



Evaluating an HIV and AIDS Community Training Partnership Program in five diamond mining communities in South Africa

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ABSTRACT

In 2006, De Beers Consolidated Diamond Mines in South Africa entered into a partnership, with the Soul City Institute for Health and Development Communications to implement an HIV and AIDS Community Training Partnership Program (CTPP), initially in five diamond mining areas in three provinces of South Africa. The aim of CTPP was to improve HIV knowledge and to contribute to positive behavior changes in the targeted populations. This paper describes the evaluation of the CTPP, one year after implementation. The evaluation combined qualitative interviews with key informants and trainers and a post-intervention survey of 142 community members.

The successes of the CTPP included capacity building of trainers through an innovative training approach and HIV and AIDS knowledge transfer to community trainers and targeted communities in remote mining towns. The Soul City edutainment brand is popular and emerged as a major reason for success. Challenges included insufficient attention paid to contextual factors, resource constraints and the lack of a monitoring and evaluation framework. Independent evaluations are useful to strengthen program implementation. In remote areas and resource constraint settings, partnerships between non-governmental organisations and corporations may be required for successful community HIV and AIDS initiatives.

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1. Introduction

South Africa has the largest number of HIV infections in the world, with an estimated 5.5 million people living with HIV (UNAIDS, 2006; UNAIDS & WHO, 2007). Mining is one of the most important sectors of the South African economy (Baxter in Williams et al., 2000) and is also one of the worst affected sectors by the HIV epidemic (Campbell & Williams, 1999; Williams et al., 2000). Early estimates within the mining industry placed HIV infection prevalence between 20% and 30%, while the mean prevalence among miners was 29% in Carletonville, the largest gold mining complex in the world (Williams et al., 2000). In 2004, seroprevalence studies and ongoing voluntary counseling and testing (VCT) campaigns carried out at De Beers diamond mines in South

Africa, estimated an HIV prevalence of 10% among its South African employees (De Beers, 2006). Knowledge, Attitudes and Practice (KAP) studies have shown several high-risk behaviors, including low levels of condom use in high risk sexual encounters and interaction with commercial sex workers (De Beers, 2006), thus confirming the findings of other KAP studies in mining towns (Auvert et al., 2001; Zuma, Gouws, Williams, & Lurie, 2003; Zuma et al., 2005).

In consort with mining sector developments and in recognition of the threat that the epidemic poses to its operations, De Beers has over the years instituted a number of HIV and AIDS prevention, treatment and care programs to reduce and mitigate the impact of the epidemic among its employees (Bolton, 2008; De Beers, 2006; Smart, 2004; Williams et al., 2000). The De Beers Workplace Program was launched in 2000, initially targeting employees and their immediate families (De Beers, 2006). The company is aware of the devastating impact of the HIV epidemic on communities in which they operate, as many of the workers are members of the surrounding, predominantly rural communities. As part of its corporate social investment program, De Beers Consolidated Mines initially committed R10 million a year (about US\$ 1.2 million) for at least three years, to a community-based HIV/AIDS Program (De

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Beers & Soul City, no date). The intention of the De Beers Community HIV/AIDS Program is, where possible, to extend what has already been implemented in the workplace into the communities, to facilitate the implementation of new programs, and to support the efforts of Government (De Beers, 2006). De Beers intends to build a comprehensive HIV and AIDS Community Program which focuses on the key areas of prevention, education and training while facilitating and supporting treatment, care and support for those infected and affected.

The first major partnership announced as part of the De Beers Community HIV/AIDS Program was with the Soul City Institute for Health and Development Communications (IHDC) (Soul City, 2007). Soul City is a multi-media 'edutainment' and development communication program in operation since 1992 (Soul City, 2007). The Program combines radio, television, newspapers and magazines to impart messages and to advocate on healthy public policy. Evaluations done since the inception of Soul City IHDC have shown repeatedly that Soul City has had a positive impact on health literacy and that it contributes positively in the fight against HIV and AIDS (Goldstein, Japhet, Usdin, & Scheepers, 2004; Goldstein, Usdin, Scheepers, & Japhet, 2005; Scheepers et al., 2004).

This paper describes the evaluation of the Soul City/De Beers HIV and AIDS Community Training Partnership Program (CTPP) implemented in five diamond mining communities in three provinces of South Africa. The objectives of the evaluation were to determine: the main activities of the community trainers (peer educators) and the barriers and facilitators to their actions; impact of the training program on the community trainers; and impact that the training has had (if any) on the surrounding mining communities. In the first part of the paper, we describe the Soul City CTPP intervention, the cascade model used for training and the characteristics of the study population. In the second section of the paper, we briefly describe the evaluation approach and methods. This is followed by the presentation of the key results of the evaluation, including the factors influencing the implementation of the CTPP. The concluding section discusses the evaluation findings and contains the key lessons learnt.

2. Background

2.1. The Community Training Partnership Program (CTPP)

The Soul City IHDC uses multi-media to achieve a positive impact on health and social outcomes (Goldstein et al., 2004, 2005; Scheepers et al., 2004). The Soul City edutainment program consists of a prime time television drama series per topic that is complemented by daily radio drama in nine South African languages (Goldstein et al., 2004). Colour booklets are produced for each series to give more detailed health information and the characters from the television series are depicted in illustrations in the booklets. The booklets are distributed nationally through newspapers. The popularity, penetration and power of the edutainment program have given rise to amongst others: educational packages based on the radio and television dramas; life skills materials for schools; "Soul Buddys", a multi-media program for children aged 8–12 and a Master Trainers (or Train the trainers) Program (Goldstein et al., 2004).

The Master's Trainers Program, which is supported by De Beers, aims to contribute to positive behavior change in targeted populations, both through complementing the brand of the popular television and radio series and through training of community trainers (Soul City, 2006a). The specific objectives of the CTPP are to: *train master trainers attached to partner non-governmental organizations (NGOs) who then train community trainers in the diamond mining communities; educate communities*

around De Beers diamond mines about HIV and AIDS; and distribute the Soul City Materials.

Thus, as part of the CTPP, Soul City IHDC trains master trainers in its partner NGOs in a *cascade model* of training, using a training pack based on the Soul City television series (Soul City, 2006b). The partners are NGOs in each of the nine South African provinces that are selected and contracted by Soul City. The Soul City training pack consists of four workbooks: Workbook 1: Living positively with HIV and AIDS; Workbook 2: Women, Children and HIV and AIDS; Workbook 3: You and your anti-retroviral treatment and Workbook 4: Counseling skills for non-counselors (Soul City, 2006c). These workbooks are complemented by posters; comic books and interactive workshop discussions. The master trainers integrate the training materials and training into their activities; work in a partnership with Soul City both to distribute the HIV and AIDS materials and to cascade the training down to community trainers. The community trainers are envisaged as peer educators whose task is to impart various aspects of HIV and AIDS to communities in the mining areas.

In February 2007, Soul City and De Beers requested a qualitative evaluation of the process and impact of the CTPP in the five mining areas, in order to inform future programs and/or activities. The evaluation was done one year after the CTPP was implemented in the diamond mining towns. At the time of the evaluation, 883 community members had reportedly been reached by the CTPP. Fig. 1 illustrates the cascade model of Soul City training in the HIV and AIDS CTPP with De Beers Diamond Mines.

2.2. Study setting

The populations of interest were those communities living in the towns surrounding the diamond mines in Gauteng, Limpopo and Northern Cape provinces and where the CTPP had been implemented. All the study areas were remote, predominantly rural, diamond mining towns, with the population per town ranging from 6 500 to 105 000. The main source of household income is from mining, and common challenges include poverty; high unemployment rates; dependency on social grants and large distances to the nearest referral hospital (De Beers, 2006).

2.3. Approach and methods

The CTPP evaluation consisted of four study components: interviews with *key informants*; an assessment of the work and activities of the *master trainers* working in the NGO training partners; an assessment of the CTPP impact on the *community trainers* and an assessment of the CTPP impact on the *targeted communities* (Table 1). Permission for conducting the evaluation was obtained from the South African Human Sciences Research Council's ethics committee.

Key informants were selected purposively and included four individuals from the Soul City IHDC who have been involved in the partnership program since its inception and who have trained the master trainers; two managers from De Beers/Tshikululu who have been involved in the conceptualization and/or implementation of the program; five community leaders from three of the mining communities where the evaluation was conducted and who had prior exposure to the CTPP and two HIV workplace coordinators from De Beers mines. The community leaders interviewed consisted of a town mayor; community development worker, a school principal; an area coordinator of pre-school education; and the head of a para-legal advice centre. One focus group discussion was also held with a group of eight HIV and AIDS activists involved in one small mining town. These activists were community members involved in voluntary HIV advocacy activities, ranging from community awareness to provision of para-legal advice on

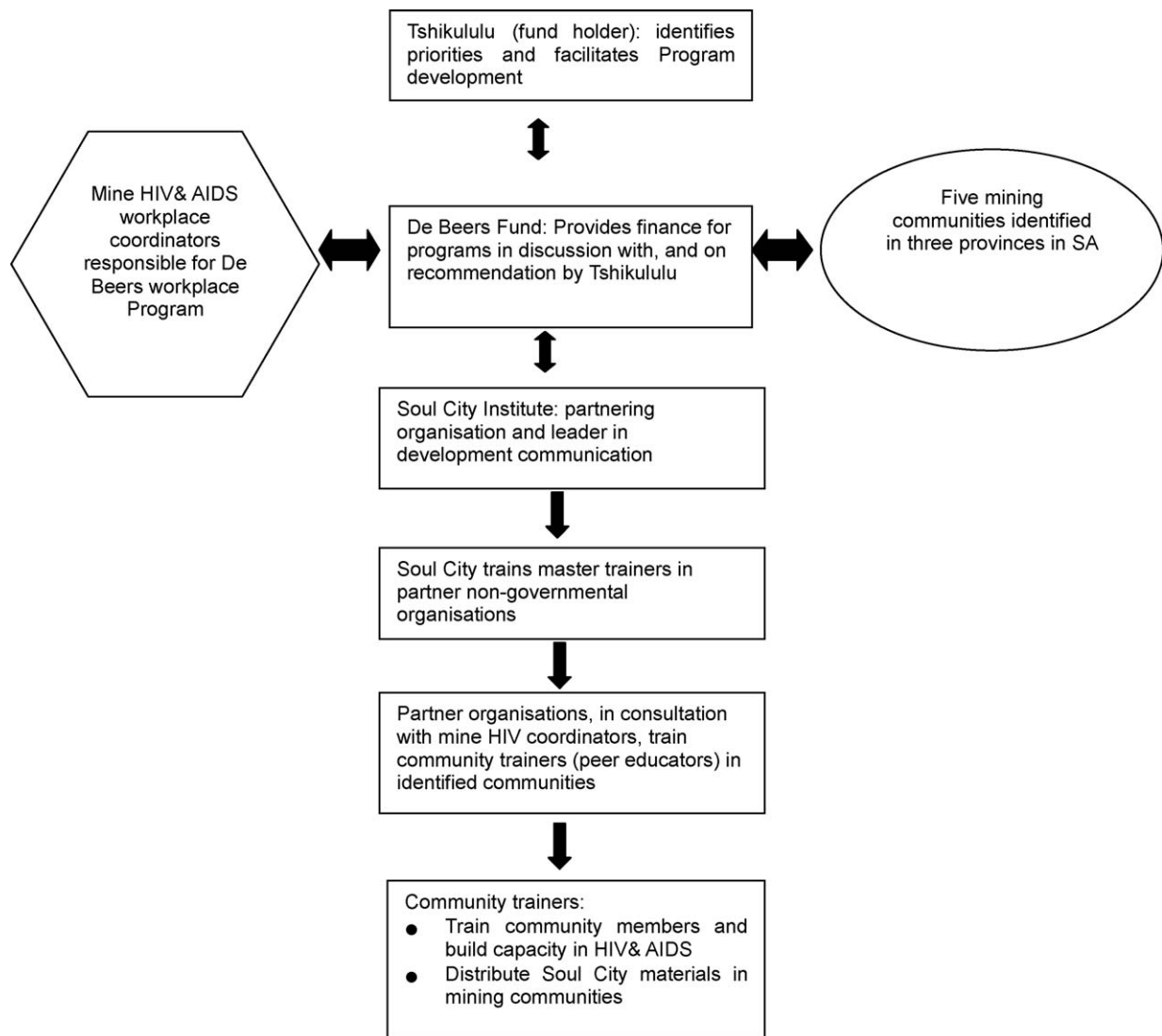


Fig. 1. The HIV&AIDS CTPP framework used in the five diamond mining communities.

human rights. The key informants were interviewed with a semi-structured interview schedule after informed consent had been obtained. The schedule focused on: perceptions/views of the CTPP; program implementation, including successes and limitations; perceptions of the impact of the program on trainers and surrounding communities; recommendations for program improvement and/or future development.

The *master trainers* from each of the partner NGOs ($n = 9$), trained by Soul City and with access to the Soul City materials for their training courses, were interviewed. A semi-structured questionnaire was used for the interview after informed consent had been obtained. The questionnaire focused on: biographical information of the master trainers; involvement in the CTPP; achievements/successes and challenges; training outputs and approaches used; availability of materials and monitoring and evaluation of the CTPP. The records of training reports submitted by the master trainers to Soul City were also reviewed and focused on: the nature of the training done; number of participants; training approaches used; training content; attendance register; evaluation by training participants; and any other relevant information.

All the 12 *community trainers*, i.e. ordinary community members who had undergone training as part of the CTPP, were

interviewed, using a semi-structured questionnaire. The questionnaire focused on: role and activities in the CTPP; training received as part of CTPP; degree of implementation of the CTPP, including facilitating and constraining factors and the perceived reasons for these; access to, and availability of, the Soul City materials for training activities; HIV and AIDS and condoms knowledge and attitudes; monitoring and evaluation of the CTPP and recommendations for future CTPP activities.

The interviews with key informants, the master and community trainers were conducted by members of the research team.

Community members were selected purposively and included ordinary members of the mining community who had participated in any HIV and AIDS awareness or education activities conducted as part of the CTPP. These individuals excluded key informants, master and community trainers. Participants were interviewed by trained interviewers in the language of their choice at a suitable, convenient venue and the interviews were checked by members of the research team. A cumulative total of 142 individual interviews were conducted in five communities living close to the five diamond mines in three provinces (29% in Gauteng, 13% in Northern Cape and 57% in Limpopo), thus reaching 16% of the total mining community members reportedly exposed to the CTPP. The individual community interviews were

Table 1
HIV and AIDS Community Training Partnership Program Evaluation Components.

No.	Target of evaluation	Objectives	Methods	Instruments
1	Key informants: • Soul City • De Beers • Community leaders • Mine HIV coordinators	Assess views and opinions on CTPP and recommendations for program improvement	• Interviews with 13 key informants; • One focus group discussion: eight participants	Semi-structured interview schedule
2	Master trainers in NGO training partners	Assess work and activities and barriers and enablers/facilitators to their actions	• Record review • Interviews with nine master trainers	Checklist Semi-structured questionnaire
3	Community trainers	Assess activities of community trainers Determine impact on community trainers	• Interviews with 12 community trainers	Semi-structured questionnaire
4	Community impact of program	Determine impact on the surrounding community	• Interviews with 142 community members post-CTPP exposure	Semi-structured questionnaire

Table 2
Demographic characteristics of participants.

Participants	Sex		Age	Education
	Male	Female		
13 Key informants	8	5	25–59	Not ascertained
FGD (eight participants)	1	7	18–49	Not ascertained
Nine master trainers	7	2	25–49	Grade 12 and above
12 community trainers	4	8	18–24 (n=4) 25–59 (n=8)	Grade 8–11 (n=3) Grade 12 and above (n=9)
142 community members	26	116	18–24 (n=33) 25–59 (n=111)	Grade 7 or less (n=14) Grade 8–11 (n=63) Grade 12 and above (n=61)

conducted with a semi-structured questionnaire that was previously translated into four other South African languages, after informed consent had been obtained. Questions were developed from the Soul City workbooks, posters and comics and covered the following areas: exposure to Soul City HIV/AIDS materials and their opinions of these; what they learned from the four workbooks, including likes and dislikes; personal and relationship changes since exposure to the Soul City workbooks; knowledge retained by community members (HIV and AIDS: prevention, care, support, anti-stigmatization); risk perception; sexual behavior, VCT; and views on anti-retroviral treatment (ART); suggestions or recommendations for improving the training program.

The demographic characteristics of the participants from the various groups interviewed are shown in Table 2.

2.4. Data analysis

The qualitative data were transcribed verbatim and analyzed using thematic content analysis (Kruger, 1994; Mostyn, 1985). The steps consisted of open coding using the respondent's own words and phrases and without preconceived notions or classification. Two members of the research team used five completed interviews to develop initial categories independently. These categories were then discussed by all members of the research team, and agreement reached. Once the categories were agreed to, the information from all the interviews was then coded and various themes identified.

The quantitative information was coded and analyzed using SPSS version 14. Only basic descriptive analysis was done.

3. Results

The successes of the CTPP included capacity building of trainers through an innovative training approach and HIV and AIDS

knowledge transfer to community trainers and to targeted communities in remote mining towns. The Soul City edutainment brand emerged as a major reason for success. Reported challenges and constraints to the CTPP implementation included insufficient resources, high turnover of community trainers and low coverage of certain target groups (e.g. men, youth). The absence of a monitoring and evaluation framework made it difficult to evaluate the quality and quantity of work performance of the master and/or community trainers or to do comparisons across the five mining towns.

3.1. HIV and AIDS knowledge transfer to community trainers and to mining communities

All the 12 community trainers were exposed to the first three Soul City workbooks, and rated the training they had received as excellent or good, although half indicated the need for additional training. Community trainers were of the opinion that the CTPP has benefited them at a personal level:

"It has empowered me with facilitation skills. It has also helped me convey the message on HIV/AIDS to my friends and the community at large. The community has been very receptive to the program. They have provided assistance in various ways, e.g. offered a training venue." (Gauteng community trainer 1)

"I lacked information on ARVs but since the training my level of knowledge and confidence on this subject has improved a lot." (Limpopo community trainer 1)

Overall community trainers interviewed had adequate knowledge on HIV and AIDS, and had a good knowledge of ways to prevent HIV infection. They displayed largely positive attitudes towards People Living with HIV (PLHIV). However, one quarter (3/12) agreed with a statement that suggested discrimination against PLHIV, while one third (4/12) agreed with a statement suggesting that gay people deserve to get HIV. The community trainers also

Table 3
South African mining communities' knowledge on HIV and AIDS.^a

Basic knowledge	Correct (n = 142)	%
HIV can be transmitted by infected needles	140	99
People can protect themselves from HIV by using a condom correctly every time they have sex	137	96
The only way to know if you have the HIV virus is to have an HIV test	136	96
You can get HIV through contact with infected blood	136	96
A person can get HIV by using a cup or plate that has been used by a person with HIV/AIDS	135	95
HIV can be transmitted from mother to child through breast feeding	135	95
Having sex with a disabled or old woman can cure HIV and AIDS	135	95
People who are HIV positive can often live for a long time if they live in a healthy way	134	94
ART is not a cure for AIDS, but can help people with AIDS to live a longer healthier life	134	94
HIV and AIDS are almost always passed on through unprotected sex	133	94
The transmission of HIV can be prevented from mother to baby	132	93
Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV	129	91
HIV can be spread by mosquitoes	128	90
Having sex with more than one partner can increase a person's chance of being infected with HIV	124	87
One can get HIV through witchcraft	124	87
A woman cannot get HIV if she has sex during menstruation	123	87
Having sex with a virgin can cure HIV/AIDS	123	87
There is a vaccine that can stop adults from getting HIV	118	83
There is no cure for AIDS	97	68
You cannot get HIV and AIDS from hugging or kissing	95	67
A person cannot get infected with HIV if he/she has only one partner	94	66
You cannot tell if someone is HIV positive just by looking at them	91	64

^a Options were: true, false and don't know. Don't know responses were grouped under incorrect responses.

had good knowledge on condoms as a barrier to sexually transmitted infections (STIs) and HIV but they had knowledge gaps on the correct use of condoms. For example only 1 out of 12 community trainers responded correctly on whether Vaseline could be used as a lubricant or whether condoms could be re-used.

The majority of community members interviewed were from three mining areas in two provinces of Limpopo and Gauteng (87%); three in four were above 25 years old, four in five were female, nine in ten were Black African and almost nine in ten had Grade 8 or more formal education.

All respondents had attended the Soul City/De Beers HIV and AIDS training. Around 90% of the participants had been exposed to workbooks 1–3 and had seen Soul City posters, and about two-thirds were aware of the comic books used and the counseling workbook. The majority of community participants had also been exposed to Soul City television series (97%) and to the radio messages (84%). In response to an open ended question on how the Soul City workbooks changed their own behavior or their relationship with others, communities' reported behavior changes since exposure to the CTPP related to personal changes (e.g. faithfulness, condom use) and relationships to others (e.g. no discrimination).

The majority of community respondents gave correct responses on most of the items in the HIV and AIDS knowledge index (Table 3). However, as can be seen from Table 3, there were some misconceptions on whether it was possible to tell if someone is HIV positive just by looking at them; whether a person can get infected with HIV if he/she has only one partner; whether one can get HIV from hugging or kissing and whether there is a cure for AIDS.

Respondents were asked to indicate agreement or disagreement with statements that measured stigma elements addressed in the Soul City workbooks. Almost all respondents agreed to respecting PLHIV (99%), respecting the privacy of others (99%) and maintaining confidentiality about another person's HIV status (98%). However, 15% (22/142) agreed with a statement suggesting that HIV is a punishment from God, 19% (27/142) agreed with a statement suggesting discrimination against PLHIV; while 37% (52/142) agreed with a statement that gay people deserve to get HIV. Respondents were also asked to rate how comfortable they were in interacting with PLHIV, with the range of completely comfortable to not at all comfortable. Almost 94% said they feel

completely comfortable being in the same room with someone with AIDS, while 62% felt completely comfortable washing and dressing the sores of a relative with AIDS.

When asked about sexual behavior change, most respondents (81%) had been sexually active in the past three months, 27% said they had had two or more sexual partners in the past three months and 29% had had sex with a non-regular partner in the past three months. Almost two in three indicated that they had used a condom at last sexual encounter, while 23% had not used a condom with a non-regular partner at last sexual encounter (Table 4).

3.2. The Soul City brand played a major role in the CTPP successes

Interviews with key informants, master trainers and community trainers revealed that the well-known Soul City brand, coupled with the Soul City training materials and training approach stood out as the key reasons for the reported achievements and successes. The *Soul City brand* is associated with a broader development approach and with giving hope to people, as can be seen from the following quotes:

"The [TV] stars were invited to two mining sites. It was well received by the communities because Soul City was a well known brand; particularly because we brought TV stars like sister Bettina

Table 4
Reported sexual behavior of mining town respondents.

Behavior element	Number	%
Had sex in the past 3 months	115/142	81
Number of sexual partners during the last 3 months?		
1	84/115	73
2 or more	31/115	27
Non-regular partners (exclude regular spouses or live-in partner) in the past 3 months	33/115	29
Have you ever used a condom?	109/142	77
Did you or your partner use a condom the last time you had sex?	89/142	63
Did you use a condom the last time you had sex with a non-regular partner? ^a	51/66	77

^a Only 66 responses to this question.

to the launch of the Program and we had very good community turn out.” (Key informant, Gauteng)

“I would say the [Soul City] brand has played a major role; people want to be a part of Soul City as it makes changes and differences in other people’s lives.” (Master trainer 2, Northern Cape)

“People trust the information in the books because it is from Soul City. Previously, there were very few people that trusted what I had to share with them without the books.” (Community trainer 3, Limpopo)

The reported successes of the CTPP included value added to existing HIV and AIDS initiatives and facilitation of new initiatives. Master trainers reported that communities have formed support groups and/or established their own organizations. Some key informants pointed out that some community trainers have been able to secure employment as a result of their involvement in the program. Others pointed to the intrinsic personal benefits, such as increased empowerment, self-confidence and capacity building among community trainers. According to one key informant:

“The trainers’ reputation and standing in the target communities has been boosted by the training and association with Soul City and with the program. Most of the trainers were already doing work in their communities: the association with Soul City has enhanced their profile. The training has improved the trainers’ self-confidence and has inspired them to think bigger, for example, working with more established NGOs or the government.”

Key informants reported that the CTPP implementation in remote, predominantly rural mining towns was a success, as it is often difficult to reach these areas and that the CTPP has strengthened the relationships between mines and communities. The CTPP has also facilitated the establishment of partnerships and the involvement of all relevant stakeholders i.e. private sector, NGOs, government and communities, in the planning and roll out of the program. Lastly, it was pointed out that the CTPP has assisted people to confront issues of personal significance.

“One of our biggest achievements was that we were able to minimize the stigma attached to HIV/AIDS in the communities, and we achieved this by helping people to gain more knowledge and understanding on HIV/AIDS.” (Master trainer 2, Limpopo)

“I have seen a lot of personal changes from the training participants e.g. some have gone for testing. Some have shown commitment to serving their communities and to bring change in their communities.” (Master trainer 4, Gauteng)

3.3. Insufficient attention to the contextual factors in the mining town

Key respondents indicated that the CTPP was seen as an intervention whose main objective was to increase the levels of community awareness on the seriousness of HIV and AIDS, and which ultimately should result in positive behavior change and adoption of safer sexual practices. The desired outcome was a reduction in the high levels of HIV infection in these target communities.

Contextual factors that were faced by the CTPP in the five target areas included common challenges such as high levels of unemployment, poverty, violence (especially sexual violence) and alcohol abuse. There were also differences across the five mining towns, e.g. in certain towns on major transport routes there

was reportedly much higher levels of commercial sex work, whereas in other areas HIV was attributed to bewitchment, or levels of stigma were very high. It was unclear how the contextual issues and differences across the five mining towns had been taken into account in the CTPP design or in its implementation. These broader issues could also not be addressed by the training program, resulting in reported dissipation of some of the initial excitement and enthusiasm about the CTPP. In addition, although a number of stakeholders such as churches, the mayors, schools and local community organizations were involved in implementation, there was little, if any, involvement by the target communities in the development of the program. Key informants commented as follows:

“De Beers bought into an existing program. By the time the program was introduced to these communities it had already been developed; there was no involvement by the target communities in the development of the program.” (Key informant, Gauteng)

“Soul City and De Beers drove implementation and the target communities played a minor role. The project managers within De Beers and Tshikululu [fund holder] were involved in providing strategic direction. Soul City would develop the training package and train the master trainers in both facilitation and education around the topics of the training package. The master trainers would then train the second tier (i.e. community trainers) who then in turn cascade the training down to the community.” (Key informant, Northern Cape)

In many of the towns, basic HIV knowledge was very low, and this necessitated a revision and adaptation of the training program. Consequently, the cascade model did not work in practice and hence the relationship between master trainers, community trainers and community members was blurred. Thus, instead of implementing the ‘train-the-trainer’ program, the approach had to be revised to provide basic information on HIV and AIDS to the community trainers. Hence, the master trainers ended up providing HIV training to both community trainers and to community members, resulting in fewer people being trained or reached as originally anticipated.

Another structural issue cited was difficulties in accessing quality public health care services, especially VCT services in some of the mining towns, thus off-setting the potential impact of the CTPP.

“There is lack of professionalism amongst local health workers, confidentiality and privacy are not adhered to, patient’s info and medical records are always compromised. Hence many people saw De Beers as an alternative for accessing VCT services. People do not feel comfortable to go for HIV testing and counseling [to the public health services] because their identity is compromised, visitors or other patients are able to tell if you’ve gone for either testing or counseling. They also look at your face after testing, and can see if you are positive, because you look bad.” (Focus group discussion, Northern Cape)

3.4. Challenges and constraints to the CTPP implementation

Among the CTPP implementation challenges was the high turnover of community trainers (peer educators). The latter was due to the lack of financial incentives and financial support for community trainers, as it was seen as a voluntary activity. Hence once the community trainers got employment they pulled out and because it was felt that most people were breadwinners and could not do “voluntary work forever.” This challenge was exacerbated by the lack of a clear selection process of these community trainers,

inadequate situation analysis prior to CTPP implementation and because of the lack of basic HIV knowledge that constrained the work of the CTPP in the early stages. One of the respondents described it as follows:

“We have assumed that there was basic knowledge of HIV and AIDS to train trainers. In fact, we found that in the same cases, there was little knowledge, so we started with the provision of basic HIV and AIDS education training before training them as trainers.” (Key informant, Gauteng)

A further problem was that the partner NGOs with master trainers responsible for community training were located outside the targeted communities, and were often viewed as outsiders. In one of the areas, there was a change in partner NGO, allegedly unknown to the community trainers. Master trainers commented that it had not been easy to get the stakeholders together or to get teachers to attend the workshops.

Financial and infrastructural resource constraints were additional problems. There was lack of suitable training and meeting facilities in some target communities and the remoteness and distances between different areas and towns, posed challenges to the efficient cascading of the training, as can be seen from the quotes below.

“Accessing proper or comfortable venues for training especially in informal settlements; bad infrastructure in informal settlements, e.g. poor road conditions, etc.” (Master trainer 1, Gauteng)

“Poor attendance of training workshops in some areas and difficulties in accessing remote rural areas due to bad road conditions.” (Master trainer 2, Northern Cape)

“Accessibility of material -I had difficulty in accessing materials on time. Lack of materials, this year, it has been difficult to get materials. It is a challenge working without materials.” (Master trainer 4, Gauteng)

Across all five areas, men were not actively involved in the program, and in some areas there were problems with getting young people involved. One master trainer commented as follows:

“Men are still resistant and negative towards this issue. We have recently started a forum that aims to mobilize men (targeting primarily older age groups) to unite and engage in a variety of activities. It also serves as a platform to encourage dialogue (or talks) on issues such as HIV/AIDS.” (Master trainer, Gauteng)

There were also some misperceptions among communities, e.g. trainers reported being chased away during door-to-door visits on some occasions as it gave the impression that there were people in households living with HIV. Many community members saw the CTPP as an opportunity for employment, with a general expectation that people would be able to get jobs after the Soul City training.

Lastly, language barriers in the remote towns were mentioned by the majority of master and community trainers. Most of the training material is written in English, although the workbooks contain translation of keywords. At the time of the evaluation, the translations of the new workbooks were either in process or not yet distributed to the local areas. This impeded the implementation of the CTPP, especially among community members with literacy problems.

3.5. Lack of an overall monitoring and evaluation framework

Key informants and master trainers acknowledged that there had been inadequate monitoring and supervision of the CTPP, and that this may have reduced the impact of the program.

None of the master trainers interviewed mentioned supervision, monitoring and evaluation as their work activity or responsibility. All master trainers reported the use of a combination of approaches to training, including use of audio-visual equipment; real life scenarios; open discussions on certain issues; role plays and general adult education methods. The research team attempted to quantify the outputs of the master trainers, but this proved a difficult exercise, and contradictory, self-reported information, in a non-uniform format was obtained. An accurate list of outputs from master trainers could not be obtained, making it difficult to do comparisons across the five mining towns.

Most community trainers reported spending 1–3 days per week on the CTPP (9 out of 12), but this could not be verified and no evidence was provided by them. Stated responsibilities varied across the five sites, but in the main involved training (including planning, organization and conducting workshops) and peer and/or community education activities. Slightly more than half of the community trainers (7 out of 12) indicated that they keep record of their activities and have a formal system for follow up on training activities in the mining community. However, none of these trainers (7 out of 12) could produce the monitoring register for inspection.

4. Discussion

The evaluation of the CTPP was conducted by an external independent team, and assisted with the documentation of the CTPP and its implementation in the five diamond mining areas in South Africa. The evaluation has also been useful to assess some of the reported CTPP successes, constraints and the complexities of implementation in remote diamond mining areas. The reported successes included value added to existing HIV and AIDS initiatives; facilitation of new initiatives; introducing an innovative training approach; empowerment and capacity building of trainers; strengthening relationships between mines and communities and assisting people to confront issues of personal significance.

The CTPP has also facilitated the penetration of the well-known Soul City mass media communications approach in remote, rural towns. Although evaluations of the effectiveness of mass media interventions on changing HIV-related knowledge, attitudes and behaviors in developing countries have yielded mixed results (Bertrand, O'Reilly, Denison, Anhang, & Sweat, 2006), multi- and mass media campaigns have the potential to impact positively on knowledge and attitudes, and to promote safer sexual behavior (Liskin, 1990; Myhre & Flora, 2000; Oakley, Fullerton, & Holland, 1995; Peltzer & Seoka, 2004). This was found in the CTPP evaluation, where community members reported improved knowledge, but with limited positive behavior changes. There was a relatively high proportion of participants who reported having multiple sexual partners (27%) and lack of condom use with non-regular sex partners (23%). Reported HIV risk behavior among participants appears to be higher when compared with the findings of the 2005 national population-based survey, where only 16% reported two and more sexual partners in the past 12 months (Shisana et al., 2005). However, reported condom use at last sex (63%) was higher than that found in the 2005 national population-based survey where 38% reported condom at last sex (Shisana et al., 2005). Changing community norms regarding multiple and concurrent partnerships remains one of the key research questions (Wilson & Halperin, 2008). Furthermore radical

behavioral changes require a multi-level approach that encompasses HIV prevention and treatment, biomedical interventions and addressing structural determinants of the epidemic (Coates, Richter, & Caceres, 2008).

Although the CTPP was envisaged as a community-level intervention in order to promote change in norms and HIV risk, many components of a successful community popular opinion leadership (CPOL) approach were not in place (Kelly, 2004). The CTPP could have benefited from a detailed situation analysis and formative research that guided its development and took account of the contextual factors in the mining towns, rather than been seen simply as an extension of De Beers Workplace Program, albeit combined with the popular Soul City brand and the use of existing training materials. Issues that need to be resolved for future program implementation include sustainability and how the CTPP could facilitate or deal with the need for structural changes in the mining towns; dedicated financial resources for the community trainer component; retention of community trainers, including the possible payment of an incentive; and funding of other logistical issues (e.g. transport).

The lack of a standardized, clear, yet user-friendly monitoring and evaluation framework for the CTPP was absent and needs to be developed to enable measurement of inputs, outputs, process and outcomes and to allow for comparisons across the mining areas.

5. Lessons learned

The main strengths of the CTPP evaluation were the use of mixed quantitative and qualitative methods, using different data collection tools; the geographical reach of three provinces and five remote diamond mining towns and the triangulation of results to arrive at practical program improvement recommendations. These were achieved despite a relatively small evaluation budget of US\$ 14 000. As was the case with an evaluation in Peru, our CTPP evaluation was helpful in examining CTPP implementation and the key elements necessary for program strengthening (Maiorana et al., 2007). Thus, we recommend a combination of qualitative and quantitative approaches for the evaluation of complex programs, with multiple layers of implementation across different geographical areas.

Useful lessons were learned during the evaluation. Firstly, the time taken for these kinds of evaluations should not be underestimated, and adequate time must be budgeted to deal with logistical issues such as obtaining list of interviewees, negotiating community entry, setting up interviews, travelling in remote areas and training interviewers fluent in local languages and with an ability to ask questions on sensitive issues.

Secondly, obtaining a representative sample of community members was extremely difficult. The vast distances between mining communities in one of the provinces meant that the communities selected were those living closest to the mines. We were also dependent on the information supplied by key informants, master and community trainers, in sampling community members, who had prior exposure to the CTPP. Despite attempts to interview equal numbers of men and women, the majority of community members exposed to the CTPP were women and hence the majority of study participants were women. Several reasons could be attributed to the over-representation of women: in the study areas men work in the mines, which historically have been the main source of employment; unemployed women may be keener to become community trainers in the hope of getting future employment; the female community trainers may access other women better than men, and women may be more receptive to this type of community awareness activities.

Thirdly, a classical impact evaluation of the CTPP on mining communities was not possible, as the intervention had only been in

place for 1 year, and baseline information was not available. By its nature, the cross-sectional nature of the evaluation represents a snapshot at a point in time. Ideally, clear indicators with which to measure progress and potential impact should be identified at the start of the program and baseline information should be obtained, with which to do later comparisons.

Fourthly, the sample of community members interviewed was purposively selected and relatively small (16% of CTPP 'exposed' community members). The study depended entirely on self-reported information and of behaviors that may be subject to socially desirable responses. Although the evaluation findings cannot be generalized to all mining communities, the study gives important insights into the successes and challenges of an innovative HIV community training program, initiated by a large corporation in partnership with an NGO.

This evaluation makes an important contribution to knowledge on HIV program implementation in remote mining areas, and documents a unique partnership between a large diamond mining conglomerate and a well, branded multi-media edutainment program. In remote areas and resource constraint settings, non-governmental organizations with a successful brand that join forces with large corporations may be required for successful community HIV and AIDS initiatives. Independent evaluations are useful to identify challenges and to strengthen program implementation.

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