

OPEN

HIV Communication Capacity Strengthening: A Critical Review

Cheryl Lettenmaier, BSN, MPH,* Joan Marie Kraft, PhD,† Keris Raisanen, MPH,*
and Elizabeth Serlemitsos, MBA, MPH*

Abstract: HIV communication is most effective and sustainable when it is designed and implemented locally and tailored to the local context. This requires capacity strengthening at national, subnational, and community levels. Through a review of the published and selected “grey” literature, we examine HIV communication capacity strengthening: definitions, measurements, implementation, and effects. We found limited documentation of HIV communication capacity needs or systematic approaches to address them. Most HIV communication capacity strengthening to date has focused on building individual competencies to design and manage social and behavior change communication programs through training courses, often coupled with networking opportunities for participants, post-training mentoring, and technical assistance. A few of these efforts have been evaluated through pre- and post-training tests and qualitative interviews with participants and have shown potential for improvement in individual skills and knowledge. Health communication capacity assessment tools that measure individual and organizational competencies exist, but they have most often been used to identify capacity building needs, not for evaluating capacity strengthening efforts. A new definition of capacity strengthening, grown out of recent efforts to improve effectiveness of international health and development programs, focuses on improving organizational and societal systems that support performance and individual competencies. We propose a holistic model for HIV communication capacity strengthening and call for rigorous documentation and evaluation to determine and scale-up optimal capacity building interventions for strengthening social and behavior change communication for HIV prevention, care, and treatment in developing countries.

Key Words: capacity building, capacity strengthening, social and behavior change communication, health communication, strategic communication, HIV/AIDS

(*J Acquir Immune Defic Syndr* 2014;66:S300–S305)

INTRODUCTION

Social and behavior change communication (SBCC) has been an integral component of HIV programming since the 1980s, and it has had demonstrated effects on knowledge, social norms, service uptake, and behavior ranging from condom use to partner reduction and HIV counseling and testing.^{1–5} People designing, implementing, and studying HIV communication recognize that SBCC is most effective at shaping social norms and encouraging individual and community practices to prevent and mitigate HIV/AIDS when the process is locally owned and driven, when it adheres to well-accepted principals of design and implementation, and when tailored to local realities.^{6–10} This demands capacity in HIV communication at country, subnational, and community levels.

Through a review of the literature, this article gauges how this recognition has influenced capacity strengthening for HIV communication. First, we discuss definitions and approaches to capacity strengthening for health and HIV communication and then methodologies and indicators for measuring communication capacity. Next, we describe what is known about existing gaps in capacity, efforts to address them, and evidence of effectiveness of those efforts. Finally, we propose a model to guide HIV communication capacity strengthening.

METHODS

We searched the published and selected “grey” literature for reports describing capacity building for HIV behavior change communication (BCC) in developing countries and their effects. We sought reports on the (1) capacity strengthening definitions, approaches, and measures; (2) assessments of existing capacity; and (3) descriptions and evaluations of HIV BCC capacity strengthening approaches. We applied various combinations of search terms for (1) capacity, capacity strengthening, capacity building, and technical assistance (TA); (2) BCC, health communication, prevention, and social marketing; (3) HIV/AIDS; and/or (4) health to PubMed, Global Health, Applied Social Sciences Abstract Index, Communication and Mass Media Complete, and Google/GoogleScholar. We also searched implementers’ Web sites

From the *The Johns Hopkins Bloomberg School of Public Health, Department of Health, Behavior and Society, Center for Communication Programs, Baltimore, MD; and †United States Agency for International Development, Office of Population and Reproductive Health, Washington, DC.

The views, findings and conclusions in this article are those of the authors and do not necessarily reflect the views of the United States Agency for International Development.

The authors have no funding or conflicts of interest to disclose.

This is an open access article distributed under the terms of the Creative Commons Attribution-Noncommercial No Derivative 3.0 License, which permits downloading and sharing the work provided it is properly cited. The work cannot be changed in any way or used commercially.

Correspondence to: Cheryl Lettenmaier, BSN, MPH, The Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21202 (e-mail: cheryll@jhucppug.org).

Copyright © 2014 by Lippincott Williams & Wilkins

(eg, FHI360, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs [JHU CCP]). Our searches yielded few relevant published articles. For example, a search of PubMed using the terms “capacity building” and “HIV” yielded 386 titles. On inspection of abstracts, only 28 addressed an area of interest listed above; 10 of those described capacity building for BCC in the United States. The remainder addressed capacity building for HIV clinical care or research ($n = 70$) or did not address capacity building ($n = 288$). Narrower searches yielded fewer reports, many irrelevant. When applied to PubMed, the terms “capacity building” and “HIV” and “BCC” yielded 19 titles; 2 described approaches to capacity strengthening and 1 provided evaluation results. Given the dearth of the literature, we drew on coauthors’ experience working on the JHU·CCP HIV communication capacity building efforts, added a “snowball” approach to the “grey” literature, and contacted colleagues working in the field to identify additional reports.

RESULTS

Defining and Approaching Health Communication Capacity Strengthening

HIV communication is the use of media and activities at national, regional, and local levels to promote specific HIV-related behavior, including use of services, among large numbers of individuals.^{1,11–13} In this article, the terms HIV communication, SBCC, and BCC are used interchangeably.

The United Nations Development Program defines capacity building as “the process by which individuals, groups, organizations, institutions and societies develop abilities to perform functions, solve problems, and set and achieve objectives.”¹⁴ We could find no standard definition for HIV or health communication capacity strengthening per se. However, the health promotion literature commonly regards capacity building in a way consistent with the United Nations Development Program definition: “a set of strategies that can be applied both within and across systems to lead to a greater capacity of people, organizations and communities to promote health.”¹¹ In the literature and in this article, the terms capacity strengthening, building, and development are used interchangeably.

Historically, capacity strengthening has meant building a workforce with the required knowledge and skills to achieve objectives. By this narrow definition, capacity development involves strengthening knowledge and skills to perform core functions. Most HIV communication capacity strengthening to date has focused on human resource development, aiming to build a critical mass of individuals capable of designing and managing HIV communication programs.^{11,15}

A new definition of capacity strengthening is growing out of recent attempts to improve development program effectiveness. In the 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action, donors pledged to work within countries’ institutions and systems, to strengthen institutional capacity to lead and manage development,¹⁶ and to build core competencies to implement programs. Thus, the past decade has seen an increased interest in improving the effectiveness of capacity strengthening and a shift in emphasis on

how it takes place. Capacity strengthening approaches now aim to facilitate enabling environments where development workers can learn and innovate, and reforming workplace systems and organizational norms and values that influence the ways individuals work. It goes beyond building individual competencies to influencing organizations, sectors, and political environments that influence performance.^{17–21}

In this review, we define HIV communication capacity strengthening in 2 ways: (1) building individual competencies (knowledge, attitudes, and skills) and (2) strengthening systems at organizational and societal levels to support effective HIV communication programs.

Measuring HIV Communication Capacity Strengthening

The large body of the literature on the measurement of capacity strengthening in international HIV, health and development^{11,19,21–23} provides indicators of capacity strengthening^{10,23} that may be applied or adapted for use and that point to the importance of building both individual and organizational capacity. For example, Morgan¹⁷ suggests that capacity strengthening indicators should measure the following: (1) capacities developed, in terms of the product or output of the effort, (2) performance (program outcomes), and (3) permanence (sustainability of capacities). LaFond and Brown²² suggest a 4-category schema for indicators that reflect (1) the change strategy; (2) organizational, behavioral, material, and technical changes; (3) performance and the environment; and (4) participants’ ownership of capacity building, monitoring, and evaluation processes.

Indicators of individual competence in HIV communication exist. These include the Galway Consensus core competencies for health promotion: catalyzing change, leadership, assessment, planning, implementation, evaluation, advocacy, and partnerships.²⁴ In addition, there are competency maps for health communication training^{11,25} and the competencies assessed in the Communication for Change (C-Change) *Social and Behavior Change Communication Capacity Assessment Tool (SBCC-CAT) for Use with Individuals*,²⁶ which include the ability to conduct situation analyses, develop creative briefs, and design monitoring and evaluation plans for SBCC programs.

AIDStar Two and the United States Agency for International Development (USAID) describe a framework for capacity strengthening among HIV organizations^{22,27} structured around 4 components: standards, indicators, organizational functions, and practices. The JHU·CCP BCC Capacity Assessment²⁸ and the SBCC-CAT²⁶ both include indicators of organizational communication capacity, such as whether the organization has a communication strategy, regularly pretests communication materials, and coordinates communication programs with partners.

Recently, measurement of capacity strengthening has moved from quantifiable measures toward qualitative methodologies that assess change at individual and system levels.²⁹ Some methodologies have been developed to describe changes in organizational behavior and processes that occur during capacity strengthening. Outcome Mapping (OM) is one such methodology.³⁰ Its 3-stage process allows

a program to (1) define what changes it will influence and how it will do so, (2) develop a framework for monitoring actions and progress toward those changes, and (3) develop an evaluation plan. OM, described as a management tool rather than an evaluation tool, is often listed as a successful method for capacity building.²⁹ Another qualitative methodology for measuring changes in capacity is Most Significant Change, a participatory process of collecting field-level stories, which are increasingly winnowed by stakeholders until the single most significant story is identified.^{31,32} Methodologies such as OM and most significant change, when combined with individual and organizational capacity assessments, can paint a holistic picture of how systems and individual capacities change.²⁹

HIV Communication Capacity Gaps and Approaches to Build Capacity

Although capacity strengthening is considered an integral aspect of effective SBCC programming,^{10,11} and many HIV projects include efforts to improve SBCC capacity,^{11,33,34} we found limited documentation of SBCC capacity needs or systematic approaches to address them.

Our search identified 2 published and 3 unpublished reports of capacity assessments that identified gaps for HIV SBCC at organizational and individual levels.^{35–39} At the organizational level, a capacity assessment among Ministries of Health and National AIDS Authorities in 5 developing countries, using the C-Change SBCC CAT, found that few staff had formal training in SBCC, in-service training was uncommon, funding and TA was often donor driven, and strategies to ensure roll out to local levels did not always function well.^{35,36} Common gaps in individual capacity emerged in 2 separate training needs assessments conducted in 2003 and 2005 among 154 members of the African Network for Strategic Communication in Health and Development (AfriComNet) from 17 countries. Participants of both assessments reported having experience in some aspects of SBCC, including pretesting materials, training, and strategy design. However, 69% reported “limited or no experience” in social marketing; 54% reported “limited or no experience” in folk media; and many had “limited or no experience” working with high-risk youth (52%), vulnerable children (64%), or people living with HIV (33%).^{37,38} Similarly, a 2008 South African assessment of SBCC MPH students identified the need for a broader understanding of medical topics and epidemiology, how to apply SBCC theories, and how to implement, monitor, and evaluate SBCC.³⁹

Our search identified reports on 7 efforts to build capacity for health or HIV-related communication in developing countries, including Peru, Kenya, South Africa, Namibia, Ethiopia, Tanzania, and Rwanda.^{39–42} Reports focused on the efforts to build individual core competencies, with some designed to strengthen organizational systems.

One approach combines training with opportunities for networking among participants. Since 1989, JHU·CCP has offered a 3-week course in health communication, which has included more than 3000 participants from 35 countries. Participants are encouraged to maintain contact after training

through alumni networks in Asia and Africa. Comparisons of pre- and post-training tests among 35 participants in Tanzania between 2011 and 2013 showed improvements in average knowledge scores of 123%–386% (Elizabeth Serlemitsos MBA, MPH, personal communication, 2014). The course supplements collaborative learning approaches, where developing country organizations receive grants and TA to design, implement, and evaluate health and HIV communication.⁴² In a similar approach, 4 Peruvian universities in collaboration with 2 local nongovernmental organizations offered a combination of health communication training courses, internships, and networking opportunities from 2002 to 2005. An assessment of the effort identified the need for strengthening institutional and individual capacity, ensuring institutional commitment, building local ownership, and engaging local universities for long-term sustainability.^{11,40}

Other efforts to build capacity rely more on local ownership for implementing courses and maintaining SBCC networks. For example, The C-Change project partnered with the Southern African AIDS Trust (SAT), a network of 135 organizations operating in 6 southern African countries, to fill gaps around HIV communication design, messaging, and approaches. Between 2009 and 2012, SAT members “cascaded” their expertise through training, peer-to-peer support, mentoring organizations as they completed assignments, and SBCC tools.^{39,41} Likewise, AfriComNet has worked since 2005 with a network of universities in 8 African countries to develop and offer 10 short courses on core competencies in HIV communication. The network also conducts regional workshops on HIV communication issues and maintains a Web site for African health and HIV communicators.¹¹ By 2013, the network had 1600 members and had enrolled 2000 people in short courses (Charles Kakaire, MsDM, personal communication, 2014).

Another approach is to offer formal university-based training. Soul City Institute for Health and Development Communication in South Africa partnered with the University of Witwatersrand School of Public Health to offer short courses and a field of SBCC study within the school’s Masters of Public Health (MPH) Program. In 2010, the university admitted 14 of 42 applicants to the MPH program and enrolled 150 participants in short courses tailored for new and mid-career professionals.^{11,41}

Recently, USAID has supported 2 sequential global SBCC capacity strengthening projects: C-Change and the Health Communication Capacity Collaborative (HC3). In addition to its collaboration with SAT and support to the University of Witwatersrand MPH program, C-Change developed online capacity assessment tools and training modules. C-Change also implemented capacity strengthening programs in Namibia, Kenya, Guatemala, and South Africa that applied the SBCC-CAT and conducted tailored training, onsite mentoring, and TA to support implementation of SBCC programs.^{11,41,43}

The 5-year HC3 project, which began in 2013, focuses on building SBCC capacity among developing country organizations through blended learning approaches that integrate face-to-face TA with virtual technologies. The project is establishing on-line platforms that allow

communities of SBCC professionals to interact and learn. HC3 also provides mentoring and internships for university faculty and students to strengthen academic training in HIV and health communication (Katherine Holmsen PhD, personal communication, 2014).

Evaluating What Works for HIV Communication Capacity Building

Evaluations of capacity building for HIV communication programs are few, and mostly document “lessons learned.” Among those identified were several articles, including some in a special journal supplement on the capacity building efforts of the United States Centers for Disease Control and Prevention^{44–46} and a handful of reports from developing countries. Among the reports of capacity building initiatives that were evaluated in the United States,^{47–49} none had comparison groups, and only 2 collected baseline and postintervention data.^{48,49} Two evaluations of training and TA efforts reported outputs and qualitative outcomes, such as number of TA requests, perception that training objectives were met, use of logic model tools, and the creation of networks of TA providers.^{47,48} One study assessed self-reported capacities across multiple domains.⁴⁹

In reports from developing countries, process measures and qualitative interviews suggest beneficial outcomes from training courses and networking approaches. Qualitative interviews with participants of JHU CCP’s 3-week health communication course reported improvements in knowledge about BCC processes, sharing information within organizations, diagnosing organizational problems, and building staff relationships (Elizabeth Serlemitsos, personal communication). Likewise, participants of AfriComNet short courses reported improvements in advocacy work and managing information (Charles Kakaire, personal communication).

SBCC capacity efforts that combine training with on-the-job experience, mentoring, and TA showed encouraging outcomes.^{41,50–52} One report identified outcomes through a set of pre–post training tests and qualitative data to document capacity building outcomes from a training and mentoring program that also provided computers and other information technology resources to 29 women’s nongovernmental organizations in Uganda, Zambia, and Zimbabwe. The evaluation suggested increases in knowledge, understanding of how to use various media, the use of needs assessments to guide communication strategy, and pretesting of messages (point estimates not provided).⁵⁰ Two reports describe capacity building efforts for peer-led HIV BCC programs for adolescents using a training and TA approach.^{51,52} A comparison of pre- and post-training assessments of sexual and reproductive health (SRH) knowledge and attitudes among 111 peer leaders showed significant increases in mean scores both immediately and 6 months after training. In-depth interviews 6 months after training identified improvements in their ability to share sensitive knowledge, speak publicly, and prepare for changes in their bodies and relationships.⁵² The other program included training and TA for community members and youth.⁵¹ Focus groups and observation 6 months after the project identified substan-

tial improvements to peer leaders’ skills and confidence; youth reported that the project had significantly built their ability to conduct situation analyses, plan programs, and implement HIV prevention activities. The evaluation also reported a sense of project ownership and strengthened skills in project planning among district authorities, older community members, and youth. The C-Change project with SAT conducted self-administered capacity assessments at baseline, midline, and endline. A comparative analysis showed moderate improvements in core competencies, including conducting situation analyses, clarifying objectives, developing creative briefs, revising monitoring, and evaluation tools, and preparing reports.⁴¹

Discussion, Recommendations, and Conclusions

Capacity strengthening is recognized in the HIV communication community as essential to sustainable SBCC programming, and capacity strengthening efforts are underway in several developing countries. Most have focused on building individual competencies, some have worked to influence institutional systems, and almost all have been externally driven. Few efforts have been systematically documented, and none that we are aware of has been rigorously evaluated, although capacity assessment tools that identify core individual and organizational competencies have been developed and used to identify capacity building needs.

Capacity strengthening efforts in HIV communication need to draw on experiences from the broader development community. We propose using and evaluating a holistic model for HIV communication capacity strengthening—a pathway that addresses core competencies, systems strengthening, and supportive policies, structures, norms, and values (Fig. 1).

The pathway to sustainable capacity in HIV communication describes an internally driven process that starts with a spark—a desire for change engendered by systemic inefficiencies, institutional ineffectiveness, and/or individual frustrations. Such sparks reflect the appreciation that good quality health communication can influence behavior.

Driven by this spark, program implementers need to strategically design capacity strengthening interventions, based on assessments of individual competencies, the organizational or institutional milieu, and the sociopolitical environment. Capacity strengthening should be tailored to address gaps at all these levels.^{11,18–22,53}

To build sustainable communication capacity, leadership needs to allocate adequate human, financial, and material resources and implement supportive policies and strategies. Indicators of such an enabling sociopolitical environment include effective coordination and collaboration, HIV communication guidelines and standards, and effective resource allocation.

For institutions to effectively design and implement HIV communication, they need managerial systems, leadership, and values that include a shared vision, openness to partnerships, fostering a learning environment, commitment to quality, and generating or allocating adequate resources. The literature on development capacity strengthening

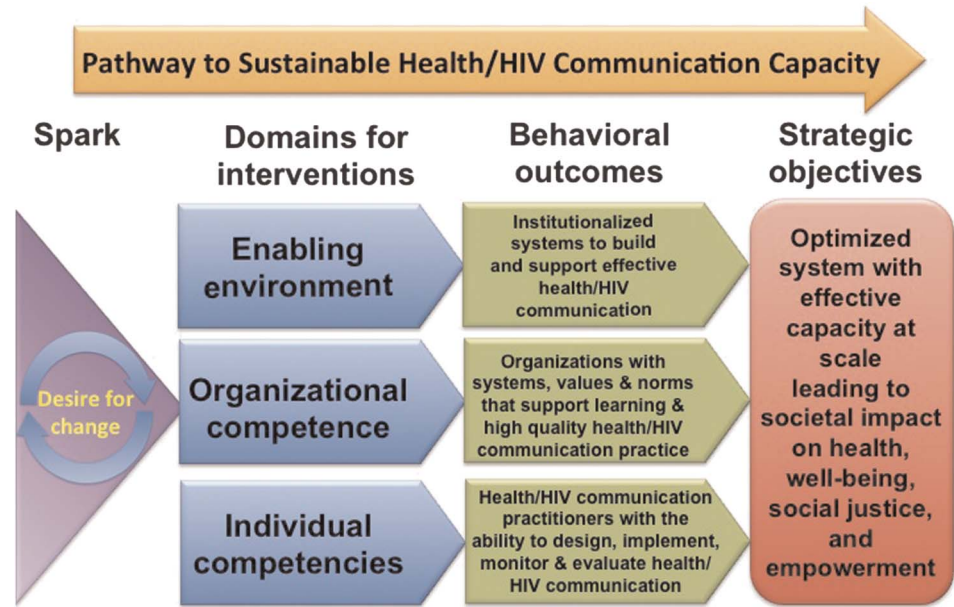


FIGURE 1. A holistic model for HIV communication capacity strengthening.

suggests that such changes need to be internally driven, and external TA should take the form of coaching, mentoring, and linking with other institutions and resources.^{21,40,53,54}

Evaluations are needed to better understand the conditions under which such efforts build capacity and lead to more effective and sustained programs. Evaluations should draw from and adapt existing capacity indicators. Assessments should gauge individual competencies, including the knowledge and skills to design, implement, and evaluate HIV communication and indicators of the organizational milieu and broader enabling environment, such as commitment, shared vision, creativity, supportive policies, guidelines, strategies, and resource allocations.

REFERENCES

- Noar SM, Palmgreen P, Chabot M, et al. A 10-year systematic review of HIV/AIDS mass communication campaigns: Have we made progress? *J Health Commun.* 2009;14(1):15–42.
- Vidanapathirana J, Abramson M, Forbes A, et al. Mass media interventions for promoting HIV testing. *Cochrane Database Syst Rev.* 2005; CD004775. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004775.pub2/pdf>. Accessed May 5, 2014.
- Myhre S, Flora J. HIV/AIDS communication campaigns: progress and prospects. *J Health Commun.* 2000;5(suppl):29–45.
- Bertrand JT, O'Reilly K, Denison J, Anhang R, et al. Systematic review of the effectiveness of mass communication programs to change HIV/AIDS-related behaviors in developing countries. *Health Educ Res.* 2006;21(4):567–597.
- LaCroix JM, Snyder LB, Huedo-Medina TB, et al. Effectiveness of mass media interventions for HIV prevention 1986 to 2013: a meta-analysis. *J Acquir Immune Defic Syndr.* 2014;66(suppl 3):S329–S340.
- Wu Z, Luo W, Sullivan SG, et al. Evaluation of a needle social marketing strategy to control HIV among injecting drug users in china. *AIDS.* 2007; 21 Suppl 8:S115–22. doi: 10.1097/01.aids.0000304706.79541.ef [doi].
- McKee N, Bertrand J, Becker-Benton A. A paradigm shift from behavior change to social change. In: McKee N, Bertrand J, Becker-Benton A, eds. *Strategic Communication in the HIV/AIDS Epidemic.* New York, NY and New Delhi: Sage Publications Inc.; 2004:41–53.
- Airhihenbuwa C, Makinwa B, Obregon R. Towards a new communication framework for HIV/AIDS. *J Health Commun.* 2000;5(suppl): 101–111. Available at: <http://www.tandfonline.com/doi/abs/10.1080/108107300406820?journalCode=uohcm20>. Accessed May 4, 2014.
- Stoneburner R, Low-Beer D. Population-level HIV declines and behavioral risk avoidance in Uganda. *Science.* 2004;304:714–718.
- McKee N, Bertrand J, Becker-Benton A. A paradigm shift from behavior change to social change. In: McKee N, Bertrand J, Becker-Benton A, eds. *Strategic Communication in the HIV/AIDS Epidemic.* New York, NY and New Delhi: Sage Publications Inc.; 2004:48–49.
- Capacity building (and strengthening) in health communication, the missing link. In: Obregon R, Waisbord S, eds. *The Handbook of Global Health Communication.* West Sussex, United Kingdom: John Wiley and Sons Inc.; 2012:559–565.
- McKee N, Bertrand J, Becker-Benton A. Strategic communication in the fight against HIV/AIDS. In: McKee N, Bertrand J, Becker-Benton A, eds. *Strategic Communication in the HIV/AIDS Epidemic.* New York, NY and New Delhi: Sage Publications Inc.; 2004:30–31.
- Rogers E, Storey D. Communication campaigns. In: Berger C, Chafee S, eds. *Handbook of Communication Science.* London, United Kingdom: Sage Publications Inc.; 1987:817–846.
- United Nations Development Programme (UNDP). *A Synopsis of General Guidelines for Capacity Assessment and Development.* New York, NY: UNDP; 1997. Available at: <http://mirror.undp.org/magnet/cdrb/GENGUID.htm>. Accessed April 17, 2014.
- Vian T, Koseki S, Feeley G, et al. Strengthening capacity for AIDS vaccine research: analysis of the Pfizer Global Health Fellows Program and International AIDS Vaccine Initiative. *BMC Health Serv Res.* 2013; 13:378–389.
- The Organisation for Economic Co-operation and Development (OECD). *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.* Paris, France: OECD; 2008. Available at: <http://www.oecd.org/dataoecd/11/41/34428351.pdf>. Accessed April 16, 2014.
- Morgan P. The design and use of capacity development indicators. Canadian International Development Agency. 1997. Available at: <http://www.oecd.org/development/governance-development/1919953.pdf>. Accessed April 16, 2014.
- Ortiz A, Taylor P. *Learning Purposefully in Capacity Development: Why, What and When to Measure.* Paris, France: International Institute for Educational Planning; 2009. Available at: http://www.iiep.unesco.org/fileadmin/user_upload/Cap_Dev_Rethinking/pdf/Learning_purposefully.pdf. Accessed April 16, 2014.

19. Baser H, Morgan P. *Capacity, Change and Performance Study Report. Synthesis Discussion Paper Number 59B*. Brussels, Belgium: European Center for Development Policy Management; 2008. Available at: <http://siteresources.worldbank.org/INTCDRC/Resources/CapacityChangePerformanceReport.pdf>. Accessed April 16, 2014.
20. Watson D. Embracing innovative practice; monitoring and evaluating capacity and capacity development. *Capacity Org*. 2006;29. Available at: http://www.capacity.org/capacity/export/sites/capacity/documents/journal-pdfs/CAP29_0906_ME_ENG.pdf. Accessed April 16, 2014.
21. Land T, Hauk V, Baser H. *Capacity Change and Performance; Capacity Development: Between Planned Interventions and Emergent Processes: Implications for Development Cooperation. Policy Management Brief No. 22*. Brussels, Belgium: European Center for Development Policy Management; 2009. Available at: <http://cercle.lu/download/parteneriats/ECDPMcapacitychangeperformance.pdf>. Accessed April 16, 2014.
22. LaFond A, Brown L. *A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries. MEASURE evaluation Manual Series, No. 7*. Chapel Hill, NC: Carolina Population Center, University of North Carolina at Chapel Hill; 2003. Available at: <http://www.cpc.unc.edu/measure/publications/ms-03-07>. Accessed April 16, 2014.
23. Watson D. Measuring capacity development: combining the “best of two worlds” in monitoring and evaluation of capacity development. In: Ubels J, Aquaye-Baddoo NA, Fowler A, eds. *Capacity Development in Practice*. London, United Kingdom: Earthscan; 2010:239–249.
24. Allegrante J, Barry M, Airhihenbuwa C, et al. Domains of core competency, standards, and quality assurance for building global capacity in health promotion: the galway consensus conference statement. *Health Educ Behav*. 2009;36:476–482.
25. Irigoien M, Whitacre T. *Mapping Competencies for Communication for Development and Social Change: Turning Knowledge, Skills, and Attitudes into Action*. Washington, DC: The CHANGE Project; 2002. Available at: <http://www.commdev.ohio.edu/unicef4d/C4Dcompetenciesreport.pdf>. Accessed April 16, 2014.
26. *SBC Capacity Assessment Tools*. Washington, DC: C-Change, Academy for Educational Development; 2011. Available at: <http://www.c-hubonline.org/resources/sbcc-capacity-assessment-tools>. Accessed April 16, 2014.
27. AIDStar Two and the United States Agency for International Development. Organizational capacity building framework: a foundation for stronger, more sustainable HIV/AIDS programs, organizations and networks. Technical Brief Number 2. January 2011.
28. Johns Hopkins Bloomberg School of Public Health (JHU). *Assessing an Organization's Capacity in Health Communication: A Six Cs Approach*. Baltimore, MD: JHU; 2000. Available at: http://www.thehealthcompass.org/sites/default/files/strengthening_tools/CapacityAssessTool%2004Jan13.pdf. Accessed April 17, 2014.
29. Simister N, Smith R. *Monitoring and Evaluating Capacity Building: Is It Really That Difficult? Praxis Paper 23*. Oxford, United Kingdom: International NGO Training and Research Centre; 2010. Available at: <http://www.intrac.org/data/files/resources/677/Praxis-Paper-23-Monitoring-and-Evaluating-Capacity-Building-is-it-really-that-difficult.pdf>. Accessed April 16, 2014.
30. Jones H, Hearn S. *Outcome Mapping: A Realistic Alternative for Planning, Monitoring and Evaluation*. London, United Kingdom: The Overseas Development Institute; 2009. Available at: <http://www.odi.org.uk/publications/4118-outcome-mapping-realistic-planning-monitoring-evaluation>. Accessed April 16, 2014.
31. Davies R, Dart J. The “most significant change” (MSC) technique: a guide to its use. 2005. Available at: <http://www.mande.co.uk/docs/MSCGuide.pdf>. Accessed April 16, 2014.
32. Maxson M. *The “Real Book” for Story Evaluation Methods*. Washington, DC: GlobalGiving Foundation; 2010. Available at: <http://www.globalgiving.org/jcr-content/gg/landing-pages/story-tools/files/-story-real-book-2010.pdf>. Accessed April 16, 2014.
33. McKee N, Bertrand J, Becker-Benton A. Communication for social and behavior change. In: McKee N, Bertrand J, Becker-Benton A, eds. *Strategic Communication in the HIV/AIDS Epidemic*. New York, NY and New Delhi: Sage Publications Inc.; 2004:54–109.
34. Piotrow P, Kincaid DL, Rimon JG, et al. Management, implementation and monitoring. In: Piotrow PT, Kincaid DL, Rimon JG, Rinehart W, Samson K, et al. *Health Communication Lessons From Family Planning and Reproductive Health*. Westport, CT: Praeger Publications; 1997:109–129.
35. Diala C, Adelaja A, Astatke H, et al. *Health Communication Assessment of Ministries of Health and National AIDS Authorities in 6 Countries. C-Change/FHI 360*; 2012. Available at: <https://www.c-changeprogram.org/sites/default/files/MOH-NAA-Health-Communication-Assessment-FINAL.pdf>. Accessed April 17, 2014.
36. Martin R, Freimuth V. *Assessment of Capacity Strengthening in the C-Change Project. Global Health Technical Assistance Project*; 2011. Available at: [http://www.ghtechproject.com/files/1_581_C-Change_Public_Version_\(final\)_508_\(secured\)_1-31-12.pdf](http://www.ghtechproject.com/files/1_581_C-Change_Public_Version_(final)_508_(secured)_1-31-12.pdf). Accessed April 17, 2014.
37. Kiragu K, Kuria J. *The First HIV/AIDS BCC Regional Network Meeting, Results of the Participants Survey*. Population Council/Horizon Project; 2003. New York, New York.
38. HIV/AIDS Regional BCC Network. Training needs assessment East and Central Africa; 2005. Personal Communication, Charles Kakaire, MSDM, Coordinator, AfriComNet, 2014.
39. Christofides NJ, Nieuwoudt S, Usdin S, et al. A South-African university practitioner partnership to strengthen capacity in social and behavior change communication. *Glob Health Action*. 2013;6:67–74.
40. Waisbord S. When training is insufficient: reflections on capacity development in health promotion in Peru. *Health Promot Int*. 2006;21:230–237.
41. C-Change (Communication for Change). Tailored, long-term capacity strengthening with the Southern African AIDS Trust. 2012. Available at: https://www.c-changeprogram.org/sites/default/files/C-Change_CaseStudy_SAT_FINAL.pdf. Accessed April 16, 2014.
42. Rimon J, Sood S. Institutionalizing communication in international health: the USAID-Johns Hopkins University partnership. In: *The Handbook of Global Health Communication*. West Sussex, United Kingdom: John Wiley and Sons Inc.; 2012:582–207.
43. C-Change. *C-Change Final Report*. Washington, DC: C-Change/FHI360; 2013. Available at: <https://www.c-changeprogram.org/sites/default/files/C-Change-Final-Report-March2013.pdf>. Accessed April 17, 2014.
44. Holtgrave D. Resilient organizations, mobilized communities, and evidence-based HIV prevention programs: examining the influence of a national investment in HIV/AIDS capacity building. *J Public Health Manag Pract*. 2007;13(suppl):S1–S4.
45. Vega M. The CHANGE approach to capacity building assistance. *AIDS Educ Prev*. 2009;21(suppl B):137–151.
46. Millery MP, Messer PA. What is capacity building? Lessons from a national demonstration program of HIV education for social service providers. *J HIV AIDS Soc Serv*. 2005;4:79–96.
47. Nu'Man J, King W, Bhalakia A, et al. A framework for building organizational capacity integrating planning, monitoring, and evaluation. *J Public Health Manag Pract*. 2007;13(suppl):S24–S32.
48. Sheth L, Operario D, Latham N, Sheoran B. National-level capacity-building assistance model to enhance HIV prevention for Asian & Pacific Islander communities. *Journal of Public Health Management and Practice*. 2007;13:S40–S48.
49. Takahashi LM, Candelario J, Young T, Mediano E. Building capacity for HIV/AIDS prevention among Asian Pacific Islander organizations: The experience of a culturally appropriate capacity-building program in southern California. *Journal of Public Health Management and Practice*. 2007;13:S55–S63.
50. Pillsbury B, Mayer D. Women Connect! Strengthening communications to meet sexual and reproductive health challenges. *J Health Commun*. 2005;10:361–371.
51. Hoy D, Southavilay K, Chanlivong, et al. Building capacity and community resilience to HIV: a project designed, implemented, and evaluated by young Lao people. *Glob Public Health*. 2008;3:47–61.
52. Fongkaew W, Fongkaew K, Suchaxaya P. Early adolescent peer leader development in HIV prevention using youth-adult partnership with schools approach. *J Assoc Nurses AIDS Care*. 2007;2:60–71.
53. McKee N, Manoncourt E, Yoon CS, et al. Involving people, evolving behaviour: The UNICEF experience. Communication for development and social change. 2008:254.
54. Land T, Keijzer N, Kruijer A, et al. *Capacity Change and Performance; Insights and Implications for Development Cooperation. Policy Management Brief No. 21*. Brussels, Belgium: European Center for Development Policy Management; 2008. Available at: <http://cercle.lu/download/parteneriats/ECDPMcapacitystudy.pdf>. Accessed April 16, 2014.