

Compassion Practice by Ugandan Nurses Who Provide HIV Care

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Abstract

Compassion is fundamental to ethical nursing practice; it represents a commitment to acknowledge and respond to the suffering of the patient. Many structural, economic, and sociopolitical challenges confront Ugandan nurses in their efforts to incorporate compassion into their care of persons with HIV illness. After reviewing the literature related to compassion fatigue, the author describes nursing in sub-Saharan Africa and presents a qualitative study exploring the impact of education on 24 nurses' lives, including their capacity to avoid or mitigate the development of compassion fatigue. Data were collected through interviews, observation, and focus group discussions. Findings illustrate the barriers participants faced in providing competent care and the liberating effects of new knowledge and skills. Engaging in meaningful relationships, maintaining hopeful attitudes, and advocating for the profession were found to transform and affirm the nurses' approach toward their work and enhance their experiences of compassion satisfaction. The author discusses the unique aspects of the experience of compassion among Ugandan nurses caring for persons with HIV illness.

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...compassion practice requires willingness and ability to be in relationship with another person. [which] may be difficult and debilitating...or it may be a fulfilling and energizing experience. Compassion is commonly viewed as intrinsically linked to the caring work and values of the nursing profession. It is defined as the acknowledgement of another's suffering and is accompanied by the expression of a desire to ease or end that suffering (van der Cingel, 2009). The role of a nurse is to be present and offer care to those who experience the consequences and distress of health problems. Because of this obligation to humanity, the concept of compassion is extremely relevant to nursing practice. Engaging in compassion practice requires the willingness and ability to be in relationship with another person. Such a commitment may be difficult and debilitating for the nurse, or it may be a fulfilling and energizing experience.

Compassion fatigue is a term that describes the weariness and stress felt by some nurses as they struggle to sustain the ability to witness and respond to profound suffering in their patients. Compassion satisfaction, on the other hand, refers to the inspiration and revitalization experienced by the nurse who shares in and contributes to the relief of such suffering. The purpose of this article is to explore the concept and consequences of compassion practice as revealed during an ethnographic study involving nurses and nurse-midwives who provided care to HIV-infected and -affected people in Uganda.

Literature Review

Considerable ambiguity and multiple perspectives characterize the discourse around the phenomenon of compassion fatigue in the healthcare literature. Introduced initially by Joinson (1992) to describe a symptom of burnout among emergency room nurses, the term has since been discussed in association with secondary, indirect, or vicarious traumatization (Meadors, Lamson, Swanson, White, & Sira, 2009; Sabo, 2006; Simon, Pryce, Roff, & Klemmack, 2005; Sinclair & Hamill, 2007), nurses' stress (McGibbon, Peter, & Gallop, 2010), and the moral stress or distress experienced across a range of healthcare disciplines (Aycock & Boyle, 2009; Forster, 2009). Coetzee and Klopper (2010),

in a concept analysis examining the phenomenon of compassion fatigue within nursing practice, described compassion fatigue as the terminal outcome of a progressive, cumulative, and intense process that manifests with physical, emotional, social, spiritual, and intellectual effects. Despite a lack of consensus about its definition, most authors agree that healthcare providers and their workplaces bear a certain cost related to compassion fatigue. This cost includes decreased productivity, high rates of absenteeism and turnover, and decreased quality of patient care (Najjar, Davis, Beck-Coon, & Carney Doebbeling, 2009; Simon et al., 2005).

Many of the research studies addressing compassion fatigue and reported in peer-reviewed journals were conducted in specialty, acute-care units, such as pediatrics, critical care, and oncology units, in high-income countries (Ainsworth & Sgorbini, 2010; Aycock & Boyle, 2009; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Meadors et al., 2009; Perry, 2008; Simon et al., 2005; Sinclair & Hamill, 2007; Yoder, 2010) and focused on recruitment and retention issues. The few references to compassion fatigue as it exists in low- and middle-income countries (LMIC) have often discussed donors' attitudes related to international aid and foreign policy regarding war, famine, disease, and death (Anonymous, 2004; Moeller, 1999) or burnout among nurses in sub-Saharan Africa who are overwhelmed by workload and resource-constrained settings (Cilliers, 2003; Gaede, Mahlobo, Shabalala, Moloji, & van Deventer, 2006; Turan, Bukusi, Cohen, Sande, & Miller, 2008; Uebel, Nash, & Avalos, 2007).

Compassion satisfaction...refers to the inspiration and revitalization experienced by the nurse who shares in and contributes to the relief of such suffering. A few authors have examined protective factors and processes that limit the manifestation of compassion fatigue or that promote compassion satisfaction in nurses. Perry (2008) reported that oncology nurses who maintained a positive, appreciative attitude and who engaged in meaningful relationships with patients were able to successfully avoid compassion fatigue. Burtson and Stichler (2010) observed that compassion satisfaction in acute and critical care nurses was an indication of self-actualization achieved through their work. Other authors have recommended that nurses find a balance between their work and their personal lives, and that their employers take responsibility for promoting healthy work environments in which negative outcomes are minimized (Abendroth & Flannery, 2006; Aycock & Boyle, 2009).

A review of the literature revealed that the concept of compassion practice by nurses in the context of the cultural, economic, and sociopolitical environments of LMIC has received little attention. In this article I will describe nursing in sub-Saharan Africa and present a qualitative study exploring the impact of education on 24 nurses' lives, including their capacity to avoid or mitigate the development of compassion fatigue. I will present two themes that emerged relating to compassion practice: (a) integrating and dis-integrating, and (b) re-integrating, along with subthemes for each of these themes. In the discussion section I will summarize the compassion fatigue experienced by Ugandan nurses caring for persons with HIV illness.

Background: Nursing in Sub-Saharan Africa

More than two-thirds of the world's people with HIV illness live on the African continent, home to many of the poorest countries on the planet. Nurses and nurse-midwives in sub-Saharan Africa face complex, overwhelming issues as they struggle to provide safe, ethical care to people with HIV and AIDS. Although the numbers of new HIV infections and AIDS deaths in Africa have been declining over the past decade, the total number of people living with HIV continues to rise (UNAIDS, 2010). More than two-thirds of the world's people with HIV illness live on the African continent, home to many of the poorest countries on the planet. The resources required to initiate and monitor antiretroviral therapy for HIV-infected people are rapidly becoming inadequate as drug distribution programs continue to scale up (Bärnighausen, Bloom, & Humair, 2007; UNAIDS, 2010). Increasing numbers of frontline workers are required to deal with this immense workload. It is imperative that these workers be appropriately supported with educational and material resources to ensure their well

being and that of their patients. Without strategies to increase the number and capacity of healthcare providers, any hope of reducing the burden of the AIDS epidemic will be futile (Uebel et al., 2007).

In addition to the challenges faced by their counterparts in high-income countries, LMIC nurses face additional barriers that add a layer of complexity to their roles in the workplace and the community. The nursing workforce comprises mostly women who are at increased risk for infection with HIV as a function of their cultural and social status in relation to men. Indeed, women account for 60% of all people living with HIV in sub-Saharan Africa (UNAIDS, 2010), a figure that reflects their relative lack of capacity to protect themselves. Furthermore, nursing in Africa is not a highly valued or respected profession; nurses are often the victims of violence in the workplace with little opportunity for compensation or alternative employment (Buchan & Calman, 2005). In the absence of adequate supplies of personal protective equipment, nurses are constantly exposed to the transmission hazards inherent in the work environment. Fear of stigmatization inhibits many nurses from being tested for HIV (Dieleman et al., 2007; Kyakuwa, 2009); consequently, those who are infected may avoid disclosure and delay treatment until the disease is advanced.

...nursing in Africa is not a highly valued or respected profession...Recent evidence has suggested that an expanded role for nurses in HIV clinics has the potential to improve efficiencies and patient outcomes (Castelnuovo et al., 2009; Chang et al., 2009). Clearly, nurses are a key component to any strategy for easing the burden of the epidemic; failure to attend to the many challenges they face will result in an extension of the tragedy related to the HIV epidemic in sub-Saharan Africa.

I conducted a two-year qualitative study with registered nurses at a major teaching and referral hospital in Uganda that offered new knowledge about strategies for recognizing and building capacity among a group of nurses who provided HIV care. Following completion of a 6-month HIV education program, which included theory and practice modules designed to enable nurses to be better prepared to address prevention, counseling, symptom management, and treatment related to HIV illness, participants were invited to share their personal and professional experiences related to caring for HIV-infected or -affected persons. Full details of the study are available elsewhere (Harrowing, 2009). After participating in this educational program, the nurses reported enhanced capacities and new insights related to both their roles as nurses and the importance of education in assuming leadership and advocacy responsibilities within the profession and their communities. In this article, I will focus on the nurses' experiences of compassion fatigue and provide examples of compassion satisfaction and resilience that might inform and instruct nurses in similar contexts and situations.

The Study

The fundamental question I sought to answer was: What is the impact of an HIV education program on the lives of Ugandan nurses and nurse-midwives? Using critical qualitative methodology as outlined by Carspecken (1996), I worked with 24 female participants to achieve greater understanding of the effects of the education program and process on their personal, professional, and social lives. Anticipating that gender, cultural, social, political, and economic factors might influence Ugandan nurses' abilities and opportunities to engage in professional development activities and to influence policy implementation, I chose a critical approach with the expectation that it would facilitate the exposure of subtle power and control operatives. The purpose of critical methodology is not merely to increase knowledge; rather the aim is to reveal injustices and generate political action that can redress those wrongs (Kincheloe & McLaren, 2005). Madison (2005, p. 5) observed that the criticalist moves from "what is" to "what could be" to contribute to emancipatory knowledge and the discourses of social justice.

Their narratives of the struggle to reinvent themselves and their nursing practice illustrate what can be accomplished when opportunities are seized and ideals are re-ignited, even in the unforgiving terrain of the sub-Saharan HIV pandemic. I spent a total of 18 weeks in Uganda over a 2-year period. Data were collected through semi-structured interviews that lasted 60 to 100 minutes. These

interviews were audiotaped with permission of the participants. Many of the nurses were also observed as they interacted with patients during counseling sessions and other nursing-related encounters. Tapes and field notes were transcribed verbatim and entered into a qualitative data management program (NVivo7); thematic coding occurred simultaneously with data collection. I also learned about the community through such activities as learning the local language, shopping in the market, attending church services and cultural events, visiting museums, traveling on public transportation, and reading local newspapers and magazines. Rigor was enhanced, as recommended by Morse, Barrett, Mayan, Olson, and Spiers (2002), by persistent and prolonged engagement, frequent consultation with experienced qualitative researchers, maintenance of detailed memos and field notes, and the concurrent collection and analysis of data.

Ethical approval for the study was obtained from the relevant academic and healthcare institutions in Canada and Uganda. Informed and ongoing consent was obtained from participants at each encounter. Participants' patients granted permission for observation of clinical interactions after participants explained the purpose of my presence and addressed any questions and concerns.

Participants for the educational program were selected by the senior nursing administrator of the hospital. The women who consented to take part in the study represented a broad range of nursing specialties, including acute and community care settings. Many were dually-trained (nursing and midwifery) and all had 15-30 years of experience. All held diplomas in nursing, two had baccalaureate degrees, and one was working on a master's degree. Several were in management, teaching, or supervisory positions; many were within 10 years of retirement (mandatory at age 60). All participants were interviewed at least once; one or two follow-up interviews were conducted with 14 participants to clarify or expand on ideas presented during earlier interactions. An additional 100 hours were spent observing 14 of the nurses in their worksites and during counseling sessions with patients.

Study Findings

...few other employment opportunities existed and nurses were under great pressure to keep (and appreciate) their jobs. Participants described in agonizing detail the personal and professional challenges associated with the circumstances and constraints imposed by their environment. Their personal and professional challenges were intertwined as the pandemic (a public challenge) was also a personal challenge for every Ugandan nurse. Despite their marginal working conditions, few other employment opportunities existed and nurses were under great pressure to keep (and appreciate) their jobs. Their small incomes were essential to feed, clothe, and educate the many family members who depended on them. Some of the participants supported up to twenty children, only 4 or 5 of whom were their own biological offspring. They often worked at two jobs, going from one worksite directly to another, arriving tired, late, and hungry. In addition, unreliable or inadequate public transportation or delays from traffic disruptions often caused them to arrive at work late, necessitating the staff from the previous shift to work overtime. Without a collective agreement between employer and employee to ensure fair working conditions, nurses' extra work was uncompensated.

Mortality rates were high, with some nurses reporting 5 or 6 deaths per 80-100 patients in a 24-hour period on the high acuity units. Medical supplies and personal protective equipment were not readily available, thereby increasing the risk of disease transmission and injuries to staff and patients alike. Patients were often admitted to overcrowded nursing units where the only space to squeeze an extra sleeping mat was on the floor, between or under the beds. Nurses routinely cared for 40 patients each during an 8-hour shift on a unit with non-functioning toilets, no bed linens, medication shortages, and no potable water. A patient without family members in attendance to assist often did not receive basic personal care. Patients frequently arrived at the hospital in very poor condition after days of travelling from rural areas. Mortality rates were high, with some nurses reporting 5 or 6 deaths per 80-100 patients in a 24-hour period on the high acuity units. It was not uncommon for families to cast

blame for unhappy outcomes on the nearest target; nurses often tolerated verbal, and sometimes physical abuse.

Participants described a trajectory of nursing practice that was increasingly burdened by HIV's imposition of overwhelming hopelessness and grief (see Figure). Their ability to provide compassionate care diminished as the environmental challenges mounted and personal reserves were depleted. However, exposure to the educational opportunity (described above) enabled participants to regain the motivation and energy necessary to re-situate compassion at the center of their care. What follows in this article are the experiences of participants as they navigated careers motivated by, and founded on compassion, only to be blindsided by HIV early in the journey. Their narratives of the struggle to reinvent themselves and their nursing practice illustrate what can be accomplished when opportunities are seized and ideals are re-ignited, even in the unforgiving terrain of the sub-Saharan HIV pandemic.

Figure. Compassion practice experience of Ugandan nurses

Figure. Compassion practice experience of Ugandan nurses

Compassion Practice: Integrating and Dis-Integrating

This theme included participants' recollections as to why they entered nursing, how the arrival of the human immunodeficiency virus changed 'everything' in nursing, and the manner in which they suffered both as healthcare professionals and as family members. Each of these subthemes will be described below. Participants chose their own pseudonyms (names) to use in this study.

Called to serve. Participants consistently described altruistic motivations and nurse role models as their inspiration for entering the nursing profession. Ruth recalled that as a young woman, "I had compassion and a sense in my heart towards people." Jackie agreed, saying, "I have been called to serve, and I will serve." Laura noted that she wanted to "be able to really help the community." Many had contact as children with nurses in the community and had admired their status and influence with local decision makers. Most recognized the importance of education and the quality of life it would bring to them and their families. Nursing offered an opportunity to gain that education for little cost, and prospective students were strongly supported and encouraged to do well in secondary school so that they would be admitted to the training programs.

Nursing careers that began in the pre-HIV era enjoyed relative stability and were reasonably well resourced. Participants who had practiced in the pre-HIV era recalled that in those days hospital patients slept on beds with clean linens and were served hot meals. Treatments and procedures were simple but available. Nurses had the opportunity to interact in meaningful ways with patients and families, and felt appreciated for their knowledge and skills. Ruth recalled that "[villagers] respected us, and that used to be so big."

Impact of HIV. Everything changed with the arrival of the human immunodeficiency virus. Resources quickly became inadequate, levels of fear and apprehension rose rapidly, and a smothering blanket of stigma and suspicion settled over Uganda. Workloads escalated and nurses found they were unable to provide care to the high standard they had come to expect of themselves. Participants described a dramatic shift in public perceptions of their profession as evidenced by media portrayals of alleged cruelty by nurses toward patients, as well as by behaviors noted during interactions with patients. Participants agreed that nurses sometimes would "lose their cool" in the face of overwhelming demands from patients but insisted that not every nurse was guilty. Christine defended her colleagues:

[Nurses] are not enough and then since we are the ones who are ever on the ground, people take it that you don't want to do your work because we are lazy or we are ignorant, but sometimes it is

because we don't have things to use. People do not understand that, because the politicians who are saying 'things are there' so why should you say they are not there?

Lorna described a common scenario:

At times someone found someone asking, "Musawo [Nurse] ..." but before she finishes you don't have the time, you just rush away, and then in return they have insulted you because you haven't given what you are supposed to give.

Participants were only too aware that the quality of their work did not meet professional standards.

Initially, with little knowledge of the etiology of the illness or protective strategies, participants began to see their colleagues contract and succumb to the virus. Public tragedy, personal suffering. Participants not only witnessed terrible and traumatic events at work as a result of AIDS and its effects on patients, but they were also completely immersed in the consequences of the epidemic within their families and communities. Initially, with little knowledge of the etiology of the illness or protective strategies, participants began to see their colleagues contract and succumb to the virus. Extended family members fell ill and required the attention of the healthcare professional who was under increasing pressure from her spouse and children to refuse requests to provide that care. Participants were called home to their villages for funerals with increasing frequency; no replacement nurses were called in to cover their shifts so remaining staff coped as well as they could. Participants described in horrific detail the irreversible maelstrom of events and circumstances that both culminated in a healthcare system in chaos and also left their professional values and assumptions in tatters. As Jackie said, "A lot of what we expected has lost meaning."

In discussing their response to the unfolding disaster of the Ugandan AIDS epidemic, participants first of all acknowledged the suffering experienced by the patients. Participants described the toll on the individual of not only the physical, emotional, and social effects of the illness, but also of their own attempts to treat and comfort that too often fell short of expectations. Grace observed that "there are some times you have to be with the patient when you are not going to do anything to him." However, finding time to "be with" patients was difficult.

Participants recounted occasions when they had been delayed in attending to a patient, only to discover that the person had died while waiting; they described the responsibility and guilt they felt as a result. Another time, one nurse on duty had to choose between two newly admitted patients in acute respiratory distress; only one survived. Ruth admitted, "It's terrible ... I feel I have done nothing. Sometimes you feel like even giving up. You don't want to see those things." Eunice expressed the frustration that comes with knowing you can do better when you have the appropriate resources. She went on to say, "When you get used to doing things substandard it can become a habit... You then lose the essence of doing it fully right." Paula summed up her feelings by commenting, "It really haunts you if you don't really help that client." In addition to the grief and disappointment associated with less than ideal outcomes for patients, Eunice pointed out that the situation "cripples the nurses and it's not good for the nursing profession because then we don't offer quality service."

Compassion Practice: Re-integrating

This theme of re-integrating includes the ability of the participants who had received the educational sessions to expand their professional skills and engage the healthcare system in a more productive manner, to provide more comprehensive service within their communities, and to cope more effectively in their day-to-day work challenges. Following is a discussion of these subthemes.

Expanding and engaging. A key outcome of the HIV education program undertaken by the participants was their new understanding of the nurse's role in creating and sustaining therapeutic relationships with patients. Prepared in their basic training programs to be simply "dispensers of

advice, sympathy, and medications,” they found that engaging more fully with people allowed them to practice what Wallis called “ideal nursing—really caring for the patient all around.” Christine described a new awareness of the importance of eliciting the patient’s story in order to better understand the context of the health concern. Jackie’s sense of satisfaction and contentment was evident when she said “I know I’ve made a future, to a certain point, for one who has had a problem.”

A brief touch, a moment of eye contact, or a simple greeting began to take on greater significance as participants acknowledged the value of such gestures in establishing a common bond of humanity... During the two years of data collection, participants were observed progressing from a relatively narrow focus on HIV and its diagnosis, treatment, and prevention, to a much wider capability for facilitating patient-centered problem solving in a range of contexts and situations. They had also developed more effective leadership and management skills, and more readily engaged in conflict resolution with staff and colleagues. Jackie noted that respect for the relationship between nurse and patient was becoming more critical than the nurse’s need to rush away. Although workloads had not changed, participants’ perceptions of the time and effort required to make a connection with a patient had been altered. A brief touch, a moment of eye contact, or a simple greeting began to take on greater significance as participants acknowledged the value of such gestures in establishing a common bond of humanity between caregiver and care recipient.

As a result of their new skills and knowledge, participants perceived greater patient satisfaction with the nursing interventions they implemented. They also articulated greater personal contentment with their contributions to patient well being, based on the degree of patient engagement in and ownership of their own care. Although there was a period of adjustment as participants learned to involve patients in actively addressing their own problems, rather than providing them with a list of instructions, there was a heightened sense of confidence and pride in this new capacity to empower patients. Indeed, as Paula observed, the patients “really identify the problem, also find out the solution to their problem. And usually they come back and say, ‘You really helped me.’”

A greater capacity for empathy was a positive result that enhanced personal and professional relationships. In addition, the discovery of spiritual strength and patience for enduring suffering was identified...Context and community. Participants also identified other benefits of the education program. They began to seek opportunities for health promotion in community and social settings and found great satisfaction in raising awareness with neighbors and family members. Communication with adolescent children about sexual health, normally a difficult subject to broach, became much more open and comfortable. Examples of spontaneous teaching in the market or on public transport were shared; some participants offered counseling sessions to couples after Sunday church services. Eventually, the scope of teaching and intervention expanded to include counseling for substance use, marital problems, palliative care, grief, suicide, and infertility concerns. Participants were pleased when patients referred friends and family members to them, interpreting that action as confirmation of their skills. These efforts to teach and support outside of the work setting were all done on a volunteer basis.

Personal growth and improved health were welcome consequences the participants had not anticipated. Ruth commented that in difficult situations “I tend to counsel myself that it will pass.” Physical symptoms such as headaches and crying attributed to excessive stress and “holding things tight” were noted to have eased. Sandra believed that the education program forced participants to re-evaluate their ability to be authentic and sincere despite a tendency “in some cultures, some tribes in Uganda, [to be] not as truthful as they should be.” A greater capacity for empathy was a positive result that enhanced personal and professional relationships. In addition, the discovery of spiritual strength and patience for enduring suffering was identified as a beneficial outcome of the education program and the instructor’s expectation of personal reflection in preparation for the counseling role.

Strategies for coping. Participants identified a number of strategies that enabled them to cope with the day-to-day challenges of their work. They endeavored to make connections with patients, even if

only to briefly greet or touch them. They learned to delegate some duties to allow them more time for counseling. Interestingly, Paula addressed her sense of being “haunted” by staying in touch and following up with her patients; instead of limiting her contact with patients, she increased it. Others used personal resources to buy medications or food for patients who could not afford such items. Sandra tried to be optimistic and felt she was more committed to changing the system, recognizing that she was in a position to understand what was required to improve the situation. Acknowledging that their efforts “counted for something” was helpful in affirming participants’ ability to contribute. When nothing else could be done, participants prayed for their patients.

The most important factor in participants’ development of a more hopeful outlook for both themselves as individual practitioners and the nursing profession was the opportunity for education. All commented about the attitude change that accompanied their selection for the program and the pride and confidence they felt in their ability to effect real change in the lives of patients. Not only did they feel that practicing nurses needed access to ongoing education, but that nursing students also required in-depth knowledge of therapeutic communication and counseling techniques in order to provide them the tools for effective, ethical nursing practice. As Sandra pointed out, “The way forward remains always almost education.”

Discussion

A number of the recommendations offered by authors who have studied compassion fatigue and burnout in high-income countries would be difficult to implement in low- and middle-income countries. Compassion, understood as an emotion through which one feels concern for the suffering of others along with a desire to ease that suffering, emerged as a dominant theme in the narratives of nurses who struggled daily to offer care to HIV-infected and -affected people in Uganda. Identified as a motivational factor for entering the profession as young women, it remained a quintessential feature of their current practice despite the overwhelming challenges associated with the pandemic. Indeed, when discussing the suffering that accompanied systemic and environmental barriers to good healthcare, participants time and again expressed their concern for patients and their families prior to addressing their own distress. Even when relating incidents of verbal or physical abuse from those in their care, participants focused on the desperation behind the behaviors and not on their own personal trauma.

Consistent with Coetzee and Klopper’s (2010, p. 240) definition of compassion fatigue, participants in this study were heavily exposed to the risk factors associated with compassion fatigue: intense and prolonged contact with patients, use of self, and stress. I suggest that the Ugandan nurses faced additional issues that might increase their vulnerability. I encourage further research to ascertain the impact of stigma, isolation, and moral distress on susceptibility to compassion fatigue. These influences on the lives and practice of nurses working in HIV care have been documented (Campbell & Foulis, 2004; Dieleman et al., 2007; Harrowing & Mill, 2010; Turan et al., 2008), but little is known about the role of compassion on their manifestation.

Participants reported experiencing, during their careers, many of the empirical indicators of compassion fatigue. They responded to the toll of excessive workload and inability to meet patient needs by experiencing physical symptoms such as weariness and headache. At times, participants withdrew from patients and failed to address their needs. Indeed, the media have publicly accused Ugandan nurses of callous and indifferent treatment. Participants agreed that they sometimes accepted substandard care as the new normal. Additionally, they often neglected their own personal health and relationships with their families.

Perhaps we can learn from the nurses in the current study who acknowledged and eloquently identified the many challenges they faced, and who went on to also identify the strengths and assets they can employ in their day-to-day work. However, in contrast to the many authors who found links between compassion fatigue and burnout (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Cilliers, 2003; Edward & Hercelinskyj, 2007; Turan et al., 2008), participants in this study reiterated that

burnout, and the departure from nursing that often follows burnout, was not an option because of the life-threatening risk that their leaving nursing represented for patients who would be “left to die.” More than once I was told that nurses could not give up in these difficult circumstances because, as Sandra expressed it, “there’s nobody who is going to have it easier than me.” As well, employment opportunities for nurses were limited, and participants could not afford to surrender their incomes to escape the traumatic workplace. Hence, participants fostered the ability to maintain positive attitudes and achieve meaningful contributions in order to maintain their integrity. Similar strategies are cited by Espeland (2006), Aycock and Boyle (2009), and Simon et al. (2005) as useful in the prevention and treatment of compassion fatigue. In her exploration of protective strategies utilized by exemplary oncology nurses, Perry (2008) found that a positive attitude toward, and appreciation of nurse-patient relationships in particular and life in general, contributed to the avoidance of compassion fatigue. Coetzee and Klopper (2010) noted the restorative functions of relieving suffering for the nurse. The experiences shared by participants in this study certainly provided additional evidence to support the importance of patients and nurses finding fulfillment in their mutual relationship.

A number of the recommendations offered by authors who have studied compassion fatigue and burnout in high-income countries would be difficult to implement in low- and middle-income countries. For example, reducing contact between healthcare providers who are experiencing personal loss and patients with life-limiting illness, as suggested by Simon et al. (2005), is not realistic in a country where every person has been affected by AIDS deaths. Aycock and Boyle (2009, p. 190) asserted that organizations must ‘step up’ and provide better environments, including opportunities for retreats and counseling, for nurses. Desirable as this strategy might be, it is not likely to occur soon in resource-challenged LMIC. Imploring nurses to be aware of their own limitations, as suggested by Ainsworth and Sgorbini (2010), is a first step to avoiding compassion fatigue; however, what to do once that awareness has been achieved is the difficult part. Perhaps we can learn from the nurses in the current study who acknowledged and eloquently identified the many challenges they faced, and who went on to also identify the strengths and assets they can employ in their day-to-day work. Participants found ways to leverage the relatively inexpensive input of a new resource, namely education, into a powerful tool for changing attitudes, improving patient care, and creating the beginnings of a critical mass for achieving change.

Conclusion

Compassion is an integral component of professional nursing practice. It represents a commitment by the caregiver to recognize, validate, and ease the suffering of the patient. The work of fulfilling that commitment can overwhelm nurses, particularly when they labor in a complex, resource-challenged context, such as Uganda, where the ongoing nightmare of HIV illness continues to affect every family and community. The line that separated professional from personal, public from private, was blurred beyond recognition. Within this devastating and complex context, nurses were found to be susceptible to the factors that contribute to compassion fatigue and indeed many manifested some of the indicators of that condition. However, in the absence of a comprehensive strategy for mitigating its effects, nurses exhibited personal and collective resilience that served to protect them from the potential career-threatening effects of compassion fatigue. The opportunity to participate in an educational program that enabled the nurses to engage in meaningful relationships with patients was a catalyst for re-igniting their enthusiasm for nursing. Using their new knowledge and skills as a vehicle for health promotion, the nurses reached out to patients, neighbors, and family in an ever-expanding network of concern and commitment for the well being of others.

Their educational experience was the means for transforming their own attitudes and practices and for re-inventing themselves for public presentation of their beloved profession. It is important to note that compassion fatigue has effects that extend beyond individual nurses who struggle to find the personal resources that will allow them to connect with their patients. It manifests within a complex, relational environment that has widespread implications for patients and nurses alike. Ugandan nurses acknowledged their personal experiences of distress and weariness, yet their concern was always for their patients, their communities, and the nursing profession as a whole. As they

recognized the liberating power of education within themselves, they began to explore strategies for creating change at institutional and societal levels. Their educational experience was the means for transforming their own attitudes and practices and for re-inventing themselves for public presentation of their beloved profession.

Future research must focus on the creation of capacity among nurses who are vulnerable to the effects of compassion fatigue by investigating those elements of nursing practice, the practice setting, and education that promote nurses' enactment of professional values. In this way, nurses may foster healthy environments supportive of autonomous and competent practice that will benefit and sustain the larger community in which nurses are integral members.

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