

International Twinning and Technical Assistance Projects: How Do U.S. State HIV/AIDS Programs Benefit?

INTRODUCTION/PURPOSE

Funded by the Centers for Disease Control and Prevention Global AIDS Program (CDC/GAP), the National Alliance of State and Territorial AIDS Directors (NASTAD) links U.S. state public health programs and international HIV/AIDS programs. As part of a strengthened, unified U.S. government response to the HIV/AIDS pandemic, NASTAD engages in twinning relationships to provide peer-based technical assistance (TA) to increase HIV/AIDS program capacity of Ministries of Health (MOH) and National AIDS Control Programs (NACP) as well as national and state level councils and committees worldwide. The philosophy of NASTAD's global program is grounded in the NASTAD domestic peer-to-peer technical assistance model and a broader twinning model. U.S. state AIDS directors and their program staff are currently working, or have formerly worked, in AIDS program management positions within public health departments; these positions are analogous in program responsibility to their counterparts in national and state level AIDS programs abroad.

According to Health Canada and the Interagency Coalition on AIDS and Development (ICAD), twinning is defined as a formal, substantive collaboration between two organizations¹. "Formal" means that there is an agreement or contract, verbal or written. "Substantive" means that the interaction is significant and that it lasts for a period of time. "Collaboration" means that the two organizations work together on a specific project or to exchange information or skills.

According to the American International Health Alliance (AIHA), twinning partnerships are defined by a formal agreement held between U.S. healthcare providers and their counterparts overseas, who work collaboratively to develop a detailed work plan that outlines their goals, specifying how they will achieve them over a period of time, primarily through the exchange of information and skills.

At NASTAD, twinning is a peer-to-peer bidirectional exchange of information, training, and technical assistance between two individuals with parallel job responsibilities, two health departments, and/or two states, provinces or districts.

At NASTAD, the two entities are government entities in the U.S. and their public sector counterparts in the partnering country. The government entities usually are state AIDS directors, AIDS program staff and their corresponding health departments. This partnership is a formal collaboration. For example, NASTAD is participating in a formal twinning relationship with the Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC) based in Trinidad. NASTAD also has matched five state/municipal HIV/AIDS programs in Brazil with five state/local health department HIV/AIDS programs in the U.S. NASTAD also supports a twinning partnership between the Massachusetts Department of Health (MDPH) and the Department of Health of the Eastern Cape in South Africa.

NASTAD's Global AIDS Technical Assistance Program (GATAP) has provided TA to twenty countries since its inception in 2001. It has involved thirty U.S. states and territories and thirty-nine health department staff, specifically state AIDS directors and their staff. In addition, fifteen U.S. states have hosted delegations from seven countries.

State AIDS directors and state AIDS program staff are truly unique in that they provide "real time" TA. That is, they are speaking from the point of view of a peer, someone that is actively engaged in exactly the type of activity for which they are providing support to someone else.

BACKGROUND

NASTAD country TA teams are composed of current and former state health department professionals and NASTAD staff. Initially, each potential TA provider is given an

application to complete that assesses their skill set, language capacity, and availability for providing international TA through NASTAD's global program. Upon receipt of the application, it is entered into a database of TA providers. From this database, candidates are prioritized for interviews based on the TA category they fall under. TA categories are modeled after the CDC/GAP technical strategies and program areas. Candidates are screened on a rolling basis through a one-hour interview conducted by two NASTAD global program steering committee members and one NASTAD senior staff person. After the interview, it is determined if the candidate is eligible to enter into a pool of TA candidates. Eligible TA candidates are ranked according to the recommendation (high, medium, low) given by the interview committee and are placed in a pool of potential TA providers if successful.

With guidance from NASTAD staff, country teams communicate through email, conference calls, and team meetings to respond to a specific TA request abroad. They plan with in-country partners to design a work plan and time line which describe the goals and objectives of the TA. They also design a proposed schedule for in-country site visits, being sure to incorporate evaluation. The country team is composed of different state AIDS program staff who have strength in the particular TA area. Some team members may come from high incidence states and others may come from low incidence states. Some may be from more rural states where others may come from more urban areas. Their efforts are coordinated by a NASTAD global program staff person known as the "Country Lead" who maintains continuity of the TA by acting as a liaison between the in-country partners and the team. The Country Lead is supported by a "Country Second" who is mostly responsible for logistics coordination.

TA assignments can be either short-term or long-term. Short-term assignments are usually one-time TA assignments when TA providers respond to a specific CDC request, such as assessment of a surveillance system in Madagascar. Ethiopia is an example where the NASTAD Ethiopia Team has been providing TA for the last three years in the area of community planning, specifically in designing a community planning manual and training people in the community planning process.

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The purpose of this specific survey was to document lessons learned and benefits to domestic HIV/AIDS work from international twinning relationships and TA provided by U.S. state health department professionals through NASTAD's global program. In particular, TA providers were asked: a) what are the domestic, U.S. benefits of providing international technical assistance by state health department professionals through NASTAD's global program and b) what kind of bidirectional exchange of knowledge is occurring through NASTAD's global program?

METHODOLOGY

Forty surveys were emailed to former and current TA providers and consultants. The survey was pretested with consultants who are current NASTAD TA providers. The data source is TA providers who were health department staff at the time of onsite TA during the past three years. In all, twenty-five surveys were completed and returned by email, fax, and phone. Questions were asked on professional and personal lessons learned and application of these lessons in their health departments and HIV/AIDS work.

RESULTS

Twenty-five TA providers from nineteen states returned surveys. They had participated in providing TA to eighteen countries. Specific TA activities included assessment of HIV/AIDS program and infrastructure capacity, trainings on client-centered counseling and community planning, state model development for HIV prevention and care programs, developing an epidemiologic profile, and carrying out needs assessments. Other activities were surveillance, district planning, proposal writing, organizational development, and evaluation.



These TA providers have been at state health departments for anywhere from two to thirty years with a mean of 10.4 years. For twelve TA providers, this was their first professional international experience. Through NASTAD, they have provided technical assistance in Brazil, Botswana, Burundi, Cambodia, China, Guyana, Angola, Nigeria, Thailand, Jamaica, Trinidad, Sierra Leone, India, Ethiopia, Zimbabwe, South Africa, and Haiti. Ten TA providers have been part of more than one TA experience.

PROFESSIONAL BENEFITS/APPLICATION OF LESSONS LEARNED

With each international experience, the U.S. health department staff utilized and improved their skills in interviewing, facilitating meetings, counseling, and listening. Because these TA teams are composed of different people from different states, they improved their ability to work constructively with people who have different skills, backgrounds, and opinions. One TA provider wrote that they have a “better sense of how to be productive and creative through a group process.” They also believe that they have gained better skills in observation, information gathering, and final report writing. These cross-state teams also facilitated shared U.S. experiences between Americans engaged in global work.

Another affirmation for certain respondents was the value of working with different populations. “It reinforces my understanding that common needs can bring very diverse people to the table to find solutions,” one TA provider on the NASTAD India Team wrote.

The TA providers surveyed also wrote that they have improved language skills such as French and Portuguese. They became more aware of global HIV/AIDS funding issues, especially how domestic decisions affect international programs. “I am more aware of the linkage between U.S. policy and international public health concerns. I see the linkage between domestic politics and how these issues play out internationally with respect to funding,” wrote another TA provider.

As the NASTAD country teams have worked in politically sensitive countries, the TA providers have gained some understanding and proficiency in managing politically

sensitive interactions with powerful partners. TA providers wrote that they get a better sense of what to look for in the big picture, how it impacts the programs that they are responsible for, and how to negotiate for what is needed in such a context.

They also realized “creative ways to do more with less” after being in resource constrained countries. One TA provider said, “I am less willing to dismiss ideas without large budgets attached to them and am more determined than ever that organizations that I work with have their own evaluations.”

Another TA provider stated, “I have been more sensitized to the issue of carrying out activities without any increase in funding and making better use of our own dollars.”

They also realized the similarities in the challenges different countries face. One TA provider to Brazil said, “In Brazil, I learned that their country was dealing with the same issues and controversies on HIV reporting as the U.S. and state where I worked.”

Overall, TA providers have returned with new perspectives and guidance for the HIV/AIDS programs that they administer. “Applying what I know about state AIDS programs to another environment has forced me to take a step outside of the day-to-day routine and critically analyze what we do and why we do it. This perspective is of strategic value to our program.”

U.S. TA providers are examining epidemiologic data differently. This was one of the most cited lessons learned and there are many examples from different state health departments. One TA provider said, “In terms of the specific work I do, it’s been nice that, as a part of the TA process, I’ve had to take a fresh look at data and the description of these data for public health planning. At the health department, you can get into the habit of looking at similar analyses time and time again, so it was a useful exercise to start anew with someone else’s data and data sources and take a critical look at them. This exercise made me take a more critical look at the data we use here in our state. It also made me think more about the reasons we collect the information that we do, the need to prioritize what information gets collected because data collection is a



resource intensive process, and how to communicate clearly about why data are collected and how they can be used for health planning.”

Another TA provider said, “My on-site TA work involved creating an epidemiologic profile. My experience abroad has provided insight into on-going efforts assembling California’s own epidemiologic profile. In emphasizing the importance of data to inform policy and prevention efforts abroad, I am especially concerned that this message also is heard domestically.”

Other TA providers from different U.S. states also have returned to their health departments and have approached state HIV/AIDS data with new perspectives: in Minnesota, HIV/AIDS data has been analyzed by separating African born and African American populations after one person traveled to Nigeria. In California, HIV/AIDS data has been analyzed with respect to initiation of antiretroviral therapy and survival after one TA provider’s work with Brazil surveillance data. Also in California, local community groups requested the San Francisco Department of Health (SFDH) investigate the potential for HIV transmission across the Pacific Rim. As a result, the SFDH analyzed data from gay Asian men and found that sexual networks in San Francisco span the Pacific Ocean.

One TA provider designed protocols and survey instruments for the evaluation of surveillance systems and HIV treatment in Brazil and also used it in the development of survey protocols within his jurisdiction and for the development of a surveillance training module.

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TA providers have applied strategies used internationally to the local context in the U.S. such as “when resources are tight, focus on the highest risk,” leading them to prioritize their data collection and subsequent intervention strategies.

The Florida Department of Health and TA to the Caribbean exemplifies bidirectional sharing of knowledge. As a result of TA to the Caribbean through the NASTAD/CCNAPC twinning relationship, the Florida Department of Health gained new knowledge on improving access to services for Caribbean populations living in the U.S. and made contacts in the Caribbean to receive ongoing and accurate information about Caribbean cultures, attitudes and behaviors. The National AIDS Program Coordinators in the Caribbean and the Florida Department of Health currently are in contact with each other and exchange information regularly. Therefore, there is updated knowledge and understanding of mobile and migratory populations between Florida and the Caribbean.

Tools also are being exchanged. In Florida, an HIV/AIDS program assessment tool used by NASTAD in the Caribbean was used for the fifteen HIV/AIDS programs throughout the state of Florida to assess their capacity in HIV/AIDS programming.

As a result of TA, new groups have been set up to guide HIV planning in health departments. One India Team member wrote, “In the development of our state’s epi profile we now have a users committee to advise those collecting data and doing analysis. This should help make the results more relevant to non epidemiologists. I also have talked [about my global TA] with a number of HIV community forums here and local clients express concern for others and increased gratitude at their relative good fortune to be in the U.S.”

Minnesota formed an African Community HIV Advisory Group to the state planning group. The state’s program website contains information in Amharic and Somali. The Georgia Department of Human Resources Public Health Division followed Minnesota’s lead and also formed an HIV/AIDS Immigrant/Refugee Advisory Board to serve as a liaison between the state’s ethnic communities and the public health division.

The state of Washington gained information about behavior change communication strategies from their participation on the India Team. “Participation in the development of the epidemiologic profile in India has given me a fresh perspective for presentation and use of data in planning HIV prevention and care services here



in Washington. Also, discussions about risk groups, particularly men who have sex with men and who don't identify as such, have helped me to think about what we may learn from our partners in India in terms of prevention messages and strategies for this population.”

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Other TA providers wrote that they have applied to their own work some of the recommendations they have made to others, especially regarding presentation of data in the epidemiologic profile.

The Massachusetts Department of Public Health (MDPH) is involved in a twinning partnership with the Department of Health of the Eastern Cape in South Africa. Massachusetts has documented the following benefits to their public health and clinical programs in Massachusetts: alternative models of community mobilization in public health campaigns, alternative systems of protocol-driven clinical care in low resource areas, and innovative low literacy public health campaign materials.

CULTURAL COMPETENCE

According to those surveyed, working globally has given state AIDS program staff an increased understanding of immigration and refugee issues and the demographic impact of these groups in the U.S.

State AIDS program staff participating in the NASTAD global program have increased their cultural competency and have taken this into consideration in the design of services. “I’m more aware of issues surrounding the depth and strength of the stigma associated with HIV and how it may come into play with African-born immigrants to the U.S.”

TA providers have broadened their sense of connection with immigrant residents in their states. “I have used information about the cultural and environmental context of AIDS in Africa to help explain and highlight HIV prevention and care needs of Africans in Minnesota—with local advocacy groups, with legislators, and with other government agencies.” They also have shared educational materials from Ethiopia in Amharic with outreach workers in the Ethiopian community in Minnesota and may order such materials from Ethiopia for ongoing use.

TA providers have become more attentive to cultural issues by working globally. “Going on my first trip to Ethiopia I was reminded of the many cultural issues we take for granted here in U.S. We assume that just because an individual is living in the U.S., they are part of the ‘U.S. culture’ forgetting that there are hundreds of ‘U.S. cultures.’ This has allowed me to institute changes to our prevention and care programs that address the varied cultures that are present and help to have my staff work with the understanding that the programs we are funded to provide need to be exceptionally aware of and sensitive toward the culture of the individual and group,” one TA provider from Delaware wrote.

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Another TA provider from Texas said, “I have learned how we all are much more alike than different. That caring and demonstrated commitment goes a long way in helping you accomplish different tasks.”



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TA providers admitted to having a heightened awareness of the value of having service providers from the culture of the populations that are being targeted, and also recognizing the use of cultural events as an opportunity to address HIV issues.

“I have learned about the customs and practices of the Caribbean people. It helps you make decisions in the office. We ordered \$10,000 of HIV/AIDS literature, and looking at the literature, I asked where is the Haitian literature? I realized that when that same piece of paper is in their language, it becomes more valuable,” one Caribbean Team member said.

Finally, one India and Nigeria Team member said, “I have deepened my understanding of how stigma and discrimination can impede access to services.”

PERSONAL BENEFITS

Providing international TA has affected the TA providers surveyed on a personal level as well. For example, “All these experiences from Haiti make me a better public health practitioner and researcher,” one TA provider said to summarize his experience.

They also have been moved by professionals they meet in country. “Certainly the opportunity to travel to and learn about a part of the world with which I was very unfamiliar has been very valuable. Working with professionals in another country who have, many times, very difficult working conditions and yet continue to be passionate and hopeful about their work and their cause has been inspirational. It’s also put into perspective what the term ‘resource constrained’ really means... It’s been important to me to be able to do something constructive, as well as represent myself as an individual who is interested in being a good global citizen.”

Another stated, “Preparing for my trip to Brazil, I read a history book about Brazil and came across Bossa Nova music which I really didn’t previously know about.

Bossa Nova music had such an affect on me that I took guitar lessons for awhile, which is saying a lot given that I never in my life had played music or had any musical aptitude.”

As part of NASTAD’s global program, TA providers have met peers and colleagues allowing them to have collegial, mentoring relationships with both other members on their country teams *and* counterparts abroad. It has reenergized them professionally and has given them renewed enthusiasm, commitment, motivation and excitement. One TA provider said, “It reenergizes you. You meet other AIDS directors and other professionals in other countries. It becomes pretty wearing on your work after being in the health department for a long time. This opportunity allows me to look at things differently when you see the other perspective.”

DIFFUSION OF INFORMATION

TA providers have shared their experiences with different audiences. They have given presentations about their TA experience specifically about the country they worked in and its HIV/AIDS epidemic to their health department staff. The majority have presented their work to their health departments through brown bags and staff meetings. Others have spoken at different venues. “I have spoken about it at planning council and consortia meetings as well as with my friends and relatives,” one TA provider said. Another TA provider gave a presentation about her international experience to a local women’s organization and gave a talk to a local board of health.

These TA experiences have allowed people to become global citizens within various educational forums. “I’ve done a couple of presentations at local high schools about public health in general and also the work that I’ve been doing in India. Last month I was asked to do a presentation and teach in a couple of anthropology classes at the college where I graduated from)about my work in India.” Other TA providers have incorporated their work in their teaching at other universities, schools of medicine, residency training programs, and schools of public health.



As a result of participating in international TA, TA providers have realized the interconnectedness of domestic and global public health. “This work has helped maintain and increase my interest and challenge of working in HIV after ten years in the U.S. It has reinforced in me the concept of interconnectedness in public health. This is increasingly important in communicable disease considerations.”

A symposium was convened in March 2003 by NASTAD in Washington, D.C. to share some of the initial lessons learned at “home” by U.S. states involved with the global pandemic. The purpose also was to demonstrate that state health departments have much to offer in the nation’s global initiatives, and that global activities have an impact on domestic efforts. The primary lesson then and now is that the U.S. is part of the global pandemic, U.S. AIDS directors have experience to share, there are lessons to learn right here at home, and our borders are permeable.

DOMESTIC TA

NASTAD members also have the opportunity to provide TA to other U.S. states through NASTAD’s *domestic* peer TA program. The TA delivered through the domestic program is varied, covering many topics such as community planning, policy and program development, interventions for communities of color, rapid testing, counseling/testing/referral, viral hepatitis integration, general prevention services, and youth. Another type of domestic TA is when current members mentor new AIDS directors to help them become acclimated to their new positions and navigate the state and

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federal bureaucracy. In this survey, it was asked how providing international TA affected their time and ability in providing domestic TA through NASTAD. Those who have provided domestic and global TA said that it has enriched their ability to provide domestic TA.

One TA provider who had provided TA in India and Nigeria said, “It has reinforced that peers can often be the best providers not just based on technology or content, but also due to the affinity that is almost automatically shared by someone in the same position or with similar challenges and responsibilities in the real world as opposed to the drop-in consultant world.”

For those who do currently provide domestic TA, they felt that providing international TA positively affected their ability to provide domestic TA. “I’ve provided domestic TA for a number of years related to using epidemiologic data for HIV prevention planning. I think more than affecting my ability to provide the TA domestically, my participation in GATAP has really boosted my enthusiasm for doing it [domestically].”

Another TA provider stated, “I never provided domestic TA, but my experience in GATAP definitely increased my utility for domestic TA. I now have a broader scope and more in-depth knowledge of the interaction of the different components of an HIV/AIDS program.”

CONCLUSION

As many NASTAD TA providers are on teams, they gain new skills in team management, group dynamics, and interpersonal and intercultural communication. TA providers learn about how to conduct business in international and cross-cultural settings with needed cultural diplomacy skills. They interact and work side-by-side with professionals from national and state HIV/AIDS programs in other countries on a true peer-to-peer basis and share struggles and successes. TA providers form mentoring relationships with one another and learn from each other about work in their respective states. State health department staff are reenergized and revitalized for their work domestically. Many of those surveyed stated that they have broadened their perspectives on international public health, programs, policy and funding, specifically global HIV/AIDS issues.



In summary, all twenty-five respondents said that they would be willing to provide TA again. One TA provider wrote, “It is one of the most meaningful experiences of my professional and personal life.” The majority did respond that being involved in the NASTAD global program has been very enriching and rewarding.

TA providers felt that this work was valuable. “In spite of the arguments made regarding the diversion of scarce resources from domestic programs to international ones, I strongly believe that this type of international collaboration is critically important at many levels and should not be in any way diminished.”

The following quotes represent how TA providers feel about their TA experience:

“I do appreciate the goals of our work and believe that directed public health capacity building (as well as policy capacity building) is critical to successfully address of HIV.”

“I have thoroughly enjoyed opportunities that this TA has afforded me and I feel privileged to have been a part of this effort and hope that we are able to continue into the future.”

In conclusion, state AIDS program staff engaged in twinning and international technical assistance activities have brought concrete lessons learned home to their HIV/AIDS work here in the U.S. Also, state health

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departments gain recognition nationally and internationally as vital players in the U.S. government response to global HIV/AIDS. U.S. state health departments learn and apply new programmatic strategies, specifically for data collection and analysis; therefore there is improved planning and implementation of U.S. state health department AIDS programs. They have realized how to “do more with less.” State AIDS programs and NASTAD provide true peers to their colleagues abroad, and gain equally from this exchange.

For more information on the NASTAD global program please call (202) 434 8090 or visit www.nastad.org.

¹ Definition from: “Beyond Our Borders: A Guide to Twinning for HIV/AIDS Organizations,” Health Canada and Interagency Coalition on AIDS and Development, Ottawa, Canada, 1999.