

## CHALLENGES AND FACILITATORS TO BUILDING PROGRAM EVALUATION CAPACITY AMONG COMMUNITY–BASED ORGANIZATIONS

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We have been collaborating with many community–based organizations (CBOs) to increase their capacity to implement our evidence–based HIV prevention intervention. A frequent issue in these collaborations is how CBOs can evaluate their implementation of the intervention using feasible and sound methods. This study sought to provide the foundation for evaluation recommendations, tools, training, and technical assistance to help CBOs build their evaluation capacity. We conducted a qualitative study of 21 CBOs, 12 funders, and 11 technical assistance providers regarding beliefs and attitudes about evaluation, preferences and requirements for evaluation, evaluation methods that are currently being used at CBOs, and recommendations regarding feasible and effective evaluation that CBOs can use. The themes that arose in the telephone interviews are organized around three major topics: facilitators and barriers to conducting evaluation, evaluation methods that CBOs use, and how to increase CBOs' capacity to conduct evaluations.

In recommendations about how to curtail HIV infections in the United States, the Institute of Medicine has called for more widespread implementation of HIV prevention interventions that have been shown to be effective through rigorous scientific methods (Ruiz et al., 2001). In response, the Centers for Disease Control and Prevention (CDC) reviewed all scientifically conducted, rigorously evaluated intervention studies in the United States to determine which interventions show evidence of effectiveness (Johnson et al., 2002). Programs with evidence of effectiveness are listed in the CDC's (1999, revised) *Compendium of HIV Prevention Interventions With Evidence of Effectiveness*. The CDC has encouraged community–based organizations (CBOs) and

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community-planning groups to consider implementing these evidence-based interventions. At this time, the Mpowerment Project (described below) is the only evidence-based program in the *Compendium* designed specifically for young gay/bisexual men. As a result, this research team has been collaborating with numerous CBOs to increase their capacity to implement this intervention by offering replication materials, training, and technical assistance (TA). Research has shown that such collaborations between researchers (in their capacity as TA providers) and CBOs are invaluable in translating science and research-based interventions to practice (Kelly, Somlai, 2000).

Evaluation capacity frequently arose during our collaborations as an important topic. CBOs struggle with how they can evaluate their implementation of the intervention both for their own needs and to meet their funders' requests for evaluation, and we as researchers wonder how to facilitate CBOs' capacity for conducting such evaluations. The methods that we used to evaluate the efficacy of the Mpowerment Project are clearly not appropriate for CBOs. We conducted randomized controlled trials of the efficacy of the intervention in which entire communities were randomly assigned to control or intervention conditions. Large cohorts of young gay/bisexual men were recruited from each of the communities and followed longitudinally. We used complex survey instruments, paid research participants, paid for data entry, used complex statistical methods, and worked with statisticians. As is frequently the case in intervention research, the evaluation component of the study was substantially more expensive than the intervention itself. Clearly, CBOs implementing the Mpowerment Project need alternative evaluation methods that are feasible and sound, and one goal of this study was to provide the foundation for such evaluation recommendations and to develop evaluation tools that our partner CBOs can use. It was intended that study results would inform replication materials and a technology exchange system that we have been developing to facilitate CBO capacity to implement the Mpowerment Project.

The other goal of this study is to gain an understanding of barriers and facilitators to CBOs' capacity to enact effective evaluations and, on the basis of this information, to develop recommendations about how to facilitate CBOs' capacity to conduct evaluation. Organizations that fund HIV prevention efforts increasingly expect agencies to be accountable for their programming by requiring outcome evaluations despite evidence that CBOs find conducting such evaluations difficult (Marx, Franks, Kahn, Sanstad, & Werdegar, 1997). Additionally, many CBOs do not have the resources to conduct evaluations independently (Davis, 2000; Kelly, Heckman, 2000). Poorly conceived and conducted evaluations are often not helpful to the implementing agency, the funder, or the HIV prevention field (Miller & Cassel, 2000). Our emphasis is on how to build CBOs' own capacity to evaluate interventions and how TA providers can collaborate with CBOs to facilitate this capacity. We also examined how funders' expectations might affect CBOs' evaluation activities. In this article, our use of the term *capacity building* is defined as "a process that improves the ability of a person, group, organization or system to meet objectives or to perform better" (Brown, Lafond, & Macintyre, 2001).

To understand issues regarding conducting evaluation and building evaluation capacity among CBOs implementing the Mpowerment Project, it is necessary to have some understanding of the intervention itself. The Mpowerment Project was developed, implemented, evaluated, and replicated by our team (Kegeles, Hays, & Coates, 1996; Kegeles, Hays, Pollack, & Coates, 1999). It is a multicomponent intervention,

reflecting the complexity of the psychosocial issues that result in young gay/bisexual men being vulnerable to HIV/AIDS (Hays, Rebchook, & Kegeles, 2003). The Mpowerment Project focuses on community building, community organizing, empowerment, and reaching out to and influencing the norms and behavior of entire communities of young gay/bisexual men. The intervention has been implemented and rigorously evaluated in several communities, and it has been shown to effectively reduce rates of unprotected anal intercourse in young gay/bisexual men. The Mpowerment Project comprises five interrelated components that function synergistically (a) *informal outreach*, in which young men speak with and encourage their friends to have safer sex in the context of their social networks; (b) *formal outreach*, which is conducted at venues where young gay/bisexual men congregate and involves a series of social outreach events that the project sponsors; (c) *small groups*; (d) a *publicity campaign*; and (e) a *project space* that serves as a drop-in center and where outreach events are held.

In this article, we report on the findings of a qualitative study, in which semistructured interviews were conducted with representatives from U.S. CBOs, AIDS service organizations (ASOs), and health departments that implement HIV prevention programs; funders of HIV prevention services; and TA providers. The interviews were intended to provide a comprehensive understanding of “real world” program evaluation methods and CBO evaluation capacity issues by examining beliefs and attitudes about evaluation, preferences and requirements for evaluation, evaluation methods that are currently being used at CBOs, and recommendations regarding feasible and effective evaluation that CBOs, ASOs, and health departments can use.

## METHODS

### ORGANIZATIONS INTERVIEWED

Telephone interviews were conducted with representatives from 44 organizations, including 21 CBOs/ASOs or health departments (“CBOs”), 12 funders, and 11 TA organizations or individual providers (“TA providers”). The CBOs were all currently implementing and evaluating HIV prevention programs that include at least one of the intervention components found in the Mpowerment Project intervention (i.e., small groups, outreach, social marketing, and/or a drop-in center). To reflect diverse experiences, we sampled from some of the largest CBOs in the United States as well as smaller organizations. The funding organizations all were currently providing funds for HIV prevention programming that were similar to one or more of the Mpowerment Project components. The TA providers included both individuals as well as organizations that all provide assistance to CBOs to evaluate HIV prevention programs. The TA providers were also diverse with respect to providing TA to organizations targeting different populations (gay/non-gay; ethnic minority/non-minority focus). The CBOs, TA providers, and funders were all diverse geographically.

CBOs and TA providers were identified by searching the CDC’s National Prevention Information Network (NPIN) online database ([www.cdcnpin.org](http://www.cdcnpin.org)). We generated a list of CBOs through key word searches that corresponded to a component of the Mpowerment Project intervention, as well as more conceptual terms (prevention, evaluation, empowerment). Our search emphasized organizations that were serving young gay/bisexual men in particular, but we did not limit the search only to such organizations. We also used this database to identify TA providers. Organizations were then contacted to explain the goals and objectives of the study, to determine whether

or not an interview with them would be advantageous (e.g., were they indeed implementing such interventions, did they have some experience in the area), and if they would be willing to participate. The initial list was augmented by the addition of previously unidentified contacts suggested during conversations with potential participants. Several times an organization was contacted that no longer engaged in work that was germane to the study, but they referred us to other organizations that had not been previously identified.

To identify funders, an initial list of organizations was compiled from several different sources: the CDC's NPIN, the *National Guide to Funding in AIDS* (Cartarella, 1999), and the *HIV/AIDS Resources: A Nationwide Directory* (Guides for Living, 1999). Within the latter two sources, charitable organizations were grouped according to their funding objectives and recent grantees. Searches were conducted of the following terms: program evaluation; health education: youth; health education: minorities; public education, and so on. There exists a corresponding list of recently awarded grants for each philanthropic organization listed. From this list we determined if the organization had specific and recent experience funding programs similar to the Mpowerment Project. CBOs that were identified on the funding lists were also added to the list of potential CBOs to contact.

#### DATA COLLECTION AND SEMISTRUCTURED INTERVIEWS

Semistructured, open-ended telephone interviews were conducted by a member of the research team experienced in the conduct of qualitative interviews. The interviewer received training on the interview protocol prior to conducting the interviews. The interviewer took detailed, near verbatim, notes using a word processing program as the interviews took place (budgetary constraints prohibited the use of transcription). Each interview lasted 1–2 hours. Study participants were paid \$50 for their time in participating in the interviews.

CBO interviews were conducted with prevention education managers or program coordinators who often also served as front line staff. Interviews explored goals and objectives of the CBO's HIV prevention programming, the type of programming the organization was implementing, what process and outcome evaluation methods were used for each type of program, what methods and measurement tools were used to assess the program's overall effectiveness, experiences in implementing evaluations, experiences with TA providers, and recommendations for evaluating HIV prevention programs.

Interviews with TA providers explored the type, frequency, and nature of evaluation requests they received from CBOs, common barriers and facilitators to evaluation they had witnessed, examples of specific evaluation tools and methods CBOs they had worked with were using, issues concerning evaluation data analysis, and recommendations for evaluating HIV prevention programs.

The interview for funders explored what evaluation expectations and/or requirements they have of their funded organizations, impressions of CBOs' capacity for conducting evaluation, what resources are made available to organizations they fund to conduct evaluations (i.e., money, capacity-building assistance, suggested data collection tools), experiences, and suggestions regarding evaluation.

#### DATA ANALYSIS

We analyzed the interviews for emergent themes using standard grounded theory procedures (Strauss & Corbin, 1994) for qualitative data analysis. In accordance with this data analytic approach, we first identified major themes as they emerged in our

TABLE 1. Themes That Emerged From CBOs, TA Providers and Funders; Proportion of Respondents Who Mentioned a Theme and Number of Times Theme Was Expressed<sup>a</sup>

	CBOs (N = 21)		TA provider (N = 9)		Funder (N = 12)	
<b>Barriers and facilitators</b>						
Difficulties conceptualizing & designing evaluation	71%	28	100%	11	33%	7
Difficulties with evaluation tool	71%	41	44%	5	25%	5
Difficulties with data	33%	11	44%	7	33%	3
Staffing challenges	66%	43	88%	32	91%	37
Importance of goals and object	33%	15	22%	2	75%	15
Negative attitudes	19%	8	66%	12	25%	4
Low funding	14%	29	0%	0	50%	7
Funding requirements	28%	20	22%	3	16%	2
Positive impact of evaluation	33%	21	0%	0	25%	4
Range in skills	9%	2	55%	6	16%	2
<b>Evaluation Methods CBOs Use</b>						
Process evaluation	95%	59	55%	11	91%	34
Outcome evaluation	33%	11	44%	4	33%	5
Anecdotal information	76%	57	22%	2	16%	2
<b>Helping CBOs Conduct Evaluations</b>						
Need buy-in and champion	42%	14	88%	17	50%	13
Understand importance and utility of evaluation	0%	0	66%	6	0%	0
More focus on smaller CBOs	19%	4	44%	5	25%	4

Note. CBOs = community-based organizations; TA = technical assistance. <sup>a</sup>Proportion was based on the N of that group; thus, if all respondents had mentioned a theme, the proportion would be 100%. The second figure refers to the number of different times that respondents mentioned a theme. Hence, this figure could be larger than the N.

data rather than adhering to any preconceived conceptual framework. Then two raters independently assigned codes to the text. Discrepant codes were read and discussed until both coders reached agreement. Text could be coded as fitting into more than one theme. Upon completion of the coding phase, we analyzed our data for thematic patterns. Themes were organized into three major topics: facilitators and barriers to conducting evaluation, evaluation methods that CBOs use, and how to best collaborate with CBOs to build their capacity to conduct better evaluations. The last category includes issues regarding the CBO itself, as well as how TA providers and funders can help build capacity.

## RESULTS

### THEMES REGARDING FACILITATORS AND BARRIERS TO CONDUCTING EVALUATION

*Difficulties Conceptualizing and Designing Appropriate Evaluations.* Most CBOs, all of the TA providers, and many funders expressed that it is difficult for CBOs to conceptualize and design meaningful evaluations of their prevention programs (Table 1). Often CBOs that struggled with evaluation did not have the skills to design evaluation and were confused about different approaches to evaluation. A CBO respondent said, "The evaluation process is so unclear for a lot of us . . . including myself." A TA provider said, "It seems so complex and scientific and beyond the reach of them to do." But in addition, many CBOs were implementing interventions for which it is difficult to conduct outcome evaluations, such as outreach and social marketing campaigns. A CBO staff member said, "Since we don't follow these individuals, I don't know how to measure anything else be-

sides who we talked to and when.” A funder stated, “It’s difficult [to evaluate] because you can’t always attribute the change to the [social marketing] campaign.”

*Difficulties Developing or Using Evaluation Tools.* Most of the CBOs, nearly half the TA providers, and a substantial number of funders expressed that a major capacity issue for CBOs was their need for assistance in developing or using evaluation tools. Often the difficulty concerned developing meaningful evaluation questions that generate useful data. One CBO respondent said, “Sometimes the questions are too general and don’t speak to what we are covering in the workshops.” Another CBO respondent stated, “We had problems developing a tool . . . We’re not actually finding out what we want to find out.” But respondents also frequently mentioned difficulties with the tools because of low response rates by intervention participants. Many TA providers and funders said that TA in developing evaluation tools was the most typical issue for which CBOs requested assistance. University researchers, other TA providers, or other evaluation experts often provided useful help regarding evaluation tools according to CBO respondents. A funder stated, “We assist grantees in selecting and modifying survey scales, instruments, and methods previously used in research.”

*Difficulties Collecting or Analyzing Evaluation Data.* Many CBOs, nearly half the TA providers, and a third of the funders said that CBOs have difficulties in collecting and/or analyzing their data. In many cases, the CBOs had collected evaluation data but then had not been able to use the data for various reasons, including that they simply did not know how to analyze it or they did not have funding to do data entry and analysis. Expressed one CBO staff member, “Data are just sitting in boxes.” Another CBO staff member stated, “We just have not had time to run an analysis on it.”

*Challenges in Staffing.* The majority of CBOs and nearly all the TA providers and funders mentioned difficulty conducting evaluations that stem from staffing issues. This includes time available for staff to conduct evaluations, staff turnover, and staff with insufficient knowledge about how to do evaluations. Staff turnover issues were mentioned frequently. In an example of having insufficient staff, one CBO respondent said, “We only have one person working [in our prevention department]. The manpower alone is a problem, so we don’t have that component [evaluation]. He does all the presentations, all the outreach.” In reference to insufficient knowledge, another CBO respondent said that “a lot of [the staff] don’t have the experience or expertise to even use the computer very well.”

*Challenges in Setting Clear Program Goals and Objectives.* Most of the funders, some TA providers and one third of CBOs mentioned that clear program goals and objectives are prerequisites for good evaluation. Said one funder, “I think one of the most important things is being able to state what the goals and objectives of the program really are . . . Without that you won’t be able to evaluate it and that’s where we get tripped up sometimes.” Yet a number of the CBOs did not seem to know the difference between their general program goals and their program objectives, and the need to make the latter measurable, concrete, and achievable. Moreover, both funders and TA providers observed that CBOs’ lack of clear objectives is a major barrier to conducting effective evaluation. In addition, CBOs were often unclear about what reasonable and appropriate goals and objectives are for their program and specific target population. One CBO staff member said, “We had trouble measuring what we initially said we were going to do . . . we overestimated our goals.” In addition, CBO respondents sometimes seemed not to have thought through the logic of how their program objectives related to the overall program goal. For example, one program’s

goal was to change high-risk women's sexual risk behavior. The organization was implementing small groups in order to influence the women's behavior. But attention had not been given to the content of the small groups regarding how any of the various topics discussed in the groups might lead to behavior change.

*Negative Attitudes Toward Evaluation.* Two thirds of TA providers, one quarter of funders, and one in five CBOs expressed that CBO staff have negative attitudes toward evaluation. Fear that evaluation results might reflect poorly on the CBO staff or on the program was expressed by many respondents, as was the concern that poor evaluation findings might result in future funding problems. A TA provider commented, "People are being assessed, and that is threatening in that they may be judged as ineffective managers or leaders." A funder stated, "A lot of organizations are afraid of it because it may reflect poorly on them, and there's a lot of competition for the money." In response to a question about evaluation of a specific program, a CBO respondent said, "The staff person was resistant to that . . . she was not hosting the sessions frequently and she was resistant to having documentation of that fact." Many CBOs failed to mention any way that evaluation was helpful to programming or to the CBO itself.

*Low Funding.* Half the funders and some of the CBOs reported that funding problems have a significant impact on ability to conduct evaluation. They often had insufficient funding in order to conduct and complete evaluation activities. Said a CBO respondent, "Before, when we were funded by the CDC, we had more positions, so we were able to do more evaluations, but since the CDC cut funding . . . we don't do [evaluations] anymore."

*Funding Requirements.* Some CBOs, TA providers, and funders commented that evaluation activities were conducted in order to satisfy funders' requirements or to prepare for future submissions of grant proposals in response to RFPs (requests for proposals). In response to the question about how the information from evaluation efforts is used, a representative from a CBO stated that "[it's] . . . good information for grant proposals."

*Positive Impact of Evaluation.* Some of the CBOs and funders commented on other positive effects of evaluation, other than its use for funders, such as its use in assessing if they were reaching their target population or if they needed to change the HIV prevention messages. One CBO stated, "[The evaluations] have been very useful . . . There are certain events where we have really been able to assess the success . . . one event we won't repeat because of the response." Another CBO respondent said, "We use it to revise and update the activities, make programmatic changes, and also for reporting to the contractors." A funder, commenting on evaluation work undertaken by the CBO they were funding, stated that "they thought they knew the target population very well and during the evaluations they found out new information and were surprised by what they found . . . They learned a lot from that . . . Even though they had been working with that population for many years, they found they had a lot to learn from it."

*Range in Skills.* More than half of the TA providers commented on the varying levels of skill found among staff at CBOs concerning developing or implementing evaluations. In addition, TA providers commented that sometimes CBOs' executive directors had great ideas about doing evaluation, but the front line staff, who would be expected to carry out evaluation activities, did not understand how to conduct them. For example, a TA provider commented, "All the people are at different levels . . . One that I work with is way up on all of this, so I'm working on a more technical

realm with them while another struggles to collect data or really understand the concepts of evaluation and so we're working on that."

#### THEMES REGARDING EVALUATION METHODS THAT CBOs USE

*Process Evaluation.* Nearly every CBO and funder and more than half the TA providers mentioned the collection of process data by CBOs when asked how they evaluate their programs. Almost all of the CBOs collected some process information such as demographic characteristics and the numbers of people they reach, the number of condoms they distribute, the number of conversations they have with the target population, and the number of groups they run. However, such information was not always systematically gathered. A TA provider reported, "They [a CBO] did one evaluation of the project . . . all process." Similarly a funder said, "many of them are already doing process evaluation work."

*Outcome Evaluation.* When asked how CBOs evaluated their programs, considerably fewer respondents mentioned outcome evaluation methods. Similarly, only one third of the funders mentioned that outcome evaluation was required. Outcome evaluation sometimes included changes in attitudes, knowledge, beliefs, and behavioral intentions, but behavioral changes were relatively rarely examined. In contrast to the discussion about process evolution, what was most often mentioned about outcome evaluation was the difficulty of doing it. One CBO representative said, "We had problems developing a tool for outcomes . . . This tool [that we are using] is supposed to be the tool for that but we're not actually finding out what we want to find out . . . It gives us numbers for the funders but it doesn't really tell us if we taught them anything . . . It doesn't give us outcomes."

CBOs found outcome evaluation for small group interventions to be considerably less difficult to conduct than outcome evaluation for outreach and social marketing intervention approaches (very few were implementing drop-in centers). In contrast, most CBOs implementing small groups had good ideas about how to conduct outcome evaluations of them, including the use of pretest and posttests. However, even outcome evaluation for small groups was not easy. The agencies implementing small groups wanted to conduct posttests subsequent to the groups but were concerned about lack of follow-up of group participants, lack of resources to pay participants to return surveys, bias in who they are able to track over time versus who they lose, and confidentiality issues in seeking respondents. One director of HIV prevention education said, "We try to do a 3-month follow-up, but some of that is not as successful as it could be . . . It's hard to get people to fill those out."

As difficult as small group interventions were to evaluate, CBOs felt completely perplexed about how to conduct outcome evaluations for outreach and social marketing methods. Similarly, CBOs who were implementing multicomponent programs for the same target population did not evaluate their programs en masse to see if the combination of their programming was having an effect. They either solely conducted process measures (e.g., tracked the number of contacts the outreach worker had, counted how many discussions occurred, examined recall of social marketing products such as signs) or did no evaluation at all.

*Anecdotal Information.* The majority of CBOs mentioned anecdotal information when asked how they could gauge if their programs were effective. Often such information supplanted outcome measurement as an indicator of programmatic success. For example, an individual from a CBO said, "We have anecdotal information but actual measurement is really difficult." Another individual said, "What

makes me feel like it's a success is seeing the change in the way that people address community and each other . . . seeing people be more frank and honest about their practices." As might be predicted, neither many TA organizations nor funders mentioned anecdotal information when asked how their programs' effectiveness might be assessed.

#### THEMES REGARDING HOW TO INCREASE CBOs' CAPACITY TO CONDUCT EVALUATIONS

##### *Need Buy-In From all Levels and a Champion of Evaluation at a Higher Level.*

Nearly all of the TA providers and half the funders and CBOs mentioned the need for buy-in from staff as a strong facilitator of CBOs' capacity to enact effective evaluation methods. A number of respondents reported that if an administrative person (e.g., executive director or program manager) emphasizes the importance of evaluation and promotes its use as an important component of programming, then other staff are more likely to buy into it. It appears that effective evaluation is very unlikely to occur otherwise. Yet acceptance of evaluation only by upper management is insufficient, as evidenced by this TA provider: "An executive director may have a good idea about evaluation, but the burden may fall on the front line staff who many not be interested or have any knowledge about what is involved." Said one CBO staff member, "It's better to have all the staff there and have everyone participate and buy in." A funder commented that "staff also need to buy in . . . It's a big issue when they see resources taken away from the 'real work.'"

##### *CBOs Need to Understand the Importance and Utility of Evaluation.*

Two-thirds of the TA providers reported that their role in working with CBOs is often not just to suggest ways of conducting evaluation but instead also involves explaining why evaluation is important in and of itself and further, that it is an essential component of programming. Clearly, CBOs are not going to increase their capacity to implement feasible and sound evaluations, or seek ongoing collaborations with TA providers, if they do not recognize the benefits of doing so. Said one TA provider, "We spend a lot of time just trying to explain why evaluation is important." Another TA provider said, "A lot of work is done around understanding evaluation . . . and how it isn't a separate task from the program."

*Improve CBO-TA Provider Collaborations.* Many TA providers expressed that it is not always easy for them to provide meaningful TA to CBOs, and likewise, some CBOs and funders expressed that TA they receive from providers is not always very helpful. Some CBOs reported that they had worked with TA providers in conducting an evaluation of their programming and that it had been a very frustrating experience because the evaluators simply "spewed out numbers" at them, rather than collaborating with them in order to produce meaningful information for the CBOs' use. There were instances cited of TA providers simply developing a tool for evaluation and delivering it to the CBO, without collaborating with the CBO so that together they could analyze problems and revise it or develop an approach that seemed more appropriate to the CBO. Sometimes CBOs commented that the lack of an ongoing relationship with a TA provider was also problematic. One CBO staff member said, "We have some interns from the \_\_\_ School of Public Health right now . . . We find that it's kind of hit or miss if we get an intern . . . lucky to have one right now. [But] there is no way to get back in touch with them to let them know that the tool isn't working." In contrast, another CBO respondent raved about their relationship with a university-based

TA provider, commenting on how helpful it was to have a long-lasting relationship with someone who really understood their programming and evaluation issues.

*Particularly Focus on Smaller CBOs' Capacity Challenges.* CBO size seemed to be related to differences in attitudes about evaluation, collaboration with TA providers and in evaluation capacity. Many of the smaller CBOs, which have fewer financial and staffing resources, seemed to perceive evaluation to be a burden that detracted from programming. Moreover, they usually did not utilize evaluation results as a tool for analyzing and improving their programming. Instead, evaluation often seemed to be perceived as something forced on them from outside, with little benefit to their CBO. In contrast, it appeared that many of the larger CBOs, which have relatively more resources, were conducting well-conceived, methodologically sound evaluations that yielded results that they were using in developing new intervention approaches or used to refine their current intervention approaches. Many of the respondents from these organizations seemed to understand the utility of evaluation in creating better programming that effectively reaches the groups they are attempting to target. There also seemed to be a pattern that the larger CBOs often collaborated with TA providers, particularly with university-based researchers, in conducting evaluations, but frequently the smaller organizations did not do so. Some of the smaller CBOs did not know how to obtain TA.

## DISCUSSION

The focus of this research regarding how to build CBOs' capacity to conduct evaluation came as a result of collaborations between this research team and organizations implementing the Mpowerment Project. The focus of the collaborative activities previously had been solely about how to translate the research-based intervention to practice, but the CBOs articulated the need for additional focus on evaluation methods that they could use. It became clear that a focus on evaluation capacity building was also an integral part of translating research into practice. It is not only important to translate evidence-based interventions to practice in order to reduce HIV infections, but CBOs also need assistance in developing their capacity to evaluate how effectively they are implementing such interventions. Hence, collaboration between researchers and service providers yields new areas of research relevant to stemming the tide of HIV infection, as well as resulting in more effective program implementation.

### BARRIERS TO CBOs' CAPACITY TO CONDUCT EVALUATION

CBOs reported considerable challenges in implementing meaningful evaluations of their HIV prevention programs. Many CBOs found evaluation difficult to understand, design, and implement, and they suffered from a lack of feasible and meaningful evaluation tools and methods relevant to their programs. Many CBOs did not know how to analyze evaluation data once it had been collected. In addition, many CBOs had not thought through the internal logic of their programs; they could identify what they were doing in their programs and could speak about the overarching goals of their programs, but they had never delineated the specific objectives that their programming was trying to achieve nor how these objectives related to their program goals or to broader goals of HIV prevention. Because they had not considered specific program objectives, or had not conceptualized them in concrete and measurable terms, they were confused about exactly what they should be evaluating. Thus, their

evaluation attempts were not helpful for their own internal assessments of their programs' success.

Organizational and funding issues were also major barriers to implementing effective evaluations. A number of CBOs stated that high staff turnover impeded their ability to conduct evaluations. After all, they pointed out, they cannot evaluate their programs when they cannot hold on to their staff. In addition, a number of CBOs said that they lacked funding to complete an evaluation. For example, some reported that, without an incentive, insufficient numbers of people would complete the forms. Others stated that data were collected, but there were no resources for data entry or data analysis, and so the data simply remain unanalyzed. A different funding-related issue is that often the CBOs had insufficient resources to implement the intervention well; they did not then want to spend their scarce human and financial resources on evaluating a program rather than on implementing the program. Sometimes management staff understood the inherent utility of evaluation, but line staff, who carry out the programs and deal with clients in an ongoing, personal level, only saw negative aspects of it. Evaluation was sometimes only seen as a drain of resources, rather than being beneficial to the CBO.

#### FACILITATORS TO BUILDING CBOs' CAPACITY TO CONDUCT EVALUATION

The results of this research provide a myriad of possible actions that can be undertaken to build CBOs' capacity to conduct evaluations. First, it is important that all levels of staff at CBOs recognize that there is substantial benefit to the organizations themselves in conducting good evaluation, beyond that it should be done because funders require it. It is crucial that front line staff, rather than only management, understand the benefits of evaluation. Faced with myriad challenges they must deal with in order to implement effective HIV prevention, implementing effective evaluation methods will not be a priority for many CBOs, and for line staff in particular, unless they recognize the value of evaluation for the purpose of creating better programming or refining their current programs. CBOs who are reluctant to implement evaluations need help to recognize that effective programming and effective evaluation can be integrally related.

Moreover, many CBOs need assistance to understand that the very *process* of conducting evaluations can be beneficial, by assisting them in thinking out the rationale of their programming. That is, in order to design an informative evaluation, they need to specify the objectives of their programs, the outcomes that they expect to achieve, and how these relate to the overall goals of their efforts. Effective TA for CBOs must also focus on how the *outcome* of evaluation efforts can also benefit CBOs' internal needs—not only to satisfy funders. Evaluation data can help a program learn if it is reaching the desired target population, is addressing important topics prioritized by the CBO, is being conducted with sufficient intensity, and so forth.

For evaluation to be seen as a benefit that outweighs its costs, evaluation needs to be implemented in such a way that it enhances, and does not detract from, CBOs' ability to implement their programs. Organizations are understandably loath to reduce their programming in order to evaluate if their programming is effective. One possible way to facilitate this would be for supplemental funding to be earmarked specifically for evaluating the evaluation.

It was clear in the interviews that collaboration with TA providers often helped CBOs implement good evaluation methods, by building CBOs' capacity to implement

feasible and sound evaluations and sometimes, by having the TA providers conduct evaluations themselves. When staff turnover is a problem, TA providers can help sustain evaluations. TA providers can develop evaluation instruments, help design appropriate evaluation methods, help enter and analyze data, and help interpret findings. Sometimes the TA providers can be funded through alternative means, such as through contracts with the local, state, or federal government, or as part of a research-based collaborative activity, rather than directly by the CBOs.

The best TA seemed to occur when it involved an on-going collaborative process between the CBO and the TA provider. This was when the TA provider worked with the CBO in an ongoing relationship; understood the CBO's mission, goals, and objectives; and when the TA provider and CBO could work together to establish evaluation methods for the CBO to use. This type of collaboration enabled the development of evaluation method that reflected the CBOs' needs and capacity. This also helped ensure buy-in from the CBO staff because they did not feel that an evaluation method was being imposed on them without their involvement and input, and hence, their sense of ownership of the evaluation approach. One TA provider stated, "I always have a feedback session, multiple feedback sessions, just to make sure that if there are any questions those questions get answered. So much depends on developing rapport." The TA providers, often university researchers, were also able to develop methodologically and scientifically sound evaluation methods. It is clear that developing a collaborative relationship between CBO and TA provider requires time and effort. It is also clear, however, that knowing how to access TA is a learned skill itself. The larger CBOs were more likely to seek effective help and develop such collaborations. Clearly the smaller CBOs need to be targeted for help as well, even if they do not know how to obtain such assistance. Such collaborative relationships between TA providers and smaller CBOs may be facilitated by third-party organizations such as health departments.

The study findings also indicate that it would be beneficial for funders to be aware of the constraints CBOs encounter in conducting programming and evaluation. Some funders indicated a desire for outcome evaluations for the programs that they fund but did not seem cognizant of the difficulties in conducting outcome evaluation. For example, CBOs (and their TA providers, if they existed) were unable to develop outcome evaluations for community-level interventions, such as social marketing and outreach, or for multilevel or multicomponent programs. Funders often seemed unaware of other barriers to effective evaluation, such as high staff turnover, low number of staff, inexperienced staff, and very short funding cycles, which do not allow sufficient time in order to conduct an intervention and evaluation. One funder, for example, commented that it was difficult to get programs up, going, and evaluated in a short period of time and then later reported that his agency funded programs for 1 year only. Hence, often, for myriad reasons, CBOs had difficulties in achieving the objectives or goals that they had expressed in their proposals to funders. Yet CBOs expressed reluctance to communicate honestly with their funders about these problems out of fear that their funding would be decreased or eliminated.

Funders expressed primary concern about ensuring that they were funding appropriate and effective services but also indicated that they desired greater information about how the programs were really being implemented and what outcomes were occurring. Some funders indicated an openness to considering changes to program design, objectives, and goals when the need arises. Furthermore, funders indicated that they often knew of individuals or organizations that could provide TA to the CBOs or

would consider providing supplemental funding to help CBOs build capacity in program implementation and evaluation. Hence, it seems that if there were mechanisms by which CBOs could express their difficulties to funders, then the problems could be addressed. Clearly, this would require time and effort to develop rapport and trust between funders and CBOs and a sense on the part of the CBO that they would not be penalized for expressing their concerns about their programs and their evaluation needs and methods to their funder.

There is a need for greater clarity of what is meant by “evaluation.” CBOs and funders alike were often confused about why one would conduct process evaluations versus outcome evaluations, and mistook one for the other. Often they considered only the outcome question “Did the program change the sexual risk behavior of the target population?” However, focusing on this outcome was often too grandiose, either because of the likely impact of the intervention (e.g., a single-session group) or because there was insufficient funding to conduct an evaluation to detect such an outcome. Often only the “grand” outcome was considered rather than the critical process question “Was the intervention implemented effectively?” or “Do we reach our target population?” Sometimes CBOs believed that they were examining outcomes when they were focusing on process evaluation (e.g., “How many condoms were distributed?” rather than “Did the condom distribution method result in greater condom use?”). Clearly, TA needs to focus on helping CBOs identify when they are doing which kind of evaluation (including formative evaluation, which was mentioned quite rarely). TA should also focus on helping CBOs to understand the purpose of the different types of evaluation methods and the questions that the different approaches can answer. Often, process evaluation is indeed what CBOs should focus on. It may be impossible for them to answer the grander questions of reductions in HIV infection rates or behavior change, but they may have the capacity to conduct process evaluation to determine if they are reaching their program objectives.

Table 2 offers a list of recommendations that CBOs, TA providers, and funders consider regarding building CBOs’ capacity for implementing effective evaluation. The findings from this study largely support a thoughtful piece by Miller and Cassel (2000) regarding how CBOs can build meaningful evaluation activities. Interestingly, our study was conducted at the same time that another, similar study was conducted by Napp, Gibbs, Jolly, Westover, and Uhl (2002). In that study, the authors interviewed 61 CBOs who were receiving CDC funding and 28 TA providers. Similar evaluation recommendations were made in that paper, which further corroborates the findings here.

## LIMITATIONS

As with any study, there are potential limitations of this research. Sites selected do not constitute a representative sampling of cities, nor do the organizations selected represent the plurality of HIV/AIDS prevention programs within each locale. Furthermore, the objective of the interviews was not to test a specific hypothesis related to evaluation. Interviews were intended to gather information that would inform the creation of tools and methods specific to evaluating the Mpowerment Project for organizations wishing to adopt the intervention. Therefore, the results reported here do not necessarily represent the full spectrum of issues related to HIV prevention program evaluation. Additionally, though participants were told at the beginning of each interview that the goal of this research was to “hear about the real problems and successes

**TABLE 2. Recommendations for Building Community-Based Organizations' (CBOs') Capacity for Conducting Evaluation**

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1. CBOs must critically analyze the internal logic of their interventions.
    - a. From this, they can develop concrete and measurable objectives, processes they want to see, expected outcomes, and the relationship of these to program goals.
    - b. These form the basis of evaluations.
  2. CBOs need to prioritize evaluation from the outset.
    - a. CBOs should consider evaluation as an integral part of their programming, and not only conducted in response to funder requirements.
      - i. CBOs should plan evaluation so that it begins before implementing the program.
      - ii. CBOs should use evaluation as a tool for their own work in creating and refining their intervention programming.
    - b. All levels of staff should be helped to buy in to the importance of evaluation and the benefits of evaluation to the CBO.
    - c. Funders desiring evaluation should consider earmarking monies for evaluation rather than requiring CBOs to take money out of programming.
  3. Technical assistance (TA) can be enormously helpful in building evaluation capacity by CBOs.
    - a. TA providers and CBOs need to work to develop effective collaborative relationships that build trust and mutual respect.
    - b. TA providers and CBOs need to collaborate in order to develop evaluation methods that are feasible for CBOs.
      - i. Sustainable methods for when the TA provider is not there should be developed.
      - ii. Evaluation methods should be kept as simple as possible.
      - iii. Evaluation methods should be developed that meet the needs of the CBOs, given their staffing and funding.
  4. Attention needs to be given to different types of evaluation methods.
    - a. CBOs and funders need to understand the difference between process and outcome evaluation and what information is yielded by which approaches.
    - b. Funders must be realistic about when CBOs can accomplish outcome evaluations.
    - c. When CBOs implement evidence-based interventions which are difficult to evaluate with outcome evaluations, CBOs' focus should primarily be on process evaluation that assesses implementation of the intervention with fidelity.
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experienced with program evaluation” rather than idealized accounts, some respondents may have expressed socially desirable responses.

#### IMPLICATIONS FOR TRANSLATING RESEARCH TO PRACTICE

This study was undertaken because in our collaborations with CBOs implementing the Mpowerment Project, we found that they needed practical, feasible, and methodologically sound ways of evaluating the intervention. We had wanted to learn in this research how CBOs evaluate interventions that contain multiple components that work synergistically and how to feasibly evaluate community-level intervention approaches. What we found instead is that CBOs only conduct outcome evaluation for those programs that are most amenable to evaluation, such as small groups (and CBOs pointed out that those are not so easy to evaluate either). CBOs only conduct process evaluation on community-level approaches and often misunderstand when they are conducting outcome versus process evaluation. Furthermore, we found that many CBOs had not thought out the logic of why they are implementing particular programs and how they expect the programs to reach desired goals.

On the basis of these findings, we came to three conclusions about how we could be of assistance to CBOs with which we collaborate. First, we now address the issue of evaluation in our replication materials that we provide to CBOs wanting to implement our intervention. We offer suggestions about how to evaluate the intervention, provide information about the rationale for different types of evaluation, explain about the difference between formative, process, and outcome evaluation, and pro-

vide specific evaluation tools that can be used in conducting the different types of evaluation.

Our second conclusion was that we needed to include a program logic model (Connell & Kubisch, 1998; Kumpfer, Ross, & Shur, 1993) with our evaluation materials so that the logic underlying the program is clearly spelled out. This includes a delineation of when and why particular activities should be done, the expected outcomes of each activity, the objectives of those activities, and how these relate to the broader goals of HIV prevention. A logic model for the Mpowerment Project is available from the authors upon request.

Our final conclusion is that we question the need for CBOs to conduct an outcome evaluation of the intervention that includes behavior change, given the extensive, rigorous, and costly evaluation methods that were used in the original research to establish the efficacy of the intervention. Given that it is extremely difficult for CBOs to implement a methodologically sound outcome evaluation of the overall program, a more efficient use of resources is to focus the evaluation on implementing the intervention with fidelity to the original methods used in the research. Thus, we prioritize *process* evaluation in our replication materials and our collaborative work, and strive to build capacity to implement the intervention effectively. We emphasize the importance of using process evaluation in an ongoing way to critically and continually analyze if the program is being implemented effectively. Finally, we also emphasize that this ongoing critical analysis be regarded as a crucial part of the programming itself.

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