?
- What are top capacity-building representative projects in the current program portfolio and who are the stakeholders in these projects?

- For the three projects identified, what are some concrete examples of stakeholder involvement in each of the processes listed below?

  - Assessing needs
  - Designing projects
  - Implementing projects
  - Monitoring projects
  - Assessing their impact

- For the top three projects identified, to what degree are traditionally under-represented stakeholders (e.g., rural poor, women, and ethnic minorities) engaged in the tasks listed below?

  - Assessing needs
  - Designing projects
  - Implementing projects
  - Monitoring projects
  - Assessing their impact

EVALUATION

- For the same three representative projects, what impact indicators are being used to track progress toward meeting project objectives?
- To what extent does the evidence (e.g., internal and external evaluations) suggest that the organization is achieving intended impact?
- To what extent does the evidence suggest that the organization's capacity is being enhanced?
- Does the organization routinely use result-based indicators to track progress in achieving objectives?
- Is the organization routinely monitored through internal evaluations?
- Does the organization achieve intended impact as demonstrated through internal and external evaluation?
- Does the organization enhance organizational capacity as demonstrated through evaluation?
- Does the organization have a mechanism for program evaluation? If not, how has your agency addressed the development of program evaluation?
- How are evaluation tools developed and standardized?
- How does the organization utilize the evaluation data?
- How does the organization identify outcome objectives?

- Does the organization collect both quantitative and qualitative data on programs? Give examples of each.

SUSTAINABILITY

- For the same three representative projects, to what degree has the organization addressed each of the sustainability issues listed below?

  - Economic sustainability (how recurrent costs associated with project activities will be met)
  - Political sustainability (how project-supported innovations will be accommodated within the framework of existing laws, policies, and political institutions)
  - Institutional sustainability (how the long-term viability of institutions created through project activities will be maintained)
  - Cultural sustainability (how project-supported innovations fit within the framework of existing norms, values, roles, and practices)

- To which types of sustainability (environmental, economic, political, social, and cultural) does the organization pay most attention?

  - Economic sustainability (how recurrent costs associated with project activities will be met)
  - Political sustainability (how project-supported innovations will be accommodated within the framework of existing laws, policies, and political institutions)
  - Institutional sustainability (how the long-term viability of institutions created through project activities will be maintained)
  - Cultural sustainability (how project-supported innovations fit within the framework of existing norms, values, roles, and practices)

- To which types of sustainability (environmental, economic, political, social, and cultural) does the organization pay least attention?

  - Economic sustainability (how recurrent costs associated with project activities will be met)
  - Political sustainability (how project-supported innovations will be accommodated within the framework of existing laws, policies, and political institutions)
  - Institutional sustainability (how the long-term viability of institutions created through project activities will be maintained)

■ Cultural sustainability (how project-supported innovations fit within the framework of existing norms, values, roles, and practices)

● How effectively does the organization demonstrate the impact of its work to its constituency and the general public?

Isolating and examining the different program components (i.e., program content, stakeholder involvement, evaluation, and project sustainability) can help an organization to better frame an assessment of program-related activities. To ensure that program activities continue and expand, it is important that the organization has a functional governance structure.

TOOL 6 Governance Diagnostic Tool

While all non-profit organizations are required to have a board of directors, and legally, all boards hold the ultimate fiscal responsibility for an organization, many organizations will vary in how their boards are selected, and expectations for their board members.   Some organizations may have a board comprised of members or constituents, while others may consist of benefactors. Some boards limit their roles to those of development and fund-raising, and others to setting policy parameters within which their organization may operate.

While the diversity with which boards operate and are formed is vast, there are key questions that may be asked of any board to assess functionality. This tool provides a menu of such questions which may be helpful in assessing an organization's governance structure. Please note, not all questions are appropriate for all organizations. In addition, this tool does not provide answers or solutions to address problems with an organization's governance structure, rather the questions are provided merely to suggest the broad range of items that must be attended to if a well-functioning organization is to exist.

Finally, administering this tool requires a basic understanding of non-profit governance, as an understanding of the implications of the questions posed and answers provided is key to the success of the activity. As such, this tool should be utilized in partnership between organizational representatives, management consultants, and/or capacity building assistance providers.

MISSION
- Is there a clear mission under which the organization operates?
- Is there a clear process for clarifying and revising the organization's mission and beliefs on a periodic basis?
- Are the organization's mission and goals supported by its structures? Describe.

ORGANIZATIONAL STRUCTURE
- Is there a clear organizational structure that is recorded and can be shared with staff, board members, and clients or constituents?
  Does the organization's constituents serve on the organization's board? If not, is there a clear and meaningful way for constituents and/or clients to be heard by the board of directors?

HIV Prevention Capacity Building: A framework for strengthening and sustaining HIV prevention programs

- Does the board have clear lines of communication with the organization that assure non-conflicting messages?
- Are by-laws examined for needed revision or updates on a regular basis?
- Does the board operate in accordance with its by-laws?
- Is the governing body active in monitoring and protecting core resources, including completion of an external audit when required?
- Do senior board and management officials understand their roles in core resource acquisition? Is there training provided to board members on the topic, or are board members recruited for experience in resource acquisition?
- Does the governing structure operate effectively and efficiently? If so, provide examples. If not, explain how the organization is planning to address this issue.
- Does this structure make organizational sense and facilitate the work?

ROLES/RESPONSIBILITIES
- Is the role of the overall board in relation to the organization clearly defined?
- Are there clear lines of accountability (individual, group, and organizational)?
- Are the board's fiscal responsibilities clearly delineated and are expectations for the board's involvement in fundraising clearly defined?
- With respect to each of the areas listed below, what are some representative actions that the board has taken in the last 12 months?

    - Fundraising
    - Public relations
    - Advocacy
    - Financial oversight
    - Policy definition
    - Strategic direction setting
    - Representation to key constituencies

- What has been the discernable impact of these actions on the organization?
- Is the governing body active in monitoring and protecting core resources, including completion of an external audit when required?
- Are roles within the organization clearly defined, yet flexible enough to adapt to changing needs?
- Are departmental lines or divisions between groups crossed easily, particularly in cases when collaboration would mean an improved product? Or, are departmental lines jealously guarded, serving as an impediment to collaboration?

- Does the staff have linkages with/access to other researchers and units in the organization that are important to their work?
- Can staff create important coordinating units with ease? If not, what are the current barriers?
- Are the means for coordinating staff and units fostered and encouraged?

STRATEGIC PLANNING

- Does an organizational strategy exist that is updated on a regular basis?
- Is there a process for scanning the environment in order to consider potential threats and opportunities?
- Does the planning body scan the external and internal environment in order to understand the forces affecting the organization? Explain.
- What conclusions about the organization's operating environment have been drawn as a result of these planning activities?
- What changes were made in the organization's operations to reflect an enhanced understanding of the environment in which the organization operates?
- Is the organizational strategy known by the board of directors, senior managers, researchers, and other staff? How is this information provided to the organization's board, researchers, staff, and managers? How is the organization able to effectively evaluate the board's and staff's understanding of the strategy?
- Is the strategy generally accepted and supported in the organization?
- Is the strategic plan used as a way of helping to make decisions?
- Does the strategic plan support issues of equity?
- Has the strategy helped clarify priorities, thus giving the organization a way to assess its performance?
- What are three important activities/initiatives that have been initiated over the last 12 months?
- To what extent do these activities/initiatives reflect the strategic and operating plans?
- Are the organization's activities developed and implemented in ways that are consistent with their strategic and operating plans?
- Does the organization routinely track progress in achieving the strategic objectives?
- Is there a process for monitoring application of the strategy? Describe.

A functional governing system that helps an organization to achieve its mission, maintain its structure, and plan strategically for the future is key to the success of an organization.

APPENDICES

APPENDIX 1 Annotated Resources on Capacity Building

The following section is an annotated bibliography. It provides a list of citations to books, articles, and documents used in the development of the Capacity Building Assistance Framework and each citation is followed by a brief description, the annotation, of the source cited. The purpose of this section is to inform the reader of the relevance, accuracy, and quality of the sources cited. Additional resources that were used to create this document are listed at the end of the section, including: websites, meeting summaries, presentations, current research, program descriptions and summaries, assessment tools and summaries, and final project reports.

APPENDIX 1

AIDS-Special Supplement. Turning HIV Prevention Research into Practice, Supplement to Vol. 12, No. 5, 2000.

> Discusses capacity building at length.

Altman D. Sustaining interventions in community systems: On the relationship between researchers and communities. *Health Psychology* 1995;14(6):526-536.

> Important goals of research-based community interventions include the long-term maintenance of effects and fostering of collaboration between researchers and community leaders. This article reviews the challenges associated with transferring innovations to community systems, changing program delivery from an experimental context controlled by researchers to program delivery controlled by community organizations, and sustaining long-term effects of interventions. It is suggested that researchers who develop and implement community interventions in diverse health areas need to confront several issues: 1) fostering effective long-term relationships between researchers and the communities they study and in which they intervene; and 2) designing and implementing interventions that are useful to community systems after the formal phase of research ends.

Amaro H and Hardy-Fanta C. I*mpact of Ryan White CARE Act Title I on Capacity Building in Latino Community-based Organizations: Findings from a Study of Two Cities.* Rockville, MD: US Dept. of Health and Human Services, Public Health Service, HRSA, 1995.

> The study was funded by the Health Resources and Services Administration (HRSA) to develop and pilot-test a methodology for evaluating if and how the Ryan White CARE Act Title I funds have helped develop, expand, and enhance HIV/AIDS services in Latino community-based organizations. Based on agency questionnaires and interviews with staff and administrators in two eligible metropolitan areas (San Diego and Boston), the authors found that both funded and non-funded agencies need to strengthen their infrastructures and to build overall capacity for their agencies to survive and compete. The authors make seven recommendations for HRSA action based on their study findings.

Belshaw C. The evaluation of technical assistance as a contribution to development. Originally published in the *International Development Review*, June 1966.

> The paper discusses methods of evaluating technical assistance. It presents the limitations on project evaluation and discusses the contribution of aid, as well as possible approaches to evaluation, recommended criteria, and strategies for development.

Bobbitt-Cooke M and Cole TB. Critical factors in building local capacity to prevent and control injury: North Carolina's experience. *Journal of Public Health Management and Practice* 1997;3(6):35-42.

> In fiscal years 1991-1992, a state injury control program awarded $258,000 to 33 local health departments for 50 community-based injury prevention projects. To determine whether this program helped build the capacity of local health departments to prevent injury, project reports were reviewed and project directors were surveyed. Some degree of success was demonstrated for all local projects for four of six factors developed to assess capacity building. However, continued support is necessary to assure that the local health departments can sustain this capacity and continue to develop proficiency in data monitoring and evaluation.

Braithwaite R and Lythocott N. Community empowerment as a strategy for health promotion for black and other minority populations. *Journal of the American Medical Association* 1989;261(2):282-283.

> Examines the importance of community empowerment as a method of health promotion. References the work of Paulo Friere with illiteracy in Brazil as an example. Provides a solid background argument that can be applied to HIV prevention community planning and the need for community empowerment.

CDC/ASPH, Institute for HIV Prevention Leadership. General information.

> Contains general information about the institute, whose mission is to create a learning environment for HIV prevention professionals which results in effective HIV prevention program development and management.

CDC HIV/AIDS Prevention Research Synthesis Project. Compendium of HIV Prevention Interventions with Evidence of Effectiveness. November 1999.

> Discusses a variety of projects and their effectiveness for a multitude of different populations, including drug users, homosexual adults, men who have sex with men (MSM), and youth.

Centers for Disease Control and Prevention. Advancing HIV Prevention: New Strategies for a Changing Epidemic. Atlanta, GA: CDC, 2003.

> Recognizes recent increases in diagnosed HIV infections among MSM and heterosexuals and links to possible increase in HIV incidence. Discusses trends in HIV/AIDS morbidity and mortality and HIV testing. Describes four key strategies for addressing changing trends in epidemic including: making HIV testing a routine part of medical care; implementing new models for diagnosing HIV infections outside medical settings; preventing new infections by working with persons diagnosed with HIV and their partners; and further decreasing perinatal HIV transmission.

Centers for Disease Control and Prevention. CDC Mission. Last updated October 2003.

> CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. Explains that CDC seeks to accomplish its mission by working with partners throughout the nation and world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

CDC National AIDS Clearinghouse. Dissemination/Knowledge Transfer Activities Summary. June 1997.

> The CDC National AIDS Clearinghouse is the government's largest health-related information service and has extensive experience providing a wide range of technology and knowledge transfer services. Currently, the Clearinghouse disseminates the majority of information on HIV/AIDS produced by the federal government.

Centers for Disease Control and Prevention. CDC Strategic Plan through 2005. 2001.

> Highlights CDC's strategic plan for HIV prevention and lays out the blueprint for actions that will be taken to carry out the plan, including: assessing current CDC HIV budget allocations against the priorities in the plan and realigning spending as needed; defining unmet needs; allocating new resources; directing prevention research activities at CDC; highlighting opportunities to strengthen collaboration across federal agencies and with other partners; assessing the annual performance of CDC and its grantees in meeting priority goals, objectives and strategies; and allowing the plan to serve as the basis of a yearly "report card" to the public on the activities of CDC and its grantees. The strategic plan defines national and international goals for HIV/AIDS prevention and control.

Chavis DM. Building community capacity to prevent violence through coalitions and partnerships. *Journal of Health Care for the Poor and Underserved* 1995;6(2):234-245.

> Examines the potential role of community coalitions in building the capacity of community leaders and their institutions to better serve their constituencies. Identifies essential capacities for communities to prevent social problems within the following categories: resource acquisition and mobilization; political; and psychosocial. Also examines methods

of assistance that function to build community capacity such as training and consultation, information and referral, and communication.

Cheema S. Capacity Development: Technical Advisory Paper 2. New York, NY: United Nations Development Programme, Management Development and Governance Division, Bureau for Policy Development, 1997. http://magnet.undp.org/cdrb/Techpap2.htm

> Provides an overview of capacity building related to international development and provides an argument for its application. Examines a framework for interrelated dimensions required in sustainable capacity building. The dimensions are: (1) individual; (2) entity; (3) interrelationships between entities; and (4) enabling environment.

Collins C, Kohler C, DiClemente R and Wang MQ. Evaluation of the exposure effects of a theory-based street outreach HIV intervention on African American drug users. *Evaluation and Program Planning* 1999;22:279-293.

> The Street Outreach to Drug Abusers, Community AIDS Prevention (SODA-CAP) project implemented and evaluated an HIV-prevention intervention aimed at current drug users. The intervention was developed using social cognitive theory and the transtheoretical model of change. The outreach team assessed individuals' stages of change for the target behaviors and they were given stage-appropriate, role-model stories. The program effects were evaluated using a quasi-experimental design with a repeated, cross-sectional sampling method in which community surveys were administered at baseline, 12 and 22 months. Multivariate statistical models were developed for four outcomes (condom use with main and other partners, treatment entry, and stopping all drug and alcohol use).

Cottrell L. The Competent Community. In: Kaplan BH, Wilson RN, and Leighton AH (eds.), *Further Explorations in Social Psychiatry*. New York : Basic Books, 1976.

> Provides an argument for the need of community involvement in health promotion. Identifies a competent community as central to success in health promotion and provides a description of how to define community competence and the essential conditions of community competence.

DeGoff A. *From Research to the Front Lines*. Draft Report.

> This is a draft report on the results of a descriptive study conducted by Ms. DeGoff. The research concerned access and utilization of HIV/AIDS prevention-related social and behavioral research by 24 community-based organizations in the San Francisco area, and aimed to 1) describe the access and use of the HIV/AIDS prevention-related research; and 2) identify both barriers and facilitating factors influencing their access and utilization of research.

Del Vecchio-Good M. Local knowledge: Research capacity building in international health. *Social Science Medicine* 1992;35(11):1359-1367.

> The paper discusses the process of building capacity in international health projects and the implications for anthropology using examples from the Applied Diarrheal Disease Research project funded by USAID. Two aspects of training are exemplified.

Deutsche Gesellschaft fur technische Zusammenarbeit, GTZ, *Capacity Building for Sustainable Development Concepts, Strategies and Instruments of the German Technical Coorperation*. Eschborn, Germany, 1999.

> Provides an overview of the following: 1) the policy goals and instruments of the German development cooperation; 2) information regarding the technical cooperation's goal and mission; 3) presents capacity building as the primary task of German technical cooperation; 4) implementation principles and approaches of German technical cooperation; 5) discusses selected Instruments for technical cooperation and capacity-building; and 6) gives a brief overview of the GTZ and the organization's modes of delivery.

Eng E and Parker E. Measuring community competence in the Mississippi Delta: The interface between program evaluation and empowerment. *Health Education Quarterly* 1994;21(2):199-220.

> Argues that assisting people to reduce health risks is important but is not enough. Programs must also seek to improve political efficacy, social justice, and control over the

quality of community life for individuals (i.e., community competence). Examines definitions of community competence and methods for measuring it.

Fetterman DM, Kaftarian SJ, and Wandersman A. *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage Publications,1996.

> Explanation of the empowerment evaluation theory, at times in contrast to traditional evaluation theories. According to the theory, there is a need to get program recipients directly involved in program planning and evaluation. Offers a clear model of stakeholder involvement throughout an evaluation and highlights the value of having sponsors and other external agencies involved at every stage.

Fishbein M and Hornik R. Panel on Information Dissemination, Intervention Diffusion and Media Coverage. NIMH Statement on Behavioral Methods, Draft.

> This material identifies 3 panel objectives. These are: 1) identifying important and relevant information about HIV and how to rapidly disseminate it to appropriate audiences in useful and usable ways: 2) making sure that successful behavior change interventions are made known to, adopted, and appropriately adapted by communities at risk; and 3) ensuring that government agencies and the scientific community can best provide public information, by understanding how the media coverage of HIV/AIDS affects national and community-specific norms and behaviors as well as how media coverage of HIV/AIDS is shaped.

Florin P, Chavis D. Community Development, Community Participation and Substance Abuse Prevention. Prevention Office Bureau of Drug Abuse Services, County of Santa Clara, San Jose, CA. May 1990.

> Provides a definition for community development and a rationale for its application. In addition, this material documents benefits of community development as a prevention strategy for substance abuse and provides recommendations for implementing community development.

Goodman R, Speers M, McLeroy K, Fawcett S, Kegler M, Parker E, Smith SR, Wallerstein N. Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior* 1998;25(3):258-278.

> The article describes the dimensions that CDC-convened symposium participants (1995) suggested as central to the construct of community capacity. These included: participation and leadership skills; resources; social and inter-organizational networks; sense of community; understanding of community history; community power; community values; and critical reflection.

Hawe PK and Lesley Lloyd B. Working invisibly: Health workers talk about capacity building in health promotion. *Health Promotion International* 1998;13(4):285-295.

> A practice-based, participatory research study in New South Wales explored how health promotion workers use the term capacity building. Workers easily identified outcomes of capacity-building but had difficulty articulating quality indicators or good process. Capacity building seemed invisible, hidden from funders and administrators because it is not directly linked to risk factor behaviors and hidden from other workers to make it more effective. Working invisibly affects quality control, guiding theory, practice ethics, peer support, worker morale, and funding mechanisms.

Hawe P, Noort M, King L, Jordens C. Multiplying health gains: The critical role of capacity building within health promotion programs. *Health Policy* 1997;39(1):29-42.

> Identifies levels and possible dimensions of capacity building as currently addressed in the health promotion literature. Argues that capacity building is instrumental in health promotion and states the need for abilities to measure capacity building.

Higginbotham. Capacity building for health social science: The International Clinical Epidemiology Network (INCLEN) social science program and the International Forum for Social Science in Health (IFSSH). *Acta Tropica* 1994;57:123-137.

The paper describes the unfolding of two complementary efforts to build global capacity in health social science. The INCLEN model infuses the transdisciplinary perspective into international health through equipping social scientists to speak a common language with clinical epidemiologists and sensitizing clinicians to the ways social science contributes to research and policy. The IFSSH has been formed to help build this infrastructure and provide impetus for a viable scientific community of health social scientists.

Institute of Medicine. *The Future of Public Health*. Washington, DC: Institute of Medicine of the National Academy, 1998.

Contains proposals for ensuring that public health service programs are efficient and effective enough to deal with current and future public health issues. Recommendations are made for core functions in public health assessment, policy development, and service assurances. It also identifies the level of government--federal, state, and local--at which these functions would best be handled.

Institute of Medicine. *No Time to Lose: Getting More from HIV Prevention*. Washington, DC: Institute of Medicine of the National Academy, 2000.

Presents the Institute of Medicine's strategy for prevention of AIDS in an era of new advances in treatment and greater prevalence of individuals at risk for contracting and spreading HIV. Outlines strategies that seek to accomplish goals in prevention through the use of cost-effective resource allocation, proven prevention programs, new surveillance and prevention technologies, greater translation of prevention science to community-level action, and the elimination of social barriers that impede prevention effectiveness.

Jackson C, Fortmann S, Flora J, Melton R, Snider J, Littlefield D. The capacity-building approach to intervention maintenance implemented by the Stanford Five-City Project. *Health Education Research* 1994; 9(3): 385-396.

Compares an applied model of program dissemination to one of building capacity. Identifies key components of a capacity-building program and lessons learned from implementation.

Janssen RS, Holtgrave DR, et al. *Advancing HIV Prevention: New Strategies for a Changing Epidemic.* Slide Presentation. April 17, 2003.

> Overview of the new strategies proposed for the advancement of HIV prevention. Related to the CDC publication with the same title. Based on recognition of changing trends in testing and prevalence rates in the United States.

Jimerson A, DeGoff A., Schechter C, Blake S, Hanlon. Why Have Some States Adopted HIV Prevention counseling While Others Have Not? Applying Diffusion Theory. September 1999.

> Describes application of diffusion theory.

Johnson K. Building capacity through collaborative leadership. *International Journal of Health Planning and Management* 1996;1(4):339-44.

> This paper is based upon material from the manuals and training program underpinning the "Sustaining Community-Based Initiative" from the Healthcare Forum of the W.K. Kellogg Foundation. To address the problems of urban communities in the U.S., a new approach using the concept of "collaborative empowerment" is proposed. This planning and organizational method allows community- and neighborhood-based organizations to design, implement, and assess problem-solving strategies that increase their effectiveness at dealing with community issues. The use of organizational management principles and practices in community involvement and strengthening community leadership is illustrated through practical examples.

Kang R. Building community capacity for health promotion: A challenge for public health nurses. *Public Health Nursing* 1995;12(5):312-318.

> Provides a limited perspective on capacity building, but a strong argument for community engagement and a working definition of community.

Keck CW and Mullet M. Building capacity in public health practice. Akron Health Department, OH 44308, USA. *American Journal of Preventive Medicine* 1995;11(3 Suppl):9-10.

Strengthening the linkages between public health practice and academia can improve the ability of local health departments to fulfill their community obligations. While links to schools of public health are ideal, links with any relevant academic program can be useful. Benefits to local health departments may include: physical facilities; technical capacity to analyze data or conduct surveys; meeting facilities; qualified teachers; an accreditation mechanism to provide continuing education credits for public health professionals; and the potential for underwriting support for consulting. The benefits of links to practice institutions for academic institutions are also outlined. Both the local health department and the academic institution will benefit from this synergism.

King L, Hawe P and Wise M. *From Research into Practice in Health Promotion: A Review of the Literature on Dissemination.* National Centre for Health Promotion. Australia, 1996.

Provides an overview of published literature based on myriad topics involving research into practice in health promotion.

Kotellos KA, Amon JJ and Benazerga WM. Field experiences: Measuring capacity building efforts in HIV/AIDS prevention programmes. *AIDS* 1998;2 Suppl 2:S109-17.

The authors propose a pluralistic model for measuring capacity building efforts in HIV/AIDS prevention programs. Their theoretical framework is based on seven capacity-building strategies: technical skill building; management skill building; management systems development; resource diversification; network building; organization cross-fertilization; and multi-sectoral collaboration. They also outline the practical steps necessary to implement a monitoring and evaluation plan for capacity building. The practical steps discussed are: building consensus; conducting a baseline assessment; defining objectives and benchmarks; monitoring progress; measuring outcomes and analyzing and interpreting results. The capacity building conceptual framework which links strategies, variables, and outcomes can guide programs with information that can impact sustainability.

Kraft JM et al. A Technology Transfer Model for Effective HIV/AIDS Interventions: Science and Practice. 2000.

> Provides a review of diffusion of innovations and technology transfer literature. Presents a technology transfer model for HIV interventions and identifies participants and activities directed toward the use of effective interventions by prevention services providers (e.g., health departments and community-based organizations) in each phase of technology transfer: pre-implementation; implementation; and maintenance and evolution. Discusses preimplementation and implementation activities in regards to process evaluation. Takes the perspective of providers.

Minority Capacity Building in Health Services Research, Final Report. Washington, DC: Association of American Medical Colleges (AAMC) Division of Community and Minority Programs.

> The Agency for Health Care Policy and Research funded the AAMC in 1991 to address the paucity of health services research on minority populations and to increase the number of underrepresented minority researchers in medical schools conducting health services research. To address the first goal, the AAMC sponsored a 1992 conference, *The Role of Class/Race and Ethnicity in Health Services Research*. The AAMC Health Services Research Institute for Minority Faculty was created to address the second goal. The Institute hosted several meetings for two cohorts of minority faculty. Selected fellows attended an initial six-day training seminar followed by a research symposium, a mock study section review, and a final seminar. Fellows were also linked with a senior health services researcher who served as a technical consultant/mentor as they developed their proposals.

Moyer A, Coristine M, MacLean L, and Meyer M. A model for building collective capacity in community-based programs: The elderly in Need Project. *Public Health Nursing* 1999;16(3):205-14.

> Stages of capacity building are examined in an action research project designed to strengthen the ability of communities to care for frail and isolated older adults. The four stages identified and described include: (1) identifying common ground; (2) establishing self as community player; (3) working on a common project; and (4) working on a multi-agency, multi-sectoral project.

Mpango P. Concepts of capacity and capacity building in the case of Tanzania. Workshop for Development of and Training on Approaches and Methods for National Capacity Building. *Maastricht* May 1998: 26-29. http://www.oneworld.org/ecdpm/en/events/98003/mpango.htm

> Addresses capacity building related to international development, specifically in Tanzania. Develops an operational definition of capacity building focused on three cornerstones: developing professionalism; institutional autonomy; and managerial effectiveness.

Mulligan RK. Catalyst for community capacity-building: a role for public sector practitioners. *Economic Development Review* 1995;13(4):58-61.

> Johnson City, Tennessee adopted new governance practices in its quest for successful economic development options. Local officials facilitated the creation of a long-term strategic vision and managed government functions and services to strengthen the local economy. The city government also implemented community capacity-building strategies. This successful approach resulted in development planning, transportation systems, housing programs, and other initiatives. The author states that public-sector practitioners are uniquely positioned to fill leadership roles in community capacity-building strategies.

NASTAD Draft Concept Paper. TA/CBA Communication Protocol/Principles Technical Assistance/Capacity Building Assistance, 01/30/01.

> The two goals of this paper are: (1) the development of a standard protocol or checklist that outlines key steps in TA/CBA that are understood by all stakeholders (health departments, CBA providers, PPB/CBAB project officers, CBOs); and (2) promoting the dissemination of CDC's policies around the coordination of TA/CBA.

NASTAD Draft. TA/CBA Communications Protocol Checklist, 02/07/01.

> A protocol for communications around all types of HIV prevention TA/CBA provided in the U.S. through CDC DHAP-Intervention Research and Support to foster coordination of the system(s) of CBA/TA and state CDC policy regarding this coordination. This includes how

national providers, health departments, community-based organizations, CDC, and HIV prevention community planning groups should work together on the identification, delivery, and follow-up of CBA/TA.

NASTAD HIV Prevention Community Planning Bulletin, October 2000.

The bulletin focuses on capacity building.

NASTAD Issue Brief. *Technical Assistance and Capacity Building Provided to Community-Based Organizations by Health Departments,* Mach 2000.

The article addresses issues such as the need for capacity building. Also it analyzes the programs within five different states. These states are Colorado, Florida, Maryland, Massachusetts, and Rhode Island. Some of the topics discussed are organizational infrastructure, STD/HIV interventions, community mobilization, and evaluation.

NASTAD, AED, CDC. Bright Ideas: *Innovative or Promising Practices in HIV Prevention and HIV Prevention Community Planning.* Washington, DC: NASTAD, 2000.

The document is a directory of innovative programs nationwide. Programs in all states and selected cities are outlined. The document contains short program descriptions for each of the projects included and contact information for programs.

National Community AIDS Partnership. *Evaluating HIV/AIDS Prevention Programs in Community-Based Organizations.* Washington, DC: National Community AIDS Partnership, 1993.

This publication serves community-based service providers, government funders, and managers of prevention programs as a guide. It outlines the process of selection of appropriate methodology for the programs being evaluated and also discusses the needs and resources of the organization conducting the evaluation.

O'Donnel L et al. The role of technical assistance in the replication of effective HIV interventions. *AIDS Education and Prevention* 2000;12, supplement A.

> Examines the role of technical assistance in supporting the replication of proven HIV interventions. A case study of the replication of the VOICES/VOCES intervention is provided to illustrate points. Findings illustrate how technical assistance supports replication by establishing a conversation between the researcher technical assistance providers experienced with the intervention and new users.

Patton MQ. *Utilization-Focused Evaluation*, 3rd Edition. Thousand Oaks, CA: Sage Publications, 1997.

> Highlights some specifics of how to conduct an evaluation. Describes ways to focus an intervention.

Penn R. Building community capacity: The role of community government. *Community Development Journal* 1993;28(4):316-320.

> City authorities are moving from being service providers to becoming enablers of change. Only a local authority can play a central role in strategically transforming cities despite uncertainty about cities' needs and solutions, competing interests from individuals and communities, and fragmentation of local authority into special purpose agencies. The strategic potential of a local authority is discussed in a case study of community government in Bradford, United Kingdom.

Poole D. Building community capacity to promote social and public health: challenges for universities, editorial. *Health and Social Work* 1997;22(3):163-170.

> Provides a definition of community capacity building and the need for community action structure to support health promotion. Examines the role of universities in preparing students for community capacity-building work in the field.

Rogers EM. *Diffusion of Innovations*, 4th ed. New York: The Free Press, 1995.

Addresses challenges to speeding up the rate of diffusion of an innovation. Provides case studies and examples of the challenges to the diffusion of innovation that offer insight into the process.

Rogers EM. Diffusion Theory: A Theoretical Approach to Promote Community-level Change. In Peterson JL and DiClemente RJ (eds.), *Handbook of HIV Prevention*. New York: Kluwer Academic Press, 2000.

Provides a theoretical overview to programs aimed at creating community-level change.

Schwartz R, Smith C, Speers M, Dusenbury L, Bright F, Hedlund S, Wheeler F, Schmid T. Capacity building and resource needs of state health agencies to implement community-based cardiovascular disease programs. *Journal of Public Health Policy* 1993;14(4):480-494.

Defines capacity building in the context of state health departments addressing health needs. In reference to cardiovascular disease (CVD), the article identifies five core components to building state capacity for reducing risk and the related resources needed. Also identifies components needed for community-based CVD programs, which closely resemble the components needed for the HIV prevention community planning process: community organization; needs assessment; data; priority setting; comprehensive and integrated interventions; program monitoring; and evaluation.

Smith R. Filling the lacuna between research and practice: An interview with Michael Peckham. *BMJ* 1993; 307.

Stockdill SH, Baizerman M and Crompton DW. Toward definition of the evaluation capacity building process: A conversation with the evaluation capacity building literature. *New Directions for Evaluation* 2002;93:7-25.

An overview of literature on evaluation-focused capacity building.

Taveras S and Duncan T. Organizational capacity-building for HIV prevention. *Consultants Meeting: Capacity Building Assistance to Improve the Delivery of HIV Prevention Services for Communities of Color*, September 9-10, 1999, Conference Binder.

> Proposes a framework for capacity building limited in application to community-based organizations that conduct HIV intervention activities. Identifies a definition for capacity, capacity building, and core competencies. Enumerates and defines six mechanisms and/or forms for capacity building with organizations.

Technology Transfer. Research to Practice: Identifying Effective Programs for Translation, Dissemination and Diffusion. April 1996.

> This document is a model of how to enhance the quality of HIV prevention activities.

Technology Transfer. Steps in the Technology Transfer Activities of DHAP.

> This is a step-by-step guide to successfully transfer technology, as applied to CDC's Divisions of HIV/AIDS Prevention. It contains an outline and discusses what is outlined more at length, bulleting the key steps.

Technology Transfer. Working Group on Information Sharing, Technology Transfer, and Research Utilization, 1995.

> This is a draft of the CDC working group on information sharing, technology transfer, and research utilization. It outlines the goal of the working group, the composition thereof and contains the agenda along with other miscellaneous.

Turnock BJ, Handler AS and Miller CA. Core function-related local public health practice effectiveness. *Journal of Public Health Management and Practice* 1998;4(5):26-32.

> In 1995, a random sampling of local health departments assessed progress towards a year 2000 national health objective which called for 90% of the population to be served by a local health department effectively carrying out public health's core functions. The assessment tool used 20 core function-related measures of local public health practice to measure performance in assessment, policy development, and assurance. The findings suggested little overall improvement in core function-related performance between 1993 and 1995; the authors concluded that considerable capacity building and performance improvement is needed within the public health system.

U.S. Department of Health and Human Services. "With Understanding and Improving Health and Objectives for Improving Health." *Healthy People 2010*. 2nd ed., 2 vols. Washington, DC: U.S. Government Printing Office, 2000.

> The document presents 467 objectives to improve the health of Americans by the year 2010. As the objectives identified are national, not solely federal. The achievement of the objectives is regarded dependent in part on the ability of health agencies at all levels of the government and on non-governmental organizations to assess objective progress.

Valdiserri RO. Technology Transfer: Achieving the Premise of HIV Prevention. In Peterson J and DiClemente RJ (eds.), *Handbook of HIV Prevention* New York: Kluwer Academic Press, 2000.

> Discusses technology transfer-related issues in the HIV prevention sphere.

West GR, Willingham M, Holtgrave D, Crissmen C and Williams Y. *Building Strangthening and Sustaining Community Infrastructure and Organizational Capacities for HIV Prevention*. Atlanta, GA: Division of HIV/AIDS Prevention, Intervention Research and Support, National Center of HIV, STD, and TB Prevention, CDC.

Discusses how the sustainability of substantially reducing HIV transmission in the United States depends on many factors, including: 1) gaining and sustaining public support for HIV prevention; 2) Securing and mobilizing human and financial resources; 3) building organizational capacities to design and implement effective programs, and 4) sustaining organizational and programmatic capacities for the long term. Also discusses CDC's direct funding of CBOs.

Windsor R et al. *Evaluation of Health Promotion, Health Education, and Disease Prevention Programs, 2nd Edition*. Mountain View, CA: Mayfield Publishing, 1994.

Examination of health promotion, education, and disease prevention programs. Provides evaluation of identified programs

ADDITIONAL RESOURCES

WEBSITES

Association for the Study and Development of Community (ASDC)
http://www.capablecommunity.com/approach.htm

ASDC's strategy is to provide an integrated approach to building the capacity of organizations and institutions to develop the health, economic equity, and social justice of communities.

Capacity.org
http://www.capacity.org

The website, Capacity.org, is an initiative of the European Centre for Development Policy Management which studies the policy and practice of capacity building within international development. Links to more than 10 cited definitions of capacity building, an annotated bibliography, databases, newsletters and related sites.

Community Development Foundation
http://www.cdf.org.uk

Provides a definition of community development as a structured intervention. Publication list includes numerous resources on community development and capacity building. The Foundation is based in London with offices in Scotland, Wales, Leeds and Leicester.

Human Settlements Development Programme, Asian Institute of Technology, Bangkok, Thailand
http://www.hsd.ait.ac.th/capacity/uc2.htm

This webpage is a part of the website for Human Settlements Development in Asia. It defines capacity building and rationale for using capacity building.

Natural Resource Management. NRM_changelins
http://nrm.massey.ac.nz/changelinks/

This site provides a practical resource for those who work with communities (in the wider sense of the term) to help them identify and adopt more sustainable natural resource management practices.

Technology Transfer Information Center, US Department of Agriculture, National Agricultural Library
http://www.nal.usda.gov/ttic/faq/orgs.htm

Links to professional organizations and societies addressing technology transfer.

The Virtual Library on Urban Environmental Management, Global Development Research Centre, Japan
http://www.gdrc.org/uem/capacity.html

This webpage provides a link to several pages and publications on capacity building related to international development. Includes a link to a page on defining capacity building with several cited references.

MEETINGS

Draft CPG Project Area Conference Call Guide for *Companion* Input.

The CDC Program Guidance indicates using behavioral science in the HIV prevention community planning process. AED is in the process of developing a document with the CDC for community planning groups to use in assessing interventions. The focus of the document will be on summarizing the best literature on the intervention studies for specific interventions and target populations. The document has a working title, the Companion, and it will be the actual companion piece to the May 1995 AED publication, Overview of HIV/AIDS Prevention Interventions: An Approach to Examining Their Effectiveness.

NMAC, Enhancing the Capacity for HIV Prevention: A Formula for Success, April 1-5, 2001.

The conference, which was CDC funded, represented a skills building opportunity for directly funded CBOs. The conference emphasized the community-based organization's role on the front line of HIV prevention in helping to prevent new HIV infections, providing services to persons living with HIV, and overall, playing a critical part in helping to end the epidemic.

Senior Staff Retreat, CDC's Division of HIV/AIDS Prevention, July 19-20, 1995; Fieldstone Inn, Hiawassee, Georgia.

The goals included: enable staff to work together as a division and set priorities; heal the wounds from reorganization; get to know staff; learn more about the responsibilities of the Division; determine short-term priorities; and discuss the Division's future and direction. Retreat facilitators: Steve Jones, Janet Collins, Kim Miller, and Theresa Brimer.

Technology Transfer Meeting, Rough draft for Comment, 10/17/1997.

> Outlines the handling of incoming questions from grantees, prevention non-grantees, and policy makers and also outlines the systematic assessment of programs.

Technology Transfer Working Group, CDC's Divisions of HIV/AIDS Prevention, December 14, 1995; General meeting notes, including minutes, summary, and draft outline for the report.

> Discussion at the meeting addressed numerous aspects of the materials distributed prior to the meeting. The importance of technology transfer exercises to the implementation of HIV prevention programs was acknowledged and the "roundhouse" model was used to illustrate how technology is transferred to CDC grantees. Some key principles were articulated, including: 1) all CDC researcher staff and CDC-funded extramural researchers must be able to identify the specific programmatic need for information to be generated by their research; and 2) all CDC program staff and CDC's programmatic grantees must be able to identify the scientific basis of their programs.

Unicoi Retreat Follow-up, 06/11/1997

> The goal of the retreat was to research, develop, implement, and evaluate a comprehensive CDC system for the transfer of HIV prevention technologies, research findings, and successful experience from other areas to program operations and inform researchers of priority program needs for new technologies.

Working Group on Information Sharing, Technology Transfer, and Research Utilization, December 14, 1995.

> This packet contains the agenda for the working group as well as the draft working definitions of key terms, the draft table of contents of the group's deliverable report, and the draft group process steps.

PRESENTATIONS

Collaborative Technology Transfer Model, CDC's Division of HIV/AIDS Prevention.

> The presentation outlines the process of identifying interventions to be transferred to programs; deciding what to transfer and to whom; and how to develop/maintain/evaluate technology transfer systems. Also, the presentation discusses the resources and documents available, the various dissemination systems, training, as well as national/local technical assistance providers.

Beadle de Palomo F. CDC's Integrated TA System for HIV Prevention, Academy for Educational Development, May 1999.

> The presentation explains what Technical Assistance is. It also gives and overview of the evolution of the present day TA system and the future of the TA system is discussed.

Cleveland J. CDC Divisions of HIV/AIDS Prevention Technical Assistance and Capacity Building.

> The presentation discusses the definition of technical assistance as well as who receives it, who delivers it, the different types available, and the role of technical assistance for capacity building.

Dietz S. HIV Prevention Technology Transfer, Training and Technical Support Systems Branch, Divisions of HIV/AIDS Prevention, CDC; June 30, 1997

> The presentation discusses technology transfer issues including the barriers, facilitators, system drivers, processes, translation systems, program development systems, transfer systems, various types of transfer activities, and collaboration.

Taveras S and Duncan T. Capacity Building for HIV Prevention at Organizational and Community Levels. HRSA, 2000.

> The presentation defined capacity building and discussed the outcomes and levels of capacity building. Further, it discussed issues such as skills building, information transfer, technical consultation, technical services, technology transfer, and funding.

CURRENT RESEARCH

CITY Project, Description of capacity building activities in the CITY project. Capacity Building Activity Inventory, Divisions for HIV/AIDS Prevention.

> This is considered secondary information, and is to be used as an example of a capacity-building activity. The core values of the program are the building of community capacity and organizational capacity by emphasizing the need to communicate effectively, implement sustainable programs, and secure adequate resources to support the programmatic efforts.

DHHS and CDC: Assessing the Evaluation Capacity of Health Departments Funded for HIV Prevention. Contract for MACRO, 09/28/1999 – 12/29/2001. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Core information, central to framing and implementing capacity building from CDC's perspective. Primary goal of the task is to assess and describe the current evaluation capacity of federally funded health departments.

HIV Prevention Research Synthesis. Capacity Building Activity Inventory Divisions for HIV/AIDS Prevention. www.cdc.gov/hiv/pubs/hivcompendium.pdh

> This is considered secondary information, and is to be used as an example of a capacity-building activity. This research was included in the Compendium of HIV Prevention Interventions with Evidence of Effectiveness.

NACCHO Programs, www.naccho.org/project47.htm

> This is an outline of the research and development efforts made towards the Assessment Protocol for Excellence in Public Health (APEXPH).

Research to Practice Project, Expert Review of HIV Prevention Studies Collected through the CDC/BIRB Research Synthesis System.

> Research to Practice Project, feasibility review of effective HIV prevention programs identified by BIRB's expert review process.

Strengthening HIV/AIDS/STD Prevention Though Use of Behavioral Data in Programmatic Decision-Making. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered to be core information, central to framing and implementing capacity building from CDC's perspective. This abstract discusses the effort being made to address the limited/fragmented access local health departments have to relevant behavioral data.

Section 5 – Program Descriptions and Summaries.
Descriptions
Best Practices for Positives; Science, Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Best Practices in the National Minority AIDS Initiative. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

BSSV; Science, Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Capacity Building Assistance, CDC – two documents: a chart and a presentation

> These documents introduce CDC's capacity building assistance system. They include background information of the idea as well as procedural information for requesting CBA for CDC grantees and non- CDC grantees.

Capacity Building Assistance Providers (CBA), CDC

> This chart enumerates the programs and organizations providing capacity building assistance that are currently funded by the Division of HIV/AIDS Prevention Training Support System Branch of the CDC.

Diffusion of the Popular Opinion Leader Intervention. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Direct Technical Assistance to CDC funded HDs, CBOs, CBAs, and CCDs. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Evaluation coordination of the PHIPP project and Technical Assistance to the PHIPP Grantees. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Evaluation of Project Linkage Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Evaluation Technical Assistance for the HD Evaluation Guidance. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

MSM Alert. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

National Minority AIDS Initiative, CDC.

This document is a directory. It lists the names and addresses of all organizations receiving funding under the National Minority Initiative nationwide. However, it does not include grantees under program announcements 00023 and 00100.

Organizational Charts for both the Divisions of HIV/AIDS Prevention, as well as for the NCHSTP. CDC, 2000

These two charts show the organizational framework behind the DHAP and the NCHSTP.

Price Fellowships for HIV Prevention Leadership Program, 2000. The CDC Foundation

This document provides information about the CDC Foundation's 2000 Price Fellowships for HIV Prevention Leadership Program. It introduces the fellowship, as well as states the program's purpose. Further it provides information regarding the applicant's eligibility, as well as the fellow's requirements and provides instructions for submitting the application package.

Qualitative/Ethnographic support for the HAART Adherence Studies. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

Considered being core information, central to framing and implementing capacity building from CDC's perspective.

REP Training Curriculum Development. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Replicating Effective Programs. Evaluation, and Technology Transfer Team. Capacity Building Activity Inventory Division for HIV/AIDS Prevention.

> Considered being core information, central to framing and implementing capacity building from CDC's perspective.

Technology Transfer Product Review Criteria, CDC, October 3, 1995

> This material outlines a protocol for technology transfer review. It discusses the intervention, format, target audience, target population, goal, the conceptual framework, etc.

Overall Goals for CBA Evaluation

> This is a framework for evaluating NRMOs related to capacity building activities.

Section 6 - Summaries and Final Reports

AECF, Evaluating Comprehensive Community Change, from the Evaluation Conference, March 1997

NRMO, Community-Based Organization Technical Assistance Needs Assessment, Executive Summary, July 1999

NRMO, Evaluation Final Reports for the Evaluation of the NRMO Initiative, December 1999.

> Contains the Executive Summary, the Technical Report, the Appendices, and the case Studies Report.

> Taveras, S. Consultation on Capacity Building Assistance for HIV Prevention Programs report. Capacity Building Branch, CDC. Buckhead, GA: August 25-26 2003.

GLOSSARY

Accountability: Answerable to; a framework for how a group and its members will be responsible to itself and the community as it carries out its mission.

Acquired immunodeficiency syndrome (AIDS): AIDS is the condition that results from HIV infection and is marked by the presence of opportunistic infections that do not impact persons with healthy immune systems.

Application: The health department's formal request to CDC for HIV prevention funding. The application contains a proposed budget to support a specific set of prevention interventions/activities. The budget is expected to reflect the priorities described in the jurisdiction's comprehensive HIV prevention plan.

Capacity Building Assistance: A planned, structured process by which individuals, organizations, and communities develop skills and abilities to enhance and sustain HIV prevention efforts. The goal of capacity building, which may include training, technical assistance, and infrastructure development activities, is to foster self-sufficiency and the self-sustaining ability to improve HIV prevention processes, programs, and interventions.

CARE Act: The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the primary federal legislation created to address the health and support service needs of persons living with HIV/AIDS and their families in the United States. Enacted in 1990, the CARE Act was reauthorized in 1996 and in 2000.

Centers for Disease Control and Prevention (CDC): The federal agency responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability through partnerships throughout the nation and the world to monitor health, detect and investigate health problems, conduct applied research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training. Based in Atlanta, it is an agency of the U.S. Department of Health and Human Services.

Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.

Community Planning Group (CPG): The official HIV prevention planning body that follows the HIV Prevention Community Planning Guidance to develop a comprehensive HIV prevention plan for the project area.

Comprehensive HIV Prevention Plan: An overview of all HIV prevention programs and activities occurring in a jurisdiction. The plan is developed through a participatory, science-based planning process. It identifies prioritized target populations and priority prevention activities/interventions for each target population.

Cooperative Agreement: A financial assistance mechanism when substantial federal programmatic involvement with the recipient during performance is anticipated by the awarding office. A cooperative agreement is more restrictive than a grant and the relationship is bi-directional between the recipient and the funding entity.

Coordination: Aligning processes, services, or systems, to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information such as progress reports with state and local health departments or structuring prevention delivery systems to reduce duplication of effort.

Cost-effectiveness: Available information about the relative costs and effectiveness of proposed strategies and interventions, either demonstrated or probable.

Demographics: The statistical characteristics of human populations such as age, race, ethnicity, sex, size, and other vital statistics that can provide insight into the development, culture, and sex-specific issues that the intervention will need to take into consideration.

Diversity: The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizing individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, health or disease status, or other ideologies. It is the exploration of these differences in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

Epidemic: The rapid spread, growth, or occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.

Epidemiologic Profile: An HIV/AIDS epidemiologic profile is a document that describes the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-positive and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV/AIDS on an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics. The epidemiologic profile serves as the scientific basis from which HIV prevention and care needs are identified and prioritized for any given jurisdiction.

Epidemiology: Epidemiology is the study of the spread and causes of disease in human beings.

Evidenced-based: Behavioral, social, and policy interventions that are relevant and methodologically rigorous are evidence- or science-based. These interventions have been evaluated using behavioral or health outcomes; they report positive, negative or no change (null) findings; they use control/comparison groups (or pre-post data without a comparison group if a policy study); and they have no apparent bias when assigning persons to intervention or control groups or they have adjusted for any apparent assignment bias. Successful interventions for one group (e.g., urban men who have sex with men (MSM), or MSM of color) may not translate to success with another (e.g., rural white MSM). However, the steps used to develop the intervention, such as formative research, needs assessment, evaluation, are portable. CDC expects its grantees to deliver evidence-based HIV prevention interventions and provides technical assistance and capacity building to enable them to do so. CDC develops science-based interventions for populations for whom research is lacking or minimal.

Human Immunodeficiency
Virus (HIV):   HIV is the virus that causes AIDS. Persons with HIV in their system are referred to as HIV infected or HIV positive.

HIV Prevention
Community Planning: The cyclical, evidence-based planning process in which authority for identifying priorities for funding HIV prevention programs is vested in one or more planning groups in a state or local health department that receives HIV prevention funds from CDC.

HIV Prevention Counseling: An interactive process between client and counselor aimed at identifying concrete, acceptable, and appropriate ways to reduce risky sex and needle-sharing behaviors related to HIV acquisition (for HIV-negative clients) or transmission (for HIV-positive clients).

Incidence: The number of new cases in a defined population within a certain time period, often a year, which can be used to measure disease frequency. It is important to understand the difference between HIV incidence and reported HIV diagnoses. Because anonymous tests are not included and therefore do not reflect all persons infected or all those diagnosed with HIV, HIV data do not represent incident cases.

Inclusion: Meaningful involvement of members in the process with an active voice in decision making. An inclusive process assures that the views, perspectives, and needs of all affected communities are actively included.

Injection Drug User (IDU):   A person who uses a needle to inject drugs into his or her body.

Intervention:　A specific activity (or set of related activities) intended to bring about a health outcome (e.g., HIV risk reduction in a particular target population, early diagnosis of HIV). An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.

Intervention Plan:　An intervention plan sets forth the goals, expectations, and implementation procedures for an intervention. It should describe the evidence or theory basis for the intervention, justification for application to the target population and setting, and the service delivery plan.

Jurisdiction:　An area or region that is the responsibility of a particular governmental agency. This term usually refers to an area where a state or local health department monitors HIV prevention activities (i.e., Jonestown is within the jurisdiction of the Jones County Health Department).

Logic Model:　A logic model is a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan to do, and the changes or results you hope to achieve. The most basic logic model is a picture of how you believe your program will work. It uses words and/or pictures to describe the sequence of activities thought to bring about change and how these activities are linked to the results the program is expected to achieve.

Men who have Sex with Men (MSM):　Men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact), whether or not they identify as "gay."

Met Need:

A need for HIV prevention services within a specific target population that is currently being addressed through existing HIV prevention resources. These are available to, appropriate for, and accessible to that population (as determined through the community services assessment of prevention needs). For example, a project area with an organization for African American gay, bisexual, lesbian, and transgendered individuals may meet the HIV/AIDS education needs of African American men who have sex with men through its outreach, public information, and group counseling efforts. An unmet need is a requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population. For example, a project area lacking Spanish-language HIV counseling and testing services will not meet the needs of Latinos with limited English proficiency.

Multiplier Effect:

A multiplier effect refers to changes in a level of activity that lead to further changes in the level of other activities. In HIV prevention terms, a multiplier effect relates to prevention of infection among individuals with the highest numbers of sexual or needle-sharing partners. Prevention among these individuals will avert a greater number of future infections than prevention efforts directed at low-risk individuals.

Outcome Evaluation:

Evaluation employing rigorous methods to determine whether the prevention program has an effect on the predetermined set of goals. The use of such methods allows one to rule out factors that might otherwise appear responsible for the changes seen.

Outcome Monitoring: Efforts to track the progress of clients or a program based upon outcome measures set forth in program goals. These measurements assess the effects of interventions on such client outcomes as knowledge, attitudes, beliefs, and behavior. Monitoring will allow one to identify that changes did occur, but one cannot conclude that the intervention was responsible for the change. This would take a more rigorous approach (see Outcome Evaluation).

Outreach: HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials and may include peer opinion leader models.

Parity: The ability of CPG members to equally participate and carry-out planning tasks/duties in the community planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills building to participate in the planning process and to have equal voices in voting and other decision making activities.

Partner Counseling and Referral Services (PCRS): A systematic approach for notifying sex and needle-sharing partners of HIV-positive persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

People Living with

HIV/AIDS: A person or persons living with HIV or AIDS.

Prevalence: The total number of people living with a specific disease or condition in a defined population on a specified date. For HIV/AIDS surveillance purposes, prevalence refers to living persons with HIV disease regardless of time of infection or diagnosis date. Note the difference between prevalence of a condition in the population and the prevalence of cases, namely that to be a case, a person must be diagnosed according to a definition.

Prevention Case

Management (PCM):   Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.

Prevention Need: A documented necessity for HIV prevention services within a specific target population. The documentation is based on numbers, proportions, or other estimates of the impact of HIV or AIDS among this population from the epidemiologic profile. It also is based on information showing that members of this population are engaging in behaviors that place them at high risk for HIV transmission from the epidemiologic profile and community services assessment.

Prevention Program: An organized effort to design and implement one or more interventions to achieve a set of predetermined goals (e.g., to increase condom use with non-steady partners).

Prevention Services: Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other diseases. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

Priority Population: Population for which prevention programs can make the biggest impact on the epidemic (i.e., if HIV rates can be reduced in such a population, then it would have a major impact on the epidemic in the jurisdiction). Priority populations form the set of population groups that are then prioritized as target populations.

Prioritize: Rank-order list of priority target populations.

Program Announcement: The publication by CDC that describes the amount of funding available for a particular public health goal and solicits applications for funding. The program announcement describes required activities and requests that applicants describe how they will carry out the required activities.

Program Indicator: A program indicator is a quantitative measure of program performance. Program indicators may take the place of program objectives. A specific level of achievement is identified for each indicator (e.g., at least 84% of persons who have positive test results return for their results and receive post-test counseling). An example of a level of achievement for clients in a group-level intervention is, "at least 60% of Asian MSM who enroll in a group-level intervention will attend all five sessions of the group."

Project Area: Same as "jurisdiction."

Qualitative Data: Information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of common themes and patterns of response rather than with numeric or statistical analysis. Qualitative data often complement and help explain quantitative data.

Quantitative Data: Numeric information (e.g., numbers, rates, and percentages).

Referral: A process by which immediate client needs for prevention, care, and supportive services are assessed and prioritized and clients are provided with assistance (e.g., setting up appointments, providing transportation) in identifying and accessing services. Referral does not include ongoing support or management of the referral or case management. There should be a strong working relationship with other providers and agencies that might be able to provide needed services.

Representation: The act of serving as an official member reflecting the perspective of a specific community.   A representative should truly reflect that community's values, norms, and behaviors (members should have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent). Representatives must be able to participate as group members in objectively weighing the overall priority prevention needs of the jurisdiction.

Representative Sample: A sample that is similar to the population from which it is drawn and thus can be used to draw conclusions about the population.

Risk Factor or Risk Behavior: Something that actively contributes to the production of a result. For example, drug use is a factor that increases risk of acquiring HIV infection; and factors such as sharing injection drug-use equipment, unprotected anal or vaginal sexual contact, and commercial unprotected sex increase the risk of acquiring and transmitting HIV.

Scientific Soundness: This term is used to emphasize the need for clear and logical evidence to support the inclusion of a specific characteristic, strategy, or approach in the design and implementation of the intervention. An intervention with a scientific basis is grounded in behavioral and social science theories developed or adapted by the provider. A theory is a statement of the hypothesized relationships between what a provider proposes to do and how those activities will reduce HIV risk behaviors in the service area.

Socioeconomic Status (SES): Socioeconomic status is a factor that helps to describe a person's societal status. For instance, SES may be measured by income levels, relationship to the national poverty line, educational achievement, neighborhood of residence, or home ownership.

Surveillance: The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition.

Target Populations: Prioritized populations that are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. Groups are often identified using a combination of behavioral risk factors and demographic characteristics.

Technical Assistance (TA):   The provision of direct or indirect support to build capacity of individuals or groups to carry out programmatic and management responsibilities with respect to HIV prevention. CDC funds a National Technical Assistance Providers' Network to assist HIV prevention community planning groups in all phases of the community planning process.

Unmet Need: See "met need."

Acronyms

AETC	AIDS Education and Training Center
AHP	Advancing HIV Prevention
AIDS	Acquired Immunodeficiency Syndrome
BSSV	Behavioral and Social Science Volunteers Program
BST	Behavior Skills Training
CBA	Capacity Building Assistance
CBO	Community Based Organization
CBB	Capacity Building Branch
CDC	Centers for Disease Control and Prevention
CDPH	Chicago Department of Public Health
CDPHE	Colorado Department of Public Health and Environment
CMS	Centers for Medicare & Medicaid Services
CPG	Community Planning Group
CTR	Counseling, Testing, and Referral
DEBI	Diffusion of Effective Behavioral Interventions
DHAP	Divisions of HIV/AIDS Prevention
DHHS	Department of Health and Human Resources
FA	Focus Area
GISV	Group Initial Site Visit
GSG	Grassroots School of Grant Writing
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IDSA	Infectious Diseases Society of America
IHD	Initiatives for Human Development
IHS	Indian Health Services
IOM	Institute of Medicine
KABP	Knowledge, Attitudes, and Behavior Practices
MAPP	Mobilizing for Action through Planning and Partnerships
MMWR	Morbidity and Mortality Weekly Report
MSM	Men Who Have Sex With Men

NGO	Non-governmental Organization
NIH	National Institutes of Health
NMAC	National Minority AIDS Council
NMO	National Minority Organizations
OAPP	Office of AIDS Programs and Policy
OCD	Organizing for Community Development
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PIR	Parity, Inclusion, and Representation
PLWHA	People Living with HIV/AIDS
PT	Partnerships Team
PTC	Prevention Training Center
REACH	Relating, Exchanging, and Capacity Building for HIV Prevention
R.I.O.T.	Rapid Intervention Outreach Teams
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SAT	Science Application Team
STD	Sexually Transmitted Disease
TATP	Technical Assistance and Training Program
TB	Tuberculosis
T&D	Training and Development Team
TA	Technical Assistance
WHO	World Health Organization