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WHITE PAPER · NGO & CIVIL SOCIETY SECTOR

On the OHS Amendment Bill 2021 and what it requires of you.

You cannot

pour from

an empty cup.

Vicarious trauma, compassion fatigue, funding precarity, moral distress, the OHS Amendment Bill makes them workplace dangers in the same legal category as machinery guarding, with director and trustee personal liability attached.

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CONTENTS

What this white paper covers.

01 Executive summary

02 Introduction

03 Key provisions of the OHS Amendment Bill

- 3.1 Section 1: definition of psychosocial hazards
- 3.2 Section 8: mandatory written risk assessment
- 3.3 Section 16: personal criminal liability
- 3.4 Section 24: psychological injury reporting

04 Eight NGO-specific psychosocial hazards

- 4.1 Vicarious trauma and secondary traumatic stress
- 4.2 Compassion fatigue and emotional labour
- 4.3 Funding precarity and chronic job insecurity
- 4.4 Role overload and under-staffing
- 4.5 Community violence exposure
- 4.6 Moral distress and ethical conflict
- 4.7 Isolation and lack of supervision
- 4.8 Organisational instability and leadership dysfunction

05 The COIDA evidence gap in the NGO sector

06 Cross-sector NGO risk profiles

- 6.1 GBV / trauma support organisations
- 6.2 Child protection and social services
- 6.3 Community health workers and home-based care
- 6.4 Refugee and humanitarian assistance
- 6.5 Faith-based organisations / FBOs

07 Section 16 liability: what NGO directors and trustees must know

- 7.1 Who is personally liable
- 7.2 Defences that do not exist
- 7.3 Trustee liability: a critical issue
- 7.4 Three practical steps before promulgation

08 The Sociosafety™ approach

09 Implementation roadmap

9.1 Phase 1: awareness and governance
9.2 Phase 2: psychosocial risk assessment
9.3 Phase 3: mitigation
9.4 Phase 4: monitoring and reporting

10 Conclusion and call to action

11 References

01 Executive summary

The South African Occupational Health and Safety (OHS) Amendment Bill 2021 fundamentally redefines employer duty of care to include psychosocial hazards, a seismic shift that places non-governmental organisations (NGOs), non-profits, faith-based organisations, and community-based organisations at the centre of a new legal landscape. The NGO sector employs hundreds of thousands of South Africans across approximately 100,000 registered non-profits, delivering essential services in child protection, GBV support, HIV/AIDS care, refugee assistance, community health, and humanitarian relief. Yet this sector, built on a foundation of compassion and service, faces a profound and largely unacknowledged crisis: the psychological injury of its own workforce.

The OHS Amendment Bill closes this gap permanently. Under the amended Act, vicarious trauma, compassion fatigue, funding precarity, role overload, community violence exposure, moral distress, isolation, and organisational instability are all legally foreseeable psychosocial hazards that NGO employers must assess, mitigate, and report. Directors and trustees are now personally liable under Section 16 of the Act, facing criminal penalties of up to R100,000 and four years' imprisonment for repeat offences. The mission-driven culture of the sector does not exempt employers from this duty of care, it intensifies the urgency of compliance.

This white paper presents the legal, operational, and strategic imperatives for NGO compliance. It identifies eight sector-specific psychosocial hazards, with particular emphasis on the foreseeability doctrine, a groundbreaking legal interpretation that positions trauma exposure, caseload overload, and structural under-resourcing as foreseeable occupational hazards requiring employer mitigation, regardless of whether any worker has previously lodged a COIDA claim. The paper introduces the Sociosafety™ approach as a sector-ready compliance methodology and provides a four-phase, 12-month implementation roadmap for NGO boardrooms, field sites, and counselling centres.

Key findings

- The NGO sector faces a distinct psychosocial hazard profile shaped by trauma exposure, resource constraints, mission-driven self-sacrifice, and structural funding precarity, requiring tailored risk assessment and mitigation strategies.
- Vicarious trauma, compassion fatigue, and moral distress are foreseeable psychosocial hazards under Section 8, creating new legal obligations for clinical supervision, peer debriefing, caseload limits, and post-incident trauma support.

- Section 16 personal liability extends to NGO directors, CEOs, trustees, board members, programme managers, and senior staff who control or manage a workplace, with no exemption for small organisations, no defence based on limited budgets, and no protection for well-intentioned leaders who fail to act.
- Compliance requires integration of psychosocial risk assessment into existing governance and operational systems, engagement of staff and unions, and alignment with funder reporting on staff wellbeing and organisational sustainability.

KEY TAKEAWAY

NGOs cannot hide behind mission-driven culture or resource constraints. The OHS Amendment Bill has closed the psychosocial safety gap, and directors and trustees are personally liable.

02 Introduction

2.1 The NGO sector landscape

Non-governmental organisations form the backbone of South Africa's social service delivery. Approximately 100,000 registered non-profit organisations (NPOs) operate across the country, employing hundreds of thousands of workers and engaging countless volunteers [10]. These organisations deliver critical services in contexts where state capacity is limited or absent: child protection, gender-based violence (GBV) support, HIV/AIDS care, refugee assistance, community health, disability services, mental health counselling, and humanitarian relief. The sector includes registered NPOs, faith-based organisations (FBOs), and community-based organisations (CBOs), spanning formal employers with dozens of staff to small grassroots collectives operating on shoestring budgets.

These organisations are characterised by mission-driven cultures, high proportions of trauma-exposed work, significant gender and racial diversity in the workforce, structural dependency on donor cycles, and historically low levels of formal OHS infrastructure. The NGO workforce includes social workers, trauma counsellors, community health workers, GBV first responders, child protection officers, humanitarian aid workers, faith-based caregivers, and volunteer stipended workers, all delivering essential services under conditions of chronic resource constraint.

2.2 The historical blind spot

For decades, occupational health and safety in the NGO sector has been treated as a peripheral concern. Where OHS has been addressed at all, it has focused on physical safety, fire evacuation procedures, fieldwork transport, basic first aid. Psychosocial hazards have been almost entirely invisible in NGO governance, often dismissed as “soft issues”, relegated to wellness programmes, or simply normalised as inevitable features of caring work.

However, this historical neglect has created a dangerous blind spot: the systematic under-recognition of psychological injury in the workforce. Social workers carrying caseloads of 200+ beneficiaries, trauma counsellors listening to vivid descriptions of abuse on a daily basis, community health workers conducting home visits in high-violence settlements, humanitarian aid workers navigating funding cliffs while making triage decisions, these psychosocial hazards have been treated as the inherent “cost of

caring" rather than as occupational injuries requiring assessment, mitigation, and reporting (Padmanabhanunni, 2020; Mawora et al., 2025).

The consequences of this neglect are profound. Research demonstrates that psychosocial hazards in the NGO sector are associated with elevated rates of burnout, depression, anxiety, secondary traumatic stress, substance abuse, absenteeism, presenteeism, and turnover (Hines et al., 2024; Manqindi, n.d.). The economic costs are staggering, yet they have remained largely externalised, borne by workers, their families, beneficiary communities, and the public healthcare system rather than by employers.

2.3 The OHS Amendment Bill: a paradigm shift

The South African OHS Amendment Bill 2021 changes this calculus permanently. By explicitly expanding the definition of "hazard" and "risk" to include psychosocial factors, the amended Act brings mental health and psychosocial wellbeing into the core legal framework of occupational health and safety. NGO employers can no longer claim that psychosocial hazards fall outside their duty of care. The Act makes clear that the obligation to provide a safe and healthy work environment extends to psychological safety, emotional wellbeing, and protection from foreseeable psychosocial harm.

For NGOs, this paradigm shift has immediate and far-reaching implications:

- **Risk assessment obligations:** Employers must conduct comprehensive written psychosocial risk assessments covering all foreseeable hazards, trauma exposure, caseload overload, funding precarity, supervision deficits, community violence, moral distress, isolation, and organisational instability.
- **Mitigation requirements:** Employers must implement reasonably practicable control measures to eliminate or minimise psychosocial risks, including caseload limits, clinical supervision, peer debriefing, safety protocols for fieldwork, and structural protections against funding-driven precarity.
- **Incident reporting:** Psychological injuries and incidents must be reported under Section 24, including diagnosed mental health conditions arising from workplace hazards, secondary traumatic stress with functional impairment, and burnout-related sick leave.
- **Personal liability:** Directors, CEOs, trustees, board members, and programme managers are personally liable under Section 16, facing criminal penalties of up to R100,000 and four years' imprisonment.
- **Funder reporting alignment:** Many NGO funders are increasingly interested in organisational health, staff wellbeing, and sustainability. OHS compliance work can be integrated into funder narratives, demonstrating organisational maturity and risk management.

The stakes are high: legal liability, reputational damage, workforce attrition, programme disruption, and, most importantly, the mental health and wellbeing of hundreds of thousands of South African NGO workers who deliver essential services to the country's most vulnerable communities.

03 Key provisions of the OHS Amendment Bill

The OHS Amendment Bill introduces four critical provisions that fundamentally alter the legal landscape for NGO employers. These provisions are not aspirational, they are mandatory, enforceable, and carry significant penalties for non-compliance. This section provides a deep analysis of each provision, with particular attention to its application in NGO and civil society contexts.

3.1 Section 1: definition of psychosocial hazards

> **WHAT THE BILL CHANGES**
>
> *Section 1 of the Amendment Bill expands the definition of "hazard" to include any source of potential psychological, emotional, or social harm arising from work activities, work organisation, workplace relationships, or the work environment. "Risk" is correspondingly defined to include the likelihood and severity of psychological, emotional, or social harm. The definition explicitly encompasses stress, trauma, burnout, moral distress, vicarious trauma, secondary traumatic stress, compassion fatigue, bullying, harassment, violence, and organisational factors that negatively impact psychological health and safety [19].*

This definitional expansion is the foundation of the entire psychosocial compliance framework. By explicitly including psychological, emotional, and social harm within the statutory definitions of hazard and risk, the Amendment Bill removes any ambiguity about whether psychosocial factors fall within the scope of NGO employer obligations under the Act.

NGO context

Vicarious trauma in trauma-exposed roles, compassion fatigue in caring professions, role overload from caseloads exceeding safe limits, moral distress from triage decisions in resource-constrained environments, community violence exposure during fieldwork, isolation in lone-working contexts, and organisational instability driven by funding precarity are all legally recognised hazards that NGO employers must assess and manage.

Organisational factors are included

The definition also encompasses organisational factors: under-staffing, role overload, inadequate supervision, funding precarity, and organisational instability are all recognised as psychosocial hazards if

they create foreseeable psychological risk [21], [22]. This means that NGO employers cannot argue that resource constraints exempt them from liability, resource constraints may themselves constitute a hazard that must be assessed and mitigated.

3.2 Section 8: mandatory written psychosocial risk assessment

> **WHAT THE BILL CHANGES**
>
> *Section 8 imposes a general duty on employers to provide and maintain a work environment that is safe and without risk to the health of employees. The Amendment Bill clarifies that this duty extends to psychosocial hazards and requires employers to identify all reasonably foreseeable hazards, assess the associated risks, implement reasonably practicable control measures, monitor and review effectiveness, and provide information, instruction, training, and supervision.*

The "reasonably practicable" standard

The "reasonably practicable" standard is a cornerstone of South African OHS law. It requires employers to balance the severity and likelihood of harm against the cost, time, and effort required to implement control measures. The standard does not permit employers to avoid action simply because it is expensive or inconvenient. Where the risk of harm is high, employers must implement control measures even if they are costly or operationally challenging.

What this means for NGO employers

Section 8 compliance for NGO employers requires the assessment of all eight sector-specific hazards identified in Section 4 of this white paper; the development of mitigation plans tailored to organisational context, role type, and beneficiary population; clinical or reflective supervision structures for trauma-exposed workers; caseload audits and structural protections against role overload; safety protocols for community-based fieldwork; and transparent processes for managing the moral distress that arises from triage decisions in resource-constrained environments.

No size or budget exemption

There is no exemption for small organisations or resource-constrained employers. The obligation to conduct a written psychosocial risk assessment applies to every NGO, regardless of size, budget, or sector. A small CBO with five staff members has the same legal obligation as a large national NGO with hundreds of employees. The scope and complexity of the assessment may differ, but the obligation does not. Informal awareness of psychosocial hazards is not sufficient. A written, documented risk assessment is a legal requirement [24].

KEY TAKEAWAY

Section 8 compliance is not a one-time exercise. It requires ongoing psychosocial risk assessment, continuous improvement of control measures, and regular consultation with employees and union representatives, with all activities documented to demonstrate compliance in the event of inspection or legal challenge.

3.3 Section 16: personal criminal liability

WHAT THE BILL CHANGES

Section 16 imposes personal criminal liability on directors, managers, and other officers of an organisation who fail to take all reasonable steps to ensure compliance with the Act. The Amendment Bill clarifies that this personal liability extends to failures to comply with psychosocial hazard obligations under Section 8. Penalties: R50,000 fine or 2 years imprisonment for a first offence; R100,000 or 4 years for repeat offences [25].

Section 16 liability is strict

Directors, trustees, and managers cannot escape liability by claiming they were unaware of psychosocial hazards or compliance failures. The law imposes a positive duty to know, to inquire, and to take reasonable steps to ensure compliance. Ignorance is not a defence.

Who is personally liable

In the NGO sector, Section 16 liability extends to:

- **Directors and CEOs:** executive responsibility for OHS compliance across the organisation, including psychosocial hazard management.
- **Trustees and board members:** responsibility for setting policy, approving budgets, and allocating resources for psychosocial risk mitigation. Trustees are liable if they approve budgets or staffing structures that create foreseeable hazards.
- **Programme managers and senior staff:** direct responsibility for psychosocial risk assessment and mitigation in their area of management, regional offices, field sites, counselling centres, shelters.
- **Health and safety officers and HR practitioners:** responsibility for developing risk assessment tools, training programmes, support services, and incident reporting systems.

KEY TAKEAWAY

Directors, trustees, and senior managers must take proactive, documented steps to ensure psychosocial compliance, board-level oversight, adequate resources, policy implementation, regular audits, and reviews. Documentation is what makes "reasonable steps" legally meaningful.

3.4 Section 24: psychological injury reporting

WHAT THE BILL CHANGES

Section 24 requires employers to report certain incidents to the Department of Employment and Labour, including incidents that result in serious injury or occupational disease. The Amendment Bill clarifies that "serious injury" includes psychological injury, PTSD resulting from workplace incidents, severe depression or anxiety resulting from workplace psychosocial hazards, suicide or attempted suicide where workplace factors are implicated, and burnout-related sick leave exceeding three days.

Reporting obligations

NGO employers must report psychological injury incidents within seven days of becoming aware of the incident. The report must include details of the incident (date, location, circumstances), the affected employee (role, department), the psychosocial hazard(s) that contributed to the injury, control measures in place at the time, and immediate actions taken following the incident.

NGO context

NGO employers must report PTSD following exposure to traumatic beneficiary material or community violence; severe depression or anxiety resulting from chronic caseload overload, vicarious trauma, or moral distress; secondary traumatic stress with functional impairment; compassion fatigue and burnout leading to sick leave or resignation; and any psychological injury resulting in more than three days of absence from work.

A new data trail

This reporting obligation creates a new compliance pathway: psychological injuries that were previously managed informally — through employee assistance programmes, sick leave, or quiet resignations — must now be formally reported if they meet the Section 24 criteria. Repeated psychological injuries in a

specific role or department may trigger inspections, investigations, and enforcement action if the employer has failed to conduct a Section 8 risk assessment or implement mitigation measures [29].

KEY TAKEAWAY

Failure to report a psychological injury incident is a criminal offence. NGO employers must establish incident reporting systems that capture psychological injury, train managers to recognise and report it, and ensure all reports reach the Department of Employment and Labour within the required timeframe.

04 Eight NGO-specific psychosocial hazards

The NGO sector presents a distinct psychosocial hazard profile shaped by trauma-exposed work, structural resource constraints, mission-driven cultures of self-sacrifice, and the economic and political pressures facing civil society. This section identifies eight sector-specific psychosocial hazards, supported by evidence from the research literature and South African NGO contexts. Each hazard constitutes a Section 8 compliance obligation for NGO employers.

4.1 Vicarious trauma and secondary traumatic stress

Vicarious trauma is the psychological injury that occurs when a worker is indirectly exposed to the traumatic experiences of others. It develops through empathic engagement with beneficiaries who have experienced trauma, listening to their stories, witnessing their suffering, and bearing responsibility for their care [30], [31]. Secondary traumatic stress is a related construct, characterised by acute stress reactions that mirror the symptoms of PTSD: intrusive thoughts, hypervigilance, avoidance, emotional numbing, and mood disturbances [32], [33]. Vicarious trauma is not a sign of weakness or unsuitability for the work, it is a predictable occupational injury that occurs when trauma-exposed workers lack adequate support, supervision, and recovery time [36].

South African evidence

Studies of social workers, trauma counsellors, and humanitarian aid workers report prevalence rates ranging from 24% to 75% [37], [38]. Among South African lay trauma counsellors in the Western Cape, secondary traumatic stress and burnout were identified as major concerns, with workers reporting significant psychological and emotional risks from providing care to traumatised populations [14]. A study of GBV first responders across community-based organisations found high levels of vicarious trauma, burnout, and compassion fatigue, with significant decreases observed only after a structured wellness and supervision intervention was implemented [9].

Mitigation strategies

- **Mandatory clinical supervision:** regular, structured, reflective supervision for all trauma-exposed workers, the most evidence-based protective factor against vicarious trauma.
- **Peer debriefing protocols:** structured peer-support after high-intensity cases or incidents involving severe trauma material.

- **Caseload limits:** professional standards-based caseload caps for trauma-exposed workers, with periodic audits.
- **Trauma-informed organisational culture:** explicit recognition of vicarious trauma as a foreseeable occupational injury, not a personal failing.

> FORESEEABILITY ARGUMENT
>
> *Vicarious trauma is a foreseeable hazard in any organisation whose work involves direct contact with traumatised beneficiaries. If your organisation provides GBV support, child protection, trauma counselling, refugee assistance, or any service requiring empathic engagement with trauma survivors, vicarious trauma must be assessed and mitigated under Section 8 — regardless of whether any worker has previously lodged a COIDA claim. The evidence base establishes foreseeability.*

4.2 Compassion fatigue and emotional labour

Compassion fatigue is the cumulative psychological and emotional exhaustion that results from sustained empathic engagement with suffering. It is sometimes described as “the cost of caring” — the toll that repeated exposure to others' pain takes on a worker's capacity to feel, connect, and respond with compassion [43], [44]. Emotional labour is the work of managing one's own emotions in order to meet the emotional demands of a role. For NGO workers, particularly those in health-focused NGOs, hospice care, child protection, and disability services, emotional labour is constant and largely invisible [46], [47].

Empathy is a finite resource. When workers give empathy continuously, without opportunities for rest, reflection, or replenishment, their capacity for compassion becomes depleted. This depletion manifests as emotional numbing, detachment from beneficiaries, cynicism, irritability, and a sense of helplessness [48], [49]. Compassion fatigue is not a character flaw, it is a predictable outcome of sustained emotional labour in under-resourced, high-demand environments.

South African evidence

For South African NGO workers, compassion fatigue is compounded by the scale and intensity of need. Workers in HIV/AIDS care, GBV support, and child protection services are exposed to high volumes of suffering in contexts where resources are scarce and outcomes are often uncertain [51], [52]. A scoping review of health professionals found that compassion fatigue is caused by prolonged, continuous, and intense contact with patients' suffering, leading to physical and mental illness, low self-esteem, higher turnover, absenteeism, and job dissatisfaction [14].

Mitigation strategies

- **Caseload caps with mandatory recovery time:** structured rest periods after high-intensity cases.
- **Reflective supervision:** regular supervision that integrates emotional processing, not just case management.
- **Peer support structures:** formal peer groups, balint groups, or buddy systems for emotional processing.
- **Recovery and renewal practices:** explicit organisational permission and time for workers to engage in restorative activities.

4.3 Funding precarity and chronic job insecurity

Funding precarity refers to the chronic instability and unpredictability of financial resources in the NGO sector. South African NGOs are structurally dependent on donor cycles, grant funding, and government contracts, most of which operate on 12-month cycles with no guarantee of renewal [57], [58]. This creates a work environment characterised by chronic job insecurity: workers do not know whether their contracts will be renewed, whether their programmes will continue, or whether their organisation will survive the next funding cliff [59].

Chronic job insecurity is a tier-1 psychosocial hazard under ISO 45003:2021, the international standard for occupational health and safety management of psychosocial risks [60]. Job insecurity is associated with increased anxiety, depression, sleep disturbances, reduced job satisfaction, and impaired physical health [61]. The psychological mechanism is clear: uncertainty about the future creates chronic stress, which activates the body's stress response systems and leads to cumulative wear and tear on mental and physical health [62].

South African evidence

A study of South African forensic social workers found that job stress, including concerns about job security, was a significant factor contributing to turnover intentions [29]. Research on non-profit leadership identified chronic funding instability as a structural stressor that intersects with vicarious trauma and compassion fatigue, creating unique burnout risks [27]. Workers in insecure roles are less likely to seek help for mental health concerns, less likely to report workplace hazards, and more likely to tolerate unsafe working conditions because they fear losing their jobs [67].

Mitigation strategies

- **Transparent communication:** advance notice about contract renewals and funding decisions; honest organisational updates.
- **Funding diversification:** deliberate strategy to reduce dependency on single donors.
- **Financial reserves:** building organisational buffers against funding gaps where possible.
- **Fair retrenchment processes:** documented procedures that prioritise worker dignity, advance notice, and support.

> FORESEEABILITY ARGUMENT
>
> *Under-resourcing and funding instability do not exempt an NGO employer from Section 8 obligations. The Amendment Bill does not include a "resource constraint" exemption. If funding precarity creates foreseeable job insecurity, and ISO 45003:2021 establishes that it does, then the hazard must be assessed and mitigated, even if it cannot be fully eliminated.*

4.4 Role overload and under-staffing

Role overload occurs when a worker's job demands exceed their capacity to meet those demands within the available time, resources, and support structures [71]. In the NGO sector, role overload is endemic. Social workers routinely carry caseloads that exceed safe limits, one social worker for hundreds of beneficiaries is not uncommon [11], [12]. Community health workers are expected to conduct home visits, provide health education, manage chronic disease patients, and deliver psychosocial support, often without adequate training, supervision, or administrative support [1], [72]. Programme managers juggle multiple donor reporting requirements, staff supervision, beneficiary services, and fundraising, often working far beyond contracted hours [73].

Under-staffing is the structural cause of role overload. When organisations lack the financial resources to hire adequate staff, the work does not disappear, it is redistributed among existing workers, who must do more with less. This creates a vicious cycle: overloaded workers burn out and leave, which increases the workload for remaining staff, which accelerates burnout and turnover.

South African evidence

Research on South African social workers found that high caseloads, multiple role demands, and blurred job descriptions were significant contributors to work-life balance challenges and burnout risk [2]. A study of non-specialist health workers in South Africa found that high caseloads and complex cases in understaffed, overcrowded environments were primary sources of chronic work-related stress and

secondary traumatic stress [1]. Overloaded workers provide lower-quality services, make more errors, and are more likely to experience compassion fatigue and vicarious trauma because they lack the time and cognitive resources to process their own emotional responses [78], [79].

Mitigation strategies

- **Caseload audits and structural limits:** professional standards-based caps with documented review processes.
- **Service-volume decisions:** transparent, board-level decisions about which beneficiaries can be served given available capacity.
- **Job design review:** regular review of role descriptions to identify and reduce overload.
- **Administrative support:** investment in admin capacity to free direct-service workers from paperwork burden.

4.5 Community violence exposure

Community violence exposure refers to the psychosocial hazard faced by workers who operate in high-crime, high-violence environments as part of their job duties. In South Africa, many NGO workers, particularly community health workers, outreach workers, social workers conducting home visits, and GBV support workers, routinely work in informal settlements, townships, and rural areas where violence is endemic [83], [84]. These workers are exposed to the threat of violence, witness violence, and in some cases, are directly victimised by violence.

Workers who operate in violent environments experience chronic hypervigilance, fear for their personal safety, and anticipatory anxiety about potential harm [86]. Even when violence is not directly experienced, the constant awareness of risk creates sustained stress activation, which has cumulative psychological and physiological impacts. Community violence exposure is compounded by the fact that NGO workers often lack adequate safety protocols, security support, or trauma debriefing after violent incidents [88].

South African evidence

A study of non-specialist health workers found that they operate in understaffed, overcrowded, low-resource settings where violence and crime are prevalent [1]. Research on South African social workers found that fieldwork in high-crime areas, including home visits in informal settlements, was a source of chronic stress and fear [90]. The impacts include post-traumatic stress symptoms, anxiety, hypervigilance, avoidance of certain work tasks or locations, and in severe cases, resignation from the role.

Mitigation strategies

- **Safety audits of work areas:** documented assessment of fieldwork locations and routes.
- **Working in pairs:** structural protocol for fieldwork in high-risk areas; emergency communication procedures.
- **Trauma debriefing:** post-incident psychological support after exposure to violence.
- **Access to rapid response:** partnerships with security services or community-based safety structures.

> **FORESEEABILITY ARGUMENT**
>
> *Community violence exposure is a foreseeable psychosocial hazard for any NGO that deploys workers into high-risk areas. Foreseeability is established by crime statistics, local knowledge, and the lived experience of workers. Section 8 requires a documented risk assessment and mitigation plan — not the elimination of all risk, but demonstration that reasonable steps have been taken to protect workers.*

4.6 Moral distress and ethical conflict

Moral distress is the psychological injury that occurs when a worker knows the right course of action but is prevented from taking it by resource constraints, organisational policies, or systemic barriers [96], [97]. It is the distress of being unable to act in accordance with one's professional values and ethical commitments. For NGO workers, moral distress is a daily reality. Social workers must make triage decisions about which beneficiaries receive services and which are turned away because caseloads are full [98]. Programme managers must allocate scarce resources, knowing that some beneficiaries will go without. Trauma counsellors must end therapy sessions prematurely because funding has run out, even when the client is still in crisis [100].

When a worker is repeatedly forced to act in ways that violate their professional ethics or personal values, they experience a form of psychological injury characterised by guilt, shame, anger, helplessness, and a sense of complicity in harm [101], [102]. Over time, moral distress erodes professional identity, reduces job satisfaction, and contributes to burnout and turnover. Moral distress is distinct from other psychosocial hazards because it arises not from the work itself, but from the constraints within which the work is performed — it is a structural hazard, rooted in the under-resourcing and systemic inequities that characterise the sector.

South African evidence

Research on non-profit leadership identified moral overload, the burden of making ethical decisions in resource-constrained environments, as a key stressor that intersects with burnout and compassion fatigue [27]. A study of mental health and substance use care workers in South Africa found that systemic frustrations, such as unclear referral processes and lack of additional support, contributed to work-related stress and a sense of "task dumping", which reflects moral distress [1].

Mitigation strategies

- **Ethics debriefing:** structured spaces for workers to name and process moral distress.
- **Inclusive triage processes:** distributing the burden of difficult decisions across teams rather than concentrating it on individual workers.
- **Transparency about constraints:** honest organisational communication about why some needs cannot be met.
- **Advocacy infrastructure:** channelling moral distress into systemic advocacy for sector reform and increased resources.

4.7 Isolation and lack of supervision

Isolation refers to the psychosocial hazard faced by workers who operate in remote, field-based, or lone-working contexts without adequate collegial support, supervision, or organisational connection. Lack of supervision refers specifically to the absence of regular, structured, reflective supervision for workers in trauma-exposed or emotionally demanding roles [111]. Both hazards are prevalent in the NGO sector, particularly among community health workers, outreach workers, home-based care workers, and rural programme staff [112].

Clinical supervision, regular, structured, reflective conversations with a trained supervisor, is a well-established protective factor against vicarious trauma, compassion fatigue, and burnout [115], [116]. Supervision provides a space for workers to process their emotional responses, reflect on their practice, receive validation and support, and develop coping strategies. In the absence of supervision, trauma-exposed workers are at significantly higher risk of psychological injury [118].

South African evidence

A study of South African lay trauma counsellors found that inadequate supervision and support were major contributors to secondary traumatic stress and burnout [14]. Research on reflective supervision in South African nonprofit organisations found that supervision was a critical mechanism for preventing practitioner burnout in highly traumatised environments [3]. A study of child welfare workers found that

lack of adequate supervision for trauma-exposed workers was a foreseeable hazard that increased the risk of secondary traumatic stress and turnover [119].

Mitigation strategies

- **External clinical supervision:** where budget permits, contracted clinical supervisors for trauma-exposed roles.
- **Peer supervision models:** structured peer groups meeting regularly to reflect on practice.
- **Group supervision:** senior-staff facilitated reflective practice for teams of workers.
- **University partnerships:** partnerships with academic institutions for student supervisor placements.

> **FORESEEABILITY ARGUMENT**
>
> *Lack of adequate supervision for trauma-exposed workers is a foreseeable hazard under Section 8. The research base establishing supervision as a protective factor is extensive and unambiguous. If your organisation employs workers in GBV counselling, child protection, trauma therapy, or refugee support without regular, structured, reflective supervision, you are knowingly exposing those workers to a foreseeable psychosocial hazard.*

4.8 Organisational instability and leadership dysfunction

Organisational instability refers to the psychosocial hazard created by high leadership turnover, governance crises, funder-driven mission drift, board conflicts, and frequent organisational restructuring [128]. Leadership dysfunction refers to the harm caused by ineffective, inconsistent, or toxic leadership practices, including poor communication, unclear decision-making, favouritism, and failure to address workplace conflicts [129].

Organisational instability creates chronic uncertainty, which activates stress responses and undermines workers' sense of safety, predictability, and control. Leadership dysfunction compounds this by eroding trust, creating interpersonal conflicts, and failing to provide the support and direction that workers need to navigate instability. These hazards undermine the effectiveness of every other mitigation measure: supervision, peer support, and self-care strategies are less effective when the organisational environment itself is chaotic or toxic.

South African evidence

A study of toxic workplaces and burnout among South African social workers found that organisational culture and leadership practices were major contributors to burnout [2]. Research on non-profit

leadership identified emotional, ethical, and structural pressures, including governance crises and donor dependency, as unique stressors for NGO leaders, which in turn affect the entire organisation [27].

Mitigation strategies

- **Leadership succession planning:** structured pipelines and development programmes to stabilise leadership.
- **Board governance practices:** clear conflict-of-interest policies, accountability frameworks, and review processes.
- **Transparent communication:** structured processes for communicating organisational decisions and changes to staff.
- **Conflict resolution mechanisms:** documented procedures for addressing workplace conflicts and leadership dysfunction.

05 The COIDA evidence gap in the NGO sector

One of the most striking features of psychosocial hazards in the South African NGO sector is the near-total absence of mental health claims under the Compensation for Occupational Injuries and Diseases Act (COIDA). Despite overwhelming evidence that NGO workers experience high rates of vicarious trauma, compassion fatigue, burnout, secondary traumatic stress, and other psychological injuries, COIDA claims for these conditions are vanishingly rare [142].

This absence of claims is not evidence of healthy workforces. It is evidence of a systemic failure to recognise, report, and compensate occupational psychological injuries. Four factors explain this evidence gap.

5.1 Stigma

Mental health conditions remain highly stigmatised in South African workplaces, and NGO workers are not immune to this stigma [143]. Workers fear that disclosing a mental health condition will lead to perceptions of weakness, unsuitability for the work, or inability to cope [144]. In a sector where workers are expected to be resilient, compassionate, and mission-driven, admitting to psychological injury feels like a failure. The culture of mission-driven self-sacrifice intensifies this stigma: “the beneficiaries need us more” becomes a barrier to acknowledging one's own injury.

5.2 Lack of awareness

Many NGO workers, and their employers, are unaware that psychological injuries can be claimed under COIDA. COIDA is widely understood to cover physical injuries (e.g., a slip and fall, a car accident during work travel), but the compensability of mental health conditions arising from workplace psychosocial hazards is less well-known [146]. Workers experiencing burnout, vicarious trauma, or compassion fatigue may not recognise these conditions as occupational injuries, and may instead attribute them to personal failings or the inherent difficulty of the work.

5.3 Claims complexity

COIDA claims for psychological injuries are more complex than claims for physical injuries. They require medical diagnosis, evidence of causation (proof that the injury arose from workplace hazards rather

than personal factors), and often, legal or administrative support to navigate the claims process [148]. For NGO workers, already overloaded, under-resourced, and time-poor, the burden of pursuing a COIDA claim may feel insurmountable.

5.4 Job insecurity

NGO workers on short-term contracts or in precarious employment fear that lodging a COIDA claim will jeopardise their future employment [150]. They worry that they will be perceived as "difficult", that their contracts will not be renewed, or that they will be informally blacklisted within the sector. This fear is not irrational: in a sector characterised by funding precarity and high competition for limited positions, workers have legitimate reasons to avoid actions that might be perceived as threatening to their employers [152].

KEY TAKEAWAY

The OHS Amendment Bill does not require a prior claims history to establish liability. Foreseeability is the standard. If a psychosocial hazard is inherent to the nature of the work, and the evidence establishes that it is, then the employer must assess and mitigate it, regardless of whether any worker has previously lodged a COIDA claim. The absence of claims is not a shield. It is a gap the Amendment Bill is designed to close.

This shift is particularly significant for the NGO sector, where the culture of self-sacrifice and the structural barriers to claiming have created a false impression of low risk. The risk is not low — it is under-reported. The OHS Amendment Bill corrects this by making risk assessment and mitigation a legal obligation, independent of claims history [155].

06 Cross-sector NGO risk profiles

Different types of NGOs face different psychosocial risk profiles. The following five sub-sectors represent the highest-risk categories within the South African NGO landscape. Each profile identifies the primary psychosocial hazards, the populations most affected, and the key mitigation priorities.

Sub-sector	Primary psychosocial hazards
GBV / trauma support	Vicarious trauma, secondary traumatic stress, compassion fatigue, community violence exposure
Child protection & social services	Moral distress, role overload, vicarious trauma, caseload overload, organisational instability
Community health workers / home-based care	Isolation, lack of supervision, community violence exposure, compassion fatigue, physical-psychosocial overlap
Refugee & humanitarian assistance	Compound trauma, vicarious trauma, political instability stress, funding precarity, organisational instability
Faith-based organisations / FBOs	Role conflict, spiritual bypass, emotional labour, lack of professional boundaries, compassion fatigue

6.1 GBV / trauma support organisations

Populations affected: GBV counsellors, trauma therapists, first responders, hotline operators, shelter staff, court support workers.

Risk profile: GBV and trauma support organisations face the highest vicarious trauma exposure in the NGO sector. Workers in these organisations listen to detailed accounts of violence, abuse, and trauma on a daily basis. Research on GBV first responders in South Africa found high levels of vicarious trauma, burnout, and compassion fatigue, with significant symptom reduction observed only after structured wellness and supervision interventions were implemented [9]. Workers in this sub-sector are also at risk

of community violence exposure, as they often work in high-crime areas or accompany clients to court or police stations.

Mitigation priorities: Mandatory clinical supervision for all trauma-exposed workers; peer debriefing protocols after high-intensity cases; caseload limits; trauma-informed organisational culture; and access to mental health support services.

6.2 Child protection and social services

Populations affected: Social workers, child protection officers, foster care supervisors, family preservation workers, adoption and reunification staff.

Risk profile: Child protection and social services organisations face a unique combination of moral distress and role overload. Social workers in this sub-sector routinely carry caseloads that exceed safe limits, make triage decisions about which families receive services, and navigate complex ethical dilemmas with inadequate resources [11], [172]. Research on South African forensic social workers found that job stress and role overload were significant contributors to turnover intentions [29]. Moral distress is particularly acute, as workers are often forced to close cases prematurely or turn away families in need due to capacity constraints.

Mitigation priorities: Caseload audits and limits; ethics debriefing and reflective supervision; transparent decision-making processes for triage and case closure; peer support structures; advocacy for increased funding and staffing.

6.3 Community health workers and home-based care

Populations affected: Community health workers (CHWs), home-based care workers, adherence counsellors, TB and HIV outreach workers, palliative care workers.

Risk profile: These workers face a unique combination of isolation, lack of supervision, and community violence exposure. They operate in remote or high-risk areas, often working alone, with minimal organisational support or supervision. Research on South African non-specialist health workers found high caseloads, complex cases, and chronic work-related stress in understaffed, overcrowded, low-resource settings [1]. The physical and psychosocial hazards overlap in this sub-sector: workers face both the risk of infectious disease exposure and the psychological toll of witnessing suffering and death in under-resourced communities.

Mitigation priorities: Safety protocols for fieldwork; working in pairs in high-risk areas; regular supervision (even if conducted remotely via phone or video); peer support groups; trauma debriefing after exposure to violence or death.

6.4 Refugee and humanitarian assistance

Populations affected: Refugee support workers, asylum case workers, humanitarian aid workers, emergency relief staff, resettlement coordinators.

Risk profile: Refugee and humanitarian assistance organisations face compound trauma exposure: workers are exposed not only to the trauma narratives of refugees and displaced persons, but also to the ongoing political instability, violence, and uncertainty that characterise humanitarian crises [178]. Research on aid workers found elevated rates of burnout, vicarious trauma, and mental health conditions, compounded by funding precarity and organisational instability [19], [179]. Workers in this sub-sector also face ethical dilemmas and moral distress when resources are insufficient to meet the scale of need.

Mitigation priorities: Trauma-informed supervision; peer support and debriefing; rotation policies to limit duration of exposure to high-intensity crises; mental health support services; organisational stability measures including diversified funding and transparent communication.

6.5 Faith-based organisations / FBOs

Populations affected: Faith-based counsellors, pastoral care workers, church-based social workers, FBO programme staff, volunteer caregivers.

Risk profile: FBOs face unique psychosocial hazards related to the intersection of faith, mission, and professional practice. Workers often experience role conflict: they are expected to provide professional services (counselling, social work, health care) while also embodying spiritual values and maintaining pastoral relationships with beneficiaries. This blurring of professional and spiritual roles can lead to boundary violations, emotional labour, and compassion fatigue [183]. “Spiritual bypass”, the use of spiritual beliefs to avoid or minimise psychological distress, is also a risk, as workers may be discouraged from acknowledging their own suffering or seeking mental health support [184].

Mitigation priorities: Clear role definitions and professional boundaries; training on the distinction between pastoral care and professional counselling; supervision that integrates both professional and spiritual dimensions; normalisation of mental health support-seeking within faith-based contexts.

07 Section 16 liability: what NGO directors and trustees must know

Section 16 of the Occupational Health and Safety Act, as amended, imposes personal criminal liability on every person who controls or manages a workplace and who fails to comply with the Act's requirements. For NGO directors, trustees, CEOs, and programme managers, this provision is not theoretical, it is a direct, enforceable legal obligation with severe penalties for non-compliance.

7.1 Who is personally liable

- **Directors and CEOs:** executive authority over organisational operations and responsibility for implementing OHS policies and procedures.
- **Trustees and board members:** responsibility for setting policy, approving budgets, allocating resources, and overseeing governance. Trustees are liable if they approve budgets or policies that create foreseeable psychosocial hazards, for example, staffing structures that create role overload, or failure to allocate resources for supervision in trauma-exposed roles [3], [156].
- **Programme managers and senior staff:** control over specific workplaces such as regional offices, field sites, or service delivery centres. If a programme manager has authority over staffing, workload allocation, or safety protocols in their area of responsibility, they are potentially liable under Section 16.

What are the penalties?

The penalties for Section 16 violations are severe and apply per violation. If an employer fails to conduct a Section 8 risk assessment, fails to implement mitigation measures, and fails to report a Section 24 psychological injury, each failure is a separate violation, and penalties can accumulate [158].

Offence	Maximum fine	Maximum imprisonment
First offence	R50,000	2 years
Repeat offence	R100,000	4 years

7.2 Defences that do not exist

The OHS Amendment Bill does not recognise the following defences. NGO directors and trustees must understand that none of these arguments will shield them from Section 16 liability.

"We are a small NPO"

The size of your organisation does not reduce your legal obligation. A small CBO with five staff members has the same Section 8 obligation as a large national NGO with hundreds of employees. The scope and complexity of the risk assessment may differ, but the obligation does not [159].

"We have no budget"

Resource constraints do not exempt you from Section 8 compliance. The Amendment Bill does not include a "resource constraint" exemption. If you cannot afford to hire additional staff to reduce role overload, you must find other mitigation measures, such as reducing service volumes, prioritising certain beneficiary groups, or advocating for increased funding. The legal standard is reasonable mitigation, not perfection [160].

"Our staff are volunteers and passionate about the work"

The passion and commitment of your workforce do not reduce the foreseeability of psychosocial hazards or your duty to assess and mitigate them. Volunteers and stipended workers are covered by the OHS Act if they are under your control or management. Their willingness to work in difficult conditions does not exempt you from liability [161].

7.3 Trustee liability: a critical issue

Trustee liability under Section 16 is particularly significant for NGO boards. Trustees who approve budgets that systematically under-resource psychosocial risk mitigation are potentially personally liable. For example:

- A board that approves a staffing structure requiring social workers to carry caseloads of 200+ beneficiaries, knowing that this creates foreseeable role overload and burnout risk, is potentially liable [162].
- A board that fails to allocate budget for clinical supervision in trauma-exposed roles, despite being aware of the risk of vicarious trauma, is potentially liable [163].
- A board that approves a budget with no provision for employee assistance, mental health support, or psychosocial risk assessment, despite being aware of the Amendment Bill's requirements, is potentially liable [164].

Trustees cannot delegate their way out of liability. While day-to-day implementation of OHS compliance may be delegated to management, the board retains ultimate accountability for ensuring that the organisation complies with the law. Trustees must ask: has a Section 8 psychosocial risk assessment been conducted? What hazards were identified? What mitigation measures have been implemented? What budget has been allocated for psychosocial risk mitigation? If the board cannot answer these questions, it is failing in its governance duty, and individual trustees are at risk of personal criminal liability [165].

7.4 Three practical steps every NGO director must take before promulgation

THREE STEPS BEFORE PROMULGATION

1. Conduct a baseline psychosocial risk assessment.

Use the Sociosafety™ Workbook or another structured tool to identify psychosocial hazards in your organisation. Document the assessment in writing. This is your Section 8 compliance foundation [166].

2. Brief your board on Section 16 liability.

Ensure that every trustee understands their personal liability under the OHS Amendment Bill. Present the psychosocial risk assessment to the board and secure board approval for a mitigation plan and budget allocation [167].

3. Implement at least one high-impact mitigation measure before promulgation.

You do not need to solve every problem immediately, but you must demonstrate that you are taking reasonable steps to mitigate identified hazards. Prioritise measures that address the most severe or prevalent hazards in your organisation, such as implementing supervision for trauma-exposed workers, reducing caseloads, or establishing peer support structures [168].

These three steps will not eliminate all psychosocial hazards, but they will demonstrate that you are taking your Section 8 obligations seriously, and that is the legal standard. Reasonable mitigation, documented in writing, is the defence against Section 16 liability [169].

08 The Sociosafety™ approach

Ignite Purpose has developed Sociosafety™, a sector-specific compliance methodology designed to enable NGO, faith-based, and community-based employers to meet their psychosocial hazard obligations under the OHS Amendment Bill. This section presents the methodology, its theoretical foundation, and three deployment models for boardrooms, regional structures, and frontline service delivery.

8.1 Why generic tools fall short

Most psychosocial risk assessment tools are designed for low-hazard corporate office environments. They fail in NGO contexts because they:

- Do not address sector-specific hazards (vicarious trauma, compassion fatigue, moral distress, funding precarity, community violence exposure).
- Require clinical psychology expertise that is not available at field-site or programme level.
- Produce generic recommendations that do not integrate with mission-driven cultures, donor reporting cycles, or existing organisational structures.
- Do not generate legally defensible documentation for Section 24 inspection readiness.
- Carry pricing structures that are inaccessible to resource-constrained NGOs.

8.2 Theoretical foundation: Psychosocial Safety Climate (PSC)

The Sociosafety™ methodology is grounded in Psychosocial Safety Climate (PSC) theory, a leading framework for understanding and managing psychosocial hazards. PSC theory posits that organisational climate, the shared perceptions of policies, practices, and procedures, shapes psychosocial hazards and employee wellbeing.

Four dimensions of PSC

- **Management commitment:** the extent to which senior management demonstrates commitment to psychosocial safety through resource allocation, policy development, and visible leadership.
- **Management priority:** the extent to which psychosocial safety is prioritised alongside (or above) programme delivery, donor reporting, and cost control.

- **Organisational communication:** the extent to which the organisation communicates openly about psychosocial hazards, encourages reporting, and responds to employee concerns.
- **Organisational participation:** the extent to which employees, paid, stipended, and volunteer, are involved in psychosocial risk assessment, mitigation planning, and decision-making.

The Sociosafety™ methodology assesses PSC across these four dimensions and identifies organisational climate factors that contribute to psychosocial hazards. An NGO with low management commitment to psychosocial safety (prioritising programme output over staff wellbeing) and low organisational participation (excluding workers from decision-making) is at high risk of psychosocial harm. The methodology provides targeted interventions to strengthen PSC and reduce psychosocial hazards.

8.3 Three deployment models

The Sociosafety™ methodology can be deployed in three distinct ways, each addressing different dimensions of the NGO compliance challenge.

> **MODEL 1 — FRONTLINE SERVICE DELIVERY**
>
> *For Programme Managers, Field Coordinators, Counsellors, Community Health Workers, and frontline supervisors. Phased deployment over 12 months: baseline assessment of role-specific psychosocial hazards, participatory mitigation planning with employees and union representatives where applicable, control measure implementation (caseload audits, supervision structures, peer debriefing, fieldwork safety protocols, post-incident trauma support), and quarterly monitoring with follow-up assessments.*

> **MODEL 2 — REGIONAL & MULTI-SITE**
>
> *For Regional Managers, Operations Directors, HR Practitioners, and Health and Safety Officers in NGOs with multiple sites or regional structures. Phased deployment over 12 months: cross-site baseline assessment, participatory mitigation planning, harmonisation of supervision and reporting structures across sites, control measure implementation, and quarterly site-level monitoring with consolidated regional reporting.*

MODEL 3 — BOARD & TRUSTEE

For Boards of Trustees, Directors, CEOs, Audit Committees, and Funders. Section 16 liability audit with gap analysis. Organisation-wide psychosocial risk register identifying top hazards across programmes. Funder reporting alignment for staff wellbeing and organisational sustainability narratives. Quarterly board reports and annual compliance audits. Designed to enable trustees to satisfy their personal duty of care under Section 16.

8.4 Key features

- **Sector-specific hazard profiles:** pre-populated profiles for GBV / trauma support, child protection, community health, refugee assistance, faith-based organisations, and humanitarian relief.
- **Validated assessment instrument:** an 84-item instrument across six dimensions (Workload, Autonomy, Recognition, Fairness, Community, Values congruence), built and refined with South African organisations from 2022 to 2026 across healthcare, financial services, mining, public sector, and professional services — and tailored for NGO contexts.
- **Listening Circles:** structured small-group conversations run by a trained practitioner sit alongside the quantitative instrument, capturing workforce voice in ways a survey alone cannot — particularly important in trauma-exposed or precarious settings where formal reporting is suppressed.
- **Compliance documentation:** generation of compliance documentation for Section 8 (written risk assessments, hazard registers, mitigation plans) and Section 24 (incident reports, medical referral pathways).
- **Board-level reporting:** trustee dashboards and board reports that enable Section 16 compliance through documented “reasonable steps”.
- **Integration:** designed to integrate with existing OHS management systems, supervisory structures, and funder reporting frameworks.

8.5 Engagement model

Sociosafety™ engagements are scoped to the size, complexity, and resource level of the organisation, with explicit NGO-sector accessibility:

- **Small CBOs, FBOs, and grassroots collectives:** self-service workbook with user guide, training videos, multilingual templates, and email support. NGO-sector pricing with pro bono partnerships for qualifying organisations.
- **Mid-sized NGOs and regional structures:** facilitated baseline assessment, participatory mitigation planning workshops, quarterly monitoring, and Section 8 and Section 24 compliance documentation.
- **Large national NGOs and umbrella bodies:** full deployment across all sites and programmes, Section 16 liability audit, board-level psychosocial risk register, funder reporting alignment, quarterly board reports, annual compliance audits, and trustee training. Network licensing for umbrella bodies to deploy across member organisations.

All engagements are scoped through a direct conversation with the leadership team. Contact details are at the end of this paper.

09 Implementation roadmap

This section provides a detailed four-phase implementation roadmap for NGO employers to achieve full compliance with the OHS Amendment Bill's psychosocial hazard provisions within 12 months.

Phase	Months	Focus
Phase 01 — Awareness and governance	1–3	Build organisational awareness and secure governance-level commitment to compliance
Phase 02 — Psychosocial risk assessment	4–6	Conduct comprehensive written psychosocial risk assessment under Section 8
Phase 03 — Mitigation	7–9	Develop and implement a prioritised mitigation plan
Phase 04 — Monitoring and reporting	10–12	Establish ongoing monitoring, audit, and Section 24 reporting readiness

9.1 Phase 1: awareness and governance

> PHASE 01
>
> *Months 1–3. Phase 1 deliverables: board briefing on the OHS Amendment Bill; board resolution committing to compliance; named individual or team responsible for implementation; baseline scan of psychosocial hazards across the organisation; budget allocation for assessment and mitigation work.*

Objective

Build organisational awareness of the OHS Amendment Bill and secure governance-level commitment to compliance.

Key activities

Month 1: board and management briefing

Conduct a briefing session for senior management and the board of trustees on the OHS Amendment Bill, focusing on Section 8 obligations, Section 16 personal criminal liability, and the eight NGO-specific psychosocial hazards. Use this white paper as the briefing document.

Month 2: board resolution and budget

Secure a board resolution committing the organisation to OHS Amendment Bill compliance. The resolution should include acknowledgment of the organisation's Section 8 obligations, approval of a budget allocation for psychosocial risk assessment and mitigation, and delegation of responsibility for implementation to a named individual or team.

Month 3: baseline hazard identification

Use the Sociosafety™ Workbook or another structured tool to conduct an initial scan of psychosocial hazards across the organisation. This does not need to be a full risk assessment yet — it is a preliminary identification of the hazards that will be assessed in the next phase.

9.2 Phase 2: psychosocial risk assessment

> PHASE 02
>
> *Months 4–6. Phase 2 deliverables: written psychosocial risk assessment (Section 8 compliance); organisational hazard register; site-level and programme-level risk profiles; board presentation; documented evidence base for mitigation planning.*

Objective

Conduct a comprehensive written psychosocial risk assessment as required by Section 8.

Key activities

Month 4: deploy the assessment tool

Deploy the Sociosafety™ Workbook or another structured risk assessment tool. Engage staff in the assessment process through surveys, Listening Circles, focus groups, and one-on-one interviews. The goal is to gather data on the presence, severity, and prevalence of psychosocial hazards across different roles, programmes, and sites.

Month 5: analyse and build the hazard register

Analyse the assessment data and complete the hazard register. For each identified hazard, document the nature of the hazard, the populations affected, the severity and likelihood of harm, and any existing mitigation measures already in place. Benchmark against standards such as ISO 45003 and ILO guidelines.

Month 6: board presentation and approval

Present the completed risk assessment and hazard register to the Board Social and Ethics Committee or Risk Committee. Secure board approval for the assessment and for the mitigation plan that will be developed in Phase 3.

9.3 Phase 3: mitigation

> PHASE 03
>
> *Months 7–9: Phase 3 deliverables: prioritised mitigation plan; high-impact control measures implemented; staff communication of the mitigation plan; supervisor and manager training; pilot deployment with documented learning.*

Objective

Develop and implement a prioritised mitigation plan to reduce or eliminate identified hazards.

Key activities

Month 7: develop the mitigation plan

For each identified hazard, identify feasible mitigation measures. Prioritise measures that address the most severe or prevalent hazards, and that are achievable within the organisation's resource constraints. Use the Sociosafety™ mitigation planning tools to guide this process.

Month 8: implement high-priority measures

Focus on “quick wins” that can be implemented immediately: establishing peer support structures; implementing caseload review processes; developing safety protocols for fieldwork; scheduling regular supervision sessions for trauma-exposed workers; setting up trauma debriefing pathways after high-intensity incidents. Pilot test in selected sites before enterprise-wide rollout.

Month 9: communicate and train

Communicate the mitigation plan to all staff. Transparency is critical: staff need to know that the organisation has identified psychosocial hazards and is taking action to address them. This communication builds trust and demonstrates organisational accountability. Conduct supervisor and

manager training on psychosocial hazard recognition, control measures, incident response, and Section 16 personal liability.

9.4 Phase 4: monitoring, audit, and reporting

> PHASE 04
>
> *Months 10–12. Phase 4 deliverables: quarterly review process; Section 24 reporting protocol; Section 16 liability audit; board report on psychosocial compliance; integration of psychosocial data into funder reporting; continuous improvement plan.*

Objective

Establish ongoing monitoring and audit systems to assess control measure effectiveness, ensure continuous compliance with Sections 8, 16, and 24, and integrate psychosocial risk data into funder and stakeholder reporting.

Key activities

Month 10: quarterly review process

Establish a quarterly review process for the psychosocial risk assessment and mitigation plan. Assign responsibility for this review to a named individual or committee. The review should assess: whether mitigation measures are being implemented as planned; whether new hazards have emerged; and whether any psychological injuries have occurred. Collect employee feedback through surveys, Listening Circles, and staff consultations.

Month 11: Section 24 reporting protocol

Use the Sociosafety™ reporting templates to create a clear process for identifying, documenting, and reporting psychological injuries that meet the Section 24 criteria. Train managers and HR staff on this protocol, including definitions of reportable incidents, reporting procedures, and timelines.

Month 12: Section 16 audit and funder reporting

Conduct a Section 16 liability audit to assess whether directors and trustees have taken “all reasonable steps” to ensure psychosocial compliance. Document all reasonable steps taken, including board oversight, resource allocation, policy development, training, audits, and incident reporting. Integrate psychosocial risk assessment and mitigation into funder reporting, many funders are increasingly interested in organisational health, staff wellbeing, and sustainability.

Beyond month 12

OHS compliance is not a one-time project, it is an ongoing organisational commitment. After the first 12 months, the organisation should have a written psychosocial risk assessment and hazard register (Section 8 compliance); a documented mitigation plan with evidence of implementation; a Section 24 reporting protocol; and a quarterly review process to ensure ongoing compliance and continuous improvement.

This infrastructure positions the organisation not only for legal compliance, but also for long-term sustainability, staff retention, and mission effectiveness.

10 Conclusion and call to action

The South African OHS Amendment Bill 2021 represents a watershed moment in occupational health and safety law. By explicitly expanding the definition of “hazard” and “risk” to include psychosocial factors, the amended Act brings mental health and psychosocial wellbeing into the core legal framework of employer duty of care. For NGOs, faith-based organisations, and community-based organisations, the backbone of South African civil society and the front line of social service delivery, this paradigm shift has immediate, far-reaching, and unavoidable implications.

10.1 The argument synthesised

NGOs cannot hide behind mission-driven culture

Decades of exclusive focus on programme delivery and beneficiary outcomes have created a dangerous blind spot: the systematic neglect of staff psychosocial wellbeing. The OHS Amendment Bill closes this gap permanently. Vicarious trauma, compassion fatigue, role overload, funding precarity, community violence exposure, moral distress, isolation, and organisational instability are all legally foreseeable psychosocial hazards that NGO employers must assess, mitigate, and report.

Foreseeability is the legal standard

The OHS Amendment Bill does not require a prior claims history to establish liability. If a psychosocial hazard is inherent to the nature of the work, and the research evidence establishes that vicarious trauma, compassion fatigue, burnout, and moral distress are inherent to trauma-exposed, resource-constrained, beneficiary-facing NGO work, then the hazard must be assessed and mitigated. The absence of COIDA claims is not a shield. It is a gap that the Amendment Bill is specifically designed to close.

Directors and trustees are personally liable

Section 16 imposes personal criminal liability on directors, trustees, and officers who fail to take all reasonable steps to ensure psychosocial compliance. The “I didn't know” defence does not work. The “we are a small NPO” defence does not work. The “we have no budget” defence does not work. Directors, CEOs, trustees, and programme managers are personally liable, facing criminal penalties of up to R100,000 and four years' imprisonment for repeat offences.

Compliance is achievable within 12 months

The four-phase implementation roadmap enables NGO employers to achieve full compliance within 12 months: awareness and governance (Months 1–3), psychosocial risk assessment (Months 4–6), mitigation (Months 7–9), and monitoring, audit, and reporting (Months 10–12).

10.2 The stakes

- **Legal liability:** criminal prosecution of directors and trustees under Section 16, with fines up to R100,000 and imprisonment up to four years.
- **Reputational damage:** public exposure of psychosocial compliance failures, particularly damaging for organisations whose legitimacy rests on mission credibility.
- **Workforce attrition:** loss of skilled workers due to burnout, vicarious trauma, and unaddressed psychosocial harm.
- **Funder confidence:** increasing funder scrutiny of organisational health, staff wellbeing, and sustainability.
- **Human cost:** preventable psychological harm to hundreds of thousands of NGO workers delivering essential services to South Africa's most vulnerable communities.

10.3 The opportunity

Compliance with the OHS Amendment Bill is not merely a legal obligation, it is a strategic opportunity. NGOs that proactively address psychosocial hazards will attract and retain talent, sustain programme quality, strengthen reputation, achieve funder confidence, and build resilient workforces capable of delivering on their mission for the long term.

Compliance is mission-aligned. You cannot sustain a mission to serve others if the people delivering that mission are psychologically injured, burned out, or traumatised. Protecting your people is protecting your mission.

10.4 The call to action

FOUR STEPS FOR NGO DIRECTORS AND TRUSTEES

1. **Conduct a baseline psychosocial risk assessment.**

Use the Sociosafety™ Workbook or another structured tool to identify psychosocial hazards across your organisation, document the assessment in writing, and establish the foundation for Section 8 compliance.

2. **Brief your board on Section 16 liability.**

Ensure every trustee understands their personal liability under the Amendment Bill, present the risk assessment, and secure board approval for a mitigation plan and budget allocation.

3. **Implement at least one high-impact mitigation measure before promulgation.**

Prioritise measures that address the most severe or prevalent hazards in your organisation — clinical or peer supervision for trauma-exposed workers, caseload audits, fieldwork safety protocols, or trauma debriefing pathways.

4. **Engage Ignite Purpose for compliance support.**

Request the Sociosafety™ Workbook, book a facilitated baseline assessment, or commission a Section 16 liability audit. NGO-sector pricing and pro bono partnerships are available for qualifying organisations.

NGOs cannot hide behind mission-driven culture or resource constraints. The evidence is clear. The law is clear. The path forward is clear. Do not wait for a Section 16 prosecution. Do not wait for a preventable psychological injury. Do not wait for a funder withdrawal. Act now to protect your workforce, your directors, your trustees, and your mission.

Your people are your mission. Protect them.

TO BEGIN YOUR SECTION 16 LIABILITY AUDIT

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