Technical Assistance for the Evaluation of Community-Based HIV Prevention Programs

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Funding agencies are using technical assistance (TA) to strengthen the evaluation capacity of community-based organizations (CBOs) engaged in HIV prevention efforts. The authors used qualitative methods to identify the types of evaluation TA needed by CBOs, to understand CBOs' past experiences with evaluation TA, and to elicit ideas for optimal delivery of evaluation TA. Assistance in developing evaluation tools and data analysis were the most commonly cited needs. Preferred TA providers were characterized as having practical expertise, accessibility, cultural competence, communication skills, and collaboration skills. Critical elements of an ideal TA system were adequate funding, program-specific TA, and extensive interaction between TA providers and CBO staff. Study data were used to generate a set of recommendations for health educators and others who may provide CBOs with TA for evaluating prevention programs.

Keywords: *evaluation; technical assistance; HIV/AIDS prevention; community-based organizations*

HIV/AIDS remains a serious public health problem in the United States. Despite significant breakthroughs in treatment in recent years, no cure is in sight. At the end of 1998, between 800,000 and 900,000 Americans were estimated to be living with HIV/AIDS,[1] and the incidence of HIV infections was thought to be holding steady at about 40,000 per year.[1] With an effective vaccine still many years away, prevention education remains the primary strategy for controlling this disease.

Much of prevention education has been conducted at the local level by community-based organizations (CBOs) funded either directly or indirectly (through state or local health departments) by the Centers for Disease Control and Prevention (CDC). As the epidemic has persisted and expanded, CBOs, health departments, and CDC have been increasingly concerned about whether these programs were having an effect on their intended populations. Agencies realized that strong evaluations were needed so programs

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could be improved and limited prevention resources could be directed to those endeavors that were proving effective in increasing knowledge and skills associated with risk reduction, altering risk behaviors, and ultimately reducing HIV incidence.[2-4]

To facilitate more effective evaluation of HIV prevention programs, CDC and some health departments began offering evaluation technical assistance (TA)[a] to CBOs to increase their appreciation for the importance of evaluation and to provide staff with the requisite knowledge and skills to conduct appropriate evaluation activities.[4-5] In some instances, CBOs contracted with TA providers to conduct evaluations for them. Although public health literature notes CBOs' needs for TA in the design and implementation of HIV prevention programs,[6-8] studies establishing the need for TA in evaluation are relatively rare.[9] Little research has been done to determine the content or form of evaluation TA most needed by CBOs or the most appropriate systems for its delivery.

To better understand the needs and concerns of CBOs related to evaluation, CDC contracted with the Research Triangle Institute to conduct the Program Evaluation Technical Assistance Assessment. The purpose of this study was to gather information that described beliefs and attitudes regarding evaluation, assessed existing needs and resources for TA, and identified preferences regarding the provision of TA. This article focuses on CBOs' needs for, experience with, and ideas about TA.

METHOD

We used a qualitative approach to data collection and analysis. Qualitative methods are uniquely suited to capturing rich descriptions and generating explanations without constraint by predetermined categories of analysis.[10,11]

Study Planning

Information from our preliminary investigations (unpublished data) was used to guide site selection and development of topic guides for field data collection.

Cities or metropolitan areas were selected to assure variation in size (according to 1996 estimated population) and AIDS epidemiology (according to 1996 AIDS case rate per 100,000, calculated from CDC surveillance reports). Population was categorized as medium (500,000 to 1.5 million) or large (1.5 million to 4 million). Metropolitan areas with fewer than 500,000 persons were excluded because they contained few CDC-funded prevention programs; those with more than 4 million were excluded because their size and complexity would make it difficult to capture a comprehensive picture of evaluation

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a. Throughout the rest of this article, TA will refer specifically to technical assistance with program evaluation rather than any of the other areas in which HIV/AIDS prevention programs may receive technical assistance.

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Table 1. Data for Selected Sites

Population	AIDS Case Rate	
	Low[a]	High[b]
Medium (500,000 to 1.5 million)	Buffalo, New York Oklahoma City/Tulsa, Oklahoma	Hartford, Connecticut New Orleans, Louisiana
Large (1.5 million to 4 million)	Cleveland, Ohio Minneapolis, Minnesota	Atlanta, Georgia San Diego, California

a. Low = below the 1996 average case rate for metropolitan areas greater than 500,000.
b. High = at or above the 1996 average.

and TA activity with the resources available for this study. AIDS case rates were categorized as either less than the average case rate for metropolitan areas with a population of more than 500,000 or at or above that rate.[12] In addition, sites were limited to those receiving CDC funds and those in which a CDC project officer and health departments staff were available and willing to facilitate access to CBOs. Selected sites were geographically diverse and represented a range of evaluation resources. Table 1 presents the mix of size and AIDS case rates for the eight selected sites.

Topic guides for CBO staff, health department staff, and TA providers were developed to address constructs identified during preliminary research. Topic guides were extensively reviewed by CDC staff, pretested with the education director of a CBO not in a study site, and further refined based on observations from this test. The topic guides contained specific questions for addressing a standard set of topics. The guide provided a framework for covering topics of interest but was designed to allow the interviewer considerable latitude to adapt questions as needed, to explore new lines of discussion, and to focus on topics with which the respondent was most conversant. The guide included numerous probes interviewers could use to elicit more specific and detailed information or to explore a topic at a deeper level.

Data collection

CBO respondents were interviewed on-site; TA providers and health department staff were interviewed on-site or by telephone. Two members of the project team participated in each on-site interview, alternating roles as lead interviewer and note taker. With the respondent's permission, on-site interviews were audiotaped as backup for written notes. A single member of the project team conducted telephone interviews, which were not audiotaped. All five members of the project team had considerable interviewing experience; training for this project consisted of extensive discussion of project goals and objectives, interviewing strategies, and the interview guide. The principal investigator was present for at least the first two interviews conducted by each of the other team members.

Representatives from all CBOs at each site except one were interviewed. At that one site, selection was necessary, and per health department recommendation, CBOs with a high level of evaluation activity were intentionally overrepresented. Within each CBO, the study team asked to interview the person most knowledgeable about evaluation. In some instances, CBO staff felt it important to include more than one person to adequately

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Table 2. Number of Interviews Conducted[a]

Site	CBOs		TA Providers		Health Departments	Total
	Indirectly Funded	Directly Funded	Local	Federally Funded		
Atlanta	7	2	3		1	13
Buffalo	5				1	6
Cleveland	8		1		1	10
Hartford	7	1	2		1	11
Minneapolis	10	1	3		1	15
New Orleans	5	1	1		2	9
Oklahoma City/Tulsa	5		2		1	8
San Diego	8	1	2		1	12
National				14		14
Total	55	6	14	14	9	98

NOTE: CBO = community-based organization; TA = technical assistance.
a. For each CBO, TA provider, or health department, a single interview was conducted, with one to three staff members participating. This chart indicates the number of interviews conducted, not the number of persons interviewed.

represent the program and its evaluation. In either case, the organization was the unit of analysis.

All site visits were conducted from November 1998 through February 1999. On-site interviews lasted approximately 90 minutes; telephone interviews tended to be shorter. Table 2 summarizes the number of interviews conducted by site and by the agency or role of persons interviewed. Most CBOs were relatively small, with five or fewer full-time employees reported for half the CBOs. The large majority received CDC funding through state or local health departments (noted on Table 2 as indirectly funded); some projects targeting racial/ethnic minorities were funded directly by CDC. TA providers were evenly divided among national providers contracted by CDC through its TA networks and local providers. Some local providers had contracts with state or local health departments to provide CBOs with TA; some operated independently.

Analysis

Field interview notes were transcribed by the note taker. Telephone interviewers transferred their handwritten notes to electronic summaries immediately after the interview. To protect confidentiality, all identifying information was removed from the summaries prior to analysis.

The study team used QSR NUDIST8 software to facilitate coding and analysis. The structure of the qualitative analysis flowed directly from the interview guide domains, using a hierarchical coding structure that allowed specific dimensions of meaning to be examined separately and new codes to be added as analysis progressed. Multiple team members coded three complete interviews to identify inconsistent interpretations of codes and overlapping codes. Revisions were made to the coding structure; definitions were refined until interrater reliability for the test files approached 100%. The remaining interviews were coded by a member of the team who made that site visit or by the person conducting the telephone interview.

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The study team first conducted top-level coding and prepared descriptive summaries for review and discussion of four major topics: relationships with funding agencies, beliefs about evaluation, evaluation experiences, and TA experiences and preferences. To further explore each of these topics, the study team used iterative processes of data review, hypothesis development, and hypothesis testing, using summary matrices and displays to reveal patterns or clusters within the data. Study team members examined data on topics of interest, added additional coding to identify finer distinctions of meaning, and partitioned the data set to examine data from subsets of respondents. These processes were repeated until distinctions emerged with sufficient clarity that they could be described with confidence.

RESULTS

Interview results are described in three sections: (1) the types of TA needed to improve the evaluation of HIV prevention programs; (2) CBOs' experience with TA, including who provided TA, the extent to which they used TA, and the perceived strengths and weaknesses of TA providers; and (3) ideas for an optimal TA system.

Types of TA Needed

CBO respondents indicated a broad range of perceived needs for evaluation TA, from "no need at all" to a need for someone "to do it all." The two CBOs that indicated no need for TA were from a single study site without a system for providing TA to CBOs. It is possible that these responses stemmed from not knowing the benefits of TA. Those respondents who wanted someone "to do it all" stated that they could use a full-time consultant or evaluator to assume complete responsibility for evaluation.

Despite the range of responses, there was considerable consistency in the needs identified; TA providers and health department staff generally agreed with CBO respondents' assessment of their TA needs. Respondents cited the development of evaluation tools and data analysis much more often than any other needs. They mentioned all other needs with about the same frequency. Needs did not vary by funding mechanism (i.e., whether CBOs received funding directly from CDC or through state and local health departments), by CBO size, or by respondents' level of education or level of training in evaluation.

Evaluation Tools. CBO respondents identified assistance in designing or identifying appropriate evaluation tools as a primary need. Respondents wanted help in incorporating scientifically valid measures of specific concepts into surveys and questionnaires that have been tailored to their populations. They sought advice on how to administer questionnaires during activities such as street outreach without compromising the intervention. They wanted survey instruments that were short, simple to use, and not laden with intrusive questions that could undermine client trust. CBO respondents were particularly interested in measuring behavior change and other outcomes, although they were aware of the difficulties of doing this.

Data Analysis. CBO respondents at almost every site wanted help selecting and using analytic software, entering data, generating reports, and interpreting findings. Whereas some indicated prior analytic experience and skills, others reflected little understanding of data analysis (e.g., hoping "you could push a button and spit it out.") Some CBO

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respondents preferred that a TA provider assume the entire function of data analysis, from data entry to reporting, stating that their organization had neither the staff nor the computing resources for this task.

Orientation to Evaluation. A number of CBO respondents requested a basic orientation to evaluation, beginning with what it is, why it is important, how it contributes to the program, and why it is important to collect data in a consistent manner. TA providers confirmed the need for training. They underscored the importance of viewing evaluation as an essential tool for program management, noting that a negative or inaccurate understanding of evaluation could have a detrimental effect on program design, staff recruitment, and staff training. If perceived as "more paperwork" or mere "number crunching," evaluation would be considered a purposeless task, especially when compared with service delivery.

Evaluation Planning and Design. Several CBO respondents mentioned needing assistance in designing an evaluation plan so their efforts in program evaluation were on the right track from the outset. As one respondent noted, "We've put together a yearlong research plan. We need someone we could sit down with and say, 'These are the things we want to do. Do they make sense?'" TA providers expanded on this need. They indicated that CBOs frequently brought in independent TA providers to assist with evaluating programs long after the design phase was completed. These TA providers often found that the programs were not designed in a way that facilitated evaluation: Goals and objectives were not clearly defined, data were not collected in uniform fashion, forms were not standardized, and/or tracking systems were not established. CBOs needed evaluation TA at the beginning of the program planning process so that mechanisms for a rigorous but feasible evaluation could be built into the overall program design.

Knowledgeable Partners in Evaluation. Many CBO respondents noted that health departments were critical partners in evaluating prevention programs and that health department staff knowledge of the evaluation process was critical to its success. Yet a number of CBO respondents expressed the opinion that contract monitors (the health department staff members who serve as the primary liaison between health departments and CBOs) knew very little about evaluation, often less than the CBO staff whose programs they reviewed. These respondents maintained that the contract monitors focused on administrative issues and did not appreciate or understand evaluation. The perception that contract monitors lacked substantive evaluation expertise undermined CBO confidence that health departments believe evaluation is important and are committed to helping CBOs do it well. Several CBO respondents said that any TA should begin with health department staff. Many TA providers and some health department staff agreed that contract monitors needed training on evaluation.

Other Needs. Several CBO respondents indicated a need for general networking. They thought networking (through collegial meetings or a catalogue or clearinghouse of evaluation experiences and resources) would show how similar programs conducted evaluation and what interventions they found most effective. None of these respondents had access to health department-contracted TA providers. It may be that they felt more isolated than did respondents from sites with health department-contracted TA providers. All TA providers with health department contracts reported conducting group training on evaluation, and these workshops provided a forum for interaction with peers.

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Other identified needs included data collection and program review. Most data collection requests centered on identifying simple methods staff could use for the accurate and consistent collection of quantitative data. Extensive TA was requested by a few CBO respondents who felt they needed a general program review. These respondents wanted someone external to their organization to observe, review, and assess all their prevention programs and suggest ways to improve them.

Experiences With TA

Most CBO respondents relayed some past or current involvement with evaluation TA. Only a few respondents reported not being able to obtain TA when they had sought it.

TA Sources. CBO respondents reported obtaining TA from a variety of sources. At four of the eight study sites, state or local health departments had contracted with TA providers. Besides providing group training on evaluation to all funded CBOs, these TA providers offered limited assistance to individual CBOs. Two of these four sites instituted a TA bank, which allowed each CBO to "withdraw" a set number of hours of individualized TA each year. Providers at the other two sites gave individualized assistance as requested and as time permitted.

The availability of TA varied at the other four sites. At two sites, there was none. At a third site, the health department had contracted with a TA provider, but that provider worked exclusively with health department staff. The TA services were not directly available to CBOs; instead, CBOs requested evaluation assistance from health department staff. At the remaining site, the health department had recently contracted with a TA provider, but no services had been provided yet.

Some CBOs contracted directly with independent TA providers, in addition to or instead of health department-contracted TA providers. Independent TA providers also served as evaluation contractors for CBOs directly funded by CDC. One health department without a contracted TA provider allowed CBOs to charge independent TA services to the health department contract. University faculty constituted the most common source of independently provided TA. They might be paid directly by the CBO, be written into a grant, or volunteer their services. As paid consultants, they sometimes assumed the lead role in an evaluation, with responsibility for design, instrumentation, and analysis. Volunteer involvement usually was limited to reviewing evaluation instruments.

A few CBO respondents mentioned other sources of TA, including student interns, national or regional minority organizations, and CDC staff.

TA Usage. Availability of health department-contracted TA was clearly linked to the amount of evaluation TA received. Respondents from CBOs at the four sites with such arrangements reported three times as many TA experiences as did those from CBOs at the four sites without them. However, not all TA at sites with health department–contracted TA came from those contract providers; slightly less than half came from other sources, mainly university faculty and other independent TA providers. Considering only TA provided by other sources, CBO respondents with health department–contracted TA still reported considerably more TA experiences than CBOs without formal TA systems. This suggests that working within health department–contracted TA systems might have made CBO staff more aware of, and interested in, TA and motivated them to seek TA more often, whether health department contracted or not.

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Strengths and Limitations of TA Providers. Strengths and limitations are discussed together because the presence of a given attribute was often perceived as a strength and the absence of the same attribute as a limitation.

Practical Expertise. CBO respondents liked TA providers who "knew AIDS," had "real-world experience," understood the constraints under which their program operated, or had "street smarts." Familiarity with the CBO and its programs was seen as contributing to TA efficiency, obviating the need for lengthy orientations. In contrast, TA providers who were viewed as "armchair" evaluators and who had not "worked the streets" had less credibility. Their advice was often suspect and sometimes ignored.

Accessibility. CBO respondents spoke favorably of TA providers who were available for meetings, returned phone calls, and met CBO timelines. Respondents preferred TA providers who were willing to come to the CBO, work on-site, go out into the field, and work alongside the frontline staff. CBO respondents wanted to receive the TA soon after requesting it. Having to arrange meetings weeks or months in advance, then having to reschedule them at the last minute because the TA provider was overbooked, was a frustrating shortcoming.

Cultural Competence. CBO respondents expressed a strong preference for TA providers who were of their population's culture and could speak the language, literally and figuratively. If that was not possible, then at the very least the providers needed to be willing and able to step outside their own cultural framework and be educated by CBO staff.

Good Communication Skills. CBO respondents appreciated TA providers who were "easy to talk to" and easy to understand, who could demystify the process of evaluation. One person commended her TA providers by saying, "If I don't understand something, [they] will take it down a notch and explain it to me in lay terms." Working without these skills seriously compromised a TA provider's effectiveness. Another person attributed a breakdown in communication to speaking two different languages: "They talk in a very academic, bureaucratic, outcomes-based language, whereas we think in terms of service provision."

Collaboration Skills. CBO respondents appreciated TA providers who communicated a desire to work as partners with CBO staff, who expressed interest by posing good questions and sharing insights, and who did not impose their opinions on staff. As one respondent put it, "They didn't tell us that this is the way you have to do it. They let us decide for ourselves what was best for us." By contrast, CBO respondents resented TA providers who displayed arrogance or did not attend to the concerns of program staff. One person described a TA experience as follows: "Unfortunately, they didn't listen to anybody. They just told us, 'Wake up, this is the way it's going be, and by the way, I've got to catch a plane.'"

Ideal TA System

Interviewers asked respondents to describe the ideal system for delivering evaluation technical assistance. Respondents were told that in an ideal system, resource constraints would not be an issue and that, therefore, they should feel free to think boldly.

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Funding/Resource Commitment. Many CBO respondents assumed that an ideal system would involve a considerable commitment of time and resources, far more than what was offered by the existing TA system at any study site. Complying with interviewer instructions to think boldly, some respondents hoped for a commitment equivalent to one TA staff person for each CBO. TA providers and health department staff noted that in addition to funding for evaluation, adequate program funding was necessary for CBOs to implement what had been learned from evaluation.

Program-Specific TA. Although not often mentioned explicitly, most CBO respondents described a system that provided TA to individual CBOs rather than to citywide gatherings of CBOs. As opposed to a "cookie-cutter" approach, the ideal TA would be tailored to the needs and concerns of each CBO and its level of evaluation experience and sophistication. A number of TA providers expressed similar opinions.

Time Commitment. A tailored approach to TA assumes a high degree of interaction between TA provider and CBO staff, with the provider spending substantial time at the CBO and in the field with frontline staff. Many CBO respondents specifically mentioned extensive time on-site as a critical component of their ideal system and criticized the model of an outside expert flying in for 1 or 2 days and then leaving. Many also saw the ideal TA provider as an on-call consultant, ready to work with CBO staff for a minimum number of hours each month. A number of CBO respondents specified that the TA provider should be local to ensure availability as well as familiarity with the community and the CBO. However, a few CBO respondents noted that a considerable portion of the work could be carried out by fax, phone, and e-mail.

Comprehensiveness. Quite a few CBO respondents indicated that TA should encompass the full range of programs offered by a CBO and not just focus on one or two. Several described an interaction that would examine all programs together ("broader outcomes"), set up a data collection system that cut across all programs, assess all service delivery in terms of how well it served the CBO's purposes, and provide input into strategic planning. A number of CBO respondents mentioned the need to design evaluation at the beginning of any prevention program and to integrate evaluation into all planning processes.

Access to Evaluation Resources. Several CBO staff members stated that they would like access to scientifically sound and culturally appropriate evaluation materials that had been used successfully by other organizations. They imagined accessing such resources through a library, manual, or notebook, preferably via the Internet. However, a number of CBO respondents had very limited computer resources and currently lacked Internet access.

Training/Networking. Despite the clear emphasis on TA that is tailored to individual CBOs, a few respondents maintained that group training on evaluation basics would be helpful, especially workshops that focused on the practical benefits of evaluation. Several CBO respondents expressed the opinion that the range of CBO skills and experience was too broad for one community-wide training to be effective, proposing that CBOs be grouped by level of evaluation capacity, with appropriate TA training provided for each group. A health department-contracted TA provider expressed the opinion that a successful TA system would involve both individual TA and group training. Group work would facilitate an appreciation of, commitment to, and competence in evaluation at the commu-

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nity level. Such training also would provide a forum for sharing evaluation experiences, brainstorming strategies, and celebrating achievements. A number of CBO respondents mentioned opportunities for networking as a component of an ideal TA system. One respondent suggested a mentoring program that would link similar organizations at varying levels of evaluation capacity.

Independence. A few CBO respondents indicated a strong preference that TA not be contracted by the health department. They noted that the close relationship between health departments and their contracted TA providers could make it difficult to ask for technical help. They expressed concern that if CBO staff revealed deficits in program or evaluation capacity to TA providers, those deficits might be relayed to the health departments and negatively affect future funding.

Level of TA Provider Involvement. CBO respondents seemed fairly evenly divided on the extent to which TA providers should consult on evaluation activities and the extent to which they should conduct them. Some CBO respondents wanted a high level of interaction with the TA provider and saw the provider in a capacity-building role, helping staff to develop their own evaluation skills. Others envisioned the TA provider as an external evaluator who would "take the ball" or "do it" with minimal involvement of, or demands on, the CBO. Analysis by site, respondent, and CBO variables revealed that CBO staff members who expressed the latter preference had less evaluation training, worked in smaller CBOs, and had less access to health department-contracted TA providers.

CBO staff with less training may want outsiders to conduct their evaluations because they find evaluation more mystifying and intimidating than do those with more training. Staff members from smaller CBOs may have less time to work with a TA provider or to follow through on a TA provider's advice than staff members from larger agencies and therefore prefer that the TA provider conduct the evaluation. As for respondents without access to health department-contracted TA, a perceived lack of support in evaluating prevention programs may have shaped their desire for an outside expert to "do it all."

It is unlikely that the "consult" versus "conduct" delineation will distinguish TA providers in any absolute sense. Even if the focus of evaluation TA is on developing the internal evaluation capacity of CBOs, there will always be the need to balance showing CBOs how to evaluate their programs and doing it for them, with smaller CBOs and CBOs with less experienced staff requiring more hands-on assistance. The true challenge will not be deciding whether to consult on evaluations or conduct them but rather when and how to do each.

LIMITATIONS OF THE STUDY

The underlying assumption of this study is that properly structured and delivered, TA can facilitate scientifically sound and programmatically useful evaluations of HIV prevention efforts. However, this study did not review HIV prevention program evaluations themselves. Therefore, the extent to which TA enabled CBOs in this study to conduct more and better evaluations is unclear. Many CBO staff members expressed the opinion that the TA they received had improved the quality of their evaluations, but the effect of TA on the success of HIV program evaluation efforts remains an area for future research.

Although qualitative methods are ideally suited to exploratory studies such as this one, their potential biases are applicable here. Data may not accurately represent the distribu-

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tion of attitudes toward evaluation if respondents either provided socially desirable responses or took the opportunity to vent frustrations to the interviewer. In addition, our sampling strategy restricts interpretation of results. The sites selected do not constitute a representative sampling of cities; for instance, we excluded cities with populations less than 500,000 and greater than 4 million. Nor do the CBOs interviewed represent the universe of HIV prevention programs within any site; we only interviewed CBOs that were directly or indirectly funded by CDC. CBOs in cities of other sizes and CBOs with other funding sources may have different TA needs and greater or lesser access to TA. Although we suspect basic principles of TA provision that surfaced in this study will apply in other settings, we urge caution in generalizing our findings to other sites and settings.

The exploratory nature of the sampling and data collection processes does not, and was not intended to, support conclusive tests of hypotheses. Researchers can use qualitative methods, however, to link variables and processes to an outcome—in this case, evaluation behavior. Inferences of causality are strengthened by both the consistency with which these variables and processes are observed and the plausibility of the mechanisms linking them to outcomes.[10] Within our study, we heard many themes, including some unexpected ones, across sites and program types. Their logic and consistency strengthens our confidence that further investigation would support the general findings of this study.

IMPLICATIONS FOR PRACTICE

This study yielded nine recommendations directly or indirectly related to evaluation TA. Although originally developed for CDC, they are clearly relevant to health educators who provide evaluation TA to community-based organizations. Whether health educators are assisting these organizations evaluate a specific prevention/risk reduction program or helping them develop general evaluation capacity, these recommendations should facilitate the provision of TA that is relevant, accessible, and useful to CBOs.

Define and Describe Evaluation Broadly. CBO respondents at less advanced stages of evaluation capacity were often quite anxious about their abilities to evaluate their programs. TA providers can help demystify evaluation and thereby reduce CBO staff anxiety, by identifying the many routine CBO activities that constitute evaluation and by relating how the skills involved in these activities can be applied to other evaluation methodologies. For instance, TA providers can explain to outreach workers that completing contact sheets is an evaluation activity and show them how the information from those sheets can be aggregated to determine whether the outreach program is operating as intended. Likewise, community educators should know that polling workshop attendees to determine what other programs they would attend is also an evaluation activity, in this case one that assists in program planning and development.

Consistently Use Simple Evaluation Terms. TA providers who overuse jargon and technical terms risk overwhelming less advanced CBO staff. TA providers should explain evaluation concepts simply, perhaps pairing lay and technical terms to build comfort with the language of evaluation. The distinctions between formative, process, impact, and outcome evaluation can be confusing even for those with some experience in evaluation. More familiar terms, for example, *needs assessment*, *activity reports*, and *pretests* and *posttests*, may make evaluation seem a less intimidating endeavor.

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Tailor the TA to the CBO's Evaluation Capacity. When planning evaluation TA for a specific CBO, funding agencies and TA providers should take into account the level of resources and expertise available to that CBO in conducting evaluation activities. TA for CBOs at lower levels of evaluation capacity should stress the potential usefulness of evaluation to those agencies. TA goals for these CBOs would include engaging program leadership in the evaluation process, identifying simple, low-cost evaluation strategies, and using data from existing evaluation activities to support program improvement efforts. TA activities might involve recommending or designing appropriate data collection instruments, then training staff in their use. For CBOs with more advanced capacities for evaluation and an established appreciation of its value, TA should focus on broadening the base of evaluation skills among CBO staff and providing specific expertise that remains beyond the CBOs' capacity. TA providers might teach CBOs how to incorporate behavior change theory into program and evaluation planning and help staff adapt data collection instruments to specific populations and interventions.

Balance Evaluation Support and Capacity Building. Funding agencies and TA providers should identify factors and conditions that indicate when to teach CBO staff how to conduct various aspects of evaluation and when it is more efficient and effective to conduct those evaluation components. For instance, in small CBOs with few staff and none with evaluation experience, it may make sense to teach staff techniques for collecting data during prevention programs but not how to analyze those data. TA providers might assume responsibility for data analysis, then meet with staff to help them interpret the findings and use them to improve programming.

Provide Appropriate TA to Funding Agencies/Contract Monitors. This study found that if health department staff lacked knowledge of, and experience with, evaluation research, they could not set reasonable evaluation expectations for CBOs, offer CBO staff substantive advice in evaluating their prevention programs, or use the evaluation data that CBOs provided. The sense among some CBO staff members that they could not discuss evaluation with health department contacts undermined their confidence that the health department was committed to evaluation and to helping CBOs do it correctly. It is essential that program funders and monitors understand evaluation if they are to provide CBOs with the requisite support for conducting strong evaluations.

Maximize the Usefulness of Group TA. TA providers should tailor group training to CBO staff skills, experience, needs, and concerns. It is particularly important to segment audiences by evaluation capacity. CBO staff who have achieved a certain level of evaluation expertise should not be subjected to "Evaluation 101" trainings. Likewise, those with little evaluation experience will derive minimal benefit from more sophisticated trainings on sampling strategies and data analysis. Bringing together CBO staff of varying evaluation capacities can provide useful opportunities for networking and motivation but should be done outside group training sessions.

Ensure the Cultural Competence of TA Providers. CBO respondents held strong beliefs about the importance of cultural competence and its implications for evaluation. Funding agencies should meet with CBO staff to discuss the pariticular facets of cultural competence that are necessary to provide effective TA in those organizations. By accompanying CBO staff during data collection activities, TA providers can better appreciate the challenges in conducting evaluation that is appropriate to specific cultural contexts.

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Ensure the Accessibility and Availability of TA Providers. CBO respondents wanted a long-term, consistent relationship with a TA provider who is easily accessible and readily available for consultation and assistance. TA providers can demonstrate availability by offering to attend a CBO's workshops or join its staff in outreach efforts in an effort to better understand its prevention programming and its particular evaluation challenges.

Designate Funds to Support Evaluation. Allocation of funds devoted specifically to evaluation-related activities will reflect the importance that the funding agency places on evaluation and will help mitigate CBO concerns that evaluation takes resources away from program services. Without adequate funding for evaluation, CBOs will not have the resources needed to follow through on the advice and counsel of even the best TA providers.

CONCLUSION

Because this study focused on TA for the evaluation of HIV prevention efforts, the primary application of its findings and recommendations will be to HIV prevention programs and their funders. It seems likely, however, that many of the TA needs and concerns identified by CBOs doing HIV prevention work would pertain to community agencies engaged in other health promotion/disease prevention activities and to the health departments and other agencies that fund these activities.

Whatever the public health problem, the desire to maximize the effectiveness of prevention efforts underscores the need for strong program evaluations to continuously improve the quality of those efforts. Likewise, competition for limited prevention funding dictates increased attention to program evaluation to prove the efficiency and effectiveness of prevention efforts. Unfortunately, the local agencies that are best situated to conduct successful community-based prevention efforts often lack requisite evaluation resources (e.g., funds, time, and trained and experienced staff). TA can play a critical role in the provision of these resources and can thereby assist community-based organizations in evaluating their prevention programs, in using the results of those evaluations to improve their programs, and in confirming for themselves, their funders, and the public that their programs are having the intended effects.

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