What Is Capacity Building? Lessons from a National Demonstration Program of HIV Education for Social Service Providers

Mari P. Millery PhD a & Peter A. Messed PhD a

a Mailman School of Public Health, Columbia University, 722 W. 168 Street, Rm. 11-14, New York, NY, 10032, USA


To link to this article: http://dx.doi.org/10.1300/J187v04n02_07

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to
What Is Capacity Building?
Lessons from a National Demonstration Program of HIV Education for Social Service Providers

Mari P. Millery, PhD
Peter A. Messeri, PhD

ABSTRACT. The purpose of this paper is to examine the concept of capacity building and describe an HIV/AIDS education program for social service providers that implemented capacity building in nine ethnic/racial minority communities in the U.S. Quantitative and qualitative evaluation data from the Targeted Provider Education Demonstration (TPED) will be presented to illustrate a capacity building approach. Training-of-trainers (TOT) was a central mechanism for transferring expertise to local communities, and program effectiveness was demonstrated by having 60% of all training programs in the last project year delivered by TOT trainees. Lessons learned about capacity building became a major outcome of the TPED evaluation. It was essential to provide technical assistance and address organizational development issues in participating community-based agencies. These agencies were utilized as a mechanism of rooting the interventions in the local communities in a sustainable way. Reinforcement of inter-organizational linkages...
facilitated growth of community capacity. A multi-level model of capacity building that emerged based on the TPED experience is discussed in the context of literature on capacity building. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Capacity building, HIV/AIDS education, social service provider education, training-of-trainers, community-based organizations

The transformation of HIV/AIDS into a chronic health condition and the epidemic’s concentration in communities of color has stimulated interest in building HIV service capacity in health and social service agencies located in affected communities. In this paper we describe a capacity building program that extends the traditional mission of HIV/AIDS professional training programs in two important respects. First, it expands a focus on training individual clinicians with direct medical care responsibilities to the broader array of providers of psychosocial services who are critical in assisting marginalized individuals in gaining access to quality HIV medical care and then staying in care (Messeri, Abramson, Aidala, Lee, & Lee, 2002). Second, the capacity building approach shifts attention from targeting individual trainees to targeting strategically situated agencies, as training becomes one of the mechanisms to build agency and community capacity. The agencies targeted for this type of program serve minority communities disproportionately affected by HIV. These agencies have a high level of cultural competency to work with local populations. They also have the potential to become local leaders in HIV training and information dissemination. However, the staff of these agencies typically has minimal specialized training in working with HIV clients and the agencies lack resources and infrastructure to sustain local HIV services without continuing assistance from outside organizations. Building organizational and community capacity to sustain HIV care is a worthy goal, but training models to achieve it are not well understood. The purpose of this article is twofold. First we review the development of capacity building concepts and models in international development and health promotion. Second, we describe models and lessons learned from a pioneering HIV/AIDS capacity building program targeting community-based social service agencies.
BACKGROUND: CAPACITY BUILDING

International Development and Health Promotion Contexts

The concept of capacity building emerged in the context of international development. Starting in the early 1970s, the U.N. used the term “institution building” for “interventions or activities where organizations in one country helped those in another country to improve their ability to carry out certain functions or achieve certain objectives” (Maconick & Morgan, 1999, p. 14). Military, trade, education, science, and healthcare were examples of specific institutional areas being built.

Beginning in the late 1980s the U.N. approach shifted to a model of capacity building that focused on enhancing the planning, policy formulation and performance monitoring capabilities of developing nations (Eade, 1997; Hilderbrand & Grindle, 1994; Maconick & Morgan, 1999). Although training was always a cornerstone of U.N. development efforts, more recent international development programs have taken the idea of creating sustainable local resources one step further by emphasizing local training capacity. The U.N. experience illustrated that development efforts were most likely to persist when programs to train individual government workers were combined with technical assistance to change organizational support and incentives. “[A]ttempts to change people’s organizational behavior and performance improving their knowledge and skills was usually only effective when the incentives, support structures and organizational context acted in the same direction” (Maconick & Morgan, 1999, p. 35).

Capacity building has emerged as an important issue for health promotion in the United States, where there has been much concern about sustaining community-based programs that have been initiated through federally-funded, time-limited research and demonstration projects (Hawe, Noort, King, & Jordens, 1997). Capacity building programs are best documented for cardiovascular health (McAllister, Puska, Koskela, Pallonen, & Maccoby, 1980; Lefebvre, Lasater, Carleton, & Peterson, 1987; Schwartz et al., 1993; Bracht et al., 1994; Jackson et al., 1994; Shea, Basch, Wechsler, & Lantigua, 1996; MacLean et al., 2003). For example, the Minnesota Heart Health program, a nine-year community-level demonstration project, established community boards that started as junior partners with the university-based research team, but gradually gained equal, and by the end of the program, senior partner status. Seventy percent of the interventions were continued after federal funding was withdrawn and 60% were still maintained three years later.
The Stanford Five-City Project, another of the pioneering community health risk reduction projects, undertook a capacity building program to transfer to local groups knowledge, skills and resources that would be needed to sustain local health promotion activities. The methods included training-of-trainers, cooperative learning and technical assistance (Jackson et al., 1994). Capacity building programs have also been conducted in other areas of health, such as cancer (Meissner, Bergner, & Marconi, 1992), diabetes (Giachello et al., 2003), and violence (Chavis, 1995).

A secondary literature has developed around the international and domestic capacity building programs to define and classify key features. LaFond, Brown and Macintyre (2002), drawing upon the experience of developing sustainable local health systems in developing countries, defined capacity building as a “process that improves the ability of a person, group, organization or system to meet its objectives or to perform better” (p. 10). Their framework maps capacity building on four levels: 1–system (general health care structure and policies); 2–organizational; 3–human resource; and 4–individual/community (customers and their communities) (see Table 1). Crisp, Swerissen, and Duckett (2000) define capacity building applied to health in a not dissimilar way from LaFond et al.–“interventions which have changed an organization’s or community’s ability to address health issues by creat-

<table>
<thead>
<tr>
<th>LaFond et al. Levels of Community Capacity</th>
<th>Crisp et al. Capacity Building Approaches</th>
<th>Goodman et al. Dimensions of Community Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>System</td>
<td>Partnership (interorganizational relationships)</td>
<td>Social and Interorganizational Networks</td>
</tr>
<tr>
<td>Organizational</td>
<td>Top-down Organizational (changing agency policies and practices)</td>
<td>Necessary Resources</td>
</tr>
<tr>
<td>Human Resource</td>
<td>Bottom-up Organizational (providing skills to staff)</td>
<td>Appropriate skills</td>
</tr>
<tr>
<td>Individual/Community</td>
<td>Community organizing (recruiting individual community members)</td>
<td>Participation, Leadership, Sense of community, Understanding of community, Community power, Community values, Critical reflection</td>
</tr>
</tbody>
</table>
ing new structures, approaches and/or values” (p. 100). As shown in Table 1, they outline four specific approaches to capacity building that correspond to the four levels of LaFond et al.

The literature has developed in more detail, the manner in which capacity building leads to sustainability. For this purpose, community capacity is often introduced as an intermediate “outcome” between sustainability and the “process” of capacity building. Shadiac-Rizkallah and Bone (1998) propose that general community participation (and empowerment) leads to community “ownership,” which in turn increases community capacity and self-sufficiency. A panel of experts convened by the Centers for Disease Control and Prevention (Goodman et al., 1998) formulated a ten-dimensional model of community capacity for assessing the likely success for implementation and maintenance of community health promotion programs. These dimensions include: participation, leadership, appropriate skills, necessary resources, social and interorganizational networks, sense of community, understanding of community power, community values, and critical reflection. They span all four levels of the LaFond et al. (2002) framework, but are clearly centered on the individual/community level of capacity building (see Table 1).

**HIV/AIDS Related Capacity Building Programs**

A limited number of capacity building initiatives have been documented specifically in the area of HIV/AIDS. Ramos and Ferreira-Pinto (2002) describe a HIV/AIDS prevention capacity building program funded by Centers for Disease Control and Prevention and the U.S.-Mexico Border Health Association. This six-year training and technical assistance program utilized a cooperative training approach, which is based on a participatory model of training-of-trainers (TOT), and involved a total of 285 community-based agencies. The goal was to establish self-sustaining training networks. A detailed participatory needs assessment and planning process was followed by training workshops, and a process where an increasing proportion of the workshops were co-facilitated by the TOT trainees, and then solely conducted by the TOT trainees. Out of the total 106 interagency workshops over the six-year period, 21 were co-facilitated, and during the last three years, there were 24 workshops delivered by the TOT graduates. During the final year of the project, 42% of all workshops were conducted by CBO staff that had received training in the TOT program. A similar strategy to measuring success of TOT was adopted in the TPED program, as described below.
Silvestre, Arrowood, Ivery, and Barksdale (2002) report on a capacity building program for community-based HIV prevention that used a community leadership development model. This program focused on identifying indigenous leaders in several gay and ethnic minority communities and assisted in the establishment of community development leadership groups that planned and implemented local prevention interventions. Training and technical assistance was provided to the groups. Eight groups were successfully organized in five cities.

Returning to the international context, Kotellos, Amon and Benazerga (1998) reviewed evaluations of capacity building projects in HIV prevention in more than 20 countries. They outline a model of seven capacity-building strategies, which include: technical skill building, management skill building, management systems development, resource diversification, network building, organization cross-fertilization, and multi-sectoral collaboration. These strategies are illustrated by several case study examples of successful programs.

**Synthesis of Literature**

Several key characteristics clearly appear across different models and reports on capacity building. The essence of capacity building has to do with enhancement of competencies in organizations and communities. Participation of local community is considered critical. The long-range goals generally center on enhancement of local expertise and program sustainability. Most models of capacity building identify multiple levels of operation, and what is considered particularly important is to address organization-level issues, in addition to building skills of individuals in training programs. Table 1 presents a comparative summary of the key components of three different multi-level models.

There are many commonly used methods and techniques for implementing capacity building. Training that enhances critical skills among local individuals is typically complemented by other ways of providing access to resources. Training-of-trainers is frequently used as a mechanism of transferring self-sustaining training capacity to local entities. Technical assistance is offered to develop capacity on the agency level. Strengthening of inter-agency networks and partnerships is often used to further general community capacity. Some programs focus specifically on creating partnerships between local agencies and academic institutions. Although the published academic literature on capacity building is somewhat limited, there are many resources for those interested in practical models of implementing capacity building. Sev-
eral such models have been published by different foundations and are available on the Internet.¹

**TPED PROGRAM**

The Targeted Provider Education Demonstration was a multi-site demonstration program designed to bring innovative models of capacity building and HIV/AIDS education and training to social service providers in racial/ethnic minority communities. The program was funded by the Health Resources and Services Administration (HRSA) for the three-year period of 1999-2002. Nine programs were implemented across the United States. Local community-based agencies were expected to be partners in the program and to become conduits for creating locally sustainable capacity for HIV/AIDS education. The program specifically targeted social service providers, including social workers, case managers, substance abuse counselors, outreach workers, peer counselors, and other non-clinical staff who work with individuals infected with HIV.

**Methods and Data Sources**

Two phases were included in the evaluation design, surveys and on-site interviews. For the first phase, seven of the nine TPEDs completed a paper-and-pencil survey and participated in a telephone follow-up interview. The survey asked the TPED staff to describe the project goals, major barriers to achieving the goals, and their educational/capacity building model. It probed specifically about project activities where different levels were targeted, including individual learner, group, agency, and inter-agency levels. The TPEDs were also asked to characterize the community-based agencies involved in their project, including their type, size, age, profile of services, and approach to continuing HIV education for staff. Once the surveys were analyzed, key informants at each TPED participated in telephone interviews that provided an opportunity to clarify answers and elaborate on emerging themes.

Based on balancing the diversity of capacity building models and the geographic distance from the evaluators, four TPEDs were selected to participate in the second phase that consisted of an on-site visit by an evaluator. These TPEDs also recruited a total of eight local community-based agencies to be visited. During the visits, the evaluator con-
ducted interviews with TPED staff and observed steering committee or advisory committee meetings and training events when possible. The visits to participating community-based agencies included interviews with “agency officials” and individuals who had received TPED training. The interviews were conducted either individually or in small groups of two to three informants. A total of 29 persons participated in the interviews. All participants signed informed consent forms approved by the Columbia University Internal Review Board (IRB). The interview protocol included questions about the agency, and about the activities and impact of the TPED program. The interviews were audiotaped and later transcribed. In addition to the transcripts, field notes were recorded based on the observations. A team of two evaluators conducted qualitative thematic analyses of the data by using QSR-N6 software.

All nine TPEDs collected systematic descriptive data on all training events and participants by using two forms, the TPED Program Record (TPR) and the TPED Participant Information Form (TPIF). The merged data set for the project yielded a total of 1,797 program forms and 28,958 participant forms. A unique participant identification code was recorded on 85% of the participant forms, making it possible to estimate counts of unduplicated participants.

**Description of TPED Models**

A key feature of all TPEDs is linking agencies located in the affected communities with funding sources and other resources so as to extend the HIV “network of care” to include social service providers who possess initiate understanding of the culture and environment of the clients. One TPED staff member well articulated the unique ability of local community-based organizations (CBOs) to conduct culturally competent trainings:

A community-based organization is the direct link you need in order to make the connection between care providers and members of the community. You know when you talk about training on cultural competency, which is quite popular, if you’re using a CBO to do your training, the whole concept of cultural competency is so integral to who they are that you no longer need to have it so separated out. It becomes a part of the environment itself. And it has an impact on both the care provider and their approach towards the consumer or the patient.
Academic medical centers were the lead agency for five of the seven TPEDs completing phase 1 survey. Each of these TPEDs subcontracted training to multiple community-based agencies in order to reach other smaller agencies in the communities. Two of the TPEDs were entirely community-based. One was a single community-based organization that utilized local consultants to conduct trainings, and the other was a consortium of several CBOs. Between one and ten agencies participated in each TPED (Table 2). The TPEDs worked with diverse types of local agencies. Large agencies such as well-established AIDS Service Organizations (ASOs) sometimes served as subcontractors, while many smaller CBOs became recipients of training programs. Several faith-based organizations participated in the TPEDs.

The seven TPEDs that were surveyed facilitated capacity building through three types of activities. All TPEDs developed curriculum and professional training. Five TPEDs offered technical assistance services and two undertook coalition building. The TPEDs developed written and visual instruction materials based upon core competencies regarded as essential for social service providers, such as prevention, adherence, medical basics, and psychosocial issues. Some programs were more likely to promote a standard curriculum, while others put more emphasis on closely tailoring the activities to agency needs. Six TPEDs emphasized adult learning principles in the design of their training techniques. Five TPEDs complemented their training activities with technical assistance to participating agencies on a range of organizational and infrastructure development topics.

### TABLE 2. Types of Community-Based Agencies Participating in TPED

<table>
<thead>
<tr>
<th>TPED</th>
<th>CBOs</th>
<th>ASOs</th>
<th>Faith-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: (Coalition of CBOs)</td>
<td>9</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>B: (University-based)</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>C: (CBO)</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>D: (University-based)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E: (University-based)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: (University-based)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G: (University-based)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Two TPEDs that did not participate in the survey are excluded from this table.
Two TPEDs explicitly included coalition building in their model. One structurally operated as a consortium, while the other one was university-based and actively joined existing coalitions. Most other TPEDs participated in regional coalitions, and all reported increased inter-agency networking as a result of staff interactions at trainings or meetings.

Training-of-trainers programs were the core component of capacity building, and their goal was to have selected individuals in the participating agencies take on the role of internal trainer for the agency staff and then reach out to offer training to other smaller agencies in the community. The newly trained trainers always received some type of follow-up support in their own training efforts. Sometimes they started as co-trainers with more experienced trainers. Once they were on their own they had access to ongoing guidance and advice from the TPED staff, and typically continued using training materials and curricula developed by the TPED.

TPED staff involved in capacity building efforts consistently reported that much more was required for successful capacity building than just training. Since increased capacity means that the agency is generally growing, other issues with agency infrastructure, staffing, leadership, and funding needed to be addressed. One TPED staff member described the process as “building an arm of education in the agency.” It was generally reported that successful capacity building required surprisingly many resources and intensive involvement on the part of the TPED staff. A lot of time was spent with agency staff in person, on the telephone and by e-mail solving specific problems. For example, many of the small agencies required intensive guidance with the tasks related to grant management and reporting requirements as a sub-contractor. Other examples were helping the organization with strategic planning, leadership and management practices, staff recruitment and retention, and selection of information technologies.

To help define the scope of the capacity building effort, the TPEDs worked collaboratively to produce a framework for elements of capacity building (see Table 3). The framework included a list of capacity building mechanisms that could be used to address specific topics in different content areas. As shown in Table 3, the TPEDs also enumerated lists of topics for two different content areas. The first focused on how to organize trainings (comparable to LaFond et al. (2002) human resource level of capacity building) and the second captured more general issues of enhancing organizational infrastructure (comparable to LaFond et al. organizational level). During this process of analyzing the components it became apparent
that even though many of the mechanisms and content areas may sound simply like training-of-trainers combined with technical assistance, there is a difference between technical assistance, which is reactive typically aiming to repair a specific problem after the fact and capacity building, which is proactive aiming to prepare the agencies themselves to identify, address, and prevent those problems.

**Quantitative Overview of Training Activities**

The nine TPED programs documented a total of 1,797 completed training events that reached 21,840 different individuals. The total
number of participant encounters was 36,967. Most events were 1 to 5 hours long and ranged in modality from didactic lectures to highly individualized practical training. Interactive skills-building workshops were the most frequent training modality. The topics most frequently listed as one of the top three training topics were: (1) Prevention methods; (2) Medical treatment update; (3) Adherence; (4) Early intervention; (5) Social support issues; (6) Diagnostic tests and disease progression; (7) Barriers to care and treatment; (8) Coordination of care and treatment/referral systems.

The TPEDs succeeded in reaching a high proportion of participants who are members of racial/ethnic minorities (74% of total participants). Half of all participants (50%) were African American/Black (including Hispanic and non-Hispanic Blacks), and 35% were Hispanic (of any race). A very wide variety of occupations were represented among the participants. The largest groups were: social workers (11%), case managers (10%), health educators (7%), mental health providers (6%), outreach/community workers (6%), peer educators (5%), substance abuse providers (5%), program support staff (3%), nurse aides (3%), prevention specialists (3%), clergy/faith-based counselors (3%), and home health care providers (3%).

**Diffusion of Training into Community: Trainings by TOT Graduates**

The TPEDs reported high levels of success in their major capacity building efforts: training-of-trainers. The goal of the TOT was to graduate individuals who would become internal trainers for staff in their own agencies and also reach out to other smaller agencies in the community to do trainings. The programs conducted a total of 122 TOT events with a total of 2,020 participants (not unduplicated). Many of these newly trained “community-based” educators went on to conduct their own programs. The proportion of these “second generation” programs steadily increased during the three-year grant period from 15% of 103 training programs in 2000, to 46% of 991 programs in 2001 and 60% of 546 programs conducted in 2002.

**LESSONS LEARNED FROM TPED PROGRAM**

A major objective of the TPED program was to promote expanding the mission of the targeted agencies to include HIV services. The TPED
programs reported good success in convincing targeted agencies that HIV training should be available to all staff. In this way all employees would have some basic knowledge to respond appropriately to the unique needs and sensitivities of their HIV+ clients. Educating all staff regardless of occupational categories had the further benefit of overcoming employee resistance to acceptance of HIV services as part of the agency’s mission.

The level of HIV/AIDS knowledge and skills varies widely in the targeted social service provider population. For some, it was important to increase comfort with HIV and to correct misinformation and myths regarding HIV, while for others the main function of the training was to receive updated information on the latest medications and treatment approaches. In addition, the TPED trainees who were interviewed consistently reported that the trainings increased their understanding of their clients’ lives. Social service providers need ongoing education in best practices of providing social support as well as updated information on the medical aspects of HIV disease. It was also observed that this target audience in particular benefits from trainings based on adult learning techniques, instead of school-type or didactic trainings which some clinical provider groups tend to prefer.

Major barriers to training social service providers are extensive workloads and lack of time or reluctance to spend “billable” hours in training. Short, intensive training sessions and creative scheduling were used to address these barriers. Management-level recognition of the importance of HIV training and commitment to the program were found to be essential for securing staff training time. This commitment often grew gradually as a result of successful initial training programs.

Adding HIV services and adding a training component often strained the smaller agencies’ infrastructure. The TPED programs attempted to address this by providing assistance in general organizational development. One type of scenario where the TPEDs observed organizational “growing pains” involved small CBOs established by charismatic community leaders to address specific issues in the community. These organizations sometimes had trouble expanding beyond their original mission and tended to have very limited resources for tasks such as contract management, grant writing, or human resource development. They were ideal targets for capacity building efforts.

Although not all TPEDs formally took on coalition building as a goal, they all reported that their programs resulted in increased connections among local agencies. There was increased awareness among participating agencies of local resources and a decreased sense of competition.
over funds and clients. Greater awareness of services provided in the community and increased awareness of local referral resources builds a local “network of care” where agencies work together to best address clients’ service needs. These results indicate that inter-agency level activities should be a part of all programs that have a goal of building community-wide capacity.

**Model of Capacity Building**

The model of capacity building that emerges from the TPED program operates on four levels (see Table 4). Training and TOT are the core components, complemented by agency-level technical assistance and inter-agency networking. The right-hand column of Table 4 outlines how different levels of capacity building have different targets for their impact, ranging from individuals to agencies and the network of

| TABLE 4. Multiple Levels of Community Capacity Building in Continuing HIV Education |
|-----------------------------------|---------------------------------|------------------|
| Level                             | Successful Techniques           | Target of Impact  |
| Training                          | Adult Learning Principles       | Individual Agency Members’ Human Resource |
| Training of Trainers              | Training Skills Building; Co-facilitation; Ongoing Support | Local Training Capacity |
| Technical Assistance              | Organizational Development Consultation | Community-based Agencies |
| Inter-Agency Collaboration        | Coalition Building; Networking Opportunities; Sharing Referral Resources | Network of Care in Community |

Downloaded by [University of California San Francisco] at 12:12 27 September 2012
care in the community. The middle column lists some specific techniques applied on the different levels by the TPED programs.

This model is consistent with multi-level models of capacity building presented in the literature. It agrees with the conclusion reached by the group of experts convened by CDC in 1995, who stated that community capacity is multidimensional and ecological, operating on individual, group, organizational, community, and policy levels (Goodman et al., 1998). As Table 4 illustrates, the TPED activities correspond to the more generic other multi-level models of capacity building presented by Crisp et al. (2000), and LaFond et al. (2002) that were summarized in Table 1.

The TOT component of the TPED capacity building effort was successful in generating “second generation” trainings by TOT trainees. As discussed by Ramos and Ferreira-Pinto (2002), TOT can be viewed as an application of Paulo Freire’s pedagogy. According to Freire (1972), sharing of newly acquired knowledge with others is a critical part of learning. In the qualitative data, ample evidence was found of satisfaction of the TOT trainees with participation in the program. Following is an interview excerpt of a TOT participant describing the process of setting up her own training activities:

But I fell in love with the whole thing. It was something so different from what I had been doing with the counseling and testing, because I had to develop the curriculum and I had to research all of the stuff and put together the training manual and schedule the trainings and market the program. And it was a lot of fun. It took me by myself six months to do all of that but it did get done.

The success of the TPEDs’ capacity building efforts had one unanticipated downside. Several cases were reported where TPED trained staff left for better jobs in other agencies. This created great frustration among the TPED staff because as the staff left they took the newly built capacity with them. However, there was also evidence that many of these individuals stayed within the same communities, indicating that community capacity was still enhanced. High level of staff turn-around is common in community-based agencies (e.g., Somlai et al., 1999). The limited organizational infrastructure in many of these agencies contributes to their inability to offer competitive salaries and promotion opportunities. Since this problem has been widely reported in the context of capacity building programs, anyone attempting to do capacity building should have awareness and realistic expectations about stability of staff in community-based
agencies. There do not appear to be any simple solutions to this problem. To lessen the possibility that TOT trainees may leave their jobs as a consequence of their new skills it is advisable that the new training function be integrated into their job descriptions and appropriately rewarded.

The TPED experience indicates that, in addition to training and TOT, a capacity building program needs to include an organizational development and technical assistance component. Specific areas of assistance may range from staff recruitment and information technologies to grant writing and strategic planning. Such needs in CBOs were assessed in the capacity building project reported by Ramos and Ferreira-Pinto (2002). Among their sample of CBOs, 45% had no long-term strategic plan, 32% had no organizational chart, and 42% had no systematic process for designing projects. Somewhat similar to the TPED model of capacity building, they had two tracks of training curricula—program development and infrastructure development. Topics in the infrastructure development track included better utilization of existing staff, establishment of medium and long-term strategic planning, and fund-raising and proposal writing.

CONCLUSION

A multi-level model of capacity building, similar to models described in the literature, emerged from the TPED program. Training, TOT, technical assistance, and coalition building were combined to implement programs that had an optimal likelihood of being sustained in the local communities. Community-based agencies were utilized as the vehicle of rooting the programs in the communities. Although we do not have data to present on the longer-term sustainability outcomes, we know that during the course of the project period, the major responsibility for training activities was transferred to local staff trained in the TOT programs. The TPED program exemplifies how the notion of capacity building has evolved since the early models of “institution building” into a participatory model of actively involving local communities in addressing acute social problems such as HIV/AIDS.

NOTES


2. The estimate of an unduplicated number of participants was possible because anonymous unique identifiers were collected from the participants.

REFERENCES


RECEIVED: 4/21/04
ACCEPTED: 6/20/04