THE CHANGE APPROACH TO CAPACITY-BUILDING ASSISTANCE

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The CHANGE approach to capacity-building assistance (CBA), developed over 4 years by the Latino Commission on AIDS Manos Unidas' Program to assist Latino-serving community-based HIV prevention programs in eight northern U.S. states, Puerto Rico, and the U.S. Virgin Islands, is a system for providing community-based organizations (CBOs) with not only the skills to implement interventions from the Centers for Disease Control and Prevention's Diffusion of Effective Behavioral Interventions (DEBI) project, but also the capacity to reorient to the disruptive innovation of the DEBIs. The CHANGE (customized, holistic, analytical, network-building, grassroots, evaluatory) approach entails an integrated CBA-model emphasizing community and programmatic diagnosis and reflection and the enhancement of staff skills through tailored curricula in six areas: community-assessment, target-refinement, recruitment and retention, basic skills, program implementation, and evaluation. The CHANGE model encourages active CBO participation in the learning process rooted in the experiences of the organization as a member of its community.

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The community-based organization (CBO) historically has been in the vanguard of HIV prevention program implementation. HIV prevention programs frequently were designed based on local knowledge rather than empirically validated behavioral theories. This does not invalidate the impact of locally designed prevention programs but, rather necessitates an understanding of determinative local factors. However, in 2002 the Centers for Disease Control and Prevention (CDC) began to push for the integration of behavioral theory-based, empirically supported prevention programs by asking CBOs receiving CDC funding to implement interventions from the CDC's Diffusion of Effective Behavioral Interventions (DEBI) project (CDC, 2003; Collins, Harshbarger, Sawyer, & Hamdallah, 2006). The DEBIs can have distinctly different

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implementation methodologies from traditional local programs and require more rigorous styles of provision, documentation, and assessment of services on the part of CBOs. DEBIs can be regarded as a "disruptive technology" (Christensen, 1997), specifically a "low-end" disruption because the rate at which the improvement is introduced exceeds that at which users can adopt the new performance.

What makes the DEBIs a disruptive technology? Christensen, Bohmer, & Kenagy (2000) noted that disruptive innovations are typically cheaper, more reliable and simpler than an established technology. The DEBIs are considered reliable as effective interventions through demonstrations at a specific site receiving and utilizing substantial funding (Dworkin, Pinto, Hunter, Rapkin, & Remien, 2008). They are considered simpler because they essentially "come in a box." This article argues that the actual complexity is masked by the prepackaged nature of the DEBIs. CBOs have to do formative assessments where once they assumed an understanding of their community. They now have to collect more data with greater rigor, and they have to follow a preprogrammed intervention without specific protocols for effective management. The DEBIs superficially appear as a "prevention franchise," but nuanced protocols for local implementation are not part of the package, which handicaps CBOs if they do not adjust the protocols to their local environment (Dworkin et al., 2008). The "cheaper" characteristic attributed to a disruptive technology, drawn from business models, has an analog in the nonprofit world. In order to increase the likelihood of obtaining CDC funding for a prevention program, a CBO is well-advised to utilize a DEBI (Mckleroy, Galbraith, Cummings, Jones, Harshbarger, 2006). Obtaining funding for a locally designed program is more problematic.

Although the DEBIs are marketed as more reliable (pretested), simpler (predesigned), and cheaper (preapproved by the major funder), their disruptive impact has been underappreciated, and the gap between the theory of the DEBIs and their practical use is a wide one. The technology of the DEBI emerged on the market of prevention strategies, but effective tactics for adapting DEBIs to preexisting organizational structures and local circumstances have not developed at the same pace (Dworkin et al., 2008). Hence, CBOs frequently find themselves illequipped to implement the new technology and are "disrupted" as technological change is introduced faster than the prevention community can adapt to it. Sometimes it is useful to see the forest for the trees, but neglect the trees and the forest will disappear--just as in the HIV field our attention is often on the larger picture of incidence and prevalence rates, but we must recognize that the "health" of the organizations providing crucial services at the community level is important. Reorienting prevention programs toward DEBIs cannot be accomplished solely through packaged trainings, as this presumes CBOs, which are enormously diverse in staffing, resources, populations served, provider networks, and community relationships, are interchangeable.

Few dispute the value of attuning prevention research to practice through DEBIs, but adjusting to the new reality is generally disruptive to a CBO (Dworkin et al., 2008). To operate effectively in a DEBI-oriented environment, CBOs are discovering the need to adjust patterns of organizational practice, to address issues of program sustainability and to develop local tactics to complement the prevention strategies offered by the DEBIs. This reorientation is best facilitated through capacity-building assistance (CBA) providers who can help them combine behavioral theory, local implementation experience and existing skill sets. Organizational diagnoses are needed as part of CBA to ensure continuous, culturally responsive services to those infected and affected by HIV.

CBA providers act as integrators and mediators between the new venture and the organization (Gilbert & Bower, 2002). Well-conceived CBA, modeled on techniques for designing successful business models to assimilate disruptive technologies, facilitate the DEBI implementation at the local level and provide the necessary framework for organizational success. Inclusion of evidence-based interventions locally is meaningless if they so disable a CBO as to prevent it from functioning effectively. Capacity building is a major strategy to develop workforce and institutional capacity (Tang, Nutbeam, Kong, Wang, & Yan, 2005) and is integral to the strengthening of CBOs to reduce HIV incidence in communities of color at high risk (Dauner, Oglesby, Richter, LaRose, & Holtgrave, 2008).

In 2004, a cooperative agreement between the CDC and the Latino Commission on AIDS formed a CBA program called Manos Unidas (Joined Hands), targeting Latino-serving HIV prevention programs in the northern United States, Puerto Rico, and the U.S. Virgin Islands. Manos Unidas' specific goal, as funded by the CDC, was to improve the capacity of health departments and CBOs to design, develop, implement, and evaluate effective HIV prevention interventions for racial/minority individuals whose behaviors places them at risk for acquiring or transmitting HIV and other STDs. Lacking coherent models in the literature for CBA, Manos Unidas developed an integrated model of capacity building for HIV prevention programs to address needs of Latino-serving CBOs. This article presents the CHANGE model for capacity building. It describes the theoretical precursors in theories of disruptive technologies, values of the model and six focal areas of programmatic enhancements accomplished through CHANGE-centered CBA. The CHANGE model was designed to address the means by which CDC's prescribed DEBIs can be translated into sustainable, Latino-tailored programs.

The contribution of this article is twofold, intended to bridge the needs of practitioners and the interests of researchers. First, it will delineate a model and invite assessment of capacity building in the HIV prevention field that is actively applied in the field--the CHANGE model of CBA. Second, this article hopes to inspire further theoretical and empirical work on how disruptive innovations in the nonprofit health sector impact quality and sustainability. This discussion is organized around the following themes: (a) the development of CHANGE, (b) the CHANGE framework for addressing disruptive innovation, (c) the implementation of CHANGE, and (d) questions to ponder as more disruptive innovations (i.e., DEBIs) are diffused into prevention efforts at the community level.

DEVELOPING CHANGE

There is increased impetus to move evidence-based HIV prevention interventions into community-based settings (Aarons & Sawitzky, 2006). However, as the DEBI project emerged, CBOs resisted abandoning homegrown programs for packaged interventions (Collins et al., 2006). DEBIs represented the introduction of different techniques, requirements, and mind-sets into prevention program management, and these differences are often at odds with traditional styles of service delivery. Although DEBIs are intended to address the gulf between empirical research and field practice, they extrapolated from a specific instance of success to assumptions that the methodology applied could be generalized. The CHANGE model is intended

to synchronize the DEBIs with the reality of local application. It is important to understand what the DEBIs represented to the CBOs. Given observable difficulties in implementing DEBIs, the argument that DEBIs represented a disruptive technology was not only compelling but also provided theoretical precursors well suited to engaging problems of local adaptation.

The CHANGE model was designed around six basic capacity-building values derived from successful business models for disruptive innovations, that is, that capacity building can only be effective if it is (c)ustomized, (h)olistic, (a)nalytical, (n)etwork-building, (g)rassroots, and (e)valuatory. These values helped identify the need to address six focal areas (community assessment, target refinement, recruitment and retention, basic HIV skills, program implementation, and evaluation), found to be key to effective programs and subject to enhancement through CBA. Fundamentally, what underlies the CHANGE *model is t*he need for creative thinking when integrating disruptive technologies and helping a CBO identify organizational level changes given that the disruption may lead to a distressed organization (Bunear Puplampu, 2005). A framework must be developed to assist the CBO to manage knowledge creation, retention, transfer, and utilization. Furthermore, such a framework must borrow from fields outside HIV prevention such as industrial psychology and business management. Empirical public health research can suggest potentially successful strategies via the DEBIs, but field application requires practical skills from other sources.

As Christensen (1997) posited, disruptive technologies eventually displace established ones. This displacement at a community organization may threaten the organizations' existence; thus a model that acknowledges the grassroots nature of the organization while integrating the disruptive innovation must be utilized. Disruptive technologies render established technologies obsolete, potentially destroying the value of the grassroots orientation that long-established CBOs have promoted. The CHANGE model strives to recognize and address the grassroots orientation of the CBO, ensuring that the local perspective is not lost.

When an organization is faced with a disruptive technology, it needs to review, revise, and reinvent its business model (Johnson, Christensen, & Kagermann, 2008). The elements of a successful business model include (Johnson et al., 2008): customer value proposition (CVP), profit formula, key resources, and key processes. The CVP is the way to help the customer (the CBO) get a specific job done and to solve a fundamental problem in a given situation that needs a solution (Johnson et al., 2008). In other words, the business model needs to be customized. The profit formula is the blueprint developed when comparing the existing model to that which is needed. It requires that the organization be analytical and holistic in its approach.

Key resources are assets such as people, technology, products, channels, and brand. A CBO's key resource is its brand —its connection to the community and its staff-who are often of the community and/or peers. How the CBO networks and combines resources with others is key in how it provides services to the community. The grassroots nature of the CBO is clearly a key resource.

Key processes such as metrics, norms, and standards comprise the fourth element of the business model. The key resources and processes are primarily addressed in the action planning stage where key focal areas are identified for capacity building. These four elements comprise the building blocks of any organizational endeavor and form the base of the CHANGE model for capacity-building assistance.

THE CHANGE MODEL

In addressing fundamental elements of a successful business model for reorienting CBOs to the DEBIs, the CHANGE model was developed with six core values. But the CHANGE model does not establish a prepackaged set of protocols for CBA as this would be falling into the same trap the model is meant to address. The CHANGE model describes a process for recognizing (a) the disruptive effects of the DEBIs on an organization, (b) addressing gaps in ability and turning the disruption into an opportunity, and (c) providing a means to redesign local practice so that DEBIs are utilized in the most efficient and effective way.

THE VALUES

*Customized.*Successful transition from local practice to evidence-based interventions requires CBOs to take ownership of new programs, which can only occur if the CBO is adequately prepared. The tremendous diversity in local contexts and populations affected by HIV limit the effectiveness of one-size-fits-all solutions (Lasker & Weiss, 2003). Consultant-delivered, prepackaged CBA cannot be as effective as long-term relationships with CBA providers who can customize their services to the needs of the CBO. Customization in the CHANGE model begins with an organizational needs assessment conducted by the CBA provider. The assessment begins with an examination of the organization's readiness to change (Cunningham et al., 2002). Helfat and Lieberman (2002) recommended conducting a "resource profile" of organizations and comparing the profile to that of the required innovation. Lack of preCBA assessment can lead to misallocation of CBA resources and alienate the CBO (e.g., generating perceptions of "being talked down to"). Establishing CBO confidence through participatory assessment is vital.

In assessment, capacity gaps for achievement of program goals and objectives are identified by defining capacities at individual, team, and organizational levels, followed by structured interviews with staff and management. This multilayered needs assessment is undertaken precisely because staff and management often differ in their understanding of capacity. Existing capacities are compared with future needs, reviewed with key stakeholders (i.e., executive directors and program managers), and an action plan is formed. The action plan links the assessment with specific CBA tactics that lead to increased knowledge and enhanced program implementation by the CBO. This process reflects the customer value proposition. Although the implementation of a DEBI can be organizationally disruptive, the form the disruption takes will vary locally. The CBA provider must initially assess the specific context in which the DEBIs are being implemented to design a program of capacity building that addresses disruptive effects.

Holistic. Typically, CBOs have multiple interrelated needs. In trying to derive the "profit formula," one must recognize that prevention programs are only part of an organization that must be integrated effectively into a larger operation. Without adequate attention to the entire context in which a CBO operates, CBA may present untenable solutions to problems or neglect potential barriers to effective implementation. This argues for a comprehensive, holistic approach. Prolonged engagement allows the CBA provider to learn the organizational culture, discern how CBA on one focal area impacts another, and permits identification and tracking of strategies and tasks. CBA providers using a holistic approach look at how issues relate to each

other, and how different services and programs are integrated. In this way, the organization, whose parts must function in concert to be most effective, can exercise control over its own growth, knowledge, skills and resources and is actually involved in making decisions and taking actions (Zimmerman, 2000).

Analytical. Researchers have noted that organizations must critically scrutinize their actions in order to grow (Argyris & Schon, 1996). CHANGE assists organizations to understand and revisit the local context, appreciate values, assets and history of the local environment and use these to identify prevention strategies likely to work. The organization develops an ongoing capacity to self-evaluate in the process of reorienting itself. Through organizational assessment, teaching organizations to do community assessments, and promoting outcome monitoring, CBA can enhance their ability to critically assess strengths, weaknesses, and outcomes. CHANGE asks CBOs not just to understand what they do but also what led them to do it. In trying to develop profit formulas, CBOs have to be analytical, comparing the existing model of service delivery to that needed by the new DEBI models.

Network Building. Researchers have found that institutional rivalries and lack of communication can limit effective collaborations across CBOs (Cotrell, 1977). As Amaro and Campa (1989) indicated, "a major obstacle to meeting the challenge presented by the AIDS epidemic, specifically as it pertains to the needs of community based agencies which serve the Latino community, has been the lack of cooperation and collaboration between agencies" (p. 26). Social networks provide support through shared information, guidance, resources, peer support and motivation (Goodman et al.,1998; Heaney & Israel, 2002). As such, network size and relationships may enhance capacity (Hawe et al., 2000; Wickizer et al., 1993). A basic premise of CHANGE is that capacity building requires communication between the CDC, CBA providers, CBOs, and health departments through interagency forums. Facilitating cooperation among CBOs and diverse agencies is more likely to sustain innovation (Bauman, Stein, & Ireys, 1991) as they can share key strategies and resources. The CBO's networking capacity is thus a key resource that needs to be considered when developing a new business model. When CBO funding is in constant jeopardy, resource sharing with networks is no longer optional, rather is a necessity in maintaining services.

Grassroots. CHANGE emphasizes expertise that organizations have available to them. CBA providers should capitalize on the knowledge base of the organization (Campbell & Campbell, 1996). When CBA providers act as the "main problem solvers," problems tend to be viewed narrowly within professional boundaries, ignoring community knowledge, skills, and resources (Lasker & Weiss, 2003). A CBA provider must approach assistance as a partnership, not a repair job, by incorporating the CBO's knowledge of community history. CBOs feel that grassroots interventions are being displaced. This grassroots nature is at the heart of why CBOs are often effective, and in essence this is what differentiates the CBO "brand" from other sorts of services such as federal, city, and state run prevention programs. The local roots and the nongovernmental nature of a CBO are among the strengths that allow them to reach local populations. DEBIs and CBA ignore local information at their peril. Problems in recruiting participants for DEBIs among organizations that normally recruited fairly easily within their local communities are a clear example of the disconnect between DEBIs and the local context. The fact that an intervention is

empirically validated is irrelevant if no one attends it.

Evaluatory. Latino (and other minority) organizations often exhibit a lack of trust of outsiders' intentions based on historical experience with "hit and run" projects and a perceived lack of equal power and respect (Marin & Marin, 1991; Zambrana, 1996). The Manos Unidas approach is to not only help the CBO self-analyze but also to seek continuous feedback on the capacity building services delivered. Through ongoing input, and adjusting services based on feedback, CBA mirrors the evaluatory and analytical approach to a CBO. As noted by capacity-building researchers (Ebbesen, Heath, Naylor, & Anderson, 2004), there is a perception that exploration of capacity refers to performance appraisal. By soliciting feedback on our CBA performance we equalized the relationship between CBA provider and CBO. The evaluation component is typically the fourth element of successful business models. The idea is simple but often ignored. Every CBA experience is a learning experience that informs not only the CBO, but the CBA provider. We should always assume we can refine our service delivery, and the only real way to understand this is through ongoing evaluation.

IMPLEMENTATION OF CHANGE

"When business model innovation is clearly called for, success lies not only in getting the model right but also in making sure the incumbent business doesn't in some way prevent the new model from creating value or thriving" (Johnson et al. 2008, p. 58). One might reasonably assume this is why the CDC funded CBA at the same time that it mandated DEBIs (Dworkin et al., 2008; Kegeles et al., 2000). Although the DEBIs were presented as complete packages, there was recognition that some adjustment would be needed to incorporate them. Many organizations approach innovation without a game plan (Anthony, Eyrung, & Gibson, 2006). Instead they take strategies that worked in the past and try to execute them with the new innovations (Anthony et al., 2006). After engaging in the CVP analysis (the assessment) and the profit formula formulation (the comparison of new needs against the current model), the organization has to focus on the new competencies needed, avoiding competency traps: engrained habits and ways of behaving that make significant change in the organizations modes of operation very difficult (Leonard-Barton, 1992).

Organizational behavior literature typically considers organizational efficiency as a function of design relying on four pillars: structure, process, people, and technology (Edosomwan, 1996). These pillars need to be addressed synergistically and holistically. To provide a holistic approach and a broad spectrum of customized services, those services must be provided by well-trained CBA providers possessing diverse core skills. The Manos Unidas team, for example, comprise a behavioral scientist, a community leader, experienced program implementers with training and coaching expertise, and evaluation specialists.

CHANGE entails three stages: organizational assessment (including assessment, feedback, and action planning), action plan implementation (providing coaching, training and guidance in six key focal areas), and CBA evaluation. The CHANGE process uses an action research and multisource feedback approach (Church & Waclawski, 2002; Dalton, 1996). This active participation from the entire staff is known to bring about systematic change in an organization (Church & Waclawski, 2002).

STAGE 1: THE ORGANIZATIONAL ASSESSMENT

The first stage of the CHANGE CBA model entails an organizational assessment to understand local context and needs. Doctors do not generally prescribe medicine without examining a patient, nor should CBA begin suggesting adaptive measures to an organization without first attempting to establish not just the "facts on the ground" but also the local understanding of those facts. This method has also been referred to as a diagnostic funnel, creating a unique diagnostic paradigm specific to the organization receiving assistance (Gregory et al., 2007). This diagnostic method is a holistic in the sense that it identifies the range of relevant variables, depicts the interrelationships of the variables and describes how performance can be impacted by these variables (Burke, 2002).

Manos Unidas' assessment processes entailed interviewing staff and administrators. Each confidential interview was conducted following a semistructured interview guide that allowed for easy, fast rapport to be established. The assessment also included observations of operations and review of documents including curricula and protocols. The assessment data was complied and reviewed by the CBA team and a report produced. The reports were in the format of "mirroring" (feedback) reports (Ramos, 2007). Our first series of reports were typically extensive, starting with the positive and ending with negative feedback (the staff's perceptions of weaknesses and threats). However, as the CBA program was evaluated it was necessary to counterintuitively reverse this because of several agencies' adverse reaction to seeing their staff's comments at the end of the report. The mirroring activity entailed reviewing each page of the report with the CBO administrators, establishing agreement with report findings. There were times where certain wording had to be changed (although not the findings). Some executive directors expressed frustration at seeing what their staff thought of the organizational climate and capacity. However, they often came to value those comments and engaged in crafting an action plan to address programmatic needs.

In the CHANGE model, organizations were integrally involved in developing, planning, and evaluating the capacity building process. Assistance evolved based on feedback, ongoing analysis, and contextualization as deeper understanding of capacity was nourished. The CBOs owned solutions they were actively engaged in customizing.
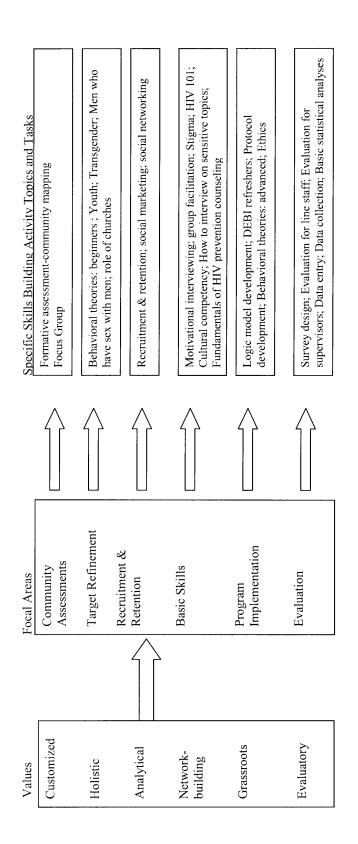
ACTION PLAN IMPLEMENTATION

Past research on capacity building (Waisbord, 2006) noted that often only half the people who received training reported opportunities to apply what they had learned. With this in mind, we included supervisors and upper level management in capacity building efforts, encouraging them to assess opportunities in the workplace to implement new skills and knowledge. If contextual factors are ignored, CBA could essentially equip individuals with necessary competencies, but fail in immediate and tangible impacts on performance. Thus, we needed to address how CBA work would be incorporated into the workplace. To address the needs found in the assessments, action steps often included the delivery of trainings, coaching sessions, observations of (with immediate feedback) program implementation, networking (serving as mediators) to enhance information transfer, and the provision and creation of tools. CHANGE incorporated its values to guide capacity building in six focal areas needed to effectively implement DEBI programs--community assessment, target refinement, recruitment and retention; basic HIV prevention skills; program implementation, and evaluation.

These focal areas emerged through Manos Unidas' long-standing relationship with CBOs and through an understanding of past research. For example, Gandleman et al. (2006) noted that in order for CBOs to implement new interventions successfully there needed to be a thorough understanding of the community targeted for receipt of the services, the requirements of the intervention (the core skills), and the capacity of the agency to implement the intervention. Some of the more pressing capacity-building needs include recruitment and retention, group facilitation, implementing with fidelity, an understanding of selection criteria and behavioral theories (Collins et al., 2006). Agencies have also increasingly articulated the need for pre-implementation planning, formative research, group facilitation skills, behavioral science theory and evaluation (Collins et al., 2006). By tying the six focal enhancement areas to the six values of CHANGE (customized, holistic, analytical, networking, building, grassroots, evaluatory), the planning of tasks can be customized for successful program implementation through CBA. The CHANGE values act as the foundation and guiding structure of the activities and CBA tactics used to enhance these six focal areas for effective DEBI implementation (Figure 1).

Community Assessment. In 1988, the Institute of Medicine (1988) identified assessment as a core public health function. Program assessment by the CBA provider is necessary, but insufficient. Community assessment clarifies how an intervention's characteristics, community needs, and agency capacities interact. In a review of 20 organizations' capacity to implement new health promotion strategies, researchers (Joffries et al., 2004) found that 50% reported difficulties assessing community health needs and seeking input from community groups. In Manos Unidas' work with CBOs, absence of assessment was frequently attributed to a lack of resources, claims to prior knowledge of community needs, and concerns that assessment activities take too much time away from direct service provision. To assist CBOs, Manos Unidas provided formative assessment training, including community mapping fieldwork. Community mapping offers additional information about community resources and typically involves participatory approaches to program development and implementation (Kerka, 2003).

Target Refinement. CBOs often have difficulty recruiting and retaining clients for DEBIs (Collins et al., 2006). Such difficulty surprised the CDC who imagined grassroots organizations would have little problems with recruitment (Collins et al., 2006). Such a view does not take into account the fact that CBOs are instructed to screen their clients for program appropriateness for a given DEBI. *Manos Unidas* coached program implementers on developing new screening techniques, linking the underlying behavioral theory, program goal, and target characteristics. CBOs were coached to think about not only their broad target population but to do so in terms of psychological profiles, migration patterns, and acculturation level. It follows logically that by refining understanding of both target population and screening, CBOs will have greater success at recruitment and retention.

Recruitment and Retention. Besides CDC's observations (Collins et al., 2006), Manos Unidas has repeatedly observed that recruitment and retention is problematic for CBOs implementing DEBIs. Manos Unidas provided trainings on this subject, including coaching sessions where participants created their own recruitment and retention plan based on the skills imparted in the training. An advanced session trained on the use of social network strategies.

FIGURE 1. The CHANGE Model's Values, Focal Implementation Areas and Specific Tasks
Note. DEBI = Diffusion of Effective Behavioral Intervention.

Basic Prevention Skills. As Shea et al. (2006) noted, trainings need to address basic skills common to many evidence-based interventions. We found that such core basic skills included client-centered interviews, group facilitation, motivational interviewing; and HIV 101.

Program Implementation. Implementing DEBIs requires the use of protocols, aided by development of logic models, to standardize the process (Dworkin et al., 2008). Protocol development can be an afterthought, with "interventions in a box." The nuances of program implementation are not captured in the "box," and thus CBOs needed help developing tools to ensure consistency. Manos Unidas found that with high staff turnover at agencies, protocols tend to smooth transitions. CBA activities included review of protocols, protocol development training, and observation of program implementation with feedback.

Process and Outcome Monitoring. Staff are more likely to sustain an innovation if they believe it is effective, and measurement can demonstrate effectivity (Tornatzky & Klein, 1982). Manos Unidas found that because many DEBIs were not originally implemented with Latino target populations there has been skepticism regarding them in the Latino CBO community. Past research has shown (Amaro et al., 2005) that community prevention group members can be skeptical of data because some lacked the capacity to understand and apply the data, feeling it did not reflect reality. Thus, enhanced evaluation skills (including data interpretation) are vital. We framed evaluation as generating new knowledge and discovery leading to buy-in and data-based reflection.

CBA IMPLEMENTATION EVALUATION

Our CHANGE model demanded that we assist programs by assessing how CBA itself was being delivered. Monitoring capacity building is complex, in part owing to diffuse inputs but mainly owing to difficulty in ascribing causation to subsequent events. The methods for assessing the benefits of building capacity remain elusive (Potvin, 1996). Evaluation efforts need to account for the fact that capacity building is an evolutionary process (Johnson et al., 2008). The prevention program is the target of change and aggregates of individual staff change may not reflect program change and may occur in unanticipated domains (Crisp, Swerissen, & Duckett, 2000). Contextual aspects that Manos Unidas found to have influenced the monitoring of capacity include staff turnover, program refunding, and staff understanding and valuation of evaluation.

Individual training and coaching sessions were separately assessed using pre- and post-knowledge tests, process-feedback questionnaires, and 1-year follow-up structured interviews. From August 2004 through August 2008, Manos Unidas provided 157 skills building sessions ranging from a half day to 3 days, with over 1,770 participants, from over 350 organizations, representing 320 cities and 69% of the participants from CBOs and 11% from health departments. There was a high level of satisfaction with the sessions, substantial use of skills 1-year after, and considerable change in knowledge according to the pre/post comparisons. Specifically, 72% of those that completed pretests and posttests (N = 909) increased their score of correct answers from pretest to posttest. Participant satisfaction questionnaires (N = 2,278) revealed that 88% were satisfied, 93% indicated that their learning experience was good, or very good and 80% felt more comfortable with the topic at the

end of the session. When asked if they had previously attended the particular training topic, only 26% indicated they had done so. Furthermore, 97% reported that there was a need for the training topic. Thus, CBA utilizing the CHANGE model was perceived as effective, new and needed.

QUESTIONS TO PONDER

Long-term impacts need to be measured as well. However, CHANGE is akin to community level interventions, which are notoriously hard to evaluate (Craig, Dieppe, Macintyre, Michie, Nazareth, et al., 2008) It is similar to a community level intervention in that there are multiple factors affecting the CBO, from individual employee attitudes and capacities to funding demands, local political contexts, and community cohesiveness. This level of assessment requires more resources than the CDC has provided. The CDC, in providing funding for these CBA grants, did not outline evaluation methodologies primarily because the CDC itself does not have concrete CBA benchmarks set. The CDC has access to the funded CBAs, and it should do a more complex comparative analysis of the differing CBA models if and when others have been articulated as this one has been. A challenge for the near future is to test and refine the applicability of the CHANGE model.

This article sets forth a model for capacity building in organizations implementing the disruptive innovation of the DEBIs, but there are many questions requiring further exploration by practitioners and academic researchers. At what point does the disruption engendered by the DEBIs begin? Does the mere fact that the CDC has already launched the DEBIs cause a disruption throughout the community of prevention CBOs? Is the DEBI project inherently disruptive or do disruptions depend on the perspective and infrastructural profile of a CBO? What innovation processes (e.g., resource allocation, capacity readiness, staffing patterns, organizational culture, decision-making structure) characterize a CBO that has successfully taken on a disruptive innovation such as the DEBIs? What aspects of the national DEBI context affect the success of established CBOs? The CHANGE model tries to balance the need to implement evidence-based interventions locally with the possible seismic disturbances caused by the new emphasis on the DEBIs (Dworkin et at., 2008). Without updated theoretical models to structure inquiries into the DEBIs in the field (Mckleroy et al., 2006), and models to use in helping CBOs restructure through capacity building assistance, the DEBIs can only be regarded as idealistic, generic, impractical, and at worst potentially destructive at the local level of implementation. The CHANGE model offers a coherent theory-based set of tactics to bring the DEBIs "down to earth."

Research clearly needs to continue into the complex nature of evaluation in an applied environment. Note that the CDC has been unable to get an evaluation database systematically off the ground as of the writing of this article and has had at least 5 years to do so. A review of the literature does not tell us how CBOs compare in terms of DEBI implementation over the span of 2 years or more. A literature review also does not tell what makes a successful adaptation at the local level, although there are more published guidance on adaptation steps (Mckleroy et al., 2006). It is up to the CBA provider to help assess many of these factors, but it takes a concerted, systematic and ongoing collaborative effort that the CDC is still in the process of assembling. Ultimately, critics may fairly ask, "Does the CHANGE model for CBA

work?" The answer is a definite maybe. In the short term, it has been perceived by our consumers as easing the disruptive effects of the DEBIs at the local level. In the long term, further research is needed to determine its lasting impact. What CHANGE does provide for the long term is the structure under which practitioners and researchers can begin to ask the appropriate research questions related to local implementation of the DEBIs.

DISCUSSION

CBOs do not operate in a controlled laboratory environment. The very fact of application is a complicating factor. Instructions on implementing a "black box" intervention are interesting, and the appeal of the DEBIs can often be found in the uniformity with which they might be applied. This uniformity allows for meaningful comparative evaluation, but it is a common business mistake to design a project based on the metrics established to evaluate the success of the project. Although DEBIs may represent more reliable, cheaper, and simpler techniques for prevention programs, they are simply tools. Succinctly put, the CBOs' success with DEBIs comes from "enveloping the new technology in an appropriate, powerful business model" (Johnson et al., 2008, p. 59).

Capacity-building programs, such as Manos Unidas, can have complex effects. CHANGE highlights the balance between science and practice, allowing for customization while introducing basic elements of scientific rigor to the assistance provided. This model represents a prototype stemming from systematic organizational, community, and regional needs assessments, along with extensive literature reviews of CBA successes, and is intended to fill a large gap in the prevention field, that is how to incorporate generic, but theory-based interventions into existing organization structures, patterns of service, and a unique cultural milieu.

One of the important elements in the formulation of the model was that the Manos Unidas program was provided on a continuing basis over 4 years, through a single institution, rather than as a series of individual ad hoc consultancies. Utilizing the CHANGE model, teaching and learning processes were developmental, leading progressively to a greater degree of organizational input and management to ensure sustainability and maintenance of HIV prevention programs. CHANGE recognizes the utility of the DEBIs but emphasizes integrating them within the organization.

Although the broad mandate for capacity building activities came from the original cooperative agreement with the CDC, the detailed development of the project was the responsibility and result of the diverse staff within the Manos Unidas program which is itself housed within a CBO. CHANGE emanates directly from the fact that it was part of the community and reflective of its diversity. At the onset of this program, there was little to guide CBA providers on how to handle innovations such as the DEBI program. This article hopes to inspire further inquiries into disruptive technologies at the CBO level. The CDC is attempting to provide validated tools to accomplish this through the DEBIs. CHANGE attempts to maximize the utility and applicability of these tools in an increasingly complex, multicultural society.

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