

Zero Tolerance Village Alliance Intervention Model

EVALUATION AND REPORT 2010 - 2012



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*THE THOHOYANDOU VICTIM
EMPOWERMENT PROGRAMME*

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“Violence has reduced compared to before the implementation of this programme. We used to keep quiet when we were being abused because it seemed natural. Now we know how to stand up and make a difference in our lives and the lives of our children.”

-Female resident of Tshiombo

This evaluation of the Zero Tolerance Village Alliance (ZTVA) was not possible without the fortitude of Fiona Nicholson and her passionate staff at the Thohoyandou Victim Empowerment Programme (TVEP). Gumula Foldrick and Tapiwa Mukaro, along with former TVEP staff member, Prince Nare, each played a vital role in mobilizing their departments to provide excellent support for this research endeavor. Another debt of gratitude is owed to Chiefularo Ndou, the in-house researcher who spent so much time ensuring fidelity to the research protocol while also assuming the duty of resident translator. A special word of thanks is extended to the Help Desk Advisors, in particular Agnes and Serena, all of whom worked tirelessly under less-than perfect conditions to gather vital statistics. Finally, to Mike Aquilina and Joanne Tyler, both statisticians from varied backgrounds, a special note of thanks for contributing to the quantitative aspect of this work. Without this incredibly diverse and self-motivated team, none of this would have been possible.

Please note that this is an abridged report. The complete, 68-page evaluation is available upon request by emailing Fiona@tvep.org.za

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1. Overview

1.1 Introduction

In 1997, the **Thohoyandou Community Policing Forum (TCPF)** together with the **South African Police Service (SAPS)** initiated the establishment of a **Victim Empowerment Committee (VEC)** in accordance with the provisions of the *National Crime Prevention Strategy*. With seed funding from the **Department of Health (DOH)**, the **SAPS** and local businesses, the first 24/7 One Stop Trauma Centre was opened in a regional hospital in September 2001 and “break the silence” campaigns were initiated. The committee was registered as the *Thohoyandou Victim Empowerment Trust* in January 2002, with provision for a range of stakeholders to be co-opted as Trustees. This trust later morphed into the **Thohoyandou Victim Empowerment Programme (TVEP)** under the direction of one of the initial Trustees, Fiona Nicholson.

The approach of **TVEP** is rights-based, and covers the Thulamela municipality, with a population of 585,000 (Census 2001, 2011 pending). It accommodates one regional and two district hospitals, 48 clinics, 3 health centres, 7 police stations and satellites, and 500+ crèches, schools and tertiary education facilities that accommodate an estimated 220,000 children and learners.

Throughout its 15-year evolution, **TVEP** has consistently boasted a team of 40+ staff and 30+ local volunteers, of whom all but five have been historically disadvantaged South Africans. **Voluntary Service Overseas** and the **US Peace Corps** have each provided resource volunteers on a revolving basis who have assisted in the building of in-house capacity.

Presently, **TVEP** objectives include:

- The creation of a supportive environment for survivors of sexual assault, domestic violence, child abuse and the HIV/AIDS pandemic;
- The education and capacitation of community members about their rights and responsibilities as they pertain to sexual assault, domestic violence, child abuse and HIV/AIDS;
- The rehabilitation and empowerment of survivors of sexual assault, domestic violence, child abuse and HIV/AIDS;
- The provision of holistic survivor support services to ensure that justice is served; and
- Oversight to ensure the State delivers on policy mandates.

The sustained and increased proliferation of **sexual and gender-based violence (SGBV)** and **domestic violence (DV)** in the Thulamela municipality, as evidenced by **TVEP**'s ever-growing database that contains perpetrator and survivor statistics dating to 2001, gave rise to the urgent need for an intervention that ambitiously seeks to promote activism on a community-wide level.

Through a series of community dialogues to determine survivor reluctance to exercise their legal and human rights despite evidence that most understood their *individual* rights, **TVEP** developed a needs-based intervention programme that would theoretically increase crime reporting while concomitantly building knowledge and capacity in the marginalised regions within their existing areas of enumeration (the Thulamela municipality).

TVEP explored why victims of **SGBV** and **DV** were reluctant to report crime, which led to the realisation that the socio-cultural environment did not lend itself to an atmosphere of safety and supportiveness. Many key informants shared a fear of “what will the neighbours say?” and, with that, what retribution would be sought as the result of reporting violence?

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To subvert these professed fears, **TVEP** hypothesized that the creation of a village-wide empowerment programme that speaks about social concerns, and, which culminates in a public pledging ceremony to express support for victims, would strengthen feelings of safety and security. The end result, it was theorised, would be increased numbers of survivors who report to **TVEP** help desks, area clinics and hospitals, and the police for care in the months following village induction into the **ZTVA** programme. Prospectively, the aim is to see an eventual reduction in the numbers of **SGBV**- and **DV**-related assaults.¹

Hence, the **Zero Tolerance Village Alliance (ZTVA)** was modeled using a novel, grassroots approach grounded in anecdotal and empirical evidence. **ZTVA** was developed in direct response to the realization that knowing personal entitlement to basic human rights, such as specialized treatment and care for victims of assault, was not enough to affect care-seeking behaviours. They selected four thematic areas from which to develop a community-based intervention programme: sexual assault, domestic violence, child abuse and HIV/AIDS.

1.2 Background: ZTVA

In July 2010, an initial meeting was held between stakeholder members of **TVEP**, **Population Council** and monitoring and evaluation specialists to discuss the logistics of a programmatic plan to provide enhanced, expert support for the implementation and sustained impact of the **ZTVA** intervention model. This effort was also intended to provide measurable indicators of success across a number of variables that speak to the **ZTVA** mission of increasing knowledge and awareness in target villages with regard to HIV exposure risk and stigma, **post-exposure prophylaxis (PEP)**, survivor services and human rights.

Funding for this feasibility assessment was provided in part by the Regional Swedish-Norwegian HIV and AIDS Team for Africa through the Population Council. Initial budgeting for the program covered feasibility, impact, and cost-effectiveness measures for three villages and one baseline to endline study.

Dr. Jill Keesbury, **Population Council** Country Director, Zambia, outlined the history of their activities in Sub-Saharan Africa, citing regional studies that have proved effective in similar, marginalised areas. The core of their research activities and strategies historically targeted contextually- and culturally-appropriate and informed responses to **SGBV** using the trauma centre model. This model utilizes a holistic approach to provide survivor services via participation of community that accounts for traditions, culture, religion, and ritual to augment the rehabilitation processes. The **ZTVA** model aligns with these programmatic functions as outlined.

Rationale for **TVEP** deployment of the programme was based upon the fact that **TVEP** is viewed as a strong organization with deep roots in the Limpopo Province of South Africa, a region historically faced with challenges of health and prevention service delivery due to a number of socio-political factors. The anticipated ease of implementation and expected community support was bolstered by **TVEP's** network of different NGO partners that currently implement projects relevant to their field of work. They benefit from having a shared technical support network, as well.

The **ZTVA** intervention encapsulated the shared goals of all stakeholders as expressed by **TVEP's** mission statement, which was devised in 2002:

“To generate an attitude of zero tolerance towards sexual assault, domestic violence, child abuse, and HIV/AIDS-related stigma in Limpopo's Thulamela municipality.”

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1.3 Programme objectives

SGBV “non-reporting” is perceived as a major barrier to health promotion and risk reduction efforts as indicated by anecdotal evidence gathered from community informants and stakeholders. The adaptive strategy chosen for employ is one that uses a series of workshops that culminate in a “pledge ceremony.” This approach would theoretically enable the processes of health knowledge and human rights empowerment through the creation of more open partnerships between high-ranking village officials (kings, chiefs, councilors, police and clergy) and their constituencies.

The improved establishment of village-wide cooperatives hinges upon the involvement of culture-bound hierarchies while building partnerships within regional government departments positioned to address issues that pertain to **SGBV** and human rights. In the Thulamela municipality, this requires active acknowledgment of patriarchal, traditional leadership structures. *Ownership* of the ZTVA programme by village chiefs and other high-ranking officials was targeted, in lieu of “buy-in,” as a means of ensuring sustainability.

For the first several months of implementation, villages are given support and resources needed to undertake the **ZTVA** model. They are not, however, inducted into the Alliance until they meet certain criteria that attest to the village’s commitment to reduce violence and HIV within their community. These criteria serve as benchmarks for each community to strive for, and focus their efforts on key indicators that **TVEP** believes are critical for programme success. These include:

- Participation of a substantive¹ number of adults and youth in a series of 5 workshops or dialogues that cover people’s rights relevant to **TVEP’s** 4 thematic areas as well as accountability monitoring;
- Adherence of government service providers to their relevant and respective mandates (e.g. police to be trained in Victim Empowerment, Clinics to display Victim’s Charter);
- Existence of a village committee that will continue ensure that people’s rights are not violated after the exit of **TVEP**;
- Existence of a short-term, community-run safe house for victims of domestic violence, sustainably managed
- Existence of a functioning support group for **PLWHA**, sustainably managed;
- Existence of a functioning support group for **Orphans and Vulnerable Children (OVC)**, sustainably managed;
- Existence of GirlsNet, sustainably managed; and
- At least 4 Female Condom distribution sites consistently supplied.



“We learned about stigma, rape, HIV testing, rights and responsibilities to our children, xenophobia and how to get a protection order if we feel threatened.”

-Female resident of Lunungwi

2. Research and Evaluation

2.1 Research baseline and endline survey objectives

The objective of the survey instruments was to measure the impact of the component parts of **ZTVA** in two intervention villages as compared with one control village. To this end, a robust instrument was developed to capture data previously viewed as misrepresentative, inaccurate or missing.

At baseline, comprehensive sociodemographic, behavioural and attitudinal variables were collected to create a general view of multivariate challenges faced by the pilot sites, inclusive of factors related to poverty such as education, housing, access to communication, toilet facilities, and transport. A total of 425 variables were captured prior to **ZTVA** launch. At endline, selected variables from baseline were extrapolated in keeping with predetermined core indicators as outlined by the **Population Council** to measure village-wide impact.

Pre- and post- intervention data collection, coupled with qualitative **focus group discussion (FGD)** analyses, enabled the establishment of an evidence base to affirm or challenge the efficacy and impact of component parts of the **ZTVA** model.

2.2 Research design and methodology

Research elements of the **ZTVA** intervention were structured as population based evaluation studies with pre- and post- intervention (**ZTVA**) surveys collected from a random sampling of $\geq 10\%$ of village residents. Surveys at both baseline and endline were administered to determine knowledge and capacity impact across the four thematic areas of focus with a special focus on post-exposure prophylaxis (**PEP**). **FGDs** aimed to determine impact *specifically* among village residents who had participated in the **ZTVA** workshops, which further facilitated the study of process measures on outcomes.

2.3 Sample selection and implementation background

Between January and February 2011, a random sampling of 1134 participants from three villages (Mangondi, Tshiombo, and Lunungwi) in the Thohoyandou region of the Limpopo Province participated in a survey using paper and pencil data collection. Two villages were assigned to the **ZTVA** condition (health promotion and risk reduction) and one assigned as a control site.

The three villages selected are geographically distant from one another, have similar sociopolitical structures (a mix of traditional and non-traditional leadership) and, according to the most recent census data available at the time of **ZTVA** design (Census 2001), had similar populations. Pilot village locations were selected to reduce cross-contamination, which could impact endline assessments.

The aim of the exercise was to ascertain a number of factors relating to sociodemographic data, HIV/AIDS knowledge and beliefs, survivor treatment-seeking behaviors, **PEP** awareness, and culture-bound gender norm perceptions. Survey instruments used for projects that targeted similar Southern African regions were examined and key variables extracted to develop the most robust data collection tool possible in consideration of the limited resources available to **TVEP**.

To effectively implement the project, it was essential that all questionnaires and intervention modules be administered in indigenous, TshiVenda language. This required the initial questionnaire to be translated and back-translated to insure fidelity to the original. Nearly 99% of respondents at baseline spoke TshiVenda as their primary language. Ten (0.9%) spoke Xitsonga and six participants spoke Spedi, Zulu, Ndebele, or Sotho.

Twelve months after the baseline data collection and subsequent exposure to the **ZTVA** model intervention (January and February 2012), an abridged questionnaire to collect core indicator data was administered to determine primary and secondary outcomes with the aim of measuring the efficacy and sustained intervention effect.

2.4 Research instruments

Paper and pencil survey administered by **TVEP** staff and volunteers in TshiVenda language was the primary instrument used for the analysis of **ZTVA**. For those with challenges relating to literacy, the survey was administered orally. Participant feedback gathered during workshops was used to guide the process of reinforcing concepts delivered in each of the topic sessions. Data collected from these sessions was stored for later examination.

Semi-structured interviews (**FGDs**) with participants after the intervention programmes were conducted for each intervention village site, which rounded out the qualitative data collection component. The control village did not participate in **FGDs**.

Process measures were put in place to ensure that all aspects of the research and implementation were noted, both quantitatively and qualitatively. This procedural design also served to inform potential changes to enrich programme delivery.

2.5 Training

As part of the process to ensure the research component of **ZTVA** was conducted with fidelity to the protocol, **TVEP** staff developed a *Research Skills Training Manual* to impart basic research skills to field workers who ultimately solicited participation in the villages. The training was conducted with fifteen participants who were appointed as data collectors. Help desk advisors (**HDAs**), the first point of contact for most survivor cases in the rural areas targeted by the **ZTVA** intervention, comprised the majority of the trainees, all of whom were trained by **TVEP** staff in the methods of research subject consent and data collection. Additional staff members and volunteers also attended trainings, including **Monitoring and Evaluation (M&E)** staff and the **ZTVA** manager who were involved in the supervision of the data collection.

2.6 Statistical analysis

Data variables were analysed using the **Minitab Release 14.20** statistical software package. Given the ordinal data gathered from the surveys and the marginal differences in sample sizes between the baseline and endline groups, a **Mann-Whitney U (Mann-Whitney-Wilcoxon or Wilcoxon rank-sum test)** non-parametric statistical hypothesis test was selected to evaluate the disaggregated responses (by village and sex) at a 95% confidence interval with median responses represented for each variable.

Significance was determined primarily through the observation of a shift in the median response to a specific question, though marginal significance was measured in cases with significant increases or decreases in percentages within a paired group (i.e. female responses from Lunungwi at baseline versus female responses at endline increased X% though the median response remained static).

The robustness and efficiency of this analytic approach allows for assessment of the **Hodges-Lehmann estimate (HL)** of the difference in central tendency between the baseline and endline populations via delivery of median response shifts. Further, a normal distribution is attainable via the **Mann-Whitney U** test for sample sizes >20, therefore it presents a practical approach to the analysis of complex social science phenomena.

Outcomes of the two intervention arms of the research were compared with the control village site. The intervention effect was measured using a non-parametric 0.95 confidence interval for which **HLΔ (median) change** is noted as well as **p values** (a statistical estimate of probability that a randomly-chosen subject from endline has a higher weight than one randomly chosen from baseline) for each variable and associated disaggregated respondent group.

3. ZTVA Intervention Design

3.1 ZTVA intervention design

This methodology incorporates lessons learned over 6 years of developing the **ZTVA** project, during which various modules were tested on a grassroots level. **TVEP** first applied the **ZTVA** theoretical approach to 8 villages with high rates of domestic violence and sexual assault, as identified through their database. Due to funding constraints, these efforts were abandoned until a later partnership with Population Council and Raising Voices was realised.

Substantive qualitative information from the region informed the **ZTVA** intervention as it is being delivered today:

To ensure sustainability and full ownership, community members in the respective villages are involved and participate in the planning and implementation of the intervention. The ZTVA is a community driven project aimed at addressing problems identified by all stakeholders in their own respective localities.

The processes in place to support the aims of **ZTVA**, while also ensuring consistent maintenance of linkages with community representatives and government departments, is rigorous.

3.1.1 Select implementation site

A remote village with high prevalence of domestic violence and sexual assault will be selected for implementation. It is important to identify a village that has never been targeted by any **TVEP** campaigns, so as to protect the integrity of the evaluation

3.1.2 Hold community campaigns & dialogues

Hold campaigns and community dialogues to explain and promote ownership of the project, explain criteria and outline a *Memorandum of Agreement (MoA)*, and appoint a Stakeholder Forum (max. 9 members). This Forum must be representative of structures and agencies in that particular community i.e. traditional authority, civics, churches, education, business and other civil society agencies operating in the pilot site.

3.1.3 Establish stakeholder forums, sign MoA

Meet with the Stakeholder Forum to determine protocols, frequency of meetings, and reporting guidelines; discuss & sign MoA. A member of the Stakeholders Forum will be selected to play a liaison role between **TVEP** and the community. This Community Liaison Officer (CLO), like all members of the Forum, must be a resident in the community, literate, currently unemployed, and have a proven track record that demonstrates commitment to gender equality, gender justice and leadership.

3.1.4 Train stakeholder forums

Train Stakeholder Forum members on good governance procedures and policies, as well as **TVEP**'s thematic areas.

3.1.5 Community mapping

The mapping will incorporate population demographics specifically age and gender, and will identify all structures and agencies that can be targeted such as schools, crèches, churches, farms, clubs, societies, businesses, civic and traditional structures and so forth. This mapping process must also identify any other CBOs providing services in the area, with which partnerships can be formed to avoid any duplication of services.

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3.1.6 Develop timeline

A realistic timeline is developed by the Stakeholder Forum and **TVEP's** Technical Assistants (TA), taking into account school holidays and allowing for unscheduled delays.

3.1.7 Identify, train & contract Peer Educators (Community Activists)

Six volunteer community activists, 2 middle age (male and female), 2 youth (male and female), 2 elderly (male and female) resident at each site are identified and trained on **TVEP's** thematic areas.

3.1.8 Conduct baseline study

Baseline data on knowledge, attitudes, skills and practices around **SGBV** and HIV/AIDS are collected to clarify the training & empowerment needs of each site, and to compare against endline data. A research specialist is contracted to develop and supervise the baseline and endline studies and analyse the findings in coordination with **TVEP's** newly-established Research Unit.

3.1.9 Endorse community map and timeline

The community map and timeline are endorsed by the Stakeholder Forum prior to the commencement of activities, and attached to the **MoA**. This also provides details of specific target areas and the total number of people to be trained, engaged in workshops, and/or dialogued.

3.1.10 Develop monitoring & evaluation tools

The Stakeholder Forum is invited to give inputs on all monitoring and evaluation tools to be used by the project, following which they will be trained to monitor the project under the supervision of **TVEP's** M&E Unit. This is to enhance their ownership of, and accountability for, the success of the **ZTVA** project.

3.1.11 Commence with trainings, workshops & dialogues

Workshops and/or dialogues are held for members of the general community, but more thorough training of stakeholders is facilitated, as required. These needs are ascertained through the community mapping. For example, if nurses at the nearest clinic have not been trained on **PEP**, or if police at the nearest satellite are not trained on the Victim's Charter, this will be captured in the **MoA**, and appropriate training facilitated. Sectors to be targeted must include men, pensioners, adults, youths, children and people of influence (such as civic members, traditional leaders, religious leaders, police officers, medical officers, educators, ward councillors, and business owners).

For the project to be institutionally sustainable, educational establishments within the regional purview are also exposed to the intervention, with particular focus on how to use advocacy tools for empowerment. This begins with the School Governing Bodies (**SGB**), moving on to the educators and finally the learners. Learners are then invited to elect an educator they trust to be their "confidant". These School Confidants remain the contact for **TVEP**, the local Social Worker and Child Protection Units, and are trained to ensure that abuses of all types are appropriately and efficiently handled. While the "confidant" shall be appointed by the learners, the concept shall be "pre approved" by the principal and **SGB** as well as the Department of Education at District Level.

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3.1.12 Assist Stakeholder Forum to meet ZTVA criteria

Note that if any of the following are not already in existence at the intervention sites, **TVEP** will assist only with the development and/or establishment of such, thereafter it will become the sole responsibility (with **TVEP** on call support) of the Stakeholders Forum to ensure that the structures are sustainable.

- Safe House – secure, known, easily accessible, furnished & equipped, sustainably managed
- Home Base Care Group – functioning, sustainably managed
- OVC Care Group – functioning, sustainably managed
- HIV+ Support Group – functioning, sustainably managed
- Female and Male Condom distribution sites consistently supplied
- 2 Female Condom Ambassadors trained and accessible to the community

3.1.13 Partnerships

Local –

Identify, partner and help to mobilise any other NGO/CBOs active in similar or supplementary fields (e.g. home based care, or **HBC**). If not already in existence, facilitate the establishment of a village committee who will take responsibility for providing both practical and emotional support for child headed households, and monitoring their progress (e.g. **HBC** volunteers, clinic nurse, pastor, civic leader etc.).

National –

Collaborate with research partners to evaluate the intervention and to assess its suitability for roll-out in other rural communities, refugee camps, regions and/or countries.

3.1.14 Alignment of public service points

Ensure that all government agencies delivering services to the pilot community are conforming to Batho Pele as well as their own departmental deliverables and policies. This will include *but is not limited to*:

- SASSA: to ensure social grants are processed efficiently;
- The Dept. of Social Development: to ensure that OVC and Child Headed Households are receiving appropriate care, emergency relief and food parcels are available, cases of abuse attended promptly;
- Police stations: capacitation to ensure reporting is victim friendly and that staff is appropriately empowered to implement the provisions of the Domestic Violence Act, Victims Charter, The Sexual Offences Bill, the Children's Act, access to PEP, etc.;
- Clinics: to provide PMTCT advice, VCT, and have effective systems in place to ensure that they can never run out of medications, milk formula, or female and male condoms;
- Learning establishments: via participation in the Safe Schools Programme, and have sufficient educators trained in Life Orientation: and
- Community members: through their Stakeholders Forum, Community Activists and Village Committees will be assisted to draft their own (rights-based) protocol to be followed when a challenge has been met with regard to service delivery.

3.1.15 Public service information

To further promote sustainability of a human rights culture, public service notices should be in evidence, and regularly updated. For example, every school must publicly display posters advising children of their rights, and providing relevant contact numbers. Clinics, police stations, SASSA and any other government agencies must display their Batho Pele principles, as well as any other informative posters or literature that relates to the services they provide, preferably in the ethnic language of the region. Community Activists will be encouraged to engage with the **TVEP** Resource Centre for access to the internet and ICT materials.

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3.1.16 Monitoring & Evaluation

TVEP's M&E Unit submits monthly reports to Management and the Stakeholder Forum to ensure accountability and adherence to timeline.

3.1.17 Pledge-taking ceremony & awarding of ZTVA membership

Once all the criteria have been met, a public function is held and men of the village are invited to take a public pledge to proactively address the eradication of gender-and child-based violence, as well as HIV-based stigma, in their village. Those that take the pledge will be asked to sign a Roll of Honour, which will be kept in a secure place available to the public in the village (e.g. Offices of the Traditional Council, civil society or SAPS), and will be given a **TVEP** Badge of Honour to identify them as men who have taken the pledge. Men who subsequently breach the pledge will be publicly removed from the Roll by the Stakeholder Forum as a means of "naming and shaming".

Community members who have "Broken the Silence" by reporting, acting or speaking out against any form of abuse or violence during implementation will be recognised at the ceremony, and awarded a Badge of Courage.

3.1.18 Alliance identification

At the pledge taking ceremony, the village is given a large sign post declaring their status and name of the village. A small allowance is also available for them to use in a way that will help build a sense of community, such as road signs, a bus shelter or a community notice board.

3.1.19 Endline evaluation

An endline survey is conducted and data analysed for comparison against the baseline so as to assess the impact of the project.

3.1.20 Project documentation

The successes, challenges and lessons learned from the project are thoroughly documented to guide roll-out to other sites and to assess viability of expansion to other regions and situations.

3.1.21 Project continuation

TVEP will convene annual meetings of Stakeholder Forums where they can share challenges and successes, and the CLOs will remain as TVEP's contacts within each village. It is TVEP's intention to broadcast the existence of the ZTVA, and encourage researchers, funders, CBOs, government agencies and like-minded organisations to make use of the structures already in place. To this end, the CLOs, Stakeholder Forums and Community Activists are available to facilitate other research or projects beneficial to other communities.

ZTVA facilitator speaks to crowd of residents and members of the Stakeholder Forum about Gender Equity issues in Tshiombo, 2011.

There is No Excuse for Abuse!



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4. Sociodemographic data

4.1 Population characteristics of villages

According to settlement demographic data presented by the *Department of Water Affairs Directorate of Planning and Information* in December 2011, two of the three research sites' populations had grown marginally since the 2001 census. In their recent report, all three were still categorized as small rural settlements with populations <5,000 inhabitants. Specific population statistics are shown on the table below in relation to the percentage of inhabitants surveyed:

Rural settlement name	Population: December 2011	Total number of households	Persons per household	Total of population surveyed: Baseline	Total of population surveyed: Endline
LUNUNGWI	1277	268	4.76	413 (32.3%)	437 (34.2%)
TSHIOMBO	1049	220	4.77	407 (38.8%)	414 (39.5%)
MANGONDI	3116	654	4.76	314 (10.1%)	329 0.6%

4.2 Sociodemographic characteristics of respondents

Core demographic attributes were targeted at both baseline and endline to ensure adequate population size and composition matching to deliver a confidence interval of 95%. It is important to note that individuals sampled within each pilot site were not tracked from baseline to endline due to feasibility challenges, thus the approach from a population level.

A total of 1134 individuals participated in the baseline assessments. The total sample disaggregated by sex reflects expected participation rates (47.4% male compared with 52.6% female) in line with the discrepant male-to-female ratio in the Thulamela municipal region (45.1% male and 54.9% female).

A total of 1180 individuals participated in the endline survey (increase of 3.89% from baseline). The total sample disaggregated by sex again reflects the anticipated rates of male-to-female participation:

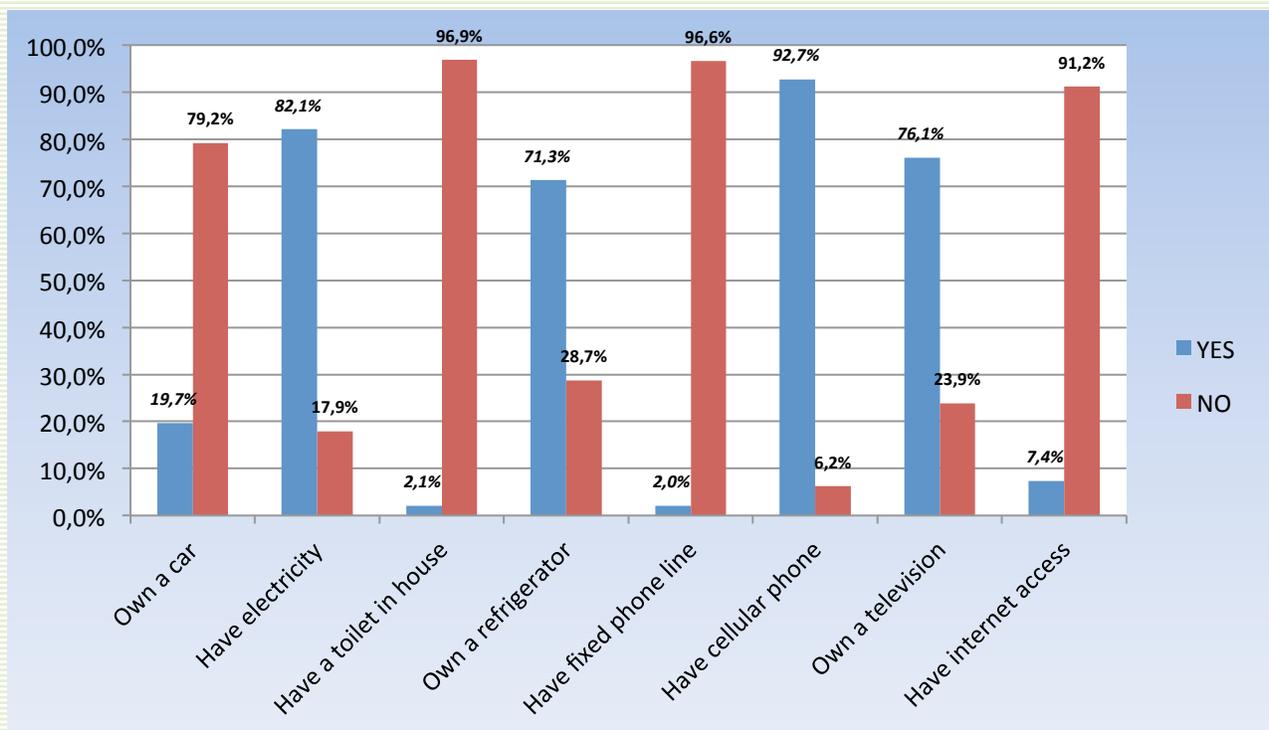
Rural settlement name	Total surveyed: Baseline	Male respondents: Baseline	Female respondents: Baseline	Total surveyed: Endline	Male respondents: Endline	Female respondents: Endline
LUNUNGWI	413 (36.4%)	211 (51.1%)	202 (48.9%)	437 (37.0%)	184 (42.1%)	253 (57.9%)
TSHIOMBO	407 (35.9%)	166 (40.8%)	241 (59.2%)	414 (35.1%)	170 (41.1%)	244 (58.9%)
MANGONDI	314 (27.7%)	160 (51.0%)	154 (49.0%)	329 (27.9%)	130 (39.5%)	199 (60.5%)
TOTAL	1134 (100%)	537 (47.4%)	597 (52.6%)	1180 (100%)	484 (41.0%)	696 (59.0%)

The mean age of participants was 40.28 years at baseline and 39.50 years at endline (SD range of 15.81 – 17.28). Baseline and endline marital characteristics were also similar. Almost two thirds of participants (64.7%) were married, while 59.6% reported living with their spouse or partner at baseline. Endline respondents shared similar characteristics without a shift in the mean response for any of the six disaggregated groups.

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4.3 Factors that contribute to “consensual” poverty

Given that “poverty” has been designated a key driver for **SGBV** in rural areas (together with high unemployment), the capture of variables relevant to its loose definition was deemed important to the research.¹ Therefore, at baseline several additional variables were collected to provide a complete sociodemographic picture of the pilot sites as well as the control. These included number of children, vehicle ownership, and residential services and possessions (inclusive of number of rooms, electricity, ablutions, refrigeration, fixed line and cell phone ownership, television, and internet access). Taken together, these supplemental factors contribute to poverty — not in accord with conceptual frameworks defined by the Copenhagen Declaration of 1995 — rather, in terms consistent with the democratic South African agenda of transformation, which accounts for socially perceived necessities.



4.4 HIV prevalence and stigma measured at baseline

The Limpopo Province has an HIV prevalence rate of 18.5% according to the National Department of Health (2007). This number decreased from 21.5% in a two-year period starting in 2005 which indicates successful HIV education strategies that target high risk groups such as young women in the region. However, the number of respondents at baseline who reported knowing someone with HIV/AIDS was low across all three sites. 36.9% reported knowing *any* person with HIV/AIDS with 12.2% reported knowing a family member who has HIV/AIDS. Just over half (55.1%) of participants reported having ever been tested for HIV; 42.2% reported **Voluntary Testing and Counseling (VCT)** in the six months prior to the questionnaire administration.

The Limpopo Province has an HIV prevalence rate 18.5% according to the National Department of Health (2007).

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Attitudes toward HIV-infected individuals indicated considerable stigma in the region at baseline. Nearly 25% of respondents believed that **people living with HIV/AIDS (PLWHA)** should be subject to certain restrictions on their freedom. 38.7% reported not wanting to be friends with, or associate with, **PLWHA**. 43.0% believed that those living with HIV should not be allowed to engage in sexual activity. 43.2% asserted that those living with HIV should not have children.

5. ZTVA impact assessments

5.1 HIV voluntary counseling and testing (VCT) impact

VCT formed a core component of the **ZTVA** intervention in keeping with government mandates to increase the number of those voluntarily submitting to HIV tests across South Africa. The resulting impact of **ZTVA** on the intervention sites is clear, particularly among male respondents in the pilot villages for which an **HLA** was measured in terms of median shift.

Consequently, the control site also experienced marginal/significant percentage shifts in **VCT** despite the absence of **ZTVA**, though not as profound as those shifts noted in the intervention sites. Further examination of this phenomenon revealed an aggressive campaign for implementation of **VCT** across HIV/AIDS-affected populations in the Thulamela municipality as a portion of their “Special Programmes” budget to be implemented on/around June 2011. This operational plan delegated to the Departments of Health and Social Development was in effect post-baseline for all target sites involved in **ZTVA** research and, therefore, may have skewed results accordingly at endline.¹

Despite this, the significance measures across **ZTVA** intervention sites outweigh those in the control:

Lunungwi total increase = 26.5%

Tshiombo total increase = 30.2%

Mangondi total increase = 13.6%

Analysis of **VCT** is further broken down according to respondent totals for each cohort disaggregated by sex with associated p-values and **HLA** significance. Note that both intervention sites saw a median shift among male cohorts:

Rural settlement name	Female respondents tested: Baseline	Male respondents tested: Baseline	Female respondents tested: Endline	Male respondents tested: Endline	p-value with 95% CI	HLA Significance
LUNUNGI	106	68	194	106	<0.0001 female <0.0001 male	Sig % increase Median shift 1 - 2
TSHIOMBO	126	51	196	109	<0.0001 female <0.0001 male	Sig % increase Median shift 1 - 2
MANGONDI	102	51	144	61	<0.0001 female <0.0276 male	Sig % increase Marginal % increase



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5.2 PEP knowledge and ZTVA impact

PEP knowledge increased significantly in the village of Tshiombo for all PEP-related variables except one. Aside from this anomaly (owing to confusion around newly-implemented police policies), all PEP-related variables addressed in the research showed marked increases in knowledge post-ZTVA intervention. The following series of graphics exhibit increased knowledge or correct response patterns disaggregated by sex and cohort site.

Responses from intervention sites with regard to PEP and anti-pregnancy medication provisions saw significant knowledge increases in ¾ of the intervention cohorts as compared with none in the control:

Rural settlement name	Female respondents: Baseline	Male respondents: Baseline	Female respondents: Endline	Male respondents: Endline	p-value with 95% CI	HLΔ Significance
LUNUNGWI	66	85	138	110	0.2528 female 0.0449 male	None Marginal % Increase
TSHIOMBO	70	42	146	108	<0.0001 female <0.0001 male	Median shift 3 – 2 Median shift 3 – 2
MANGONDI	21	22	36	24	0.9535 female 0.7361 male	None None

Again, responses from intervention sites with regard to PEP and anti-hepatitis medication provisions saw significant knowledge increases as evidenced by median shifts from “don’t know” to “yes” across all four cohorts. No change was noted in the control:

Rural settlement name	Female respondents: Baseline	Male respondents: Baseline	Female respondents: Endline	Male respondents: Endline	p-value with 95% CI	HLΔ Significance
LUNUNGWI	44	49	111	81	0.0076 female 0.0075 male	Median shift 3 – 2 Median shift 3 – 2
TSHIOMBO	49	27	93	68	<0.0001 female <0.0001 male	Median shift 3 – 2 Median shift 3 – 2
MANGONDI	12	17	26	16	0.9363 female 0.9456 male	None None

ZTVA villages exhibited significant increased knowledge on the topic of PEP 28-day adherence and efficacy when compared with the control. This speaks to increased knowledge with regard to ARV adherence and effectiveness for PLWHA, as well. This variable, on its own, should be exemplified as an accomplishment for ZTVA:

Rural settlement name	Female respondents: Baseline	Male respondents: Baseline	Female respondents: Endline	Male respondents: Endline	p-value with 95% CI	HLΔ Significance
LUNUNGWI	75	76	146	111	<0.0001 female <0.0001 male	Median shift 3 – 2 Median shift 3 – 2
TSHIOMBO	71	43	145	111	<0.0001 female <0.0001 male	Median shift 3 – 2 Median shift 3 – 2
MANGONDI	25	25	39	26	0.8836 female 0.6434 male	None None

Knowledge that PEP is offered 24 hours a day further illustrated ZTVA impact:

Rural settlement name	Female respondents: Baseline	Male respondents: Baseline	Female respondents: Endline	Male respondents: Endline	p-value with 95% CI	HLΔ Significance
LUNUNGWI	127	121	202	152	0.0015 female <0.0001 male	Marginal % Increase Significant % Increase
TSHIOMBO	128	91	192	147	<0.0001 female <0.0001 male	Significant % Increase Significant % Increase
MANGONDI	76	63	73	58	0.0519 female 0.4658 male	None None

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Comprehension that health centres are equipped to handle survivor services inclusive of PEP provision increased across ZTVA sites:

Rural settlement name	Female respondents: Baseline	Male respondents: Baseline	Female respondents: Endline	Male respondents: Endline	p-value with 95% CI	HLA Significance
LUNUNGWI	126	138	204	154	0.0008 female 0.0044 male	Marginal % Increase Marginal % Increase
TSHIOMBO	144	99	201	153	<0.0001 female <0.0001 male	Significant % increase Significant % increase
MANGONDI	82	69	82	65	0.0669 female 0.3346 male	None None

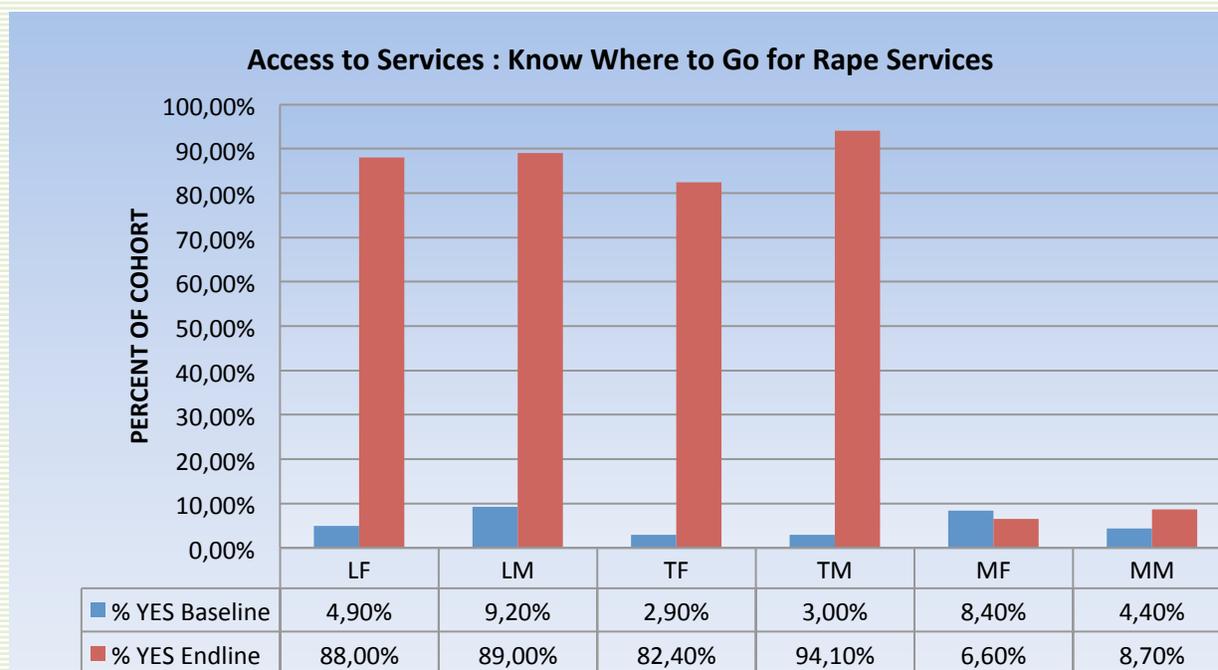
Taken cumulatively, the two sites exposed to the ZTVA intervention outpaced the control with a great degree of significance as evidenced by 21 independent median shifts as compared with zero in the control cohorts. There is ample evidence to suggest that the impact of ZTVA with regard to PEP education is both profound and effective on a population level.

5.3 Self-reported incidence of SGBV

While no statistical significance was observed for this variable, it is important to note that in the **ZTVA** intervention cohorts, self-reported experiences of **SGBV** increased for both sites. In contrast, there was a reduction in self-reported incidents in the control cohorts. Similarly, those who reported physical violence within the past 12-month period also increased across **ZTVA** sites, while declining in the control.

5.4 Access to services knowledge impact

A crucial first step to reporting and seeking care in cases of **SGBV** hinges upon the knowledge of where to seek help. The single most profound shift in knowledge captured as a result of this research pertains to the awareness of where rape services provider sites, inclusive of **TVEP Helpdesks**, are located.



6. ZTVA qualitative feedback

6.1 Focus group discussions & general feedback

Guided, open interviews in the form of **FGDs** were held in both **ZTVA** intervention sites shortly before the oath-taking and village induction ceremonies. These forums provided important qualitative data that contributes to the evaluation of **ZTVA** efficacy as evidenced at endline.

6.2 Tshiombo participant feedback

Tshiombo **FGDs** were strongly encouraged by the local chief and were organized in an outbuilding located on his property. A total of fifteen women attended with six men.

A semi-structured interview took place to measure the impact of **ZTVA** on those who had participated in the workshops. Additionally, the discourse sought to assess popularity of the programme as it was modeled and to solicit information about possible improvements.

Overall, the group was extremely gregarious and were further encouraged by the presence of their chief who, while not attending the entire session, presented himself three times to ensure that everything was running smoothly.

Participants in Tshiombo expressed knowledge around the four core areas of focus as set forth by **ZTVA**. The ability to cite issues of HIV stigma, human rights, and access to care and justice is a clear indication that participants, particularly female, had absorbed workshop information.

They raised interesting points around issues of gender. The suggestions that men and women meet separately to encourage more open discourse relative to sensitive topics demonstrated a vested interest in making ZTVA work. Partnership building within their own gender groups to gain insights and assistance with regard to child-rearing and knowledge empowerment was evidenced by comments that touched on these issues.

Male participants were gregarious and openly engaged with their female co-participants, often resulting in a back-and-forth during which reasoned arguments were further explored in light-hearted and productive ways. They also expressed that male participation could be enhanced by modifying locations and times of the workshop modules to accommodate their work schedules. As an aside, they also focused on the issue of meals provision. Food is a major incentive for participation in marginalized areas where poverty is a serious issue.

Finally, the group affirmed what was already believed true with regard to information materials dissemination: it is imperative that access to information via pamphlet distribution be tailored to the **ZTVA** programme in TshiVenda.



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6.3 Lunungwi participant feedback

FGDs with participants from Lunungwi presented a number of logistical issues. Firstly, the terrain upon which the village itself is situated is very difficult to negotiate. The chief's kraal, the selected location for the session is located far outside the main areas of settlement and high on the mountainside. Attendees had to walk a far distance to attend on a particularly hot summer day. Despite these barriers, twelve males participated along with nineteen females.

By comparison with Tshiombo participants, those in Lunungwi offered more obtuse responses to direct questions that pertained to the **ZTVA** programme. They offered rich qualitative data with regard to the issue of HIV stigma by stating they "learned to live" with their HIV positive neighbours. Their repeated return to the issue of HIV hinted at an overarching theme of HIV infection in the area and many expressed a sense of relief and knowing their status and being able to disclose publicly without fear of retribution.

Similar to Tshiombo, the group expressed a majority desire to engage in the workshops separately by sex prior to engaging again with the male groups. This, they felt, would empower the different groups to have more productive sessions during which their newly-taught negotiation skills could be tested in a larger forum.

6.4 Facilitator and Data Collector feedback

To solicit feedback from the front line of the data collection process, a **FGD** was scheduled with members of the **ZTVA** team. This was held at an abandoned bottle store at the entrance to Mangondi where they were collecting data to round out the **ZTVA** endline survey.

HDAs and **TAs** came across as frustrated during the discussion. The aim of the interaction was to determine means of simplifying the data collection process, as there were concerns that each site survey was taking longer than anticipated.

Feedback from the session indicated that women were not comfortable with the processes in place, particularly in a context of gender power, yet these issues were not raised with **TVEP** coordinators throughout the course of the research. As indicated by some responses, the fear of being assaulted while in the commission of a job is a reality that most would take for granted. Further to this, the notion that female data collectors return to their homes with fear of dispute from their male partner enhances the urgency of amending the processes in place. Male data collectors need to be in place, or more effectively perhaps, matched pairs of male and female data collectors should be dispatched in future efforts.

6.5 FGD Discussion

It is clear from the facilitator and participant feedback that they perceive the **ZTVA** programme as successful in the villages. The anecdotal evidence provided during the guided interview highlighted the challenges of nuanced cultural beliefs and attitudes toward gender-based violence but also provided concrete information that illustrate changes in the target population. These changes are in line with the expected programme-specific process measures outlined in the core indicators grid for the project.

Logistically, programme funds and workshop venue locations were cited as the only challenges to maintaining consistency throughout the intervention period. Retention barriers (employment, transport, etc.) are common to behavioural health projects; minor adjustments to protocol schedules and a general flexibility on behalf of the facilitators served to address those. Their creative problem solving ultimately served to lend support to the **ZTVA** programme participants while concurrently enhancing uptake.

The complete transcripts of all FGDs are found in the unabridged evaluation. Email fiona@tvep.org.za

7. ZTVA Oath-taking ceremonies

7.1 Experiences from Lunungwi

On 18 February 2012, the community of Lunungwi was invited to take part in an oath-taking ceremony to formally induct both the village and its residents into the **Zero Tolerance Village Alliance**. Lunungwi was the first village selected for the alliance, having also been the first village exposed to the **ZTVA** programme workshops and intervention curricula one year previous.

The pledge ceremony was conducted in situ in the village with active participation of local government, a stakeholder forum consisting of chief-approved delegates, and villagers. This served the overarching purpose of inducting Lunungwi as the first member of the **ZTVA** body using a construct of multi-party solidarity and positivism.

The fundamental design of the ceremony aims to test the theory that not only individuals have been empowered to take personal responsibility for their actions via the **ZTVA** framework, but that the added power of taking group responsibility further motivates adoption of the **ZTVA** principles. Women and children who witness the ceremony, it is theorised, would also be motivated to make empowered decisions with regard to **SGBV** and **DV** reporting, even in the absence of workshops.

By means of informal census (visual sweep and headcount), the numbers of villagers, delegates and other parties present were estimated at the start of the event. Individuals seated within the three tents were separated by role and age. Men and women who were committed to take a pledge were seated in one tent; delegates in another; adolescents and younger children in a third.

By the ceremony midpoint, additional village residents had arrived on site. Random samples of adult latecomers were interviewed to determine their cause for tardiness. Cumulatively, their responses spoke to conflicts with other events, given that the ceremony was scheduled for a Saturday. Some members of the community were unable to attend on time (or were completely absent) due to bereavements or church activities. In addition to these challenges, a regional athletics event that was held the same day precluded the attendance of one key stakeholder (a teacher) and some of the younger local residents. Further, the soccer pitch was reserved for a match at 15h00 so the ceremony needed to maintain a relatively tight schedule in order to allow for the sporting activity.

The overall percentage increase from start to midpoint (based upon estimates: 23.4%) highlights the effectiveness of the “snowball effect” in recruitment. Word-of-mouth recruitment in settings that present challenges due to their de-centralized physical arrangement is often a primary means of gathering support for community-based initiatives.

Attendance is illustrated below:

Demographic	Attendance at Start	Attendance at Midpoint	Percent Change
Adult Male	77	118	53.2%
Adult Female	88	130	47.7%
Delegate Male	16	16	0.0%
Delegate Female	10	10	0.0%
Child (0-10 years)	256	270	5.5%
Child (11-17 years)	75	110	46.7%
TOTAL	522	644	23.4%

8. Conclusions and discussion

While **ZTVA** has evidenced itself to be a successful programme in terms of knowledge and capacity building in intervention sites when compared with the control, there are additional nuanced factors that contribute to its effectiveness. A key factor that appears to affect village-wide adoption for both male and female residents is active involvement from leadership, in these cases, a chief.

Empirical evidence from site visits revealed that the chief of Tshiombo was very involved in all aspects of **ZTVA** from start to finish. He enlisted a group of community activists to attend workshops to ensure that his constituency was accessing information that would enhance the health and wellness of his village. He requested that members of “his” team report back with their experiences. From inception to village induction, Tshiombo mobilized its leadership, thereby sustaining participation in the **ZTVA** programme not only in terms of workshops but also in terms of research. The presence of a safe house on his property as well as his frequent “check-ins” with **ZTVA** staff during various activities speaks to this commitment.

The resulting successes of the Tshiombo-based intervention are clear, not only in the statistical data presented, but also in the qualitative assessments from **FGDs** and the number of participants in the oath-taking ceremony.

In contrast, the leadership of Lunungwi was absent to the detriment of the village and **ZTVA**. As a result, organization of **ZTVA** activities and research was often hindered due to lack of community leadership, which led to frustrations on both sides. Residents of the area struggled to attend meetings and **FGDs**, as they were held in a location far removed from the village centre that was insisted upon by the chief who, himself, did not attend. He did not liaise with **ZTVA** staff after the initial proceedings that allowed for village participation. While the intervention effect among this population was clear, similar to the outcomes in Tshiombo, the significance of change was generally lackluster by comparison.

In summary, there is ample quantitative and qualitative data to endorse the expansion efforts of **ZTVA**, as the majority of indicators thus far affirm the hypotheses asserted at project outset: communities exposed to **ZTVA** exhibit enhanced knowledge and capacity with regard to HIV/AIDS, **SGBV**, human rights and access to care. To provide more support for **ZTVA** scale-up to neighbouring communities, provinces, and countries, further prospective analyses are recommended to gauge long-term effects on incidence of **SGBV** and **DV** across **ZTVA** sites, while concurrently implementing across the region.



ZTVA Roll of Honour			
#	Name	Signature	Date
1	Tshimbo M.P.E.	[Signature]	18/02/2012
2	Kombumani R.E.	[Signature]	18/02/2012
3	Mphahlele M.A.	[Signature]	18/02/2012
4	Mphahlele A.P.	[Signature]	18/02/2012
5	Pfisterer M.H.	[Signature]	18/02/2012
6	Pfisterer R.A.	[Signature]	18/02/2012
7	Mandima A.H.	[Signature]	18/02/2012
8	Mphahlele M.H.	[Signature]	18/02/2012
9	Mphahlele M.H.	[Signature]	18/02/2012
10	Mphahlele M.H.	[Signature]	18/02/2012
11	Mphahlele M.H.	[Signature]	18/02/2012
12	Mphahlele M.H.	[Signature]	18/02/2012
13	Mphahlele M.H.	[Signature]	18/02/2012
14	Mphahlele M.H.	[Signature]	18/02/2012
15	Mphahlele M.H.	[Signature]	18/02/2012
16	Mphahlele M.H.	[Signature]	18/02/2012
17	Mphahlele M.H.	[Signature]	18/02/2012
18	Mphahlele M.H.	[Signature]	18/02/2012
19	Mphahlele M.H.	[Signature]	18/02/2012
20	Mphahlele M.H.	[Signature]	18/02/2012

