

NEEDS ASSESSMENT FOR INTEGRATED TRAUMATIC STRESS SERVICES: MPUMALANGA PROVINCE, SOUTH AFRICA

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EXECUTIVE SUMMARY

This study is concerned with assisting the process of transformation of mental health services to victims of violent crime in Mpumalanga province. Mpumalanga is a rural province which presents various challenges to service delivery. Ideally a public health approach to caring for victims of violent crime is called for. Such an approach requires the availability of a range of well coordinated services that meet the needs of a wide diversity of victims of violence within their social, cultural and historical context.

Criteria which an integrated service delivery model should strive for include: being strongly evidence based, appropriate to particular needs of clients, accessible in terms of geography and cost, of high quality, coordinated, make efficient use of available resources, be contextually embedded and ethical. A theoretical five level model of integrated service delivery to victims of violence is presented. The five levels are education and awareness raising activity, victim support, trauma counselling, trauma therapy and in- and out-patients care. While clients may enter the system at any level it is envisaged that referral should be towards more intensive aspects of care predominantly. It is further envisaged that more highly trained and experienced personnel will provide training, support and supervision to their less highly trained colleagues.

A telephone survey was conducted using a snowball sampling technique. In this way 241 organisations providing services to victims of violent crime in Mpumalanga were identified. These service providers provided information relating to their organisation and each of the levels of service provision discussed above. This information was aggregated and presented to a consultative workshop of the participating service providers. At this workshop the data was validated and the researchers understanding of the results deepened.

A range of issues were identified relating to each level of service provision and recommendations regarding these are listed on the following page. In all the data shows that service provision has been turned around over the past ten years with the emergence of a set of strong victim support services. Unfortunately these services are not adequately supported by trauma counselling and trauma therapy and so victim support workers are forced to try to assist in cases for which they are poorly equipped. This is a threat to the wellbeing of clients and victim support workers and as such is a critical and urgent problem facing the sector.

Finally, this method of needs assessment is recommended for use in other provinces.

Summary of recommendations:

1. Emphasis should not be placed on opening new victim support schemes, except in the few areas where virtually no services have been identified.
2. Emphasis should be placed on the sustainability and capacity building of existing schemes.
3. This emphasis should be reflected in the way donor moneys are disbursed to the victim empowerment sector in Mpumalanaga.
4. This emphasis should be reflected in VEP policy in the province.
5. Victim support services should target the entire population of people living within South Africa.
6. Trauma counselling, and therapy services should be directed towards vulnerable groups, especially victims of rape, child abuse and neglect, and intimate partner violence.
7. The provincial Department of Social Development must ensure that the provincial VEP forum is functioning and effective, and the provinial VEP is well project managed.
8. All stakeholders must commit to a plan of action for the province which will move service provision towards the ideals laid out in this report.
9. A coordinated education and awareness raising strategy is needed for the province. Such a strategy should make better use of more cost effective media options including radio and print media.
10. Existing providers of counselling and therapy for people suffering from traumatic stress must be encouraged and assisted to find training that ensures that they are equipped to offer the services in question at an appropriate standard.
11. People equipped to provide counselling and therapy must start to think of supporting frontline workers as part of their work. They should be compensated for this work and victim support schemes and donors must allow for these costs.
12. More social work posts are needed to provide counselling and therapy services to victims of violent crime in Mpumalanga.
13. That Themba Lesizwe and the Department of Social Development use an amended version of the methodology used in this study to conduct similar needs analyses of other provinces within South Africa.
14. That all future planning for capacity building be built on good information about existing services and the expressed needs of service providers.

INTRODUCTION

After 10 years of democratic government, South African society is still struggling to transform all aspects of service delivery to the point that all citizens have access to high quality support and care. Only when this transformation is achieved can South Africa claim that the human rights of all our citizens are protected. This study is concerned with the transformation of a certain set of services, those relating to the support, care and empowerment of victims of violence. These services are the shared responsibility of several different government departments, notably social development, health, criminal justice, policing, education and correctional services. Services to victims of violence are typically provided in partnership with a broad range of non-governmental and community-based organisations.

The support, care and empowerment of victims of violence draws upon the body of mental health theory concerned with traumatic-stress. Traumatic stress theory deals with the way human beings respond to situations which threaten their lives, safety, and future wellbeing. Human responses to threat and danger vary widely and demand a broad range of services in response. Some people experience very little or no distress as a consequence of victimization, while others may experience chronic distress and severe psychological disturbance. Such powerful negative consequences may only be ameliorated by long term care and pharmacological treatment (see for example, Friedman, 2003).

The development of high quality services for victims of violence faces three simultaneous challenges:

1. To transform an inequitable and highly entrenched mental health care system;
2. To provide a broad range of co-ordinated services that meet the very varied needs of victims of violence; and,
3. To provide services that are appropriate to the varied cultural and social contexts of South Africa.

These challenges must be met in the current context of broader transformation in the country. The implications of this are that many of the systems with which mental health services for victims of violence interact are equally inefficient and ineffective. Policing, the court system, social welfare services, prisons and health services are all struggling with the problems of transformation. Further, mental health services are by necessity competing for funds with other services which are themselves under great strain. Important examples include services to combat the spread of HIV/Aids in South Africa and to care for people

infected or affected by the virus; the provision of adequate housing, water, nutrition, and employment; and the prevention of crime and conviction and correction of offenders.

Nevertheless, the support and care of victims of violence remains an important responsibility of the South African government. These services depend upon mental health workers finding ways to implement the facilitating laws and policies that have been developed and agreed after broad consultation. This reports aims to contribute to that process by exploring efficient approaches to monitoring, assessing and prioritizing the mental health service provision needs of rural regions of the country. With this information it is possible to draw up more impactful capacity building strategies.

BACKGROUND AND BRIEF LITERATURE REVIEW

South African society has become known as one of the most violent on the planet. Despite the miraculous political transformation of a decade ago, organised violence remains an everyday part of life in this country. South Africa's violent history includes the ravages of colonial rule, apartheid rule, civil conflict and organised crime. Suffice to say that, as South Africa enters the new millennium, levels of violence remain staggeringly high.

Although the cities and metropolitan areas of South Africa have the highest rates of most violent crimes, South Africa's rural provinces are by no means exempt from the frightening statistics. In fact, rurality itself presents a range of problems for service delivery of all kinds, not least of which is the provision of mental health services to victims of violent crime (American Psychological Association for Rural Health, 1995). Also, while many city dwellers complain about the stressors of urban life, living in rural communities is also associated with poorer health and poorer quality of life (Statistics South Africa, 2004a). Some of the problems associated with rurality are:

A widely dispersed population means that people often have to travel long distances to reach even rudimentary services. In fact, the small populations in particular areas make it very difficult to sustain some services on a cost effective basis.

Rural areas typically lack skilled personnel. More skilled personnel are drawn to the opportunities, facilities and services which can more easily be sustained in cities. This means that there are fewer (per capita) highly skilled personnel in rural communities.

People in rural communities tend to be poorer than their urban counterparts which means that they are often unable to pay for services, making sustainability even more difficult. For example, urban victim support programmes are often able to access small amounts of funding from local businesses to keep the service running. This is much more difficult for rural programmes (Higson-Smith, Bedell and Mudau, 2004).

In many cases rural facilities are staffed by young and inexperienced professionals, (see for example, the community service programme currently operating in South Africa for many categories of health professional). The impacts of this are in fact enormous. Firstly, such inexperienced professionals require much closer monitoring, support and supervision than their more experienced colleagues. When their close support is not available the quality of the service may be compromised. Secondly, placing young professionals in situations where they are dealing with very difficult cases without adequate support is unethical and dangerous. Thirdly, most of these professionals move back to the cities as soon as they are able resulting in a constant flow of new workers in mental health facilities. To build high quality service facilities requires the ongoing effort of committed people over an extended period of time.

Mpumalanga faces all the challenges of rural communities in South Africa. The following short section describes the province in a little more detail.

Mpumalanga

With a population of around 3.1 million people, Mpumalanga represents 7% of South Africa's population, and a similar percentage of the country's total area. Roughly 65% of the population live in non-urban areas and 39% are under 15 years of age (with only 3% being over 65 years). Approximately 90% of the population are black with the remainder being largely white. Of the economically active portion of the population, more than a third are unemployed. Nearly 20% of the population have had no formal education whatsoever, and only 4% have formal education beyond high school. There are 3 policing areas and 91 police stations in Mpumalanga. In other ways Mpumalanga is similar to other poorer and less developed areas in South Africa. Health, mental health and social welfare services are relatively few and far between.

Origins of violence in South Africa today

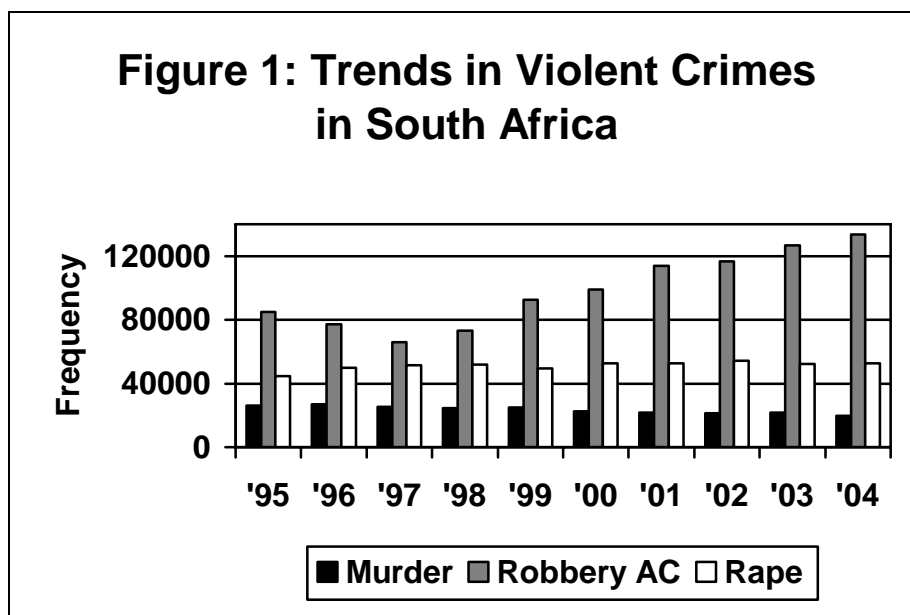
When one considers the country's long history of oppression and civil conflict alongside the related economic divides between people, it is not really that surprising that levels of violence are so high. If nothing else the work of the *Truth and Reconciliation Commission* (TRC) reminded South Africans of just how deeply the wounds of the past run. Despite the optimistic international picture of South Africa as a country of miraculous transformation and reconciliation, a great deal of bitterness remains between people of different language groups, religious beliefs, ethnic backgrounds, and economic classes. The origins of violence are multiple and interrelated. It is pertinent to mention a few of these:

- The history of oppression and human rights abuses. Decades of State violence have undermined many South Africans' respect for human life and dignity.
- A high incidence of traumatic-stress related emotional problems. It can be argued that levels of violence in South Africa are exacerbated by the very high number of people who have survived but never completely healed from the cumulative effects of multiple, grievous, traumatic exposure. Cycles of violence are described in detail in the literature on traumatic stress.
- Massive historical militarization of society, especially of young people. This is illustrated by the past conscription of white males under apartheid, school cadet training, youth as leaders in the struggle, and the paramilitary training of youth in situations of civil conflict.
- Proliferation of licensed and unlicensed firearms.
- Organised crime involved in weapons dealing, drug dealing, car theft, bank robbery and cash in transit heist syndicates, and trafficking in women and children.
- Enormous economic divides within the country. This problem is exacerbated by high levels of unemployment which frustrate lawful attempts at economic advancement.

After nearly 300 years of oppressive rule, it would be naive to expect a transformation to a peaceful society in only a few years. Nevertheless, it is sad to note that after years of struggle, many South Africans are still forced to live in a society which is as dangerous and stressful as almost any in the world.

Violent crime in South Africa over the last 10 years

In recent years much has been made by government leaders about crime being under control in South Africa (see for example the Presidents' State of the Nation speeches in 2004 and 2005). The slight reduction in some crimes, notably murder, is offered in support of this statement. However, other crimes such as robbery with aggravating circumstances and rape have not shown such patterns of steady decrease. Figures 1 through 3 below are derived from published police statistics of reported crime from 1994 to 2004 (SAPS, 2005).



Of course some crime statistics are more reliable than others due to reporting rates, changing classification of crimes, and other variables. Murder is generally considered the most reliable of reported crime statistics. Table 1 below contains comparative frequencies for murder for the world, Africa and South Africa.

	Murders per 100 000 pop.
World ¹	8.8
Africa	22.2
South Africa ²	42.7

Table 1

With figures close to five times as high the world average, even crimes which are showing significant improvement remain unacceptably high in South.

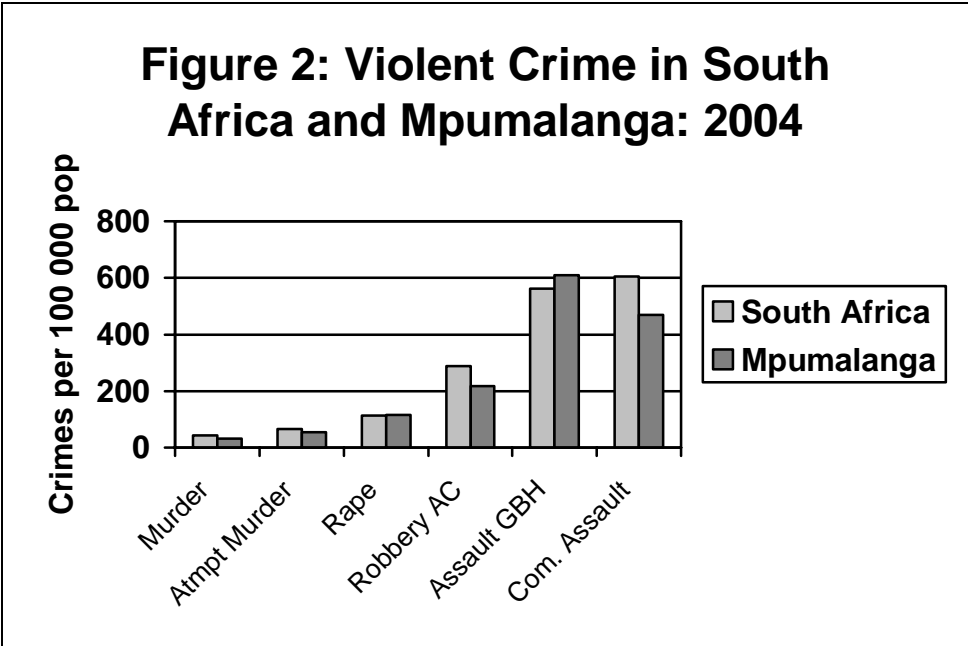
¹ World and Africa figures are taken from the WHO *World Report on Violence and Health* (Krug, et al., 2002)

² South African figures taken from SAPS published reported crime statistics (SAPS, 2005).

These statistics are calculated from *reported* cases. Of course there are many people who for a wide range of reasons do not report victimization. Schönreich (2002) reviewing the last *Victims of Crime Survey* (conducted by Statistics South Africa in 1997), reflects that around 95% of vehicle thefts, 60% of vehicle hijackings, and 59% of burglaries were reported. Less serious property crimes and some interpersonal violent crimes were more often not reported. Only 41% of robberies and 38% of assaults were reported. It is likely that even a survey of this kind drastically underestimates the prevalence of crimes such as assault in the domestic situation, rape, and various forms of child abuse and neglect. Adding all the unreported cases to the total mentioned earlier substantially increases any estimate of how many people are victimized in South Africa each year.

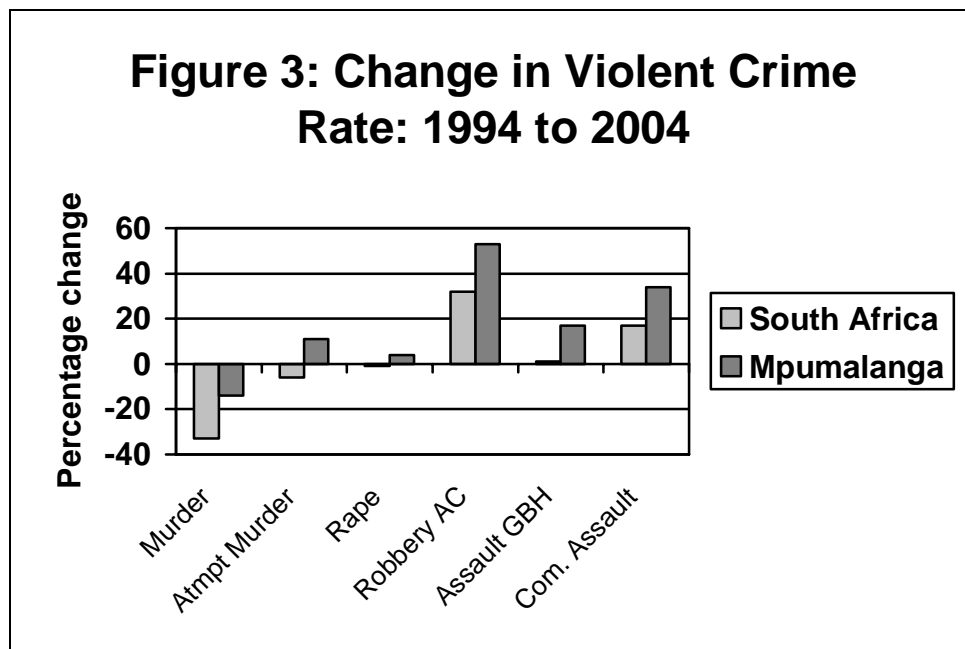
Violent crime in Mpumalanga over the last 10 years

In figure 2, the numbers of reported violent crimes per 100 000 population for South Africa generally and Mpumalanga specifically are illustrated. Selected violent offences are included, namely murder, attempted murder, rape, robbery, robbery with aggravating circumstances, assault with intent to do grievous bodily harm and common assault.



It is clear that for most crimes Mpumalanga has a slightly lower rate than that of the country as a whole. Assault with intent to do grievous bodily harm is the notable exception to this trend, with Mpumalanga showing a significantly higher rate.

Figure 3 illustrates the percentage change in crime rates from 1994 to 2004 for the same selection of violent crimes. Once again the number of offenses per 100 000 population for South Africa and Mpumalanga were used to calculate these figures.



In this case it is clear that compared with South Africa as a whole, Mpumalanga is faring rather badly. For example, whereas murder rates have decreased across the country by 33% over the last decade, in Mpumalanga they have dropped by less than half that figure. A similarly pessimistic picture emerges for crimes that have increased over the past ten years across the country. While the rate of robbery with aggravating circumstances has increased by nearly 32%, the rate in Mpumalanga has increased by more than 50%. Should these trends continue it will not be long before Mpumalanga has higher violent crime rates than the country's average for more crimes than just assault with intent to go grievous bodily harm.

History of traumatic stress services in South Africa

The suffering caused by various forms of violence in South Africa is increasingly being acknowledged. This has certainly not always been the case. Fifteen years ago mental health services for victims of violence were virtually non-existent in the country. Those services that did exist served almost exclusively white and privileged people. While it is true that small groups of progressive mental health workers worked supportively with anti-apartheid activists and their families, these services were negligible in the face of litany of brutality that characterized the apartheid government's rule in the 1970s and 1980s (Coleman, 1998).

However the political changes that have swept through South Africa in the past fifteen years have resulted in the rapid expansion of specialist psychosocial trauma services in the country. A vast range of such services exists today. Sadly, the quality of these services is extremely variable and they are not in any way equitably distributed. Even today, the majority of the country's population has little or no access to adequate psychosocial care following traumatic exposure. More, high quality services are desperately needed.

There are too many different service providers to list by name. However there are some categories of service provider, which should be mentioned:

- **Government Departments:** A range of government departments at local, regional and national level are engaged in particular projects relating to trauma resulting from crime and violence. These include the departments of health, education, welfare, justice and safety and security.
- **Interdepartmental government initiatives:** Various inter-departmental government initiatives have played an important role in the development of services. These include the Truth and Reconciliation Commission (TRC), the National Crime Prevention Strategy (NCPS) and in particular the Victim Empowerment Programme (VEP) that emerged under the NCPS.
- **Private sector initiatives:** Various larger private sector organisations provide psychosocial care for trauma survivors. This has been motivated in part by altruism; in part by a desire to demonstrate social responsibility; and in part by the realization that by supporting trauma services they are contributing to reconciliation, peace-making and violence prevention, and as such are investing in a more secure economic future.
- **Non-government, church, and community-based organisations:** These structures have long played a lead role in speaking out against human rights abuses in the country and supporting the victims of such abuses. Today many of these structures offer services to survivors of organised violence. Although a few of the larger structures do have a formal working relationship under *Themba Lesizwe*, the vast majority of service providers continue their work outside this structure.

- **Welfare Agencies:** Welfare agencies provide a similar range of services to the non-government organisations of (d) above. They are presented here as a distinct group as they are funded and controlled at least in part by the government department of welfare.
- **Hospitals:** Various private and government hospitals have developed psychosocial services for survivors of violence.
- **Tertiary Education Institutions:** Several universities, and other institutions offering tertiary education have developed specialised trauma counselling courses and offer outreach services. In addition many academics are engaged in a range of research, training and direct service provision on an institutional or private basis.
- **Private Practitioners:** Private practitioners from a variety of backgrounds offer psychosocial services to survivors of violence.

Quality of trauma services in South Africa

Given the broad spectrum of services outlined above, a question arises as to the quality of these services. As might be expected, the quality of service provision to survivors of violence in South Africa is extremely variable. Although services of exceptional quality do exist, it is also true that some survivors of violence receive services that are inadequate and poorly informed. The vast majority of services fall between these two extremes.

It is also a sad fact that the better services are only available to those who are able to pay for them. In other words, despite many peoples' best efforts to the contrary, poorer people are less likely than wealthy people to receive adequate assistance.

The reasons for the variable quality of services are multiple and include the lack of resources that many organisations face, poor management and supervision, and poor support of personnel involved in trauma work. However, perhaps the most important causes of poor service provision are:

- The lack of adequate theoretical underpinning of much training in the area of traumatic-stress intervention in South Africa.
- Trauma counselling is not as yet generally recognised as requiring specialised training.
- No standards or regulatory laws are in place regarding trauma counselling in South Africa.
- For these reasons, professionals in the industry are not motivated to obtain specific trauma training.

Many health care professionals in South Africa are providing care to survivors of violence on the strength of only a few days specialized training. In most cases they are doing so with little or no support and supervision. This limited training does not equip practitioners with all the information and skills demanded by the work. Nor does it provide the skills necessary to manage the problems of secondary traumatic stress (also called compassion fatigue). Far from detracting from the important work of these dedicated people who are attempting to provide whatever support they can, given limited resources, this project aims to provide these key personnel with more sophisticated knowledge, skills and support, thereby enhancing their capacity, and increasing their working-life in otherwise emotionally destructive work.

The problem of lack of standards for trauma practice and training is more complex in the degree to which it involves established training institutions, legislation, and regulatory boards. Currently, only the training provided by tertiary institutions in more general fields (including medical practice, psychiatry, clinical psychology, nursing, and psychiatric nursing) is regulated, and hence only those courses offer any kind of accreditation. None of these courses offer specialised training in trauma work. Similarly there is currently no system of qualifications for trauma work beyond the more general qualifications and registrations such as “clinical psychologist”, “general nurse”, etc. The result is that a number of people offer care to survivors of violence without having their skills officially recognised and without any kind of regulation. There are currently important initiatives underway in the country to develop a process of accreditation for training courses as well as a broader range of mental health professionals. It is important that trauma work be well represented in these debates in order that survivors of organised violence are ensured of quality services.

It is clear that problems of violent crime are as important in Mpumalanga as they are in the rest of the country and that services to victims face a difficult journey if they are to meet the real and expressed needs of the community. This study helps to assist with that journey.

OBJECTIVES OF THE STUDY

This study has six broad objectives:

1. To produce a public health model of traumatic stress service provision that is appropriate to the geography, diversity of cultures and resources of South Africa's less densely populated provinces. This model should incorporate public education and awareness work, community-based social support networks, early intervention or "debriefing" services, training and supervision of frontline trauma practitioners, trauma therapy, out- and inpatient psychiatric treatment.
2. To map the full range of services listed above in one rural province (namely Mpumalanga province).
3. To identify gaps in the existing network of services as compared with the model for service provision described under point (1).
4. To build networks by introducing this full range of service providers to the work of Themba Lesizwe and SAITS.
5. To produce a plan for the strategic development of traumatic stress services in Mpumalanga in collaboration with service providers in the province.
6. To provide Themba Lesizwe with a tested methodology for service delivery needs assessment that can be applied in other regions of Southern Africa.

METHODOLOGY

Design overview

In this study the researchers attempted to sample the entire population, that is all organisations in Mpumalanaga offering mental health services to victims of violent crime. A senior person in each organisation participated in a detailed telephonic interview that examined the nature of the organisation, the range of services offered, the client population serviced by the organisation, as well as the priority needs facing that organisation. Results of

this survey were presented in aggregate form to representatives of organisations that participated in the survey. This process served to verify and deepen the results of the survey.

Sample:

Inclusion criteria for participation in the study were kept relatively broad. Any organisation offering services to victims of violence, intended to provide emotional support, alleviate distress or improve mental health were included. Services that might provide an emotional benefit as a bi-product (but not as a core aim), such as court preparation, or income generating projects were not included in the sample.

The sample was derived using “snow-ball sampling”. In this technique each participant (in this case, service providing organisations) is asked to identify other participants who meet the sampling criteria of the study. Researchers began the study with a set of lists of mental health service providers in Mpumalanga province. These initial lists included:

- South African Institute for Traumatic Stress (SAITS) membership list
- Themba Lesizwe affiliate list
- Business Against Crime Victim Support list
- VEP service provider list (Department of Social Development)
- Hospitals and Clinics list
- Courts list
- Local social welfare office list

Unsurprisingly these lists showed a great deal of overlap, since in part they were compiled off each other. Furthermore, many of the contact details on these various lists were out of date. Nevertheless, these lists provided a substantial start to the search for mental health service providers in Mpumalanga province.

At the end of each interview, respondents were asked a series of questions designed to identify other service providers in their area. Respondents were asked who they take referrals from, to whom they refer cases that are beyond their scope, and for information about any other organisations that offer similar or complementary services to their own in the region. As much information (contact numbers and names) was taken as possible. These new organisations were added to the existing lists of service providers included in the study.

This process of adding new names to the list until the point at which the respondents were supplying contacts that had already been identified by previous participating organisations, and no new names were being added to the lists. At this point the researchers were certain that they had contacted virtually all the service providers in the province and the sampling process was completed. A complete list of organisations participating in the study is included in appendix A.

Instrument:

The structured interview used comprised 8 sections which are detailed here:

1. Organisation's details

- i. Organisation name.
- ii. Contact person(s).
- iii. Physical and postal addresses.
- iv. Contact phone numbers, email, webpages.

2. Awareness raising / education activities

- i. Form of awareness raising / education.
- ii. Target groups.
- iii. Number of people reached per month.

3. Victim support services

- i. Which staff provide service? How are they trained?
- ii. Exact nature of service.
- iii. Broad demographics of client base.
- iv. Predominant crimes reported.
- v. Number of people assisted per month.

4. Trauma counselling

- i. Number of sessions.
- ii. Which staff provide service? How are they trained?
- iii. Where is counselling conducted?
- iv. Broad demographic of client base.
- v. Predominant crimes reported.
- vi. Number of people assisted per month.

5. Trauma therapy

- i. Number of sessions
- ii. Which staff provide service? How are they trained?
- iii. Where is therapy provided?
- iv. Broad demographics of client base.
- v. Predominant crimes reported.
- vi. Number of people assisted per month.
- vii. What approach to therapy is used?
- viii. Are support groups available?
- ix. How many people benefit from support groups?

6. In- and outpatient care

- i. How many trauma related cases are in care?
- ii. Is psychotherapy included in the care? Offered by?
- iii. Is pharmacotherapy available? Offered by?
- iv. Typical length of stay.
- v. Broad demographics of client base.
- vi. Predominant crime reported.
- vii. How many people treated per month?

7. Priority development needs

8. Referral data

- i. To whom are referrals made?
- ii. From whom are referrals received?
- iii. Other organisations in the network.

Clearly not all organisations provide all services, although many provide more than one. Where organisations did not provide particular kinds of services, those sections of the interview were left out. All participants answered sections 1, 7, and 8. All organisations were asked to supply supporting documentation in the form of education materials, monitoring or annual reports, etc. The full instrument used in the research is included in appendix B.

Survey procedure:

A specially trained interviewer phoned each organisation on the contact lists (original lists plus referrals from earlier participants) and asked to speak with the most senior manager

present. Interviewers were instructed to find a senior person who had sufficient knowledge of the organisation's work to answer the questions in the interview schedule. Where such a person was available and had time to participate in the interview, the interview was conducted immediately. Where such a person was not available or did not have time, the researcher made an appointment for a later telephone interview at the respondent's convenience.

In some cases it was exceptionally difficult to speak to the appropriate persons in organisations and many appointments were not kept by respondents. When the researcher had failed to collect the needed data on five separate telephone calls the name and contact numbers of the organisation were retained in the database but the body of the data collection process was abandoned.

Some government agencies, notably those answering to the departments of social development and health, require permission from provincial level for participation in research. Both these provincial departments, as well as the provincial VEP office were furnished with complete research proposals and a request to allow their staff and agencies to participate in the study. Permission was quickly received from the department of social development and the VEP. Despite repeated requests to the department of health permission was not given for health personnel to participate in the survey. Nevertheless, some data from providers associated with the Department of Health is included as some service providers felt that since the study did not in anyway impact upon patients and required information that is all available to the public, permission was not required.

Data from all interviews was captured using an Excel spreadsheet and transferred for analysis to the Statistical Package for Social Sciences (SPSS, ver 10.0) for analysis. Qualitative items were analyzed using thematic content analysis and included in the spreadsheets and analysis.

Consultative workshop

All organisations that had been identified as service providers (regardless of whether they had actually contributed to the survey) were invited to attend a workshop. This workshop was scheduled for a Saturday in Middleberg, a time a location most easily accessible to people from all around the province. The workshop was attended by 64 people representing 51 organisations that participated in the survey.

The workshop was opened with short presentations about Themba Lesizwe (given by Zuzelle Pretorius, Deputy Directory of Themba Lesizwe), SAITS (given by Nomfundo Mogapi, Director of SAITS), and the nature of the study (Craig Higson-Smith, Principle Investigator). Following this the overall results of the study were presented. Participants had an opportunity to ask questions about methodology and results. Various comments were made at this point about the results of the survey. After this the representatives were split into five small groups, each assigned to discuss the challenges facing one of the levels of the 5-layer model. The results of these small group discussions were captured and reported back to the plenary.

The researchers kept detailed notes of all discussion held during the day, and these are reported on in the results section below.

A THEORETICAL PUBLIC HEALTH MODEL OF SERVICE DELIVERY:

The purpose of the *World Report on Violence and Health* (Krug, Dahlberg, Mercy, Zwi and Lozano, 2002) released by the World Health Organisation (WHO) was to,

... challenge the secrecy, taboos and feelings of inevitability that surround violent behaviour, and to encourage debate that will increase our understanding of this hugely complex phenomenon.

While the last decade in South Africa has seen enormous progress towards recognizing the suffering and rights of victims of violence, the country is still a long way from protecting those rights and responding to the suffering associated with having those rights infringed. According to the WHO, the key to better services for victims of violence lies in responding to violence as the public health problem that it is, that is by adopting a public health approach.

A public health approach to violent crime must include strategies aimed at primary and secondary prevention of violence, as well as care for individuals, families and communities affected by violence. While the latter has an important contribution to make in the prevention of violence (through breaking the much written about cycles of violence), their core aim is to assist victims of violence to return to a relatively healthy and happy existence. These services are the focus of this research.

An important challenges facing the victim empowerment sector in South Africa is the lack of consensus about the meaning of terms. For example, the word “debriefing” is widely used in

various contexts but has different meanings. For some this term is a short form of “Critical Incident Stress Debriefing” (CISD), a particular technique used to assist survivors of violent crime and other traumatic experiences. Others use the word “debriefing” to refer to any short term intervention for victims that follows quickly after victimization. Still others use the term to refer to the supervision and support given to mental health personnel working with trauma survivors that is designed to prevent and/or ameliorate the effects of secondary traumatic stress. A similarly problematic term is “trauma counselling”. Some practitioners use this term to refer to general counselling with victims of traumatic events, while others use the term when describing particular techniques of counselling which are specially designed for use with traumatised persons. Exactly the same problem exists with the term “trauma therapy”. A successful public health model of service provision to victims of violent crime must assist the sector to develop a common language when talking about service provision.

A public health model of service delivery to victims of violent crime must fulfil various criteria. The following is a list of eight such criteria which are critical components of service delivery:

1. **Evidence-based:** The efficacy of all intervention strategies must have been demonstrated through efficacy studies which meet high standards of scientific and ethical rigour. Existing treatment outcome studies have demonstrated the effectiveness of a wide range of techniques for trauma service provision. Techniques that are not scientifically supported must be viewed as exploratory until such evidence exists.
2. **Appropriate:** Various factors determine the kind of service that is most appropriate to meet the particular needs of any survivor of violent crime. These factors include the person’s premorbid functioning and trauma history, the nature of the event itself, as well as the amount of support that a person receives following victimization. Appropriacy requires having a range of different services available to victims of violent crime and some means of directing people towards the service(s) that are most appropriate to their needs. There is also a need for services directed towards particular groups in the population, such as children, the elderly, people with disabilities and refugees.
3. **Accessible:** All victims of violent crime must be able to access mental health services. This means that services must be geographically located in places that people can travel to with relative ease, and they must be available at costs which people can afford. For many South Africans, this means that services must be free.

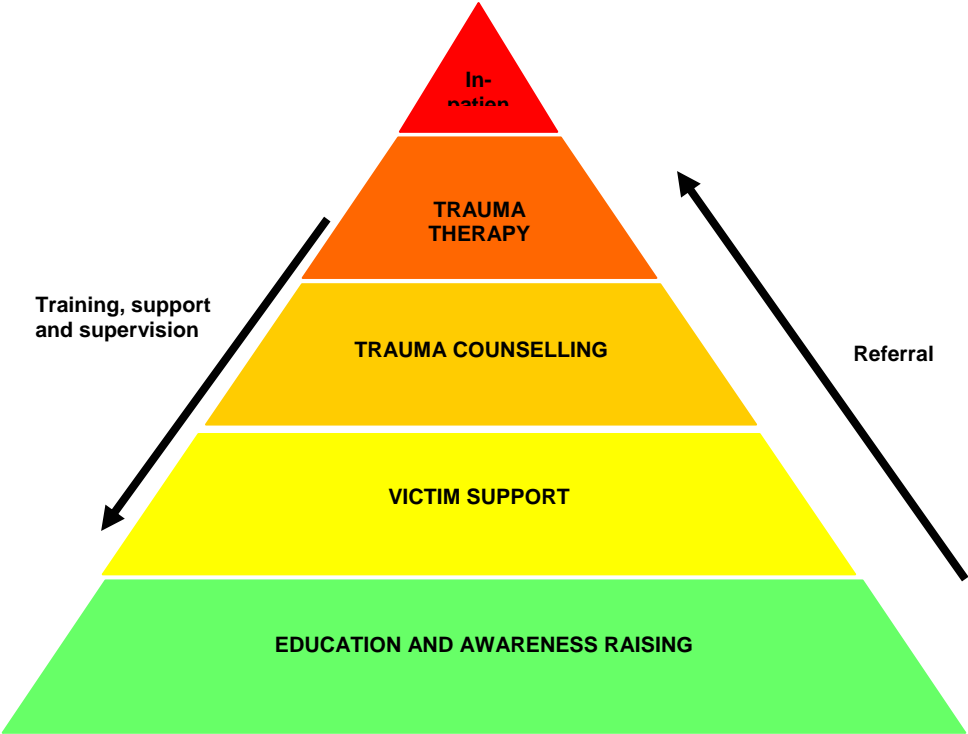
4. **Quality assured:** It is critical to ensure that service delivery meets the highest level of professionalism. While the first point in this list ensures that the techniques used in service delivery are of a certain quality, it does not speak to the manner in which that technique is employed. Quality assurance highlights the importance of staff selection, training, accreditation, monitoring and supervision processes.
5. **Co-ordinated:** A comprehensive service delivery model requires various kinds of service, offered by different people, in different places. Such complexity demands a well organized system of networking and referral between services. Victims should be able to access the most appropriate services by as simple a route as possible, not having to repeat their story needlessly to multiple service providers until they eventually access someone who is able to assist.
6. **Efficiency:** Services need to make the best use of South Africa's limited resources. These resources include the availability of skilled mental health personnel, physical infrastructure, time and money.
7. **Contextually embedded:** Services need to be embedded in the social patterns, histories, cultures and languages of local communities. This requirement involves close cooperation with civic structures, local government, traditional leaders and healers. It also means offering services in all languages that are commonly spoken in South Africa.
8. **Ethical:** Services must be delivered in accordance with the highest ethical standards. Every effort must be made to protect the privacy, dignity and human rights of all victims of violence. This also means that the mental health of all service providers must be protected. Secondary traumatic stress remains a serious problem among South African service providers, contributing to high levels of distress and serious symptomatology among service providers, high burnout and staff turnover, and finally, poor service delivery.

Figure 4 on the following page depicts a theoretical model organised around five levels of service delivery. More details of each level are included in Table 2 that follows. The *width of each level* refers to the proportion of the general population that requires the service at any time. Thus for example, education and awareness raising is utilized by the entire population, whereas in-patient care is only necessary for a small proportion of victims of violence that

are not responding to other forms of treatment. The *height of the level* within the pyramid refers to a range of factors relating to that kind of service provision. Levels of service delivery closer to the top of the pyramid are more expensive, take longer, and require more highly skilled and qualified service providers. Finally, *the colour of each level* refers to the psychological health of the typical client at each level of service provision. Thus recipients of education and awareness raising are likely to be emotionally healthy and thus the level is illustrated in green. People using victim support services are also likely to be psychologically healthy although in great distress, and so on. Patients in psychiatric care are not typically psychologically healthy and prognosis for full recovery is often poor. As such this level is coloured red.

The arrows on either side of the pyramid refer to two processes which are indispensable to a public health model of service provision to victims of violence. While clients can enter the system at any level, in general they should be referred upwards to more intensive kinds of care. As such the capacity to assess and refer appropriate is essential to all levels. Thus there is a referral arrow pointing towards the top of the pyramid. However, service provision to victims of violence is complicated and distressing. Thus processes of supervision and training are represented in a downward arrow. Health care workers in the higher levels have an ethical responsibility to support their colleagues working in lower levels.

Figure 4: 5 Level Model of Integrated Trauma Service Provision



	TARGET POPULATION	EMOTIONAL STATE	DURATION OF INTERVENTION	CONTENT OF INTERVENTION	REGULATION	CRITICAL LINKAGES
IN and OUT PATIENT CARE	Very small proportion of victims who cannot be contained within their families and communities without psychiatric medication	Meet the diagnostic criteria for recognised psychological disorders. Typically high levels of distress.	Varies widely between acute treatment for episodes of mental illness and chronic care	Combinations of containment, psychopharmacological intervention and therapy	Health professionals registered with HPCSA Professional societies	Clinics and hospitals Depts. of Social Dev. and Health HPCSA Universities
TRAUMA THERAPY	Small proportion of victims who do not respond to trauma counselling, or whose symptoms persist beyond a month	Many will meet diagnostic criteria for recognised psychological disorders. High levels of distress	Typically between 6 and 12 sessions, although sometimes ongoing on a weekly basis for a year or more	Includes uncovering repressed traumatic content, desensitising triggers, and changing entrenched defensive behaviours	Health professionals registered with HPCSA Professional societies	Clinics and hospitals Depts. of Social Dev. and Health HPCSA Universities
TRAUMA COUNSELING	Roughly 10% of people recently victimized who do not make significant progress within 3 weeks	Majority are psychological health and in great distress. Need assistance to mobilise internal healing resources	From 1 to 6 sessions of around 45 minutes each	Mediated re-exposure Reframing cognitive distortions Symptom management Problem solving and decision-making	Currently unregulated New standards of practice and training urgently needed	Clinics and hospitals Welfare agencies Courts Depts of Social Dev. and Health
VICTIM SUPPORT	Any people recently victimized	Majority are psychologically healthy but with a high level of distress	From 1 to 4 sessions of around 45 minutes each	Emotional support Mobilize coping Mobilize support Information Practical assistance and problem solving	Currently unregulated New standards of practice and training urgently needed	SAPS Courts Hospitals Depts of Criminal Justice, Police and Social Development
EDUCATION and AWARENESS RAISING	General population	Very diverse Majority healthy with low distress.	Ongoing and repeated.	Victims' rights Available services Signs of trauma Recovery process Helping yourself and others	Advertising standards authority Broadcasting authority	Electronic, print and internet media companies. National organisations and most govt. depts.

Table 2

RESULTS OF THE SURVEY

The survey succeeded in tracking down more than 241 trauma service providers in Mpumalanaga province. It is worth noting that this is more than double the number of names contained in the initial lists. Clearly many smaller organisations have not managed to make their work known to the major role players by whom such lists are compiled. Of these identified service providers the researchers were able to get data from 214 (89%) of them.

Type of services:

Table 3 below reveals that the majority of service providers are non-profit making and non-governmental. The private sector only accounts for 11% of service providers (mostly mental health professionals in private practice) and government services account for a further 12%. In contrast to these non-government, community-based and faith-based organisations account for 70% of service providers.

Distribution of organisations by type		
	<i>Frequency</i>	<i>Percent</i>
Non-government	117	49
Faith based	48	20
Government	30	12
Private	27	11
Community-based	2	1
Unspecified / missing	17	7
Total	241	100

Table 3

The question then arises as to how these services relate to the theoretical model outlined above. The number of organisations offering services at each level is recorded in the next table. Note that most organisations offer services at more than one level as so the totals frequency is much higher than the total number of service providers.

Distribution of organisations by level of service		
	<i>Organisations</i>	<i>Percent</i>
Education & Awareness	103	48
Victim Support	137	64
Trauma Counseling	74	35
Trauma Therapy	15	7
Inpatient Care	9	4

Table 4

Geographic Distribution

The geographic distribution of services is key to a planning. Researchers tracked down the municipal region in which services are located from the contact addresses given. The following distribution emerges.

Geographic distribution of sample		
<i>Municipal Region</i>	<i>Organisations</i>	<i>Percent</i>
Albert Luthuli	13	5.4
Delmas	4	1.7
Dipaleseng	6	2.5
DR J S Moroko	3	1.2
Emalahleni	19	7.9
Greater Groblersdal	16	6.6
Greater Tubatse	1	0.4
Highlands	4	1.7
Highveld East	34	14.1
Kwamhlanga	7	2.9
Lekwa	14	5.8
Mbombela	46	19.1
Middelburg	8	3.3
Mkhondo	4	1.7
Msukaligwa	9	3.7
Nkomazi	14	5.8
Seme	6	2.5
Thaba Chweu	11	4.6
Thembisile	9	3.7
Umjindi	8	3.3
Unlocated	2	0.8
Total	241	100.0

Table 5

It is worth noting that the researchers were able to locate at least one service provider in every municipal area within the province. This is a very positive sign for the accessibility of services, especially in a largely rural province. At the same time the distribution of services is far from equitable with some municipal regions having very many services while other have virtually none. Compare, for example, Mbombela (the area that surrounds Nelspruit) that contains 19% of the provinces services, compared with the Greater Tubatse region, which has 1 service provider (only 0.4% of the provinces services). As expected services do tend to cluster around urban centres.

Core expressed needs:

A very broad range of needs were expressed to the researchers during the interview. The most commonly mentioned themes are contained within table 6 below.

Most commonly expressed needs		
	<i>Frequency</i>	<i>Percent</i>
Training / capacity building	60	17
More staff	55	16
Financial support	24	7
Food, clothes, toys, etc.	24	7
Shelters	23	7
Transport facilities	19	6
Other equipment	18	5
Referral options	11	3
Awareness raising	11	3
Community support	9	3
Cooperation with SAPS	7	2
Volunteer management	7	2
Help with secondary trauma	5	2
Education materials	5	2
Poverty alleviation programmes	4	1
Medical supplies	3	1
Clients give wrong info	3	1
Cooperation with social services	2	1
Other	54	12
Total	344	100

Table 6

Two categories stand out from the rest with respect to frequency of mention. Requests for various forms of training or capacity building came from 60 service providers. In most cases service providers did not specify particular areas of training need, suggesting that there is still a great deal of work to be done in establishing basic skills of victim support and trauma counselling in this province. The second key category is the need for more staff. Clearly many service providers are feeling overburdened by their caseloads. In some cases requests were made for particular categories of skilled staff, especially social workers and psychologists. These requests speak once again to capacity building, and the difficulty that rural frontline service providers face in finding suitably skilled workers and/or referral options to meet the complex needs of rural communities. Note that the needs for shelters and other referral options are not much further down the list of core needs.

Education and Awareness Raising

Of the service providers participating in the survey 103 (43%) offered some form of education or awareness raising service. These 103 organisations were asked what forms their education and awareness programmes took. Many organisations use multiple strategies. A total of 211 responses were received as indicated in table 7 below.

Form of media used in education and awareness raising activities		
	<i>Frequency</i>	<i>Percent</i>
Short talks	59	28
Day workshops	42	20
Pamphlets	38	18
Posters	19	9
Radio broadcasts	14	7
Newspaper articles	6	3
Community meetings	6	3
Participating in national campaigns	5	2
Presentations at schools	5	2
Other	17	8
Total	211	100

Table 7

This table shows that nearly 50% of the awareness raising and education work being done in Mpumalanga is done through the medium of speaking to people directly from various platforms (short talks, workshops, school presentations, community meetings, etc.) Although this is undoubtedly the most effective way to communicate with people it is also by far the most expensive. Out of the 103 organisations, only 38 used pamphlets, 14 made use of radio, and only 6 had managed to use newspapers to get their message across. Further, it is worth noting that no organisation in this sample was able to use television to get their message out to the public. This is most likely due to the rural nature of the Mpumalanga province. Organisations in centres from which television is routinely broadcast are much more likely to be able to use this medium of awareness raising.

Victim Support

Of the organisations participating in the survey, by far the greatest number 137 (57%) offer some form of victim support service. There is no cost for these services in 97% of organisations offering victim support in Mpumalanga. The remaining 3% of organisations charge a minimal fee or charge on a sliding scale according to the client's income. The number of clients being assisted per month varies enormously from a minimum of 1 to one organisation that claims to be assisting 1,000 victims per month. The distribution shows a very strong positive skew with most organisations assisting between 10 and 65 victims per month (median=20).

Victim support services are the front line of traumatic stress service provision in many communities. It is at this point that people who are victimized receive basic services and are first screened for referral on to more intensive forms of psychosocial care. As such it is

important that these services are available to all members of the community. The results of this survey show a worrying gender imbalance. Of the organisations offering victim support services 71% offer services predominantly to women, with the remaining 29% offering services to both men and women. No organisation participating in the study offered services predominantly to men. Now while international research clearly shows that women are more likely to suffer from post-traumatic stress during their lifetimes (despite men having higher levels of violent exposure, see for example Kessler, et al. 1995), these figures do not justify the high proportion of frontline services that are directed primarily towards women. The argument is often made that victim support services help prevent violent crime by breaking the cycles of violence. While this is undoubtedly an important aspect of frontline service provision, this opportunity is lost when most resources exclude men, the group from which the vast majority of violent offenders come.

The ethnicity patterns are much more positive. A full 87% of victim support services in Mpumalanga assist primarily black victims of violent crime. A further 3 % service predominantly white people, and the remaining 10% provide assistance to a mixed group of people. Given the ethnic demographics of the province (refer to background and literature review earlier in this report), these figures look exactly right, another indicator of how far mental health service provision has moved in the past decade or so.

The kinds of problems most commonly presenting also creates an interesting picture. Firstly, the range of problems is very large with 44 different categories emerging in the data. Secondly, not all involve victimization. The twelve most common presenting problems are listed in the following table, followed by the number and percentage of organisations that mentioned that problem.

Common problems presenting for victim support		
	<i>Organisations</i>	<i>Percent</i>
Intimate partner violence	85	62
Rape	58	42
Child sexual abuse	33	24
Other forms of child abuse	18	13
Assault	12	9
Other sexual offences	11	8
Petty crime- youth offenders	6	4
Burglary	5	4
Trauma in schools	5	4
HIV/AIDS related problems	5	4
Neglect of a child	4	3
Bereavement	4	3

Table 8

Clearly the most common forms of victimization reported to victim support services is closely related to the gender bias discussed earlier. Most importantly, the most common presenting problems are more difficult to respond to than simpler kinds of victimization (such as armed robbery, assault and hijacking). Intimate partner violence is often continuous or repeated, and in many cases the victim is still living with the perpetrator. Rape has significant impact upon issues of self-esteem and capacity to share intimacy with others. Finally, all crimes involving children present added complexity because of the all important developmental process which characterizes childhood. All of these factors are important predictors of longer term psychosocial consequences (including post-traumatic stress disorder) and typically require intervention beyond that possible at victim support level. The question arises as to whether victim support workers are suitably trained and supervised to do this work. If they are not there is reason for serious concern as to the quality of the service being provided, the possibility of doing harm, and the emotional health of the service providers themselves.

Trauma Counselling

A total of 74 organisations (31% of the total sample) reported that they offered trauma counselling services. Of these service providers, 86% provide services predominantly to black victims of violence, 2% service the white population predominantly, and 12% reported that their client base is very mixed. The gender pattern shows similar results to that of victim support. Of the total sample of organisations offering trauma counselling services, 73% aim their services at women and children. A further 26% aim their service at the whole population. One organisation targets men for trauma counselling.

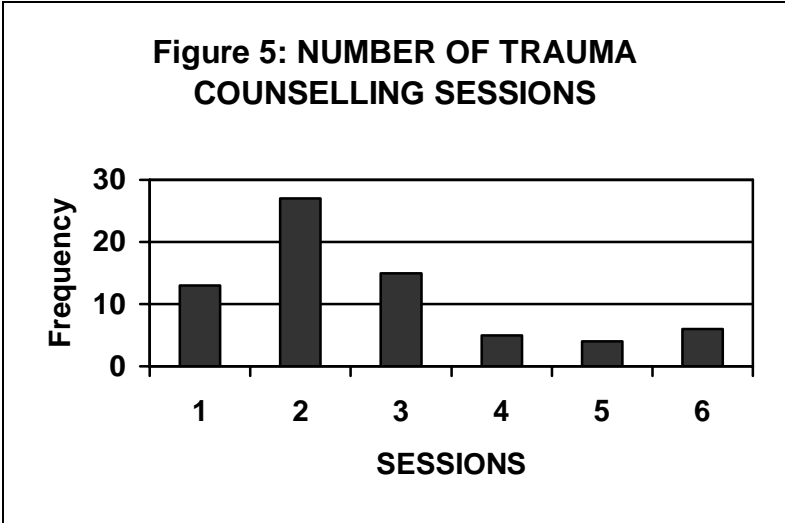
Table 9 lists the most common presenting problems. Not unexpectedly the pattern is very similar to that of victim support with crimes against women and children accounting for the majority of cases.

Common presenting problems for trauma counselling		
	<i>Organisations</i>	<i>Percent</i>
Rape	33	28
Intimate partner violence	31	26
Child abuse	22	18
Other violent crime	8	7
HIV/AIDS related problems	5	4
Attempted suicide	3	3
Youth problems	3	3
Bereavement	3	3
Burglary	3	3
Substance abuse	2	2

Table 9

At first glance these figures seem very reassuring. There is a significant group of organisations offering trauma counselling in the province, to an appropriate distribution of clients, presenting with problems that we know to be among the most emotionally damaging forms of victimization.

Figure 5 shows a distribution of how many sessions the typical client receiving trauma counselling attends. While the distribution has a positive skew it is clear that the majority of clients receive three or fewer trauma counselling sessions.



While there is certainly room for brief interventions of only a few sessions in a holistic and integrated public health care response to trauma, when one considers the most common kinds of victimization being dealt with, there is cause for worry. Such issues as rape, child abuse and intimate partner violence are very complex and typically demand more than two or three sessions for successful resolution. While a survey at organisational level does not allow researchers to draw firm conclusions about how many sessions people who have been victimized in particular ways receive, the fact that the majority of clients are reporting complex forms of victimization and receiving short term care is cause for concern.

Trauma Therapy

Only 15 service providers (6% of the total sample) described themselves as providing trauma therapy. Of these 12 (80%) are in or close to Nelspruit. The others are all in urban centres. While it makes sense that tertiary services including trauma therapy are located in urban centres, the fact that they tend to be clustered in a single place is a problem. Mpumalanga

covers a large area and the clustering of services around Nelspruit makes it extremely difficult for the majority of the rural population to reach tertiary mental health services.

As for the other categories rape, intimate partner violence and child abuse head up the list of presenting problems. These are all problems for which therapeutic intervention is the appropriate level of response.

Twelve of the 15 are government organisations, two are non-government, and one is private. There seems to be a clear lack of skills for more intensive psychological intervention in the non-government sector. However, before we assume too much about therapeutic services in the government sector it is worth checking some details about those services. The survey enquired who provided the service and what therapeutic techniques were used. According to our respondents, therapy was provided by psychologists in 8 service providers, by social workers in 2, by doctors and nurses in 2, and in 1 service provider by a lay counsellor. (Two service providers were unable to answer this question). Since it is against the law for doctors, nurses and lay counsellors to provide psychotherapy, we can reduce the number of service providers providing psychotherapy to victims of trauma in Mpumalanga to 10. In response to the question around the chosen approach to psychotherapy, 2 service providers were unable to answer the question, 7 service providers mentioned client-centred therapy, and 3 service providers each mentioned psychodynamic and cognitive-behavioural psychotherapy. One service provider referred to their therapeutic work as eclectic. While all of these answers are appropriate, it is worth noting that client-centred therapy is not usually used for traumatic stress work, but is taught as a general model of short-term general psychotherapy. Not one technique that is especially associated with traumatic stress work was mentioned. These results suggest that the service providers offering trauma therapy have limited specialist training in traumatic stress work, but are instead using general models of psychotherapy with traumatized clients.

In- and Out-patient Care

Ten service providers were identified (4% of the total sample) that are capable of providing in- and out-patient care to psychiatric patients. Length of treatment ranged from 1 or 2 weeks (4 service providers each), to 12 weeks maximum (1 provider). All service providers include pharmacological treatment, with anti-depressants being by far the most common medication used. Only one service provider mentioned the use of anxiolytics. Rape was the most common form of victimization leading to hospitalization.

RESULTS OF THE CONSULTATIVE WORKSHOP

At the consultative workshop, delegates were given a brief overview of the results of the survey. Responses focussed on two areas:

1. Several delegates expressed astonishment at the number of services that had been identified through the survey. From these discussions the group arrived at several conclusions, namely:
 - a. Local service providers were insufficiently networked and were not making the best use of available resources.
 - b. It was argued that many of the organisations mentioned offered only a negligible service as an adjunct to their core business, for example the courts and hospitals. While this is undoubtedly true they still represent starting points for service delivery which have capacity for development.
 - c. Delegates were in a better position to network more effectively following the meeting.
2. Much interest was expressed for the 5 level model of service delivery to victims of violent crime outlined above. Participants said that it helped clarify the different kinds of service and where their organisations could fit into a bigger picture.

Following the plenary meeting, delegates were asked to assemble into smaller groups with each group representing one of the five levels of the model³. Each group was then tasked to answer a set of questions relating to that level of service provision in Mpumalanga:

- What is the current position of service provision at that level in the province?
- What are appropriate short and long term goals (1 and 5 years)?
- What are the first steps towards making these goals reality?

The results of these discussion are summarized in the following sections.

³ Insufficient attendance from psychiatric hospitals resulted in there not being sufficient delegates for the in- and outpatient care level to have its own group.

Education and awareness raising:

Current position: Delegates noted that most awareness raising work happened on an *ad hoc* basis and was not guided by any clear strategy. National campaigns provided much of the impetus for this level of work. They also noted that there was no common understanding about victim empowerment or trauma service provision in the province and that this hampered awareness raising work

With respect to key gaps in this level of service provision delegates pointed out that funding contracts, organisational policies and budgets all worked to reduce the amount of energy and time put into awareness raising and education. They felt that this level of the model was not properly planned for and that it was assumed that this function would happen around the work of actual service provision. Delegates also noted the lack of readily available materials for education work, and highlighted particularly the need for materials relating to victims' and children's rights. The lack of co-ordination between service providers was also discussed as a key problem facing education and awareness raising around victimization in Mpumalanga.

Goals for the future: Under this heading, delegates highlighted the immediate need for the development of a co-ordinated awareness and education strategy for the province which made the most effective use of the available resources. They felt that all stakeholders should commit themselves to facilitating a common understanding of victim empowerment. Ultimately all members of the public need to be aware of their rights and to know where they can access services if they or people close to them are victimized.

First steps: Service provider representatives agreed that the provincial NCPS committee should be the co-ordination point for this work. Delegates felt that there should be a formal memorandum of agreement that spelt out the roles and responsibilities of all participants, including the various government departments and service providers.

Victim support:

Current position: It was appreciated that there are victim support services in all the major centres and many smaller towns. The key gap mentioned was that there is no marketing of these services (see previous section), and that people learn about the service through word of mouth. It was noted that the absence of a working provincial VEP forum makes it very difficult to co-ordinate services and build capacity.

Goals for the future: It was felt that Mpumalanga should aim to have free victim support service in every police station, court, hospital and clinic. The scope of services should be clearly defined and better marketed. Representatives argued that victim support workers need better training.

In the medium term the victim support group wanted to see uniform operating procedures for victim support services to ensure a high quality of service. All victim support centres should be registered non-government organisations. Volunteers should be reimbursed for travelling, food and other costs and there should be career opportunities in victim support work. These representatives would also like to see more research into the long term cost-effectiveness, accessibility and sustainability of this level of work. They also wanted to see more shelters coming into existence where victims of domestic violence might be sent for short periods. Finally, they expressed a need for more social workers and psychologists in the victim empowerment sector to whom they could refer clients.

First steps: The most important first step was argued to be the need for a functioning VEP forum in Mpumalanaga. The delegates looked to the Department of Social Development to get this going as the lead department in the VEP. This should be followed by the development of a code of conduct for victim support workers, including a policy that victim support workers are reimbursed for their costs by the government.

Questions from the floor following this presentation clearly demonstrated that many people did not understand the different between victim support work and counselling. It was also queried as to whether the service worked. The answer from many victim support workers was that people tell them that they have helped enormously.

Trauma Counselling:

Current position: There are not enough counsellors or therapists able to do trauma counselling. In fact most districts have none. Further, most service providers do not know each other so where skilled people do exist they are sometimes not fully utilized. This has resulted in many people doing trauma counselling without being trained for it, and without any supervision. Currently complicated trauma cases are being referred to general practitioners.

The definition of exactly what comprised trauma counselling was extensive. Delegates queried whether whether it is possible for volunteer counsellors to fulfil this function. Some

felt this to be necessary since social workers are stretched between their statutory obligations and trauma counselling. Others felt that this was asking too much of volunteer counsellors, especially in the absence of appropriate support and supervision.

Finally, it was pointed out that many people working in the victim empowerment sector in Mpumalanga were feeling very burned out and suffering from secondary traumatic stress. Given the amount of work, the available resources and the gaps in training and supervision this is predictable.

Goals for the future: Service providers represented at the meeting strongly expressed their need for specialized training in trauma counselling. Helpers of all kinds are using general counselling techniques for trauma work and this is often not appropriate. However, the group said that such training must involve stringent selection criteria, trainers that are specialist in traumatic stress work, and accreditation of courses. The group also felt that government departments should support this goal and ensure that both government and non-government personnel received this training.

The medium term goals were to establish a suitable pool of trauma counsellors spread throughout the province. These counsellors should be accredited and regularly supervised. In addition a system of continued training and development was proposed.

First steps: It was felt that a clear definition of trauma counselling, as well as clear job description of a trauma counsellor position should be determined. The definition should clarify relationships between trauma counselling and other kinds of service to victims (including victim support), and also with other kinds of counselling (including general counselling, bereavement counselling, and HIV/AIDS counselling). The job description should cover points such as reasonable caseloads for trauma counselling, methods of record keeping, and so on. It was suggested that this might be something that Themba Lesizwe of SAITS might usefully undertake.

This needs to be followed with an intensive training programme in the province, and all organisations need to build in suitable support structures for both victim support workers and trauma counsellors.

Comments from the floor suggested that care for the carers should be offered by psychologists only, since they were the most highly qualified and experienced for this work.

Trauma therapy:

Current position: It was felt by this group that there were very few therapists in the province, and that hardly any of those were committed to work in the field of traumatic stress. The price of private therapy is beyond the reach of the majority of the population, and even those with medical insurance are only covered on a limited basis.

Goals for the future: It was felt that more government employed social workers should be made available to do trauma therapy on a regular basis. It was noted that this would depend upon training in trauma therapy for the social workers. It was also felt that psychologists in private practice have an ethical responsibility to support community-based mental health services at affordable rates. Finally, it was felt that more interns and newly graduated professions should do trauma therapy in the province as part of their community service.

General discussion:

A key question asked in the plenary discussion was which level of the model was most important to victim care in the context of Mpumalanaga. While most people felt that all levels were equally important since the model works together in a holistic way, it was also stated that victim support might be thought of as the most important level since it provided services for the largest portion of the population. Others argued that the education and awareness raising level was the most important because it is preventative.

One participant commented that members of the community were bored with health messages and did not really take the education work in. It was suggested that we should work through influential people within communities. Traditional healers and youth leaders were specifically mentioned. It was mentioned that when professionals visit communities they are not able to communicate well with community members since they come from such different contexts.

A further concern raised about the education and awareness raising model is that victim support and trauma services are seen as being services for rape survivors. It was felt that this perception needed to be challenged among both service providers and the target population.

Then representatives of victim support services in the courts raised some issues around the criminal justice system. Specifically these include the need for better court procedures to

protect victims of violence, and more extensive victim protection services. Finally, it was mentioned that there are funds available through the Department of Justice for awareness raising and education work relating to victim rights.

The state of psychiatric hospitals also came under the spotlight in the plenary discussion. A worker from an institution in the province felt that sometimes the way psychiatric patients are cared for could result in trauma. It was felt that a great deal of attention needed to be given to matters of capacity building for hospital staff dealing with victims of violence.

The meeting ended with a strong statement that progress would only be forthcoming when the Department of Social Development, as the lead programme in the Victim Empowerment Programme, took responsibility for co-ordinating services and pulling together a functional victim empowerment forum.

DISCUSSION AND RECOMMENDATIONS

Service delivery to victims of violent crime in Mpumalanga

Given South Africa's history of having very good, expensive tertiary level services which are unsupported by primary and secondary services, the findings of this survey are extremely positive. Clearly policy over the last ten years which has focussed on providing basic services to the entire population is starting to work in the victim empowerment sector at least. There is a lot for mental health service providers to be proud of. Naturally, implementation of the vision for an integrated mental health services for victims of violence contained in this report, has a very long way to go. There are many important challenges remaining, and it is with a view to overcoming these challenges that the following recommendations are made.

As things stand at present the strongest level of service provision in Mpumalanga is that of victim support. All major centres have a victim support service of some kind and so the vast majority of the population have some access to these services. To a large degree the growth of this level of service provision has been due to government and donor policies which have emphasized the development front line service especially in rural areas, and various NGO projects, notably the Business Against Crime Community Based Victim-Support Programme and NICRO's Victim Support Programme. However, as NGOs in the victim empowerment sector have come under increasing financial threat in the past two years these key organisations in victim support have started to falter and can not be relied upon to support

these services in the future. As a result of these factors, the following recommendations seem appropriate:

1. Emphasis should not be placed on opening new victim support schemes, except in the few areas where virtually no services have been identified.
2. Emphasis should be placed on the sustainability and capacity building of existing schemes.
3. This emphasis should be reflected in the way donor moneys are disbursed to the victim empowerment sector in Mpumalanaga.
4. This emphasis should be reflected in VEP policy in the province.

The targetting of frontline services also requires critical reflection. There is without doubt a demand for services that target vulnerable groups, such as women, children, the disabled and refugees. The question arises at what level of an integrated service model should this targetting occur. Broad accessibility is the most important advantage of building up frontline victim support services. If these services explicitly or implicitly target particular groups at the expense of others, an important part of their value is lost. It is particularly important than men feel comfortable accessing these services if the claim that victim support is preventative of violent crime is to make any sense. Arising from this point are the following recommendations:

5. Victim support services should target the entire population of people living within South Africa.
6. Trauma counselling, and therapy services should be directed towards vulnerable groups, especially victims of rape, child abuse and neglect, and intimate partner violence.

Problems with the co-ordination of services has been a problem for the victim empowerment sector for as long as it has been in existence. Mpumalanga has not escaped. For an integrated service to function properly there must be clear communication and cooperation between all stakeholders. Clearly this is not yet a reality in the province and the following suggestions relate to this problem:

7. The provincial Department of Social Development must ensure that the provincial VEP forum is functioning and effective, and the provinial VEP is well project managed.

8. All stakeholders must commit to a plan of action for the province which will move service provision towards the ideals laid out in this report.
9. A coordinated education and awareness raising strategy is needed for the province. Such a strategy should make better use of more cost effective media options including radio and print media.

The lack of trauma counselling and trauma therapy capacity in the province is a critical and urgent problem. Currently victim support workers are trying to manage cases for which they are not adequately trained. They do this because there is few other providers available to which they can refer. Sometimes even the organisations that do claim to offer trauma counselling or therapy are in fact using general counselling models that have limited application in the field of traumatic stress. These problems are a direct threat to the mental health of victims of violence and frontline helpers in the province. It is dangerous and unethical for managers, decision-makers and donors to allow this situation to persist. As a result the following is recommended:

10. Existing providers of counselling and therapy for people suffering from traumatic stress must be encouraged and assisted to find training that ensures that they are equipped to offer the services in question at an appropriate standard.
11. People equipped to provide counselling and therapy must start to think of supporting frontline workers as part of their work. They should be compensated for this work and victim support schemes and donors must allow for these costs.
12. More social work posts are needed to provide counselling and therapy services to victims of violent crime in Mpumalanga.

A great deal of progress has been made to service delivery to victims of violent crime in Mpumalanga. It is essential that providers and decision-makers continue to monitor this progress and adjust policy as required.

Implications for future needs analysis work and planning

The use of this approach to needs analysis in Mpumalanaga province has highlighted a serious lack of information that impacts upon the work of decision-makers and planners in the victim empowerment sector. Many of the service providers that were uncovered during this process have not been included in the consultative forums and capacity building exercises of the past. Their names and contact details were not on any of the regularly used contact lists. And yet, these organisations are providing services to victims of violent crime,

and no matter the nature and quality of those services, represent important sites of service delivery. Further, it is the responsibility of all role players in the sector to monitor the quality of services to victims, and where necessary build capacity so that service provision is appropriate to the needs of victims. Clearly the way the victim empowerment sector conducts needs analysis demands critical analysis.

While the methodology used in the study did unearth a great deal of information that is not readily available, the study was not perfect. Several important pieces of data are missing. In the original proposal for this study a partner organisation with a well developed Geographic Information System (GIS) was included. For reasons of expense this part of the study was removed. However, in future it would be very valuable to compare the geographic distribution of different levels of service with population and crime distributions. This would show much more accurately where the key gaps in service provision are.

The five level model of service provision worked very well as an overall structure for the needs analysis. The model makes intuitive sense to most service providers and has been well received in various fora in the past year (VEP conference, standards generating body for victim empowerment, various SAITS training courses). In future it might be useful to send service providers a copy of the model in advance so that when asked about each level they have clear definitions of exactly what is being discussed.

The use of telephonic interviewing has its advantages and disadvantages. The key disadvantage is that it is biased against any member of the population that does not have access to a telephone. There is no reason to believe that this bias strongly affected this study. At no point were researchers referred to an organisation that had no telephone number. Indeed, it is hard to imagine a service provider in South Africa being able to operate without a telephone. The most important advantage of telephone interviewing is the cost and time efficacy. Researchers could never have travelled to all 241 service providers identified in this study. The only other possibility is a mailed questionnaire. This is not suitable for this kind of work due to the response rate for mailed surveys, often 10% or lower. In this form of research it is important to sample as close to the whole population as possible.

The semi-structured interview itself worked well for a pilot study. However, it was quite long and this made it more difficult for researchers to get service providers to complete the interview. In future the interview could be much more structured. Ideally the questions would be faxed through to the respondent (together with structured response categories) and then worked through over the phone with the interviewer.

The consultative forum worked very well at a number of levels. Firstly, it served to validate the data. Respondents discussed the preliminary findings and made many helpful comments which contributed greatly to the quality of the study. Secondly, it mobilized local service providers to discuss their common challenges and made it possible for new and stronger networks to emerge. In provinces where the VEP structures are not well organised this is of considerable benefit. Finally, the consultative forum served to build local service providers' awareness of the work of Themba Lesizwe and SAITS.

13. That Themba Lesizwe and the Department of Social Development use an amended version of the methodology used in this study to conduct similar needs analyses of other provinces within South Africa.
14. That all future planning for capacity building be built on good information about existing services and the expressed needs of service providers.

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Appendix A: List of organisations contacted

Emalaheni

Vosman Victim Support
Oggies Victim Support
Witbank Victim Support
Phola Clinic
Kriel Trauma Centre
Witbank Trauma Centre
Blinkpan Victim Support Centre
Kriel Magistrates Court
Lovelife Mpumalanga
Khanya Community Project
Witbank Hospital
Roman Catholic Church
The African Methodist
Belfast Dep of Social Services
Siyabuswa Dep of Social services
Ms L Storm
Mrs M J Mavrothalassitis
Witbank Social Services
Goelam Mandela Children

Kwamhlanga

Ekangala Victim Support
Kwamhlanga Victim Support
Kwamahlanga Magistrates Court
Ekangala Magistrates Court
Kwamhlanga CPU
Kwamhlanga Hospital

Mbombela

Nelspruit Victim Support
Rape Intervention Program
Lifeline Nelspruit
White River Trauma Centre
Nelspruit CPU
Zwelisha Clinic
Louivelle Womens Support Centre
Phola Nsikasi Com Health Ct.
Tsepo Themba HBC
Mpumalanga Council of Churches
Vulamento Youth Club
Sakhasive HBC
Lesedi Rural Multipurpose Service Centre
Lowveld Alcohol & Drug Help Centre
Afrika School of Missions
Nelspruits Magistrates Court
Millenium Home of Hope
Masocii HBC
Sister Love
Methodist Church

African Methodist Episcopal Church
Evangelical Lutheran Church
African Gaza Church
Elshaddai Tebernacle Church
Uniting Presbyterian Church in SA
Salvation Army Church
The Reform in Christ Church
Apostolic Faith Mission
Betesda Christian Church
Msogwaba Ministers Fraternal
Matsulu Ministers Fraternal
New Creation Church
Bambanani Matsula Ministers Fraternal
Church of the Province of SA
Evangelical Presbyterian Church in SA
Christian Fellowship
Kanyamazane Clinic
Man for Change
Nicro Mpumalanga
Rob Ferreira Hospital
Hazyview Dep of Social Services
Kanyamazani Social Services
Ehlanzeni Dep of Social Services
ACTS Clinic
Aestimatum - Private Psychologist
Matsula Health Centre

Dipaleseng

Balfour Victim Support
Balfour Victim Support
Grelingstad VEP
Balfour Magistrates Office
Dipaleseng Fraternal
Balfour Department of Social Services

Seme

Amersport Victim Support
Volksrust Trauma Centre
Volksrus Dep of Social Services
Sinani Victim Support
Volksrus Magistrates Court
Ms S J Maree

Thaba Chweu

Pilgrims Rest Victim Support
Masisizane Comm Centre
Sabie Victim Support
Lydenburg Hospital
Graskop Magistrates Court
Matibidi Ministers Fraternal

Lydenburg Magistrate Court
Sabie Magistrates Office
Evangelical Lutheran Church
Mashishing Ministers Fraternal
Lydenburg Social Services

Msukaligwa

Ermilo Victim Support
Ermilo Victim Support
Breyten Municipality Clinic
Ermelo Privicial Hospital
Breyton Magistrates Court
Greater Breyten Forum in Mpumalanga
Ermelo Ecumenical Council
Mr P G C Oosthuizen
Ermelo Social Services

Highveld East

Bethal Victim Support
Kinross Victim Friendly facilities
Town Council Clinics Bethal
Mbalenhle Victim Support
Evander Victim Support Centre
Slyanakekela Victim Support Centre
Slyanakekela Victim Support Centre
Slyanakekela Victim Support Centre
Driefontein Victims Support
Leslie SAPS Victim Support Cnt
Child Protection Unit Secunda
SAP EAS
Moutse Magistrates Court
Evander Dep of Social Services
Swedish Free Church
Mr R V Mbuli
Govan Mbeki Fraternal
Mr JJ Liebenberg
Mr P J Kasselmann
Mrs Z Crous
Ms L E Botha
Miss L H Van Niekerk
Mr S Arumgam
Mr S J Crous
Mr J M Wells
mr P J Botha
Mr T C Botha
Ms H P Steynberg
Mrs S Botha
Ms M M Malan
Ms E C Human
Anita Maartens
Evander Hospital

Curamus Trauma Support

Mkhondo

Piet Retief Trauma Room
Piet Retief Magistrates Court
Piet Retief Social Services
Piet Retief Hospital

Albert Luthuli

Carolina Victim Support
Badplaas Victim Empowerment Ct
Carolina Magistrates Office
Elukwatini Magistrates Court
Woman Against Woman Abuse
Ikhaya Lezingelozzi Church
Masakhane Church Leaders Fellowship
Nhlanzatshe Ministers Fraternal
Niniva Holly Church
Elukwatini Social Services
Mayflower Social Services
Embhuleni Hospital
Carolina Hospital

Highlands

Belfast Victim Support
H A Grove Hospital Belfast
FAMSA Northern Mpumalanga
Bethal Magistrates Court

Middelburg

Middelburg Victim Support
BAC Victim Support
Masibambisane Victim Support Ct
Child Protection Unit Middelburg
Hendrina Magistrates Court
Middelgurg Magistrates Court
Greater Middelburg Pastors Forum
Senzokuhle Advice Centre

Lekwa

Haarsboek Victim Support
Sakhile VEP
Morgenzon Magistrates Court
Standerton Hospital
Standerton Magistrates Office
Uniting Baptist Church
CMR - Standerton
Ms Z Du Toit
Mr C Van Zyl
Mr D B Redelinghuys
Ms M Lyons
Ms P L Wagner

Standerton Social Services
Standerton Social Services

Umjindi

Barbeton Hospital
Grip
Barbeton Magistrates Court
Ma Africa Clinic Barbeton
Faith Assembly Church
United Christian Church of Africa
Emjindini Ministers Fraternal
Barbeton Hospital

Nkomazi

Tonga Victim Support Centre
Shongwe Hospital
Nkomazi Community Advise Office
Nkomazi Community Advise Ctr
Masisukumeni Women Crises Ctr
New Covenant Church
Mzinti Ministers Fraternal
Schoemansdal Ministers Fraternal
Jeppes Reef Fraternal
Schulzendal Ministers Fraternal
Langelooop Fraternal
Tonga Social Services Department
Mangweni Social Services Office
Tonga Department of health

Greater Groblersdal

Dennilton Victim Support
Groblersdaal Magistrates Court
Nsikasi Magistrates Court
Groblersdal Hospital
Phaphamani Home Based Care
Philadelphia Hospital
Fountains for New Hope & Realities
Mdutjane Magistrates Court
Kubonakele Human Rights & Justice Centre
Power of God Apostle
Insikazi Ministers Fraternal
Groblersdal Ministers Fellowship
Kabokweni Dep of Social Services
Ebonisweni Cinic
Jesus Maranatha Bible Church
Themba Hospital

Delmas

Delmas Magistrates Court
Bernice Samuels Hospital
Ms M F Caldeira

Mr G S Coetzee

DR J S Moroko

Hope for Life

Home Base Care Health Org

AIDS Sexuality & Health Org

Mbibane Magistrates Court

Vaalbank Development Organization

Bakamosa HBC

Thembisile

Mmamethlake Victim Support

Ndibani Victim Support

Leseding Out-Reach Centre

Kwaggafontein Court

Ekgangala Ministers Fraternal

Ekgangala Dep of Social Services

Mbibane Dep of Social Services

Mkobola Social Services Ofiices

Kwamahlanga Social Services

Greater Tubatse

Burgersfort Clinic