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**A wellness programme to prevent and manage compassion fatigue amongst
nurses working in an antiretroviral clinic in a public tertiary hospital**

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“All the glory and praise goes to my Heavenly Father”

Declaration

Student Number: 89624212

I, **Mercia Jane Tellie**, declare that **A wellness programme to prevent and manage compassion fatigue amongst nurses working in an antiretroviral clinic in a public tertiary hospital** is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

14 November 2016

Mercia Jane Tellie

Date

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ABSTRACT

Introduction: Compassion fatigue is an extreme state of tension and preoccupation with the suffering of those being helped and affects those who work in caring professions. Helping people in distress can traumatise the helper because of their empathetic ability. Nurses who work in ARV clinics witness the suffering of their patients when they listen to their patients' descriptions of the trauma that they have to cope with. The patients get the chance to let go of the trauma and to share their concerns. Unfortunately the nurses often absorb some of the emotional pain of their patients and not all nurses are equipped to handle the situations in such a way that they do not become secondarily affected by the trauma of their patients and therefore, become vulnerable to develop compassion fatigue. If compassion fatigue is not identified in time and addressed adequately, the affected nurses may develop feelings of hopelessness in their ability to take care of their patients with detrimental effect on the quality of nursing care to these patients.

Aims: Firstly, to explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in antiretroviral clinics; and secondly, to develop a wellness programme to aid in the identification and management of episodes of compassion fatigue as well as the prevention of future occurrences of such episodes of compassion fatigue amongst nurses working in antiretroviral clinics.

Methodology: The researcher conducted the study in two phases. In Phase one, a single embedded case study design, with three sub-units situated within the case, namely nurses who work in the adult, ante-natal and paediatric ARV clinics in a tertiary public hospital, was used. Purposive sampling was used to select seven nurses. Data was collected using semi-structured interviews. The researcher used content analysis as described by Elo and Kyngäs (2008) to analyse the transcribed interviews. The themes identified include the risk to develop compassion fatigue, manifestation of compassion fatigue and strategies to prevent and manage compassion fatigue. For document analysis the researcher used professional and enrolled nurses' job description and the employee health and wellness programme for public service. In Phase two, the researcher developed the wellness programme to aid in the identification, prevention and management of compassion fatigue amongst nurses who work in antiretroviral clinics and the Delphi Method was used to refine the wellness programme.

Findings: Nurses working in the ARV clinics are at risk of developing compassion fatigue due to work environment issues such as challenges created by the health care system,

lack of support from management, and their overwhelming work load. The cost of the nurse-patient relationship also contributed to nurses being at risk of compassion fatigue. Aspects that were identified that relate to the cost of a relationship with patients who are HIV positive include caring for traumatised patients, vicarious exposure to traumatic experiences of patients, and the influence caring for patients who are HIV positive has had on nurses' personal lives and their families. Nurses can traumatise their family members by continually not being available for them through emotional withdrawal. Nurses presented with physical, psychological, spiritual symptoms and changes in their behaviour that are indicative of compassion fatigue. Various strategies to prevent and manage compassion fatigue were identified: both what nurses can do, and what they expected from management. Nurses' job description is generic and does not spell out their role and function within antiretroviral clinics. The implementation of the health and wellness programme is lacking. The findings of Phase one and related literatures formed the bases from which the researcher developed the wellness programme to aid with the identification, prevention and management of compassion fatigue.

Conclusion: Nurses are at risk of developing compassion fatigue due to the cost of the nurse-patient relationship with patients who are HIV positive. The key to prevention of compassion fatigue is awareness and a number of strategies that can aid in the identification, prevention and management of compassion fatigue have been identified and included in the wellness programme. Managerial support and practicing of self-care is important to maintain the health and well-being of nurses who work in antiretroviral clinic.

Key words: Compassion fatigue, HIV/AIDS, wellness programmes, case study, Delphi Method.

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LIST OF ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

HIV: Human Immunodeficiency Virus

HIV/AIDS: Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretroviral

PLWA: People living with Acquired Immunodeficiency Syndrome (AIDS)

CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 Introduction

According to the UNAIDS (2016:n.p.) in 2015, 36.9 million people were living with HIV and 2.1 million new HIV infections were reported globally. During the year 2015 in eastern and southern Africa an estimated 19 million people are living with HIV and approximately 960 000 new HIV infections were reported. In the same report 29 6 million died from AIDS-related causes globally and 960 000 died in east and southern Africa.

South Africa (SA) has a high prevalence rate of Human Immunodeficiency Virus (HIV) infections (Tshililo and Davhana-Maselesele 2009:135). According to UNAIDS gap report (2016:n.p.) an estimated 7 million people are living with HIV in South Africa and 380 000 new HIV infections were reported during 2015. The prevalence of HIV infections and the Acquired Immunodeficiency Syndrome (AIDS) pose public health challenges in South Africa. Therefore, in response to the challenges, the number of antiretroviral (ARV) clinics has increased from 490 in 2010 to 540 in 2013, and the number of nurses who are trained to initiate ARV treatment has increased from 250 in 2010 to 23 000 in 2013 (Motsoaledi 2013:1).

Patients with HIV infection and AIDS require support to cope with their health needs (Uebel, Nash and Avalos 2007:501). Nurses who deliver the support and attend to their health needs experience high workloads and often become emotionally drained (Champ 2006:28).

This study thus focused on the development of a wellness programme to prevent and manage compassion fatigue amongst nurses who work in ARV clinics in a public tertiary hospital in the Gauteng Province of SA.

1.2 Background

The first ARV clinics in the Gauteng province opened in April 2004 (Rishikesh, MacPhail, Mqhayi, Wing, Cherish and Venter 2007:1) and by July 2010 approximately 300, 000 patients were enrolled in the 61 clinics (BauNews 2010:n.p.).

1.2.1 The health care needs of people with HIV/AIDS

HIV/AIDS is a progressive disease and the health care needs of people living with HIV/AIDS (PLWA) change over time (Ogden, Esim and Grown 2004:22). They can remain healthy for years before experiencing periods of severe illness during which they require extensive physical and psychological care (van Dyk 2012:65; Harrowing 2011:8). Emotional needs exist from the time of diagnosis until the final stages of AIDS (Smith 2007:198).

1.2.2 The health care needs of people with HIV/AIDS and the nursing profession

According to the ICN (2002:n.p.) 'Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.' In caring for patients with HIV/AIDS nurses are involved with them and their families over a prolonged time (Smith 2007:23). In South Africa nurses in ARV clinics initiate and manage the treatment of HIV/AIDS patients and are thus involved in the treatment of these patients from diagnosis until complications develop and patients get admitted to hospitals (Uebel, Fairall, van Rensburg, Mollentze, Bachman, Lewin et al. 2011:3). The health care needs of these patients are diverse and range from physical, psychosocial, and spiritual. The delivery of care usually requires a strong nurse-patient relationship and frequent clinic visits (Bidwell 2014:1). It can thus happen that nurses get to know their patients very well and thus share the emotional experiences of their patients with them that could lead to nurses developing compassion fatigue (van Dyk 2012:422). Compassion fatigue presents in different ways. The nurses can try to protect themselves from exposure to the trauma of their patients by becoming insensitive to patients' needs (Atkinson 2005:1) or they try and avoid their patients (Stamm 2005:5) through absenteeism from work (Abendroth 2005:2) or by focusing more on the paper work of the clinic rather than attending to the needs of their patients (Joinson (1992:116; 119). In all instances the needs of the patients are not addressed and the quality of health care is compromised (Gueritault-Chalvin, Kalichman, Demi and Petersen 2000:150).

1.2.3 Compassion fatigue and taking care of people living with HIV/AIDS

Joinson (1992:119) was the first person to refer to 'a unique form of burnout that affects people in care giving professions', now known as compassion fatigue. Figley (1995:1; 12) investigated this phenomenon and came to the conclusion that it is associated with the

cost of caring for traumatised patients as the caregivers tend to share the suffering of those for whom they care. Living with HIV/AIDS is associated with severe emotional reactions that repeat from time to time during the development of the condition to the extent that the patients feel traumatized (Smith 2007:198). Hence, nurses have to support their patients to have quality lives beyond HIV/AIDS diagnosis (van Dyk 2012:283). According to Joslyn (2002:1) and Harrowing (2011:1) nurses can show so much empathy towards their patients that they become exposed to the traumatic suffering of their patients. Such nurses are, as Figley (1995:7) states it 'in harm's way', as they experience the same trauma as their patients (van Dyk 2012:292). Nurses of HIV/AIDS patients may also feel that their efforts to care for their patients make no difference because they are at risk to die notwithstanding the care that they render to them (van Dyk 2012:423).

1.2.4 Compassion fatigue and burnout

Burnout and compassion fatigue are two distinct, yet related occupational stress syndromes (van den Berg, Janse van Rensburg-Bonthuysen, Engelbrecht, Hlophe, Summerton Smit et al. 2006:2). Some of the symptoms of the two conditions are also similar. The distinguishing factors are in the onset and the effect on the caregivers (Lombardo and Eyre 2011:2).

Burnout is associated with caring professions and occurs in the presence of high workloads and little support Stamm (2009:13) and presents as emotional exhaustion and feelings of depersonalization (Malatjie 2010:22). Sufferers from burnout are unhappy and feel disconnected from their work environment (Stamm 2005:21). The condition develops over time (Lombardo and Eyre 2011:2).

Compassion fatigue can emerge suddenly with no or little warning as a result of accumulative exposure to other peoples' trauma. This causes caregivers to experience emotional exhaustion. In contrast to burnout, people who suffer from compassion fatigue experience a sense of hopelessness and they tend to isolate themselves from their support systems. The recovery rate of compassion fatigue is faster than in the case of burnout (Figley 1995:12).

Some nurses are more prone to develop compassion fatigue than others. Nurses who show empathy towards their patients (Sabo 2008:24; 2011:2-3) and those nurses who have unresolved episodes of trauma in their own lives, and who over-identify with their patients may develop compassion fatigue (Figley 1995:15).

1.3 Problem statement

In the Department of Health 2015/2016 report 3 407 336 patients who are HIV positive were receiving ARV treatment as of March 2016 (Wilson 2015:n.p.). In order to ensure that patients who need ARV get the necessary treatment, the number of clinics that provide ARV treatment increased from 490 in 2010 to 540 in 2013 (Motsoaledi 2013:1). Nurses had to be trained to initiate and manage patients on ARV treatment (Cameron, Gerber, Mbatha, Mutyabule and Swart 2012:1). In 2010 a total of 250 nurses were trained in response to the HIV/AIDS epidemic. Due to the demand for care to treat patients with the HIV/AIDS disease, the number of nurses trained increased to 23 000 in 2013. The Nurse Initiated Management of Antiretroviral Therapy (NIMART) programme supported by doctors to provide care to difficult cases increased access to ARV treatment in South Africa from 923 000 in February 2010 to 1, 9 million in 2013 (Motsoaledi 2013:1). According to Wong, Omar, Sethlako, Osih, Feldman, Murdoch et al. (2012:1) the public tertiary hospital based in Johannesburg where the study took place provided ARV treatment to 3000 patients who are HIV positive. ARV programme monitoring and evaluation has been a huge challenge and monitoring of the nurse-initiated management of antiretroviral treatment (NIMART) only started in 2010 (Venter 2012/2013:41-43). According to Ngobeni (2015:17) the NIMART programme started in 2010 and the nurse-patient ration is 1:40. Thus, nurses work load has increased due to the large number of patients who require anti-retroviral treatment.

Nurses who work in ARV clinics witness the suffering of their patients (Abendroth 2005:34) when they listen to their patients' descriptions of the trauma that they have to cope with (Sabo 2011:2). The patients get the chance to let go of the trauma and to share their concerns. Unfortunately the nurses often 'absorb some of the emotional pain of their patients' (Struwig 2002:6-7). Not all nurses are equipped to handle the situations in such a way that they do not become secondarily affected by the trauma of their patients (Figley 1995:15). If compassion fatigue is not identified in time and addressed adequately, the affected nurses may develop feelings of hopelessness in their ability to take care of their patients (Harrowing 2011:2-3) with detrimental effect on the quality of nursing care to these patients and patient dissatisfaction (Harris and Griffin 2015:83; Sabo 2008:25). Compassion fatigue may result in avoidance behaviour, causing nurses to neglect patient care (van Mol. Kompanje, Benoit, Bakker and Nijkamp 2015:2) because nurses loss their nurturing ability (Knobloch Coetzee and Klopper 2010:239; Joinson 1992:116). According to Weinstein (2016:2-3) fatigue whether physical or psychological can lead to compromised decision-making, reaction time and critical thinking and this can lead to

unsafe nursing care practices because nurses are more prone to make mistakes such as medication errors. While working in the adult ARV clinic the researcher observed that despite the fact that nurses chose to work in that ARV clinic, they exhibit negative attitudes towards those patients who are HIV positive, to such an extent that they refused to allow some of them access to the clinic. This motivated the researcher to conduct the study.

The research questions that guided the study were: Why are nurses who work in antiretroviral clinics at risk of developing compassion fatigue? How could a wellness programme contribute to the identification, management of existing and prevent the occurrence of future compassion fatigue amongst nurses working in antiretroviral clinics?

1.4. Aims of study

The aims of the study was firstly to explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in antiretroviral clinics; and secondly to develop a wellness programme to aid in the identification and management of episodes of compassion fatigue as well as the prevention of future occurrences of such episodes of compassion fatigue amongst nurses working in antiretroviral clinics.

1.5 Objectives

The objectives of the study were to:

- Explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in antiretroviral clinics in a public tertiary hospital;
- Develop a wellness programme for nurses working in antiretroviral clinics to aid in the identification and management of episodes of compassion fatigue, to prevent the occurrence of future episodes of compassion fatigue amongst nurses working in antiretroviral clinics in a public tertiary hospital.

1.6 Clarification of concepts

The following concepts are used in the study:

Nurse

In this study a nurse is a person registered in terms of The Nursing Act, 2005 (Act No. 33 of 2005) in a category under Section 31(1), according to Regulation R.425 and R.683 or enrolled according to Regulation R.2175 (South African Nursing Council [SANC] n.d.:63).

Compassion fatigue

According to Figley (2005:1) it 'is a state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper.' For the purpose of this study compassion fatigue is the phenomenon under study which negatively affects the well-being of nurses who work in antiretroviral clinics.

Wellness

Wellness is an active process of becoming aware of one's own health and making choices about a healthy and fulfilling life. For the purpose of this study wellness is awareness of how working within an anti-retroviral clinic can result in vulnerability of nurses to develop compassion fatigue and taking informed decision to practice self-care and use of strategies that contribute towards a healthy and fulfilling life at work and home.

Wellness programmes

Wellness programmes are programmes offered by organisations of which the goal is to improve the well-being of their employees as well as encouraging them to positively change their health behaviour (Merrill, Aldana, Garrett and Ross 2011:782). For the purpose of this study the wellness programme is the programme developed by the researcher to aid in the identification, management of existing compassion fatigue, and prevention of the occurrence of future compassion fatigue amongst nurses working in antiretroviral clinics.

Antiretroviral clinic

An antiretroviral clinic is a setting in a primary health care setting or out-patient department that provides antiretroviral treatment that suppresses or prevents the replication of the Human Immunodeficiency Virus (HIV) (van Dyk 2012:402). For the purpose of this study antiretroviral clinics include the adult, ante-natal and paediatric antiretroviral clinics within a tertiary public hospital where antiretroviral treatment is provided.

Operational definition of ‘extent’

The degree to which something is the case (Oxford South African Concise Dictionary 2010:413).

For the purpose of the study ‘extent’ is the degree to which compassion fatigue manifest amongst nurses causing changes in their physical, psychological/emotional, social and behavioural functioning.

1.7 Significance of the study

The study focused on the extent to which compassion fatigue manifests amongst nurses working in antiretroviral clinics. The knowledge gained from the research findings, contributed towards the development of the wellness programme that can be used to promote the well-being of nurses. Through implementation of the wellness programme management can identify and manage compassion fatigue when it occurs amongst nurses; and the interventions can be used to minimise the negative effect of compassion fatigue. The wellness programme developed during the study is applicable to nurses who work in ARV clinics and may even be transferable to other nurses who work in ARV clinics at primary healthcare level or to other helping professions.

1.8 Context of the study

The study took place in the adult, ante-natal and paediatric antiretroviral clinics in a tertiary hospital. During the time of the study antiretroviral treatment, was only provided in hospital out-patient departments because the management and treatment of HIV/AIDS was doctor centred (Venter 2012/2013:261). Nurses who worked in antiretroviral clinics based in hospital out-patient departments render basic nursing care related to out-patient care.

The study was conducted in the Gauteng province in a public tertiary hospital in the adult, paediatric and ante-natal ARV clinics that provide ARV treatment to patients who are HIV positive. Nurses who work in ARV clinics in the Gauteng province, initiated and managed 20 535 patients on antiretroviral treatment from October 2010 to March 2012 (Nyasulu, Muchiri, Mazwi and Ratshefola 2012:232).

1.9 Research methodology

The research study was conducted in two phases. Next, the researcher will give a brief overview of what each phase entails. These phases are described in detail in chapters two (Phase one) and six (Phase two).

1.9.1 Phase One

This phase presents the methods used to conduct this study. In phase one of this study the researcher discusses the single embedded case study design which had three sub-units situated within the case, namely; nurses who work in the adult, ante-natal and paediatric ARV clinics in a tertiary public hospital. The researcher also discusses the context of this study, data collection using individual interviews, data management, data analysis and the findings of the qualitative data of this study.

1.9.2. Phase Two

Phase two of the study covers the development and refinement of the wellness programme. The researcher used the findings of Phase one, related literature and the theoretical frame work of this study to develop the wellness programme. The researcher used the Delphi Method outlined by (Brooks 1979 cited in Yousuf 2007:3) to refine the wellness programme in order to determine which interventions should be included that will aid in identifying and managing existing compassion fatigue, as well as interventions that will prevent future occurrence of compassion fatigue. The researcher identified a panel of experts for use in the Delphi technique through articles or research reports that they have published consisting of academics, doctors, nurses, psychologists, and social workers nationally as well as internationally. The Delphi participants had to rate the wellness programme interventions based on the validity of the interventions, whether it is reproducible, cost-effective, reliable, applicability and its clarity. The participants had to rate the interventions using a Likert rating scale (Polit and Beck 2012) indicating whether they agree or disagree with the inclusion of an intervention. Participants who had an extreme response had to motivate their response.

1.10 Ethical considerations

A research proposal, number 179/2009, was submitted to the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria, for approval to conduct the study (Appendix G). Permission was also requested from the Department of Health, Gauteng

Province (Appendix F). Institutional permission was obtained from the CEO of the selected hospital (Appendix D). In addition, consent was obtained from the participants. The participants' rights were explained to them prior to their participation and a document including information and informed consent was given to participants as part of the consent process (Appendix A).

The researcher will next describe the ethical principles that guided the study.

1.10.1 The principle of respect for human dignity

The principle of respect demands that participants voluntarily participate and that they be given adequate information on the study as well as the possible consequences of participation. Respect for the person incorporates two basic tenets; firstly that participants be treated autonomously and secondly that the vulnerable be protected (Christians 2000:140). To ensure anonymity and protection of vulnerable participants, the researcher will communicate the research report ensuring that participants' identity is not linked with their responses, and that participants remain anonymous by omitting their names in the research report. Privacy implies the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner (Polit and Beck 2012:162). The researcher treated all data and information obtained as confidential. When dealing with competent adults, participation should be based on informed consent. Hence, the potential participants were informed about the nature of the study, the kind of issues to be explored, how participants were to be selected and what the risks and benefits to the participants were. The prospective participants were assured of the confidentiality of the study. They were further assured that they will have the freedom to withdraw from the study at any time without prejudice. Should the participants have any queries they were advised to contact the researcher or her supervisors.

1.10.2 The principle of beneficence

Under the principle of beneficence researchers must secure participants' well-being by avoiding harm and if there are any risks involved to minimise harm as far as possible (Christians 2000:140). In any research study participants can be harmed in a physical and/or emotional manner. Emotional harm is often more difficult to predict and determine than physical discomfort, but often has more far reaching consequences for participants (Polit and Beck 2012:163). The researcher strived to minimise the potential risks and maximise the potential benefits by asking questions in a friendly and non-threatening manner. Any risks and benefits involved in participation in the study were explained to participants, a possible risk might have been emotional discomfort experienced by

participants as they shared their experiences of working in ARV clinics. However, to overcome the risks pertaining to emotional discomfort the researcher monitored the participants during interviews. The participants were referred for supportive sessions with a psychologist based at the hospital in situations where needed. Nurses who work in ARV clinics could benefit from the wellness programme developed during the study that would provide interventions to identify, manage existing compassion fatigue and prevent the occurrence of future compassion fatigue.

1.10.3 The principle of justice

The principle of justice allowed for the fair distribution of benefits, and burden, to participants (Christians 2000:140). The researcher selected participants based on the research requirements and not based on their vulnerability. The researcher treated all participants in a non-prejudicial manner and emphasized that they can withdraw from the study at any time (Polit and Beck 2012:173-174).

1.11 Organization of the thesis

Chapter One: Orientation to the study.

Chapter Two: Paradigmatic perspective, philosophical framework and theoretical framework of the study.

Chapter Three: Research methodology.

Chapter Four: Findings of Phase One.

Chapter Five: Discussion of the findings.

Chapter Six: Phase Two development of the wellness programme.

Chapter Seven: Conclusion, limitations and recommendations.

1.12 Summary

This chapter provided the motivation for the study, the background information and problem statement that led to development of the study. This was followed by a discussion of the aim, objectives, concept clarification, significance and context of the study, the research methodology and ethical consideration that guided the study. Thereafter a brief outline of how the study was organized was presented.

In chapter two the Theoretical Framework utilised in the study will be discussed.

CHAPTER TWO

PARADIGMATIC PERSPECTIVE, PHILOSOPHICAL FRAMEWORK AND THEORETICAL FRAMEWORK OF THE STUDY

2.1 Introduction

In this chapter the researcher discusses the paradigmatic perspective and the theoretical framework that underpins the study. The four main concepts of the metaparadigm of nursing namely; person, health, environment and nursing are also discussed in this chapter. The metaparadigm was applied to ensure that the study contributed to the knowledge base of the discipline (Lee and Fawcett 2013:97).

2.2 Metaparadigm of nursing

Fawcett (1984:85) defined the metaparadigm of any discipline as ‘a statement or group of statements identifying its relevant phenomena.’ According to Fawcett and DeSanto-Madeya (2013:5) the notion of a metaparadigm was introduced in nursing in the late 1970’s when nursing was struggling to be recognised as a science Rawnsley (1996). Hardy (1978) argues that a metaparadigm guides scientists through the vast incomprehensible world, helping them to focus their academic endeavours in a particular discipline. In 1984 Fawcett argued that the knowledge base of nursing at that time supported the evidence of the existence of a metaparadigm of nursing and called it the central unit of nursing, namely: person, environment, health and nursing. These concepts were formalised as the metaparadigm of nursing in a paper that Fawcett presented in 1984, ‘The Metaparadigm of Nursing: Present status and future refinement.’ The metaparadigm of nursing points out the particular nature of nursing to the public and distinguishes nursing from other disciplines such as natural, social and human sciences. The metaparadigm guides the development of nursing knowledge (Kim 2010 cited in Fawcett and DeSanto-Madeya 2013:8).

The metaparadigm of nursing including its central concepts was presented at a conference, ‘The what of theory development’ in 1977. Originally the central concepts were described as, man, society, health, and nursing, as well as propositions regarding their relationships. However, since its inception in 1977 Fawcett changed man to person, and then to human beings to ensure that it is culturally acceptable. She also changed society to environment in the interests of a broad perspective of the surroundings of

nurses and nursing participants (Lee and Fawcett 2013:97). According to (Fawcett cited in Lee and Fawcett 2013:97), the concepts of the metaparadigm of nursing are as relevant today as in any other time in nursing's history, 'because they are a way to identify what are the boundaries and scope of the knowledge of nursing.'

The researcher will next discuss the four concepts of the metaparadigm of nursing, namely: nursing, human-being, environment and health.

2.2.1 Nursing

'Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of the ill, the disabled and dying people' (ICN 2002:n.p.). Watson (1988) in *The Caring Theory* sees nursing as 'centred around helping the patient achieve a higher degree of harmony in a holistic manner (mind, body and soul).'

According to Fawcett (1995:7), nursing is concerned with the principles and laws that govern the life process, well-being and optimal functioning of human beings, the patterning of human behaviour in interaction with the environment, the nursing actions or processes by which positive changes in health are affected, and the wholeness or health of human beings in continuous interaction with the environment.

For the purpose of this study nursing was seen as the art of compassionate and empathetic caring for patients who are HIV positive in order to promote their health (Knobloch 2007:9).

2.2.2 Human being

Fawcett (1989:6) states that person (later referred to as human being) refers to individuals, communities or a particular group. The human being or the nursing client, is seen as an open system that is continually changing in a mutual process with the changing environment. Recipients of nursing actions may be well or ill and include individuals, families and communities (The College of New Jersey [TCNJ] 2014:n.p.). According to Fawcett and DeSanto-Madeya (2013:6) human beings are no longer passive recipients of nursing care but rather active participants.

For the purpose of this study human being referred to patients who are HIV positive and who attend either the adult, paediatric or ante-natal antiretroviral clinics in a public tertiary hospital where the study was conducted.

2.2.3 Environment

According to Fawcett (1989:6) environment refers to the settings in which nursing care is rendered and includes the internal as well as the external surroundings (Berman and Snyder 2012:1), however, the environment does have an impact on people's health (George 2011:54). Fawcett and DeSanto-Madeya (2013:6) state that environment also refers to human beings significant others and local, regional, national and worldwide cultural, social, political and economic conditions that are associated with the health of human beings. According to Erickson et al. (2013:2) in holistic nursing man and environment are in continuous, dynamic interaction, the environment is both internal and external and always influences the client's wellness. TCNJ (2014) refers to environment as the landscape and geography of human social experience, the setting or context of experience as everyday life and includes variations in space, time and quality. It also includes societal beliefs, values, mores, customs, and expectations. They furthermore conceptualized environment as the arena in which the nursing client encounters aesthetic beauty, caring relationships, threats to wellness and the lived experiences of health. According to Jarrin (2012:14) nurses' way of being or caring is a reflection of both the internal and the external environment of both nurses and patients. Thus, the environment has an impact on the quality of patient care delivered.

For the purpose of this study the environment refers to the adult, paediatric and ante-natal ARV clinics in a public tertiary hospital where the health needs of patients who suffer from HIV/AIDS are taken care of. In this environment nurses and patients enter into a partnership to improve the health and well-being of patients.

2.2.4 Health

According to Berman and Snyder (2012:299) health is defined by the WHO (1984) as a state of complete physical, mental and social well-being, and does not merely mean the absence of disease or infirmity. Health refers to the state of wellness of a person and not merely the absence of disease (Fawcett 1989:6).

According to TCJN (2014:n.p.) health is the synthesis of wellness and illness and is defined by the perception of the client across the life span. Health is also seen as contextual and relational. Wellness, in this view, is the lived experience of congruence

between one's possibilities and one's realities based on caring and feeling cared for. Illness is defined as the lived experience of loss or dysfunction that can be mediated by caring relationships. Inherent in this concept is each client's approach to stress and coping. The degree or level of health is an expression of the mutual interactive process between human beings and their environment.

For the purpose of this study health referred to the expression of the mutual interactive process between human beings (the patients) and their environment (the ARV clinics).

2.3 Paradigmatic perspective

A paradigm refers to patterns of shared understanding as well as assumptions that people have about reality (Berman and Snyder 2012:41) and the world around them and is composed of certain philosophical assumptions that guide and direct people's actions and thinking (Mertens 2010:7).

In this study the researcher adopted constructivism as paradigm. Yin (2014:7) indicates that the case study research method, although oriented towards a realist perspective, can embrace a relativist perspective. Constructivism is relativistic in nature and adopts a relativist ontology and a transactional epistemology (Lincoln and Guba 1985 cited in Denzin and Lincoln 2005:184). Constructivist paradigm grew out of the philosophy of Edmund Husserl's phenomenology and Wilhelm Dilthey's study of interpretive understanding (Eichelberger 1989 cited in Mertens 2014:16).

Adopting a constructivist approach allows the researcher to give meaning to the way things are, and to identify factors that otherwise could not be easily exposed or described through quantitative research, nor generalised across entire populations.

Constructivists believe in, and accept that multiple social realities lead to the conclusions that knowledge is relativistic (that is, knowledge and realities are time, space and context dependent) and that inquiry should be naturalistic (Highfield and Bisman 2012:6). Constructivists believe reality is socially constructed and only knowable from multiple and subjective points of view. The knower and the known are seen as inseparable. Inquiry from this perspective is considered to be value laden. Inductive logic and qualitative methods are generally employed toward the goal of understanding a particular phenomenon within its social context (Bliss and Rocco 2013:28).

Constructivist research focuses on the meanings embedded in textual and verbal accounts. Analysis is an interpretive act rather than a scientific one. It involves sense making of everyday life and experiences through the generation of rich and compelling interpretations, which are key to producing more rigorous forms of knowledge (Kinchekoe 2008 cited in Highfield and Bisman 2012:6).

Features associated with a constructivist paradigm (Broom and Willis 2007:25-26) are as follow:

- Interpretivistic – seeks understanding with a focus on subjective meaning.
- Naturalistic – data are collected in the context of everyday life.
- Subjectivity – research practice and knowledge production are not objective or neutral.
- Complexity – is not so concerned with inference but rather with the depth of analysis.
- Validity - is high on validation that draws on the understandings of research participants, but it is not necessarily generalizable as it relies on the interpretation of the researcher.

The constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology where the knower and the known co-create understandings, which implies some kind of interaction between them, and a naturalistic (in the natural world) set of methodological procedures (Denzin and Lincoln 2005:24).

2.3.1 Ontological assumptions

Ontology is defined by (Crotty 2003 cited in Ahmed 2008:2) as ‘the study of being’ and is concerned with what in the world can be known or researched in order to discover the nature of reality. Reality can be discovered within a certain realm of probability because reality is socially constructed and perceptions of reality may change throughout the process of the study (Mertens 2010:13-14). Within constructivism there is a concentration on exploring and giving an account of how people make sense of a situation at a particular point in time (Baxter, Hughes and Tight 2006). Constructivists–interpretivists believe that multiple, constructed realities (known as the *relativist* position) exist, rather than a single true reality (Ponterotto 2005:130). Reality is thus created by the mind, where different social realms, organisations, cultures and experiences can, therefore, create multiple social realities. Although what is real is specific to an individual; similarities may exist between individuals and groups of individuals (Highfield and Bisman 2012:5). Reality, according to the constructivist position, is subjective and influenced by the context of the

situation, namely the individual's experience and perceptions, the social environment, and the interaction between the individual and the researcher (Ponterotto 2005:130).

The researcher assumed that compassion fatigue will manifest differently amongst participants working in the different ARV clinics. Hence, the researcher interviewed the nurses working in the adult, paediatric and antenatal ARV clinics to obtain their views of their reality to better understand the phenomenon under study.

2.3.2 Epistemological assumptions

According to Ahmed (2008:3) epistemology is concerned with providing a philosophical grounding for deciding what knowledge are out there and how researchers can ensure that they construct meaning through interacting with participants. The findings thereof are the result of this interactive process.

Constructivists–interpretivists advocate a transactional and subjectivist stance that maintains that reality is socially constructed and, therefore, the dynamic interaction between researcher and participant is central to capturing and describing the 'lived experience' (*Erlebnis*) of the participant (Ponterotto 2005:131). Epistemologically for the constructivist there is also acknowledgement that research is value-laden, not value-neutral, and that both those being researched and the researcher make value judgements (Highfield and Bisman 2012:5).

In this study, the researcher's main objective was to develop understanding of what should be known and how to gain such knowledge in order to understand the study process. The researcher communicated with the participants concerning compassion fatigue and focused on knowledge-gathering in order to understand their views about the manifestation, management and prevention of compassion fatigue.

2.3.3 Methodological assumptions

Methodology is the strategy, plan of action or design that researchers use to conduct studies; it describes, evaluates and justifies the use of particular methods (Ahmed 2008:5). The methodological assumption assisted the researcher on how best to obtain evidence (Polit and Beck 2012:13). A single embedded case study design was used (Yin 2014:55) because the researcher asked the questions:

'Why are nurses who work in antiretroviral clinics at risk of developing compassion fatigue?' and

'How could a wellness programme contribute to the identification, management of existing and prevent the occurrence of future compassion fatigue amongst nurses working in antiretroviral clinics?'

To answer these questions, data were collected by means of individual interviews to capture rich descriptive data from participants; content analysis was used to analyse the data. In the following section the researcher focuses on the theoretical framework of the study.

2.4 The theoretical framework of the study

The researcher borrowed two theories and one model to understand the external reality of compassion fatigue amongst nurses working in ARV clinics. The researcher chose Erikson's Human Developmental Theory (1997 see 2.4.1) and adapted it to the discipline of nursing and Watson's Caring Theory (1988 see 2.4.2) as well as Figley's Compassion Fatigue Etiology Model (2002 see 2.4.3). Using these theories and model guided the researcher to provide a simple explanation of the observed relations relevant to compassion fatigue in order to establish a body of knowledge on prevention and management of compassion fatigue amongst nurses working in ARV clinics and to stimulate further research (McMillian and Schumacher 2001:115). The theories and model used also provided a starting point for the study (Creswell 2009:64). The researcher also used the theories and model to develop the interview guide for the interviews. These were also used during the development of the interventions for the wellness programme to prevent and manage compassion fatigue. Watson's Caring Theory (1988) was used by the researcher as it specifically roots the compassionate caring philosophy to which nursing ascribe. In her Caring Theory Watson confirms that compassionate care is intrinsic to the provision of nursing care and helps to guide the internal identity of the nurse practitioner (Knobloch 2007:129). Figley's Compassion Fatigue Etiological Model (2002) was used and adapted to nursing because it provides a framework that predicts the risk of development of compassion fatigue. Since Badger (2007:1) states that assisting others as they heal from their pain and trauma requires compassion, empathy and caring, this emotional connection makes healthcare professionals vulnerable to distress. Figley (2002) agrees that being empathetic towards a traumatised patient/client can increase the risk to develop compassion fatigue. Hence, Figley's model guided the researcher in understanding the role of empathy and other situational factors in the development of compassion fatigue. The model also provided guidance on how compassion fatigue can be prevented and managed and was used during the

development of the interventions for the wellness programme. Erikson's Human Developmental Theory (1997) and specifically the first and last developmental stages was used to understand how trust or mistrust, and integrity or despair is developed and how being traumatised can violate basic trust because according to Munroe, Shay, Fisher, Makary and Zimering (1995:217; 222) any traumatic event shatters our trust; the extent to which we are traumatised depend on the degree to which trust was violated. Thus, compassion fatigue does undermine trust and change people's world views causing trauma survivors not to trust others which can have a negative effect on the nurse-patient relationships (Figley and Barnes 2005:390). The fact that people who suffer from compassion fatigue do have trust issues guided the researcher to take cognisance of it during development of the interventions for the wellness programme.

Case study researchers should enter the field with prior theories as it is an immense aid in defining the appropriate research design and data to be collected (Yin 2014:44). According to Merriam (2009:66-67) researchers would not know what to do in conducting their research without some theoretical framework to guide them. She called it 'the structure, the scaffolding, or frame of your study.' The theoretical framework is derived from the stance or orientation researchers bring to their studies. Theory affects every aspect of the study, from determining how to frame the purpose and problem, to deciding what to look at and for, to resolving how to make sense of the data collected (Merriam 2009:66). The author further indicates that a theoretical framework allows the researcher 'to see in new and different ways what seems to be ordinary and familiar.' Any framework or theory allows the researcher to see and understand certain aspects of the phenomenon being studied while other aspects are concealed (Merriam 2009:15).

The researcher will next discuss the three theories used for the theoretical framework.

2.4.1 Erik Erikson's Human Developmental Theory

In his theory of Human Development Erikson describes that people experience eight 'psychosocial crisis stages' which affect their development and personality (Erikson 1997:58). The specific developmental stage that pertained to this study is that of basic trust versus mistrust (Erikson 1997) and therefore, the other developmental stages will not be discussed.

The researcher used the first developmental stage of Erickson's Human Developmental Theory to describe the development of trust versus mistrust. This first developmental stage is applicable to this study because a person who is mistrusting cannot connect with

others and do not depend on the compassion of others due to lack of trust resulting in him/her withdrawing from others in an attempt to protect themselves. Thus, they end up not having faith and hope for their future (Louw, van Ede and Louw 2009:202). Each developmental crisis is brought about by a specific way of interaction between the individual and society. The individual must orientate him/herself according to two opposing poles; on the one hand the maturation of individuals brings about new needs and possibilities, and on the other hand society sets certain corresponding expectations and offers certain solutions (Erikson 1997:58). According to Louw, van Ede and Louw (2009:51) the solution of each crisis lies in the synthesis of the two opposites at a higher level of the two poles. When the crisis of one stage has been solved successfully, it will lead to the solution of the next crisis. Although the individual has worked through a specific crisis, the crises of the previous stages are still present and the individual will still have to deal with it.

The foundation for all later development lies in the first phase, when the child needs to acquire a sense of hope (Maier 1969:32). Thus, the first basic virtue 'hope and drive' evolves into the basic virtue, 'integrity and despair,' which has to be acquired during the last human developmental stage. If all the previous developmental stages were integrated successfully a person can look back with contentment and peace and will experience a lower sense of fear and have hope for the future (Erikson 1997:57-58). In providing care to patients who are HIV positive, nurses need to have a sense of integrity (Erikson 1997). If acquired, a sense of integrity provides a successful solution to an opposing sense of despair that nurses might experience as well as disgust in their HIV positive patients' life styles and fear that their patients will die in the absence of a cure for HIV/AIDS. In other words, this final developmental phase involves a sense of wisdom and a philosophy of life which is directly related to the future development of new developmental cycles (Maier 1969:72).

Haose-Garose, Katjire, Gorasebi (2013:93) state that nurses caring for patients who are HIV positive are exposed to more stress compared to caring for patients who are HIV negative (Smith 2005:23). The exacting and demanding nature of the nursing care that these patients require results in nurses experiencing physical and emotional exhaustion and this increase their risk of developing compassion fatigue (Harrowing 2011:4-5). Thus, nurses experience a sense of cynicism and despair and they lose hope that they can contribute positively towards the well-being of their patients. Cynicism, despair and a sense of hopelessness are symptoms of compassion fatigue which are the negative consequences of caring for traumatised patients over a prolonged period (Struwig

2002:7). Following is Table 2.1 that indicates Stage 1 and Stage 8 of the psycho-social crisis and virtues of Erikson’s Human Developmental Theory.

Table 2.1 Stage 1 and Stage 8 of Erikson’s Human Developmental Theory: The developmental crisis and the basic virtues

Stage	Psychosocial Crisis	Significant Relations	Psychosocial Modalities	Psychosocial Virtues	Mal-adaptations and Malignancies
Stage 1	Trust versus mistrust	Mother	To get, to give in return	Hope, faith	Sensory distortion-withdrawal
Stage 8	Integrity versus Despair	Mankind or ‘my kind’	To be, through having been, to face not being	Wisdom	Presumption-despair

(Boeree 1997:5)

The researcher believes that, in order for nurses to enter into a caring relationship with their patients as ascribed by Watson (1988) they need to have acquired a sense of trust during their first developmental stage (Erikson 1997) leading to a sense of hope and faith, because the child has achieved the first developmental phase of trust versus mistrust (described by Watson as one of the *carative factors* see 2.4.2). Nurses would believe that everything will work out well irrespective of the fact that there is no cure available for HIV/AIDS and this sense of hope and faith will be installed in their patients. They also need to encourage their patients to have hope because life has no meaning for a person who feels hopeless and helpless (du Toit and van Staden 2009:183).

During the first year of life a child must acquire a feeling of basic trust and at the same time overcome a feeling of basic mistrust (Erikson 1997:7). Erikson (1997:58) argues that a child receives from his/her parents a firm sense of personal trustworthiness within the trusted framework of their family/community lifestyle. A child has to discern between who and what he/she can or cannot trust based on the relationship he/she has with his/her mother who provide in his/her basic needs and this will assist them to avoid situations that are not to be trusted and unsafe. A healthy balance at crisis stage one (trust versus mistrust) ‘trust’ will allow a child to grow through the crisis ‘trust’ and also assist them to

experience and grow suitable capacity for 'mistrust' where appropriate. In cases where infants are abused or neglected they will not develop a sense of trust and this will foster mistrust. Infants develop a healthy balance between trust and mistrust if they are cared for and if caregivers do not overprotect them because overprotection will cause them to be unrealistic and vulnerable.

According to Munroe et al. (1995:211) the development of trust is important because it is the foundation on which all subsequent developmental accomplishments rest. Louw, van Ede and Louw (2009:51) state that if a child does not complete this developmental stage successfully he/she will not trust people or situations leading them to feel insecure. Thus, experiencing any traumatic events could result in compassion fatigue and traumatic events shatter trust and the degree to which an event can be seen as traumatic depending on the degree that it violates person's basic sense of trust causing feelings of exploitation (Munroe et al. 1995:211).

However, if this first stage of trust versus mistrust is achieved it will lead to hope for relationships, life and the future (Louw, van Ede and Louw 2009:51-52) and the child will have the confidence to explore his/her environment and have hope that everything will be okay, irrespective of the challenges they may face in life (Kniesl and Trigoboff 2009:40). Erikson characterises this synthesis with the word 'hope' (Erikson 1997:58). Compassion fatigue may cause feelings of hopelessness (Mollica 1988 cited in Munroe et al. 1995:210).

2.4.2 Watson's Caring Theory

Watson's Caring Theory directs compassionate caring and forms the philosophical basis for delivering compassionate nursing care to the sick, weak, wounded and traumatised (Knobloch 2007:129). The researcher used Watson's Caring Theory for this study because it roots the compassionate caring philosophy of nursing and it also provides the basis on which nursing education, practice and research is centred and thus, confirms that compassionate caring is intrinsic to the provision of nursing care (Knobloch 2007:125).

Caring is defined by Watson and Smith (2001:453) as a 'philosophical-theoretical-epistemic undertaking' and not just a way of being. It is an ethical, ontological and epistemological project that requires on-going research to expand knowledge. According to (Watson 1990 cited in Watson and Smith 2001:453) caring is central to the discipline of nursing. The more human care is actualised as an inter-subjective moral ideal in each caring situation, the greater the potential to attain optimal health for patients, allowing

nurses to find greater meaning to their own existence. Thus, they will discover their own inner power and control, while they contribute to the preservation of humanity and thus, ascribe to the altruistic value system (Watson 1988:78). Figley (2002:1437) states that healthcare professionals, e.g. nurses who experience that they contribute to the well-being of their patients will experience compassion satisfaction, a positive outcome of caring that can mitigate compassion fatigue.

To develop her caring theory, (Watson 1988) borrowed other theories of existential humanism from Maslow, Rogers, Heidegger and Erikson. She also borrowed theories of stress and care from Selye and Lazarus, and nursing theories from Leininger and Henderson. Watson's (1979, 1985 and 1989) work was also influenced by Hegel, Marcel, Whitehead, Kierkegaard, Rogers and Gadw (Fitzpatrick and Whall 1996:289). Watson's Caring Theory focuses on the spirit of human-beings rather than the physical. She identified humanistic caring as the ethics that ascribe nursing activities, thus providing the discipline of nursing with a vital philosophical perspective (Knobloch 2007:125).

According to Lyon (n.d.:1) Watson views the person (patient) as a physical, psychological and spiritual being and she acknowledges the importance of unity between the body, mind and spirit. Health corresponds to the balance of the body mind and spirit and is a subjective experience defined by the individual. Watson views nursing as an art and science with caring as the essence of nursing. Nurses should assist their patients in finding meaning to illness and suffering, thus promoting patients' health. Cara (2003:52; 55) states that Watson believed that if nurses apply these caring values they will find meaning in their work because both nurses and patients can be influenced by the caring moment. The environment is the physical space in which the caring occasions occur, where nurses and patients come together in human transaction. Therefore, the environment must contribute to healing, with attention on wholeness, comfort and maintaining dignity.

Two major elements of Watson's Caring Theory are the transpersonal caring relationship and the carative factors. Transpersonal caring means to go beyond one's own ego and be present in the here and now, allowing nurses to reach deeper for a spiritual connection with their patients in an attempt to promote comfort and healing (Cara 2003:54). Watson (1988:71) describes the transpersonal caring relationship within her theory as a professional human-to-human contact between nurses and their patients and the goal is for nurses to move their patients towards a higher sense of self and a greater sense of harmony within their mind, body, and soul (Suliman, Welmann, Omer and Thomas

2009:1). According to Cara (2003:54) nurses' caring consciousness and connection to their patients have the potential to heal because both nurses and patients connect in a mutual search for meaning, wholeness and spiritual transcendence of suffering.

Watson developed the ten carative factors in 1979; revised it in 1985 and in 1988 which acts as a guide for nursing (Cara 2003:53). According to Watson (2014:322) the author named the caring processes the ten carative factors that complimented conventional medicine but stood in contrast to curative factors. The Human Caring Theory sought to balance the cure orientation to medicine and gave nursing its unique disciplinary scientific and professional stance. These ten carative factors result in the satisfaction of certain human needs, the formation of an altruistic system of value, installation of a sense of hope and faith as well as a sensitivity to self and others. It forms the philosophical foundation of the science of caring which become actualized in the moment-to-moment caring process. Human care requires actions filled with compassion that nurses need to take when caring for their sick, weak, traumatised and wounded patients. Both nurses and patients must possess commitment, and the will to preserve the personhood and humanity (Watson 1988:51; 75).

The researcher will next discuss concepts related to the caring relationship that is necessary to provide compassionate caring to patients who are HIV positive.

2.4.2.1 Description of the concept caring

Towsley-Cook, Mae and Young (1999:197) define caring as 'a function in which nurses express concern for the growth and well-being of their patients in an integrated application of the mind, body and spirit to achieve positive health outcomes.' According to Geyer (2005/2006:53) an ethic of care makes up a large part of nurses' existence as a professional and it is firmly based on the relationship between nurses and their patients. The author further states that caring is not unique to nursing, but it is *unique in nursing*. Therefore, Pera and van Tonder (2011:17) describe caring as the hall mark of the nursing profession and caring as an essential indicator of quality health care because cure without caring poses ethical concerns resulting in a negative caring experience for both nurses and their patients.

2.4.2.2 Characteristics of a caring nurse

Watson's Caring Theory (see 2.4.2) allows nurses to return to their deep professional roots, their values and helps to describe an ideal nurse. Watson's theory allows nurses to practice the art of caring, to show compassion towards their patients and their families, to

ease their trauma and in so doing nurses can also expand their own actualization, experiencing a sense of satisfaction (Cara 2003:52). The quality of nursing care depends on the commitment, sensitivity towards patients, as well as the support nurses give to their patients (Searle, Human and Mogotlane 2009:13). Therefore, nurses should exhibit certain qualities and characteristics; they need to be compassionate, understand what their patients are feeling and have a sense of commitment to help their patients in the best possible way. This behaviour includes actions such as providing comfort, support, compassion, empathy, and trust because patients seek health care and have a great need for physical, psychosocial, and spiritual care (Dingman, Williams, Fosbinder, and Warnick 1999:31). Watson (1988:72-73) states that nurses should have a value system that is humanistic, implying that they should have faith and hope that they can contribute to the healing of their patients – this is ascribed to as the carative factors. Harrowing (2011:4) agrees that all nurses should have a philosophy of commitment to their work as well as an ethical approach to problems. They should pay attention to the needs of their patients, whilst protecting their own well-being.

According to Lui, Mok and Wong (2005:190-191) knowledge, attitude and skills form the basis of caring behaviour. In a study done by these authors, patients perceive nurses as being emotional supportive if they show a caring attitude, like being friendly and speaking in a gentle voice. This resulted in patients feeling that their psychological needs are met and they felt good. Nurses' professional competencies play a role in evaluating the quality of nurses' caring behaviour.

2.4.2.3 Empathetic ability

Empathy is the most important dimension in caring for patients; nurses who do not have a high level of empathetic understanding cannot render compassionate care and therefore, would not be at risk of compassion fatigue. Empathy can be described as a process through which people feel with one another. Through therapeutic empathising nurses allow themselves to become absorbed in identifying with their patients' experiences, they internalise their patients' feelings and their own experiences and fantasies. However, nurses must maintain boundaries and need to withdraw and detach from subjective involvement with their patients (Kniesl and Trigoboff 2009:206-207). According to Lui, Mok and Wong (2005:191) patients who suffer from a life-threatening illness e.g. HIV/AIDS, feel vulnerable and they feel their psychological needs are not met when nurses do not show empathy towards them, do not understand their frustration and do not provide emotional support. When entering the transpersonal caring relationship with their patients, nurses should be empathetic and in touch with their patients' soul. A sense of empathy

towards patients facilitates interpersonal exploration and nurses' empathetic ability increases their risk of developing compassion fatigue (Figley 2002:1438). According to Kniesl and Trigoboff (2009:41) patients feel understood and cared for when nurses express empathy towards them. As nurses interact with their patients they learn to be sensitive to their patients' needs. However, this kind of empathetic ability increases nurses' risk of developing compassion fatigue (Figley 2002:1437).

2.4.2.4 The nurse-patient relationship

Watson's Caring Theory (1988) describes caring as an evolving nursing science and incorporates a holistic approach to patient care (Cara 2003:59). The caring relationship is the basis of the ethics of care and is based on freedom and autonomy. Such a relationship includes elements of empathy as well as compassion in the beginning of the relationship, and enables nurses to disengagement later in the relationship. An ethic of care considers first and foremost the needs of the patient to be heard, accepted and responded to by their caregivers, like nurses (Geyer 2005/2006:34; 53-54). Dingman, Williams, Fosbinder and Warnick (1999:31) state that in order for nurses to form caring relationships with their patients, they should be connected to them and such caring can manifest in words, touch and silence (Shiparski 2008:64; 67). Dingman et al. (1999:31) further state that nurses should realise that being with patients in moments of physical and emotional crisis is an opportunity to connect, to give and to receive. Both parties should regard it as a learning opportunity. Nurses need to be able to put distracting thoughts aside and completely focus on what is happening in the moment.

2.4.2.5 Cost of caring

According to Najjar, Davis, Beck-Coon and Doebeling (2009:268) nurses and other health care workers are becoming more aware of the profound emotional disturbance that they experience when caring for patients who are suffering and in pain due to suffering from an incurable disease; e.g. HIV/AIDS because they might feel similar pain and fear as they listen to their patients' traumatic stories (Figley 1995:12). This is in line with the statement made by Figley (1995:1) that 'there is a cost to caring for others who are in emotional pain' (See 2.4.3 on Figley's Compassion Fatigue Etiological Model).

Watson's Caring Theory (1988) roots the compassionate caring philosophy of the nursing profession and provides the basis on which nursing education, research and practice is centred, thereby confirms that compassionate care is intrinsic to the provision of nursing care (Knobloch 2007:129). Nurses are compelled to deliver compassionate care to their patients who are HIV positive, irrespective of the fact that caring for these patients

generates significant compassion stress, dissatisfaction and physical as well as emotional exhaustion in nurses (Hall n.d.:9). Emotional exhaustion cause nurses to experience reduced capacity for or interest in being empathetic towards their patients and thus, increase their risk to develop compassion fatigue (Abendroth 2011:1).

2.4.2.6 Caring as related to nursing

Within Watson's Caring Theory (1988:29) it is indicated that the mandate for nursing within science and society is to contribute to the preservation of human life. Caring in nursing is a moral ideal whereby the goal is to protect, enhance and preserve human dignity. Human caring requires nurses to show certain emotions, concerns, attitudes and a desire to relieve the suffering of their patients and this increase their risk to develop compassion stress and in turn compassion fatigue (Figley 1995:12).

Being informed by Watson's Caring Theory allows nurses to return to their deep professional roots and values and nurses can, therefore, experience nursing as a gratifying profession whereby they can contribute to the well-being of their patients. Upholding Watson's Caring Theory allows nurses to practice the art of caring, to provide compassionate caring and to ease patients' suffering, promote healing and dignity, in so doing nurses can expand their own actualisation (Cara 2003:52) Caring can be beneficial to both nurses and their patients (Suliman et al. 2009:2).

2.4.3 Figley's Compassion Fatigue Etiological Model

The researcher used Figley's Etiological Model, (Figley 2002:1436-1438) to describe how nurses who work in antiretroviral clinics may develop compassion fatigue.

According to Figley (1995:7) compassion fatigue can be described as the natural behaviour and emotions experienced by healthcare professionals, such as nurses as a result of knowing about the traumatic experiences of their patients. It is the stress resulting from a desire to help or wanting to help those that suffer. Stamm (2009:8) argues that compassion fatigue has two parts. The first part is concerned with feelings such as exhaustion, frustration, anger and depression which are typical of burnout. The second part is secondary traumatic stress which is a negative response driven by a sense of fear and work-related trauma due to secondary exposure to extreme or traumatic stressful events. The negative effect of being exposed to traumatic events is aggravated by the severity of the patients' traumatic experiences that healthcare professionals are exposed to, including direct contact with traumatised patients, especially when the exposure is of a grotesque and graphic nature.

Following is a schematic illustration (Figure 2.1) of Figley's Etiological Compassion Fatigue Model that describes the development of compassion fatigue.

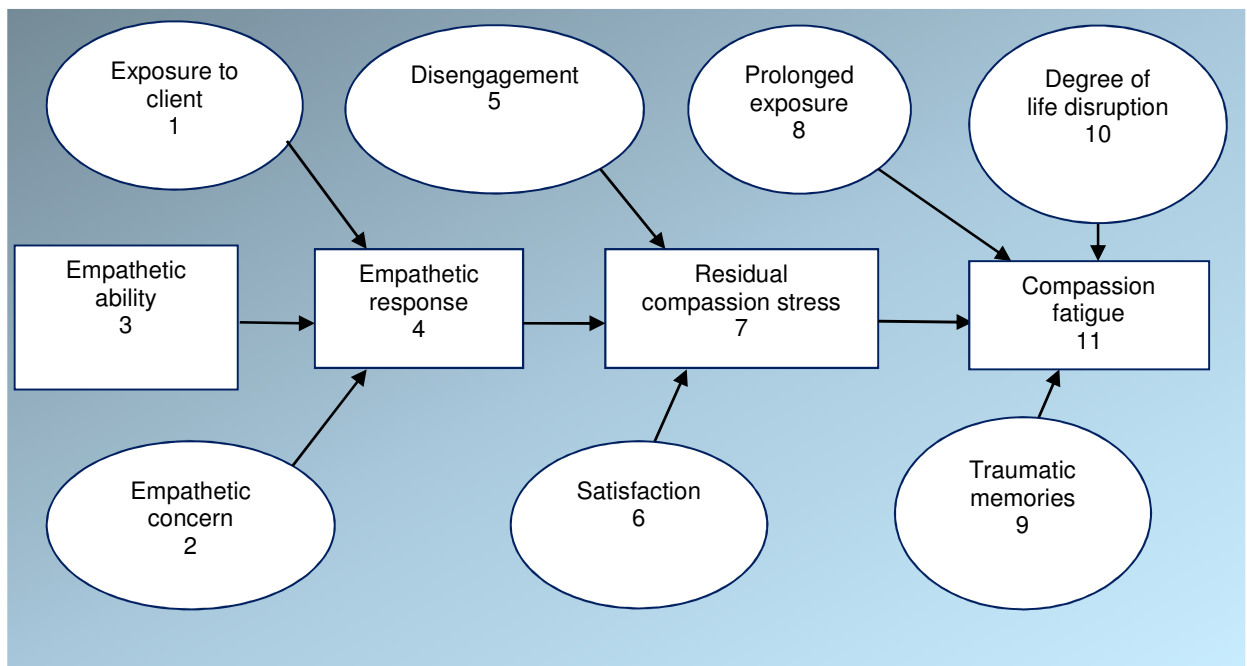


Figure 2.1 Figley's Compassion Fatigue Etiological Model (Figley 2002:1437)

Following is a discussion of Figley's Compassion Fatigue Etiological Model.

- **A brief interpretation of Figley's Compassion Fatigue Etiological Model**

Healthcare professionals are exposed to their patients' trauma. They may show empathetic concern because they have empathetic ability, resulting in empathetic response in an attempt to relieve their patients' pain. In providing empathetic care to their patients, healthcare professionals may experience satisfaction or they may disengage from the nurse-patient relationship because of the compassion stress they experience. With prolonged exposure to patients' trauma healthcare professionals may over-identify with their patients and have traumatic memories of the traumatic events and with a degree of disruption in the life of healthcare professionals they may be develop compassion fatigue.

2.4.3.1 A brief explanation of the development of compassion fatigue

Figley (2002:1436-1438) states that being compassionate and empathetic towards patients comes at a cost to healthcare professionals, such as nurses who work in antiretroviral clinics. Figley's Compassion Fatigue Etiological Model (2002) has different

variables that predicts the development and indicate the causes of compassion fatigue, including strategies required to prevent and treat compassion fatigue

Healthcare professionals' empathetic ability is the aptitude for noticing the pain of their patients and the key to helping them resulting in the healthcare professionals experience compassion satisfaction. However, the fact that healthcare professionals are empathetic to their patients makes them vulnerable to the cost of caring and thus, compassion fatigue (Figley 2002:1437). When exposed to the traumatic experiences of patients, healthcare professionals may respond in two ways. They may respond positively about the fact that they are able to help their patients and experience compassion satisfaction, or they can respond negatively, be driven by fear, work-related trauma and experience compassion stress, which result in compassion fatigue (Stamm 2009:8).

Being empathetically concerned motivates healthcare professionals to help their patients in need and they will use all their abilities and knowledge to provide the best possible compassionate care to their patients. This might have negative consequences for nurses (Stamm 2009:8) because Figley (2002) warns that healthcare professionals, who on a daily basis, are in direct contact with traumatised patients might be exposed to the emotional energy of their patients and such exposure might lead to them developing compassion fatigue (Figley 2002:1437). The process of compassion fatigue can be cumulative and progressive advancing from a state of compassion discomfort to compassion stress (Knobloch 2007:88). Compassion stress is the residue of the emotional energy that healthcare professionals absorb from empathetically engaging with their patients. If compassion stress is allowed to continue, they will develop compassion fatigue (Figley 2002:1438).

In noticing their patients suffer, healthcare professionals will make an effort to reduce the suffering of their traumatised patients through empathetic understanding. They project themselves into the perspective of their patients in an attempt to have insight into their feelings, thoughts and behaviour; this can only be achieved through compassionate caring (Watson 1988). In so doing nurses might experience pain, fears and anger similar to that of their patients. To be able to connect at such a level with their patients can be beneficial to healthcare professionals, or it can come at a cost affecting their well-being. Healthcare professionals must be aware of this and should mitigate the effect that their empathetic ability might have on them (Figley 2002:437).

The biggest stress factor is that nurses feel they cannot save their patients' lives (van Dyk 2012:423). When the stress increases in intensity it will have a negative impact on the health of nurses and their quality of life (Cowen and Moorhead 2011:758). Factors such as prolonged exposure, traumatic recollection and life's disruptions in addition to compassion stress can increase the risk of healthcare professionals to develop compassion fatigue (Figley 2002:1438). The researcher will next discuss these factors:

Prolonged exposure: The longer healthcare professionals are exposed to the suffering of their patients, the higher the risk of compassion fatigue and, the longer the period between breaks away from work, the greater the risk of compassion fatigue (Figley 2002:1438).

Traumatic recollection: Recollection of memories caused by traumatic experiences can be due to exposure to patients' traumatic experiences and when these memories are recalled it may cause an emotional reaction. These memories are triggered by certain patients' experiences that have a connection to the traumatic events experienced by the healthcare professional (Figley 2002:1438).

Life disruptions: Disruptions to life are caused by unexpected change in routine, lifestyle, social status, professional and personal responsibilities, and can cause a tolerable level of distress amongst healthcare professionals. However, if it is combined with the exposure to traumatic experiences of patients over a prolonged period of time and accompanied by recollection of traumatic memories then it can increase the risk of compassion fatigue (Figley 2002:1438). Healthcare professionals who suffer from compassion fatigue often are unable to separate their private life from life as a nurse because they do not have clear boundaries, separating home and work-life (Stamm 2009:21).

According to Knobloch (2007:74) compassion fatigue is the final stage of a progressive and cumulative process that is caused by prolonged, continuous and intense contact with traumatised patients, such as patients who are HIV positive, the use of self and exposure to stressful situations. Compassion fatigue evolves from a state of compassion discomfort that can lead to compassion stress that exceeds the nurse practitioner's endurance limits. Compassion stress may lessen nurses' empathetic ability ultimately resulting in compassion fatigue. Compassion fatigue is a state where the compassionate energy expended by nurse practitioners towards their patients has surpassed the restorative processes, with recovery power being lost.

2.4.3.2 Signs and symptoms of compassion fatigue

The symptoms of compassion fatigue have a sudden and acute onset. The person gradually feels worn down and overwhelmed and cannot cope with everything that is happening around him/her (Figley 1995:12). Healthcare professionals may feel similar fear, pain, and suffering while listening to the stories of their patients. They may develop preoccupation with their patients by re-experiencing their trauma thus, exhibit symptoms of avoidance of reminders of the patient's traumatic experiences accompanied by disengagement from the work. The response to these reminders will be numbing, they feel anxious and keep on having intrusive thoughts of the traumatic events (Figley 1995:12). Additionally, Abendroth (2005:1) states that compassion fatigue is associated with a sense of confusion and helplessness.

The demanding caring needs of patients who suffer from HIV/AIDS culminate in a stressed and exhausted nursing workforce, who experiences a sense of hopelessness, due to the fact that there is no cure for HIV/AIDS (Lombardo and Eyre 2011:3). Nurses tend to isolate themselves from people who could give support to them because their relationship with their colleagues and friends are affected. They will also complain of sleeplessness, experience excessive physical and emotional fatigue and are depressed (Strydom and Wessels 2006:4).

2.4.3.3 Consequences of compassion fatigue for nurses

Compassion fatigue is associated with negative outcomes for nurses, organisations and the quality of health care provided to patients (van den Berg et al. 2006:2). Many nurses are caught up in environments or situations that hinder their ability to experience caring connections with their patients. This may be due to the demanding workloads which result in the detachment of nurses from their primary purpose to give compassionate care to their patients (Searle 2000:151). Nurses have walled themselves off from connecting on a deeper level with their patients, resulting in them not experiencing compassion satisfaction from helping their patients in need thus, not ascribing to Watson's (1988) altruistic value system. As an act of self-preservation nurses may disengage from their work. This disconnection between nurses' actions, passion and purpose result in poor job satisfaction, costly turnover and decreased patient satisfaction (Shiparski 2008:64).

2.4.4 Summary of the three theories/models used in the theoretical framework

Nursing is a caring profession and nurses are mandated to provide compassionate care and support to their patients to achieve or maintain health (Watson 1988). According to Nevhutalu (2004:31) nurses who care for their patients need to show compassion towards

them. The quality of nursing practice is an ethical issue. Virtues and qualities, such as compassion, wisdom, openness, honesty and competence, are characteristics of a morally good person. In case of nurses, these virtues and qualities are those habits that affirm and promote the values of human dignity, well-being, respect, health, independence, knowledge and wisdom. All these can either be nourished by the nursing environment, or they can be thwarted and diminished.

According to Watson (1988:72-73), human care requires actions that nurses need to take when caring for their patients. The interventions called *carative factors* by Watson (1988) require an intention, a will to do good, a satisfactory relationship between nurses and their patients and actions to relieve the patients' suffering. Carative factors aim at the caring process, when nurses and patients enter into a helping-trusting relationship and nurses can assist their patients to attain health or die with dignity. Thus, nurses who care compassionately for sick, weak, traumatised and wounded patients do become empathetically involved that can lead to a number of stressful consequences.

In Watson's Caring Theory (1988:68-75) she describes a helping-trusting relationship between nurses and their patients, implying that nurses should have a sense of trust. Trust, according to Erikson's Human Developmental Theory (1997:58-72) should be acquired by a child during his or her first year of life which forms the foundation of all further development of any human being. A sense of trust will ensure that nurses develop a sense of integrity. Nurses who are trusting will also have faith and hope that they will contribute to the healing of their patients; this is described by Watson (1988:75) as one of the carative factors. Nurses who are caring should show empathy towards their patients. According to Figley's Compassion Fatigue Etiological Model (2002:1437-1438) this empathetic ability of healthcare professionals, such as nurses exhibits towards their traumatised or very sick patients put them at risk of compassion fatigue. Being exposed to traumatic events such as listening to the traumatic life stories of their patients who are HIV positive makes them feel vulnerable and unsafe because the HIV/AIDS epidemic has no boundaries; nurses are either infected or affected by the epidemic (Flannelly, Roberts and Weaver 2005:214). Thus, nurses are traumatised and according to (Erikson 1997) this traumatic experience can shatter nurses' assumptions of trust because it violates the sense of basic trust, leading to a breakdown in interpersonal trust with the effect that nurses experience a sense of hopelessness (Figley and Barnes 2005:390). Since nurses' trust is affected they will constantly be on guard, anticipating that they are in danger (Munroe et al. 1995:210). Caring for patients who are HIV positive induces considerable stress to healthcare professionals due to the seriousness of the HIV/AIDS disease;

patients living with HIV/AIDS recover from opportunistic illnesses over a longer period of time (Hall 2004:33-34) causing healthcare professionals, such as nurses to spend more time and energy on these patients (Tshililo and Davhana-Maselesele 2009:137; 138).

There is a cost to caring for patients suffering from terminal illnesses, such as HIV/AIDS especially when caregivers assume that currently there is no cure for HIV/AIDS. Nurses realise that their patients will never fully recover resulting in them feeling hopeless and desperately (Kniesl and Trigoboff 2009:207). The very act of being compassionate and empathetic extracts a cost. Professionals, like nurses who work in a caring environment tend to show empathy towards their patients who experience some kind of trauma. This can lead to the nurses distancing themselves from their patients who are HIV positive. The caring relationship will thus, be negatively affected, resulting in nurses over-identifying with their patients, lapsing into sympathy when they fail to incorporate patients' feelings; instead they project their own personal feelings (Figley 2002:1433-1434). However, nurses must guard against over-distancing/disengaging from their patients, which will increase their risk of compassion fatigue. Nurses who feel compassion towards their patients will respond to their needs with a sense of immediacy and will be there for them and this very act increase their risk to compassion fatigue (Kniesl and Trigoboff 2009:207). Healthcare professionals who are not able to show empathy or were not exposed to trauma will never develop compassion fatigue because empathetic ability evokes empathetic response, taking action to relieve those who suffer from their pain (Figley 1995:15). A sense of integrity will also help nurses to care for their patients who are HIV positive. A sense of integrity will provide a successful solution to an opposing sense of despair (Erickson 1997) in their patients' who are HIV positive lifestyles as well as a fear that their patients will die.

2.5 Conceptual framework

Yin (2003) refers to conceptual frameworks but fails to fully describe them or provide a model of a conceptual framework for reference (Baxter and Jack 2008:553). Miles and Huberman (1994) note that the conceptual framework serves several purposes: (a) identifying who will and will not be included in the study; (b) describing what relationships may be present based on logic, theory and/or experience; and (c) providing the researcher with the opportunity to gather general constructs into intellectual 'bins' (Miles and Huberman 1994:18). The conceptual framework serves as an anchor for the study and is referred to at the stage of data interpretation.

The researcher developed an initial conceptual framework in her exploration of the manifestation, management and prevention of compassion fatigue. The framework was based on the literature and her personal experiences. The major constructs that were proposed by the researcher are presented in Figure 2.2.

A conceptual framework in case study research does not display relationships between the constructs. The framework should continue to develop and be completed as the study progresses and the relationships between the proposed constructs will emerge as data are analysed. A final conceptual framework will include all the themes that emerged from data analysis (Baxter and Jack 2008:553).

One of the drawbacks of a conceptual framework is that it may limit the inductive approach when exploring a phenomenon. However, to safeguard against becoming deductive, the researcher journalised her thoughts and decisions and discussed them with other researchers to determine whether her thinking has become too driven by the framework (Baxter and Jack 2008:553).

Context

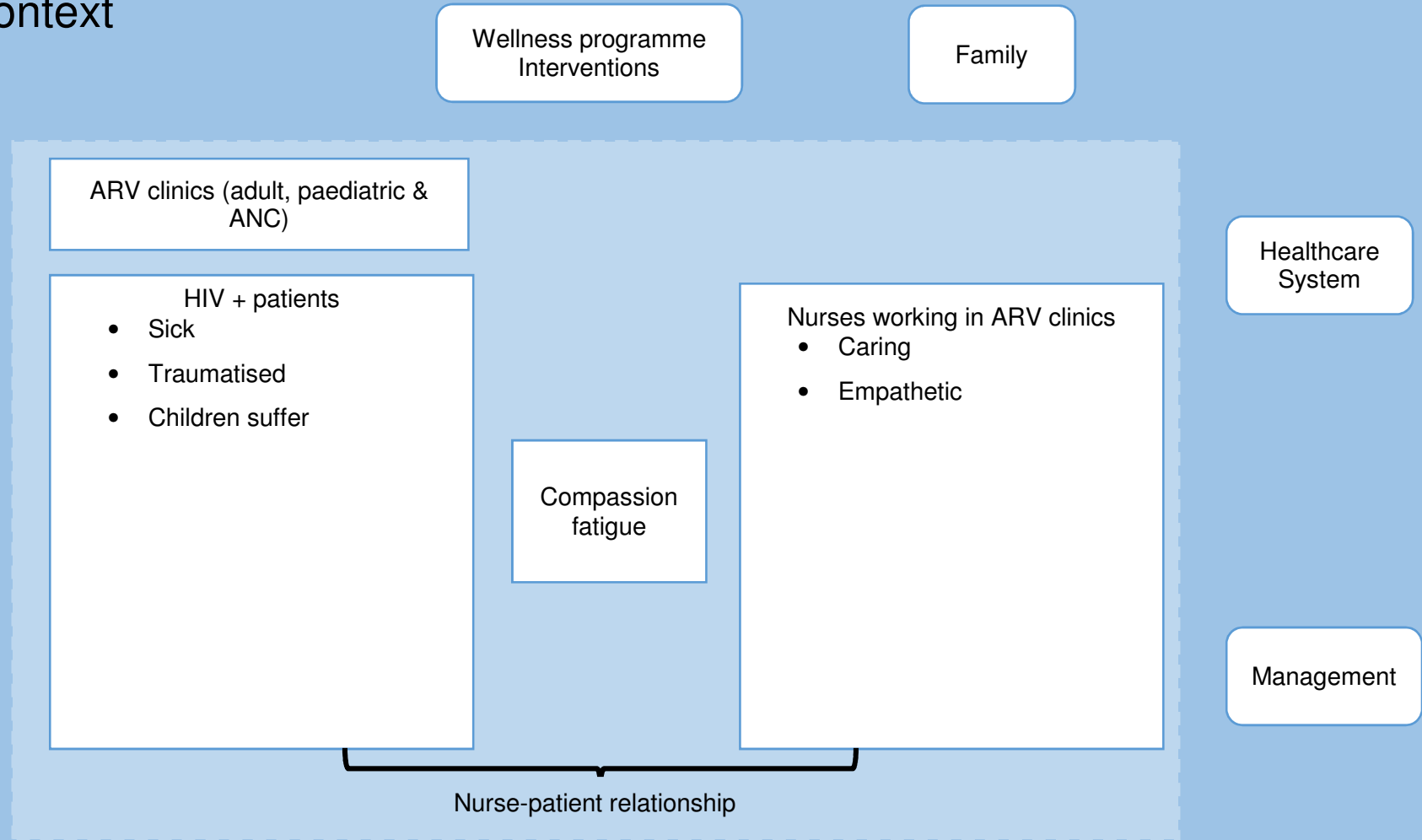


Figure 2.2 Initial Conceptual Framework of compassion fatigue amongst nurses working in antiretroviral clinic

2.6 Summary

In this chapter the researcher discussed the paradigm that underpins the study and the theoretical framework that were utilized for the study. The paradigm guided the methodology used to conduct the study and the theoretical framework is part of the research tradition in which the study is embedded (Polit and Beck 2012:129). The theoretical framework formed the framework for the development of the questions posed in the interview guide and helped to interpret the data obtained in the study. The theoretical framework also enhanced a better understanding of the extent of the manifestation of compassion fatigue amongst nurses working in antiretroviral clinics. This also guided the development of the wellness programme, interventions and action steps.

The researcher will discuss the research methodology used to conduct the study in the next chapter.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

In this chapter the researcher discusses the research methodology used to address the aims and objectives of the study. The following research questions were asked:

- Why are nurses who work in antiretroviral clinics at risk of developing compassion fatigue?
- How could a wellness programme contribute to the identification, management of existing compassion fatigue and prevent the occurrence of future compassion fatigue amongst nurses working in antiretroviral clinics?

In qualitative research studies, the aims indicate the phenomena, the participants and the setting under study (Polit and Beck 2012:79). Following are the aims of the study:

- Firstly, to explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in antiretroviral (ARV) clinics.
- Secondly, to develop and refine a wellness programme that will aid in the management of existing compassion fatigue and prevention of the recurrence of future compassion fatigue amongst nurses working in ARV clinics.

The study was conducted in two phases. In Phase One the researcher explored and described the extent of the manifestation of compassion fatigue amongst nurses working in adult, paediatric and ante-natal ARV clinics in a public tertiary hospital. In Phase Two the focus was on the development and refinement of the interventions of the wellness programme. Phase Two will be discussed in detail in chapter six.

PHASE ONE: COMPASSION FATIGUE AMONGST NURSES WORKING IN ANTIRETROVIRAL CLINICS

Following the research methodology for Phase One of the study is discussed.

3.2 Research design

According to Yin (2014:16-17) case studies have a two-fold definition that covers the scope and features thereof. The first part of the definition defines case studies as

empirical inquiries that investigate the case in depth and within real life context, especially when the boundaries between the phenomenon under study and the context is not clearly defined. The second part of the definition has to do with the features of case studies. The study inquiry deals with a technically distinctive situation in which there is many more variables of interest than data points, using multiple sources of evidence to allow data triangulation and the inquiry benefits from prior development of theoretical propositions to guide data collection and analysis.

According to Stake (2000:435) case study research has become a common way of doing qualitative inquiries and it is not a methodological choice but rather a choice of *what* to study. The focus is on the case and the case can be studied analytically or holistically, entirely or hermeneutically, organically or culturally and using mixed methods. However, the researcher used a single embedded case study design to conduct Phase One of the study. '[A] case study according to Yin (2014:4) allows investigators to focus on a case and retain a holistic and real-world perspective.'

Using case studies for qualitative research can provide rich insight into particular situations, events, organisations and persons (Rule and John 2011:1). It depends on the research question(s) on whether a case study method can or should be used. The more the research question seeks to explain a circumstance, for example *how* or *why* a social phenomenon works or whether the more in-depth description of a social phenomenon is required. If the researcher has little control over behavioural events and the focus of the study is on a contemporary phenomenon it would be more relevant to use case study (Yin 2014:2; 10).

According to Yin (2014:9) three conditions are required for deciding when to use a case study as a research method, namely:

- a) The type of question posed,
- b) The extent of control a researcher has over actual behavioural events, and
- c) The degree of focus on contemporary as opposed to entirely historical events. The researcher will next discuss the conditions of choosing a case study as appropriate to this study.

The type of question posed:

Defining the research question(s) is the most important step that a researcher has to take when doing case study research. The key is to understand that research questions have both substance and form, therefore the researcher need to ask - what is my study about,

and whether the researcher will ask a *who*, *what*, *where*, *why*, or *how* question. For this study the researcher posed the *why* and *how* questions since it is more explanatory and such questions deal with links needed to be traced over time, rather than frequencies and incidence of variable (Yin 2014:10-11).

The extent of control a researcher has over actual behavioural events:

The case study is preferred when examining a contemporary event but the relevant behaviour cannot be manipulated (Yin 2014:12). For the purpose of this study the other reasons for using a case study is because compassion fatigue is a contemporary event, the phenomenon under study cannot be manipulated and the researcher has little control over it. Some of the strengths of the case study are the ability to deal with a variety of evidence including documents, artefacts, interviews with the persons involved in the study and direct observations of the events being studied (Yin 2014:12). For the purpose of this study the researcher used individual interviews, field notes and documentation to collect data.

3.2.1 Single-case study design

Single case studies are a common design for doing case studies and can either be a holistic or an embedded design. According to Yin (2014:51) a single case study is justifiable for use under several circumstances, namely:

- a) A critical test of existing theory, or
- b) Extreme or unusual circumstances, or
- c) A common case, or
- d) A revelatory case or
- e) Longitudinal case.

For the purpose of this study a common case design was used as it was to 'capture' the circumstances and conditions of an everyday situation (Yin 2014:52). The researcher adopted Yin's (2014) approach for conducting the single case study with embedded units of analysis, because in embedded case studies attention can also be given to subunits that are incorporated into the single case. The subunits provided more opportunities for extensive analysis, enhancing insight into the single case (Yin 2014:50; 53; Merriam 2009:45).

This study had three subunits incorporated within the single case namely nurses who work in the adult, ante-natal and paediatric ARV clinics in a public tertiary hospital. The researcher was interested in looking into the same issue, but was intrigued by how

compassion fatigue manifests amongst nurses working in different ARV clinics in one public hospital. Hence, a single-case study with embedded units enabled the researcher to explore the case while considering the influence of the various clinics on the manifestation of compassion fatigue. According to Yin (2014:55) an embedded design can serve as an important device for focusing a case study inquiry.

3.2.1.1 Concerns about case study research

According to Yin (2014:19-21) case studies have their strengths and limitations causing them to be viewed as less desirable because it is confused with teaching cases, since case studies have been used to demonstrate a particular point. Case study is also regarded as not being vigorous enough, findings cannot be generalized from a single case and another limitation is the fact that case studies require too much effort and can result in massive, unreadable documents. The use of case study research do have advantages over quantitative research in that it allow for the *how* or *why* questions to be answered that cannot be answered with randomized controlled trials and can be viewed as an adjunct to experiments rather than an alternative (Cook and Payne 2002 cited in Yin 2014:23). According to Simons (2009:260) ‘case study has the potential to engage participants in the research process.’

3.2.1.2 Components of case study research

It is critical to identify the unit of analysis as it defines what the case is and it defines the initial research question(s), in some situations each question might point to a different unit of analysis (Yin 2014:31-32). The unit of analysis defines what the case is and is therefore a critical factor (Yin 2014:31). The unit of analysis for this case study was the manifestation of compassion fatigue in nurses working in the adult, paediatric and antenatal ARV clinics within a tertiary public hospital (See Table 3.1). As compassion fatigue could manifest amongst these nurses, due to the nature of their work, it was the immediate topic of the case study (Yin 2014:31).

Yin (2014:29) states that there are five components of research design to be considered when doing case study research. The researcher has adopted the five components of Yin’s approach and incorporated it in the study as follows:

The study’s questions: The research question is the heart of the study plan reflecting the line of enquiry. They remind the researcher regarding the information that need to be collected and why (Yin 2014:14). The questions applicable to the study are discussed later in this chapter.

Its propositions: Due to the descriptive nature of the study, there are no propositions for this study. According to Baxter and Jack (2008:551) not all studies need to have propositions, e.g. an explorative study would rather have a stated purpose or criteria on which the success will be judged.

Its unit(s) of analysis: Nurses working in ante-natal, paediatric and adult ARV clinics.

The logic linking of the data to the proposition: The data is linked to the purpose and aim of the study as no propositions were stated for this study.

The criteria for interpreting the findings: The interpretation of the findings will be discussed in chapter five.

3.2.1.3 Binding of case studies

Even though the case study was about compassion fatigue amongst nurses who work in ARV clinics, attention was given to hospital management that deals with nurse-related issues as well as medical officers, counsellors, family members and pharmacists (the context of the study) that are involved in the care of patients who are HIV positive. Although they were not included in the data collection but they were regarded as important because they form part of the work environment of nurses who work in ARV clinics and they would provide insight into the single case, since they form part of nurses' support systems. Inclusion of nurses who work in the adult, paediatric and ante-natal ARV clinics provided an opportunity to explore the risk factors in the physical, social and cultural environment that expose them to develop compassion fatigue as well as the extent of the manifestation of compassion fatigue amongst these nurses. Hence, they were the ideal participants to link to the objectives of the study. Participants for the study consisted of five professional nurses and one enrolled nurse who worked for the public hospital and two professional nurses who worked for the Non-governmental Organisation (NGO) that provided support to the ARV clinics within the hospital.

Once the general definition of the case has been established, bounding of the case becomes important. If the unit of analysis is a small group, as was the case in this study, then it is necessary to distinguish them from those who are outside of the immediate topic of the case study (the context). Researchers should also decide on time boundaries in order to define the estimated beginning and end of the case (Yin 2014:33). According to Yin (2014:34) bounding the case will determine the scope of data collection and how to distinguish data about the subject of the case study (the phenomenon under study) and data external to the case (the context). According to Baxter and Jack (2008:547) the establishment of boundaries in a qualitative case study design is similar to the development of inclusion and exclusion criteria for sample selection in a quantitative

study. Furthermore, the boundaries also indicate the breadth and depth of the study and not simply the sample to be included. See Figure 3.1 for the context of the case and the unit of analysis.

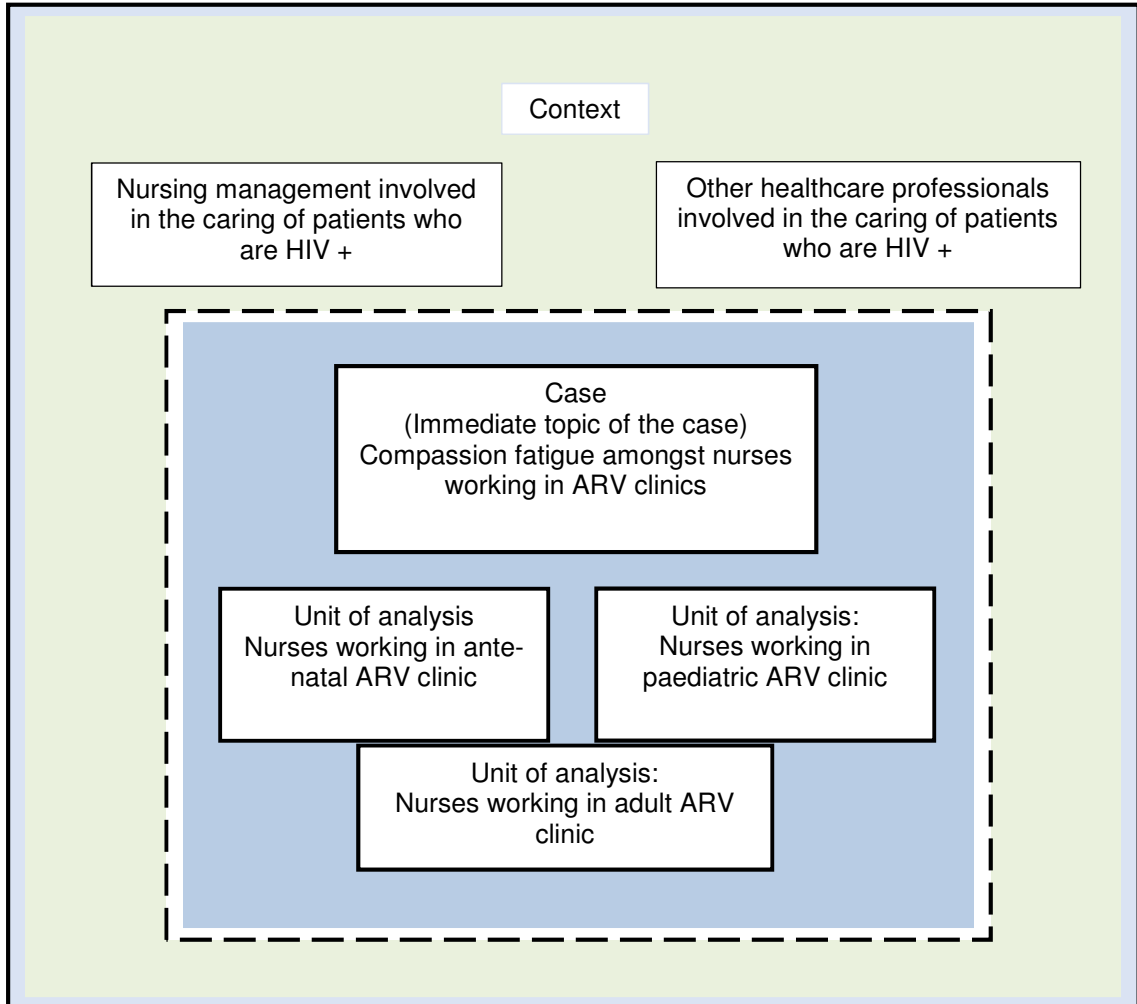


Figure 3.1 The context of the case, the case and the unit of analysis

3.3 Research methods

Research methods are techniques used by researchers to structure a study and to collect data and analyse it in a systematic way (Polit and Beck 2012:741) and research methods are grounded in certain philosophical perspectives (Speziale and Carpenter 2007:398). This study was based on a constructivist paradigm, since the researcher believes that reality is multiple and subjective and it can be constructed by individuals. The researcher interacted with the participants and the findings are the product of the interactive processes.

3.3.1 Site and participant selection

A NGO in partnership with the Department of Health (DoH) is providing care to patients who are HIV positive in all the ARV clinics at the public tertiary hospital. The staff for the NGO and DoH consisted of two project managers that manage the ARV project, unit managers that are in charge of each ARV clinic, medical officers, professional nurses, enrolled nurses, pharmacists and counsellors. Health care services are provided from Monday to Friday in the adult and paediatric clinics by both the DoH and NGO staff. However, the situation within the antenatal ARV clinic is different because health care services are only provided on Fridays for pregnant women who are HIV positive; this clinic is managed by doctors and nurses working for the NGO. Selecting the site was done purposefully as it had the likelihood that the research problem was present and the aims of the study could be reached; the site was accessible because the researcher used to work in the adult ARV clinic. The rationale for using this site was because comprehensive care to adults, children and pregnant women who are HIV positive is provided at this specialised health care centre. This allowed the researcher to explore the manifestation of compassion fatigue amongst nurses working in these clinics. The researcher used to work in the adult ARV clinic but not at the time when the study was conducted.

In deciding which sampling strategy to use the researcher was guided by the relativist paradigmatic perspective acknowledging multiple realities having multiple meanings that are observer dependent, thus, that different participants will have different perspectives (Yin 2014:17). Therefore, nurses working in the adult, paediatric and ante-natal ARV clinics were seen as the ideal participants to assist in reaching the objectives of the study. The sampling criteria list the characteristics essential for participants to qualify for membership in the target population (Rule and John 2011:64). The unit of analysis defines what the case is and is therefore a critical factor (Yin 2014:31). The unit of analysis for this

case study was the manifestation of compassion fatigue in nurses working in the adult, paediatric and ante-natal ARV clinics within a tertiary public hospital (See Figure 3.1).

According to Speziale and Carpenter (2007:29) individuals are selected to participate in a study because they have first-hand experience of a phenomena, culture or social process and they are actively involved in the study. This type of sampling are called purposeful sampling. Due to the small number of nurses working in the ARV clinics all of them were invited to participate.

The participants of the study included one enrolled nurse and six professional nurses working in the adult, paediatric and ante-natal antiretroviral clinics in a public tertiary hospital in Gauteng province who were willing to participate. All the professional nurses who participated in the study were trained in HIV management except for the enrolled nurse. See Table 3.1 for characteristics of nurses who participated in Phase one of the study.

Table 3.1 Description of participants who participated in Phase one of the study: Nurses who worked in adult, ante-natal and paediatric ARV clinics

Participant number	Category	Employed by:	Type of ARV clinic	Years working in clinic	Trained In HIV Management	Age
001	Professional nurse	Public hospital	Adult	6	Yes	64
002	Professional nurse	NGO	Ante-natal	3	Yes	45
003	Professional nurse	Public hospital	Paediatric	11	Yes	43
004	Professional nurse	Public hospital	Paediatric	3	Yes	48
005	Professional nurse	Public hospital	Adult	6	Yes	51
006	Enrolled nurse	Public hospital	Adult	5	No	47
007	Professional nurse	NGO	Ante-natal	3	Yes	41

The description of the roles and functions of the professional and enrolled nurses who work in the different antiretroviral clinics as listed in Table 3.2, is based on observations made by the researcher during the period that she worked in the adult antiretroviral clinic (before the research was conducted). However, the researcher also obtained the job descriptions for both professional and enrolled nurses employed by the public hospital (Gauteng Department of Health 2007). Unfortunately the job descriptions for the two professional nurses working for the NGO were not made available to the researcher. The reason why the researcher included the role and function of professional- and enrolled nurses in different ARV clinics is to distinguish between the differences in their role and functions. Since only one enrolled nurse who worked in the adult ARV clinic participated in the study, only the role and function observed of this specific enrolled nurse will be detailed. See Table 3.2 on the role and functions of professional and enrolled nurses who work in the different ARV clinics.

Table 3.2 Role and functions of professional and enrolled nurses working in ante-natal, adult and paediatric ARV clinics

Role and functions of professional nurses in ARV clinics		
Ante-natal ARV clinic	<p>Clinical care:</p> <ul style="list-style-type: none"> • Diagnosis of a health need and execution of a nursing regimen to meet the needs of patients • Referral to a registered person if necessary • The prevention of disease and promotion of health through teaching and counselling of individuals • Management of HIV/AIDS and minor HIV-related illnesses and health education on medication and side effects • The establishment and maintenance of an environment in which the physical, psycho-social and mental health of a patient is promoted • Physical examination of pregnant women • Promotion of breastfeeding unless contra-indicated • In the event of any illnesses or abnormalities during pregnancy, labour and puerperium refer patients for medical assistance and care • Monitoring of vital signs of patients • Voluntary pre and post-test counselling for HIV test, HIV testing of babies at six weeks • Quality improvement of services <p>Administrative work:</p> <ul style="list-style-type: none"> • Preparation of patients' files for doctor • Record keeping and retaining records • Gathering of daily and monthly statistics • Supervision of resources and equipment, ordering of supplies • Supervision of other categories of health care workers, including counsellors • Attending meetings • Attending in-service training 	
Role and function of professional nurses in ARV clinic		Role and function of enrolled nurses in ARV clinic
Adult ARV clinic	<p>Clinical care:</p> <ul style="list-style-type: none"> • Diagnosis of a health need and execution of a nursing regimen 	<p>Clinical care:</p> <ul style="list-style-type: none"> • Diagnosis of a health need and execution of a nursing regimen to



	<p>to meet the needs of patients and, where necessary, referral to a registered person</p> <ul style="list-style-type: none"> • The prevention of disease and promotion of health and family planning by teaching and counselling individuals • The establishment and maintenance of an environment in which the physical, psycho-,social and mental health of a patient is promoted • Monitoring of vital signs of patients • Voluntary pre and post-test counselling for HIV test • Quality improvement of services • Give health education on medication and side effects • Give health education on diet and referral to dietician for diet supplements and food parcels if needed <p>Administrative work:</p> <ul style="list-style-type: none"> • Preparation of patients' files for doctor • Sorting of blood results and referring patients for counselling based on results; filing results in patients' files for use by doctors • Record keeping • Gathering of daily and monthly statistics • Ordering of supplies • Supervision of other categories of health care workers, including 	<p>meet the needs of patients, and where necessary, referral to a registered person</p> <ul style="list-style-type: none"> • The prevention of disease and promotion of health and family planning by teaching and counselling individuals • Monitoring of vital signs of patients • Voluntary pre and post-test counselling for HIV test • Give health education on medication and side effects • Give health education to patients on diet. <p>Administrative work:</p> <ul style="list-style-type: none"> • Preparation of patient's files for doctor • Record keeping • Gathering of daily and monthly statistics • Attending of meetings • Attending in-service training • Supervision of resources and equipment
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	<p>counsellors</p> <ul style="list-style-type: none"> • Attending of meetings • Attending in-service training • Supervision of resources and equipment 	
Role and function of professional nurses in ARV clinic		
<p>Paediatric ARV clinic</p>	<p>Clinical care:</p> <ul style="list-style-type: none"> • Diagnosis of a health need and execution of a nursing regimen to meet the needs of patients and where necessary referral to a registered person • The establishment and maintenance of an environment in which the physical, psycho-social and mental health of a patient is promoted • Monitoring of child physical, mental, psychological development and referral if needed to a registered person • Referral of children to social worker for social grants • Giving health education to parents and caregivers on medication and possible side effects • Give health education on nutrition and diet to parents and caregivers for their children • The prevention of opportunistic infections in children through counselling • Promotion of health and family planning by teaching and counselling for primary caregivers of children • The establishment and maintenance of an environment in which the physical, psycho-social and mental health of a patient is promoted • Monitoring vital signs of patients • Voluntary pre and post-test counselling of primary caregivers prior to HIV testing of children • Quality improvement of services • Referral of mother for HIV testing if need arise <p>Administrative work:</p> <ul style="list-style-type: none"> • Preparation of patients' files for doctor • Record keeping • Gathering of daily and monthly statistics • Ordering of and supplies 	

	<ul style="list-style-type: none"> • Supervision of other categories of health care workers, including counsellors • Attending of meetings • Attending in-service training • Supervision of resources and equipment • Referral of mother for HIV testing if need arise
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The job description of both professional and enrolled nurses working in public hospitals is generic and does not provide a detailed description of nurses' role and functions in different antiretroviral clinics (Gauteng Department of Health 2007). The role and functions of professional nurses working in ante-natal ARV clinics do not include the delivery and care of new born babies. Care rendered by professional nurses who work in the ante-natal ARV involves out-patient department care for pregnant women who are HIV positive, like giving health education on medication, breastfeeding unless contra-indicated, pregnancy, labour and post-natal care, doing vital signs, drawing of blood, physical examination, making appointments and referral of patients. Professional nurses are not involved in services delivered and care to mothers and their babies during the puerperium. In the event of babies being diagnosed HIV positive they are referred to the paediatric ARV clinic. The role and function of professional and enrolled nurses who work in the adult and paediatric antiretroviral clinics involve out-patient department care of adults and children, like giving health education on medication, diet, doing vital signs, assisting doctors, making appointment and referral of patients to other departments, such as social workers or dieticians. At times both categories of nurses are involved in counselling patients for HIV testing and adherence to medication. Patients are referred for drawing of bloods to another professional nurse who works for The National Laboratory Services but stationed within the adult antiretroviral clinic that provides these services.

3.3.2 Preparation for data collection

The researcher prepared for data collection by developing a study protocol that guided the research methodology. Having a case study protocol is desirable under all circumstances. It increases the reliability of the case study and guides the researcher in carrying out data collection (Yin 2014:84). The case study protocol kept the researcher focussed on the topic and forced the researcher to anticipate problems as well as ways on how the case study report will be completed (Yin 2014:73).

The major tasks the researcher considered for data collection were:

- Gaining access to key organisations or interviewees
- Providing for unanticipated events, including changes in the availability of interviewees
- Changes in own energy, mood and motivation while doing fieldwork.

Next the researcher will discuss the major tasks pertaining to data collection applicable to this study:

Gaining access to participants is an extremely important consideration when designing data collection strategies, especially when using interviews. To gain entrance to the site, the researcher wrote a letter accompanied by the study protocol to request permission to conduct the study in the public tertiary hospital. The hospital management (Appendix D) provided provisional permission based on the approval of the protocol by the Research Ethics Committee of the Faculty of Health Science at the University of Pretoria. The Research Ethics Committee (Appendix G) approved the protocol for the study and this letter of approval was submitted together with the letter from the hospital management at the Gauteng Department of Health who granted the researcher permission to conduct the study (See Appendix F).

After approval was obtained from the Research Ethics Committee and permission from Gauteng Health Department as well as the hospital to conduct the study, the researcher approached the unit managers of the antiretroviral clinics and asked permission to discuss the aims and objectives of the study with the nurses during their tea break and to invite them to participate in the study. Individual appointments were made with nurses who showed interest in the study, at a time that was suitable for the nurses without disrupting the services at the clinics. The researcher visited the clinics and used a study summary sheet (Appendix J) in which the nature and purpose, procedure, ethical approval, risks and benefits of the study and contact details of the researcher were described, to guide her when addressing the nurses. The researcher then made an appointment with each potential participant to ensure a time that will suit each participant.

Properly designed field procedures are necessary for case study data collection. Data was collected from people and institutions in their natural settings, not in a controlled environment. Thus, real world events must be incorporated with the data collection plan because the researcher does not have control over the data collection environment. When doing interviews researchers have to cater for the interview schedule and availability of participants (Yin 2014:88-89). For the purpose of this study the researcher developed a

schedule for data collection based on appointments made with individual participants at a time that was convenient for them in order not to cause disruption to service delivery.

3.3.2.1 Development of the interview guide

Qualitative interviews are conversational and because the conversations are purposeful it requires advance preparation (Polit and Beck 2012:541), therefore the researcher used an interview guide. At the heart of the case study protocol is the interview guide that consists of a set of substantive questions that reflect on the actual line of inquiry (Yin 2014:89). The researcher therefore, developed a set of questions that guided the interviews and reflected issues to be explored. All questions were worded flexibly to allow for probing. The questions covered were derived from the research questions and literature on compassion fatigue. The interview guide (Appendix B) consisted of seven open ended questions which covered aspects of trust, despair, hope, caring, caring for HIV positive patients, stress, compassion, compassion fatigue, empathy, feelings towards HIV positive patients, and the role of nurses in anti-retroviral clinics, and two close ended questions. The researcher used open ended questions to allow participants to fully describe the phenomenon of compassion fatigue as it presents in antiretroviral clinics. According to Yin (2014:96) a pilot case study will help to refine the data collection process. However, the researcher did not do a pilot case study to test the questions on nurses similar to nurses in the study as only a small number of nurses were working in ARV clinics. She instead utilised the help of the supervisor and co-supervisor to ensure the questions of the interview guide were not misleading or vague and that it was linked to the theoretical framework of this study.

3.3.3 Collecting case study evidence

According to Yin (2014:04) case study evidence may come from various sources namely, interviews, direct observations, participant-observation, archival records and document analysis to facilitate in-depth analysis and understanding of the data, which requires the researcher to master different data collection procedures. The data collection methods chosen for this study was determined by the purpose of the study, the research questions, and available resources (Yin 2014:10; Rule and John 2011:59; 61). A major strength of case study research is the fact that multiple sources of evidence can be used for data triangulation, causing the data to be more convincing and accurate. Strengthening the construct validity of the case was done by providing multiple measures of the same phenomenon (Yin 2014:119-121). According to Baxter and Jack (2008:544) using multiple sources of evidence ensures 'that the issue is not explored through one lens, but rather a

variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood.’

3.3.3.1 Principles of data collection

Yin (2014:105) outline four principles of case study data collection that is extremely important for doing high-quality case studies, namely:

- Using of multiple data collection sources of evidence;
- Creating a case study database;
- Maintaining a chain of evidence and
- Exercising care in using data from electronic sources of evidence.

The benefits of evidence collected can be maximised when using these four principles and these principles can be used for documents, artefacts, direct observations and interviews (Yin 2014:118).

Following is a discussion of the four principles of data collection and apply it to the study (Yin 2014:118-130).

Principle 1: Use of multiple sources of evidence

The need of the use of multiple sources of evidence for case study research far exceed that of other research methods, such as experiments, surveys or histories. Using multiple sources of evidence increases construct validity and reliability of case study research. Multiple sources of evidence allow the researcher to address a broader range of historical and behavioural issues. The findings and conclusion are more convincing and accurate if it is based on different sources of information, following a similar convergence (Yin 2014:118; 120). However, the most important advantage of multiple sources of evidence is the development of converging lines of inquiry. The desired triangulation results from the principle of navigation, whereby the intersection of different points is used to calculate the precise location of an object (Yardley 2009 cited in Yin 2014:120). The use of multiple sources of evidence aims at corroborating research findings. Developing convergence data triangulation helps to strengthen the construct validity of case studies (Yin 2014:120-121). For the purpose of this study the researcher used multiple sources of evidence, namely: interviews, field notes and applicable documents (See Appendices K, M, N and Q) to corroborate the findings, ensuring that through data triangulation the participants’ perspective is rendered accurately. Construct validity and reliability of the case study findings will be increased.

Principle 2: Creating a study database

The way researchers organize and document the case study data that was collected become very important. The distinction between a separate database for evidence and case study report is necessary because the case study data, which is mainly in narrative form, were embedded in the text presented in the case study report. The main purpose of a database is to allow for retrieval of documents at a later stage. The creation of a database increases the reliability of case studies because it allows critical readers to inspect the raw data that led to the study's conclusion. The case study database should be orderly (Yin 2014:123-124). For the purpose of this study the researcher stored electronic copies of transcribed interviews, documents reviewed and field notes as appendices.

According to Yin (2014:124-125) it is very challenging to develop a database for case study data in terms of four components, namely: field notes, documents, tabular materials and narratives. For the purpose of the present study the researcher used interviews, field notes, documents, and narratives to collect case study evidence to compile the database for the study.

Field notes. For case studies, field notes take a variety of forms and are the most common components of a database. Field notes for the present study were the result of interviews, observations or document analysis and were stored in electronic files on the researcher's computer. The researcher stored the field notes in such a way that it could be retrieved with ease at a later stage (See Appendix K).

Case study documents. Documents relevant to the case were collected during the course of the study and record was kept using a bibliography list. The researcher provided a compact overview of the documents used, with a bibliography section that can also serve as an index, that facilitate the document storage and retrieval at a later stage for inspection or perusal. Both hard copies and electronic copies of documents used in this study were kept by the researcher (See Appendices M, N and Q).

Principle 3: Maintain a chain of evidence

A third principle, to increase the reliability of case study information, is to maintain a chain of evidence. The researcher kept a chain of evidence to allow any external observer or a reader of the case study to follow the derivation of any evidence from the initial research questions to ultimate case study conclusions. The chain of evidence compiled by the researcher should allow the external observer to trace steps in both directions; from

research questions to conclusions or from conclusions to research questions. The chain of evidence process furthermore indicates that the evidence was the same evidence collected during the data collection process. In addition, the researcher ensured that no original evidence was lost through carelessness or bias. By maintaining a chain of evidence the researcher tried to increase the case study's construct validity with the aim of increasing the overall quality of the case study. The researcher ensured that the relevant sources, such as the documents, interviews and field notes used in collecting data were cited. The researcher also highlighted key phrases or specific words in the documents. In the method section it was also indicated under which circumstances the evidence were collected as well as the time and place where the interviews were conducted. The researcher also ensured that the circumstances were consistent with the specific procedures and questions contained in the case study protocol to show that the data collection followed the procedures as stipulated in the protocol.

Principle 4: Exercise care when using data from electronic sources:

The researcher exercised care in searching for articles and documents from reputable websites such as the University of Pretoria's library's website for online journals and did not use any material from Wikipedia, Facebook, Twitter or YouTube.

3.3.3.2 Data collection methods

In this study multiple sources of data collection methods were used, namely; interviews, field notes and documents as any findings or conclusions reached in case study research is more convincing when it is based on multiple sources of evidence (Yin 2014:119).

The researcher will next discuss the different data collection methods used for this study:

- ***Interviews***

Interviews are one of the most important sources of collecting case study evidence (Yin 2014:110). Yin (2014:6; 112) points out that the following weaknesses may occur with interviews: researchers could be biased due to poorly articulated questions, response bias, information can be inaccurate due too poor recall and participants give answers that the researcher wants to hear.

Table 3.3 Chain of evidence

Case study questions	Case study protocol	Data collection	Data analysis	Case study report
<p>The researcher developed research questions that guided the study.</p>	<p>The researcher developed a study protocol 179/2009 that guided the method by which the case study was conducted and was approved by:</p> <p>The Research Ethics Committee of the Faculty of Health Science University of Pretoria (Appendix G)</p> <p>The Gauteng Department of Health (Appendix F)</p> <p>Institutional permission was obtained from the CEO of the Charlotte Maxeke Tertiary Hospital (Appendix D)</p> <p>Consent was also obtained from participants (Appendix A)</p>	<p>All interviews were tape recorded using a digital tape recorder.</p> <p>Filed notes were taken during interviews (Appendix K)</p> <p>All interviews were transcribed and stored in study data base.</p>	<p>The analysis process was described in detail.</p> <p>Two independent coders were used to code data in order to reach consensus on identified themes, categories and sub-categories</p>	<p>The case study report was linked back to the research questions and objectives of the study to determine whether research questions were answered</p> <p>The researcher maintained a list of all relevant articles and documents used in the bibliography list</p> <p>In-text referencing was done using literature on previous research findings that either refute or confirm the current research findings</p>

For the purpose of this study the researcher used semi-structured interviews (Appendix B) that were conducted with nurses in their natural work environment where they were faced with the reality of caring for their HIV positive patients. Following is a description of the specific phases that the researcher followed for the interviews, namely the preparatory phase, the interview phase, and the post-interview phase (Polit and Beck 2012:541-544).

The preparatory phase

Prior to data collection the researcher phoned the unit manager of the ARV clinics to secure an opportunity to address the nurses during their tea break. The researcher then made appointments with the participants who were willing to participate. The researcher used a research assistant who is trained in conducting qualitative research to conduct the interviews. To ensure that the research assistant is knowledgeable with regards to HIV/AIDS and Figley's Compassion Fatigue Etiological Model (2002), information was provided prior to data collection. In addition, a mock interview was conducted to ensure that the research assistant was familiar with the interview guide and able to use relevant probes based on the information provided by the participants.

On the day of the interviews, before the actual interview commenced, the researcher tried to make the participant feel comfortable to make it easier for them to express their innermost thoughts and feelings. The researcher introduced the research assistant to all participants and because the researcher was known to participants (the researcher worked in the adult ARV clinic prior to conducting the study), she reassured the participants that all information given will be confidential. The researcher further explained that she will be present during the interviews taking field notes while the research assistant will be conducting the interviews. The aims of the study were also explained to all participants. Before commencing with the interviews the researcher conducted the process of consent. The participants were provided with an information document containing information such as: what the research is about, procedures to be followed, participants' rights, risks and benefits, and confidentiality. They were given time to read the participation information and consent document and ask questions regarding the study should they have any (Appendix A). Participation was voluntarily and the researcher thanked the participants for their willingness to participate. The researcher further explained that all interviews would be conducted in English and sought permission from the participants to record the actual interview to which all the participants agreed. A digital tape recorder was used to record the interviews to ensure a better rendition of the information provided by the participants than to just rely on making your own notes (Yin

2014:110). Personal and background information of participants were also documented by the researcher during this phase. However, this part of the interviews was not recorded.

Conducting the interviews

The interview phase consisted of the actual communication between the research assistant and the participants. The research assistant used the interview guide to ask the questions and gave participants the opportunity to respond to each question. Interviews were conducted in an honest, open and sincere manner and empathy was shown towards participants. The research assistant showed respect towards participants and was sensitive to the emotional climate of the interviews, she paused in between the interview to reassure the participant and provide support when it appeared that the participants became emotional. Once participants have settled emotionally and indicated that the interview may continue the research assistant continued with the interview. However, questions that were of a sensitive nature were asked late in the interview when rapport was established. The dignity of participants was respected, and participants' identities and all information that they provided, were treated as confidential. The participants were protected from any harm by not asking embarrassing questions.

Open-ended questions were asked during the interviews to provide participants with the opportunity to fully describe the phenomenon of compassion fatigue. The interviews resembled guided conversations and a consistent line of inquiry was pursued, while the questions were fluid rather than rigid. Questions were posed in no specific order or wording and depended on participants' answers. In cases when clarity was sought the research assistant used probing and the *why* question was posed and participants were given an opportunity to reflect before providing a response. In situations where participants deviated from the question the research assistant guided them back and the question was repeated.

The role of the researcher during the interviews was to take notes to document everything she saw and heard. This allowed the researcher to listen actively to hear the meaning of what was being said, in order to understand and interpret the world of the interviewees.

The interviews were conducted in a place that offered privacy, with the least interruptions and noise that allowed adequate tape recording of the interviews. Except for one interview that was conducted in the participant's office, the interviews with the nurses in the adult and paediatric ARV clinics were conducted in a boardroom within the clinics. There was some background noise during the interview conducted in the participant's office;

however, it did not interfere with the quality of the data collected. In the ante-natal clinic the interviews were conducted in the nurses' consulting rooms. There was an interruption during one of the interviews by a knock on the door. The interruption did not have an effect on the quality of the data.

The researchers collected data to the point that themes became recurrent and enough in-depth data were obtained that could illuminate the patterns, categories and dimensions of the phenomenon under study. Thus, data collection took place until the participants' descriptions became repetitive and no new ideas emerged. The duration of the interviews was approximately one hour. The research assistant closed the interviews by thanking each participant for their willingness to participate and they were reassured that the data will be kept confidential.

Post-interview procedure

Following conducting the first interview, the researcher and research assistant had a discussion based on the researcher's notes that were taken and decided to change the two closed-ended questions that required only a yes or no answer probes were added to these questions to elicit more detailed information from participants. Changes were made to the interview guide to ensure that all avenues of information were explored to provide a better understanding of the extent of the manifestation of compassion fatigue amongst nurses working in ARV clinics (See Appendix B for an edited version of the interview guide).

A total of seven interviews were conducted over two days. One copy of the interview is included as an appendix, (See Appendix O on CD). Six interviews were conducted with registered nurses and one with an enrolled nurse. Two registered nurses from each of the ARV clinics were interviewed. In addition, one enrolled nurse who works in the adult antiretroviral clinic was interviewed. The researcher did not conduct any follow-up interviews.

After conducting the interviews the researcher listened attentively to the audio-taped data, checking for audibility and completeness before it was transcribed verbatim. The transcribed data were stored in a word processing programme and two hard copies of the transcribed interviews were made.

- **Documentation**

Information obtained from documentation is likely to be relevant to every case study topic and should be part of the data collection plan. The use of documentation has a variety of advantages, it is stable and can be reviewed repeatedly, it is unobtrusive and not created for the case study, it contains specific information and details of an event and is broad and can cover a long span of time, events and many setting. However, the use of documentation also has its weakness; it can be difficult to find, it might be incomplete, reporting bias or access to documents might be deliberately withheld (Yin 2014:106; 125). The researcher ensured that the documents used can be retrieved for perusal at a later stage. The researcher used the following documents for analysis to corroborate the information obtained through the interviews: job description for professional nurses and enrolled nurses (Appendices M and N see CD disk) working in the public hospital and the Employee Health and Wellness Strategic Framework for Public Service (because this document is too big it is not attached as an appendix but provided on a CD disk, Appendix Q). The existing wellness programme is not for nurses only but for all employees who work in the public sector. The researcher obtained the job descriptions from the management of the public hospital (Gauteng Department of Health 2007) and the health and wellness programme from the website page of the Department of Public Service and Administration Republic of South Africa. The job description for the two professional nurses who work for the NGO was not made available to the researcher. The NGO at the time of the study did not make provision for a wellness programme for their employees. However, the two professional nurses employed by the NGO were included as they were the only nurses who worked in the ante-natal ARV clinic who was willing to participate in the study. The researcher included these nurses from the NGO as the researcher was of the point of view that their views regarding compassion fatigue could be valuable in the development of the wellness programme.

- **Field notes**

Field notes were taken during interviews to provide details of what occurred under specific circumstances. The researcher made descriptive and reflective notes of the things heard, seen, experienced, and thoughts that the researcher had during the interviews. The field notes assisted the researcher to attach meaning to her observations regarding the participants' non-verbal behaviour, tone of voice and emotions expressed. It also provided helpful information during analysis and facilitated with identifying themes. The researcher typed the field notes and stored it for retrieval during data analysis (See Appendix K on CD disk). The researcher also kept record of her personal response to specific events that might influence interpretation of the findings.

3.3.4 Analysing case study evidence

Yin (2014:133) indicates that the analysis of case study evidence is the least developed aspect. Therefore, the researcher used the process of content analysis as described by Elo and Kyngäs (2008) to analyse the content of interviews, documents and field notes of the informal unstructured observations done during the interviews. The researcher will use inductive content analysis as described by Elo and Kyngäs (2008) to analyse the data.

The following process were used to analyse the interviews

Analysing the interviews

Transcripts of the interviews (1) were read to acquire an overall understanding of content related to the aim of the study; (2) the interviews were read repeatedly and discussed with the supervisors to achieve immersion and to gain a sense of the whole; (3) the interviews were read again (word for word) while writing notes and headings in the margin of the transcripts; (4) the process was repeated and subcategories with similar events were and incidents were grouped together as categories (Dey 1993; Robson 1993; Kyngäs & Vanhanen 1999 cited in Elo & Kyngäs 2008). (5) each category was named using content-characteristic words; (6) the lists of categories were grouped together as main categories or themes to reduce the number of categories and to provide a means of describing the phenomenon and to increase understanding and to generate knowledge (Cavanagh 1997 cited in Elo & Kyngäs 2008); (7) the abstraction process were repeated as far as possible (Elo and Kyngäs 2008; 107-115).

3.3.4.1 Ensuring high quality analysis

According to Yin (2014:133) qualitative data analysis consists of examining, categorising and verifying the data findings to draw empirically base conclusions. The study evidence constitutes of the transcripts (Appendix O) of the individual interviews and the accompanying field notes (Appendix K) and documentation (See Appendices M, N and Q).

According to Yin (2014:133) the analysis of case study evidence is the least developed aspect; therefore, the researcher used the process of content analysis as described by Elo and Kyngäs (2008). The researcher identified similar content in the transcribed interviews that was used to identify subcategories, categories and themes through a systematic process of coding. See Table 3.3.

- **Training to do the case study**

The research assistant was a psychology student, trained and experienced in qualitative research. The researcher trained the research assistant with regards to the phases of the planned case study, what evidence is being sought as well as the case study protocol. Training took the form of discussions prior to data collection and the research assistant was also guided on how to deal with problems during the study. The researcher also provided training to the research assistant on HIV/AIDS and Figley's Compassion Fatigue Etiological Model (2002).

- **The researcher's role**

According to Merriam (2009:52) 'the researcher is the primary instrument of data collection and analysis', and researchers have to rely on their own instinct and abilities. The researcher believes in multiple realities and was committed to identify the approach that led to understanding the phenomenon of compassion fatigue amongst nurses working in ARV clinics. The researcher acknowledged that she is part of the research process and also valued the participants' viewpoints. The research findings are reported in a literacy style rich with participants' commentaries.

According to Yin (2014:72) 'a well-trained and experienced researcher is needed to conduct high quality case study research because of the continuous interaction between the theoretical issues being studied and the data being collected.' Since, the research assistant conducted the interviews and is trained in conducting qualitative research; the researcher had a discussion on the attributes that researchers should master in order to ensure good quality case studies to ensure that the research assistant mastered the attributes. See Table 3.4 for the attributes that researchers should have in order to conduct good quality case study research.

- **Reporting the analysing process and the results**

Credibility of the findings of a study depends on how well the categories cover the data (Graneheim and Lundman 2004:110) and in order to increase the reliability of a study the researcher needs to demonstrate that there is a link between the findings and the data (Elo and Kyngäs 2008:112). The researcher described the analysis process and findings in detail so that the readers may have a clear understanding of how the analysis was carried out. Therefore, the researcher kept all evidence in such a way that an external observer would be able to follow the derivation of any evidence. The researcher described the content of the categories through subcategories (Burnard 1996:279). The researcher

analysed the raw data breaking it into smaller pieces and identified themes, categories and subcategories. The categories reflect the subject of the study in order to label the analysis process successful (Burnard 1991:462). In order to increase the credibility of the results the researcher sent the raw data to two independent coders to analyse the data to verify that the researcher identified all themes, categories and subcategories. The study protocol and hard copies of each of the transcripts was given to the independent coders and they signed an agreement (Appendix H) to keep all data confidential. The independent coders used a computer programme Nvivo9 to analyse the interview transcripts, to verify that all relevant themes, categories and subcategories have been identified. A working document used by the independent coders with the initial themes, categories and subcategories are included see Appendix L. After analysing the data independently, the researcher and independent coders met to discuss the themes, categories and subcategories in order to reach consensus on the coded data.

When the researcher discussed the agreed upon themes, categories and subcategories that was reached between the researcher and independent coders the supervisors disagreed and the subcategories, categories and themes were revised because the themes, categories and sub-categories identified by the independent coders would not have answered the research question. The researcher accepted the supervisors' guidance to re-code the data and was not coerced in any way. The revised themes, categories and subcategories were taken back to the independent coders and they agreed with the new set of themes, categories and subcategories.

Table 3.4 Principles and strategies used to ensure high quality analysis

Principles	Strategies
Attend to all evidence	The researcher analysed the interviews in conjunction with the field notes and documentation ensuring that no evidence was ignored.
Analysis to address the most significant aspects of case study	The researcher paid attention to all aspects of the study during data analysis by providing step by step details of the analytic techniques used and how the researcher arrived at the findings
Use of researcher's prior knowledge of the study	The researcher used her current knowledge and kept up to date through internet and journal searches, reading up on the latest information on compassion fatigue and HIV/AIDS.

Following is a discussion of strategies used to ensure that quality case study was conducted:

According to (Lincoln and Guba 1985; Guba and Lincoln 1994 cited in de Vos, Strydom, Fouche and Delpoort 2011:584), qualitative researchers need to evaluate the quality of their data and their findings. They further suggested five criteria for establishing the trustworthiness of qualitative data and the ensuing analysis, namely: credibility, dependability, confirmability, transferability, and authenticity.

3.4 Ensuring the quality of a case study design

Ensuring validity and reliability in qualitative research indicate that the study is conducted in an ethical manner (Merriam 2009:209). Yin (2014:45) suggest four tests to determine the quality of case study research, namely: construct validity, internal validity, external validity and reliability. However, the researcher decided to rather use the framework by Lincoln and Guba (1985) due to the qualitative nature of data collection process. Yin (2014:45) also refer to these concepts; therefore, the researcher deemed it as acceptable to use with a case study. The quality of any given study design can be judged according

to certain logical tests. The researcher will next discuss measures used to ensure trustworthiness of the case study.

3.4.1 Trustworthiness of the case study design

An approach to clarifying the notion of objectivity as it is manifested in qualitative research is found in the highly influential work of (Lincoln and Guba 1985 cited in Babbie and Mouton 2001:276-277). For them the key criterion or principle of good qualitative research is found in the notion of trustworthiness - the neutrality of findings or decisions. The basic issue of trustworthiness is simple: researchers need to persuade their audience that the findings of an inquiry are worth paying attention to or worth taking account of. According to Rule and John (2011:8) the concept of trustworthiness is an alternative to reliability and validity. Trustworthiness helps to gain trust and fidelity and promotes values such as rigour, transparency and professional ethics in qualitative research. The concept of trustworthiness is achieved when giving attention to transferability, credibility, dependability and confirmability as well as authenticity.

Credibility

According to Rule and John (2011:107) credibility is an alternative for internal validity and is a reflection on the extent to which a study measure in on what it is set out to study. Credibility ascertains whether there is compatibility between the constructed realities that exist in the minds of participants and those that are attributed to them? In order to achieve credibility of the research findings the researcher used two independent qualitative researchers to verify that all the theme, categories and subcategories have been identified during analysis; the researcher that stayed in the research environment during data collection and multiple data collection sources was also used (Babbie and Mouton 2001:277).

Dependability

Dependability is seen as an alternative for reliability and focusses on methodological rigour and coherence towards generating research findings that can be accepted with confidence by the research community (Rule and John 2011:107). Dependability of qualitative data refers to stability over time and over conditions. An inquiry audit is a technique relating to dependability that involves a scrutiny of data and the relevant supporting documents by an external reviewer. The researcher gave a dense description of the methods of data collection, analysis and interpretation of the data that will provide information as to how repeatable the study might be. The researcher used her supervisors, who have extensive experience in qualitative research, to check the research

plan and the implementation of the plan. During the analysis stage the researcher used independent coders who are experienced in qualitative research. The researcher and the independent coders compared and discuss the themes, categories and subcategories. Consensus was reached amongst the researcher and independent coders (Polit and Beck 2012:593).

Transferability

Transferability is an alternative for generalizability and refers to the extent to which study findings can be applied in other contexts or to other participants. The qualitative researcher is not interested in generalisations. For the purpose of this study, the researcher provided detailed descriptive information that will allow readers to make inferences on whether the research findings can be applied to new situations, it is the reader who transfers the results (Polit and Beck 2012:525; Rule and John 2011:105).

Confirmability

Confirmability guarantees that the findings, conclusion and recommendations are supported by the data and that there is an internal agreement between the researcher's interpretation and the actual evidence (Lincoln and Guba cited in Babbie and Mouton 2001:278). According to Rule and John (2011:107) confirmability is a way that a researcher's influence and biases on the study can be addressed. The researcher kept an audit trail and raw data such as, interview guide, recorded interviews, written field notes, survey results, the analysed data and process notes. Instrument used in a master file will be kept under lock and key for 15 years for reviewing as an evidence that will enable auditors to trace the conclusion, interpretation and recommendations to their sources and to determine if they are supported by the inquiry.

Authenticity

According to Polit and Beck (2012:525) 'authenticity refers to the extent to which the researchers fairly and faithfully show a range of different realities. A text has authenticity if it invites readers into a vicarious experience of the lives being described and enables readers to develop a heightened sensitivity to the issues being depicted'. For the purpose of this study the researcher used an interview guide that indicated which questions should be probed; field notes was taken on all participants' emotions and body language expressed during the interview.

3.5 Limitations of the study

The study took place in the ARV clinics within one tertiary hospital in Gauteng Province. The sample size was very small, thus it may not be representative of all nurses working in antiretroviral clinics. Therefore, the findings of the study cannot be generalised.

The fact that the researcher was known to the participants might have had an impact on how participants responded. However, the researcher reassured participants that all information provided will be kept confidential and their names would not be included in the study report.

3.6 Ethical considerations

Ethical issues arise out of our interaction with other people, other beings (such as animals), and the environment, especially where there is potential for, or is, a conflict of interests. In many cases, ethical choices involve a trade-off or compromise between the interests and the rights of different parties (Polit and Beck 2012:152). According to Yin (2014:73; 76-77) case study researchers should avoid being biased and should conduct research ethically. The researcher strived to maintain the highest ethical standards while conducting the research. Following is a description of the ethical principles as applied by the researcher.

3.6.1 Protecting human subjects

Yin (2014:77-78) indicates that specific ethical considerations arise when human subjects are used in research. The researcher applied the following measures to adhere to ethical principles as described by Yin (2014:78):

- A research proposal, number 178/2009, was submitted to the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria for *approval to conduct* the study (Appendix G). Permission was also requested from the Department of Health, Gauteng Province (Appendix F). Institutional permission was obtained from the CEO of the selected hospital (Appendix D). In addition, consent was obtained from the participants. The participants' rights were explained to them prior to their participation and an information and informed consent document was given to participants as part of the consent process (Appendix A).
- When dealing with competent adults, participation should be based on *informed consent*. Hence, the potential participants were informed about the nature of the study,

the kind of issues that will be explored, how participants will be selected and what the risks and benefits to the participants will be. The prospective participants were assured of the confidentiality of the study. Polit and Beck (2012:162) state that confidentiality is the management of private data in research ensuring that subjects' identity is not linked to their responses. Therefore, the participants' names were not used in the research report. Furthermore, participants were assured that they will have the freedom to withdraw from the study at any time without prejudice. Participants were advised should they have any queries to contact the researcher or her supervisors.

- *Privacy* implies the element of personal privacy, while *confidentiality* indicates the handling of information in a confidential manner (Polit and Beck 2012:162). Measures to ensure privacy and confidentiality include the protection of the identity of participants by keeping all data safe for 15 years and omitting their names in the research report. Practices of accountability are of the utmost importance in such a research setting and the researcher committed herself to respect participants' contributions by honouring the above stated measures to ensure responsible research.
- In any research, participants can be *harmed* in a physical and/or emotional manner. Emotional harm is often more difficult to predict and determine than physical discomfort, but often has more far reaching consequences for the participants (Polit and Beck 2012:163). Possible risks in this study involved emotional discomfort that might be experienced by participants while sharing their experiences working with traumatised HIV positive patients. However, the researcher did explain to participants prior to participation what the risks of participation might entail. The researcher strived to minimize the potential risks and maximise the potential benefits by ensuring that the research assistant asked questions in a friendly and non-threatening manner; monitored the emotional discomfort of participants during interviews and arranged that a psychologist was available for support should the need arise. The benefit of this research was to develop a wellness programme for nurses working in an antiretroviral clinic to identify, manage existing and prevent future occurrence of compassion fatigue.

3.7 Summary

In this chapter the researcher discussed the methodology used to conduct Phase one of the study, the measures used to ensure trustworthiness of the study, and all the ethical issues applicable.

In the next chapter the researcher will discuss the analysis of the qualitative data of Phase one of the study.

Table 3.5 Researcher's attributes

Desired attributes	How this has been addressed in the study
Ability to ask good questions	The ability to ask good questions is a prerequisite for case study researchers bearing in mind that asking good questions is to understand that research is about questions and not necessarily about answers. Case study researchers should have an inquiring mind during data collection (Yin 2014:73-74). The researcher kept an open mind and created a rich dialogue with the evidence reviewing it and asking questions as to why events or perceptions appear as they do and based on judgement search for additional evidence.
Be a good listener	The researcher had to listen to carefully and make keen observations or sensing what is going on and had to assimilate large amounts of new information without bias. During interviews the researcher assistant had to listen carefully to hear the exact words of participants, while, the researcher took field notes capturing the mood and affective components, understand the context from which the interviewees view the world and infer the meaning intended by the interviewee (Yin 2014:74).
Stay adaptive	The researcher had to remember what the original purpose of the study was and had to be able to adapt procedures and plans if unanticipated events occur. Therefore, the researcher has to be able to make minor changes when needed in order to pursue unexpected leads maintaining an unbiased perspective and recording such changes (Yin 2014:74-75). After the first interview the researcher and research assistant reviewed the interview guide and changed the two close ended questions to open ended questions in order to allow for probing.
Have a firm grip on issues being studied	The researcher stayed up to date with new research on the phenomenon under study and continued to search on internet for recent articles released on compassion fatigue and HIV/AIDS. This information was used during report writing to either refute or corroborate these study findings. The researcher had to interpret the information as data collection takes place to determine whether data saturation has taken place or whether additional evidence is needed.
Avoid biases	The researcher was open to contrary evidence and willing to report these contrary findings; she strived to maintain the highest ethical standards while conducting the study.

Yin (2014:73-77)

CHAPTER FOUR

FINDINGS OF PHASE ONE

4.1 Introduction

The research methodology used to address the research questions were described in the previous chapter. The aim of Phase one of the study was to explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in adult, antenatal and paediatric antiretroviral clinics. The data was collected using individual semi-structured interviews, field notes and documentation.

This chapter covers the research findings of Phase one of the study. In the next chapter the findings will be discussed with related-literature.

4.2 Data analysis

Data analysis means to organise, provide structure and elicit meaning to the raw data. Qualitative data analysis includes coding, categorising, concept mapping and theme generation (Simons 2009:117) which enabled the researcher to organise and make sense of the raw data obtained during the individual interviews. Data analysis was done using processes described by Elo and Kyngäs (2008).

4.2.1 The researcher's role in data analysis

The researcher used the process of reflexivity to guard against preconception regarding the phenomenon under study in order to increase the credibility of the study (de Vos, Strydom, Fouche and Delport 2011:422). Researchers who conduct qualitative research rely on reflexivity to guard against bias in making judgements (Polit and Beck 2012:179). During data analysis the researcher reflected critically upon her personal values; and kept it in mind, but did not write it down in order to guard against personal biases, preferences, special interest in, and fears about the research and theoretical inclinations that could affect data analysis and interpretations (Schwandt 2007 cited in Polit and Beck 2012:179). According to Merriam (2009:52) 'the researcher is the primary instrument of data collection and analysis'; hence, researchers have to rely on their own instinct and abilities. The researcher believes in multiple realities and was committed to identify the approach that led to understanding the phenomenon of compassion fatigue amongst nurses working in ARV clinics. The researcher acknowledged that she is part of the research process and

also valued the participants' viewpoints. The research findings were reported in a literary style rich with participants' commentaries (Speziale and Carpenter 2007:21). Thus, the researcher relied on her instincts and abilities, recognizing her own biases and assumptions of the phenomenon under study and acted as the voice of participants, ensuring that the research report is an accurate reflection of the findings.

4.2.2 Analysis of the qualitative data

According to Yin (2014:133) qualitative data analysis consists of examining, categorising and verifying the data findings to draw empirically based conclusions. The study evidence constitutes of the transcripts (Appendix O on CD) of the individual interviews, the accompanying field notes (Appendix K) and documentation (See Appendices M, N and Q on CD).

According to Yin (2014:133) the analysis of case study evidence is the least developed aspect. Therefore, the researcher used the process of content analysis as described by Elo and Kyngäs (2008). The researcher identified similar content in the transcribed interviews that was used to identify subcategories, categories and themes through a systematic process of coding (Hsieh and Shannon 2005:1278).

The following steps were used during data analysis for interviews and documents: (See chapter 3: 3.3.4 for more detailed data analysis process)

- (1) Read transcripts of the interviews and the documents to acquire an overall understanding of content related to the aim of the study;
- (2) Read the interviews in conjunction with the field notes as well as the documents repeatedly to achieve immersion and gain a sense of the whole;
- (3) Read the interviews and documents again (word for word) while writing notes and headings in the margin;
- (4) Use the interview transcripts and documents to group subcategories with similar events and incidents together as categories;
- (5) Name each category by using content-characteristic words;
- (6) Group the lists of categories together as main categories or themes to reduce the number of categories, to provide a means of describing the phenomenon, to increase understanding and to generate knowledge;
- (7) Repeat the abstraction process as far as possible. The analysis of the data is discussed in detail in chapter three.

4.3 Findings of Phase one

The themes, categories and subcategories identified are indicated in Figure 4.1.

The researcher identified 16 subcategories, which were grouped together into five categories from which three themes were derived (See Figure 4.1).

These themes are represented in conjunction with representative quotes from participants. The quotations used indicate the number of the interviewees e.g. participant 1) and the specific antiretroviral clinic where the participant worked at the time of the interview (i.e. adult, ante-natal or paediatric antiretroviral clinic). Notes taken during the interview reflecting participants' emotions or non-verbal communication is also included in some quotations to enhance the reader's understanding of the specific quote. The researcher will next discuss the themes, categories and subcategories. The themes are indicated in bold uppercase within a border, bold lower case is used for the categories, and subcategories are indicated in bold italic typeface.

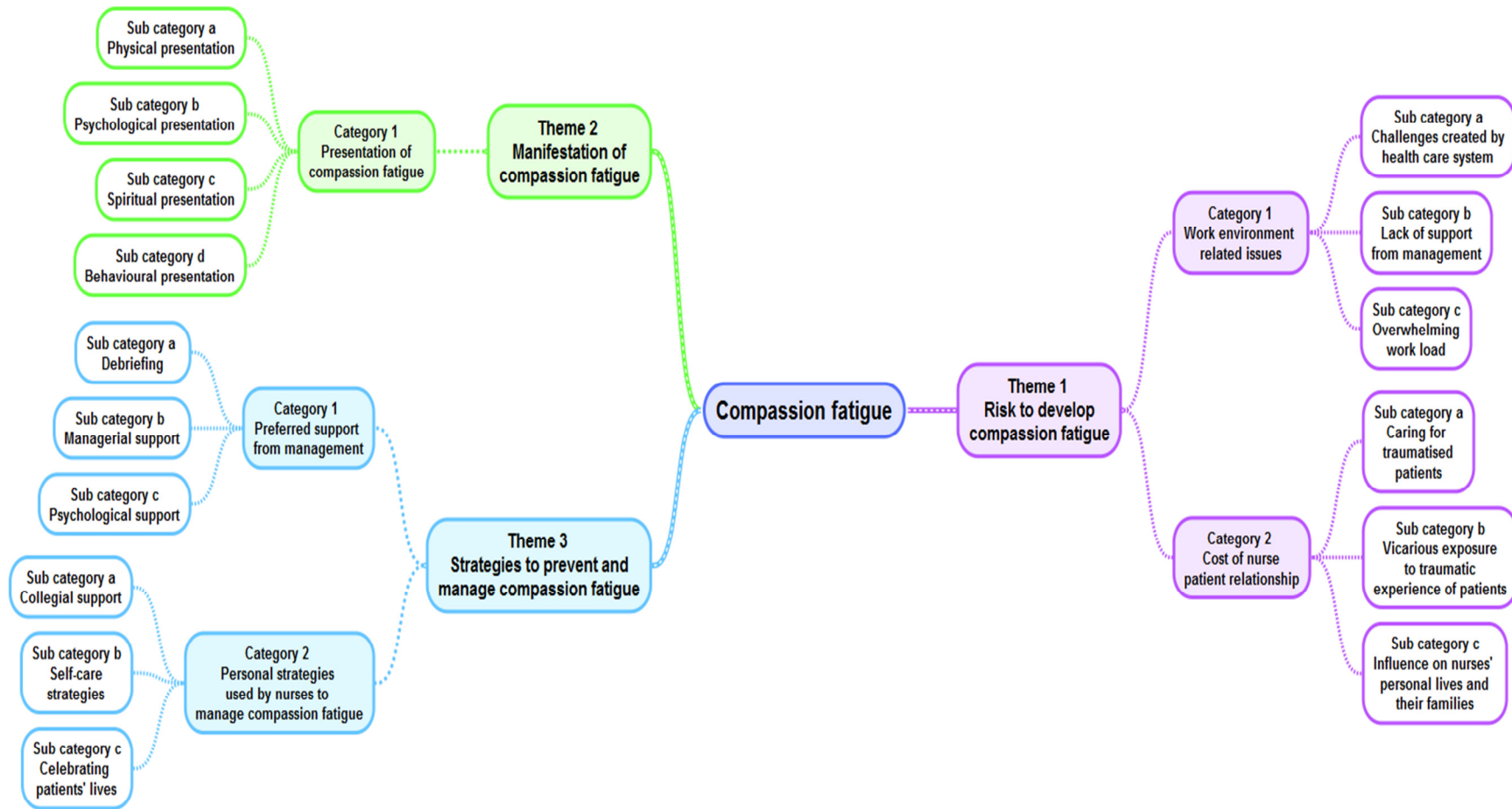


Figure 4.1 Themes, categories and subcategories

THEME 1: RISK FOR DEVELOPING COMPASSION FATIGUE

For this theme two categories and six subcategories were identified and it will be presented in conjunction with representative quotes from the participants.

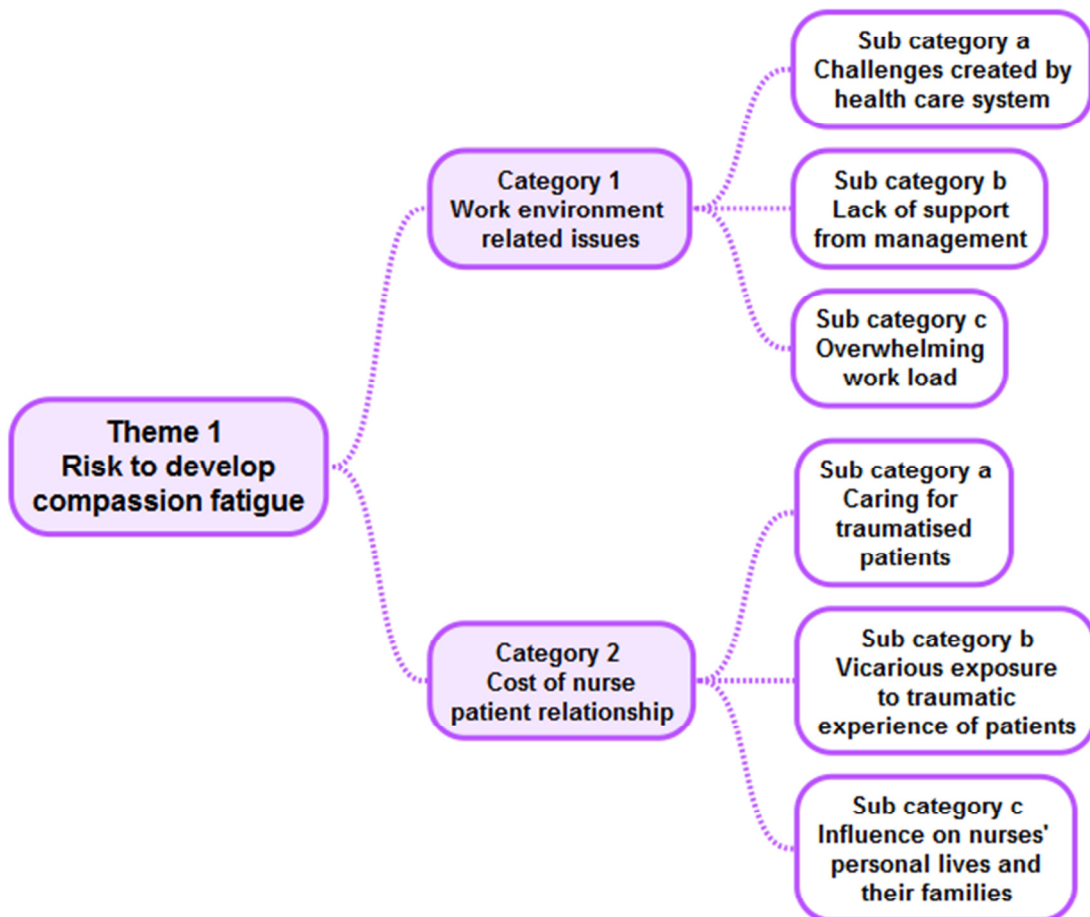


Figure 4 2 Theme 1 with categories and subcategories

An analysis of the data revealed that nurses who work in ARV clinics are exposed to certain factors that increase their stress, therefore their risks to develop compassion fatigue. A number of factors pertaining to work environmental issues as well as the cost of nurse-patient relationships were identified that may increase nurses' risk to develop compassion fatigue.

4.3.1.1 Category 1: Work environment related issues

From participants' responses it is evident that nurses are at risk of developing compassion fatigue due to the challenges they face working in antiretroviral clinics such as lack of management support, exposure to tuberculosis and the overwhelming work load.

Following is a discussion of the subcategories comprising this category: Quotes are used to indicate factors identified by participants that increase nurses' stress levels and their risk of developing compassion fatigue.

Subcategory a: Challenges created by the health care system

Various policies in the health care system need to be adhered to in the caring for patients who are HIV positive. The participants expressed their frustration with these policies as they indicated that certain aspects of the care of patients who are HIV positive are not addressed and the policies are not regularly updated. The frustration experienced by one participant who work in the adult ARV clinic is expressed in the next quote:

Participant 5 (Adult ARV clinic) "I become frustrated with the policy ... the frustration to me is lack of consistency ... there are loop-holes in the policies ... The policies are there ten or twenty years without being revised."

The increasing number of newly diagnosed patients who are HIV positive was perceived as distressing and is evident in the next quote:

Participant 3 (Paediatric ARV clinic) "...the infection rate is going up [meaning more people are becoming infected with HIV] it's not going down but then we don't get the cure..."

The poor access to ARV treatment, especially in rural areas, was also seen as an impediment to the rendering of quality care to patients who are HIV positive. They felt that patients need not die if the health care system could provide the necessary services. The following quote indicates the status of the health care service for patients in rural areas who are HIV positive as experienced by a participant who works in the ante-natal ARV clinic:

Participant 7 (Ante-natal ARV clinic) "... the hospital [in rural area] ... there is no care there ... people in the rural areas are suffering. Some [patients] die even before they even start [ARV treatment]."

Some of the participants complained about the missed opportunities for initiating ARV treatment:

Participant 2: (Ante-natal ARV clinic) "... some patients they are being missed and they are not put on antiretroviral [ARV treatment] on time and they end up not getting treatment."

The fact that adults have to wait for their CD4 blood count to drop below 200 cells/mm³ before they are eligible for ARV treatment (at the time of the study this was still the practice) is very discouraging to nurses as indicated by one participant:

Participant 4: (Paediatric ARV clinic) "... adults having to wait until their CD4 count (blood test) is less than 200, are discouraging ..."

Based on the participants' responses the researcher identified a number of challenges related to the health care system that cause barriers to patients accessing to anti-retroviral treatment. Inconsistency in implementation of policies and out-dated policies cause frustration amongst nurses. The fact that patients have to wait for their CD4 count to drop below 200 cells/mm³ as well as lack of access to ARV treatment in rural areas was also a great concern for participants because some patients die before starting ARV treatment. Participants also reported an increase in the HIV infection rate and seemed concerned since there is still no cure for HIV/AIDS.

Participants claimed that there is no wellness programme available that provides TB screening services for nurses who work in ARV clinics causing nurses to feel uncared for and led them to portray distrust in the health care system. One participant voiced her concern about not being screened for tuberculosis (TB) since healthcare workers who work in ARV clinics are exposed to infectious TB. In the next quote one participant raised her concerns:

Participant 5 (Adult ARV clinic) "I don't have trust for the health care system concerning myself ...we are not looked after [cared for], because ... working in antiretroviral site, we are admitting patients with infectious tuberculosis ... concerned we are supposed to be checked [screened] ... to see whether are we exposed or not (to infectious) tuberculosis."

A further concern expressed by participants was the time it takes before the laboratory produce patients' test results. One of the participants shared her experience where the result of the diagnostic test was received weeks after the patient died. From the next quote the researcher heard the frustration and powerlessness of being at the mercy of the health care system as the participant who worked in the adult ARV clinic voiced her experience:

Participant 4 (Paediatric ARV clinic) "... tuberculosis it was diagnosed late. By the time they got the results the person was dead, it was ten weeks after the person has passed away ..."

Participants reported that they are caring for patients who are co-infected with TB but they are never screened for TB to determine whether they themselves are infected. The late release of test results from the laboratories also causes nurses to feel frustrated and powerless.

Subcategory b: Lack of support from management

Participants felt let down by management as they felt that they do not receive the necessary emotional support from them. In the next quote the researcher picked up a sense of disappointment in management for not providing the necessary support:

Participant 5 (Adult ARV clinic) "... it's management [support], they [management] let me down ..."

Some participants reported not getting much support from management, which is evident in the next two quotes:

Participant 2 (Paediatric ARV clinic) "... management support ... there is not much [support from them] ..." and "... there are no support systems ..."

One participant felt management failed her because they do not provide debriefing services that will help in knowing how working in ARV clinics affects nurses because often nurses do not have the necessary coping skills. The following quote describe the kind of support that is expected from management:

Participant 5 (Adult ARV clinic) "... We are not looked after ... the healthcare system, sometimes they fail us because I think sometimes they must do like a debriefing that they can see whether working under HIV clinic is it affecting you or it doesn't. If it affects you, do you have coping mechanisms to survive. Sometimes you don't (cope) but you don't show."

From participants' responses it became evident that the managers are not aware how working in ARV clinics affects nurses' well-being.

Participant 7 (Ante-natal ARV clinic) "... our managers ... they are maybe not aware but we are also affected ... we need debriefing..."

Participants further indicated that there is no psychological support in the form of debriefing available that can provide some form of psychological support to nurses. Following are examples of participants' views on support systems and debriefing:

Participant 5 Adult ARV clinic) "... there are no... debriefing..."

The next quote indicates another participant's agreement on the fact that there are no debriefing facilities available for nurses who work in ARV clinics:

Participant 6 (Adult ARV clinic) "... here at work there is nothing, there is no debriefing ..."

Participants stated that there is a lack of support systems such as debriefing and wellness programmes for nurses who work in ARV clinics. One participant alluded that managers are not aware that working in ARV clinics affect them and expressed a need for debriefing.

Subcategory c: Overwhelming work load

The participants indicated that they were overwhelmed by the expectations voiced by the patients when attending the ARV clinics.

Participants revealed that the duration of consultations with patients who are HIV positive is longer. Due to the shortage of staff in the health care system, nurses feel they cannot spend the time needed with their patients who are HIV positive. The following quote is an example of how overwhelming caring for patients who are HIV positive can be:

Participant 6: (Adult ARV clinic) "... we are short staff ... you ... spend more time with the patients [patients who are HIV positive] ... we [nurses] need more time ..."

Counselling their patients cause nurses to feel emotionally drained because they have to listen, besides the challenges associated with their HIV status, to the many social, emotional and financial problems experienced by their patients that affect them emotionally. Being tired, and experiencing emotional exhaustion, cause nurses to be vulnerable to compassion fatigue. The sense of nurses being overwhelmed is indicative in the next quote:

Participant (Paediatric ARV clinic) "... Lots of them (patients) got lots of problems, not just HIV, its lots of social problems ... They want you to ... listen to their problems ... and it involves your emotional well-being as well. You spend a lot of time on them unlike any other outpatient."

Participants also reported that they spend more time providing care to patients who are HIV positive, especially when they default, than any other patients i.e. those visiting the out-patients' department.

Participant 6 (Adult ARV clinic) "... I think they (patients) need more care because sometimes they default on the treatment, they are tired to take the treatment and they need more encouragement ..."

The challenges faced in the ARV clinics care system are compounded by shortage of staff; especially skilled doctors that cause patients to wait a long time to be seen by a doctor resulting in an increase in patients' waiting time. Long queues of patients waiting to see a doctor is a common sight. The increase in patients' waiting time due to shortage of doctors is evident in the following quote:

Participant 4 (Paediatric clinic) "... patients will be waiting for long periods just to see a doctor ..."

Caring for an increased number of patients who are HIV positive cause nurses to feel emotionally exhausted. Participants reported that working in antiretroviral clinics is tiring especially during counselling when they have to listen to mothers who have so many problems causing her to feel emotionally drained.

Participant 3 (Paediatric ARV clinic) "... The counselling it is draining ... Listening can also be draining because the mothers they have got so many problems ... social ... emotional ... financial life ... it can really be draining emotionally for me."

Another participant reported that she feels tired when going to bed after a day's work:

Participant 5 (Adult ARV clinic) "... It's (work) tiring and you always feel tired when you go to bed ... it's tiring ... emotionally."

Participants reported that they need more time to provide care to their patients. However, due to the staff shortage this is not possible. They also reported that the number of patients who are HIV positive are increasing and felt that the available prevention strategies available are not working. These patients need more care and encouragement to continue taking their ARV treatment or else they will default on their treatment. Thus, caring for an increasing number of patients, under difficult situations, cause nurses to feel overwhelmed and increase their risk to develop compassion fatigue. Shortage of nurses and doctors in South Africa impede on the ability of the health care system to provide quality services.

4.3.1.2 Category 2: Cost of nurse-patient relationship

An analysis of the data revealed that nurses who work in ARV clinics are exposed to factors that increase their stress and therefore their risk to develop compassion fatigue. Contributing factors adding to compassion fatigue are the fact that some patients deny their HIV status; do not disclose their status to family and friends; nurses' emotional involvement with traumatised patients; exposure to traumatic experiences of their patients, invoke in nurses a sense of hopelessness, empathetic ability and inability to disengage as well as stigma associated with HIV/AIDS.

The following subcategories indicate the cost implications of the relationship nurses have with patients who attend ARV clinics. Quotes are used to indicate the cost of relationship between nurses and their patients who are HIV positive.

Subcategory a: Caring for traumatised patients

Having to accept a HIV positive diagnosis is not easy and it can lead to patients behaving negatively. The initial reaction of hearing about being HIV positive is denial; it is about pushing the reality of the situation away. Participants reported that patients who are HIV positive seek medical help very late when they are very sick and their CD count is very low. Being diagnosed with HIV is still seen as a death sentence and patients believe they are going to die.

Participant 2 (Ante-natal ARV clinic) "... sometimes they come late to the clinic ... their CD4 count are very, very low and they are very sick ... they all say 'oh I am going to die.'"

Patients wait until they develop problems, which then force them to seek medical help. Patients seem to struggle to come to terms with a HIV positive diagnosis because of the stigma associated with HIV/AIDS. The anguish in the participant's voice is evident in the next quote:

Participant 1 (Adult ARV clinic) "... It's like HIV they (patients) don't seek help at an early stage, they wait until they develop some problems and then they come presenting with the problems they are having and not the main problem HIV ... why they are struggling to come to terms because of the stigma attached to this disease."

Some patients still engage in risky sexual behaviour. One participant reported that the mothers of the child patients are promiscuous, have multiple partners and felt that patients' moral standards should change.

Participant 3 (Paediatric ARV clinic) "... they [child patients' mothers] have multiple partners and it is a problem ... moral that has to change ... we still have mothers who are very promiscuous ..."

The researcher could hear the anger and powerlessness in a participant's voice because some female patients reported that they are not able to negotiate condom usage because their partners are difficult and refuse to use condoms. Some patients who are HIV positive engage in risky behaviour by not using condoms, thereby putting more people at risk of becoming infected with HIV. The next quote demonstrates the anger and powerlessness expressed by the participant:

Participant 6 (Adult ARV clinic) "... Some say partner is difficult, are not using condoms. ... It makes me angry."

Prior to initiation of ARV treatment patients are counselled and informed that they have to take treatment for the rest of their life. However, participants reported that some patients default on ARV treatment.

Participant 6 (Adult ARV clinic) "Sometimes they (patients) default on the (ARV) treatment."

Participants reported that some patients default on their treatment and tell lies pretending that they are still taking their treatment regularly. Nurses' frustration is evident in the next quote because if patients stop taking their ARV treatment, viral suppression cannot take place and the CD4 count will remain low:

Participant 3 (Paediatric ARV clinic) "... You find the CD4 count (blood count) is going nowhere and the viral load is up there ... Some of them will tell lies, some tell the truth and say, I have stopped (treatment) for such a time."

Participants also reported that patients do not disclose their HIV positive status due to stigma and discrimination associated with HIV/AIDS.

Participant 3 (Paediatric ARV clinic) "... mothers not disclosing [HIV status] to their partners ..."

Participants shared the various reasons given by their patients for not disclosing their HIV status to partners, family and friends. Reasons for non-disclosure range from fear of being rejected especially by partners because in the past when they disclosed to their partners they left them. In addition, the patients do not disclose as they desire to still have children.

Participant 4 (Paediatric ARV clinic) "... didn't tell the partner [disclose HIV status] because she was afraid of being rejected ..."

Participant 6 (Adult ARV clinic) "... like those ladies on treatment but not disclosing [their HIV status] to their partners because they want a baby, they do not disclose ... they say 'I tried to disclose with the first one [first pregnancy], but he left me.'"

Participants are concerned and felt that non-disclosure of HIV status causes HIV to spread further. The concern is evident in this quote:

Participant 2 (Ante-natal ARV clinic) "... not disclosing ... is causing the spread of HIV... "

HIV testing of pregnant women is not compulsory in South Africa, when asked they can opt-out and not test for HIV. Refusal to test cause nurses to become very frustrated because they cannot enrol the pregnant woman in the prevention of mother-to-child transmission (PMTCT) programme, thereby ensuring the protection of the unborn baby against HIV transmission in utero. One participant expressed her disappointment in the next quote:

Participant 7 (Ante-natal ARV clinic) "... Some mothers even refuse to test when they are pregnant ..."

Accepting an HIV positive diagnosis is difficult. Although it is known that disclosure of HIV status could assist in stemming transmission of HIV, the participants indicated that patients who are HIV positive still find it very difficult to disclose their status to their partners, family and friends due to fear of rejection, discrimination and the stigma attached to HIV/AIDS.

Participant 6 (Adult ARV clinic) ..."It (HIV) is different because of the stigma attached, but as I can say its chronic disease, it's the same as others, but this one has a stigma that is why the patients they are struggling to come to terms."

Stigma associated with HIV/AIDS created many challenges for patients and make accepting a HIV positive diagnosis very difficult. Participants reported that some patients still deny their HIV status and the fear of death is evident in the next quote:

Participant 1 (Adult ARV clinic) "...They (patients) are suffering from denial and stigmatisation. A lot of patients do express the feeling of the fear of dying ... they have one thing on their mind, being HIV means death."

One participant reported that after her patient was diagnosed with HIV she thought she was going to die.

Participant 2 (Ante-natal ARV clinic) "... she said she is dying. [After a HIV positive diagnosis]"

A participant who worked in the ante-natal ARV clinic raised her opinion with regard to patients who are HIV positive. She stated that these patients are scared, they think that their lives are over that they are at the end of the road. She further expressed that nurses need to try and understand as well as talk to their patients; motivating them and give them hope. The same participant experienced that dealing with pregnant women is not different from, or more difficult than, dealing with patients with other conditions. The following quote highlights the participant's response:

Participant 7 (Ante-natal ARV clinic) "I can't say they (patients) are that different because you find people are different and difficult with other conditions in the hospital settings, and I would say they are not different. The only thing they need understanding like these people (patients who are HIV positive) you know they are scared, they (patients) think they are at the end of the world, at the end of the road, and they need somebody who will you know, open up, talk to them, show them the light, give them the hope. To me I don't know, maybe it's because I'm dealing with the mothers here and they are not difficult."

Patients who are diagnosed as HIV positive often feel ashamed, are probably in shock and they want to end their life. The following quote provides evidence of such negative behaviour of patients:

Participant 1 (Adult ARV clinic) "... [Patients] want to commit suicide because of diagnosis of HIV..."

People have different beliefs around the origin of HIV/AIDS. Participants revealed their patients' belief through the following quote:

Participant 3 (Paediatric ARV clinic) ... "People still believe they are bewitched."

Family members also respond differently when their family member discloses their HIV positive status. One participant states that after her patient disclosed her status to her family, they went to take out a funeral policy for her because they thought she was going to die.

Participant 2 (Ante-natal ARV clinic) "... after she disclosed to her family, they [family] all went to take out funeral policies for her ..."

Patients who are HIV positive still have difficulties in accepting their HIV positive diagnosis resulting in denial that leads to negative behaviour that cause nurses to feel powerless and angry. Patients who are in denial cause them to seek medical help very late when they are very sick with a low CD4 count, they would not use condoms and would engage in risky sexual behaviour. Reasons for non-disclosure were reported and include pregnant women's refusal to undergo an HIV test and women not disclosing their status to partners because they still want to have children. Nurses felt that non-disclosure is the cause of HIV infection to spread and it also causes patients to default treatment because they are scared of taking their treatment in front of people. Patients still believe that they are bewitched and this negatively affects their behaviour in seeking medical help. Some patients also contemplate suicide after being diagnosed HIV positive. Family members also respond negatively when a family member discloses his/her HIV status.

Nursing is about caring empathetically for the sick and traumatised, thus caring cannot take place without getting **emotionally involved with patients**. Initially ARV treatment was not universally accessible to patients who were HIV positive. ARV treatment for HIV/AIDS became available in 2004 and one participant reported working in the HIV/AIDS field since 2002 before ARV treatment was available and that she was motivated by the doctors she used to work with. From there she developed a passion to work with patients who are HIV positive. The same participant acknowledged that working with these patients is emotionally very costly because there is no cure available for HIV/AIDS; and the only care she could provide was counselling and drawing of blood for HIV testing. Caring for patients who are HIV positive is emotionally costly and increases nurses' vulnerability to compassion fatigue. The participant further describes what caring for patients entails: she feels she needs to have passion for her work and care for her patients in a non-judgmental way, to understand, to provide hope and encouragement so patients may go on living. The participant also stated that because she is a religious person she believes that people are made in God's image and she looks at people through that perspective. The participants' experience working in an ARV clinic is demonstrated in the following quotes:

Participant 1 (Adult ARV clinic) "I started working with HIV patients in 2002. Long before ... ARV's, because they (ARV) came in 2004. Like any other person I was afraid to nurse HIV patients, but I was motivated by certain doctors with whom I was working with in casualty... Those are the people who motivated me to start working with HIV patients, to counsel, take bloods ... I started actually now experiencing working with HIV patients, and from then I gained the passion and the love to work with HIV people... emotionally it (caring for HIV positive patients) is very costly ... Caring ... for me is to love that person in

what condition that person is. You have to have that love because as human beings unless you have some understanding... of a person in another perspective, because I would say I am too religious, that is one thing that tries to help me, because when I look at a person... I take that person to have been created in the image of God ... I have to take care of this person and not be judgmental, I must just be there ... and understand... encourage to go on living.”

One participant defined caring as feeling with and stepping into another person’s shoes in an attempt to understand the world of the other person. Nurses also show empathy towards their patients through acts of touching and hugging. The caring relationship between nurses and their patients is demonstrated by following quotes:

Participant 3 (Paediatric ARV clinic) “... caring means, feeling with ... you put yourself in that person’s shoes ... You empathise ... Being there with that person all the way ... “

Participant 4 (Paediatric ARV clinic) “... we touch each other we hug ... when they see me”

One participant felt that nurses should be empathetic towards their patients. She further states that she does become attached to her patients and identifies with her patients by feeling with them. The empathetic ability of participants is evident in the following quote:

Participant 1 (Adult ARV clinic)“... you must be empathetic ... you become attached with the patient and you feel with the patients.”

One participant reported how doing post-test counselling affects her. She would identify with her patients, thinking how she would respond to HIV positive diagnosis.

Participant 6 (Adult ARV clinic)... HIV post-test counselling... you get hurt... you think what if it was me, how will I accept this...”

Nurses **become more emotionally involved when caring for children**, especially if they have children the same age as that of their patients. Participants also identified strongly with children and felt heartbroken when seeing a child suffer, causing them to cry. The nurses’ emotional involvement was implicit in the response:

Participant 2 (Ante-natal ARV clinic) “... It was stressing me and I was a young mother with babies, it was affecting me. Sometimes I would cry seeing those babies suffering.”

One participant reported that situations where children are involved will affect her. The same participant indicated that some nurses would advise her to leave work problems at the hospital and not to take it home; however, she felt it is humanly impossible:

Participant 7 (Ante-natal ARV clinic) ... “Yes emotionally ... sometimes these things they will affect you ... Some (nurses) say this is a hospital thing I’ll leave it here, but as a human being, sometimes these things they will affect you ... Some situations really affect you as a person because you are a human being ... It becomes worse when children are involved... The most thing that is affecting me a lot is if kids are involved in the situation. But if it was just an adult with no children involved ... it wouldn’t have an impact as when there are children involved.”

Some participants indicated that their stress levels increase when they see that the condition of their paediatric patients’ mothers, who are also HIV positive, deteriorates. They are concerned about the child’s reaction when it becomes known to the child that her/his mother died from HIV/AIDS. Other concerns mentioned, relate to the children’s ability to cope in the absence of their mothers.

Participant 3 (Paediatric ARV clinic) “...once they (mothers) becoming sick, you become worried and you thinking that this mother is sick, so you just thinking of this child, how is she (patient) going to grow without a mother, ... the impact that is going to the child after discovering that my mother died because of the disease (HIV) ... How is this child going to cope?”

Some participants reported working in the HIV/AIDS field even before ARV treatment was available. One participant was motivated by doctors to work with patients who are HIV positive. The only care that the participant could provide was counselling and drawing of blood for testing before ARV treatment was available. The participants saw their patients as being created in God’s image and that they should care for them in a non-judgmental way, they should understand them and put themselves in their patients’ shoes, provide hope and encourage them to live positively. Participants reported that nurses do care for their patients, they hug and touch each other and feel with their patients, doing HIV post-test counselling is regarded as very difficult for participants. Pre-occupation with patients is worse when it involves the caring for children.

Empathy is the ability of nurses to recognise and understand the emotional stress of their patients. Participants’ responses indicate that they **show empathy towards their patients**, by providing the necessary support to patients. One participant reported that she feel what her patient may be feeling to the extent that she also suffers.

Participant 1 (Adult ARV clinic) "... taken by what the next person is feeling ... That thing that is affecting the person, is the thing that makes you feel you suffering yourself."

Participant 3 (Paediatric ARV clinic) "... feeling with [patients] ... You empathise ... Being there with that person all the way (nodding head)."

Participant 5 (Adult ARV clinic) "... Sometimes you become attached with the patient and you feel with the patient ..."

Participants revealed that nurses who work in ARV clinics do show empathy towards their patients. Some nurses become attached to their patients and feel what the other person feels to the extent that they also want to suffer with their patients.

Based on participants' responses the researcher deduced that participants who hear or witness the **death of their patients** are traumatised because they become attached to their patients. One participant felt that some patients lose hope, give up and die. The same participant states that she became attached to her patients and when they die, she grieves over them.

Participant 1 (Adult ARV clinic) ... "It's painful, it's hurtful (sadness in voice, talks softer) ... somehow others [patients] throw in the towel (give up) and die. It's a painful thing ... there are those patients who sometimes you attach to emotionally and then when they die you grieve."

A participant who worked in the paediatric ARV clinic described how upset the staff was when one of the children they cared for died; they were heart-broken. The same participant further indicated that there was no hope of survival for the child but still it was sad to let go, witnessing the decline in the health of the child. Talking about the death of their patients caused the participants to become emotional; the sadness and pain was evident in their voices. In addition one participant showed concern for the high death rate amongst their patients; especially amongst the mothers whose children were then left motherless.

Participant 7 (Ante-natal ARV clinic) ... "It (death) affects me; it affects me big time ... the mortality rate [death] of the mother's ... knowing that they will leave these kids without a mother ... there are so many people [mother] that I know have gone (died) and left the kids behind."

One participant who works in the paediatric ARV clinic mentioned an incident where a child she cared for died. The researcher became aware of the sadness felt by the participant when relating how heart breaking it was for her to witness the child suffering. However, the participant revealed that the child suffered too much pain and that death actually brought some relief. The sadness experienced by nurses over the death of a patient is implicit in the following quote:

Participant 4 (Paediatric ARV clinic) “... *the child is suffering, it is upsetting, but now she is free from pain ... and now she is gone (died)...*”

One participant explained that she is affected by the HIV epidemic because she just lost her sister-in-law to the HIV/AIDS epidemic.

Participant 4 (Paediatric ARV clinic) ...“*it affects you ... here is my sister-in-law who have just died. So it really affects you.*”

Another participant revealed that when she is aware of the death of a patient she will attend the funeral.

Participant 6 (Adult ARV clinic) ... ‘*Sometimes if a relative comes and tell us (of the death), maybe if I’ve got time during the weekend I do attend the funeral if it near to where I stay. But if they don’t come here and tell us, you find out late there’s nothing that we can do.*’

Participants reported providing support to the bereaved family, and one participant reported reflecting on the death of a patient allowing herself to feel whatever she feels at that moment.

Participant 1 (Adult ARV clinic) “... *It’s just a pity that sometimes others (patients) you don’t even know about their deaths, but those that you know about their death, you do have time to sit and think about them,... But you do sympathise with their relatives, children, if they are leaving children behind or whatever. You allow your emotions to feel whatever they are feeling at that particular time.*”

Participants revealed that they are affected by the death of their patients and feel sad and heart-broken. As a way of mourning the death of their patients some nurses attend the funeral of their patients to obtain closure and support the bereaved family.

Participants’ responses revealed that **nurses do grieve over the death of their patients** and that the extent to which they grieve depended on the relationship they had with those specific patients. One participant reported going through the whole grieving process.

Participant 1 (Adult ARV clinic) "... those patients who sometimes you attach to emotionally and then when they die you grieve ... even if you are not going to grieve in such a way that you lose your mind..."

Participant 2 (Ante-natal ARV clinic) "... you go through the whole grieving process ..."

Participants reported how they dealt with children who died in their care and when children die at home the family inform the nurses at the ARV clinic. The participants also shared how they support mothers who lost a child that has been in their care and felt the support they provide do make a difference because the mothers expressed feeling better after talking to them.

Participant 4 (Paediatric ARV clinic) "... we do grieve, usually we call the mother in ... we give them a hug and sit them down and talk and say the child was suffering ... and we've tried ... everyone on earth has a time to die ... Others we get a phone call and we record it ... we encourage them to come in ... they (mothers) will come here and stress ... but after talking to us they feel better and it makes a difference."

The participants indicated that it is very distressing to witness the deterioration and eventual deaths of their child patients. However, due to their case load they cannot afford to grieve for long periods over the death of patients.

Participant 3 (Paediatric ARV clinic) "... really upsetting to see them go (die) I ... grieve and then let go because I've got other patients to take care of."

One participant stated that she cannot stop thinking of her patients who died and questions arose as to whether she has done enough for these patients. Their doubt was palpable; if things were done differently maybe the patient would still be alive.

Participant 5 (Adult ARV clinic) "... you think about them when you are at home ... if maybe we had done this or that differently (guilt feelings) maybe they wouldn't have died..."

Being exposed to the death of their patients can be traumatic to nurses. The relationship nurses have with their patients may cause nurses to grieve over their patients. Participants reported that they do grieve when their patients die. Some of them even indicated that they go through the whole grieving process. One specific participant revealed that she becomes upset when children she cared for die, she can only grieve for a short period of time as she has other patients to take care of. Another participant

experienced guilt and felt that some patients would still be alive if things were done differently.

Subcategory b: Vicarious exposure to traumatic experiences of patients

Nurses who work in ARV clinics are exposed to their patients' traumatic experiences. Witnessing their patients suffer increase nurses' vulnerability to develop compassion fatigue. Participants acknowledged that they have problems **disengaging from their** patients and this affect them mentally. They would think about their patients during their off duty time when they are alone. The following aspects seemed to increase the nurses' vulnerability to develop compassion fatigue: inability to stop thinking about their patient, exhaustion and intrusive thought.

Participant 5 (Adult ARV clinic) "... when you get home you are thinking about that patient 'I wonder what is happening with that patient, I wonder how are they (patients) doing? Sometimes it affects you indirectly but when you are alone you'll think about that patient and it is affecting you mentally..."

Some participants stated that the media may trigger their memories about a certain patient and they will think about that patient all night long affecting their sleep.

Participant 7 (Ante-natal ARV clinic) "... It rest on your mind ... 24 hours you thinking about the person... Sometimes when you at home you cannot help to think about that (patient) with the baggage. Some situations really affect you ... you find that you were not thinking about that thing and then something like in the media, just trigger that and you remember that, eish! [Interjection expressing resignation] I have this situation ... and you just remember that person (patient) ... automatically it (thoughts) comes..."

From participants responses the researcher deduced that hearing about the death of their patients does affect nurses. Some nurses find it more difficult to work through the death of a patient and would relive the events that led to the death of the patient, remembering every detail and even expressed anguish thinking that the patient died because of something they have done. The following quote provide an example of a participant's pre-occupation with her patients:

Participant 7 (Ante-natal ARV clinic) ... "You start going back reliving the events that led to the death, all those things, remembering them, having memories... you think about them when you are at home..."

Based on participants' reports the researcher alluded that some nurses are unable to disengage from their patients and do become pre-occupied with them. Participants

reported not being able to stop thinking about their patients when at home; in some cases the media will trigger their memories and they will have flashbacks of the events that led to the death of patients.

Nurses' empathetic responses are implicit in the following response:

Participant 1 (Adult ARV clinic) "... you find yourself being taken by what the next person is feeling to an extent that now you are no longer yourself, you want to suffer with that person who is suffering ... That thing that is affecting the person, is the thing that makes you feel you suffering yourself."

One participant indicated that caring for patients who are HIV positive affects her and it is not easy to forget those patients. The effect of seeing her patients suffer is evident in the following quote:

Participant 6 (Adult ARV clinic) "Every time you think of that person ... It's not easy to forget. ... It was not easy for me to accept..."

According to the participants, when they witness their patients' suffering it cause them to respond empathetically in an attempt to relieve their patients' pain and this cause them to experience traumatic stress. Hence, participants' risk to develop compassion fatigue is increased.

Participants indicated that they experience a sense of **hopelessness** because of an increase in the number of patients infected with HIV and the fact that there is no cure for HIV/AIDS. The researcher sensed feelings of despair, powerlessness and stress in the participants' responses because of how they referred to the increasing rate in people diagnosed with HIV/AIDS, and the risky sexual behaviour their patients engaged in.

Participant 2 (Ante-natal ARV clinic) "... the more the numbers can get [number of people being infected with HIV], the less hope you have."

The fact that their patients are not using condoms result in an increase in nurses' stress levels and participants felt they are fighting a losing battle.

Participant 7 (Ante-natal ARV clinic) "... it stressed ... when they (patients) are not using condoms ...that's when you feel you are fighting a losing battle."

The fact that HIV/AIDS has no boundaries and that it can affect anybody and everybody caused some participants to experience a sense of powerlessness. The quote from one

participant explained how helpless she felt because there is nothing she can do to protect her family, since nobody is immune to the HIV virus.

Participant 4 (Paediatric ARV clinic) ...“HIV ... it can happen to anybody ... it is everywhere and what about my family ... what about my kids ... my husband (sounds desperate) ... it affects you ...”

Participants gave a number of reasons why nurses who work in ARV clinics experience a sense of hopelessness, such as the fact that the number of people who are HIV infected is rising, indicating that perhaps the HIV infection prevention strategies seem not to work and the fact that there is no cure for HIV/AIDS. Other factors that cause nurses to become hopeless is the fact that HIV has no boundaries and is everywhere, infecting husbands and family members as well as the fact that patients are not using condoms.

Subcategory c: Influence on personal lives of nurses and their families

Separating **work and home life** is very challenging for nurses due to their empathetic engagement with their patients. Not being able to maintain professional boundaries can have negative consequences for the well-being of these nurses. Nurses who identify with their patients' pain can become pre-occupied with their patients causing them to think of their patients even when at home and this affects their mental well-being. Nurses' pre-occupation with their patients is evident in the following quotes:

Participant 5 (Adult ARV clinic) “... when you get home you are thinking ... what is happening with that patient, I wonder how are they doing ... and it is affecting you mentally.”

Participant 2 (Ante-natal ARV clinic) “... you think about them (patients) when you are at home...”

For nurses to survive the onslaught of the HIV/AIDS epidemic they need to care for themselves. However, participants revealed that they were on their own when it came to support. They had to rely on themselves in dealing with the stress they are exposed to in caring for patients who are HIV positive.

Participant 1 (Adult ARV clinic) “... you need to help yourself ...”

Participant 5: (Adult ARV clinic) “... because we are not looked after ... you have to develop coping skills on your own ...”

Working in ARV clinics does affect the personal lives of nurses. A participant who works in the paediatric ARV clinic indicated that her neighbours who know she is a nurse, request HIV counselling when she is off duty. This additional counselling caused her to feel exhausted and burnt-out because she does not rest when off duty. In the following quote one participant shares her experience regarding her role in the community. The effect on nurses' home life is evident in the next quote:

Participant 3 (Paediatric ARV clinic) "... I take my job home ...counsel my neighbours...I always continue my work at home... it never stop..."

Participants reported feeling very tired and fatigued after work causing them to neglect their families. After a busy day at work nurses feel too tired to care for their families and tend to neglect their motherly duties towards their children.

Participant 4 (Paediatric ARV clinic) "After running a heavy clinic ... so drained. I'm having a teenager now, whom I have to attend to ... you can't even check on the books and can't even ask how you are doing, how is school. So it affects the family somehow ... most of the time you don't give much attention to your family due to tiredness and fatigue."

Participants indicated that they would tell their families that they have had a bad day at work and request not to be disturbed when resting.

Participant 7 (Ante-natal ARV clinic) "... sometimes you even verbalise ... it was not a good day for me ... you feel exhausted and when you come home, I don't want to do anything. You don't feel like being with your kids, I don't want them to disturb me, I just want to rest."

One participant revealed that she needs boundaries in her life in order to separate home and work life otherwise her children might be deprived of her attention.

Participant 1 (Adult ARV clinic) "When I'm at work, I'm at work. When I'm at home, I'm at home. These things are two different places. When I leave my work, it's finite.... when I reach my home now I am in a different environment. I cannot carry things from here otherwise their going to disturb my children there or maybe my things from home coming to disturb the patients. I need boundaries."

Based on participants' responses it is evident that nurses' personal lives as well as that of their family are affected negatively. Family members, especially children, are neglected because their parents are too tired to pay attention to their needs. One participant reported that because her neighbours know she is a nurse, they would request

counselling and this cause her to be fatigued and burnt-out because she does not rest when off duty. Another participant clearly felt that she needs boundaries and tries to separate home and work life.

THEME 2 - MANIFESTATION OF COMPASSION FATIGUE

For this theme one category and four sub-categories were identified and it will be presented in conjunction with representative quotes from the participants.

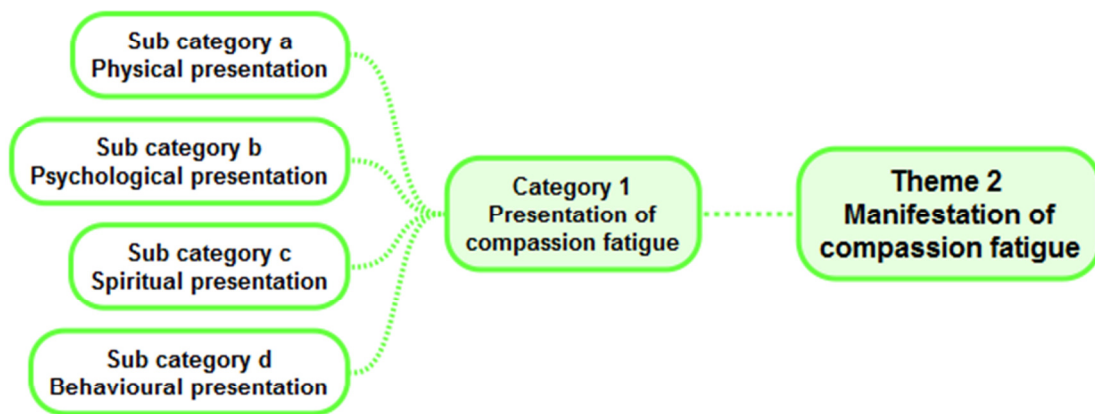


Figure 4.3 Theme 2 with categories and subcategories

Category 1: Presentation of compassion fatigue

The assumptions are that compassion fatigue affected participants physically, psychologically, spiritually as well as their behaviour towards their patients and colleagues. These assumptions are confirmed by participants’ responses. Following is a discussion of the subcategories comprising this category: Quotes are used to indicate how compassion fatigue presents itself amongst nurses working in ARV clinics as identified by the participants.

Subcategory a: Physical presentation of compassion fatigue

Participants indicated various ways in which compassion fatigue presents. Physically their energy levels were depleted, causing them to feel drained because they don’t get enough sleep.

Participant 4 (Paediatric ARV clinic) “Fatigue ... you are tired ... don’t sleep ... you’re drained ...”

One participant complained of feeling dizzy and becoming tired easily.

Participant 5 (Adult ARV clinic) "... sometimes I am having this dizziness and become tired, whereas before I would not get tired."

Participants complained regarding their physical health that could be attributed to them suffering from compassion fatigue.

Subcategory b: Psychological presentation of compassion fatigue

Participants' responses revealed that their psychological well-being is affected. The signs and symptoms mostly mentioned by the participants include: being irrational, irritable, shouting (frustration with others), being depressed, and being angry. Participants reported that they become tired of feeling pity towards other people. However, the same participant identified with people's suffering and wanted to suffer with those in pain.

Participant 1 (Adult ARV clinic) "... being irrational, angry ... Tired of feeling pity ... You find yourself being taken by what the next person is feeling to the extent that you want to suffer like that person who is suffering..."

One participant felt that her interpersonal relationship with the colleagues and patients is affected and she would speak loudly and become irritable.

Participant 2 (Ante-natal ARV clinic) "... generally all the interpersonal will be affected...even with the colleagues, not just with the patients ...very irritable and I would just speak loudly ..."

Another participant stated that she loved her work but she has reached a point where she lost her passion for her work.

Participant 3 (Paediatric ARV clinic) "... you love something and do it with passion and then, you come ... to a point when you lose that passion and that's compassion fatigue."

One participant complained feeling mentally exhausted and doubted whether she took up the right profession. While another participant indicated that at times she does not feel like being at work. After hearing this statement, the researcher thought that the specific participant might end up leaving the profession and further contribute to the existing staff shortage:

Participant 5 (Adult ARV clinic) "... Mentally I am exhausted ...I think I took the wrong profession ..."

Participant 6 (Adult ARV clinic) "... sometimes you feel ... I don't want to be at work..."

The following quote indicated that the participant was initially afraid to care for patients who are HIV positive. This could contribute to her being anxious about the situation:

Participant 1 (Adult ARV clinic) ...“Like any other person I was afraid to nurse HIV patients.”

This participant reported that counselling patients who are HIV positive could be emotionally draining because of the many problems that mothers have.

Participant 3 (Paediatric ARV clinic) “Counselling ... It can really be draining emotionally for me ... because the mothers have many problems ...”

One participant reports that that caring for patients who are HIV positive is emotionally costly to her because her patients are emotional and even want to commit suicide after a HIV positive diagnosis. The participant further stated that working with patients who are HIV positive requires a person that is emotionally balanced or else that person would become crazy.

Participant 1 (Adult ARV clinic) “It is costly emotionally because you look at this clients who is on the verge of crying or ... even want to commit suicide because of the diagnosis of HIV. If you are not a strong, emotionally balanced you can find yourself tilting (opposite of being emotionally strong) ... so it is costly...”

Caring for patients who are HIV positive could have negative effects on the well-being of nurses. The effects are evident in the next quote:

Participant 6 (Ante-natal ARV clinic) “... Yes emotionally ... sometimes these things they will affect you ... because some (patients) they come here with emotional baggage. Some (nurses) say this is a hospital thing I'll leave it here, but as a human being, sometimes these things they will affect you. Sometimes when you are at home you cannot help thinking about that with the baggage ... when you talk to them (patients) sometimes you find that it is a problem, a big problem affecting the whole family or whatever. It depends on their situations. Some situations really affect you as a person because you are a human being.”

In the following quote one participant described how the death of a patient affected her psychologically; she would relive the events that led to the death of her patients.

Participant 6 (Ante-natal ARV clinic) “... you think about them when you are at home ... reliving the event that led to the death ...”

One participant expressed having guilt feelings and felt that not enough was done to save her patients from dying.

Participant 2 (Ante-natal ARV clinic) “if maybe we had done things differently maybe they would not have died (guilt feelings)...”

Based on participants’ responses the researcher came to the conclusion that nurses who work in ARV clinics are in the depths of despair because of the increasing HIV infection rate, the many problems their patients have and the fact that patients are not using condoms all created a feeling of hopelessness in participants leading to the experience of stress and discouragement, and feeling that they [nurses] were not doing enough due to increasing numbers of patients. Counselling their patients seems to be draining their emotions causing emotional exhaustion. Participants also reported reliving events that led to the death of their patients.

Participants further reported a number of facts that cause them to experience a sense of hopelessness. One participant particularly reported feeling hopeless because of an increase in the number of patients who test HIV positive.

Participant 2 (Ante-natal ARV clinic) “... It is stressing me and discouraging me...the more the numbers get [patients who are HIV positive] It seems like we not going anywhere ... you have less hope...”

One participant felt that whoever works in ARV clinics need to have a passion for their job or else you become discouraged.

Participant 4 (Paediatric ARV clinic) “If you working in this department you have to have passion because you just going to give up ...you feel discouraged [hopeless] ...”

In the following quote one participant’s anguish is evident:

Participant 2 (Ante-natal ARV clinic) “... it stressed ... when they (patients) are not using condoms ...that’s when you feel you are fighting a losing battle.”

One participant seems to be having trust issues and reported that she does not trust the government. She also reported feeling redundant and mentally stagnant, which points to symptoms of low personal accomplishment that makes nurses vulnerable to compassion fatigue.

Participant 5 (Adult ARV clinic) ... do not trust the government ... I feel redundant... mentally stagnant...”

Participants reported that nurses who work in ARV clinics are depersonalizing patients, do not treat patients with dignity, are impatient and mad at everybody and show signs of aggression.

Participant 2 (Ante-natal ARV clinic) "... they don't treat people (patients) with dignity ... become impatient ... So they are mad (angry) at everybody."

In the next two quotes participants expressed feelings of aggression and being impatient toward patients:

Participant 4 (Paediatric ARV clinic) "... the expression and the way they talk to clients. Could tell that person has compassion fatigue ... She just screams at you and becoming impatient most of the time ..."

Participant 6 (Adult ARV clinic) "... aggressive ..."

Participants reported that people who suffer from compassion fatigue do not cope and exhibit signs of alienation and isolation not wanting to be disturbed by their children or not wanting to talk to anybody. They exhibit negative behaviour towards life and concerns related about their family are evident in this quote: Participant 6 (Adult ARV clinic) "... somebody who is not coping ... shouting maybe, don't listen to them."

Participant 3 (Paediatric ARV clinic) "...You don't feel like being with your kids, I don't want them to disturb me. I just want to rest..."

In the next quote a participant who works in the adult ARV clinic reported not wanting to talk to anybody:

Participant 6 (Adult ARV clinic) "... do not want to talk to anybody ..."

One participant reported that her attitude towards her patients has changed. Some of the participants indicated that they exhibited aggression, impatience, and a raised tone of voice. The following are examples of the impact that working in ARV clinics have on nurses' psychological health:

Participant 1 (Adult ARV clinic) "...you start just having behavioural changes towards the people (patients) that say you want to help and care for ... when a person (patient) is crying, she (nurse) also start crying ..."

In an attempt to forget about work this participant revealed that she shut down when at home.

Participant 5 (Adult ARV clinic) "... I shut down... forget about work..."

Despite reports of caring for HIV positive patients feeling emotionally exhausted, the other side of the coin was also indicated.

Participant 2 (Ante-natal ARV clinic) "I'm happy what I am doing ... You know when they come here you can see that some of them they are sick and in three month time you can see that there is life and you can see that bearing emotionally and physically they are alive again ... I'm not telling lies I have never come across any of my HIV positive patient having an HIV positive baby, I'm not telling lies ... It makes me feel good that at least there is something that we are doing right."

Hence, some nurses in the ARV clinics do experience a sense of satisfaction; they are happy and feel that they are making a difference in the lives of their patients, especially pregnant women.

According to the participants, caring for patients who are HIV positive is emotionally costly and counselling is draining them because their patients have so many problems. Participants also felt despair due to the increase in HIV infection rate, and the fact that patients do not use condoms; they felt as if they were fighting a losing battle. Participants reported changes in their attitude towards their patients, being aggressive and impatient.

Participants' relationship with their family is also affected, they neglect their duties towards their families and they expressed desire not to be at work and feeling redundant. Some participants do report that they make a difference in their patients' lives that makes them have a sense of satisfaction that could act as a buffer against compassion fatigue.

Subcategory c: Spiritual presentation of compassion fatigue

Participants reported how nurses who work in ARV clinics may be spiritually affected that could be attributed to possible compassion fatigue. Participants expressed feelings of doubt, in whether it is one virus that present differently and in whether they have taken up the right profession.

Participant 4 (Paediatric ARV clinic) ..."Sometimes you doubt... is this one virus, presenting differently ..."

Participant 5 (Adult ARV clinic) ... "I think I took up the wrong profession..."

In the following quote one participant reported not wanting to work in the ARV clinic anymore and expressed a desire to go and work in another department; ...*Participant 1 (Adult ARV clinic) ..."don't want to work in that department any more... you want to change and go somewhere..."*

Nurses who work in ARV clinics present with signs and symptoms that could indicate that their spiritual well-being have been affected. Nurses have doubt that the HIV virus can cause so much damage and they also doubt whether they are in the right profession. Nurses also express that they want to change direction, not wanting to work in the ARV clinic anymore.

Subcategory d: Behavioural presentation of compassion fatigue

Participants in their responses described how their behaviour is affected from possible compassion fatigue. One participant described the behaviour of a person who might be suffering from compassion fatigue and show signs of tardiness.

Participant 6 (Adult ARV clinic) "...Doesn't care anymore ... You can see the way she dress, the jersey ... or maybe the hairstyle ... she did not comb (touching head) ..."

From participants' responses the researcher deduces that caring for patients who are HIV positive does affect their behaviour; they do not care anymore, and even their physical appearance is neglected.

Based on the responses from participants their physical, psychological, spiritual and behavioural well-being are affected and show signs of possible compassion fatigue.

THEME 3: STRATEGIES TO PREVENT AND MANAGE COMPASSION FATIGUE

For this theme two categories and six subcategories were identified and it will be presented in conjunction with representative quotes from the participants.

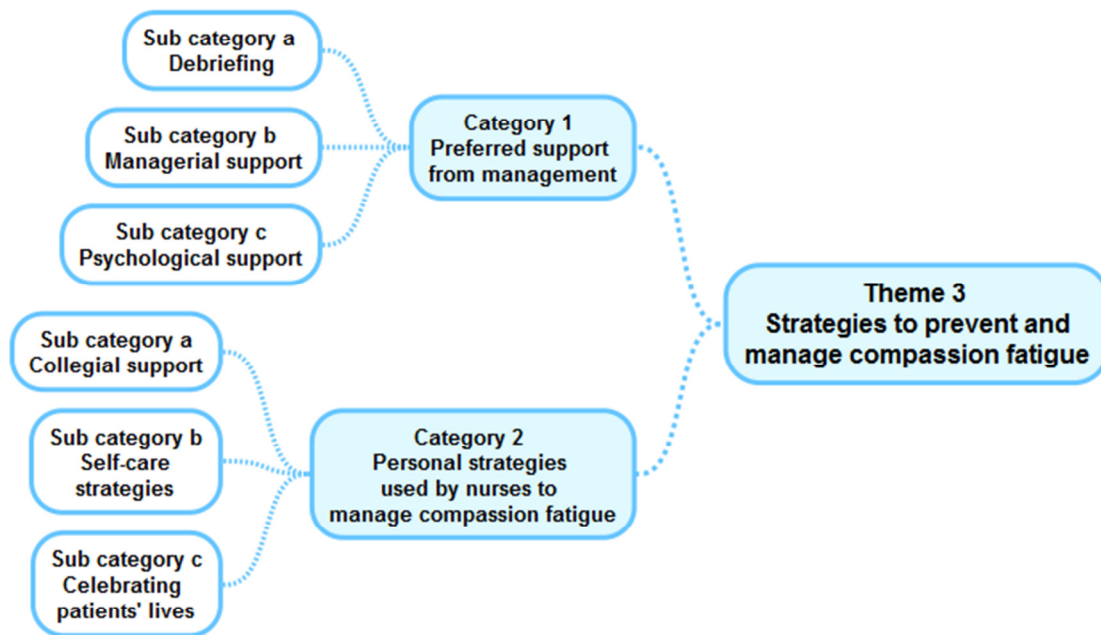


Figure 4.4 Theme 3 with categories and subcategories

4.3.3.1 Category 1: Preferred support form management

Participants vocalised the following types of preferred support form management that they thought will help them to cope better, namely: debriefing, managerial support, and psychological support. Following is a discussion of the subcategories comprising this category: Quotes are used to indicate the specific support they thought would improve the work environment in ARV clinics.

Subcategory a: Debriefing

In their responses, participants indicated that debriefing is a much needed strategy to assist them in coping with their situation in the ARV clinic. One participant felt that debriefing should be done by a social worker or psychologist giving nurses opportunity to talk about issues that affect them.

Participant 1 (Adult ARV clinic) "... debriefing ... by social worker or psychologist ... So that people can talk about their issues ..."

One participant revealed that counselling of patients is burdensome and felt that management should arrange regular debriefing sessions as it might assist in relieving their stressful situation.

Participant 4 (Paediatric ARV clinic) "... we are also being taken as counsellors... debriefing is important to us as staff ... Maybe they (management) can say that we see

that you are not doing well, what if we organise a debriefing but ... the intervals (between debriefing sessions) must not be too long ...”

Participants regarded debriefing very highly as a way to de-stress. They expressed a need to be debriefed by a social worker or psychologist and hoped that management could see the need for regular debriefing and organise such sessions.

Subcategory b: Managerial support

From participants' responses the researcher deduced that managerial support is lacking. Based on the fact that there is staff shortages in ARV clinics participants requested more staff to help them.

Participant 3 (Paediatric ARV clinic) “... from management, if we can get the support of them bringing more people to come and help us.”

In addition, participants requested that non-nursing duties such as writing of reports and statistics were also identified as a problem that could be rectified by management by employing more people.

Participant 6 (Adult ARV clinic) “... the more job is the clerical, writing in register and stats. Somebody else can do that ... (management to) employ more people”.

Healthcare workers who work in the field of HIV/AIDS depend on workshops and conferences to update their knowledge; however, participants indicated that they have not recently attended any workshops or conferences. Participants felt that all staff members should be given an opportunity to attend workshops and conferences in order to keep abreast with new developments in the HIV/AIDS field.

Participant 5 (Adult ARV clinic) “We don't attend workshops anymore, symposiums ... They (management) must make that everybody who is working here (ARV clinic) must benefit from those [workshops and symposiums] ...”

Based on one participant's response the researcher inferred that policies are not revised often enough to keep the nurses abreast of the changes in managing patients with HIV/AIDS. Policies that were implemented inconsistently were also perceived as problematic and contributing to patients experiencing problems in accessing ARV treatment. One participant also stated that there is a discrepancy between the treatment used in the public healthcare sector and the private healthcare sector, as the public healthcare sector is not using the latest available ARV drug regimen compared to the private healthcare sector and it causes problems when a patient is transferred from the

private healthcare sector to the public healthcare sector as these patients' treatment regime have to be changed.

Participant 5 (Adult ARV clinic) "... the health system is not 100% correct all the time ... usually when they set the policies they don't call people from the ground. So if the policy making people they can make a research before they draw up the policies, maybe they'll know that there are loop holes in the policies... so many things are happening, then they are still using those ARV's (anti-retroviral treatment) which started in 2004 and it's almost ten years with those... they [management] must revise the guidelines [HIV/AIDS] ... Constantly revising so that ... so that we are at par with Americans ... because most of their patients they are saying in America they are using this drug or that drug. Like now I have seen the patient from private, he is using the single drug ... he is taking one in the morning and one at night and if he is coming to join us he must drink all the three (drugs)."

Participants who work in the paediatric ARV clinic indicated the need for a pharmacy to dispense ARV treatment to children because currently the pharmacy is situated outside the clinic. There was also a request for more doctors and participants felt that if they get these resources it will make their life easier.

Participant 3 (Paediatric ARV clinic) ... If we can get more doctors ... if we can get a proper kid pharmacy, for kids on site [paediatric ARV clinic] ... it will make our lives easier."

Participants revealed that management support is needed to provide more staff, especially doctors for the paediatric ARV clinic and clerical staff to do non-nursing duties, providing these resources might be of value in preventing compassion fatigue. Participants reported a request for a pharmacy in the paediatric clinic. Participants expressed a need for recognition and debriefing facilities that will help them to cope in the ARV clinics. A request for revision of policies and consistency in implementation of policies was also reported by participants.

Subcategory c: Psychological support

Participants reported that nurses who work in ARV clinics depend a great deal on their colleagues as a support system. Talking about issues of concern to them seems to help them destress because advice can be provided on how to deal with issues.

One participant expressed a need for support from management; the participant indicated that she wanted recognition from management even if it was for small contributions.

Participant 7 (Ante-natal ARV clinic) "... small thing that would make you feel valued ... thing that would make you feel ... the support from our managers ... "

One participant indicated that she needed a psychologist to talk about problems nurses face in ARV clinics.

Participant 6 (Adult ARV clinic) "... if I have a problem and they give advice... We need more like psychologist."

One participant felt that support systems where nurses can talk about work-related issues that concern them are essential.

Participant 1 (Adult ARV clinic) "Support systems ... talk about their issues."

The support provided by the doctors is implicit in the quote "...even with our doctors, we have these meetings case discussion sessions..."

Participant 7 (Ante-natal ARV clinic) "... we discuss the cases, the challenges and it gives us strength."

While other participants value talking to a family member because it provides some kind of support that makes them feel better.

Participant 7 (Ante-natal ARV clinic) "... Talking to your family, it makes you feel better... usually I feel better... "

One participant who works in the paediatric ARV clinic reported that they do talk to their managers about the challenges they experience and that their managers do come up with solutions that decrease their stress levels.

Participant 4 (Paediatric ARV clinic) "We do brief our managers and they also come up with solutions that will help get rid of stress ..."

Participants reported that nurses' value support very much, talking to family members and support from doctors seems to relieve their stress. Participants also requested psychological support from management to recognise that they provide good services to their patients. Such recognition would make them feel valued.

4.3.3.2 Category 2: Personal strategies used by nurses to manage compassion fatigue

An analysis of the data revealed that participants who work in antiretroviral clinics experience stress on a daily basis while caring for their patients who are HIV positive and

collegial support, self-care strategies, and celebrating their patients' lives were identified as strategies to manage stress and compassion fatigue. Following is a discussion of the subcategories comprising this category. Quotes are used to indicate personal strategies used by nurses to manage compassion fatigue.

Subcategory a: Collegial support

The majority of the participants valued the collegial support; they usually talked to their colleagues during their tea break, giving advice to each other on how to deal with situations. This form of support helped to decrease nurses' stress levels and is implicit in the response:

Participant 7 (Ante-natal ARV clinic) *"...working with colleagues it helps because sometimes when you care for people and you feel there is something that disturbed you ... we discuss about it and that brings upon relief to you..."*

Participants reported that sharing their experiences brought relief and nurses realised that they are not alone, their colleagues have similar challenges.

Participant 2 (Ante-natal ARV clinic) *"I think also talking about it to your colleagues sometimes it relieves the stress. If you are having a bad day and you talk to one of your colleagues, it does help, you get some form of relief."*

Colleagues providing support towards each other during the death of a patients seems to also bring about relief. Participants reported that a weekend away would provide an opportunity to debrief and talk about their feelings.

Participant 3 (Paediatric ARV clinic) *"... after that week (when one of the children died) that we have difficulty, but we got time to speak in the tearoom ... talk about it with colleagues ... that's the way we de-stress... We were thinking ... a weekend away just as colleagues, to go and debrief and talk about our feelings."*

Participants reported that talking to colleagues about issues that affect them bring about relief. Talking about issues makes them feel that they are not alone.

Participant 7 (Ante-natal ARV clinic) *"Talking about it is relieving in a sense. Sometimes you meet with your colleagues and ... the challenges you had in the week ... will tell you how to cope ... and you'll feel that I'm not alone ... in suffering or experiencing. It makes you feel better in a way that you are not alone. It's like you thought your situation is only overwhelming to you when it's not only you, other people too are facing such, you know situations."*

One participant reported how the doctors with whom they worked in the ante-natal ARV clinic provide support to the nurses.

Participant 7 (Ante-natal ARV clinic) ... “Our doctors we meet weekly to discuss difficult cases... that gives me strength...”

Based on participants’ responses the researcher deduced that support from colleagues is highly valued. Nurses meet and talk informally in tearooms and discuss issues that concern them; this brings about relief, knowing that others face similar situations and they can share ideas. Doctors working in ante-natal ARV clinic provided support to nurses through weekly discussion of difficult patient cases.

Subcategory b: Self-care strategies

The responses from participants indicated that they are aware of the need to take care of themselves. The following quotes indicate the strategies used by the participants in taking care of them self: One participant reported using exercise as a way to de-stress:

Participant 4 (Paediatric ARV clinic) “try going to the gym ... that is de-stressing ...”

Believing in a higher being, prayer and going to church are strategies that nurses used to help giving meaning to their lives.

Participant 1 (Adult ARV clinic) “Prayer helps me a lot...I go to church on Sunday after experiencing all the stress during the week ...”

Reading the Bible and going to church brings about some relief to this participant.

Participant 6 (Adult ARV clinic) “I go home and I read the Bible ... I go to church ...”

One participant reported that prayer is the only thing that brings relief for her and that she also encouraged her patients to pray.

Participant 7 (Ante-natal ARV clinic) “... prayer is the only thing that relieves ... and I tell my patients to also pray ...”

It is important to participate in other activities outside of work as a way to disengage from work-related issues. Participants described how they break away from work when off duty, they watched television or spent time with friends. Engaging in these activities helped the nurses to feel better.

Participant 4 (Paediatric ARV clinic) “... watch television; try to forget about work, maybe chill with some friends.”

In their responses participants revealed that nurses do engage in self-care practices such as exercise, spending time with friends, colleagues and family members, and detaching from work when at home as a way to detach from work. Believing in a higher being, prayer and reading the Bible provided meaning to their lives and helped to relieve all the stress. Some participants also encouraged their patients to pray.

Participants described how they try to disengage from work when off duty by shutting down in order to forget about work or talking to somebody close. These activities helped the nurses to de-stress and make them feel better.

Participant 5 (Adult ARV clinic) "... I shut down... Forget about work..."

In the next quote a participant describes how she detach from work: *Participant 5 (Adult ARV clinic) "... I try to detach myself from work ... talk to somebody that maybe I am close to ... and that's how I de-stress*

Disengagement from patients' situations can be used as a strategy to prevent and manage compassion fatigue. In their responses, participants revealed that nurses detach themselves from work when off duty. They would forget about work by shutting down or talking to somebody that they feel close to.

Subcategory c: Celebrating the lives of their patients

The response below indicated that nurses use different strategies to disengage from work situations and thoughts of their patients. Some nurses would do something totally different and celebrate their patients' lives on days such as World AIDS day, and just networking with different people seemed to help them to de-stress.

Participant 1 (Adult ARV clinic) "... sometimes organising some things here in the clinic which we enjoy; like celebrating World AIDS day with our patients and having that moment of feeling okay. Just mingling with people and talking to people about how you feel at times."

Participation in World AIDS Day as a way to celebrate their patients' lives, networking with other people also brought some relief from stress.

4.4 Document analysis

To enhance the understanding of data gathered through interviews and to illuminate and contextualise the responses to the interview questions, the researcher examined the

Department of Public Works of South Africa's Wellness Programme and job descriptions of professional and enrolled nurses.

4.4.1 Job descriptions

The researcher obtained the job descriptions for professional (registered) and staff (enrolled) nurses, (Gauteng Department of Health 2007) developed in 2007, from the office of the nursing service management at the public tertiary level hospital (Appendices M and N). Examining the job description of professional and staff nurses, the researcher found that a generic job description is used by all public health institutions and job descriptions are not adapted for a specific discipline e.g. nurses who work in antiretroviral clinics have to use the generic job descriptions even if their role and function is so vast, details of their role and function are not captured in the job description. While working in an ARV clinic the researcher observed that nurses are delegated tasks on a daily basis according to a delegation list. The researcher also found that job descriptions are not given to nurses at appointment, but kept in the nursing service manager's cupboard. Therefore, the researcher could only gain access to nurses' job descriptions via nursing service managers. The researcher reviewed the job descriptions and will next discuss the job descriptions for the two categories of nurses.

The researcher found that the job description for both categories of nurses is generic and not specific to nurses who work in ARV clinics (Gauteng Department of Health 2007). Nurses have to adapt the nursing care plan/programme for patients who are HIV positive that will promote their health, promote self-care, treatment and rehabilitation. Hence, nurses should be aware of existing guidelines and policies and it should be made available to them in order to develop nursing care plans for their patients. Revision of guidelines and policies are very important. The researcher used the job descriptions to review in order to determine whether it contains any non-nursing duties that nurses are doing and how it affects their well-being. During review of the job descriptions the researcher found that many of the tasks that nurses who work in ARV clinics are responsible for, are not contained in the job description e.g. counselling of patients who are HIV positive (See Table 3.2). During the interviews the researcher also concluded that there were non-nursing duties such as compiling statistics that nurses are expected to carry out this take up a great deal of their time that they could have used to render patient care.

Professional nurses' job description:

The key performance areas of the professional nurses' job description (Gauteng Department of Health 2007, see Appendix M) comprise of the following: provide direction and supervision for the implementation of the nursing plan (clinical practice/quality patient care): implement standards, practices, criteria and indicators for quality nursing (quality of practice): practice nursing and health care; in accordance with the laws and regulations relevant to nursing and health care, maintain a constructive working relationship with nursing and other stakeholders; and utilize human, material and physical efficiently and effectively. The job description is generic and is also used by nurses who work in ARV clinics. Nurses have to adapt the nursing care plan/program for patients who are HIV positive that will promote their health, promote self-care, treatment and rehabilitation. Hence, guidelines and policies should be made available to nurses in order to develop nursing care plans for their patients. Revision of guidelines and policies are very important. However, participants reported loopholes in the policies and inconsistencies in the implementation of these policies, as stated in the following quote:

Participant 5 (Adult ARV clinic) "I become frustrated with the policy... the frustration to me is ... lack of consistency ... The policies are there ten or twenty years without being revised."

Participant 1 (Adult ARV clinic) "... in our clinic we are caring for the HIV positive patients because we counsel them, we give them medication. We are always monitoring them; those are the things that each and every nurse does wherever he/she is. We monitor them and see to it that you always talk to the patient, you are open to the patient so that if they are undergoing any form of strain, you are there, and you can be open and approachable, so that they can come to you and sit down and talk to you. There is such a lot in caring that one cannot stop or decide to do just a compartment of caring. Each and every person is an individual."

Participant 5 (Adult ARV clinic) "...With me when I come in the morning, you solve problems most of the time. They come with different problems, and then you solve the problem after you process the files and whatever and then there come doctors. Because doctors they have problems, so you're trying to solve the problems to the smooth running of the clinic. ... The wards have most of the problem because they don't do things right. They have just been diagnosed, then they must book for the clinic. Yah! (An interjection, meaning participant thought about what she just said and agrees with the statement). And then people are phoning from outside looking for help, information and whatever. Then you redirect those people."

Nurses who work in an adult ARV clinic are responsible for the running of the ARV clinic and are involved mostly in solving patients' problems and refer patients to another multidisciplinary team, such as social workers if they have social problems. Nurses also provide information on HIV/AIDS and ARV treatment to the public who have any queries, also does counselling on medication adherence and monitor blood results.

Participant 3 (Paediatric ARV clinic) "... they (children who are HIV positive) have been tested and they are coming to just check their CD4 (blood cell count) count, they are being seen by the doctor, then we do the counselling to prepare the mother because if they are not yet on ARV's (anti-retroviral treatment) we need to prepare them on when to start, so that's when we do counselling and with the mother. If there are any like minor ailments, like some of them they come and they are short of breath the doctor would just put them on oxygen and all of that but there are not so much of the critical cases."

One participant described the role and functions of nurses who work in paediatric ARV clinics; nurses do counselling on healthy living habits for children and mothers, they are also responsible to ensure that results for blood tests done be available and in the patients' file before consultation with the doctors and prepare patients for initiation of ARV treatment.

Participant 7 (Ante-natal ARV clinic) "...We are working with PMTCT (prevention of mother to child transmission of HIV) programme. It's counselling and doing assessments, which is getting information and physical examinations, doing all that you know preparing for those who need to start on ARV's (anti-retroviral treatment). Doing the baseline, bloods and all that goes with the assessment, and then, that is the first client. Then the on-going ones (follow-up cases) we still do the same; we check the baby, we check mom, we check the blood results; we check if she's taking treatment ok; we check if she's ready for those who haven't started; those are my daily activities. And when they have given birth we check the baby until mom is discharged."

Participants reported on the role and function of nurses who work in the ante-natal ARV clinic and stated that it is the nurses' duty to enrol the mother onto the PMTCT programme in order to care for pregnant women and unborn babies, preventing that the babies are born HIV positive. These nurses are doing physical examinations, counselling of pregnant women, drawing bloods, obtaining blood results, and preparing women for commencement of ARV treatment. In between visits adherence counselling is done to ensure patients are taking treatment. Nurses are also responsible for mothers and babies in the postnatal period.

Enrolled nurses' job description (In the job description referred to as staff nurses):

The key performance areas of the enrolled nurses' job description (Gauteng Department of Health 2007, see Appendix N) comprise of the following: development and implementation of basic patient care plans, provision of basic clinical nursing care, effective utilization of resources, maintenance of professional growth/ethical standards and self-development. Enrolled nurses function the under direct supervision of a professional nurse. This is also the case in ARV clinics.

Participant 6 (Adult ARV clinic) "... do vital signs, it depends because now we are two, other (enrolled nurse) do weights and other do blood pressure. Wait for the files and enter into register. Send other to the counsellor. Book new patients and do the stats after the clinic ... the more job is the clerical writing in register and stats. Somebody else can do that."

The participant gave a brief description of the duties of an enrolled nurse in the adult ARV clinic, and it basically include taking of vital signs, including weighing of patients and doing the daily statistic concerning patients who visited the clinic.

Nurses who work in antiretroviral clinics are faced with many challenges caring for patients who are HIV positive. Due to the nature of HIV disease, caring is very demanding and patients need more psychological care, frequent counselling and nurses are also hear and witness many patients dying. However, there are currently no standard operating procedures to provide guidance to nurses on counselling and provision of bereavement support to terminal ill patients.

The researcher concluded that because the job description for both categories of nurses is generic it is not tailored for nurses who work in ARV clinics and might, therefore, cause confusion around their roles and functions.

4.4.2 The Employee Health and Wellness Strategic Framework for Public Services

The researcher gained access via the following website: www.dpsa.org.za and reviewed the Employee Health and Wellness Strategic Framework for Public Services that was developed during 2006-2008 through an extensive consultative process by the Department Public Service and Administration, Republic of South Africa (See CD listed as Appendix Q). The key objectives of the Employee Health and Wellness Strategic Framework are to provide an integrated, needs-driven, participatory, and holistic approach to employee health and wellness in the public sector. The target audience is all public

servants in government departments and other government entities, as well as employee health and wellness line managers, and practitioners responsible for implementation of employee health and wellness programmes, top managers and political leadership.

The researcher found that a wellness programme does exist and was developed to improve the health and well-being of all categories of staff employed in the public sector and not just specifically for nurses. However, participants reported that there is no wellness programme available and they also indicated that debriefing facilities are lacking. This finding is in contradiction to the fact that the researcher found that a wellness programme does exist and was developed by The Department of Public Services and Administration in 2006-2008. The contradicting findings could be attributed to the fact that maybe nurses who work in ARV clinics are not aware of the existence of the wellness programme or, that the programme is not well implemented causing nurses in ARV clinics not to be aware of such a programme.

The health and wellness programme consists of the following sections that illustrate the key elements of the framework: the context, the strategic thrusts, principles, objectives, the legal framework, implementation plan, as well as monitoring and evaluation framework. The programme is based on an integrated approach and recognises the importance of linking individual health, safety and wellness, organisational wellness, environmental sustainability, quality management to productivity and improved service delivery. Priority areas for development of strategic mechanisms and interventions include: HIV/AIDS and TB management, health and productivity management, safety, health, environment, risk and quality management (SHERQ), and wellness management (Department Public Service and Administration, Republic of South Africa [DPSA] 2008:1-3).

During review of the document it became evident to the researcher that a framework for the health and wellness for public servants exists but implementation is lacking. The researcher will only highlight some of the gaps that occur in the functioning pillars of the in the implementation of strategies and interventions and will link it to participants' responses.

The following pillars of the health and wellness framework will be discussed next:

Building blocks of the functional pillar: Pillar 1: HIV and AIDS and TB management:

The framework recognise that HIV/AIDS and TB epidemics affect the lives of all South Africans and is a major cause of death and cover areas of prevention, treatment, care and

support, human and legal rights, access to justice and monitoring and evaluation (DPSA 2008:23-24). The researcher found that the framework guide for public service organisations in response to the HIV/AIDS and TB epidemic caring and support of the infected employees but that no interventions are implemented to ensure the safety of service providers in protecting their health and well-being, for example infection control. Following is a quote from one participant that feels uncared for because nurses are not screened for TB despite the fact that they are exposed to infectious TB cases:

Participant 5 (Adult ARV clinic ...I don't trust the health care system concerning myself... we are not looked after ... we are admitting patients with infectious TB ... we are supposed to be checked [screened] ... to see if we are exposed or not.

Pillar 4: Wellness management:

The framework recognises that individual wellness is the promotion of the physical, emotional, occupational, spiritual and intellectual wellness of an individual and includes identification of psycho-social health risks. Whereas organisational wellness promotes an organisational culture that is conducive to individuals' physical and psychosocial wellness or organisational wellness and work-life balance in order to enhance effective and efficient functioning of the public service (DPSA 2008:31). Activities for the above stated wellness management are included in the Generic Implementation Plan of the framework. However, the researcher deduced from participants' responses that the framework is not implemented in antiretroviral clinics in this specific public tertiary hospital and that compassion fatigue as such is not addressed under this functioning pillar. Following are quotes from participants illustrating that there is no system in place to ensure their well-being. Participants felt that management is not aware that working in ARV clinics has a negative effect on them. Participants also revealed that nurses who work in ARV clinic do not maintain a balance between work and their personal lives:

Participant 1 (Adult ARV clinic) "... Support systems like a person coming and sitting down and doing debriefing... a social worker or psychologist ... So that people can talk about their issues."

Participant 3 (Paediatric ARV clinic) "... I take my job home ... Some people know that I am a nurse and I work with HIV kids, I still have to counsel some of neighbours ... I get fatigued and burnout ..."

Participant 4 (Paediatric ARV clinic) "After running a heavy clinic ... so drained. I'm having a teenager now, whom I have to attend to ... you can't even check on the books and can't

even ask how are you doing? How is school? So it affects the family somehow ... most of the time you don't give much attention to your family due to tiredness and fatigue."

Participant 7 (Ante-natal ARV clinic) "... our managers ... they are maybe not aware but we are also affected ... we feel that we also do need debriefing sessions. There is no wellness programmes ... sometimes you even verbalise ... it was not a good day for me ... you feel exhausted and when you come home, I don't want to do anything. You don't feel like being with your kids, I don't want them to disturb me, I just want to rest."

Legal and Policy Framework: Under this section the political commitment to the health and the well-being of the nation is enshrined in the South African Constitution, Act 108 of 1996 and its Bill of Rights and is expressed as 'Everyone has the right- to an environment that is not harmful to their health and well-being'. However, participants in the study felt that their environment could compromise their health:

Participant 5 "... we are not looked after ... we are admitting patients with infectious TB ... we are supposed to be checked [screened] ... to see if we are exposed or not ..."

The researcher concluded that a wellness programme is available to everybody that are employed in the public sector but nurses who wo in ARV clinics are not aware of the existence of such a programme. The programme is not well advertised and lacks implementation. The programme does not specifically address compassion fatigue.

4.5 Summary of the findings of Phase One

Following is a brief summary of the findings of Phase One of the study: Based on the responses from participants the researcher concluded that the nurses in the different ARV clinics present with similar physical, psychological, spiritual and behavioural signs and symptoms that is suggestive of compassion fatigue. However, what became evident is that those nurses who work in the paediatric ARV clinic are severely affected having to witness their child patients suffer, these participants often over identified with their patients because they have children the same age. Participants who work in the paediatric ARV clinic stress levels increased when they observe that their child patients' mother become sick because they feared that the child would not have their mother to care for them. Nurses in the different ARV clinics are affected by the death of their patients and they do grief over the loss of patients. Participants in the ante-natal ARV clinic and adult clinic used to have memories of their patients and could not forget about them, even when at home. Some of these participants used to relive the events that led to the death of their

patients and would experience guilt feeling thinking that they did not do enough to prevent their patients' death. Majority of the participants complained of physical exhaustion which can be attributed to the high workload. Emotional exhaustion was also experienced, especially by the nurses in the adult and paediatric ARV clinics having to deal with the many problems their patients face. A sense of hopelessness was experienced by participants in the adult and ante-natal clinics due to their patients' negative behaviour, such as not using condoms, being promiscuous and defaulting treatment.

- Nurses who care for patients who are HIV positive are at risk of developing compassion fatigue. Risk factors are divided into work-related issues as well as the cost related to the nurse-patient relationship. Pertaining to the health care system the research findings revealed that policies and guidelines used in ARV clinics are outdated, implementation thereof is inconsistent and this cause frustration amongst nurses. Nurses have to care for an increasing large number of patients that need more care than other patients who attend out-patient departments. Accessing ARV treatment is still a problem, especially in rural areas where patients are missed and start treatment late or, they die before starting ARV treatment. The fact that patients had to wait for their CD4 count to drop below 200 μ /mmol (during the time of study) was also raised as a concern. Participants also reported that nurses being exposed to infectious TB are not screened for TB. Concerns were also reported regarding the long time it takes to diagnose TB, resulting in test results being released after patients have died. Lack of management support presented as non-availability of debriefing services resulted in nurses feeling let down by management. Reports from participants revealed that management is not aware that working in ARV clinics negatively affects nurses' well-being.
- Nurses who work in ARV clinics are faced with overwhelming workloads that are exasperated by the many social and emotional problems that patients have that demand nurses to spend more time with these patients having to counsel them. Participants reported that these patients also need more encouragement in order for them to continue adhering to their treatment regime. Caring for increasingly large numbers of patients and together with a shortage of doctors cause an increase in patients' waiting time, especially in paediatric ARV clinics.
- Caring for traumatised patients presented as patients not seeking help early, they wait until they are very sick with a low CD4 count. Participants reported that many patients have difficulty in accepting their HIV status due to the stigma and discrimination associated with HIV/AIDS. Patients still see a HIV diagnosis as a death sentence, some of them even contemplate suicide after diagnosis others believe they are bewitched. Participants reported that patients do not disclose their HIV status to family

or partners because some patients fear rejection, some still wants to have children. Participants felt that non-disclosure cause the HIV virus to spread. Participants reported being involved more emotionally when children are involved; they become concerned when the mother of their child patients becomes sick because the child would grow up without a mother. Nurses are also concerned regarding children's reaction when they find out that their mother has died from HIV/AIDS. Giving a HIV positive diagnosis is very traumatic for nurses; they hurt and experience feelings of sadness.

- Nurses are exposed to the death of their patients and are left feeling sad. One participant reported experiencing guilt feelings following the death of a patient and thought that, if things where done differently the patient might still be alive. Nurses sympathise and support family members who mourn the loss of their loved ones. Some nurses do attend patients' funeral services when they are aware of their passing. Some participants reported having lost a family member to HIV/AIDS. From the responses the researcher deduced that nurses do grieve over the death of their patients. However, one participant indicated that she cannot grief for too long because other patients are waiting for her.
- Based on participants' responses the researcher concluded that nurses are vicariously exposed to traumatic experiences of patients that presents as being pre-occupied with patients, not being able to stop thinking about patients when at home. Some participants reported that the media would trigger memories about patients and that some nurses even relive events that led to the death of their patients. Participants reported that nurse experience a sense of hopelessness because of the many people that are infected with HIV who need care and patients not using condoms, knowing that they can infect others.
- Working in antiretroviral clinics has a negative influence on nurses' personal lives as well as that of their families. Nurses feel uncared for because they have to develop their own coping skills. Participants reported that working in ARV clinics cause them to neglect their family needs because they are too exhausted when getting home. One participant reported that counselling her neighbours during her off duty time caused her to feel exhausted and burnt-out.
- Manifestation of compassion fatigue was presented as affecting nurses' physical, psychological and spiritual well-being as well as their behaviour. The most common signs and symptoms reported that could be attributed to compassion fatigue were physical and emotional exhaustion, a sense of hopelessness, guilt, tearfulness, bad attitude, aggressive behaviour, over-identification and intrusive images of traumatic events. Some participants also reported having a passion for the work they are doing,

some reported feeling happy and experience compassion satisfaction because they are making a difference to their patients' lives.

- Participants identified coping strategies to help prevent and manage compassion fatigue. Debriefing was their priority followed by self-care strategies and ways to celebrate their patients' lives. The different self-care strategies used by nurses include physical exercise, meeting with friends or just chatting and praying. Collegial support was also valued and was used to talk about work-related issues, seeking advice and case discussion meeting where difficult patients were discussed, doctors provided mentoring. On World AIDS Day nurses celebrate their patients' lives and this helped them to cope working in ARV clinics.
- Participants indicated the support that they would prefer in the work place and include debriefing, managerial support and psychological support. These support systems will help to prevent and manage compassion fatigue amongst nurses who work in ARV clinics. Debriefing that will provide nurse the opportunity to talk about work-related issues in a safe environment was reported to be important. Participants felt management should be involved in organising debriefing sessions.
- Managerial support was also regarded as important to help nurses cope in ARV clinics. It was reported that management should provide opportunities for workshops, and attending symposiums so nurses could up-date their knowledge on HIV/AIDS. Participants also requested management support to employ more staff and to open a pharmacy for children in the paediatric ARV clinic. Participants also requested that the public sector should stay up to date with recent developments in ARV drugs so that new drugs could be made available to patients.
- Participants also expressed a need for psychological support that will provide opportunities to talk about issues of concern to nurses; some participants would like a psychologist to provide psychological support. Some participants expressed a need to feel valued by managers through regular feedback on their performance.
- Pertaining to nurses' job description, the researcher found that both the professional and enrolled nurses' job description is generic and does not spell out their role and function within antiretroviral clinics.
- The Employee Health and Wellness Strategic Framework for Public Services main purpose is to ensure the health and safety of all employees. However, the implementation of the health and wellness programme is lacking, as was evident in responses from participants that there is no wellness programme in ARV clinics that provide the necessary support and the wellness programme does not specifically address compassion fatigue.

- The researcher developed the wellness programme using the themes and categories that were identified during data analysis of Phase one of the study. Interventions were identified and a number of actions for each of the interventions were identified based the findings of Phase one of the study, on previous research and related literature. The steps followed to develop the wellness programme will be discussed in chapter six.

4.6 Conceptual framework

The conceptual framework was developed to provide a framework that describes compassion fatigue amongst nurses who work in ARV clinics. The conceptual framework is based on the findings of Phase one of the study. Nurses who work in the adult, ante-natal and paediatric ARV clinics are faced with many challenges related to the health care system. Lack of debriefing facilities and management support are exacerbated by having to care for one-self can trigger the development of compassion fatigue.

Caring empathetically for patients who are HIV positive comes at a cost. These patients are usually very sick and traumatized and because nurses often know of a family member or friend who are HIV positive or in some cases patients are the same ages as their children and this cause nurses to over-identify with patients leading to pre-occupation. Other factors that makes caring for patients who are HIV positive costly are the fact that they have to care for increasing numbers of patients and being exposed to many deaths within a short period of time. Risk factors for developing compassion fatigue include the intensive demanding type of care that is required by patients who are HIV positive. Nurses' care empathetically for their patients and are exposed, in the process, to their patients' traumatic experiences. Being empathetic and exposed to patients' trauma and pain is the key to them developing compassion fatigue. The fact that the HIV/AIDS epidemic is growing and that there is no cure for HIV/AIDS; the negative behaviour of their patients causes nurses to experience a sense of hopelessness because they feel that they are not making a difference to the lives of their patients. Nurses are also affected by the HIV/AIDS epidemic and experience a sense of loss due to the epidemic that increases their risk to develop compassion fatigue.

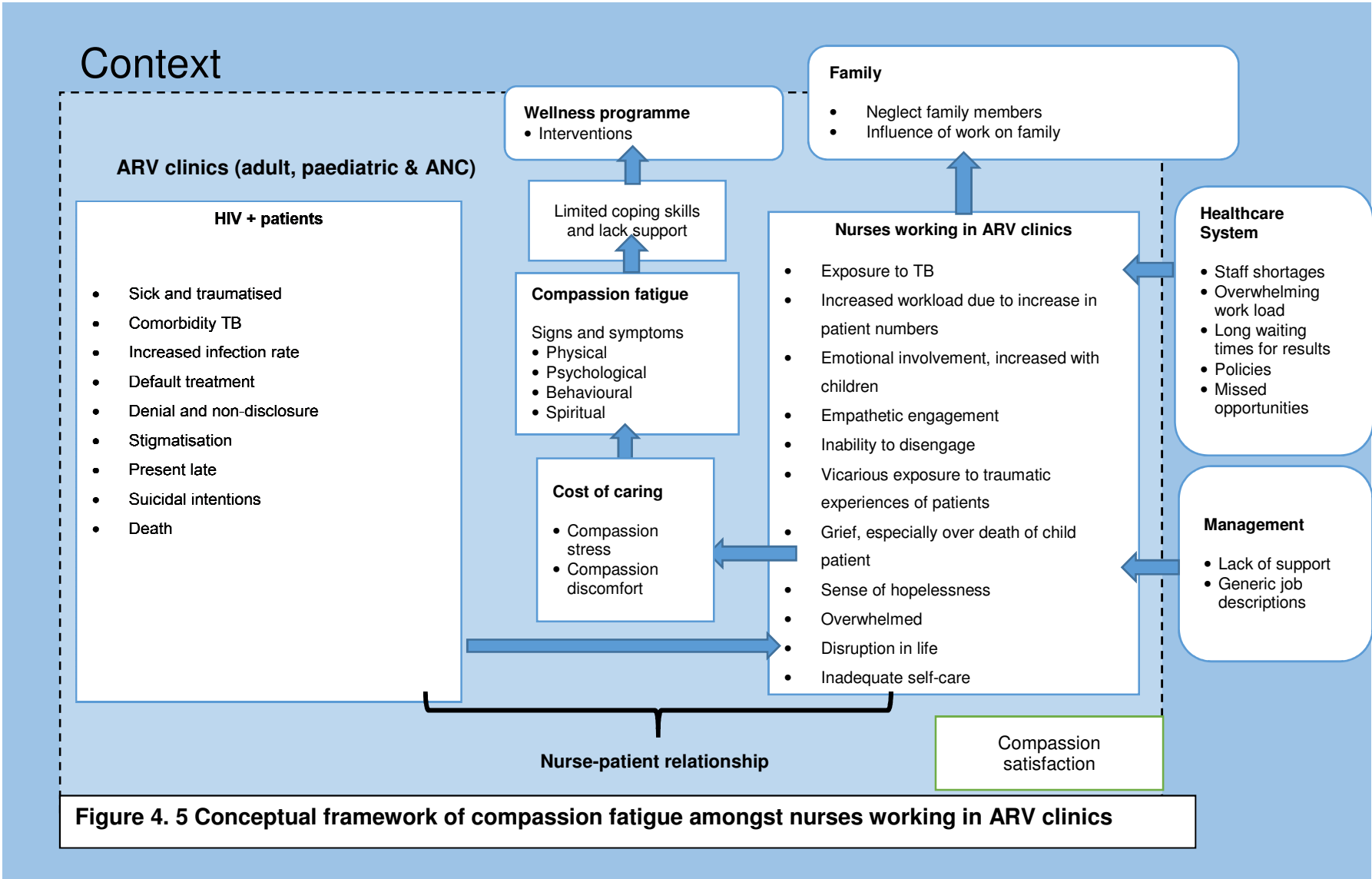
There is a cost to caring for patients who are HIV positive causing nurses' personal lives as well as their families being negatively affected. Compassion fatigue manifests from a state of compassion discomfort to compassion stress. If the compassion stress is not relieved nurses may develop physical, psychological, spiritual signs and symptoms. Their

behaviour is also negatively affected. The fact that nurses lack management support and have to develop their own coping skills, nurses' risk to develop compassion fatigue is increased. Compassion fatigue can be prevented and managed. Nurses use collegial support and celebration of the lives of their patients as coping strategies to prevent and manage compassion fatigue. Practicing self-care was also reported as an important factor in preventing compassion fatigue. Participants also indicated their preferred support that include debriefing, management support and psychological support to help them to cope better in ARV clinics. Experiencing compassion satisfaction can also act as a buffer against compassion fatigue. Wellness programme interventions with a rationale and actions were developed to identify, prevent and manage compassion fatigue.

Figure 4.5 indicates the conceptual framework of compassion fatigue amongst nurses who work in ARV clinics.

4.7 Summary

In this chapter the researcher presented the qualitative data that was analysed, and the findings of the study as well as the conceptual framework of compassion fatigue amongst nurses who work in different ARV clinics in a public tertiary hospital. A discussion of the findings will be presented in chapter five.



CHAPTER FIVE

DISCUSSION OF FINDINGS

Phase one of the study focused on compassion fatigue amongst nurses who work in the different ARV clinics in a public tertiary hospital. The major themes that were identified during the individual interviews were: 1) Risk of developing compassion fatigue; 2) Manifestation of compassion fatigue; and 3) Strategies to prevent and manage compassion fatigue. Categories (*italic*) and subcategories were identified under each theme. The subcategories (**bold and italic**) will be discussed at hand of the literature codes.

5.1 Theme 1: Risk of developing compassion fatigue

In this theme, work-related issues and the cost of the relationship between the nurses and patients in the ARV clinics were identified (See Figure 4.1 Themes, categories and subcategories).

Category 1 Work environment related issues

For this category three subcategories were identified, namely challenges created by the health care system, lack of management support and the overwhelming work load that nurses are facing.

A number of ***challenges were identified that are created by the health care system*** that nurses who work in ARV clinics are facing. System failure that prevent healthcare professionals from providing care to their patients cause healthcare professionals to feel helpless and hopeless and increase their vulnerability to compassion fatigue (Killian 2008:39). In order to implement the ARV treatment programme, policies and guidelines had to be developed. However, policies and guidelines are inadequately implemented and poorly understood or seen as an arbitrarily exercise at facility level (de Wet and du Plooy 2012:35). Hence, nurses tend to neglect the rules and regulations as stipulated in the National Policies on HIV/AIDS (Tshililo and Davhana-Maselesele 2009:142). In the present study it was found that the policies and guidelines used in the ARV clinics lack consistency, has loopholes and cause frustration amongst nurses who work in these clinics. Venter (2012/2013:38-39) indicates that because each province has autonomy regarding implementation of the ARV treatment roll-out programme it caused policies and guidelines to be interpreted differently. The fact that these policies and guidelines are

continually being changed exacerbates the situation and cause delay in initiation of ARV treatment, and in some cases patients never start their ARV treatment. The loopholes in these policies and guidelines may also lead to discriminatory behaviour by healthcare professionals towards their patients (Nyblade, Stangl, Weiss and Ashburn 2009:6). Schneider and Stein (2001:723) states that policies used in ARV programme are poorly implemented and this could lead to confusion with regard to implementation of such policies.

Some participants reported that the prevention strategies are not working because more people are becoming infected with HIV and there is no cure yet for HIV. Venter (2012/2013:38) argues that the HIV infection rate is increasing and it lead to caregivers such as nurses to feel hopeless because they cannot stop the spread of the disease since there is still no cure for HIV/AIDS. The fact that the number of patients infected with HIV is increasing cause nurses to feel that they would not be able to cope with the health care needs and demands of those suffering from HIV/AIDS. Feelings of hopelessness are common amongst nurses who care for HIV positive patients (van Dyk 2012:408; de Villiers and Ndou 2008:613).

The fact that the number of patients that need medical care for their HIV/AIDS continue to increase lead to difficulties in accessing ARV clinics, especially in rural areas. In the current study participants reported that patients who live in rural areas still have problems accessing ARV treatment. Mulaudzi, Pengpid and Peltzer (2011:26) also found that patients in rural areas experience problems accessing ARV treatment due to inequitable allocation of public resources and weak infrastructure. In addition, Abdullah (2005:261) indicated that poorly understood policies cause barriers to access health care. Participants also reported that some patients are missed by the health care system resulting in them never being tested for HIV and those patients who do test positive for HIV die before initiation of ARV treatment. Abdullah (2005:261) shares in the sentiment of the participants and states that patients are missed because they are tested for HIV at primary health care clinics and then referred to hospitals for initiation of ARV treatment. The fact that the antiretroviral programme is not wholly integrated into the rest of the primary health care services could also be the reason why patients are missed (de Wet and du Plooy 2012:34; Tshililo and Davhana-Maselesele 2009:142). A major reason for patients in rural areas to have difficulty in accessing ARV treatment is because health care facilities lack infrastructure and/or institutional capacity to care for HIV positive people. Hence, ARV treatment is not initiated on time resulting in patients dying before initiation of this life saving treatment and this cause to nurses feeling let down and

disillusioned with government (Venter 2012/2013:34; 39; Uebel, Timmerman, Ingle, van Rensburg and Mollentze 2010:590; Stein, Lewin and Fairall 2007:960).

Throughout the interviews the nurses voiced various fears and feelings they experience in caring for their patients in the ARV clinics. Some participants were especially concerned about being exposed to patients with undiagnosed TB and the possibility of them being infected with TB. Smart (2009:5) concluded that many nurses are concerned about workplace safety and fear of contracting TB due to lack of availability of protective clothing to protect them from contracting TB as well as lack of screening services for health care workers (van Dyk 2008:414; Evian 2008:313). Bock, Jensen, Miller and Nardell (2007:S109-S110) argue that patients with undiagnosed, untreated and potential contagious TB are also treated in HIV setting and nurses concerns of being infected with TB is valid because they spend many hours in close proximity with patients who suffer from infectious TB in confined spaces in busy health care facilities (Motseki 2016:20; van der Walt 2012:9-10; Vawda and Variawa 2012:489). According to Bam and Naidoo (2014:14) HIV/AIDS and TB is almost synonymous and caring for patients with HIV/AIDS who are co-infected with TB increase the challenges faced by nurses. According to Figley (2002) fear is a symptom of compassion fatigue.

In the current study the researcher found that the participants feared being infected with TB make them vulnerable to compassion fatigue. The fear was caused by nurses not undergoing any screening test for TB while they are knowingly exposed to patients with undiagnosed TB. Despite the fact that nurses are exposed to patients with infectious TB they are never screened for any symptoms of TB. Tudor et al. (cited in Tudor, van der Walt, Margot, Dorman, Pan, Yenokyan et al. 2014:6) argue that the uptake of routine TB screening amongst healthcare workers is low. In order to protect healthcare professionals from contracting TB from their patients, routine TB screening should be done to all healthcare professionals to identify TB early so that anti-tuberculosis treatment can be commenced (Uebel, Nash and Avalos 2007:503; Hall n.d.:6). Therefore, implementing infection control measures is important in order to prevent more people becoming infected with TB (Venter 2012/2013:38-39; van der Walt 2012:10).

Another participant reported that tuberculosis is diagnosed so late in patients who are HIV positive that by the time the results are released the patients have died. De Wet and du Plooy (2012:34) acknowledge that TB is diagnosed late in patients who are HIV positive because of their weak immune system and the lack of diagnostic tests for TB. Often the tuberculosis smear test results will come back negative, whereas patients do have

tuberculosis. Being diagnosed late also results in some patients dying from undiagnosed TB. Wong et al. (2012:4:5; 10) in a study done on death amongst HIV positive individuals, concluded that in Sub-Saharan Africa TB is the major killer of these patients especially during the first three months of ARV treatment commencement.

Having to face many challenges necessitate the support from managers. However participants in the study reported that ***managerial support in the ARV clinics is lacking***. Ramathuba and Davhana-Maselesele (2013:12) argue that management support in the public sector is lacking and this cause nurses to believe that they are not capable to provide quality of care (Hall 2004:34). Another study done by Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissilak, van der Kwaak and van der Wilt et al. (2007:143) in Zambia revealed that nurses who work in ARV clinics had difficulty in coping and even though managerial support was considered important it was lacking. Many authors argue that lack of management support cause an increase in nurses' stress levels and makes them vulnerable to compassion fatigue (Enerholm and Fagrell 2012:12; Goga and Thomson 2012:15; Rodriguez-Cortes 2012:14; Haber, Roby and High-George 2011:546; Uebel, Timmerman, Ingle, van Rensburg and Mollentze 2010:589). Li, Lin, Wu, Wu, Rotheram-Borus, Detels et al. (2007:262) in a study done in China found that institutional support is central to reduce the negative effects that working in the HIV/AIDS field has on healthcare professionals because managerial support promotes a positive psychological state and can help to prevent compassion fatigue. Bam and Naidoo (2014:14) argue that nurses who work in the HIV field need management support and that it is managements' duty to provide nurses with the necessary equipment, resources and support that would enable them to do their work. The absence of managerial support as well as support from social workers or psychologists for counselling, cause nurses to not be able to deal with the burden of caring for patients who are HIV positive and have a negative impact on nurses' emotional well-being.

In the current study, participants indicated that they do not have any support services or wellness programmes that provide debriefing and this cause them to feel uncared for. De Wet and du Plooy (2012:40) had similar findings in a study done amongst nurses who work in the HIV/AIDS field, nurses felt not cared for by management due to lack of institutional support. In another study done in Limpopo by Mametja (2013:62; 66) the author found that counselling and support services for staff were lacking causing them not being able to cope working in the HIV/AIDS field. Additionally, in a study on care giving in Kenya, Kangethe (2009:119) found that lack of debriefing facilities makes coping in the HIV field difficult for health care workers. Lack of counselling services may result in

negative emotions amongst healthcare professionals that can trigger compassion fatigue. They feel uneasy and cannot cope, resulting in them leaving the profession (Gilbert 2009 cited in Crawford, Gilbert, Gilbert, Gale and Harvey 2013:2; Goga and Thomson 2012:15; Knobloch Coetzee and Klopper 2010:239).

Participants in this study also reported that their managers are not aware that working in the ARV clinic affects nurses negatively and that they therefore need debriefing. According to van Dyk (2012:429) the health care system have failed nurses managers do not consider the stress that nurses' experience when working in ARV clinics and few realise that these nurses need interventions, such as debriefing services. Puig, Baggs, Mixon, Park, Kim, and Lee (2012:106) argue that managers should be aware of nurses' vulnerability to stress and compassion fatigue. However, it appears that the health profession is more concerned about the nurse-patient relationship with little attention being paid to the impact of HIV/AIDS on the caregivers' well-being (Ramathuba and Davhana-Maselesele 2013:7). Johnson (2015:36) states that globally there is a lack of recognition for the frequent negative consequences and emotional trauma, as well as sadness that nurses experience in their work. Therefore, it is important that the negative consequences of compassion fatigue should be brought under managements' attention so that awareness can be raised in an attempt to maintain nurses' caring relationships and positive attitudes (Hunsaker, Chen, Maughan and Heaston 2015:187).

According to Figley's (2002) Etiological Model for Compassion Fatigue, the author exemplifies how healthcare practitioners who care empathetically for sick and traumatised patients in difficult and challenging circumstances can become vulnerable to compassion fatigue. Malatjie (2010:25) argues that work-related stressors seem to be the main source of stress for health care workers who work in the HIV/AIDS field and if compassion stress is allowed to build up will lead to compassion fatigue (Loolo 2016:29-30; Figley 2002:1437). Healthcare professionals may not be adequately equipped to manage the high demands from caring for patients who are HIV positive and it is exacerbated by lack of managerial support. Being exposed frequently to patients' traumatic events make them vulnerable to compassion fatigue and affect their coping ability negatively (Kulesa 2014:26; Haber, Roby and High-George 2011:546; Stein, Lewin and Fairall 2007:959).

The increase in number of patients who are HIV positive cause more patients to seek health care and this cause nurses' **work load to be overwhelming**. People get overwhelmed when their coping skills are not sufficient to deal with their stressors and being overwhelmed may result in physical health problems, stress, and anxiety

(GoodTherapy.org 2013:1). Working in such a stressful environment contributes to the development of compassion fatigue (Mathieu 2007:3). Other symptoms of being overwhelmed include extreme sadness, anxiety, fear persistent anger, inability to decipher own thoughts from reality as well as short periods of depression (Berman and Snyder 2012:1083). Another issue related to the demand for nursing care is concluded from participants' reports that their patients have many problems that require more intense counselling resulting in them spending more time with patients who are HIV positive than with other patients. The nurses indicated that they feel exhausted and drained because they continuously have to encourage their patients to continue taking their ARV treatment. Author Bennett (cited in Visintini, Campanini, Fossati, Bagnato, Novella and Maffei 1996:184) state that due to the traumatic nature of HIV/AIDS, these patients need more emotional support that includes lengthy counselling sessions for HIV (HCT) testing. Having to deal with large numbers of acutely ill patients, working overtime and high workload (van den Berg et al. 2006:4), dealing with complex patients situations (Shaba and Rabenschlag 2007:140); caring for children whose parents succumbed to HIV/AIDS (Tshililo and Davhana-Maselesels 2009:140), and having to complete numerous paperwork (Rapp 2012:73) cause nurses to feel overwhelmed because of their heavy workload. Bam and Naidoo (2014:14) argue that caring for patients who are HIV positive is demanding and cause nurses to feel overwhelmed because they feel ill prepared for the increase in responsibility, and this affect their coping ability negatively resulting in poor quality of care (Mason, Leslie, Lyons, Walke and Griffin 2014:217; Kangethe 2009:118; Benoit, Veach and LeRoy 2007:309). Smith (2007:195) states that in an attempt to assist their patients, nurses may become worn down and experience emotional exhaustion. Consequently their self-care strategies fail them causing them to become vulnerable to the negative consequences of caring too much thereby increasing their risk to develop compassion fatigue (Aycock and Boyle 2009:184).

Participants who work in the paediatric ARV clinic reported a shortage of doctors that lead to an increase in waiting time because patients have to wait to be seen by a doctor. Mahomed and Bachmann (1998 cited in Atnafu, Mariam, Wong, Awoke and Wondimeneh 2015:1) state that shortage of staff in ARV clinics is the cause of long patient waiting time, which in turn can cause poor adherence to medication, missed appointments and low staff morale (Sastry, Long, de Sa Salie, Topp, Sanghvi et al. 2015:1). Maphosa (2016:32) argues that in South Africa a serious shortage of nurses and skilled doctors is experienced and this cause a slow uptake of the ARV programme, especially for children (Georgeu, Colvin, Lewin, Fairall, Bachmann, Uebel et al. 2012:1). Li et al. (2007:262) recommend that strategies are needed to attract, train and retain health care workers. The

need to recruit more health care workers will help to meet the challenges posed by the HIV/AIDS epidemic and will ensure a stable work force that will provide continuity of care for patients (Delobelle, Rawlinson, Ntuli, Malatsi, Decock, and Depoorter 2009:1067; De Villiers and Ndou 2008:12).

Participants reported feeling emotionally tired due to their workload. Tawfik and Kinoti (2006:10) concur with the findings of the study that the HIV/AIDS epidemic has increased the workload of health care workers because more people need HIV care causing nurses to feel overwhelmed. Feeling overwhelmed increase health care workers' vulnerability to develop compassion fatigue (van Dyk 2012:408; Harrowing 2011:4; Smart 2009:2; Creamer and Liddle 2005:94). Berg and Nilsson (2015:10-11) in a study done on nurses' experiences relating to caring for patients who are HIV positive, the authors found that nurses do experience stress and frustration due to the high workload. According to the South African National AIDS Council Trust's (SANAT) annual report (2014/2015), South Africa has the largest ARV programme in the world that provides ARV treatment to an estimated 3.1 million adults and children (SANAT 2014/2015:8).

The researcher came to the conclusion that nurses working in ARV clinics are caught up in an environment and situations that hinder their ability to experience caring connections with their patients and due to their heavy workload, they lack time and energy. Working in ARV clinics demands that nurses give more of themselves that result in them becoming indifferent or overly involved resulting in them feeling overwhelmed (van Dyk 2012:408; Aycok and Boyle 2009:184). Smith (2007:195) states that nurses are emotionally exhausted and as a way of coping they disconnect and avoid their patients because they do not have the energy to deal with their patients' trauma. Thus, the caring relationship as ascribed by Watson's Caring Theory (1988) between nurses and their patients are negatively influenced, resulting in healthcare professionals, such as nurses disengaging from the relationship (Figley 2002:1437). According to Figley and Barnes (2005:380) feeling trapped, on edge and exhausted may result in emotional and physical devastation, and emotional exhaustion may lead to psychosomatic illnesses, such as compassion fatigue (Janssen, Peeters, de Jonge, Houkes, and Tummers 2004:413).

In order for nurses to overcome the negative effects of working in ARV clinics the researcher recommends that nurses should maintain a balance between work and home life. Organisations should foster an environment that is supportive of work/life balance by appointing a person to run the wellness programme focussing on encouraging nurses to maintain a balance in their life and to include breaks for meals in their days, physical

activities or rest. Nurses should also be encouraged to balance work and home life, and balance demanding work with less challenging work (Pearlman and McKay 2008:27). Nurse should take time off to just relax or spend time with family and friends for spiritual renewal and personal development that reduces risk to develop compassion fatigue (Best Start Resource Centre 2012:22; Pearlman and McKay 2008:27). Other strategies to relieve work stress and thus compassion fatigue include monitoring nurses work schedule and discourage nurses from working overtime in order to reduce exposure to traumatic stressors (Emanuel, Ferris, von Gunten and Von Roenn 2011:8).

Category 2 Cost of nurse-patient relationship

The cost in caring for patients attending the ARV clinics was also described by the nurses. They focused in particular on caring for traumatised patients, them being exposed vicariously to the traumatic experiences of their patients, and the influence that these traumatic events have on their personal lives and their families.

From the participants' responses the researcher deduced that ***caring for traumatised patients*** affects the well-being of nurses negatively. Participants also reported that patients only *seek* help when they are very sick or when they have developed many other medical problems. Tshililo and Davhana-Maselele (2009:140) concur with the findings of the study and state that when patients eventually come to the clinic they are very sick, almost dying and they require more aggressive treatment to get them well again. Participants also reported that some patients present to the ARV clinic with a low CD4 count either because they are in denial of their HIV status or due to the stigma associated with HIV/AIDS. Jameson (2010:5) share in the sentiment of the participants and argue that patients are in denial because of the stigma associated with the HIV disease causing them to enter the health care system when the HIV infection has progressed to AIDS with a very low CD4 count almost beyond the point of optimal drug intervention (Marshall, De Brouwere and Kegels 2013:300; Oyeyemi, Oyeyemi and Belloe 2006:197). Bidwell (2014:3) argues that patients who have to come to terms with their HIV positive diagnosis will experience a range of emotions, including fear, shock, disbelief, sadness and depression. Thus, internal stigma may lead to unwillingness to seek help and access resources (Greeff and Phetlhu 2007:4). When HIV infection has progressed to AIDS it requires more aggressive treatment to get patients well and this increases healthcare worker stress levels as well as the mortality rate of patients (Jameson 2010:5). Stavropoulou, Stroubouki, Lionaki, Lionaki, Bakkogiorga and Zidianakis (n.d.:4) state that HIV-related stigma and discrimination are recognised as key barriers for delivering of

quality care to HIV positive individuals and is a source of caregivers' stress (Ramathuba and Davhana-Maselesele 2013:7).

Participants reported that some patients are in denial and does not want to accept their HIV positive status and this result in patients exhibiting negative behaviour. These behaviour include not using condoms, not disclosing their HIV status to friends and families due to fear of discrimination and stigma associated with HIV/AIDS. Booysen, Erasmus and van Zyl (2013:219-220) state that denial is probably the most common defence mechanism used by patients who are HIV positive because they cannot accept the truth about their diagnosis and this cause them to behave negatively blaming others for their condition, experiencing anger, despair helplessness and frustration. Participants also felt that they are fighting a losing battle because patients are having multiple sexual partners and are not using condoms. Concurring with this finding, Tshililo and Davhana-Maselesele (2009:450) found that because patients are in denial they engage in destructive behaviour and consequently engage in unprotected sex (WHO 2005:10). Amuyunzu-Nyamongo et al. (2005 cited in Kouyoumdjan, Findley, Schwandt and Calzavara 2013:12) found in a study done in Kenya that HIV positive people do not use condoms because they are unable to negotiate usage of condoms out of fear of intimate partner violence. Women feared that discussing condom use with partners will reveal their HIV status or imply that they are unfaithful to their partners (Esplen 2007:15).

Despite the fact that adherence to ARV treatment is important, participants in the study reported that some patients do not adhere to and default on their treatment, because they get tired of taking their treatment or fear taking treatment due to the stigma and discrimination associated with HIV/AIDS. Haber, Roby and High-George (2011:546) argue that patients do not adhere to their ARV treatment because they cannot take their treatment in front of others due to fear of discrimination (Smillie, Van Borek, Pick, Maan, Friesen, Graham et al. 2014:619; Conradie, Wilson, Basson, de Oliviera, Hunt, Joe et al. 2012:165). Not adhering to ARV treatment can result in disease progression, and nurses stress because of the danger of patients developing drug resistance that require a change in the regimen and often there is no other treatment available resulting in nurses feeling hopeless having to witness how their patients die due to treatment failure (Agwu and Fairlee 2013:2; Bingham 2006:450).

From the current research findings the researcher concluded that female patients do not disclose their HIV status to family or friends because they fear rejection (DeGrezia and Scrandis 2015:156). In Thailand, children who are HIV positive are often discriminated

against and rejected by schools because teachers and communities are misinformed about HIV/AIDS (Wattradul and Sriyaporn 2014:228). According to De Villiers and Ndou (2008:6), South Africans are not legally compelled to disclose their HIV status and nurses are ethically bound to keep their patients status confidential. The confidentiality around HIV/AIDS causes health care workers to face many ethical dilemmas due to the secrecy that surrounds the disease (Hall n.d.:2; 5). However, not disclosing their HIV status to family members result in an added burden on caregivers because they are unable to pass knowledge or care skills to other members of the family (Makoe, Greeff, Phetlhu, Uys, Naidoo, Kohi et al. 2008:144). Thus, caregivers are forced to bear the responsibilities of caring alone for patients who are HIV positive, causing an increase in their stress levels (Graaf 2011:26). Participants revealed that some female patients do not disclose their HIV status to their partners because they still want to have babies. Samuelsen, Norgaard and Ostergaard (2012:67) had similar findings in another study that women who are HIV positive engage in un-protective sex because they still have a wish to establish a family.

Despite the advantages of doing a HIV test on pregnant women and their unborn babies, participants in the study reported that some pregnant women refuse to test due to the stigma associated with HIV/AIDS. Thus, they cannot enrol in the PMTCT programme and the risk of their babies being born HIV positive increase. Turan, Bukusi, Onono, Holzemer, Miller and Cohen (2011:1111-1112; 117) had similar findings in a study done on stigma in Kenya, in which pregnant women refuse to test for HIV because they fear to be stigmatised; often women are blamed for bringing the virus into the house. In South Africa, HIV testing is included in ante-natal care and pregnant women who seek ante-natal care are offered a HIV test and they can chose to have it or they can refuse. According Schuklenk and Kleinsmidt (2007:1179) in situations where pregnant women refused to test is because they know they are HIV positive.

Nurses who work with patients, who are HIV positive, vicariously experience the negative feelings of their patients. Participants in the study reported that their patients are scared and need somebody that understand them because they think a HIV positive diagnosis is the end of the world. Tsarensko and Polonsky (2011:471) share in the sentiment of the participants and argue that being diagnosed HIV positive can be a turning point in any patient's life and may have an effect on their behaviour and identity. However, being diagnosed HIV positive can also teach patients how to live and appreciate life to the fullest (Shiparski 2008:68) but it can also cause immense amounts of stress and devastation to some patients because they do not know how to deal with their medical, social and personal situation following a HIV positive diagnosis (Kerr, Graftsky, Miller, Ches, and

Love 2011:485). Participants revealed that some of their patients struggle to accept their HIV positive diagnosis and even contemplate committing suicide. The findings of the study is corroborated by many authors who argue that after becoming aware of their HIV status patients do have suicidal thoughts and contemplate ending their life because of the fatality of the disease (Chan and Chung n.d.:1; Kniesl, Wilson and Trigoboff 2004:586). In a study done by Cooperman and Simoni (2005:149) on suicidal ideation amongst women living with HIV, it was found that attempts to commit suicide in the first month following diagnosis are high amongst female patients. Health care workers should screen their patients for depression and suicidal ideation taking into consideration that patients will experience a range of emotions following a HIV positive diagnosis (Bidwell 2014:3; Remien and Rabkin 2001:332).

Participants also reported that some patients refuse to accept their HIV status because they believe that they are bewitched. Authors Tshililo and Davhana-Maselesele (2009:140) state that nurses do become frustrated and their stress levels increase because their patients are denying that they are HIV positive and some believe that they are bewitched because a sangoma [traditional doctor] caused them to believe that the HIV symptoms are the result of bewitchment. Those patients who believe they are bewitched usually exhibit poor coping skills, they would refuse to test, or take ARV's and would end up not using condoms as well (Golooba-Mutebi and Tollman 2007:178-181). Often family members put pressure on patients to visit a traditional healer for treatment of HIV/AIDS (Mall 2008:4). Those patients who use traditional medicine together with ARV's may suffer side effects of drug toxicity that could be fatal (Puane, Hughes, Uwimana, Johnson and Folk 2012:500). Caring for difficult patients, like those who engage in destructive behaviour and the inability of health care workers to control their patients' behaviour become a source of stress and it negatively affects the caring relationship leading to compassion fatigue (Kotula 2015:13; Gorman and Sultan 2008:34; Smith 2007:194).

One of the participants reported that a patient told her she was hurt by the way her family reacted when she disclosed her HIV status. Her family went to take out a funeral policy because they thought she was going to die. Van Empelen (2005:12) states that disclosure of HIV positive status to family members has its advantages and disadvantages, it may increase closeness but it may also increase family members' stress levels because they become emotional and may be surprised and saddened by the news. According to Chan and Chung (n.d.:2) partners and family members of people living with HIV/AIDS often have great concerns and worries when they get to know that their family member has HIV, making it difficult for patients to get support or empathy from family members.

One participant reported that she initially feared working with patients who are HIV positive but the doctors she worked with motivated her and she later on developed a passion for working with these patients. Ncama and Uys (2003:14) share in the sentiment of the participant because in a study the authors found that nurses initially feared working with HIV positive patients due to a lack of knowledge and understanding of the disease process. Empathetic involvement with patients does not only have negative consequences but can also cause people to experience a sense of connectedness, enhance self-esteem; result in renewed hope, development of resilience, and it can result in a balanced understanding of humanity (McCann and Pearlman 1990; Richter et al. 1999 cited in Graaf 2011:10). Hunsaker et al. (2015:188) argue that most people choose nursing as a profession because they experience fulfilment from helping others.

Participants in the study indicated that they are empathetic towards their patients to the extent that they feel their patients' pain also causes them to suffer. Bam and Naidoo (2014:14) state that nurses do empathetically care about their patients and they are determined to do more for their patients irrespective of the negative effects it might have on their own health. The need for affection becomes important to patients who are HIV positive because of the lack of love and absence of close friends caused by fear, stigma, and losses that come as a consequence of the HIV disease (Benevides-Fereira and Das Neves Alves 2007:566). According to Berg and Nilsson (2015:3) nurses' role is to care for the sick, to restore their health and reduce their suffering. In doing so the emotional energy they pour into caring for their patients may induce compassion stress which is the residue of empathetic response to relieve patients' suffering that cause them to be susceptible to compassion fatigue (Harris 2015:8; Boyle 2011:2; Knobloch 2007:86).

In this study the researcher found that some nurses cannot stop thinking about their patients when at home and this increased their stress. In a study done by Delobelle et al. (2009:1067) it was found that nurses were continually worried about how the HIV epidemic is affecting their patients because they are committed to the well-being of their patients. Similarly Sheppard (2015:58), in a study on compassion fatigue amongst nurses, found that nurses are unable to disconnect from their patients when away from work.

The focus of the theoretical framework is on the empathetic ability of nurses and their empathetic engagement. Figley (1995) stated that nurses are at risk of compassion fatigue because of their empathetic ability. Empathy is an honourable trait but it also makes nurses vulnerable to compassion fatigue Larson and Larson (2006 cited in Bush 2009:26-27). According to Watson (1988:75) nurses should regard caring for the weak

and traumatised as a moral ideal directed towards preservation of human life and they should show compassion and empathy towards their patients. The nurse-patient relationship should be built on trust (which is the first human development stage Erik Erickson Human Development Theory (1997) through genuine empathetic, warm and effective communication. Such an empathetic relationship with their patients exposes nurses to their patients' pain and suffering on a daily basis (Knobloch Coetzee and Klopper 2010:235). According to (Dunkley and Whelan 2006; McCann and Pearlman 1990 cited in Loolo 2016:32) secondary traumatization such as compassion fatigue can bring disruption in to healthcare professionals' cognitive schemas or mental framework in areas of trust, belief and assumptions of safety causing them to question their foundational beliefs and assumptions about life. Caring for traumatised patients expose healthcare professionals to the painful impact of violation and trust on human lives in their society.

The participants indicated that they felt sad and experienced it as painful when disclosing a positive HIV test result during post-test counselling. Kerr et al. (2011:485) share in the sentiment and experiences of the participants that doing post-test counselling is not easy especially when having to give a positive HIV test result, it causes nurses to become emotional and it is painful and confusing because they feel ill prepared to do HIV/AIDS counselling (Dieleman et al. 2007:139). Nurses regard counselling patients who are HIV positive as the hardest part of their job because they feel inadequately prepared to do HIV/AIDS counselling and this caused them to stress (van Dyk 2012:413). Smith (2007: 194) argues that those health care workers who care for traumatised patients become physically and emotionally worn out because they identify with their patients' feelings of powerlessness, thus their risk to develop compassion fatigue increase. Figley (1995:1; 15) argues that during the process of listening to traumatised patients' stories healthcare professionals absorb the negative energy that cause them to be more vulnerable to compassion fatigue.

Some of the participants, who were also young mothers with babies, reported that they become very emotional when children are involved and would cry when seeing a child suffer. Malatjie's (2010:23) findings also indicates that traumatic stress is worse amongst nurses who work in paediatric ARV clinics because often they are mothers themselves. Nurses identify with the children that could be the same age as their own children leaving them traumatised; saddened; stressful; distressed and they would cry because they cannot relieve their patients' pain and they feel guilty as well. In caring for children who suffer from chronic illnesses such as HIV/AIDS, witnessing the children suffer, the painful

procedures performed on the children, witnessing the children's condition get worse, and seeing that children are unable to lead a normal life can trigger compassion fatigue (Enerholm and Fagrell 2012:12; Rodriguez-Cortes 2012:13). Thus, emotional involvement cause healthcare professionals to be vulnerable to compassion fatigue (Johnson 2015:1).

In order to minimise the negative cost of the nurse-patient relationship the researcher identified a number of interventions and actions to prevent and manage compassion fatigue, namely: desensitisation of nurses to the exposure of traumatic events of patients; enhancement of a culture of compassion in the organisation and enhancing positive coping skills. In order to desensitise nurses to exposure of patients traumatic events a number of actions were identified that include self-awareness that will enable nurses to identify stressors early and seek help when needed. Nurses should also be encouraged to be aware of their belief system and how people impact upon them in difficult situations because if a person is aware they can identify their stressors early and seek help and support (Best Start Resource Centre 2012:21). According to Portnoy (2011:50) it is important for healthcare professionals to engage in self-care practices, to learn to modulate their responses to stress and be aware of destructive behaviour and reach for help in order to manage compassion fatigue. Another strategy that can be used to desensitise nurses to traumatic events is to decrease exposure to traumatic events by decreasing the number of traumatised cases assigned to each nurse and reduce their case load, so they do not consistently care for difficult or challenging cases (Hesselgrave 2014:3; Huggard n.d.:5; Meichenbaum n.d.:20). In a study done nurses who work with HIV positive patients used emotional and behavioural distancing to help them avoid experiencing painful feelings or situations (Shifrin 2011:55). Nurses should be encouraged to recognise and accept the realities of working in ARV clinics and concentrate on the positive features of their own and their patients' experiences. According to McAllister and McKinnon (2009:375) practitioners should be given opportunities to reflect upon and learn from practices and from other practitioners in order to develop resilience that protect against compassion fatigue. The use of positive coping skills is another intervention that can be used to minimise the negative effects of the nurse-patient relationship. Pickett, Brennan, Greenberg, Licht and Worrell (1994:250) argues that the maintenance of realistic goals, limits and boundaries when interacting with traumatized patients are important in the desensitization process.

In the study participants reported being emotionally affected by the HIV/AIDS epidemic. They were especially concerned when the mother of a child patient becomes sick, as well as the high mortality rate of mothers. They worry how the child will cope when not having

a mother to care for him/her. Malatjie (2010:23) share in the sentiments and experiences of participants and state that traumatic stress is worse amongst nurses who work in paediatric ARV clinics. According to van Dyk (2012:56) the HIV/AIDS epidemic has left many children orphaned and after the death of the parents, children often lose their rights to the family land and home and they might end up living on the streets, suffering from malnutrition, illness and abuse. Nurses witness the death of their patients on a daily basis and the inevitable death of patients causes an increase in nurses' stress levels (Keidel 2002:201).

In the current study participants reported that they become distressed when witnessing their patients' suffering and hearing about the death of their patients especially those they were attached to. Valente (1995:21) state that death is regarded as traumatic especially when it is unexpected and more so when working with very ill and or dying children because of the relationship healthcare professionals have with their patients and their families (Braunschneider 2013:2). In a study done by Davhana-Maselesele and Igumbor (2008:71) the authors reported similar responses from nurses in their study, they become distressed when witnessing or hearing about the death of their patients and they also stated that they have difficulty in dealing with so many deaths at the same time. Literature describes HIV/AIDS as a fatal disease and nurses who work in ARV clinics are repeatedly exposed to the suffering and pain of their patients (Bush 2006:17s). According to Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu et al. (2014:xxiv) too many people are still dying from HIV/AIDS. In 2014 an estimated 136, 817 people died due to HIV/AIDS-related illnesses. Larson and Bush (2006:589) argue that being exposed to loss is a major stressor for nurses. One kind of loss that nurses must adapt to is the loss of patients when treatment is not successful. Healthcare professionals find death and dying very stressful because of the emotional attachment. Death of a patient creates an existential crisis for them (Rapp 2012:75; Iranmanesh, Abbaszadeh, Dargahi, Cheraghi 2010a:141).

Participants in the study reported that they do grieve for their patients who die and one participant reported that she goes through the whole grieving process. Van Dyk's (2007:54) had similar findings in her study (2007) that nurses do grieve for their patients and that every patient's death is regarded as a personal blow. Witnessing the death of a patient cause nurses to experience ethical and moral distress and they ascribe their grief to the deep rapport established between them as well as the fact that they get to know their patients on a personal level and connect with them (Aycock and Boyle 2009:183; Fridl, Forsberg and Bergbom 2009:233). Grief is a response to the emotional experiences related to loss and can manifest in thoughts, feelings and behaviour that are associated

with overwhelming distress or sorrow and can cause the bereaved individual's coping mechanism to become ineffective (Berman and Snyder 2012:1099; Gorman and Sultan 2008:371). Grieving over the death of a patient with inadequate coping skills are sources for compassion fatigue in healthcare professionals who work with patients who are HIV positive (Adwan 2014:334; Smith 2007:198).

One participant who worked in the paediatric ARV clinic reported that the staff members are very sad when children they care for die. However, they have to get over the death of their patients quickly because they have other patients to care for (Gerow, Conejo, Alonzo, Davis, Rodgers and Domain 2009:126) share in the sentiment of the participants and state that in situations where nurses are exposed to many deaths within a short space of time they often do not have time to grieve, they can only say goodbye to their patients and are forced to move on because the next patient need them. Thus, exposure to too many deaths within a short space of time can lead to bereavement overload and is exasperated by a lack of debriefing services (Smart 2009:6). Due to their personal relationship with their patients and the vulnerable nature of their patients nurses do experience intense emotions when a child they care for died increase their vulnerability to develop compassion fatigue (Creamer and Liddle 2005:94). According to (Piemme and Bolle 1990, Bennett and Kelaher 1993 cited in Rapp 2012:7) nurses who care for HIV/AIDS patients are at risk of bereavement overload due to the many deaths they face causing them to feel ineffective in making a difference in their patients' lives.

In this study some participants reported anguish and thought that if they had done things differently their patient might not have died. The findings of the study are corroborated by Gorman and Sultan (2008:39). The authors argue that in situations where nurses take it upon themselves to prevent their patients from dying and if the patients die, they experience a sense of guilt. Nurses may also experience a sense of defeat because they could not save their patients from dying or they feel that their actions have hastened their patients' death (Iranmanesh et al. 2010a:147; Najjar et al. 2009:268). The inability of nurses to save their patients' lives cause them to experience frustration, tension and dissatisfaction with the nursing profession and a sense of hopelessness because they formed good relationships with their patients and felt responsible for the impact of HIV/AIDS on their communities. Some healthcare professionals still regard the death of HIV positive patients as a failure of the health system (Fridl, Forsberg and Bergbom 2009:233; Davhana-Maselesele and Igumbor 2008:73). In the Ugandan study done by Harrowing (2011:.6), the author found that nurses do experience guilt and felt responsible for the death of their patients because they may have delayed in attending to their patients

only to discover later that the patient had died while waiting causing them to feel they have done nothing to stop the patients from dying. Such experiences may result in nurses leaving the profession in order to avoid further emotional stress (Mason et al. 2014:217). In Watson's Caring Theory (1988:73) the author proposed that nurses should form close relationships with their patients, show empathy, become personally involved and connect with them. However, because of the personal relationships they have with their traumatised patients nurses experience both moral and emotional distress especially when a child that they care for die and this can trigger compassion fatigue. According to Berman and Snyder (2012:1065) nurses are still responsible to care and provide support to their dying patients even if it causes them to experience role strain due to increased interaction with dying patients. The research findings are in line with Figley's Compassion Fatigue Etiological Model (2002) caring for sick, traumatised and dying patients. Being repeatedly exposed to traumatic events of patients can cause an increase in healthcare professionals' vulnerability to develop compassion fatigue resulting in them losing their nurturing ability (Kotula 2015:9). Ferrell and Coyle (2008:246; 247) argue that nurses are intimately involved in caring for patients who are traumatised and in pain, thus nurses often witness their patients' struggle with ethical concerns and spirituality during illness resulting in nurses being vulnerable to stress, anger, and unhealthy behaviour (Tunajek 2006:24), such as over-identification with patients (Joinson 1992:116), emotional exhaustion and compassion fatigue that will manifest in caregivers' behaviour, thoughts and feelings (Benoit, Veach and LeRoy 2007:301; Figley 2005:5). Dealing with death of patients on a daily basis can result in compassion stress that in turn can result in compassion fatigue resulting in re-experiencing patients' trauma in the form of intrusive thoughts and memories of the traumatic event (Figley 2002:1438). Dealing with difficult patients contribute to compassion fatigue because it result in emotional exhaustion, hopelessness and in the end lead to nurses avoiding their patients resulting in poor quality of care (Smith 2007:19).

Nurses are ***vicariously exposed to the traumatic experiences of their patients***. One participant stated that seeing her patients suffer made her also want to suffer because she is taken by what her patients are feeling. Portnoy (2011:47) states that healthcare professionals who are involved in direct patient care are exposed to suffering and negativity on a daily basis. Having to care for many terminal ill patients, such as HIV positive patients at the same time can cause compassion stress, which in turn can develop into compassion fatigue (Radley and Figley 2007:207). DeGrazia and Scrandis (2015:156) argue that patients who are HIV positive are traumatised because of sexual and/or emotional abuse as a child or adult. Thus, prolonged caring for these patients can

traumatise nurses and affect them as well as their families emotionally (Delobelle et al. 2009:1068). Circumstances that make healthcare professionals vulnerable to compassion fatigue include over-identifying with patients, witnessing the death of their patients and prolonged exposure to stressful circumstances resulting in blurring of boundaries (Bush 2009:26; Figley 2002:1436; Figley 1995:1:6).

In this study the researcher found that some participants do have problems in separating home and work life, *they cannot stop thinking about their patients when at home*. Sheppard (2015:58) had similar findings in a study done on compassion fatigue amongst nurses and argue that nurses are unable to disconnect from their patients when away from work; they worry how the epidemic is affecting their patients. Thus, the HIV epidemic has an impact on the home life of nurses. Participants also reported that the media will trigger their memories of their patients and in some cases they will think of them all night. Authors Benoit, Veach and LeRoy (2007:310) indicate that healthcare professionals have intrusive thoughts about their patients and will have difficulty in falling asleep causing them to have nightmares containing images of the traumatic event. Tosone, Nuttman-Shwartz and Stephens (2012:233) argue that traumatised patients elicit strong and often polarising counter transference responses unconsciously inducing it to their nurses. Nurses absorb the negative energy and incorporate the painful feelings, thoughts and images -enacting their patients' ordeal (McCann and Pearlman cited in Ribeiro 2004:15). According to Tosone, Nutmann-Shwartz and Stephens (2012:105) nurses are often affected or infected by HIV/AIDS that lead to blurring of boundaries that trigger compassion fatigue because they over-identify with their patients. Nurses become pre-occupied because their patients might be the same age as them or as their children that cause them to experience intense emotions and stress from the emotional support they provide to these patients (van Dyk 2007:63).

Some participants also indicated that they will relive events that led to the death of their patients and it affects them mentally. Authors Harrowing (2011:8; 9) and Allender, Rector and Warner (2010:467) share in the experiences of the participants and state that people exposed to traumatic events may persistently have intrusive, distressing re-collection of the event in the form of dreams causing them to relive the traumatic event. Kaneshiro (2010:n.p.) argues that a traumatic event is an event that is perceived and experienced by people as a threat to their safety or to the stability of their life. Prolonged exposure to traumatic events cause compassion stress that result from a desire to relieve another's pain and suffering. If not relieved compassion stress can progress to compassion fatigue (Ruysschaert 2009:162; Figley 2002:1437). Symptoms that result from exposure to

traumatic events include feelings of numbness not knowing how to respond, feelings of helplessness, fear, irritability, withdrawal from a relationship, dependency on alcohol and drugs or people might relive the traumatic event (Kaneshiro 2010:n.p; Uys and Middleton 2010:658-659).

In Watson's Caring Theory (1988) the author requires nurses to be present in the caring moment and to empathetically care for their patients, whereas Figley's (2002:1438) in his Etiological Model of Compassion Fatigue emphasise the importance of healthcare professionals, like nurses to distance themselves in between clinic visits from on-going trauma of their patients as a means of self-care. The reason why nurses become vulnerable to compassion fatigue is because they keep on giving emotionally, and may ultimately end up with an inability to attain a healthy balance of empathy and objectivity resulting in them not being able to disengage causing them to experience more stress and ultimately compassion fatigue (Pffifferling and Gilley 2000:1). To overcome the problem of nurses' inability to disengage they should be encouraged to recognize the importance of self-care that will aid in lowering or preventing compassion stress because inability to disengage increases the risk of developing compassion fatigue. Therefore, managers should encourage nurses to maintain professional boundaries and engage in self-care activities. The process of disengagement will demands a conscious rational effort from nurses to let go of the thoughts, feelings and sensations associated with their patients through engagement in self-care activities (Figley 2002:1438).

The researcher identified the establishment of a bereavement support programme as an intervention to help nurses dealing with the trauma of exposure to many patients' deaths. According to Mayer (2012:1) end-of-life education should be made mandatory for all newly appointed nurses caring for terminally ill patients. Naidoo and Sibiyi (2014:1-3) state that education on death and dying, whether formal or informal, during in-service training should focus on skills specifically related to end-of-life care. Gerow et al. (2009:126) argue that participation in caring rituals cause nurses to have a sense of security and regularity, they feel in control in the midst of emotional disorder. Many authors recommend different caring ritual that nurses can use to help them find closure after the death of their patients, namely: creating a remembrance tree of patients who have passed away, keeping a journal of fond memories of patients, writing funny anecdotes and well wishes to family of patients. Participating in such caring rituals can enable nurses to recognise and talk about their thoughts and feelings related to the passing of their patients (Fetter 2012:561). According to McSteen (2010:22) pastoral care can be used as an important support system for nurses to prevent and manage compassion fatigue in nurses who are exposed

to many patients' deaths. According to Wentzel, Shaba, Klimmek and Krumm (2011:E278) offering pastoral care services to nurses will improve their job satisfaction and prevent compassion fatigue. Pastoral care can provide support to nurses such as prayers and blessing of hands (Lombardo and Eyre 2011:3). Therefore, establishment of a referral system for pastoral care was included as an action step in the wellness programme as part of bereavement support.

The majority of participants in the study expressed that they experience a sense of hopelessness due to the fact that there is no cure for HIV/AIDS; they can only comfort their patients. The sentiment and experiences of participants in the study are shared by Herkins, Stuart, Nolan, Walfork, Engels, Bishara et al. (2007:27) who state that the fact that there is no cure for HIV/AIDS cause nurses not to be able to relieve their patients' pain and lead to nurses experiencing stress. The stress is exasperated by the fact that nurses have to watch how their patients succumb to HIV/AIDS having no alternative treatment to give to them (Enerholm and Fagrell 2012:12; Dellobelle et al. 2009:1067). Having to witness how their patients succumb to HIV/AIDS cause them to feel hopeless resulting in emotional, physical and spiritual exhaustion (Harrowing 2011:6; Aycock and Boyle 2009:184). Having to deal with the fact that their patients are going to die from AIDS make them vulnerable to compassion fatigue (Howell 2012:12). Nurses feel incompetent to care for patients who are HIV positive because they lack training causing them to feel hopeless and since they cannot cope with the evolving HIV care, their risk to develop compassion fatigue increase (Shifrin 2011:19-20; Lehmann and Zulu 2005:43).

Participants also expressed feeling hopeless because the HIV infection rate is going up. Venter (2012/2013:38) and Keidel (2002:201) argue that the increase in the HIV infection rate causes healthcare professionals to feel helpless. Healthcare professionals feel helpless because they can do nothing to stop the spread of HIV and the increase in number of patients infected with HIV cause them to feel overwhelmed (van Dyk 2012:408; Mulaudzi, Pengpid and Peltzer 2011:26). Despite concerns around the fact that HIV infection is rising participants reported that they *are fighting a losing battle* because patients have multiple partners. Tshililo and Davhana-Maselesele (2009:450) expressed their concern regarding patients who are in denial exhibiting destructive behaviour and consequently engaging in unprotected sex. Some females are scared to negotiate condom usage because they fear it will reveal their HIV status (Esplen 2007:15; WHO 2005:10). Participants in the study reported that nurses believe that patients who do not disclose their HIV status are the cause of the HIV virus being spread. Mulaudzi, Pengpid and Peltzer (2011:27) in their study found that nurses exhibited stigmatised behaviour

towards their patients and blamed them for their HIV status because of their immoral and deviant behaviour.

Acquisition of hope is important when caring for patients who are HIV positive. Based on Watson's Caring Theory (1988) the author states that nurses should have a value system that is humanistic, implying that they should have faith and hope that they can contribute to the healing of their patients (Watson 1988:72-73). According to Smith (2007:193:195) many patients who live with HIV/AIDS experience severe traumas and they feel powerless to get out of their situation. Thus, nurses who identify with their patients experience a sense of powerlessness because they feel they cannot make a difference to their patients' suffering. In order for nurses to mitigate the feeling of despair they should concentrate on the impact of the compassionate care that they are rendering and the difference they make in their patients' lives (Aycock and Boyle 2009:183-184; 187).

The researcher found that participants' are affected by the HIV epidemic and this negatively ***influences their personal lives as well as their families***. One participant reported that she counsels her neighbours when at home, she always continues her work at home, and it never stops because she assists her neighbours and their community who need counselling during her off duty time. The authors, Delobelle et al. (2009:1067), had similar findings, in a study done with nurses who work in the HIV/AIDS field. They found that caregivers' family life was directly affected by the fact that people in the community requested to be counselled at home. Nurses cannot say 'no' and even if they feel overloaded with work they are still willing to assist their community in their free time (Wentzel et al. 2011:E277; Stein, Lewin and Fairall 2007:958).

Participants in the study also indicated that working in ARV clinics is very exhausting and cause them to neglect their family to the extent that they do not feel like spending time with them. Figley (2002:1436) argues that healthcare professionals who suffer from compassion fatigue feel emotionally exhausted and this cause them to have nothing left to give. The fact that they are exhausted causes them to become impatient with their spouse and children (Mathieu 2009:4). According to Goga and Thomson (2012:15) family forms part of nurses' primary support system, therefore work stress can compound home stress and vice versa and if family relationships are affected, nurses' support systems becomes ineffective. Participants also reported that after a busy clinic they are so exhausted that they do not have time to care for their families and just want to rest when they get home. Aycock and Boyle (2009:184) argue that compassion fatigue not only affect nurses but also their family members, because they can transmit the negative energy from caring for

traumatised patients to their families. Thus, nurses can traumatise their family members by continually not being available for them through emotional withdrawal.

One participant also reported that she does not have time to help her children with their school work. Conrad and Kellar-Guenther (2006:1079) state that health care workers, such as nurses who are frequently exposed to their patients' traumatic material can affect the relationships with family and children, causing them to have less opportunity to manage their home responsibilities and/or leisure time (Bessinger 2006:19). According to Janssen et al. (2004:412; 414; 424) work-related issues can affect home life and private life can also affect work. Thus, demands from ones (work) domain can negatively or positively affect the other domain (home) because the roles and responsibilities of home and work compete with each other for the person's time and energy, resulting in conflict between work and family roles.

Participants are affected by the HIV/AIDS epidemic. One participant reported having lost her sister-in-law due to HIV/AIDS. Haber, Roby and High-George (2011:547) argue that many nurses are affected by the HIV/AIDS epidemic. They encounter HIV on a daily basis because they have a family member who suffers from HIV/AIDS and some even lost a family member to the disease (Dieleman et al. 2007:139; 143). Thieleman and Cacciatore (2014:34) states that people with a personal history of trauma is vulnerable to compassion fatigue. Thus, having lost a loved one may cause participants to be at risk of compassion fatigue. In order for nurses to deal with the loss of a loved one, they need to find ways to deal with the pain and suffering. The grieving process permits people to cope with the loss gradually and to accept it as part of reality (Berman and Snyder 2012:1100; Kniesl and Trigoboff 2009:34).

One participant reported that people need to have boundaries and should not take their work home and should also not let home issues affect her work. Kerr et al. (2011:488) argue that nurses should not take work home and they should use coping strategies, like self-talk to maintain professional boundaries when becoming too emotionally involved with their patients. According to Gerow et al. (2009:126; 127) it is important that nurses put up boundaries to help them compartmentalize their experiences. Effective boundary setting and balancing home/work life are associated with reduced levels of compassion fatigue (Jacobson 2006:146), since it helps nurses to avoid blurring of boundaries because over-identification and over-involvement has dire consequences for nurses and their families (Showalter 2010:240).

Participants reported that they have to care for themselves and develop their own coping skills. Uebel et al. (2010:592) indicated that often it is expected that nurses should act beyond their scope of practice relying on their own skills and experiences because they are inadequately trained or supervised for new tasks that will assist them when caring for patients who are HIV positive. Lack of coping skills causes nurses to feel physically and emotionally drained and uncared for (de Wet and du Plooy 2012:40). Van Dyk (2012:429) argues that it is important that caregivers, such as, nurses take care of themselves for the sake of self-preservation and emotional survival. Being empathetically involved with patients may cause nurses to overstep their professional boundaries.

Based on participants' responses and related literature the researcher identified a number of actions that can help to develop positive coping skills, such as self-awareness that will allow nurses to recognise the signs of stress and identify thoughts, feelings and behaviour they exhibit when they stress as well as techniques they use to bring relief from stress (Crowe 2016:107). According to Hesselgrave (2014:3) self-awareness is the first step in preventing compassion fatigue and seeking help. Awareness in aid healthcare workers to protect themselves against the consequences of caring for traumatised patients. Awareness of personal reaction to vicarious trauma may allow healthcare workers to implement self-care strategies (Trippany, White-Kress and Wilcoxon 2004:35). Other actions include encouraging nurses to keep a journal on experiences since journaling is a helpful intervention to reduce compassion fatigue (Harris and Griffin 2015:86). Managers can also provide opportunities where nurses can debrief informally with colleagues, where they talk about their feelings and fond memories of patients and this can help them cope with stressful situations (Yoder 2010:195). The appropriate and therapeutic use of humour is also recommended as a caring distancing technique by (Jacobson 2006:148). Nurses should also be encouraged to use faith, religion and prayer in order to make sense of the meaning of life. According to (Wittine 1995 cited in Trippany, White-Kress and Wilcoxon 2004:36) a strong sense of spirituality cause people to accept existential realities and their inability to change it. Shifrin (2011:59) argues that prayer positively enable nurses to truly and honestly express themselves to a higher power and in doing so ask for direction and strength to continue despite facing hardships. Yoder (2010:165) also recommends the use of prayer as a personal strategy to cope with compassion fatigue. The author also stated that nurses also pray for their patients to help them cope.

In his Compassion Fatigue Etiological Model Figley (2002) states that healthcare professionals can become pre-occupied with their patients resulting in boundary confusion and blurring. Blurring of boundaries happen when nurses and patients share personal

traumatic experiences and boundary confusion can trigger compassion fatigue (Tosone, Nuttman-Shwartz and Stephens 2012:105; Portnoy 2011:49). Thus, establishing professional boundaries is very important to prevent compassion fatigue (Showalter 2010:240).

5.2 Theme 2: Manifestation of compassion fatigue

In this theme, the manifestation of compassion fatigue amongst nurses who work in ARV clinics, were identified. Nurses are affected physically, psychologically, spiritually as well as their behaviour. Participants expressed more psychological effects of compassion fatigue on the well-being of nurses.

Category 1 Presentation of compassion fatigue

McHolm (2006:15) argues that although indicators of compassion fatigue vary it affect people physically, psychologically, emotionally and spiritually. According to Figley (1995:12) the symptoms of compassion fatigue have a sudden, acute onset and are disconnected from real causes and may manifest either as over or under-involvement and is a combination of secondary traumatic stress and burnout (Landro 2012:1; Joinson 1992:119). The manifestation of compassion fatigue can become progressively worse causing people to question the meaning and purpose of life, they isolate themselves from others, engage in destructive compulsive behaviour such as substance abuse, overspending, overeating, feeling apathetic and having difficulty in concentrating and low productivity (Sinclair and Hamill 2007 cited in Ledoux 2015:3).

The researcher will next discuss the presentation of compassion fatigue as it manifest amongst nurses working in ARV clinics.

Based on responses from participants the researcher concluded that nurses who work in ARV clinics are **affected physically** that could be attributed to compassion fatigue. One participant complained of dizziness. According to Gates and Gillespie (2008:247 and Aycock and Boyle (2009:185) people who suffer from compassion fatigue may present with dizziness. Some participants reported that they were physically exhausted and tired especially after a busy clinic. Another participant complained of experiencing difficulty in falling asleep. Aycock and Boyle (2009:185) argue that people who suffer from compassion fatigue do experience insomnia that leads to exhaustion. However, despite their exhaustion they continue to give of themselves and neglect self-care (Showalter 2010:240-241). Physical exhaustion may result in inability to focus, reduced motivation,

confusion, compromised problem solving, irritability, memory lapse, impaired communication, diminished reaction time and indifference and loss of empathy that may lead to compassion fatigue (Louw, Edwards, Foster, Gilbert, Louw, Norton et al. 2011:626; The Joint Commission 2011:1). Nurses who suffer from compassion fatigue will feel exhausted when they come to work even after a weekend off causing them to drag their feet (Aycock and Boyle 2009:185; Mathieu 2009:2). Authors Knobloch (2007:91) and Joinson (1992:119) state that compassion fatigue does affect the physical health of nurses; they become more susceptible to illness thus, reporting sick more often (Mathieu 2009:2).

Through the responses from participants the researcher deduced that nurses who work in ARV clinics present with **psychological symptomatology** that could be attributed to compassion fatigue. Some participants in the study reported that they lose their passion for working in ARV clinics and are tired of feeling pity. Slatten, Carson and Carson (2011:331) argue that in situations when nurses feel threatened they lose their passion for their work. According to Knobloch Coetzee and Klopper (2010:235:239) nurses who suffer from compassion fatigue lose their nurturing ability and the most noticeable effect of compassion fatigue is the inability of nurses to compassionately care about their patients. The loss of compassion happens because the compassionate energy that the nurses have used over time is depleted and has passed their restorative process. Gates and Gillespie (2008:247) highlighted a concern about nurses who are exposed to traumatic events since such exposure cause them to show decreased compassion towards their patients which negatively affect their work. According to McHolm (2006:19) health care workers should be assisted to restore their compassion towards their patients, so they can experience personal fulfilment, peace, purpose, renewed physical energy and to decrease the negative impact on families and social lives. Restoring healthcare professionals' compassion satisfaction will decrease their vulnerability to develop compassion fatigue (Figley 2002:1440).

Participants in the study reported feeling emotionally exhausted having to listen to all their patients' problems; counselling them is also draining them. Aycock and Boyle (2009:184) and Benoit, Veach and LeRoy (2007:305) share in the sentiment of the participants and state that listening to patients during counselling sessions can be emotionally and spiritually very demanding for healthcare professionals because of the stressors associated with HIV/AIDS. Emotional exhaustion occur when a person's emotional resources become depleted by the chronic demands placed on them as well as expectations from patients, supervisors and organisations (Maslach 1998, Maslach,

Schaufeli and Leiter 2001 cited in Newell and MacNeil 2010:59). Emotional exhaustion is caused by a discrepancy between job demands and the inability of the person to fulfil those job demands that is aggravated by lack of self-care (Showalter 2010: 240; Killian 2008:39; Janssen et al. 2004:413; 414). In addition, Knobloch Coetzee and Klopper (2010:237:241) state that prolonged, continuous and intense contact with traumatised patients also cause emotional exhaustion. In Figley's (2002:1436) Compassion Fatigue Etiological Model the author argues that healthcare professionals who suffer from compassion fatigue do become emotionally exhausted. They become tired of caring for their patients (Louw et al. 2011:626; Mathieu 2009:5).

Some participants in the study indicated that they over-identify with their patients, they reported when at home the media will trigger their memories causing them to be thinking about a certain patient all the time. The findings of the study are corroborated by Figley's (1995:12) statement in which the author alleged that healthcare professionals may develop pre-occupation with their patients that cause them to continually think of them, even when at home. Some participants reported becoming pre-occupied with their patient to the extent that they at times relive their patients' traumatic events. The findings of the study is in line with Figley (2002:1438) argument that people who suffer from compassion fatigue may experience traumatic recollection of traumatic events which are memories of trauma and pain of their patients which, when recalled, cause an emotional reaction that trigger the symptoms of compassion fatigue. McHolm (2006:14) states that nurses who suffer from compassion fatigue will re-experience their patients' traumatic events; they will try to protect themselves through avoidance that have serious consequences because nurses will neglect taking care of their patients' needs resulting in poor quality of care (Allender, Rector and Warner 2010:467). According to Howell (2012:14) and Figley (1995:12) the response to these reminders will be numbing resulting in anxiety and recurrent intrusive recollection of the traumatic events through thoughts, images or dreams because healthcare professionals cannot maintain a balance between empathy and objectivity leading to over-identification with patients.

One participant who is working in the HIV field for many years indicated that initially she feared working with HIV positive patients but as time went by she overcame her fear. van Dyk (2012:422; 425) states that fear of becoming infected with the HIV virus in the course of their work cause an increase in health care workers' stress levels. Fear of HIV contagion has a negative influence on the nurses-patient relationship. Ncama and Uys (2003:14) share in the sentiment of the participant and indicate that many nurses who participated in their study admitted that fear was their initial response when they became

aware of the threat of the HIV/AIDS epidemic. The authors further state that nurses were scared to come near patients who were diagnosed HIV positive and to come in contact with patients' blood and body fluids. Nurses' fear was attributed to lack of knowledge on how HIV is spread and the fear was exasperated by the fact that there is no cure for HIV/AIDS.

Based on participants' responses the researcher concluded that nurses' experience feeling guilty when their patients die; they feel that if they had done things differently their patients might still be alive. According to van Dyk (2012:319) nurses feel guilty when their patients die because they feel they did not do enough for them. Some nurses still regard the death of their patients as personal failure (Slocum-Gori, Hemsworth, Chan, Carson, Kazanjian 2011:72). Harrowing (2011:6) in a study found that nurses felt guilty and responsible when they have delayed attending to patients and later discovered that the patient had died while waiting. Nurses feel they have failed their patients because they could not save their patients from dying and suffer from survivor guilt and this drain their energy and is unhealthy for them and their patients (Wallbank 2010:66; Shiparski 2008:68). According Uys and Middleton (2010:671) guilt is a powerful emotional response to any traumatic event and nurses experience guilt when they feel they acted unethically (Ledoux 2015:7).

Participants who work in the paediatric ARV clinic reported that when one of their patients die, all staff members felt sad and distressed, even if they knew there was no hope of their patient surviving. The findings of the study is in line with De Villiers and Ndou (2008:12) argument that nurses do experience sadness when there is no progress in their patients' condition and they die. The death of a child is perceived as a major stressor for healthcare professionals (Enerholm and Fagrell 2012:12; Gorman and Sultan 2008:73). The majority of participants in the study stated that they felt overwhelmed and exhausted by the nature of the HIV/AIDS disease and the long queues of patients who wait to be cared for. Van Dyk (2007:56) in her study found that health care workers feel overwhelmed by the sheer size of the epidemic. According to Uebel et al. (2007:501) the rollout of ARV treatment demand a great deal of health care workers' time due to the large number of sick adults and children who need extensive care resulting in healthcare professionals feeling overwhelmed. Benoit, Veach and LeRoy (2007:308) argue that being overwhelmed with work can affect how people manage situations at home and vice versa resulting in health care workers avoiding situations that require emotional energy and this increase their risk to develop compassion fatigue.

Some participants reported that the HIV prevention strategies are not working because more people are becoming infected with HIV causing nurses to feel hopeless and discouraged leading to them feeling they are fighting a losing battle. Authors (Venter 2012/2013:38) and Keidel (2002:201) state that the increase in the HIV infection rate cause caregivers, such as nurses, feeling hopeless because they cannot stop the spread of the disease and they feel they cannot contribute positively to the well-being of their patients (van Dyk (2012:408). A sense of hopelessness is associated with knowing that most patients who are HIV positive are terminally ill and would die sooner or later because there is no cure for HIV/AIDS and this cause nurses to feel they have no control over their patients' symptoms (Smit 2005:27). Compassion fatigue carries a social cost and if not addressed adequately may manifest as cynicism and despair (Figley 2002:1438). Abendorff (2011:1) argues that the most insidious impact of compassion fatigue over time is its assault on nurses' hope and idealism resulting in a sense of hopelessness. According to Watson's Caring Theory (1988) nurses need to have hope and trust that they will be able to positively contribute to the well-being of their patients.

Participants also reported that their interpersonal relationships with colleagues and patients are affected. According to van Dyk (2008:326) health care workers may exhibit negative behavioural patterns and become rude and cynical which makes them less approachable to their patients and this negatively impact on the nurse-patient relationships. When confronted by the realities of AIDS, nurses can become disillusioned, which is often the first sign of compassion fatigue. Participants reported that they felt depressed. Authors Davhana-Maselesele and Igumbor (2008:70) found in another study that nurses who care for patients who are HIV positive do experience some form of depression. According to Aycock and Boyle (2009:185) and Stamm (2009:8) depression is a symptom of compassion fatigue. Participants also complained of feeling angry, frustrated and irritable by their patients' behaviour and the loopholes in policies and guidelines that is used in the ARV clinics. Allender, Rector and Warner (2010:467) share in the sentiment and experiences of nurses in the current study that people who suffer from compassion fatigue do become irritable, burst out in anger and do feel frustrated because of the poor quality of care they render within a rapid changing and uncertain environment (Hooper, Craig, Janvrin, Wetsel, Reimels, Greenville et al. 2010:425; Aiken, Clarke, Sloane, Sochalski, Busse, Clarke et al. 2001:43). Feeling of anger and frustration can be linked to nurses' experiences of being stigmatised because of their close relationship with patients who are HIV positive (Smit 2005:27). Frustration is also caused by the fact that nurses who cares for children do not get enough information from parents since parents do not disclose their children's HIV status (Enerholm and Fagrell 2012:13).

Authors Gorman and Sultan (2008:73) and Delobelle et al. (2009:1067) state that anger is a state of emotional excitement and tension caused by displeasure, frustration and anxiety in response to perceived danger. Thus, anger and frustration is common amongst people who suffer from compassion fatigue. Irritability is a key symptom of compassion fatigue, nurses might be irritated by minor events at work causing them to become annoyed and they might yell at their patients and colleagues (Stamm 2009:8). Such behaviour results in nurses not feeling good about their behaviour and thus increases their stress levels (Mathieu 2009:3).

One participant reported feeling mentally stagnant and redundant. Authors De Wet and du Plooy (2012:37) and Figley (1995:12) argue that people who suffer from compassion fatigue do have trust issues that will affect their relationship with their patients and colleagues. Van Dyk (2012:412) shares in the sentiment and experience of nurses in the current study and states that due to the fact that there is no cure for HIV/AIDS nurses feel they cannot contribute to the health of their patients causing them to have feelings of low personal accomplishments leading to them feeling redundant. Watson (2006:89) states that due to the nursing shortages nurses do become dispirited, thus causing them not to trust leaders who manage the health care system. Erik Erikson in his Human Developmental Theory (1997) argues that people lose their trust in difficult situations and develop a sense of distrust. According to (Gilson et al. 2005 cited by de Wet and du Plooy 2012:37) nurses in another research study reported dissatisfaction with managerial support. Dissatisfaction can lead to distrust between nurses and management (Ribeiro 2004:14). Trauma violates peoples' sense of basic trust resulting in assumptions of being undermined or shattered and this alters people's behaviour. When people's sense of trust has been violated they feel the world is not safe anymore causing their confidence in the future to be shaken, affecting relationships negatively (Munroe et al. 1995:211; 212).

Another participant indicated that she feels happy and enjoys working in the HIV/AIDS field because she makes a difference in her patients' lives. van den Berg et al. (2006:18) the authors had similar findings in their study that nurses who work with patients who are HIV positive do experience a sense of satisfaction and self-fulfilment for providing high standard of care. Nurses find HIV/AIDS work rewarding since they feel they are making a difference in their patients' lives leading to compassion satisfaction (Malatjie 2010:25; Smit 2005:27; Figley 2002:1438). Healthcare professionals who experience compassion satisfaction feel they have accomplished something and experience joy when their patients' condition improves (Radey and Figley 2007:211; Bride, Radey and Figley 2007:156).

Some participants in the study reported that nurses have a *do not care* attitude and at times they expressed not feeling like coming to work. Atkinson (2005:1) state that the nurses who suffer from compassion fatigue take more sick days off, affecting their productivity and some might leave the profession in the end. According to Knobloch Coetzee and Klopper (2010:238) because nurses use up all their energy, they have nothing more to give of themselves or to their patients causing them to not care about anything anymore. Participants also pointed out that people who suffer from compassion fatigue will have attitude problems, they shout at patients. They do not listen to others, become aggressive and impatient. Authors Johne and Abbott (cited in Howell 2012:14) argue that compassion fatigue affects nurses' behaviour negatively, they lack empathy and show decreased tolerance and this affect their interpersonal relationships negatively. Healthcare professionals may also display negative behaviour towards their colleagues and show less empathy towards them (Portnoy 2011:47; Stamm 2009:8; 9).

Participants also reported crying easily especially when witnessing children suffer. According to Larson and Bush (2009:596), showing strong emotions are natural and are a necessary part of helping people to cope with grief or life-threatening illness. Nurses often shed a tear with their patients and it shows the patient that the nurse truly cares. However, there is a difference between crying and sobbing and nurses should be careful not to sob in front of their patients because it shifts the focus to his/her own distress and empathy and helping patients is derailed. Some participants reported that at times they just want to shut down and forget about their patients, trying not to think about them when at home. Munroe et al. (1995:222) argue that persons who suffer from compassion fatigue have periods of alterations between withdrawal and numbing, resulting in them losing interest in their work (Atkinson 2005:1). Compassion fatigue can have a negative effect on the care provided to patients because nurses might distance themselves from their patients' traumatic situations resulting in nurses either acting as rescuers causing them to become over-involved or withdraw from the relationship resulting in emotional distancing (both Massie, Holland and Stralzer 1990; Badger 2001 cited in Larson and Bush 2006:590). Allender, Rector and Warner (2010:467) state that exposure to traumatic material of patients will cause people to avoid thoughts, people or places associated with the traumatic event resulting in them showing diminished interest in activities.

Participants reported nurses verbalising that they feel they are in the wrong profession and that they also expressed a desire to move out of the ARV clinic to go and work in another department. Compassion fatigue can affect nurses' **spiritual well-being** and result in feelings that a major change and a need to relocation are necessary. Aycock and

Boyle (2009:185) argue that nurses who suffer from compassion fatigue will show signs of alienation and isolation and would feel that major changes is required and they should change careers or quit in order to avoid facing the situation, resulting in a high turnover rate amongst nurses (Knobloch Coetzee and Klopper 2010:238; Showalter 2010:240). Participants also report that nurses expressed feelings of doubt whether it is the same HIV virus that presents differently. Aycock and Boyle (2009:185) share in the experiences of nurses and state that people who suffer from compassion fatigue do experience feelings of doubt concerning value systems and beliefs.

Based on participants' response the researcher concluded that nurses' **behaviour have changed** and this may negatively affect the nurse-patient relationship. Participants reported that nurses who suffer from compassion fatigue have a *do not care* attitude; they do not care about their personal appearance and does not even comb their hair. Atkinson (2005:1) argues that compassion fatigue does affect nurses' behaviour and may include irrationality and mood swings leading to loss of interest in work. Howell (2012:13-14) also argues that manifestation of compassion fatigue can bring about behavioural changes in nurses towards their patients and colleagues that affect their interpersonal relationships. According to ScienceDaily (2009:1) people who suffer from compassion fatigue may engage in destructive behaviour like alcohol abuse, they lose their sense of compassion, become cynical and bored and they try to protect themselves by isolating them from their support systems. Nurses may be dissatisfied with their work situation, they would not be punctual for work and neglect their duties, become insensitive in dealing with patients, and often referring to them in a dehumanized or impersonal way because such negative attitudes are caused by the stressful nature of the caring relationship between nurses and patients affecting nurses' ability to render compassionate care to their patients (United Nations 2012:77; Buchan 2006:22s).

The findings of the study are in line with The Theoretical Framework of the study. (Figley 2002:1434; 1435) states that compassion fatigue affects healthcare professionals physically, psychologically, spiritually as well as their behaviour, meaning all aspects of their being can be affected (Gorman and Sultan 2008:370). Figley (1995:1) and Knobloch (2007:88) ascribe compassion fatigue to long-term cumulative stress that progressively advance from a state of compassion discomfort to compassion stress and finally compassion fatigue. Smith (2007:193; 194) states that nurses who are continually exposed to the traumatic experiences of their patients and who are empathetic, who experience some kind of life's disruption with lack of self-care are more at risk of developing compassion fatigue (Figley 1995:12). Landro (2012:1) argues that compassion

fatigue reduces nurses' capacity or interest to bear the suffering of their traumatised patients and this can cause them to dread or even avoid their patients, leading to sub-standard nursing care because nurses do not identify their patients' problems early. Nurses do also become rude and cynical, thus patients are discouraged from asking them for help, they become less observant regarding their patients, resulting in more medication error.

The researcher recommends raising awareness on compassion fatigue; workshops should aim at enlightening employers of the devastating consequences of compassion fatigue on employees' health and productivity as well as the negative effect it can have on patients' care. Hence, Figley (2002:1438) argues that in order to create awareness an overview of compassion fatigue should be given for educational purposes as it will assist healthcare providers in recognizing signs and symptoms of compassion fatigue. Such a programme should focus on self-awareness, self-care and self-compassion (Hodge and Lockwood 2013:83; Boyle 2011:7; Portnoy 2011:47). Aycock and Boyle (2009:188) argue that when hiring new staff they should be informed of the effect of trauma work on their emotional health as well as the availability of resources. This should be mentioned during the interview and during orientation programme. As an action to create awareness amongst nurses Meyer, Li, Klaristenfeld, and Gold (2015:180) recommend that support for novice nurses should focus on education that will enable them to recognize compassion fatigue as an expected occupational hazard and not a weakness (Rourke 2007:637). According to Jacobson (2006:149) organisations should acknowledge that professionals are affected by the work they do in the traumatic stress field. Thus, acknowledge compassion fatigue as a normal response when working under difficult situations may help staff to recognize and accept it (Harris and Griffin 2015: 84).

Mathieu (2007:2; 4) argue that by completing a self-test such as the ProQOL-CFS-IV-R can help nurses to identify the presence of any symptoms of compassion fatigue. Taking the self-test will help nurses to understand their feelings and assist them in designing a compassion fatigue prevention toolkit. According to Boyle (2011:3) the identification of compassion fatigue requires assessment of various characteristics to germane counter-transference reactions and the Professional Quality of Life Scale (ProQOL-CSF-IV-R Stamm 2009) can be used for that purpose.

5.3 Theme 3: Strategies to prevent and manage compassion fatigue

In this theme, coping strategies to prevent and manage compassion fatigue amongst nurses who work in ARV clinics were identified. The nurses highly valued collegial support and described self-care practices that they engage in, as well as ways they use to celebrate their patients' lives that help them to cope. Nurses also identified management support that they would prefer to have available to them, of which debriefing came up on top, followed by management and psychological support.

Category 1 Preferred support from management

Nurses realise that in order for them to prevent and manage compassion fatigue they need support from management. The preferred support from management that was identified includes debriefing, managerial support and psychological support.

In this study participants reported that they deemed **debriefing** to be very important as a means to support them to cope with the challenges they face working in antiretroviral clinics. The findings is consistent with Kangethe (2009:120) argument that counselling services for nurses who work in antiretroviral clinics is important to allow them to express positive and negative feelings that emanate from caring for traumatised patients and impact on the nurse-patient relationship. Debriefing can help to prevent and manage compassion fatigue (Yoder 2010:196; Aycock and Boyle 2009:188). Louw et al. (2011:656) argue that debriefing is a very important part of any wellness programme giving nurses the opportunity to express their emotions and experiences in a controlled environment. Debriefing can be used to relieve tension, as well as relieve the emotional adverse effects of trauma work. The need for emotional support for health care workers must be addresses and sustainable counselling mechanisms must be implemented (Dagied et al. 2007 cited in Vawda and Variawa 2012:507). Mulaudzi, Pengpid and Peltzer (2011:31) recommend that psychological support that provides counselling should be made available to nurses.

The death of their patients increase the stress levels of nurses who participated in the study and they expressed a need for support systems such as debriefing that will allow them to talk about issues that concerns them because talking makes them feel better. Bam and Naidoo (2014:16) in a study found that nurses also requested debriefing to help them cope while working in the HIV/AIDS field. Boyle (2011:6) argues that bereavement interventions, such as debriefing can help nurses with grief resolution and management should allow them to attend funerals of their patients with whom they had a special bond

or participate in memorial services or send sympathy cards to the families of their patients. According to Aycock and Boyle (2009:186) some organisations have pastoral care and debriefing services available to assist their staff members coping with work-related stressors. Participants also indicated a desire for debriefing to happen more frequently. Authors de Wet and du Plooy (2012:38) had similar findings in another study where nurses expressed a desire to be debriefed on a more regular basis to help reduce the emotional adverse effects of prolonged exposure to the trauma on nurses of their patients who are HIV positive (Flanely, Roberts and Weaver 2005:224).

Participants also indicated that debriefing should be provided so that people can talk about their concerns. De Wet and du Plooy (2012:38) share in the sentiment of the participants and state that on-site counselling services that provide emotional support to nurses should be provided by a psychiatric nurse, therapist, counsellor or social worker, it should be accessible and offer practical solutions in order to prevent compassion fatigue (Solomon 2014:31). Campfield and Hills (2001:327; 330) state that the use of psychological debriefing following exposure to traumatic events has grown and is used in a variety of situations since the 1970's to alleviate initial distress, to restore balance, to offer reassurance, to give comfort to victims, to give information to defuse the emotional effect of the traumatic situation and also to prevent the development of posttraumatic stress disorders (PTSD). According to Boyle (2011:6) and Masters, Stillman and Spielmans (2007:11) debriefing sessions should be made available for nurses to talk about their feelings and it should be regarded as instructive rather than critical reviews to help nurses identify approaches to events in the work-place that increase their stress levels especially after a traumatic event that has occurred at work. Boyle (2011:6) argues that debriefing can be used to prevent and manage emotional distress and is crucial to prevent compassion fatigue (Killian 2008:37). Debriefing can be useful after any intense period of caring or prolonged difficult situation (Harris and Griffin 2016:85). Shifrin (2011:610) states that it is important that counselling services be made available for every staff member who work in HIV/AIDS field and that counselling can be provided by a social worker. However, time must be set aside to allow staff to attend. Therefore, the researcher included the establishment of on-site debriefing and counselling services as interventions in the wellness programme.

Managing and preventing compassion fatigue require deliberate action from managers. Participants expressed a need for **managerial support**. Managers can provide support in a number of ways in an attempt to create an environment that is conducive to the well-being of nurses as well as patients. Some participants in the study expressed a desire to

attend workshops and symposiums to learn more about HIV/AIDS. Berg and Nilsson (2015:10) share in the sentiment and experiences of the participants of this study and state that it is important that nurses be updated through training on what is happening in the HIV/AIDS field in order to maintain high quality care. In a study done by Graaf (2011:71) the author found that caregivers of patients who are HIV positive requested training to increase their knowledge in the light of the demands of their work. According to Bam and Naidoo (2014:11) training is imperative to provide quality care. Puig et al. (2012:105) and Delobelle et al. (2009:1067) state that providing training opportunities is a responsibility of management and lack of training will cause nurses to feel incompetent and their thinking, emotions, sense of control and how they manage would be affected; they would have low self-esteem and may become indifferent to their patients' needs. Harrowing (2011:8) in a study done in Uganda with nurses who provide HIV/AIDS care found that education is a powerful tool for changing attitudes, improving the quality of nursing care and for creating change. Through education people can be made aware of compassion fatigue and in doing so decrease the prevalence thereof (Hee and Kyung 2012:50). Dorse (2008:22) argues that managers should be aware of any deficiency in knowledge and skills of their staff because these issues have negative effects on their health. Manager should encourage personal and professional growth amongst nurses by providing the necessary training (Dieleman et al. 2007:146; Oulton 2006:37s).

Participants felt that another category staff could do the non-clinical work and wished that management could employ more staff especially doctors. Rapp (2012:73) had similar findings in a study done on occupational stressors amongst providers of HIV prevention and support services that caregivers felt overwhelmed by the amount of paper work that they are faced with the needs needed completion and filing. De Villiers and Ndou (2008:12) support the sentiment of participants in this study and agree that management fails to employ adequate healthcare professionals whereas the number of patients are increasing, causing physical and emotional exhaustion due to overwork. The findings of this study is in line with the study done in Zambia on the impact of HIV/AIDS on health workers, in which Dieleman et al. (2007:141; 143) found that health care facilities lacked staff. Cameron et al. (2012:2) argue that the shortage of staff can be addressed through sharing of tasks between doctors and nurses with regard to initiation of ARV treatment to do this nurses need to be trained in management of HIV/AIDS and clinical mentoring thereof.

Some participants in the study also reported that policies in ARV clinics are outdated and need to be reviewed regularly. According to (Walker and Gibson cited in de Wet and du

Plooy 2012:31) policies should be reviewed regularly and management should ensure that this happen so that nurses do not have to improvise and act as street level bureaucrats using their own discretion. Thus, if policies are reviewed regularly nurses would be less frustrated and their stress levels would decrease. In order to retain nurses in ARV clinics managers will have to ensure that personnel policies that promote institutional loyalty and retention of staff are developed, benefits that provide career development opportunities; life-long learning as well as flexible work schedule should be instituted and included in policies.

The need for management support is in line with The Theoretical Framework of the study. Zander, Hutton and King (2010:101) argue that in order to cope with stressors in the workplace nurses need support, a positive attitude, experience caring for patients who are HIV positive, a personal process of coping, resourcefulness, balance in life and the ability to overcome challenges in the everyday clinical work situation. The Theoretical framework also focuses on the provision of psychological support to nurses who work in ARV clinics. According to Salston and Figley (2003:171) the negative emotional reactivity linked to the traumatic stressor should be decreased or eliminated.

Recommendations for management support that can be provided to aid in the prevention and management of compassion fatigue:

Literature describes a number of ways in which managers can assist in preventing and managing compassion fatigue. Haber, Roby and High-George (2011:548) argue that nurses who work in the HIV field need support from management, which may be provided through equitable salary structures, training, provision of necessary resources to deliver quality health care, personal and professional development, implementation of infection control measures, and medical and financial support for health care workers who are HIV positive (Dieleman et al. 2007:146).

In a study on compassion fatigue done by Melvin (2012:610), the author recommends that the role of managers be studied to develop strategies for providing support to nurses who work with terminally ill patients. Managers should be empowered to identify nurses who show early signs and symptoms of compassion fatigue and to develop strategies to assist distressed nurses. Yoder (2010:196) in a study done on compassion fatigue in nurses concluded that managers can provide support to nurses by acknowledging the risk of nurses to develop compassion fatigue and exploring ways to protect nurse from the harmful effect of caring for traumatised patients, and supporting the use of helpful strategies. Maytum, Heiman and Garwick (2004:178) in a study on compassion fatigue

and burnout in nurses who care for children with chronic illness found that nurse managers play a key role in self-understanding of compassion fatigue and renewal of compassion in nurses as well as addressing work-related triggers. Lombardo and Eyre (2011:3) state that a mentor can provide guidance in identifying strategies that will help nurses cope with their current work situation and thus relieving their stress, helping to prevent compassion fatigue (Jacobson 2012:70). According to Larson and Bush (2006:592; 598) when demands exceed the available resources, maintaining a balance becomes very important in the management of stress and compassion fatigue, thus management should ensure that nurses have the necessary resources to provide quality care (Smit 2005:28).

Braunschneider (2013:16; 17) argues that debriefing is an important intervention that helps nurse to cope with compassion fatigue; managers can also assist in establishing support groups for nurses. Yoder (2010:195) in a study found that nurses use informal debriefing as a strategy to cope, thus managers can ensure that an environment is created that allows nurses opportunities to debrief. According to Wentzel and Brusiewics (2014:96) and Hooper et al. (2010:426) managers should provide opportunities for nurses to voice their fears and concerns in a safe environment. Thus, counselling services should be established that provide debriefing services. Graaf (2011:78) in a study done on compassion fatigue and burnout amongst caregivers of patients who are HIV positive, found that organisational support in the form of supervision and access to counselling and therapy is important interventions that be used to prevent and manage compassion fatigue. In order to provide quality care to patients who are HIV positive nurses need training on a more regular basis and managers are responsible to provide opportunities for nurses to attend HIV/AIDS training on a regular basis (Graaf 2011:71; Smit 2005:28).

Hooper et al. (2010:427) state that programmes are needed that will help to preserve and enhance nurses' interpersonal competencies and empathetic ability to care and show empathy towards their patients. Compassion in organisations can take place at all levels and can be encouraged by managers. Compassion in an organisation makes employees to feel recognized, supported, and this will foster resilience and organisational commitment (Hoffman 2009 cited in Slatten, Carson and Carson 2011:329; Kanov, Maitlis, Worline, Dulton, Frost, Lilius 2004:809). Thus, management needs to create a compassionate culture within an organisation.

Some participants in the study expressed the need to feel valued through regular feedback from management on their performance. O'Neil (2015:n.p.) shares in the

sentiment from participants and state that nurses need recognition for a job well done from their supervisors. Oulton (2006:37s) argues that managers should reward nurses for their competencies and problem-solving skills and provide regular positive feedback on their performance through appreciation events since it acts as a buffer against stress and reduce the turnover rate (Kerr et al. 2011:489; Malatjie 2010:8; Finfgeld-Connett 2005:8). According to Kelly, Runge and Spencer (2015:527) meaningful recognition and increase in job satisfaction can help to prevent compassion fatigue, therefore, the researcher included this as an action to increase nurses' job satisfaction. Compassion satisfaction is influenced by recognition and appreciation for one's work (Smart, English, James, Wilson, Daratha, Childs et al. 2013:5; Figley 2002:1437). Malatjie (2010:10) argues that reward and recognition act as a buffer against stress as it helps in the promotion of a positive work environment. Thus, healthcare professionals should focus on finding ways to increase their sense of achievement and sense of compassion satisfaction in order to lower or prevent compassion fatigue (Smart et al. 2013:5; Figley 2002:1437). Since compassion satisfaction acts as a mitigating factor against compassion fatigue, managers should establish a reward system that recognises nurses who positively contribute towards the well-being of their patients.

Being exposed to multiple deaths within a short-space of time cause nurses to be traumatised, and it results in an increase in their risk to develop compassion fatigue (Gerow et al. 2009:127; Abendroth and Flannery 2006:354; Figley 2002:1437). According to (Bennett and Kelaher 1993 cited in Rapp 2012:6) nurses who work in the HIV/AIDS field are at an increased risk of experiencing grief due to the many deaths they face that may prevent them from providing quality care. Bereavement-support programmes help nurses to find closure by allowing them to talk about their thoughts and feelings and in doing so reduces the risk of compassion fatigue (Fetter 2012:560; Macpherson 2008:148). According to Parry (2011 cited in Ek et al. 2014:509) nursing students lack sufficient skills to cope with end-of-life care. Therefore, understanding nurses' experiences of death and dying can help the health care system to prepare and educate nurses on how to deal with issues relating to end-of-life care. According to Boyle (2011:8) various authors have recommended a number of options that can ensure psychological support to nurses in the work-place, namely on-site counselling provided by a psychiatric advanced practice nurse, counsellor, social worker, therapist or chaplain, support groups; debriefing facilities, and bereavement support – attending funerals, memorial service participation, and sympathy cards to family can help with grief resolution (Aycock and Boyle 2009:186). Jacobson (2012:69) argues that emotional and social support can help nurses cope in the work environment and can help to prevent compassion fatigue. Braunschneider (2013:17)

argue that managers can encourage the use of pastoral care to help nurses to come to terms with the loss of their patients or to discuss any spiritual concerns they might have. Other support that can be provided by organizations is the provision of relaxation centers, counselling, and others resources to help nurses cope with compassion fatigue.

Resilience is a personality trait that enables a person to overcome adversity, and within a work situation enables a person to remain task-focused and productive during tough times (Warner 2012:1; Comfort, Boin and Demchak 2010:14). Resilience can be viewed as a dynamic process that allows people to successfully adapt to challenges, stress and adversity (Deshields, Heiland, Kracen and Dua 2015:n.p; Norris, Stevens, Pfefferbaum, Wyche and Pfefferbaum 2008:129). Resilience acts as a buffer against compassion fatigue because it provide protection against the harmful effects of caring for traumatised patients by enhancing greater job satisfaction, lessening anxiety and improving quality of life (Hegney, Craigie, Hemsworth, Osseiran-Moisson, Aoun, Francis et al. 2014:516-517; Potter, Deshields, Berger, Clarke, Olsen and Chen 2013:180; 186). The goal of a resilience training programme is to strengthen internal coping mechanisms to build resilience and to build a healthier work environment by empowering nurses to become stronger individuals. Thus, management should enhance nurses' resilience through training programmes that will enable nurses to perform more effectively in a stressful situation that will result in improved patient outcomes and staff satisfaction (Sullivan and Bissett 2012:3). Nurse managers can strengthen and build nurses' resilience by providing opportunities to reflect upon and to learn from practice. Managers can also expose neophytes to experienced positive role models who share strategies on how to overcome adversities (Mcallister and Mckinnon 2009:375-376).

Providing **psychological support** to nurses who work in ARV clinics is important to help them cope. The majority of participants reported that they turn to their colleagues for psychological support when they are stressed. Harrowing (2011:7) states that nurses depend on their colleagues for support. They assist each other to manage difficult situations and to make decisions regarding the management of patients who are HIV positive (Haber, Roby and High-George 2011:548). In a study conducted by Mulaudzi, Pengpid and Peltzer (2011:28) the authors agreed that urgent steps should be taken to support nurses who care for patients who are HIV positive. Strategies for the prevention of occupational stress that lead to compassion fatigue include emotional support, therapeutic counselling or debriefing; stress reduction and enhancement of coping skills (van Dyk 2007:62). Social support enhance coping in the work environment (Walker, Morin and Labrie 2012:16) and is related to less compassion fatigue (Hee and Kyung 2012:50).

Lehmann and Zulu (2005:47) state that if it is expected that nurses should continue to shoulder the disproportionate piece of the fight against the HIV/AIDS epidemic, managers and employers should hear their urgent call for help and should start supporting them. It has become imperative that employers of nurses develop and implement wellness programmes to care for them. Positive coping styles are associated with lower levels of secondary traumatic stress and compassion fatigue (Hollingsworth 1993 cited in Jacobson 2006:146). Bessinger (2006:29) argues that stress cannot be completely eliminated from our lives. However, coping strategies can assist in decreasing stress to a more healthy level, thus preventing the harmful emotional and physical effects. Tunajek (2006:25) agree that the use of appropriate coping skills improve harmony and lead to congruence of mind, body and spirit. It makes life to be fun, improves the quality of life, and provides a feeling of happiness and joy.

Category 2 Personal strategies used by nurses to manage compassion fatigue

Based on participants' responses the researcher deduced that nurses value the ***support they get from their colleagues***; they support each other by sharing their experiences especially when faced with difficult situations. Authors Kerr, Graftsky, Miller, Ches, and Love (2011:487) argue that nurses view their colleagues as their primary source of social support to help them cope with the stress of working in the HIV/AIDS field, especially when dealing with difficult patients and when giving a positive HIV-test result. According to van Dyk (2007:63) collegial support is an essential part of any wellness programme. Colleagues provide emotional support to fellow colleagues that focus on normalising their experiences in the course of their work and they understand each other's' reaction. Collegial support is valued by healthcare professionals who work with HIV positive patients and can be used as a strategy to lessen compassion fatigue (Bam and Naidoo 2014:8; Romeo-Ratcliff 2014:59; Masters, Stillman and Spielmans 2007:11). Berg and Nilsson (2015:8) argue that through good relationships an atmosphere can be created where people can talk freely and discuss their problems with one another. Collegial support encourage group cohesion that act as an effective protective factor in reducing the effects of stress and is a predictor of compassion satisfaction helping to reduce compassion fatigue (Ba, Eraly, Mahrer, Klaristenfeld and Gold 2014:95; Walker, Morin and Labrie 2012:17).

One participant reported that colleagues provide support to each other and talking about their feeling brings about some relieve. Author Catherall (1995:236) share in the sentiment of participants and state that colleagues listen to affected workers' insight and respond non-judgementally by getting the facts straight and accept the feeling that the other is

experiencing. They reassure each other that they are doing all they can as professional compassionate caregivers. The support that colleagues provide to each other is context specific and can result in improved mental health (Rapp 2012:79; Aycock and Boyle 2009:188; Larson and Bush 2006:595; Finfgeld-Connett 2005:8). Nurses face their adversity through talking about it with colleagues. Such support help nurses to vent about their frustrations, share stories about their patients and ask for help when dealing with difficult patients in a safe environment (Flannigan 2010:588). Collegial support contribute towards successful completion of work-related goals resulting in fulfilling positive work-related state of mind, the outcome is positive and result in engagement that lead to compassion satisfaction that helps to mitigate compassion fatigue (Puig et al. 2012:106; Mulaudzi, Pengpid and Peltzer 2011:31; DePanfilis 2006:1067).

Participants who work in the ante-natal ARV clinic regarded the doctors they work with as an important source of support that they provide during their weekly case study meeting during which they discuss difficult cases. The findings of the study is supported by Gerbert, Caspers, Moe, Clanon, Abercombie and Herzig (2004:366) statement that health care workers learn to cope with the uncertainty of managing patients who are HIV positive through continuous education as well as networking with other healthcare professionals to improve patient outcomes (Bam and Naidoo 2014:16; Aycock and Boyle 2009:86). Lombardo and Eyre (2011:4) argue that during group discussions issues pertaining to physical care of patients, pain management, patients' behaviour, family dynamics and work-related stressors that healthcare professionals face can be discussed. Continuous formal and informal meetings to discuss difficult HIV/AIDS cases using multiple multidisciplinary forums can be used that assists each other to manage difficult situations and to make decisions regarding the care and management of these patients. Such meetings also provide a platform where caregivers can explore how they are affected and this helps to relieve stress (Haber, Roby and High-George 2011:548; Iranmanesh, Axelsson, Savenstedt and Haggstrom 2010b:92; 93; Newell and MacNeil 2010:63). Burgess, Irvine and Wallymahmed (2010:137) recommend that organizations that employ nurses, should ensure that they get adequate support as well as clinical supervision, and have regular team meetings to discuss difficult patients to help them cope with the stressful environment as well as protect employees from the harmful effects of stress (van Dyk 2007:62; Bessinger 2006:30).

Participants indicated that they use a number of strategies to help them prevent and manage compassion fatigue, including **self-care**. According to van Dyk (2008:418) nurses should deliberately engage in self-care programmes that include stress management

activities, participation in leisure activities, physical exercises, get enough rest, eat a balanced diet, and meditate. They should also spend time with loved ones (Cowen and Moorhead 2011:761; 762). Majority of the participants in the study reported that they do engage in physical exercise as part of their self-care and it helps them to de- stress. This research finding is corroborated by (Kerr et al. 2011:488; Sanchez-Reilly, Morrison, Carey, Bernacki, O'Neil, Kapo et al. 2013:7; de Wet and du Plooy 2012:387). These authors state that some nurses use physical activity like exercise in a gym as a way to relieve their stress and it allows them to use their energy constructively, making them less susceptible to stress and thus compassion fatigue. According to Showalter (2010:241) exercise is good for the body, soul and spirit. Participating in exercise such as swimming, walking, running, jogging as well as hiking three times a week helps to get rid of stress hormones and to replenish energy to enhance physical, spiritual and emotional well-being (Lombardo and Eyre 2011:4).

Some participants reported spending time with friends relaxing and talking and just cooling down helps them to distress. Kerr et al. (2011:488) share in the sentiment of the participants and state that nurses cope at different levels which include the physical, social, cognitive and emotional, some nurses will turn to others for psychological support, feel better after talking and expressing their feelings. Authors Berman and Snyder (2012:1090) and Tunajek (2006:26) argue that relaxation techniques can be used as detaching skills to help to quiet the mind and release tension, thus it can be used as a way to distress (Huggard and Huggard 2008:3). According to (Stanton-Rich and Iso-Ahola cited in Puig et al. 2012:106) leisure behaviour and leisure satisfaction help to mitigate work-stress because engaging in non-work-related activities will increase nurses' sense of well-being and thus prevent compassion fatigue. Spending less hours per week working with patients who are HIV positive act as a buffer against stress and therefore compassion fatigue (Bennett cited in Gueritault-Chalvin et al. 2000:150-151). Therefore, Varner (2003:20) encourages healthcare professionals to take regular time off work in order to reconnect with the world outside of work. Rapp (2012:80) states that the use of internal coping strategies such as discussing issues with others, taking a break away from work or escaping from work-related stress can be used by caregivers who work in the HIV/AIDS field. Effective internal coping strategies should be recommended to healthcare professionals who work in the HIV/AIDS field to decrease the chronic fatigue, frustration and depression they experience from working in this field. According to Cowen and Moorhead (2011:760-761) and McHolm (2006:15) compassion satisfaction and disengagement from the thoughts, feelings and sensation associated with patients' trauma are the keys to prevention and mitigation of compassion fatigue.

Participants also reported that at times they organise a weekend away from home to go and debrief and talk to about their feelings. The research findings is consistent with (Miller 2004 cited by Huggard and Huggard 2008:3) that state that being surrounded by supportive people can help to manage stress, distancing themselves from the ongoing misery of patients through a conscious, rational effort letting go of the thoughts, feelings and sensations associated with caring for the traumatized (Figley 2002:438). Yoder (2010:194) argues that informal debriefing and taking action to change/manage current situation can be used as coping strategies to mitigate compassion fatigue. Sanchez-Reilly et al. (2013:77) state that self-care include stress management activities, like engaging in leisure activities and spending time with love ones are very important (Cowen and Moorhead 2011:761-762). According to Masters, Stilman and Spielmans (2007:11) nurses can join a peer support group where regular debriefing sessions take place to discuss their caseloads without violating their patient's confidentiality.

Being **spiritual**, believing in a higher being as well as engaging in prayer and reading the Bible as ways to distress were also reported by participants. Yoder (2010:194) states that being spiritual or religious which include prayer, faith and spending time with a pastor and modification of attitude by keeping up their spirit help nurses to focus on other things and help to de-stress. Literature describes how spirituality and prayer are used by nurses who work in the HIV/AIDS field to help them distress (Bam and Naidoo 2014:14; Kerr et al. 2011:488; 489; Gorman and Sultan 2008:373). According to Lehmann and Zulu (2005:47) prevention and treatment of compassion fatigue must start with protection and healing of the spirit, and with a heightened awareness addressing the emotional, spiritual and psychological need of nurses. Alkema, Linton and Davies (2008:114) argue that healthcare professionals who engage in emotional, spiritual and personal-professional self-care strategies will experience work-related satisfaction that lead to compassion satisfaction, thus helping to prevent the negative consequence of compassion fatigue. Some participants also encourage their patients to pray. The findings of the study are consistent with Kerr et al. (2011:488; 489) that nurses' spiritual foundation and religious beliefs assist them to cope in a positive way and in cases where they feel they cannot do anything they prayed for their patients. According to Berman and Snyder (2012:1070) prayer is a human response to existential moments when human beings have serious questions about existential issues and it helps to seek meaning to life. Some patients who experience feelings of guilt, anxiety, grief, anger, despair or loneliness may ask nurses to pray for them because these feelings may interfere with their ability to pray. People also engage in spirituality to communicate love and understanding, to provide comfort to others

and to build intimate relationships. Spiritual engagement makes people resilient and helps them to cope with loss, grief and bereavement (Penman 2012 cited in Solomon 2014:75)

One participant in the study indicated that when she is at home she does not want to think of work, she just switch off. Gerow et al. (2009:127) had similar findings in their study and state that nurses use detachment as a coping strategy when dealing with traumatic events. Figley (2002:1438) argues that disengagement from patients' pain or trauma lower or prevent compassion stress. According to Loolo (2016:106-107) it is important that nurses be able to consciously and objectively disengage from the patients' deep pains during the helping process because their disengaging effort will help to reduce compassion fatigue. Disengagement is a strategy that nurses use to prevent compassion fatigue and maintain their well-being through ways that promote self-care and by avoiding their patients' traumatic events (Tunajek 2006:26). According to Bush (2009:27) nurses should engage in self-care activities that rejuvenate, comfort and restore empathetic caring causing them to experience compassion satisfaction and maintain professional boundaries (Alkema, Linton and Davies 2008:101). Thus, nurses should balance self-care and caring for others because compassion fatigue correlates negatively with all aspects of self-care, meaning that people who suffer from compassion fatigue tends to neglect self-care (Parsons 2014:14).

A number of personal strategies to prevent and manage compassion fatigue have been included in the wellness programme, such as building and strengthening nurses' resilience and organisational culture that encourage self-care practices. In order to cultivate resilience strategies such and cognitive reframing, toughening up, grounding connections, work/life balance and reconciliation were recommended (Hart, Brannan and Chesnay 2014:13-14).

Practicing **self-care** is a very important intervention in the prevention and management of compassion fatigue, therefore nurses should be educated on self-care techniques and ways to maintain life balance that will improve their resourcefulness and help to build their resilience (Portnoy 2011:49). As part of self-care nurses should be encouraged to develop and maintain a healthy lifestyle by participating in exercise, spending time with family, nurturing self and good nutrition are encouraged in the wellness programme as a means to prevent compassion fatigue (Meadors and Lamson 2008:33). It is important that nurses nurture themselves and take time to pursue non-work related activities. According to Best Start Resource Centre (2012:21) participation in hobbies or being a volunteer can protect individuals from compassion fatigue because it promotes well-being. Maltzan (2011:312)

argues that nurses should be encouraged to pamper themselves to an experience that holds special meaning to them or that is enjoyable to them. Time should also be created for social interaction with other staff members, and this can be done on an annual basis organising fun days and staff may be allowed to bring their families along to enjoy a day of leisure on their off time (Shifrin 2011:61). Nurses can also be encouraged to participate in healing activities that renew life, such as gardening, painting and just enjoying nature (Meichenbaum n.d.:14). Nurses should also be educated on the use of mindfulness exercise that teaches them to intentionally deal and cope with stress, pain and illness and the demands of everyday life. Mindfulness may help to prevent and manage compassion fatigue (Potter, Deshields, Divanbeigi, Berger, Cipriano Norris et al. 2010:E57; Pearlman and McKay 2008:27). Mathieu (2007:4) argues that when nurses feel overwhelmed they should be educated to say 'no' without feeling guilty as part of self-care.

On the 1st December of each year staff who work in ARV clinics celebrate World AIDS Day (WAD) which is the day that the world commemorates everybody who have passed away due to HIV/AIDS. This is also used as an opportunity to celebrate patients' lives. Participants in the study indicated that as a way to de-stress they commemorate World AIDS Day, **they celebrate the lives of patients** who have passed away. Aycock and Boyle (2009:186) state that some organisations host patient celebrations and regular memorial services for patients to provide bereavement support to staff. Kniesl and Trigoboff (2009:207) argue that as a way of coping with the death of their patients nurses may grieve in a therapeutic way, like celebrating the deceased patient's life and share good memories, even performing caring rituals. Attending patients' funerals will assist nurses to find closure to the death of their patients help nurses to find closure (Fetter 2012:560; Gerow et al. 2009:126). O'Neil (2015:n.p.) suggests starting up a remembrance tree for patients who died will give nurses the opportunity to validate their feelings and also to facilitate a sense of community amongst staff. According to Foster (2014:26) and Huggard and Huggard (2008:4) individuals should find useful ways to leave their professional role at work at the end of the day through the use of self-distraction and behavioural disengagement as coping strategies.

5.4 Document analysis

To enhance understanding of the data gathered through interviews, and to illuminate and contextualise the responses to the interview questions, the researcher examined the Department of Public Works of South Africa's Wellness Programme and job descriptions of professional and enrolled nurses.

Job descriptions

The researcher found that the job description for both categories of nurses is generic and not specific for nurses who work in ARV clinics. Nurses have to adapt the nursing care plan/program for patients who are HIV positive that will promote their health, promote self-care, treatment and rehabilitation. Hence, nurses should be aware of existing guidelines and policies and it should be made available to them in order to develop nursing care plans for their patient-revision of guidelines and policies are very important. The researcher used the job descriptions to review whether it contains any non-nursing duties that nurses are doing and how it affects their well-being. During the review of the job descriptions the researcher found that many of the tasks that nurses who work in ARV clinics are responsible for are not contained in the job description e.g. counselling of patients who are HIV positive (See Table 3.2, Role and function of professional and enrolled nurses working in ante-natal, adult and paediatric ARV clinics). During the interviews the researcher also concluded that there were non-nursing duties such as compiling statistics that nurses are expected to carry out that take up a great deal of their time that they could use rendering patient care.

Professional nurses' job description:

The key performance areas of the professional nurses' job description (Gauteng Department of Health 2007, see Appendix M on CD) comprise of the following: provide direction and supervision for the implementation of the nursing plan (clinical practice/quality patient care), implement standards, practices, criteria and indicators for quality nursing (quality of practice), practice nursing and health care in accordance with the laws and regulations relevant to nursing and health care, maintain a constructive working relationship with nursing and other stakeholders and utilize human, material and physical resources efficiently and effectively. The job description is generic and is also used by nurses who work in ARV clinics. Nurses have to adapt the nursing care plan/program for patients who are HIV positive that will promote their health, promote self-care, treatment and rehabilitation. Hence, guidelines and policies should be made

available to nurses in order to develop nursing care plans for their patients-revision of guidelines and policies are very important.

Enrolled nurses' job description (In the job description referred to as staff nurses):

The key performance areas of the enrolled nurses' job description (Gauteng Department of Health 2007, see Appendix N on CD) comprise of the following: development and implementation of basic patient care plans, provide basic clinical nursing care, effective utilization of resources and maintenance of professional growth/ethical standards and self-development. Enrolled nurses function under direct supervision of a professional nurse, which is also the case in ARV clinics.

Discussion on job description

During the review the researcher found that both professional and enrolled nurse job description are generic and used by all professional and enrolled nurses who work in in the public sector irrespective of the discipline in which they work (Gauteng Department of Health 2007). The fact that the job descriptions are generic can cause the main focus of the job to be diluted and create uncertainty as to whether a task or activity is part of a person's job description. Pillay (2007:74) argues that an employee's job description is important and should contain a detailed description focussing on the job itself including the responsibilities, activities and deliverables of the person holding the position. A job description summarises the important features of a job, general nature of the work, i.e. duties and responsibilities, skills required, responsibility and working conditions of the job. Parfitt (2014:46) states that job descriptions should be tailored and should incorporate the values, attitudes and behaviour required for the job and the roles need to be adaptable to reflect the context according to the service area the person works in. According to Cohen (2014:8) a job description should clearly delineate what the organisation expects from the employee.

The Employee Health and Wellness Strategic Framework for Public Services:

The researcher gained access via the following website: www.dpsa.org.za to review the Employee Health and Wellness Strategic Framework for Public Services that was developed during 2006-2008 through extensive consultative processes by Department Public Service and Administration Republic of South Africa (See CD listed as Appendix Q). The key objectives of the Employee Health and Wellness Strategic Framework are to provide an integrated, needs-driven, participation and holistic approach to employee health and wellness in the public sector. The target audience is all public servants in government departments and other government entities, as well as employee health and

wellness line managers, and practitioners responsible for implementation of employee health and wellness programmes, top managers and political leadership.

The researcher found that a wellness programme exists and was developed to improve the health and well-being of all categories of staff employed in the public sector and not just specific for nurses. However, participants reported that there is no wellness programme available and they also indicated that debriefing facilities are lacking. This finding is in contradiction to the fact that the researcher found that a wellness programme, does exist and was developed by The Department of Public Services and Administration in 2006-2008. The contradicting findings could be attributed to the fact that maybe nurses who work in ARV clinics are not aware of the existence of the wellness programme, or that the programme is not well implemented, causing nurses in ARV clinics not to be aware of such a programme.

The health and wellness programme consists of the following sections that illustrate the key elements of the framework: the context, strategic thrusts, principles, objectives, the legal framework, implementation plan, and monitoring and evaluation framework. The programme is based on an integrated approach and recognises the importance of linking individual health, safety and wellness, organisational wellness, environmental sustainability, quality management to productivity and improved service delivery. Priority areas for development of strategic mechanisms and interventions include: HIV/AIDS and TB management, health and productivity management, safety, health, environment, risk and quality management (SHERQ), and wellness management (Department Public Service and Administration Republic of South Africa [DPSA] 2008:1-3).

During review of the document it became evident to the researcher that a framework for the health and wellness framework for public servants exists but implementation thereof is lacking. The researcher will only highlight some of shortcomings that occur in the functioning pillars of in the implementation of strategies and interventions and will link it to participants' responses.

The following pillars of the health and wellness framework will be discussed next:

Building blocks of the functional pillars:

Pillar 1: HIV and AIDS and TB management

The framework recognises that the HIV/AIDS and TB epidemic affect the lives of all South Africans is a major cause of death and cover areas of prevention, treatment, care and

support, human and legal rights and access to justice as well as monitoring and evaluation (DPSA 2008:23-24). The researcher found that the framework guides public service organisations in responding to the HIV/AIDS and TB epidemic by caring and supporting the infected employees but that no interventions are implemented to ensure the safety of service providers in protecting their health and well-being, for example infection control. During the interviews one participant corroborate this finding stating that the nurses who work in ARV clinics **are not screened for TB symptoms**, irrespective of the fact that they are exposed to patients who suffer from infectious TB.

Pillar 4: Wellness management:

The framework recognises that individual wellness is the promotion of the physical, emotional, occupational, spiritual and intellectual wellness of an individual and includes identification of psycho-social health risk. Whereas organisational wellness promotes an organisational culture that is conducive to individuals, physical and psychosocial wellness, and organisational wellness and work-life balance in order to enhance effect and efficient functioning of the public service (DPSA 2008:31). Activities for above stated wellness management are included in the Generic Implementation Plan of the framework (DPSA 2008). However, the researcher deduced from the participants' responses that "**there is no wellness programme**" that the framework is not communicated or implemented in antiretroviral clinics in this specific public tertiary hospital, and compassion fatigue as such is not addressed under this functioning pillar. Pillay (2007:91) argues that different methods should be used to communicate the availability of wellness programmes to employees, namely awareness campaigns, conferences, internet, orientation and induction programmes, and booklets. The author also suggested that the HIV and AIDS policy can be marketed at World AIDS Celebration days.

Wellness programmes are intervention strategies that intend to promote the well-being of employees. The possible return on resources invested in such a programme can include lower absenteeism, healthier employees, fewer accidents, and lower staff turnover (Patel 2012:4). In a study done by Sieberhagen, Pienaar and Els (2011:9), the authors found that the main activities budgeted by organisations' for their employee wellness programmes include HIV/AIDS and health services, EAP services, wellness services, counselling, training, assessment and social responsibilities. Wellness programmes can be curative and preventive in nature and the purpose is to create awareness of wellness issues, to facilitate personal change and health management as well as to promote a healthy, supportive workplace. A wellness programme typically include activities that focus on relieving the stress of employees cause by personal issues, substance abuse, health

problems, career crises and job demands. The support provided to employees through wellness programmes increases their mental well-being, energy, resilience, life and job satisfaction as well as reduced stress and depression (Renaou et al. 2008; Anonymous 2007; Thogersen-Ntoumani and Fox 2005; Berrigde and Cooper 1994; Leiter and Wahlen 1996 cited in Sieberhagen Pienaar and Els 2011:2)

5.5 Summary

In this chapter the researcher discussed the findings of Phase one of the study and the Theoretical Framework of the study. In the next chapter, in Phase two of the study, the development of the wellness programme will be discussed.

CHAPTER SIX

PHASE TWO DEVELOPMENT OF A WELLNESS PROGRAMME

6.1 Introduction

In the previous chapter the researcher discussed the findings of Phase One. In this chapter the researcher describes the development of the wellness programme for nurses working in the antiretroviral clinics in a tertiary public hospital. In chapter four the researcher identified three themes, five categories and 16 sub-categories which were used to develop the wellness programme (see Figure 4.1 Themes, categories and subcategories). For Theme 1, the risk to develop compassion fatigue interventions were identified that address factors related to the cost of the nurse-patient relationship, work environment issues that increase nurses' risk to develop compassion fatigue. For Theme 2, manifestation of compassion fatigue that presents physical, psychological, spiritual and behavioural presentation the researcher identified interventions that aid in creating awareness to compassion fatigue and availing tools that nurses can use to assess the manifestation of compassion fatigue. Whereas, for Theme 3, interventions to prevent and manage compassion fatigue were identified. These include preferred support from management as well as personal strategies that nurses use to manage compassion fatigue.

6.2 The concept of wellness

Wellness is a person's state of well-being that contributes to improved quality of life (DeVries 2009:47). Wellness is not something that will happen automatically or simply something you have or do not have (Swarbrick, D' Antonio and Nemeč 2011:335) but wellness is a conscious, deliberate process that requires an individual to become aware of choices made and how those choices influence their well-being (Swarbrick 2009:344).

The World Health Organisation (WHO 2014) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Total health has become synonymous with the term wellness; therefore, for the purpose of this study the researcher will use the term wellness. According to Strout (2012:129-130) wellness expands beyond health and every individual strives to achieve their full potential through a self-directed effort that maximize their *wellness* and individuals' perception on wellness depends on their experiences and values. Thus, the concept of wellness is not

static but it continuously gravitates towards a state of wellness because as people experience enhanced wellness they become more self-aware and want to learn new ways on how to promote their wellness. Swarbrick (2009:344) states that wellness is a conscious process that requires persons to be involved and become aware of choices that they make to live a more satisfying lifestyle. Persons need to make healthy lifestyle choices in order to maintain their well-being with regard to them getting adequate rest and sleep, nutrition, exercise, participation in meaningful activities, productivity, social contact and supportive relationships. Hence, practicing self-care is important to maintain wellness.

Hettler (1976:1-2) identified six wellness dimensions namely physical, intellectual, spiritual, emotional, social and occupational. Each of these dimensions reflects unique characteristics that interconnect with one another to represent the individual as a whole. However, Swarbrick, D'Antonio and Nemec (2011:334) added two dimensions, namely environmental and financial to the dimensions to Hettler's list of dimensions. The researcher focused on the wellness dimensions identified by Swarbrick, D'Antonio and Nemec (2011:334) during the development of the wellness programme to identify interventions that would aid in the identification, management and prevention of compassion fatigue amongst nurses working in antiretroviral clinics. In Figure 6.1 the inter connectedness of the eight wellness dimensions is indicated.

6.3 Wellness programmes

According to DeVries (2009:47) wellness programmes are interventions developed with the intention of promoting the well-being of individuals. It is achieved by integrating the personal, emotional, behavioural and environmental issues that impact on the individuals' and/or early detection and treatment of identified health risks. Employee wellness programmes are broadening their scope to promote employee wellness through inclusion of HIV/AIDS testing and treatment programme, organisational change, fitness, work/life balance, debriefing, substance abuse and mental well-being of employees (Bessinger 2006:57). Kerr, Laschinger, Severin, Almost, Thomson, O'Brien-Pallas et al. (2002:9) is of the opinion that nurses' health and well-being are affected by the challenges and constraints they face in the workplace. Therefore, the workplace of nurses should be considered when wellness programme are developed to ensure the success of such programme.

6.3.1 Purpose of wellness programmes

The purpose of employee wellness programmes is to influence and actively promote healthy and safe lifestyles that enhance employees' well-being (Bessinger 2006:78). Swarbrick, D'Antonio and Nemecek (2011:35) state that wellness programmes (see Figure 6.1 Eight dimensions of wellness) can be used to create awareness on health issues, to provide support, and empower employees to change their behaviour. In addition employees are encouraged to participate in self-care activities that will promote their well-being (Flannigan 2010:335).

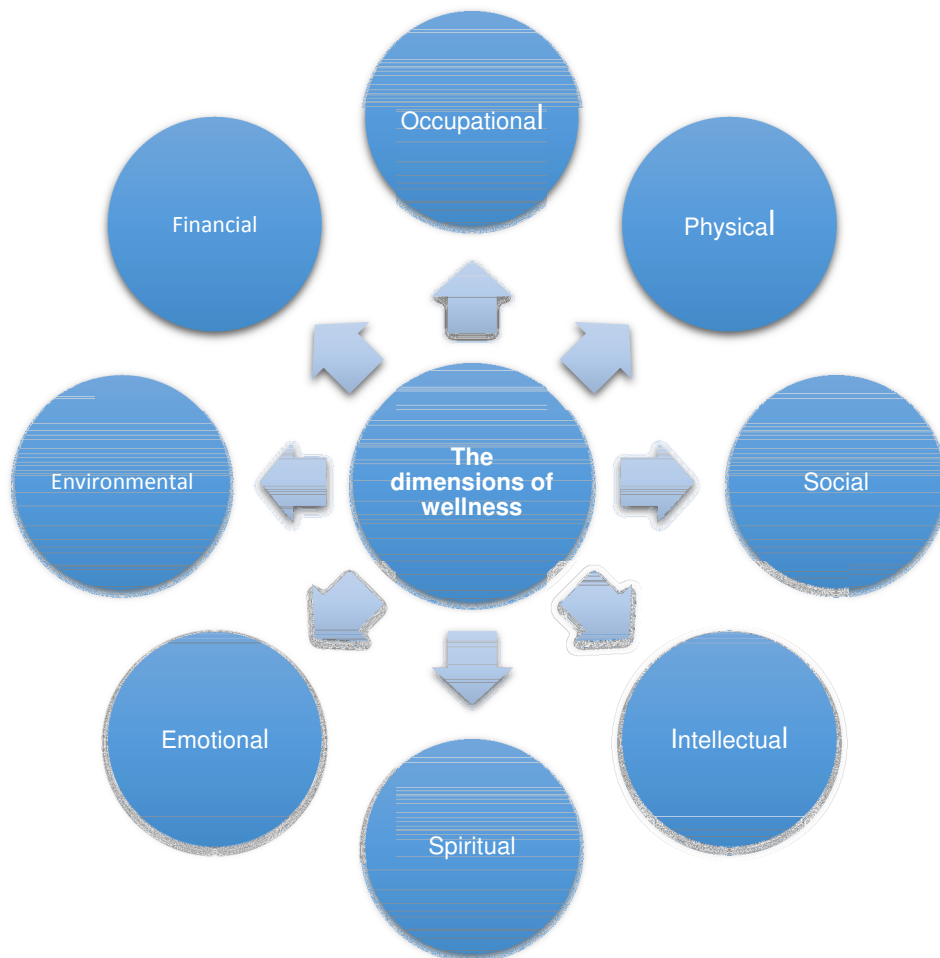


Figure 6.1 Eight dimensions of wellness Swarbrick, D' Antonio and Nemecek (2011)

6.3.2 Advantages of wellness programmes

Comprehensive, strategically developed wellness programmes that invest in employees' physical, social and mental well-being benefit both employers and employees. Employers benefit from reduced absenteeism, increased productivity and lower health care costs. Employees are assisted in coping with changes in the work environment, making informed decisions about their own health and to identify their own health risks. Thus, participating

in wellness programme activities improve employees' well-being and also increase a sense of belonging as they interact with other employees (Bessinger 2006:9). Parks and Steelman (2008:65) argue that employees who benefit from wellness programmes seem to be happy, resulting in job satisfaction because they may feel that their employers care about them (Berry, Mirabito and Baun 2010:2). Using wellness programmes as a way of recruitment and retention of employees can ensure that the organization hire the most effective and productive employees, especially when a wellness programme provides opportunities that is attractive to employees, causing the organisation's performance to be affected in a positive way (Bessinger 2006:57).

6.3.3 General scope of wellness programmes

Workplace wellness programmes should be part of the overall organizational strategy for a healthy workplace (Canadian Centre for Occupational Health and Safety n.d.:1). According to Merrill et al. (2011:782) different approaches can be used to improve employees' health, such as changing behaviour through education, health coaching, provision of free screening services with medical treatment and provision of incentives to workers to encourage participation in wellness activities. Wellness interventions seem to be a promising method for creating awareness around health issues and assisting staff to identify their own wellness strength and limitations using a person centered model guided by their supervisor (Swarbrick, D'Antonio and Nemeč 2011:335).

Bessinger (2006:57) argues that health and well-being should be integrated in employees' jobs and in their workplace to ensure a workplace environment that is stimulating and satisfying and free from hazards. Wellness programmes in general should be broad and should focus on HIV/AIDS testing and treating, organizational change, fitness, work/life balance, debriefing, trauma and substance abuse as well as the mental well-being of employees.

6.4 A wellness programme to identify, prevent and manage compassion fatigue amongst nurses working in antiretroviral clinics in a public tertiary hospital

Before the researcher discusses the wellness programme, a summary of the findings of Phase one is provided. These findings form the basis of the wellness programme.

6.4.1 Summary of findings of Phase one

In this section a summary of the findings from the interviews and documentation is given.

6.4.1.1 Interviews

Following is a summary of the themes and the related literature.

Theme 1: Risk to develop compassion fatigue:

Nurses working in the ARV clinics are at risk of developing compassion fatigue due to work environment issues such as challenges created by the health care system, lack of support from management, and their overwhelming work load. Killian (2008:39) argues that larger system failure that prevent healthcare professionals from providing care to their patients cause healthcare professionals to feel helpless and hopeless and increase their vulnerability to compassion fatigue. In a study done in Zambia by Dieleman et al. (2007:143), it was revealed that nurses who work in ARV clinics had difficulty in coping due to lack of managerial support. Several authors argue that lack of management support causes an increase in nurses' stress levels and make them vulnerable to compassion fatigue (Enerholm and Fagrell 2012:12; Goga and Thomson 2012:15; Rodriguez-Cortes 2012:14; Haber, Roby and High-George 2011:546; Uebel et al. 2010:589).

Tawfik and Kinoti (2006:10) argue that the HIV/AIDS epidemic have increased the workload of health care workers because more people need HIV care causing nurses to feel overwhelmed resulting in them becoming stressed and frustrated (Berg and Nilsson 2015:10-11). Feeling overwhelmed increase health care workers' vulnerability to develop compassion fatigue (van Dyk 2012:408; Harrowing 2011:4; Smart 2009:2; Creamer and Liddle 2005:94). In addition, the cost of the nurse-patient relationship contributed to them being at risk of compassion fatigue. Aspects that were identified included caring for traumatised patients, vicarious exposure to traumatic experiences of their patients, and the influence caring for patients who are HIV positive has on their personal lives and their families. These aspects place nurses at risk of developing compassion stress, compassion discomfort and ultimately compassion fatigue.

According to Berg and Nilsson (2015:3) nurses' role is to care for the sick, to restore their health and reduce their suffering. In doing so the emotional energy they pour into caring for their patients may induce compassion stress which is the residue of empathetic response to relieve patients' suffering that cause them to be susceptible to compassion fatigue (Harris 2015: 8; Boyle 2011:2; Knobloch 2007:86). Caring for difficult patients, like

those who engage in destructive behaviour, become a source of stress and it negatively affects the caring relationship leading to compassion fatigue (Kotula 2015:13; Gorman and Sultan 2008:34; Smith 2007:19). Aycock and Boyle (2009:184) argue that compassion fatigue not only affect nurses but also their family members, because they can transmit the negative energy from caring for traumatised patients to their families. Thus, nurses can traumatise their family members by continually not being available for them through emotional withdrawal.

Theme 2: Manifestation of compassion fatigue:

The nurses presented with physical, psychological and spiritual signs and symptoms of compassion fatigue. Their behaviour also changed as they progressed towards compassion fatigue. Physically they presented with fatigue, low energy levels, insomnia and dizziness. Psychologically they presented with depression, fear, despair, higher stress levels and feeling emotionally drained. In contrast nurses also experienced a sense of satisfaction that they made a difference in their patients' lives. Spiritually they presented with doubt in themselves as they felt the need for major change, such as a new job. The behaviour they exhibited included being irrational, aggressive, impatient, irritable and angry. They also disengaged from their patients and started to neglect their own appearance. McHolm (2006:15) argues that indicators of compassion fatigue vary but affect people physically, psychologically, emotionally and spiritually. The manifestation of compassion fatigue can become progressively worse causing people to question the meaning and purpose of life. They isolate themselves from others, engage in destructive compulsive behaviour such as substance abuse, overspending, overeating, feeling apathetic and having difficulty in concentrating and low productivity (Sinclair and Hamill 2007 cited in Ledoux 2015:3).

Theme 3: Strategies to prevent and manage compassion fatigue:

Various strategies to prevent and manage compassion fatigue were identified: both what nurses can do and what they expect from management. They regarded collegial support as important and revealed that they need to pay more attention to self-care to prevent and manage compassion fatigue. Collegial support is valued as a primary source by healthcare professionals who work with patients who are HIV positive and can be used as a strategy to lessen compassion fatigue (Bam and Naidoo 2014:8; Romeo-Ratcliff 2014:59). Nurses should deliberately engage in self-care programmes that include stress management activities, participation in leisure activities; physical exercises, get enough rest; eat a balanced diet and meditate (van Dyk 2008:418). They should also spend time with loved ones (Cowen and Moorhead 2011:761-762).

Celebrating the lives of patients' who have passed away helped nurses to find closure and this minimise their traumatic experiences and, thus lessen their risk of developing compassion fatigue. Kniesl and Trigoboff (2009:207) argue that as a way of coping with the death of their patients nurses may grieve in a therapeutic way, like celebrating the deceased patient's life and share good memories, even performing caring rituals. Attending patients' funerals will assist nurses to find closure to the death of their patients and help them to find closure (Fetter 2012:560; Gerow et al. 2009:126).

Debriefing, managerial and psychological support were deemed important in managing compassion fatigue and as a way to prevent it from recurring. Louw et al. (2011:656) argue that debriefing is a very important part of any wellness programme, it gives nurses the opportunity to express their emotions and experiences in a controlled environment that emanate from feelings that emanate from caring for traumatised patients (Kangethe 2009:120). Debriefing can help to prevent and manage compassion fatigue (Yoder 2010:196; Aycocock and Boyle 2009:188). According to Zander, Hutton and King (2010, p. 101) in order to cope with stressors in the workplace nurses need support from management, a positive attitude, experience caring for patients who are HIV positive, a personal process of coping, resourcefulness, balance in life and the ability to overcome challenges in everyday clinical work situation.

6.4.1.2 Document analysis

The researcher examined the Department of Public Works of South Africa's Wellness Programme and job descriptions for professional and enrolled nurses to enhance understanding of the data gathered through interviews, and to illuminate and contextualise the responses to the interview questions,

The nurses' job description is generic and does not spell out their role and function within antiretroviral clinics. Nurses who work in the ARV clinics are delegated tasks on a daily basis using a delegation book. Parfitt (2014:46) states that job descriptions should be tailored and should incorporate the values, attitudes and behaviour required for the job. The roles need to be adaptable to reflect the context according to the service area the person works in. According to Cohen (2014:8) a job description should be clearly delineate what the organisation expects from the employee.

The main purpose of the Employee Health and Wellness Strategic Framework for the Public Services is to ensure the health and safety of all employees (Department Public Service and Administration Republic of South Africa 2008:38). However, the

implementation of the health and wellness programme is lacking as was evident from participants' responses that there is no wellness programme in ARV clinics that provide the necessary support. In a study done by Sieberhagen, Pienaar and Els (2011:9) the authors found that the main activities budgeted by organisations' for their employee wellness programmes include HIV/AIDS and health services, EAP services, wellness services, counselling, training, assessment and social responsibilities. Wellness programmes can be curative and preventive in nature, the purpose of which is to create awareness of wellness issues, to facilitate personal change and health management as well as to promote a healthy, supportive workplace. A wellness programme typically includes activities that focus on relieving the stress of employees caused by personal issues, substance abuse, health problems, career crises and job demands. The support provided to employees through wellness programmes increases their mental well-being, energy, resilience, life and job satisfaction, as well as reduce stress and depression (The following authors: Renaou et al. 2008, Anonymous 2007; Thogersen-Ntoumani and Fox 2005; Berrigde and Cooper 1994; Leiter and Wahlen 1996; are cited in Sieberhagen Pienaar and Els 2011:2)

6.4.2 Steps used to develop the wellness programme

The researcher adapted the steps recommended by Dubois, Hershfield, Hyndman and Jackson (2001) to develop the wellness programme:

Step 1: Identify purpose, objectives and population of interest

Step 2: Develop interventions and action steps

Step 3: Refinement of the wellness programme

Step 4: Reviewing of the wellness programme

6.4.2.1 Step 1: Identify purpose, objectives and population of interest

According to Dubois et al (2001:27) it is important to understand the relationship between the goals, the population of interest and the objectives of a wellness programme. The purpose and objectives of the wellness programme as well as the population at risk of developing compassion fatigue will be discussed next.

The purpose of the wellness programme

The purpose of the wellness programme is to identify, prevent and manage compassion fatigue amongst nurses working in ARV clinics.

Objectives of the wellness programme

The objectives of the wellness programme are identification and management of existing compassion fatigue and prevention of recurrence of future compassion fatigue amongst nurses working in ARV clinics.

Population of interest

Identifying the population of interest is important because it guided the researcher to use more appropriate strategies in order to reach the objective of the wellness programme. The target population for whom the wellness programme is intended is the nurses working in the different ARV clinics.

6.4.2.2 Step 2: Develop interventions and actions

In this step the researcher identified interventions and specific actions to be taken that will achieve the objective of the wellness programme. The researcher brainstormed, with nurses who work in anti-retroviral clinics and her supervisors, possible interventions based on the findings of Phase one of the study. Related literature was also used to identify the most effective interventions. Added to this the interventions were developed bearing in mind the available resources, time, population needs and effectiveness. The key question asked was “What interventions are needed to identify, manage and prevent compassion fatigue for Phase two of the study that will promote the well-being of nurses who work in ARV clinics.”

According to Solomon (2014:13) interventions are any type of treatment, preventive care or test undertaken to improve health or, to assist with a particular problem. There are four levels of interventions in health care: namely communication and awareness programmes; screening and assessment programmes; education and lifestyle programmes and behaviour change support systems (Baun, Horton and Storlie 1992 cited in Bessinger 2006:61). Inbar and Ganor (2003:110) indicate that wellness programme interventions and strategies should focus on creating awareness through a process of self-consciousness that will lead to early recognition of signs and symptoms of compassion fatigue. Such programmes should also educate nurses on how to change their lifestyle and behaviour as well as provide support systems for nurses. Support can be provided at individual and professional level. At individual level nurses should be empowered to effectively manage their time and how to restructure their daily routine. At professional level the support provided should include interventions at the cognitive-behavioural and social-organisational level. The cognitive-behavioural interventions should address the

way nurses perceive and interpret reality and social-organisational interventions should assist nurses in dealing with crises and traumatic situations.

The researcher considered the wellness dimensions described by Swarbrick, D'Antonio and Nemec (2011) during the development of the wellness programme (see Figure 6.1 Eight dimensions of wellness). The researcher developed five interventions with 12 sub-interventions and action steps that will aid in identifying and managing existing compassion fatigue and prevent future occurrence thereof. The researcher describes the wellness programme using a rationale for the inclusion of an intervention and action steps. The rationale was obtained from related literature and states the reason why the interventions were developed and the action steps indicate the 'who', 'how', 'when' of the interventions as to what action should be taken. This wellness programme includes interventions at personal and professional level in order to minimize the risk to develop compassion fatigue as well as identification and management thereof (Najjar et al. 2009:273).

The organisation is responsible for the establishment of wellness programmes for employees. The researcher developed the wellness programme based on the premise that the organisation would enable management to appoint a person that will facilitate the implementation of the wellness programme for nurses who work in the antiretroviral clinics to prevent and manage compassion fatigue. The person appointed by the organisation to implement the wellness programme should be a psychologist or traumatologist and should have knowledge HIV/AIDS and should have previous experience of implementing a wellness programme.

The interventions are presented according to the themes identified in Phase one of the study.

Theme 1: The risk to develop compassion fatigue

The researcher identified two main interventions with related sub interventions under this theme.

Intervention 1:

Enhance nurses' ability to overcome work environmental factors that contribute to compassion fatigue

This intervention aims to provide ways of addressing the challenges nurses face in the work environment in order to minimise their risk of developing compassion fatigue.

Intervention 1a: Foster an atmosphere that is supportive of work/life balance

Rationale:

Frank and Karioth (2006:10) state that working extended hours and experiencing personal life disruption may cause nurses to be more vulnerable to compassion fatigue. According to Kulesa (2014:27) time away from direct patient care lessen the symptoms of compassion fatigue. Therefore, Bessinger (2006:19) recommends that healthcare professionals maintain a good balance between work and home life in order to defuse the tension they experience. Balancing work/life enables nurses to invest time and energy into nurturing themselves so that they are able to nurture and care for others (Boyle 2011:4). Thus, maintaining a balance between work and home life will help to decrease the risk of nurses developing compassion fatigue Zander (cited in Walker, Morin and Labrie 2012:14; Boyle 2011:7; Maytum, Heiman and Garwick 2004:177). Putting up boundaries protect nurses from experiencing negative feelings and help them to compartmentalize their experiences moving on with the day-to-day caring of their patients (Gerow et al. 2009:126-127).

Actions:

The person appointed by the organisation to run the wellness programme will be responsible to implement identified interventions and actions that will help to minimise the risk of nurses developing compassion fatigue.

- Emphasise the need for nurses to maintain a balance in their life. Encourage them to include a break for meals and physical activities or time to rest in each work day.
- Educate nurses on how to delineate and maintain professional boundaries and how to maintain emotional distance from troubling situations.
- Encourage nurses to spend time with family and engage in activities that the family can do together that will assist them to disengage from work-related issues when at home.

- Establish a system that monitor nurses' work schedules that limit the number of overtime in order reduce exposure to traumatic stressors and increase their job satisfaction.

Intervention 2

Lessen the negative effect of the cost of nurse-patient relationship

The aim of this intervention is to provide ways of ensuring that the cost of the nurse-patient relationship does not contribute to compassion fatigue.

Intervention 2a: Desensitise nurses to the exposure to patients' traumatic events

Rationale:

According to Loolo (2016:32-34) long term exposure to patients' traumatic events can bring alterations in healthcare professionals' imaginary system of memory, negatively affecting nurse-patient relationship, resulting in reduced empathy towards patients. Ray, Wong, White and Heaslip (2013:255) state that being pre-occupied with traumatised patients increase vulnerability to compassion fatigue. Portnoy (2011:50) states that healthcare professionals should learn to modulate their responses to the stressors they face. According to Figley (2002:438-1439) healthcare professionals need to be desensitised from traumatic stressors be enabling themselves to face and work through various feelings and issues associated with traumatic experiences.

Actions:

The person appointed by the organisation will be responsible to implement intervention and actions to desensitize nurses' response to the traumatic stressors that they are exposed to in ARV clinics:

- Create awareness amongst nurses of any destructive behaviour, such as over-identification with traumatized patients. Encourage nurses to reach out for help when needed in order to minimise the effect of compassion fatigue on their well-being.
- Provide professional supervision and educate nurses to identify scenarios that are most difficult and exhausting to them. Nurses should identify and review potential reactions they use when those situations arise.
- Encourage nurses to recognise and accept the realities of working in an antiretroviral clinic, accepting that HIV/AIDS is a life-threatening condition and there is no cure for

it. Emphasise the importance to concentrate on the positive features of own and their patients' experiences.

- Decrease exposure to traumatic events. Ensure that nurses have a balanced patient load and that a nurse does not consistently deal with extremely difficult patients and their families.
- Educate nurses on how to identify personal stressors in the workplace and be aware of factors that may cause compassion fatigue. Nurses should be encouraged to keep a journal on any traumatic or meaningful encounters that they have had during the day and share with colleagues at meetings, or they can practice meditation daily.

Intervention 2b: Create a culture of compassion at organisational level

Rationale:

Compassion in organisations can take place at all levels and can be encouraged by managers. Compassion in an organisation makes employees to feel recognised and they feel supported and this will foster resilience and organisational commitment (Kanov et al. 2004:809; Hoffman 2009 cited in Slatten, Carson and Carson 2011:329).

Actions:

The person appointed by the organisation will be responsible to implement intervention and actions to desensitize nurses' response to the traumatic stressors that they are exposed to in ARV clinics:

- Create a culture in the organisation that allows compassion to be expressed towards patients, colleagues, managers and supervisors.
- Recognise employees as human beings and ensure that support systems are in place that will help them to cope in the workplace.

Theme 2

Manifestation of compassion fatigue

Four subcategories were identified under this theme that covers the physical, psychological, and spiritual presentation of compassion fatigue as well as the behavioural manifestation of compassion fatigue.

Intervention 3

Enhance understanding of the manifestation of compassion fatigue

This intervention aims to raise awareness on the manifestation of compassion fatigue to ensure early identification of the development of compassion fatigue.

Intervention 3a: Raise awareness on compassion fatigue

Rationale:

Braunschneider (2013:16; 17) states that compassion fatigue is becoming very prevalent in the healthcare profession. Awareness of how compassion fatigue present is important because self-awareness and early recognition of signs and symptoms are key to the prevention thereof (Hesselgrave 2014:3; Panos 2010:3; Joinson 1992:118). However, Hooper et al. (2010:426) argue that the warning signs and symptoms of compassion fatigue often go unrecognised by nurses. Therefore, creating awareness on compassion fatigue should be the first step in any wellness programme, in order to enable healthcare professionals to consciously use the right coping skills, take appropriate action in seeking help to deal with it and practice self-care that will help to prevent the occurrence thereof (Smart et al. 2013:9; Lombardo and Eyre 2011:3; Tunajek 2006:24-25). According to Kelly, Runge and Spencer (2015:526) addressing compassion fatigue is beneficial for both nurses and the organisations they work for.

Actions:

The person appointed by the organisation to run the wellness programme will implement the following actions to create awareness on compassion fatigue amongst nurses who work in ARV clinics.

- Create awareness amongst new recruits during interviews of the possible risk of them developing compassion fatigue and the effect that it could have on their well-being, due to exposure to patients who are HIV positive while working in antiretroviral clinics.
- Include a module on compassion fatigue in the induction and orientation programme of new staff, in order to create awareness on compassion fatigue. Emphasis should be on educating the new recruits on how to recognise and manage compassion fatigue and informing them of the resources available to help them cope with the challenges they face working in ARV clinics. .

- Acknowledge the presence of compassion fatigue in a proactive way and educate managers and supervisors on identification of risk factors in antiretroviral clinics that may trigger compassion fatigue that could affect patients' care negatively.
- Provide written handouts and articles on compassion fatigue to nurses and include compassion fatigue as a topic on the in-service training schedule as means of continuous personal development.

Intervention 3b: Assess the manifestation of compassion fatigue

Rationale:

Doing the compassion fatigue self-test (ProQOL Stamm 2010), the Compassion fatigue Scale, Compassion Satisfaction and Fatigue Test and/or Compassion Fatigue Self-test can help nurses to become aware of their own compassion fatigue symptoms (Bride, Radey and Figley 2007:156). Firstly it can serve as an important tool for healthcare professionals to understand their feelings of unhappiness and dissatisfaction, and secondly it can help them to develop a warning system for themselves that will indicate when they are going into the danger zone of developing compassion fatigue (Mathieu 2007:2). These compassion fatigue tests can be used as a basis for planning self-care strategies (Stamm 2010:11). According to Panos (2010:4) unrecognized compassion fatigue will result in people to leave their professions, and/or fall into addictive behaviour such as drug abuse and gambling. Nurses can decide which test they would like to use, and access to these compassion fatigue self-tests is free of charge on the internet from: www.compassionfatigue.com or www.sidran.org; or www.proqol.org/Proqol_Test.html.

Actions:

The person appointed by the organisation will be responsible to implement intervention and actions to modulate nurses' response to the traumatic stressors that they are exposed to in ARV clinics:

- Provide access to different compassion fatigue self-tests and encourage nurses to do a self-assessment using the self-report questionnaire that will assist them in identifying any triggers and recognise the signs as well as symptoms of compassion fatigue.

Theme 3

Strategies to prevent and manage compassion fatigue

Based on participants' responses the researcher identified strategies that nurses were using to manage compassion fatigue, as well as preferred support from management that can help nurses to prevent and manage compassion fatigue. Under preferred support from management the researcher identified debriefing, managerial and psychological support as strategies to prevent and manage compassion fatigue. Personal strategies used by nurses to prevent and manage compassion fatigue included collegial support, self-care and celebration of patients' lives.

Intervention 4

Provide workplace support that will prevent and manage compassion fatigue

This intervention aims to provide support to nurses to prevent the occurrence of compassion fatigue as well as management of existing compassion fatigue.

Intervention 4a: Establish on-site debriefing and counselling services

Rationale:

Debriefing with supervisors, consultants or colleagues is regarded as being very important in the prevention of compassion fatigue (Killian 2008:37). Louw et al. (2011:656) argue that debriefing is a highly important part of any wellness programme whereby nurses are given the opportunity to express their emotions and experiences in a controlled environment. It can be used to relieve tension, as well as relieve the emotional adverse effects. Debriefing techniques can be used to prevent compassion fatigue (Pickett et al. 1994:250). Goga and Thomson (2012:15) argue that the purpose of debriefing is to provide support to individuals in managing challenges and demands within the context of their work. Good debriefing support results in an improvement in staff attitude and improvement in services delivery. According to Dominguez-Gomez, Rutledge, Hemet, and Fullerton (2009:203) formal or informal debriefing can provide opportunities to talk about work-related issues and provide relief from distress.

Actions:

The organization should provide the necessary resources and support to the person who run the wellness programme to establish debriefing and counselling services.

- Institute debriefing systems that are available and accessible to nurses when needed with a psychologist/social worker appointed for this purpose.
- Encourage nurses to attend debriefing sessions especially after exposure to traumatic events.

Intervention 4b: Provide workplace support

Rationale:

According to Boyle (2011:5-6) managing and preventing compassion fatigue requires more deliberative attention from managers. Work-related support alleviates work-stress from caring for sick and traumatised patients, promotes compassion satisfaction and in turn prevents compassion fatigue (Ray et al. 2013:257; King et al. 1998 cited in Sabo 2006:140). Support in the workplace indirectly reduces the negative effect of stressors and help to maintain the health and well-being of healthcare professionals. Providing support to those in need outweigh the difficulties experienced at work (Loolo 2016:106; Hunsaker et al. 2015:191; Sheppard 2015:57; Kulesa 2014:25). Hunsaker et al. (2015:192) argue that positive, supportive managers is more likely to have nurses with high levels of compassion satisfaction and in turn less compassion fatigue resulting in retention of knowledgeable, caring and experienced nurses. According to Inbar and Ganor (2003:111; 112) management should design an organizational culture that prevents or moderates the risk of compassion fatigue.

Actions:

Management should provide workplace support to nurses to help prevent and manage compassion fatigue.

- Implement a mentoring programme that places emphasis on enhancing professional skills and competencies of nurses and identifies nurses to be mentored and links them up to a mentor. The mentoring programme should include clinical case review sessions held once a week that focus on discussing difficult HIV/AIDS cases, the correct use of HIV/AIDS policies and guidelines as well as correct drug regimen decisions.
- Promote the establishment of a relaxation centre where staff may go for brief periods of respite, where they can get a light massage or just relax in a quiet comfortable setting.
- Establish a network of collegial support systems to provide support and guidance that will help nurses cope with work demands and addressing emotional issues of working

in ARV clinics. This can be achieved by regular discussions amongst teams where team members are encouraged to participate in making decisions regarding the care and management of difficult patients and for those nurses who work in paediatric ARV clinic. Articles on latest research findings in the HIV/AIDS field and compassion fatigue can contribute to the recognition of compassion fatigue, discussion of its implications and formulation of a team approach to address compassion fatigue.

- Diversify nurses' workload – lessen professional time spend on providing care to the most distressed patients. Mix nurses' caseload, share acute and stable HIV positive patients. Have clear limits regarding time on duty, encourage engagement in research, teaching or other activities to round off clinical service. Rotation of nurses out of the antiretroviral clinic on a regular basis will help to prevent over-exposure to patients' trauma and work-related stress.
- Nurse who work in paediatric ARV clinics should be rotating on a regular basis and assignment given to release them from clinical duties

Intervention 4c: Enhance nurses' sense of job satisfaction

Rationale:

Kelly, Runge and Spencer (2015:527) state that meaningful recognition and increase in job satisfaction can help to prevent compassion fatigue because highly satisfied nurses experience less compassion fatigue. Compassion satisfaction act as a buffer against compassion fatigue by having a protective influence upon individuals' risk levels, balancing the negative effects of caring for traumatised patients and stressful events, resulting in healthcare professionals to be less vulnerable to compassion fatigue (Smart et al. 2013:5; Figley 2002:1437). Malatjie (2010:10) argues that reward and recognition act as a buffer against stress as it helps in the promotion of a positive work environment. Thus, healthcare professionals should focus on finding ways to increase their sense of achievement and sense of compassion satisfaction in order to lower or prevent compassion fatigue (Smart et al. 2013:5; Figley 2002:1437).

Actions:

Actions should aim at improving nurses' sense of self-fulfilment and compassion satisfaction level. The following actions are suggested to increase nurses' sense of achievement and their compassion satisfaction level; the actions can be used by management and/or the person appointed to run the wellness programme to enhance nurses' job satisfaction:

- Institute a reward system that acknowledges outstanding accomplishment of staff e.g. best nurse of the month in order to increase sense of compassion satisfaction.
- Create an environment that allows nurses to achieve optimal performance and productivity. Provide opportunities for personal growth and development.
- Organise social events- such as annual retreats that allow team members to interact with each other.
- Encourage nurses to focus on the successes of the day and the sense of appreciation from patients, e.g. recognition of the psychological successes of care that contribute to the well-being of patients and their families.

Intervention 4d: Enhance the use of positive coping skills

Rationale:

Positive coping skills are associated with lower levels of secondary traumatic stress and compassion fatigue Hollingsworth (1993 cited in Jacobson 2006:146). Bessinger

(2006:29) argues that stress cannot be completely eliminated from our lives. However, coping strategies can assist in decreasing stress to a more healthy level, thus preventing the harmful emotional and physical effects. Tunajek (2006:25) agree that the use of appropriate coping skills improve harmony and lead to congruence of mind, body and spirit. It makes life to be fun, improves the quality of life, and provides a feeling of happiness and joy.

Actions:

The person appointed to run the wellness programme will implement the actions to enhance nurses' coping skills.

- Encourage nurses to keep a journal on experiences that will help to manage feelings and reflect on life-events. Identify scenarios that are most difficult and exhausting and identify and review potential responses that can be used when those situations arise.
- Provide opportunities where nurses can debrief informally with colleagues, where they talk about their feelings and fond memories of their patients.
- Encourage nurses to utilize relaxation techniques such as meditation, yoga, physical exercise and recreation. They should also be encouraged to use faith and religion to become more spiritual, in order to make sense of the meaning of life and can use prayer and also pray for patients.
- Create awareness in nurses regarding the appropriate use of humour in the workplace as a coping strategy in harsh circumstances.

Intervention 4e: Provide bereavement support programmes

Rationale:

Being exposed to multiple deaths within a short space of time cause nurses to be traumatised resulting in an increase in their risk to develop compassion fatigue (Gerow et al. 2009:127; Abendroth and Flannery 2006:354; Figley 2002:1437). According to Bennett and Kelaher (1993 cited in Rapp 2012:6) nurses who work in the HIV/AIDS field are at an increased risk of experiencing grief due to the many deaths they face that may prevent them from providing quality care. Bereavement support programmes help nurses to find closure by allowing them to talk about their thoughts and feelings and in so doing reduce the risk of compassion fatigue (Fetter 2012:560; Macpherson 2008:148). According to Parry (2011 cited in Ek, Westin, Prah, Osterling, Strang, Bergh et al. 2014:509) nursing students lack sufficient skills to cope with end-of-life care. Therefore, understanding

nurses' experiences of death and dying can help the health care system to prepare and educate nurses on how to deal with issues relating to end-of-life care.

Actions:

The person appointed to run the wellness programme can link with a palliative care association and request training for all nurses who work in ARV clinics.

- Facilitation of end-of-life training provided by palliative association that incorporate: personal fears and phobias around death dying and loss, impact of bereavement and benefits of supported workforce; manifestations of grief in the workplace; listening and communication skills; helping models as well as loss and trauma in the workplace. Managers and supervisors should be encouraged to also attend the training to enable them to deal with employee's grief.

Additional actions for bereavement support:

Management should provide the necessary resources and support to provide education on death, grieving and bereavement that include the following action steps that will provide guidance to nurses on the path of healing:

- Provide written handouts about death and bereavement to raise awareness on feelings and fears and to provide ongoing coping tips to nurses.
- Encourage nurses to find closure on the death of their patients and allow them adequate personal time to grieve the inevitable death of their patients.
- Institute multidisciplinary ward rounds to improve team work, allowing healthcare workers to share their emotional experiences caring for patients who are HIV positive and other members empathizing with colleagues.
- Encourage nurses to create a remembrance tree or memory board in the unit, in a staff-only area that is changed with each passing season and they can also create sympathy cards to send to the patients' family and encourage nurses to keep a journal to write fond memories of patients, funny anecdotes and well wishes to patients' loved ones and mail it to the family.
- Provide counselling for nurses who work in paediatric ARV clinic following the death of a child patient.
- Establish a referral system for pastoral care for debriefing and bereavement counselling to support nurses during bereavement. Allow nurses to participate in caring rituals and if possible, to attend patients' funerals to help them find closure.

Intervention 4f: Build and strengthen nurses' resilience

Rationale:

Resilience is a personality trait that enables a person to overcome adversity and within a work situation enable a person to remain task-focused and productive during tough times (Warner 2012:n.p.) Comfort, Boin and Demchak 2010:14). Resilience can be viewed as a dynamic process that allows people to successfully adapt to challenges, stress and adversity (Deshields et al 2015, n.p; Norris et al. 2008:129). Resilience acts as a buffer against compassion fatigue because it provides protection against the harmful effects of caring for traumatised patients by enhancing greater job satisfaction, lessen anxiety and improve quality of life (Hegney et al. 2014:516-517; Potter et al. 2013:180; 186). The goal of a resilience training programme is to strengthen internal coping mechanisms to build resilience and to build a healthier work environment by empowering nurses to become mentally stronger individuals. Thus, it is to enable nurses to perform more effectively in a stressful situation resulting in improved patient outcomes and staff satisfaction (Sullivan and Bissett 2012:3).

Actions:

The person appointed to run the wellness programme will implement actions to build and strengthen nurses' resilience.

- Establish a resilience training programme on a monthly basis that focuses on reinforcement of content to build and strengthen nurses' resilience. The programme will focus on seven elements of resilience, namely: connection and support, self-validated care giving, self-efficacy, self-regulation, positivity and self-care.
- Provide additional strategies that can be used to build resilience including cognitive reframing, toughening up, grounding connections, work/life balance and reconciliation.

Intervention 5

Build personal strategies to manage compassion fatigue

With this intervention the researcher aims to enhance and strengthen strategies that individual nurses can use to prevent and manage compassion fatigue.

Intervention 5a: Create an organisational culture that encourages self-care

Rationale:

Compassion fatigue affects individuals in the caring profession, therefore healthcare professionals must learn to care for themselves, participate in self-care activities that replenish their energy during the day and in their personal life in order to overcome the negative effects of compassion fatigue (Najjar et al. 2009:274). Self-care is the cornerstone in preventing compassion fatigue (Wentzel and Brusiewics 2014:96; Bush 2009:27) because it enables healthcare professionals to replenish their energy during the day, refuelling and revitalizing the physical, emotional, psychological, spiritual, relational and professional dimensions (Gentry and Baranowsky 2013:n.p.; Kearney, Weininger, Vachon, Harrison and Mount 2009:1162). Self-care promotes a sense of compassion satisfaction that acts as a buffer against compassion fatigue, since it allows the individual to take care of interests outside of work (Loolo 2016:57; Berg and Nilsson 2015:13; Parsons 2014:13-14; 33; Eastwood and Ecklund 2008:116).

Actions:

The person who runs the wellness programme should implement actions that encourage the practice of self-care by nurses.

- Provide education to nurses on self-care techniques that will improve their resourcefulness and coping techniques.
- Encourage nurses to say 'no' without feeling guilty when feeling overwhelmed.
- Create time for social interaction with other staff members, and participate in team building exercises.
- Encourage nurses to develop and maintain a healthy lifestyle and build resistance to stress through healthy eating habits, adequate rest and sleep and regular exercise.
- Encourage nurses to nurture themselves and to take time pursuing non-work related activities that they enjoy, such as walking, listening to music or reading. Emphasise the importance of inclusion of self-soothing activities in the self-care plan such as relaxing, reading a book or watching a movie.
- Educate nurses on the use of mindfulness exercise. Nurses to do mindful meditation, quiet their mind, and educate them to be present in the moment.
- Encourage nurses to engage in healing activities. Nurses can bring into the office signs of life and beauty such as a plant that remind them of life. Start a garden, paint or take a walk to enjoy nature.

- Educate nurses on how to practice positive mind skills intentionality. Celebrate and remember even minor successes. They should honour nursing as the spiritual, spirit-filled practice, using difficult situations as lessons for growth.

6.4.2.3 Step 3: Refinement of the wellness programme

In this step the researcher used the Delphi Method to refine the proposed interventions and actions for the wellness programme to achieve the objectives thereof. The interventions and actions were refined, using independent, external experts invited for this purpose. The researcher utilised the Delphi Method to get the experts' advice on how to refine the interventions (Rosenfeld, Shiffman and Robertson 2009:48). Following is a discussion of the Delphi Method used to refine the wellness programme:

The Delphi Method

The Delphi method is widely used and accepted in various disciplines and has gained increased recognition in health, nursing and medical research (Hasson and Keeney 2011:1696). The Delphi method is an iterative process used to get experts' advice on a certain issue using a series of data collection and analysis techniques interspersed with feedback. The questionnaires are designed to focus on problems, opportunities or solutions (Skulmoski, Hartman and Krahn 2007:1-2). The Delphi technique is a multistage survey that consists of multiple rounds using structured questionnaires with a panel of identified experts (Asselin 2014:11). Each subsequent questionnaire is developed based on the result of the previous questionnaire and the process stop when the research question is answered (Skulmoski, Hartman and Krahn 2007:1-2). The method can be applied to program planning (Delbeq, van de Ven and Gustafson 1975 cited in Skulmoski, Hartman and Krahn 2007:2), thus the researcher used it to refine the content of the wellness programme.

The researcher decided to use the Delphi Technique because of the following reasons:

1. Refining the wellness programme did not lend itself to precise analytical techniques but could benefit from subjective judgements on a collective basis.
2. The panellist needed to interact could not be brought together in a face-to-face exchange due to time and cost constraints (Linstone 1978 cited in Yousuf 2007:5).

Characteristics of Delphi Method

1. Anonymity: Responses cannot be identified as being from a specific panellist

2. Controlled feedback from the interaction: The results from the previous round were summarised and panellists were asked to re-evaluate their responses as compared to the thinking of other panellists
3. Statistical group response: The group's opinion is defined as a statistical average of the final opinion of an individual panellist, with the opinion of every panellist reflected in the final group response (Yousuf 2007:3-4).

- *Types of Delphi*

The two commonly types of Delphi are the *classical* and the *modified* and when either of these are used electronically it is referred to as e-Delphi (Asselin 2014:12). For this Delphi the researcher used a classical e-Delphi in which the wellness programme interventions and actions were developed by the researcher and expert advice was only sought to refine the interventions (Asselin 2014:2).

- *Advantages and disadvantages of the Delphi Method*

The Delphi technique as a research method, allows researchers to combine the expertise and knowledge of a geographically dispersed group of experts. They provide feedback on the topic of interest without them meeting each other. This method saves time and is inexpensive (Polit and Beck 2012:267). Using the e-Delphi had many advantages: panellists had easy access through URL links, results were immediately accessible to the researcher with basic data analysis such as frequency and mean already calculated. Individual results were also available that can be used for feedback for subsequent rounds (Asselin 2014:3).

- *Goals and priorities of the Delphi*

The goals and priorities of the three Delphi rounds were to refine interventions that should be included in a wellness programme to identify, prevent and manage compassion fatigue amongst nurses working in an antiretroviral clinic. The goals for the Delphi were to obtain expert advice on the inclusion of interventions and actions for the wellness programme. Participants indicated which intervention they regarded as priority by giving it a score of 1 or 2, (1= strongly agree and 2 =agree) and the intervention that is less important were given a score of 3 or 4 (3=strongly disagree and 4=disagree) (Muhammad 2006:3).

- *Development of the tool for the Delphi*

The researcher used the Google platform for developing the Delphi questionnaire. The questionnaire had five sections: Section A included an introduction to the study, Section B a summary of findings of Phase one of the study, Section C included information on how

the interventions were developed and Section D requested demographic information of participants, and Section E contained the questionnaire in which panellists should rate the interventions and provide comments on actions. Panellists only had to complete Section D and E of the questionnaire (See Appendix P). Section D comprises of the wellness programme that was developed in Phase two of the study to identify, prevent and manage compassion fatigue amongst nurses who work in ARV clinics. This section contained five main interventions and 12 sub-interventions with rationale and actions (see 6: 4.1, step 2).

- *Criteria for rating the interventions*

According to Grove, Burns and Gray (2013:388) 'Likert scale uses scale points such as *strongly disagree, disagree, uncertain, agree and strongly disagree.*' A numerical value e.g. 0-5 is assigned to these categories. For this study in round one, two panellists had to rate the wellness programme interventions based on their validity, reproducibility, cost-effectiveness, reliability, applicability and clarity using a Likert four point rating scale 1-4. The researcher also used the Likert scale rating 1-4 during the Delphi requesting experts to express their viewpoints by indicating the degree to which they agree or disagree with the inclusion of an intervention (Polit and Beck 2012:301). A score of 1 was given if panellists strongly agree, 2 for agreeing, 3 for strongly disagreeing, and a score of 4 for disagreeing to include an intervention in the wellness programme. Participants who strongly agreed or strongly disagreed were asked to motivate their response. Panellists were also asked to comment on the actions for each intervention.



Table 6.1 Likert rating scale used for inclusion of interventions in the wellness programme

Interventions	Strongly agree (1)	Agree (2)	Strongly disagree (3)	Disagree (4)
Intervention 1				
Intervention 1a				
Intervention 2				
Intervention 2a				
Intervention 3				
Intervention 3a				
Intervention 3b				
Intervention 4				
Intervention 4a				
Intervention 4b				
Intervention 4c				
Intervention 4d				
Intervention 4e				
Intervention 4f				
Intervention 5				
Intervention 5a				
Total (n)				

In Table 6.1, the total number (n) indicates the total number of panellists for a specific rating for each intervention.

Table 6.2 Criteria used to rate the validity, cost-effectiveness, reproducibility, reliability, applicability and clarity of interventions

	Validity				Cost-effectiveness				Reproducibility				Reliability				Applicability				Clarity			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Intervention 1																								
Intervention 1a																								
Intervention 2																								
Intervention 2a																								
Intervention 2b																								
Intervention 3																								
Intervention 3a																								
Intervention 4																								
Intervention 4a																								
Intervention 4b																								
Intervention 4c																								
Intervention 4d																								
Intervention 4e																								
Intervention 4f																								
Intervention 5																								
Intervention 5a																								
Total (n)																								

- *Number of iterations*

The Delphi consists of different rounds, usually two to three or, when consensus is reached to either accept or reject the idea (Asselin 2014:11; 13). The researcher used three Delphi rounds to refine the wellness programme in which consensus was reached to include interventions in the wellness programme. The purpose of the first round was to obtain panellist's views to rate whether an intervention should be included in the wellness programme and to rate whether an intervention is valid, cost-effective, reproducible, reliable, and applicable or clear. Panellists were also asked to provide comments on the actions. The purpose of the second round was to provide feedback to panellists from round one and to present them with a new questionnaire based on analysis of the first round. The panellists were asked to re-evaluate their opinion so that consensus be reached in the inclusion of intervention. The purpose of the third round was to provide feedback to panellists based on consensus that was reached on the interventions that will be included in the final wellness programme (Green 2014:3). Two weeks were allocated for each Delphi round. The panellists were given a date on which the questionnaire should be completed after which no responses were accepted.

- *Data analysis*

The researcher used the e-Delphi which immediately made results available for the individual, as well as a summary of results for all panellists. Basic data analysis in frequency and percentages was made available to the researcher (Asselin 2014:13). Likert Scale can be used with a variety of methods for analysis Wilkes (2015:47) and consists of several declarative items that express a viewpoint on a topic. Respondents are asked to indicate the degree to which they agree or disagree with the opinion expressed (Polit and Beck 2012:301). For this study the researcher used a Likert scale to score the interventions. The scores were as follows: 1 = strongly agree and 2 = agree, were included in the draft of the wellness programme. The researcher used a scale with even numbers so that panellists do not use a number in the middle, thus, forcing them to choose a number on either side. Measures of central tendency were used to present and determine consensus (Green 2014:3-4).

6.4.2.4 Steps used for conducting the e-Delphi

The researcher adapted and used the steps for the Delphi method as outlined by (Brooks 1979 cited in Yousuf 2007:3).

Step 1: Identify the panel of experts

Step 2: Determine the willingness of individuals to serve on the panel

Step 3: Gathering individual input on the inclusion and validity, cost-effectiveness, reliability, applicability and clarity of interventions.

Step 4: Analysing data from round one of the Delphi

Step 5: Compiling information for round two of the Delphi questionnaire and sending it to panellists for review

Step 6: Analysing the input from round two of the Delphi

Step 7: Compiling information from round two and send out the final wellness programme to panellists.

Following is a discussion of the steps used to conduct the e-Delphi:

Step 1: Identifying the panel of experts

The researcher did a literature search on experts who have published articles on either HIV/AIDS, end-of-life care and/or compassion fatigue. Experts who worked in the HIV/AIDS field that were known to the researcher were also identified as potential panellists. The group of panellists were diverse and included nurses, medical officers, social worker and psychologist, nationally and internationally. According to Okoli and Pawlowski (2004:5) a Delphi group does not depend on statistical power, however, the group need to be dynamic and able to reach consensus. The literature recommends a Delphi panel that consists of 10-18 experts.

- *Characteristics of the panellists*

In Table 6.3 the researcher provides a summary of the characteristics of the panellists who participated in the Delphi.

Table 6.3 Description of the characteristics of the e-Delphi panellists

Gender	Age	Country of origin	Category	Occupation	Field of expertise	Number of years working in that field
Female	46-50	South African	Nurse	Technical Advisor TB/HIV	HIV/AIDS, MDR TB and end-of-life	15
Female	≥50	United States	Nurse	Nurse	Compassion fatigue and end-of-life- care	29
Female	≥50	South African	Nurse	Nurse	MDR TB	25
Female	41-46	South African	Social Worker	Social Worker	Traumatology	21
Female	46-50	South African	Nurse	Nurse	HIV/AIDS	13
Male	46-50	USA	Social Worker	Social Worker	HIV/AIDS, compassion fatigue and traumatology	20
Female	≥50	Namibia	Nurse	Nurse	HIV/AIDS, PHC	28
Male	46-50	South African	Other	Programme Director	HIV/AIDS	20
Female	46-50	Namibia	Psychologist	Psychologist	HIV/AIDS	13
Female	≥50	South African	Nurse	Nurse	HIV/AIDS and MDR TB	3

A total number of 10 panellists participated in round one of the Delphi, of which there were eight (80%), females and two (20%) males. The panellists were diverse and consisted of nurses (60%), social workers (20%), one psychologist (10%) and other (10%). They were employed as nurses (50%), social workers (20%), psychologist (10%) and other (10%). Other occupations included a programme director and a technical advisor for TB/HIV. The

majority of panellists were from South Africa (60%), however, two were from Namibia (20%) and two from the United States of America (20%). The majority of panellists were in the age group 46-50 (50%), while 40% were in age group 50 and older, only 10% were in age group 41-45. Panellists were experts in the field of HIV/AIDS (60%), compassion fatigue (20%), traumatology (20%), and end-of-life care (20%) whereas 40% were experts in other fields such as TB and MDR-TB. Some panellists were experts in more than one field. Panellists had many years of experience of which the least were 3 years and the most 28 years. The average number of years of experience in the field of expertise was 18.7 years.

Step 2: Determining the willingness of individuals to serve on the panel

After identifying the potential panellists the researcher contacted them via e-mail to invite them to participate, using the Participants' Information Leaflet (see Appendix A1) that provided information on the role of the panellists, time frame for each Delphi round, benefits about the study, consent to participate as well as contact details of the researcher and her supervisors. Conditions of participation were included in the information leaflet. Participants were asked to voluntarily participate in the Delphi. Participants were informed that their participation in the Delphi is subjected to reading and accepting the information leaflets, and by completing the questionnaire voluntary participation is affirmed. The Outlook programme for sending the Delphi information document via e-mails was set on request for delivery, as well as reading receipt that will alert the researcher when the potential panellists have received and/or read the document and it was assumed that those who did not indicate their refusal to participate were willing. A total of 27 invitations to participate in the Delphi were sent out to potential panellists who were identified as experts in HIV/AIDS, compassion fatigue, traumatology and end-of-life care. None indicated that they were unwilling to participate. However, the researcher received responses from e-mails of two identified participants that they were not in the office for an extended period of time when the first Delphi questionnaire was forwarded to panellists.

Step 3: Gathering individual inputs on the wellness programme and compiling it into basic statements

In step 3 the researcher will discuss round one of the Delphi.

- e-Delphi Round One

During round one of the Delphi the proposed wellness programme interventions, with a rationale and actions that were developed using the research findings of Phase one and related literature were forwarded via e-mail to using Google Form to 28 panellist to whom

invitations for participation was sent out previously. The information leaflet was again attached to the e-mail to panellists with the Delphi questionnaire to clarify their role in the Delphi. The researcher identified a large number of experts to start off the Delphi in order to prevent attrition bias caused by waning of the number of participants (Polit and Beck 2012:268).

The interventions were presented in columns with the rationale underneath. Different Likert scales with four response alternatives, namely: strongly agree, agree, strongly disagree or disagree were used that aided panellists to indicate their level of agreement with regard to inclusion of an intervention in the wellness programme. If panellists strongly agreed or strongly disagreed with the inclusion of an intervention they were asked to motivate their response. The panellists also had to indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of an intervention by using The Likert scale, in which one = strongly agree, two = agree, three = strongly disagree, and four = disagree. The actions were bulleted beneath each intervention and panellists had to comment on the actions for each intervention.

Panellists were given two weeks to submit responses to this round. Responses from panellists by the given date indicated their willingness to participate, and it was assumed that those who did not respond by the given date were not interested.

Step 4: Analysing data from the panel

During this step the researcher discuss the data received from panellists during round one of the Delphi:

- *Findings of round one of the Delphi*

The following table indicates the responses from panellists of round one of the Delphi, regarding agreement or disagreement on inclusion of interventions using the Likert rating scale.

Table 6.4 Summary of inclusion of interventions using the Likert rating scale (Round One of e-Delphi)

Interventions	Strongly agree (1)	Agree (2)	Strongly disagree (3)	Disagree (4)
Intervention 1: Enhance nurses' ability to overcome work environmental factors that contribute to compassion fatigue				
Intervention 1a	5	5	0	0
Intervention 2: Lessen the negative effect of cost of nurse-patient relationship				
Intervention 2a	3	6	1	0
Intervention 2b	8	2	0	0
Intervention 3: Enhance understanding of the manifestation of compassion fatigue				
Intervention 3a	5	5	0	0
Intervention 3b	6	4	0	0
Intervention 4: Provide workplace support that will prevent and manage compassion fatigue				
Intervention 4a	7	3	0	0
Intervention 4b	5	5	0	0
Intervention 4c	5	4	0	1
Intervention 4d	3	7	0	0
Intervention 4e	6	3	0	1
Intervention 4f	4	6	0	0
Intervention 5: Build personal strategies to manage compassion fatigue				
Intervention 5a	6	4	0	0
TOTAL (n)	63	54	1	2

In Table 6.3, the strongly agree column indicates the highest score (n) 63, while a score of (n) 54 indicated an agreement with the inclusion of interventions in the wellness programme. Although most participants strongly agreed or agreed with the inclusion of interventions in the wellness programme, there was one panellist who strongly disagreed with the inclusion of intervention 2a (Desensitise nurses to the exposure to patients' traumatic events), the panellist did not agree with the wording of the intervention since the panellist believed to 'desensitize' is to become insensitive and believed that it would not

be possible to be compassionate and empathetic if a person is insensitive. The panellist suggested the wording to change to "Modulate nurses' responses to patients' traumatic events" to be a more appropriate wording. Another panellist disagreed with the inclusion of intervention 4c (Enhance nurses' job satisfaction). The panellist stated that the intervention is not evidenced based and would result as tick in the box set of outputs, and 4e (Provide bereavement support) the panellist who disagreed with inclusion of this intervention just indicated 'NA' and did not motivate as to why the panellist disagreed. The research did not exclude any of the interventions from the wellness programme because the majority of the panellists strongly agreed to include all the interventions. The researcher changed the wording of intervention 2a as suggested by a panellist and in round two of the Delphi the researcher requested panellists to indicate whether they agree or disagree with the change in wording of intervention 2a.

Table 6.4 provides a summary of how panellists rated each intervention for validity, cost-effectiveness, reproducibility, reliability, applicability and clarity using The Likert Scale 1-4, were 1=strongly agree, 2=agree, 3=strongly disagree and 4=disagree with the inclusion of an intervention in the wellness programme.

Table 6.5 Validity, cost-effectiveness, reproducibility, reliability, applicability and clarity of interventions

Likert Scale	Validity				Reproducibility				Cost-effectiveness				Reliability				Applicability				Clarity			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Intervention 1: Enhance nurses' ability to overcome work environmental factors that contribute to compassion fatigue																								
Intervention 1a	2	8	-	-	2	7	1	-	2	6	-	2	2	7	1	-	3	5	-	2	3	3	2	2
Intervention 2: Lessen the negative effect of cost of nurse-patient relationship																								
Intervention 2a	3	5	-	2	2	6	-	1	1	7	-	2	2	4	-	3	2	4	-	3	3	5	-	1
Intervention 2b	4	5	-	1	5	5	-	-	4	6	-	-	3	5	-	2	5	5	-	-	4	4	-	2
Intervention 3: Enhance understanding of the manifestation of compassion fatigue																								
Intervention 3a	5	3	-	2	5	5	-	-	5	5	-	-	5	5	-	-	5	5	-	-	3	5	1	-
Intervention 3b	4	4	-	2	4	6	-	-	4	6	-	-	2	7	1	-	4	6	-	-	3	6	1	-
Intervention 4: Provide workplace support that will prevent and manage compassion fatigue																								
Intervention 4a	5	4	-	1	3	7	-	-	3	7	-	-	4	6	-	-	4	6	-	-	4	6	-	-
Intervention 4b	4	5	-	1	3	7	-	-	5	5	-	-	3	7	-	-	6	4	-	-	3	7	-	-
Intervention 4c	3	5	-	2	2	8	-	-	4	6	-	-	3	7	-	-	3	7	-	-	3	7	-	-
Intervention 4d	3	5	-	2	3	7	-	-	4	6	-	-	3	7	-	-	3	7	-	-	3	7	-	-
Intervention 4e	3	4	1	2	3	7	-	-	3	6	1	-	3	6	1	-	3	7	-	-	3	7	-	-
Intervention 4f	3	5	-	2	3	7	-	-	2	8	-	-	2	8	-	-	3	7	-	-	2	8	-	-
Intervention 5: Build personal strategies to manage compassion fatigue																								
Intervention 5a	3	5	-	2	3	7	-	-	1	9			3	7	-	-	4	6	-	-	4	6	-	-
TOTAL (n)	42	58	1	19	38	79	1	1	3	77	1	4	3	76	3	5	4	69	0	5	38	71	4	5

									8				5				5								
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In Table 6.4, the total number (n) indicates the total score for each intervention pertaining to validity, cost-effectiveness, reproducibility, reliability, applicability and clarity. The score for validity of interventions was as follow: Strongly agree was (n) 42, agree was (n) 58, strongly disagree was (n) 1, and disagree was (n) 19. The score for cost-effectiveness of interventions was as follow: strongly agree (n) 38, agree (n) 79, strongly disagree was (n) 1, and disagree was (n) 1. The score for reproducibility of interventions was as follow: strongly agree (n) 38, agree (n) 77, strongly disagree was (n) 1, and disagree was (n) 4. The score for reliability of interventions was as follow: strongly agree (n) 35; agree (n) 76, while strongly disagree was (n) 3 and disagree was (n) 5. The score for applicability of interventions was as follow: strongly agree (n) 45; agree (n) 69, strongly disagree was (n) 0, and disagree was (n) 5. The score for clarity of interventions was as follow: Strongly agree (n) 38, agree (n) 72, strongly disagree (n) 5, and disagree was (n) 5. Since the scores for strongly agree and agree for the validity, cost-effectiveness, reproducibility, applicability and clarity were higher than the strongly disagree and disagree, the researcher did not review the interventions, only the wording of intervention 2a was changed accordingly.

After analysing the comments on the actions the researcher concluded that the actions will aid in identifying, preventing and managing compassion fatigue. The researcher only changed the actions for Intervention 2a and replaced the word 'desensitise' with 'modulate' in the context of responses of exposure to traumatic events.

Step 5: Compiling information on new questionnaire for round two and send to panel members for review

The data from round one of the Delphi was used to compile the new questionnaire for round two of the e-Delphi. The researcher affected all proposed changes for the final wellness programme and excluded interventions with a Likert score of 3 and 4 with which panellists strongly disagreed or disagreed to include in the final wellness programme. Participants' comments were used for authentication of the interventions and actions of the wellness programme.

- e-Delphi Round Two

The aim of this round was to indicate the responses from panellists in round one. The Likert score for each of the interventions and comments on actions was e-mailed to panellists who responded in round one to validate their responses in order to reach consensus on which interventions to be included and changes to be made to actions (Groves, Burns and Gray 2013:435-436). The interventions as well as responses and

comments from panellists were included in the new questionnaire and panellists were asked to indicate whether they agree or disagree, using a drop-down menu with the inclusion of each intervention. Feedback was given on the suggestion from one panellist that the wording of Intervention 2a should be changed and panellists were asked to indicate whether they agree with the change in wording and also to motivate their response.

The researcher e-mailed the new questionnaire to the 10 panellists who participated in round one of the Delphi. The panellists were given two weeks to respond. Responses from panellists by the given date indicated their willingness to participate, and it was assumed that those who did not respond by the given date were not interested

Step 6: Analysing the inputs from round two of the Delphi

After two weeks the researcher received a total of nine responses from panellists for round two of the Delphi submitted via Google platform.

- Findings of round two of Delphi

Analysing the data, the researcher concluded that all participants agreed with the inclusion of interventions except for Intervention 4c, where one panellist (11.5%) disagreed with the inclusion of this intervention. Concerning changing the wording of Intervention 2a, eight (88.9% panellists agreed, while one (11.1%) disagreed with the suggestion to change the wording (See Table 6.6). However, because the majority of panellists agreed with the change of the wording of Intervention 2a, the researcher did change the wording to: 'Modulate nurses' responses to exposure of patients' traumatic events.' The researcher used a percentage between 70%-100% to determine consensus. Thus, no intervention was omitted from the wellness programme; only the wording of intervention 2a was changed.

Step 7: Compiling information from round two and send out the final wellness programme to panellists

In step 7 the researcher used the data collected in round two of the Delphi to compile the proposed wellness programme based on the consensus reached by panellists. The researcher regarded intervention with a percentage of 70%-100% as consensus being reached by panellists on inclusion to the wellness programme. Only the wording of Intervention 2a was changed since 88.9% of panellists agreed that the wording should be changed.

Table 6.6 Summary on inclusion of an intervention using Likert rating scale (Round Two of e-Delphi)

Interventions	Agree (1)	Disagree (2)
Intervention1a	9 (100%)	0
Intervention 2a	8 (88.9%)	1 (11.1%)
Intervention 2b	9 (100%)	0
Intervention 3a	9 (100%)	0
Intervention 3b	9 (100%)	0
Intervention 4a	9 (100%)	0
Intervention 4b	9 (100%)	0
Intervention 4c	8 (88.9%)	1 (11.1%)
Intervention 4d	9 (100%)	0
Intervention 4e	9 (100%)	0
Intervention 4f	9 (100%)	0
Intervention 5a	9 (100%)	0
TOTAL (n)	106	2

In Table 6.6 majority (n) 9 (100%) of the panellists agree with the inclusion of the interventions in the wellness programme, with the exception for intervention 2a in which the wording of the intervention was changed, one (11.1%) panellist did not agree. With regard to intervention 4c one (11.1%) panellist did not agree with the inclusion of the intervention although no reason for disagreement was stated.

- *e-Delphi Round Three*

The aim of this round was to indicate and give feedback to panellists who participated in round two as to which interventions and actions were included in the final draft based on responses from round two. During this round a letter thanking the experts for their valuable contributions, as well as an electronic copy of the final wellness programme was sent via e-mail to panellists who participated in round two (Muhammad 2006:4). The final wellness programme consisted of five interventions, 12 sub-interventions with rationale and actions to aid in the identification, prevention of future, and management of existing compassion fatigue.

6.4.2.5 Methodological rigour of the Delphi Method

The researcher used the criteria of validity and reliability to increase the integrity of the Delphi (Asselin 2014:13). Following is a discussion of the measures used to ensure reliability and validity of the Delphi (see Appendix P).

Reliability refers to the degree of consistency with which an instrument measures an attribute (Polit and Beck 2012:741). According to Hasson, Keeney and McKenna (2000:1012) a dilemma exists in the sense that there is no evidence of the reliability of the Delphi Method. This will be addressed through the assumption that 'several people are less likely to arrive at a wrong decision than a single individual' (Hasson, Keeney and McKenna 2000:1013). To enhance the reliability of the Delphi the researcher invited 28 potential participants to participate in the study. The group was also heterogeneous and consisted of nurses, social workers, counsellors and programme directors who were experts in HIV/AIDS, compassion fatigue, traumatology and end-of-life care to allow for a broad range of opinion. The researcher also made panellists aware that the aim of each round was to reach consensus. The level of consensus was established prior to the first round, the acceptable level of consensus is 51%-100% (Asselin 2014:13). However, for this Delphi the researcher defined consensus using a Likert Scale of 1-4 with a percentage of 70%-100% (van der Linde, Hofstad, Limbeek, Postema and Geertzen 2005:696).

Validity refers to the degree inferences made in a study are accurate and well founded (Polit and Beck 2012:745). To enhance the validity of the Delphi method the researcher encouraged reasoned argument in which assumptions were challenged; panellists had to motivate why they strongly agree or strongly disagree with the inclusion of an intervention in the wellness programme. This assisted in strengthening decisions. *Construct validity* was increased through the researcher's interpretation of findings of round one and giving feedback to panellists of other panellists responses and giving panellists the opportunity to review their response in view of the feedback given to them (Hasson and Keeney 2011:1700). The researcher conducted three Delphi rounds to increase *concurrent validity*. As the validity of the results could be affected by the response rates, the researcher utilised a sample of 28 panellists in the first Delphi round to make provision for panellists who might withdraw (Hasson, Keeney and McKenna 2000:1013).

- *Ethical considerations*

In many cases, ethical choices involve a trade-off or compromise between the interests and the rights of different parties (Polit and Beck 2012:152). Ethical considerations are critical during the designing and conducting of Delphi studies. The study was approved by Research Ethics Committee of the University of Pretoria (see chapter 3). The researcher documented the procedure used to identify the experts. An Information Leaflet explaining the purpose, procedures, benefits, time-line and assurance that the responses of each participant will be kept confidential was used when the potential participants were invited to participate in the study (see Appendix A1). The researcher strived to maintain the highest ethical standards while conducting the Delphi when forwarding the questionnaire to panellists via e-mail. The researcher set the send/receive function on BCC, and in such a way maintained anonymity amongst panellists (Okoli and Pawlowski 2004:5). The researcher reassured panellists that confidentiality will be maintained and that their names would not be used in published manuscripts (Kennedy 2004:507).

6.4.2.6 Step 4: Reviewing the wellness programme

The wellness programme will be reviewed within three to five years because the subject matter is prone to rapid change. Reviewing of wellness programmes is important to reassign priorities amongst programme activities (Dubois et al. 2001:40).

6.5 Refined wellness programme for the identification, prevention and management of compassion fatigue amongst nurses working in an antiretroviral clinic

The interventions identified by the researcher focus on the organisation and on the individual nurses to create awareness of their risk to develop compassion fatigue, and strategies to manage existing compassion fatigue and prevent future compassion fatigue. On organisational level interventions focus on the development of policies, guidelines and protocols to create a supportive environment that enhance the health and well-being of employees. The individual interventions focus on increasing a sense of satisfaction, restoring empathetic caring, nurturing of the self and living a balanced work/life. The interventions focus on three levels, namely: awareness of risk, management and prevention.

Interventions for identification of risk and signs and symptoms of compassion fatigue focus on creating a programme on awareness of compassion fatigue; provision of education on death and grief and bereavement support to nurses; regulation and mitigation of work-related stress; establishment of work/life balance and desensitize

nurses to traumatic events exposed to. Interventions that focus on strategies to prevent and manage compassion fatigue include compiling and implementing a self-care programme; building of resilience; maintaining of work/life balance; establishing support networks for nurses; building and strengthening nurses' resilience; practicing mindfulness; increasing a sense of compassion satisfaction. Interventions that focus on preferred support that will help to prevent and manage compassion fatigue include creation of a network of support and promoting managerial support in the form of provision of debriefing service.

The refined wellness programme consists of five interventions with 12 sub-interventions, with a rationale and actions, to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics.

6.5.1 Introduction

In this section the researcher would like to orientate the reader of the wellness programme regarding the purpose and objectives as well as the target group for whom the programme was developed.

6.5.2 Objective of the wellness programme

The objective of the wellness programme is to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics who are at risk to develop compassion fatigue, or who already suffer from compassion fatigue.

6.5.3 For whom is the wellness programme intended

The wellness programme is intended for nurses who work in antiretroviral clinics who are at risk of developing compassion fatigue, or who suffers from compassion fatigue.

6.5.4 Schedule for review of the wellness programme

The wellness programme is to be reviewed one year after publication.

6.6 Summary

In this chapter the researcher made recommendations for interventions, with a rationale and actions, for inclusion in the wellness programme to identify, manage existing compassion fatigue and prevent future occurrence of compassion fatigue amongst nurses working in ARV clinics. The process for refinement of the wellness programme was also

discussed in this chapter. In chapter seven, the conclusion, limitations of the study and recommendations will be discussed.

CHAPTER SEVEN

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

7.1 Introduction

In the previous chapter the researcher discussed the development of the wellness programme to identify, prevent the occurrence of future and manage existing compassion fatigue amongst nurses working in antiretroviral clinics. The process to refine the wellness programme through the use of the Delphi research method was also discussed.

In this chapter the researcher will discuss the conclusions regarding the study. The research study is also evaluated in terms of limitations and strengths and the researcher also makes recommendations regarding the contributions that the wellness programme could make in the field of nursing.

7.2 Summary of the main findings of the study

The researcher identified three themes, five categories and 16 sub-categories in Phase one of the study using one-on-one interviews.

Following is a summary of the main findings of Phases one and two of the study:

7.2.1 Main findings of Phase one

Nurses working in the ARV clinics are at risk of developing compassion fatigue due to work environment issues such as challenges created by the health care system, lack of support from management, and their overwhelming work load. The cost of the nurse-patient relationship also contributed to nurses being at risk of compassion fatigue. Aspects that were identified that relate to the cost of a relationship with patients who are HIV positive include caring for traumatised patients, vicarious exposure to traumatic experiences of patients, and the influence caring for patients who are HIV positive has had on nurses' personal lives and their families. Nurses can traumatise their family members by continually not being available for them through emotional withdrawal.

Nurses presented with physical, psychological, spiritual symptoms and changes in their behaviour that are indicative of compassion fatigue. Physically they presented with fatigue, low energy levels, insomnia and dizziness. Psychologically they presented with

depression, fear, despair, higher stress levels and feelings of emotional exhaustion. In addition, nurses also experience a sense of satisfaction that they are making a difference in their patients' lives. Spiritually they presented with doubt in themselves as they felt the need for major change, such as a new job. The behaviour they exhibit included being irrationally aggressive, impatient, irritable and angry. They also disengage from their patients and started to neglect their personal appearance.

Various strategies to prevent and manage compassion fatigue were identified: both what nurses can do, and what they expected from management. They regarded collegial support as important and revealed that they need to pay more attention to self-care to prevent and manage compassion fatigue. Celebrating the lives of patients who have passed away helped nurses to find closure and this minimised their traumatic experiences and thus, lessen their risk of developing compassion fatigue. Debriefing, and managerial and psychological support were deemed important in managing compassion fatigue, as well as a way to prevent it from recurring. The need for management support seems to be important to help nurses to cope with stressors in the workplace as management can create a positive attitude.

Nurses' job description is generic and does not spell out their role and function within antiretroviral clinics. Nurses are delegated tasks on a daily basis using a delegation book. The implementation of the health and wellness programme is lacking.

7.2.2 Main findings of Phase two

The researcher used the findings and related literature to develop the wellness programme. Five interventions with 12 sub-interventions with a rationale and actions were identified for the wellness programme.

Theme 1: Risk to develop compassion fatigue

To address the risk of nurses developing compassion fatigue, the researcher identified two interventions and three sub-interventions. The aims of these interventions were firstly, to enhance nurses' ability to overcome work environmental factors that contribute to the development of compassion fatigue and secondly, to lessen the negative effect of the cost of nurses' relationship with patients who are HIV positive.

Theme 2: Manifestation of compassion fatigue:

For this theme the researcher identified one intervention with two sub-interventions. This intervention aims to raise awareness on the manifestation of compassion fatigue to ensure early identification of the development of compassion fatigue.

Theme 3: Strategies to prevent and manage compassion fatigue:

For this theme two interventions and seven sub-interventions were identified by the researcher. The first interventions aim to provide workplace support to nurses to prevent the occurrence and manage existing compassion fatigue. The second intervention aims to enhance and strengthen strategies that individual nurses can use to prevent and manage compassion fatigue.

7.3 Conclusion

This study draws the conclusion that there is a cost to caring for patients who are HIV positive patients. The very act of being compassionate and empathetic cause comes at a cost for nurses who work in antiretroviral clinics. Empathy is seen as a double-edged sword for the nurses, on the one hand it is necessary to provide compassionate care on the other end the act of caring makes them vulnerable to compassion fatigue. Having to care for traumatised patients who are HIV positive, being vicariously exposed to patients' traumatic events and factors that increase nurses stress levels, place them at risk of developing compassion stress and if compassion stress is not dealt with then it can progress to compassion fatigue. The manifestation of compassion fatigue can be calamitous for the nursing profession; nurses may disengage from the nurse-patient relationship and become incapable to deliver compassionate nursing care. Compassion fatigue reduces nurses' capacity or interest in bearing the suffering of their patients.

The study adds new knowledge to the phenomenon of compassion fatigue amongst nurses who work in anti-retroviral clinics and creates awareness on the effect that working in these clinics may have on the physical, psychological, social and behavioural well-being of nurses. The study further highlight the effect that working in anti-retroviral clinics have on the families of these nurses and the importance of maintaining work/life balance. The importance of practicing self-care and availability of support systems for nurses also become evident if nurses are to ascribe to Watson's Caring Theory that will allow them to give compassionate, empathic care to their patients.

The findings of the study emphasise the importance of a wellness programme that can aid in the identification, prevention and management of compassion fatigue amongst nurses who work in antiretroviral clinics. Interventions in the wellness programme aims to enhance nurses' ability to overcome work environmental factors that contribute to the development of compassion fatigue, to lessen the negative effect of the cost of nurses' relationship with patients who are HIV positive, to raise awareness on manifestation of compassion fatigue and to enhance early identification of any signs and symptoms of compassion fatigue. Lastly, to provide managerial support to nurses to prevent the occurrence of compassion fatigue and to manage existing compassion fatigue, and to enhance and strengthen strategies that individual nurses can use to prevent and manage compassion fatigue. Awareness is the key to prevention of compassion fatigue and may aid in improved nurses' job satisfaction, the higher nurses' job satisfaction the less vulnerable they are to compassion fatigue. It is imperative that the nursing profession address support and other strategies that will increase nurses' level of job satisfaction.

7.4 Implications for nursing

The main findings of the study were that nurses who work in ARV clinics are at risk to develop compassion fatigue because of their empathetic ability and relationship with patients who are HIV positive. However, compassion fatigue is preventable through a heightened awareness. With the necessary support in the work-place and support from family members, self-care and right coping strategies compassion fatigue can be overcome. Therefore, management need to review their support to nurses who work in ARV clinics to help prevent and manage compassion fatigue.

These findings have implications at the following levels:

7.4.1 Practice

The findings of the study can be used to raise awareness on the risk factors of compassion fatigue during in-service training and induction of new recruits. Awareness should also be raised on the progressive nature of compassion fatigue so that nurses can be aware of and take adequate measures to prevent the occurrence of compassion fatigue. Increase in knowledge of the existence and manifestation of compassion fatigue might enable nurses to become aware of their colleagues who might be suffering from compassion fatigue. Furthermore, it might help with the development of collegial support groups that will make it possible for nurses to seek support from peers when needed. Awareness of the risk of developing compassion fatigue should be emphasized during

interviews of potential employees. The findings of this study can also be used to encourage management to establish support systems for nurses who work in antiretroviral clinics.

The researcher recommends that the wellness programme that was developed, be implemented in antiretroviral clinics to ascertain whether the applicability thereof improve the wellbeing of nurses who work in antiretroviral clinics. Following implementation of the wellness programme it should be evaluated on its effectiveness to identify, prevent and manage existing compassion fatigue.

7.4.2 Education

The findings of this study can be used to educate neophytes who enter the nursing profession concerning the risk factors and causes of compassion fatigue. This will empower nursing students with useful information that will allow them to cope with work stressors, develop protective measures and implement self-care strategies that will enable them to prevent and manage compassion fatigue.

7.4.3 Research

Further research is required to determine the factors that contribute to the progression of compassion discomfort to compassion stress and eventually compassion fatigue and the average time it would take to progress from a state of compassion discomfort to compassion fatigue. The researcher recommends that a follow-up study be done after the wellness programme has been implemented to determine whether it assisted with early identification, prevention and management of compassion fatigue.

7.5 Limitations of the study

The researcher acknowledges the study's limitations. The research study was conducted in one tertiary hospital, in one province; therefore, the findings of the study cannot be generalized to similar groups. However, the researcher provided a detailed description of the methodology used to conduct the study, so that others may decide whether the findings are applicable to them. Another limitation of the study might be that all participants were female, thus the effectiveness of the use of the wellness programme by male nurses will remain unknown. Despite these limitations the researcher suggests that the research findings may be applied to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics. The research findings can also be used to make recommendations for further research.

7.6 Summary

The study demonstrated that nurses who work in antiretroviral clinics are at risk of developing compassion fatigue, but with the necessary support and practicing of self-care, compassion fatigue nurses will be able to recover from compassion fatigue and re-establish compassion satisfaction. Awareness programmes could also contribute to early identification of the manifestation of signs and symptoms of compassion fatigue. In addition, resilience could also be built and maintained. Resilient nurses will not only remain working in ARV clinics, but will also provide higher quality patient care.

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Appendix A: Participants' information leaflet and consent form

Appendix A: Participant information leaflet and consent form - Interview

A wellness programme to prevent and manage compassion fatigue amongst nurses working in an anti-retroviral clinic.

Dear Participant

1. Introduction

I invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to me.

2. The nature and purpose of the study

Compassion fatigue can lead to poor clinical work. Professional errors cost the organization and the nursing profession. It leads to absenteeism and high staff turnover. Nurses who are protecting themselves are likely to be motivated, open to new learning, and doing their job well. Addressing compassion fatigue does not have to be an expensive venture; teaching nurses to take care of themselves through a wellness programme can achieve this.

The purpose of the study is to first explore and describe the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic, and secondly to develop a wellness programme that will aid in the screening, prevention and management of compassion fatigue amongst nurses working in an anti-retroviral clinic.

3. Explanation of procedures to be followed

This study involves participation in one-on-one interview that would be tape recorded with your permission and last approximately one hour.

During the interview I will ask you some questions about your work with HIV positive patients.

4. Risk and discomfort involved

The participants might experience some psychological discomfort during participation in the study. The interview will take about one hour of your time.

5. Possible benefits of this study

You will benefit directly from the study because at the end of the study we will provide you with guidelines on how to prevent and manage compassion fatigue. However, the results of the study will be used to develop guidelines on how to prevent and manage compassion fatigue.

6. What are your rights as a participant?

Your participation in the study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving reason. Your withdrawal will not affect you in any way.

7. Has the study received Ethical approval?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Science at the University of Pretoria and the Gauteng Department of Health. Copies of the approval letters are available if you wish to have one.

8. Information and contact person

The contact persons for this study is Mercia Tellie if you have any questions about the study please contact me at 082 3035514. Alternatively you may contact my supervisor Prof Neltjie van Wyk or co-supervisor Dr Ronell Leech at telephone number 012 354 2125.

9. Compensation

Your participation is voluntary. No compensation will be given for your participation.

10. Confidentiality

All information that you give will be kept strictly confidential. Once I have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or the hospital.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in the study told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

I have received a signed copy of this informed consent agreement.

Participant's name (Please print)

Participant's signature Date

Investigator's name (Please print)

Investigator's signature Date

Witness's name (Please print)

Witness's signature Date

Appendix A1: Participants' information sheet - Delphi

Appendix A1: Participant information leaflet for Delphi

Title: A wellness programme to prevent and manage compassion fatigue amongst nurses working in an antiretroviral clinic in a public tertiary hospital.

Dear Participant

You are invited to participate in a Delphi panel to assist the researcher in refining the recommended interventions for a wellness programme to identify, prevent and manage compassion fatigue. This document contains information that will help you understand your role as a panellist. If there is any need for clarification, please feel free to contact the researcher at any time. Your participation and contribution is highly appreciated.

1. Explanation of the procedure to be followed:

The Delphi Method consists of different rounds of group communication to build consensus regarding recommended interventions in a wellness programme to identify compassion fatigue, prevent the occurrence of compassion fatigue, and manage current compassion fatigue amongst nurses working in ARV clinics.

Once you have indicated your willingness to participate you will receive a document containing: an introduction to the study, how interventions were developed, and the specific intervention with its accompanying rationale and actions. All communication between a panellists and the researcher is confidential and panellist are not exposed to other panellists.

At least three repetitions will be necessary to assist the researcher and panellists to reach consensus. In each round participants are requested to complete a questionnaire regarding the proposed interventions and actions. After receiving the responses the collected information will assist the researcher to refine the interventions and actions as needed. The refined interventions and actions will again be sent to all participants together with another questionnaire. The process will be repeated, and should a panellist remain outside the consensus, he/she should specify the reason therefor. In the third and possibly final round, the panellists have a final opportunity to revise their judgements.

2. Time required

Participation in a Delphi method can be time consuming, two weeks will be given to respond to

each round.

3. Benefits of the study

Providing valuable inputs regarding the proposed interventions and actions will assist the researcher in refining the interventions for the wellness programme.

4. Voluntary participation in, and withdrawal from the study

Your participation in the study is entirely voluntary and you can withdraw from the study without stating any reason should you no longer wish to take part. No compensation will be provided for participation in the study.

5. Ethical approval

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and will be adhered to. Written permission from Gauteng Department of Health was obtained.

Please feel free to contact Ms. Deepa Behari if you need any clarification pertaining to ethical inquiries at +27 12 365 3084 or deepeka.behari@up.ac.za

6. Information and contact person

The contact persons for this study is Mercia Tellie. If you have any questions about the study please contact her at +27 82 3035514. Alternatively you may contact her supervisor Dr Ronell Leech or co-supervisors Prof Neltjie van Wyk at telephone number +27 12 356 3178

7. Confidentiality

Your inputs will be confidential. Once the information have been analysed no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or the institution you work for.

8. Consent to participate

Your participation in this research is subject to reading and accepting the above information, and by completing the questionnaire you volunteer to take part in the research.

THANK YOU FOR PARTICIPATING IN THE STUDY

Appendix B: Interview Guide and edited version of Interview Guide

Appendix B: Interview Guide

Central Research question:

How does of Compassion Fatigue manifest amongst nurses working in an adult, ante-natal and paediatric anti-retroviral clinic?

Theme: Trust and despair

1. Do you have confidence in the health care system? (If no, explain briefly why not)
2. Do you believe you can make a difference in the lives of HIV positive patients? (Explain how)

Theme: Hope

1. Explain your feeling with regard to the fact that there is no cure for HIV/AIDS.
2. Do you have hope that one day scientist would find a cure for HIV/AIDS?

Theme: Caring for HIV positive patients

1. Define caring
2. Describe what you understand by the term 'a caring nurse'. (Probe)
3. How do you express caring towards HIV positive patients in your clinic? (Probe)
4. Describe caring for HIV positive patients (probe is it different from caring for any other patient).
5. Do you find caring for HIV positive patients difficult? (If yes, probe)
6. How difficult is it to care for HIV positive patients? (Probe)
7. How different is caring for HIV positive individuals compared to caring for other patients? (Probe)
8. Describe what is meant by the term 'there is a cost to caring for HIV positive patients' (probe)

Theme 3: Experiencing stress

1. What causes the most stress in your work environment? (Probe)
2. How do you cope with stress in your daily work life? (Probe, ask for example)
3. How do you cope hearing about patients who have died that you have nursed? (Probe)
4. Do you allow yourself to grieve for your patients who died? (Probe)
5. What strategies do you use to distress? (Probe)

Theme: Compassion fatigue

1. What is your understanding of the term compassion? (Probe for explanation)

2. Should nurses show compassion towards HIV positive patients? (Probe)
3. Have you ever heard of the term compassion fatigue? (Probe, where and when)
4. Do you think you suffer from compassion fatigue? Please explain.
5. Describe how a person that suffers from compassion fatigue feel? (Probe)
6. Does a person suffering from compassion fatigue show any signs and symptoms? (Need to describe)
7. Is there a difference between burnout and compassion fatigue? (If yes, explain the difference)

Theme: Working with HIV positive patients

1. How do you feel towards HIV positive patients? (Probe)
2. Describe your relationship with HIV positive patients
3. How do you feel at the end of a busy working day, having worked with very sick HIV positive patients? (Probe)
4. How is your energy level at the end of the day? (Explain)
5. How many HIV positive patients do you care for on average every month?
6. How does your experience at work affect you at home? (Explain, briefly)
7. Do you ever feel disconnected from your HIV positive patients? (Explain response)
8. In some cases the patients' lifestyle is the cause of their HIV positive status, does that bother you, and how to you respond to such cases?
9. In cases when your patients express fear of dying, how do you deal with such a situation?
10. Do you ever feel guilty with regard to the way you respond to HIV positive patients (Explain)
11. Briefly explain what a nurses' day look like in an anti-retroviral clinic? (Probe)
12. What motivated you to work in an anti-retroviral clinic? (Probe)
13. What motivate you to come to work everyday? (Probe)
14. What will make your work in the anti-retroviral clinic easier? (Probe)

Theme: Psychological support

1. How do you relate to your colleagues in the clinic, and how does this help you to cope in your work?
2. What support systems are in place in your clinic? (Explain)

For the following statements rate yourself on a scale of one to five

Scale: 0 = not at all, 1 = rarely, 2 = some times, 3 = often, 4 = always, 5 = excessively.

Theme: Empathy

1. Emotional involvement with HIV positive patients
2. Empathetic response to HIV positive patients

3. Ability to separate work from home

Theme: Personal factors

1. Have you lately lost a close friend or family member?
2. How was your personal relationship with the person you have lost?
3. What was the cause of death?
4. How recent was the loss?
5. Are you currently caring for a terminally ill family member?

Edited version of Interview Guide

Central Research question:

How does of Compassion Fatigue manifest amongst nurses working in an adult, ante-natal and paediatric anti-retroviral clinic?

Theme: Trust and despair

3. Do you have confidence in the health care system? (If no, explain briefly why not)
4. Do you believe you can make a difference in the lives of HIV positive patients? (Explain how)

Theme: Hope

3. Explain your feeling with regard to the fact that there is no cure for HIV/AIDS.
4. Do you have hope that one day scientist would find a cure for HIV/AIDS?

Theme: Caring for HIV positive patients

5. Define caring
6. Describe what you understand by the term 'a caring nurse'. (Probe)
7. How do you express caring towards HIV positive patients in your clinic? (Probe)
8. Describe caring for HIV positive patients (probe is it different from caring for any other patient).
8. Do you find caring for HIV positive patients difficult? (If yes, probe)
9. How difficult is it to care for HIV positive patients? (Probe)
10. How different is caring for HIV positive individuals compared to caring for other patients? (Probe)
9. Describe what is meant by the term 'there is a cost to caring for HIV positive patients' (probe)

Theme 3: Experiencing stress

6. What causes the most stress in your work environment? (Probe)
7. How do you cope with stress in your daily work life? (Probe, ask for example)
8. How do you cope hearing about patients who have died that you have nursed? (Probe)
9. Do you allow yourself to grieve for your patients who died? (Probe)
10. What strategies do you use to distress? (Probe)

Theme: Compassion fatigue

3. What is your understanding of the term compassion? (Probe for explanation)
4. Should nurses show compassion towards HIV positive patients? (Probe)
8. Have you ever heard of the term compassion fatigue? (Probe, where and when)

9. Do you think you suffer from compassion fatigue? Please explain.
10. Describe how a person that suffers from compassion fatigue feel? (Probe)
11. Does a person suffering from compassion fatigue show any signs and symptoms? (Need to describe)
12. Is there a difference between burnout and compassion fatigue? (If yes, explain the difference)

Theme: Working with HIV positive patients

4. How do you feel towards HIV positive patients? (Probe)
5. Describe your relationship with HIV positive patients
6. How do you feel at the end of a busy working day, having worked with very sick HIV positive patients? (Probe)
8. How is your energy level at the end of the day? (Explain)
9. How many HIV positive patients do you care for on average every month?
10. How does your experience at work affect you at home? (Explain, briefly)
11. Do you ever feel disconnected from your HIV positive patients? (Explain response)
15. In some cases the patients' lifestyle is the cause of their HIV positive status, does that bother you, and how do you respond to such cases?
16. In cases when your patients express fear of dying, how do you deal with such a situation?
17. Do you ever feel guilty with regard to the way you respond to HIV positive patients (Explain)
18. Briefly explain what a nurses' day look like in an anti-retroviral clinic? (Probe)
19. What motivated you to work in an anti-retroviral clinic? (Probe)
20. What motivate you to come to work everyday? (Probe)
21. What will make your work in the anti-retroviral clinic easier? (Probe)

Theme: Psychological support

3. How do you relate to your colleagues in the clinic, and how does this help you to cope in your work?
4. What support systems are in place in your clinic? (Explain)

Theme: Empathy

1. Describe your emotional involvement with HIV positive patients (probe)
2. Describe how your witnessing your patients suffer affect your well-being (probe)
3. Describe strategies that you use to separate work issues from your personal life (probe)

Theme: Personal factors

6. Describe your emotional experience when regarding the death of a close friend or family member? What was the cause of death? (probe)
7. Describe your personal relationship with the person you have lost? (probe)

END OF INTERVIEW



Appendix C: Letter seeking permission to conduct study – Public tertiary hospital

Appendix C: Permission Letter to Conduct Study – Public Tertiary Hospital

267 Roots Avenue

Eersterust

Pretoria

0022

16th March 2009

[REDACTED]

[REDACTED]

[REDACTED]

Johannesburg

Anti-retroviral clinic: [REDACTED]

The Hospital Acting CEO: [REDACTED]

Permission to conduct research as part of a PhD degree study

I hereby wish to ask for your in principle approval for me to conduct a research study at the [REDACTED] Academic Hospital adult, antenatal and paediatric anti-retroviral clinic as part of my Ph degree studies at Pretoria University, South Africa. The researcher needs the departments' approval before approaching the Ethics Committee of the Faculty of Health Science at University of Pretoria.

Details of the research study are as follow:

1. Title of study:

A wellness programme to prevent and manage compassion fatigue amongst nurses working in an anti-retroviral clinic.

2. Purpose of the Study

The aim of the study is to explore and describe the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic, and in phase two of the study to develop a wellness programme that will aid in screening, prevention and management of compassion fatigue

3. Description of Procedure:

Nurses will be asked to participate in an one-on-one interview that would be tape recorded with their permission.

• Interview

Nurses will be interviewed on a one-on-one basis using the interview guide. Interviews will last approximately one hour.

4. Risk or discomfort:

There are some form of psychological discomfort involved.

5. Benefit to the subject or to others, which may be expected:

The benefit of your participation in the study will contribute to the researcher understanding the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic and the implementation of a wellness programme that will aid in the prevention and management of this phenomenon.

6. Confidentiality:

The questionnaire and transcripts form the tape recorder will be kept in a safe place and will not be made available for any other research project. The data will be analyzed by the researcher. However, no information by the participants can be identified will be released or published.

7. Voluntary participation:

Participation in this study is voluntary. Participants are free to withdraw their consent to participate in this study at any time without the prejudice towards them.

Yours sincerely

M. J. Tellie

Appendix D: Institutional Consent Form



Office of the CEO
[redacted]

Academic Hospital

Enquiries: [redacted]

[redacted]: [redacted]

[redacted] [redacted]

15TH June 2009

Ms Mercia J Tellie
University of Pretoria
Department – Nursing Science

Dear Ms Tellie

RE: Permission To do research entitled " A wellness programme to prevent and manage compassion fatigue amongst nurses working in an anti-retroviral clinic"

Permission is granted for you to conduct the above research as described in your request provided:

1. The [redacted] Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

NB: You are required to submit your ethics approval to this office, before starting your research.

Kindly forward this office with the results of your study on completion of the research.

Yours sincerely

[redacted]
Acting Chief Executive Officer



Appendix E: Letter seeking permission to conduct study- Gauteng Department of Health

Appendix E: Letter seeking permission to Conduct Study – Gauteng Department of Health

267 Roots Avenue
Eersterust
Pretoria
0022

15th September 2009

Research Department
Gauteng Department of Health

Dear Sir / Madam

Permission to conduct research as part of a PhD degree study

I hereby wish to ask provisional permission in order to conduct a research study at the [REDACTED] Hospital adult, antenatal and paediatric anti-retroviral clinic as part of my Ph degree studies at Pretoria University, South Africa. The researcher needs the department's approval before approaching the Ethics Committee of the Faculty of Health Science at University of Pretoria.

Details of the research study are as follow:

1. Title of study:

A wellness programme to prevent and manage compassion fatigue amongst nurses working in an anti-retroviral clinic.

2. Purpose of the Study

The aim of the study is to explore and describe the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic, and in phase two of the study to develop a wellness programme that will aid in screening, prevention and management of compassion fatigue.

3. Description of Procedure:

Nurses will be interviewed on one-on-one basis using the interview guide. Interviews will last approximately one hour.

4. Risk or discomfort:

There are some form of psychological discomfort involved in participating in the study.

5. Benefit to the subject or to others, which may be expected:

The benefit of your participation in the study will contribute to the researcher understanding the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic and the implementation of a wellness programme that will aid in the prevention and management of this phenomenon.

6. Confidentiality:

The questionnaire and transcripts from the tape recorder will be kept in a safe place and will not be made available for any other research project. An independent coder will be used. The data will be analyzed by the researcher. However, no information whereby the participants can be identified will be released or published.

7. Voluntary participation:

Participation in this study is voluntary. Participants are free to withdraw their consent to participate in this study at any time without the prejudice towards them.

8. Publication of results:

The researcher undertakes to make the information available to the department prior to publication, on request from the department.

9. Research cost:

The researcher will try to minimize disruption of services to clients. There will be no additional costs to the Gauteng Department of Health.

Yours sincerely,

M. J. Tellie

Appendix F: Approval to conduct study- Gauteng Department of Health

CONDITIONS OF APPROVAL OF RESEARCH CONDUCTED BY POST GRADUATE STUDENTS IN GAUTENG
DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDoH & SD)



GAUTENG DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT (GDOH & SD)

POLICY, PLANNING AND RESEARCH

Enquiries: Sue le Roux

Tel: +2711 355 3212

Fax: +2711 355 3007

Email: Sue.LeRoux@gauteng.gov.za



CONTACT DETAILS OF THE RESEARCHER	
Date	05/03/2010
Tel number	082 303 5514
Fax number	
Email	None
Researcher /Principal Investigator (PI)	Ms. Mercia Jane Tellie
Supervisor	
Institution	University of Pretoria
Research title	A wellness programme to manage compassion fatigue amongst nurse working in an anti-retroviral clinic

Approval is hereby granted by the Gauteng Department of Health for the above research project to be conducted. Approval is limited to compliance with the following terms and conditions:

1. All principles and South African regulations pertaining to ethics of research are observed and adhered to by all involved in the research project. Ethics approval is only acceptable if it has been provided by a South African research ethics committee which is accredited by the National Health Research Ethics Council (NHREC) of South Africa; this is regardless of whether ethics approval has been granted elsewhere.

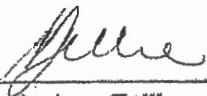
Of key importance for all researchers is that they abide by of all research ethics principles and practice relating to human subjects as contained in the Declaration of Helsinki (1964, amended in 1983) and the constitution of the Republic of South Africa in its entirety. Declaration of Helsinki upholds the following principles when conducting research, respect for:

- Human dignity;
- Autonomy;
- Informed consent;
- Vulnerable persons;
- Confidentiality;
- Lack of harm;
- Maximum benefit;



- and justice
- 2. The GDoH is indemnified from any form of liability arising from or as a consequence of the process or outcomes of any research approved by HOD and conducted within the GDoH domain;
- 3. Researchers commit to providing the GDoH with periodic progress and a final report; short term projects are expected to submit progress reports on a more frequent basis and all reports must be submitted to the Director: Policy, Planning and Research of the GDoH;
- 4. The Principal Investigator shall promptly inform the above mentioned office of changes of contact details or physical address of the researching individual, organisation or team;
- 5. The Principal Investigator shall inform the above office and make arrangements to discuss their findings with GDoH prior to dissemination;
- 6. The Principal Investigator shall promptly inform the above mentioned office of any adverse situation which may be a health hazard to any of the participants;
- 7. The Principal Investigator shall request in writing authorization by the HOD: Gauteng Department of Health for any intended changes of any form to the original and approved research proposal;
- 8. If for any reason the research is discontinued, the Principal Investigator must inform the above mentioned office of the reasons for such discontinuation;
- 9. A formal research report upon completion should be submitted to the Director: Policy, Planning and Research of the GDoH with recommendations and implications for GDoH; the Directorate will make this report available for the HOD

AGREEMENT BETWEEN THE GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDoH & SD) AND THE RESEARCHER



Ms. Mercia Jane Tellie

Principal Researcher:

Date:
2010/04/10



Mrs. Gikizwa Nkosi

Acting Director: Policy, Planning and Research (GDoH)

Date:
2010/03/05



GAUTENG DEPARTMENT OF HEALTH

BANK OF LISBON BUILDING
37 SAUER STREET JHB
PRIVATE BAG X085
MARSHALLTOWN
Tel: (011) 355 3477/3490/3500/3134/3501
Fax: (011) 355 3007



RESEARCH PROPOSAL EVALUATION FORM

Researcher's Name:	Ms Mercia Jane Tellie
Researcher's contact details:	Tel: 082 303 5514 Fax: 011 358 5400
Research Topic	A wellness programme to manage compassion fatigue amongst nurse working in an anti-retroviral clinic".
Research institution:	University of the Pretoria
Date submitted	01 February 2010
Date Reviewed:	05 March 2010
Reviewer's name:	Dr ML Likibi
District / facilities / sites where research will be conducted:	Academic Hospital
Type of research	Non Trial

CRITERIA	YES	NO	COMMENTS
1. Is this research project within the scope of the Department of Health key policy priorities/directives?	X		
2. Content of Research:			
▪ Original work	X		
▪ New facts, ideas	X		
▪ Confirmation of uncertain data		X	
▪ Repetition of known data and consequently of limited importance		X	
▪ Insufficient research information	X		
▪ Confusion of topics/questions		X	
3. Is the title of the research project suitable?	X		
4. Are the objectives of the research project adequate?	X		
5. Could the objectives be limited to better focus on the project's main objective?	X		
6. Writing style			
▪ The text of the proposal is clear	X		
▪ The nomenclature used is correct	X		



▪ The references used are relevant, comprehensive and accurate	X		
▪ The spelling and grammar are correct	X		
▪ The language needs improvement		X	
▪ The research proposal needs re-styling and re-writing		X	
7. Are the research methods appropriate to the study?	X		
8. Is data collection method in line with the study design?	X		
9. Does the study have ethical approval? If yes, name the ethics committee. Pretoria University Ethics committee	X		
10. Is the definition and measurement of variables consistent with the scope of the proposal?	X		
11. Is the time frame of the proposal adequate to meet the objectives?	X		
12. Is it stated in the proposal the method of dissemination of the results of the research project?	X		
13. Is the possible conflict of interests clarified?	X		
14. Are financial implications and financial support transparent?	X		

SUMMARY OF PROPOSAL

The study will be conducted in an anti-retroviral clinic in Gauteng province and will focus on the manifestation of compassion fatigue amongst the nurses working in the pediatric, antenatal and adult clinics and manage the occurrence.

When observed, nurses working for HIV+ patients in an adult retroviral clinic do experience a great traumatic deal on daily basis. Often HIV positive patients would arrive at the clinic late, on the brink of death and soon die. When the researcher reviewed the existing workplace wellness programme of the hospital, she observed that the programme put more emphasis is on the physical well-being of the HIV positive workforce and little is said to cater for HIV negative nurses.

The impact of HIV/AIDS on the nursing workforce is multi-faceted and complex. In addition to the increased workload, high needs for clinical care for the acutely ill HIV positive patient, the nurses have to cope with increased illness and death of these patients. The social worker working in the anti-retroviral clinics to render psychosocial support to the staff is often over worked from critical ill patients that she/he cannot attend to the psychosocial needs of the staff as well. Therefore, this area is neglected and it is expected that nurses should care for themselves. Nurses have to deal with their own grief after the death of their patient(s).



Thus there is a need to develop a wellness programme that would provide in the psychosocial needs of all nurses who are exposed to a great deal of occupational stress in an environment, which expects nurses to care for themselves.

The wellness programme is aimed at preventing and managing possible compassion fatigue amongst nurses working in an anti-retroviral clinic.

The aim of the study will be firstly to explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic. Secondly to develop, implement and evaluate a wellness programme that will aid in the screening, prevention and management of compassion fatigue amongst nurses working in anti-retroviral clinics.

The objectives of the study will be to:

- Explore and describe the extent of the manifestation of compassion fatigue amongst nurses caring for HIV positive patients in anti-retroviral clinics.
- Develop a wellness programme to care for nurses working in an anti-retroviral clinic that could aid in the screening, prevention and management of compassion fatigue.
- Implementation and evaluation of the wellness programme for nurses working in anti-retroviral clinics.

The study will consist of three phases. Phase one will explore and describe the phenomenon of compassion fatigue amongst nurses working in anti-retroviral clinics. Phase two will describe the development of a wellness programme for these nurses and in Phase three the wellness programme will be implemented and evaluated.

In phase one of this study the researcher will develop a theoretical framework to conceptualize compassion fatigue amongst nurses.

In Phase two of this study the researcher will develop a wellness programme for nurses working in anti-retroviral clinics to screen for, prevent and manage compassion fatigue.

In Phase three of the study the wellness programme developed during Phase two will be implemented and limitations will be defined and addressed for improvement of the programme.

A list of participants will be developed based on the identified names. Participants will be selected purposively and will be experts on the topic of wellness programmes, compassion fatigue and /or programme development. The sample will be multidisciplinary and will include academics, doctors, nurses, psychologists, social workers nationally as well as internationally. Participants who are interested to participate in the Delphi (30 minutes) should currently either work in the area of HIV/AIDS and/or have conducted research on the topic. Participants' identity will be kept anonymous, and this will encourage greater candour than might be expressed in a formal meeting.

The study will be submitted to the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria for permission to conduct the study. Permission will also be requested from The Department of Health, Gauteng Province (Appendix C).

Institutional permission will be obtained from the CEO of the [REDACTED] Academic Hospital (Appendix D), and the participants who will be participating in the study. The participants' rights will be explained to them prior to their participation, and information leaflets will be given to participants (Appendix A).

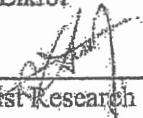


The sample in this study may not be representative of all nurses working in anti-retroviral clinics, since the study will take within one hospital's anti-retroviral clinics in Gauteng Province.

Section B: REVIEWER 'S FINAL CONCLUSION

- Accept

Reviewed by
Dr ML Likibi


Specialist Research and Epidemiology

Date: 05/03/10

 Recommended / Not Recommended

Mrs. Cilizwa Nkosi


Acting Director: Policy Planning and Research

Date: 2010/03/05

 Approved / Not Approved

**Appendix G: Ethics Committee Approval and Approval Certificate
Amendment**



The Research Ethics Committee Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

* FWA 00002567, Approved dd 22 May 2002 and Expires 13 Jan 2012.

* IRB 0000 2235 IORG0001762 Approved dd Jan 2006 and Expires 13 Aug 2011.

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1908 - 2008



Faculty of Health Sciences Research Ethics Committee
Fakulteit Gesondheidswetenskappe Navorsingsetiekkomitee

DATE: 20/11/2009

PROTOCOL NO.	178/2009
PROTOCOL TITLE	A wellness programme to prevent and manage compassion fatigue amongst nurses working in an anti-retroviral clinic.
INVESTIGATOR	Principal Investigator: Mercia Jane Tellie
SUBINVESTIGATOR	Not Applicable
SUPERVISOR	Prof Neltjie van Wyk and Dr Ronell Leech ronell.leech@up.ac.za
DEPARTMENT	Dept.Nursing Science Phone: 011 358 5300 Fax: 011 358 5400 E-Mail: mtellie@rhru.co.za Mobile: 082 3035 514
STUDY DEGREE	PhD degree
SPONSOR	Not Applicable
MEETING DATE	28 October 2009

This Protocol was considered by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria and approved by a quorum of committee members on 18/11/2009

Members of the Research Ethics Committee:

Prof VOL Karusseit	MBChB; MFGP(SA); MMed(Chir); FCS(SA) - Surgeon
Prof JA Ker	MBChB; MMed(Int); MD - Vice-Dean (ex officio)
Dr NK Likibi	MBBCh - Representing Gauteng Department of Health
Prof TS Marcus	(female) BSc(LSE), PhD (University of Lodz, Poland) - Social scientist
Dr MP Mathebula	(female) Deputy CEO: Steve Biko Academic Hospital
Prof A Nienaber	(female) BA(Hons)(Wits); LLB; LLM(UP); PhD; Dipl.Datametrics(UNISA) - Legal advisor
Mrs MC Nzeku	(female) BSc(NUL); MSc(Biochem)(UCL, UK) - Community representative
Snr Sr J Phatoli	(female) BCur(Eet.A); BTec(Oncology Nursing Science) - Nursing representative
Dr L Schoeman	(female) B.Pharm, BA(Hons)(Psych), PhD - Chairperson: Subcommittee for students' research
Mr Y Sikweyiya	MPH; SARETI Fellowship in Research Ethics; SARETI ERCTP; BSc(Health Promotion) Postgraduate Dip (Health Promotion) - Community representative
Dr R Sommers	(female) MBChB; MMed(Int); MPharmMed - Deputy Chairperson
Prof TJP Swart	BChD, MSc (Odont), MChD (Oral Path), PGCHE - School of Dentistry representative
Prof C W van Staden	MBChB; MMed (Psych); MD; FCPsych; FTCL; UPLM - Chairperson

DR R SOMMERS; MBChB; MMed(Int); MPharmMed.

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

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◆ P.O.BOX 667, Pretoria, S.A., 0001



The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567. Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

28/05/2015

**Approval Certificate
Amendment**

(to be read in conjunction with the main approval certificate)

Ethics Reference No.: 178/2009

Title: A wellness programme to prevent and manage compassion fatigue amongst nurses working in antiretroviral clinics in a public tertiary hospital

Dear Mercia Jane Tellie

The **Amendment** as described in your documents specified in your cover letter dated 7/05/2015 received on 8/05/2015 was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 27/05/2015.

Please note the following about your ethics amendment:

- Please remember to use your protocol number (**178/2009**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics amendment is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

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**Appendix H: Independent Coders' agreement letter and Independent Coders'
Declaration**

APPENDIX H

267 Roots Avenue
Eersterust
Pretoria
0022

Emoyeni Collaborations

24 June 2011

Dear Mrs. Visagie and Mrs. Maritz

Research Title: Development of a wellness programme for nurses working in an anti-retroviral clinic to prevent and manage compassion fatigue

Researcher: Ms M Tellie Ph Degree Student: University of Pretoria

Kindly use the following guidelines to analyse the transcripts of the qualitative data collected using interviews for the above stated research study:

The Tesch's (1990) method of qualitative data analysis as described in Creswell (1994: 154 – 155) which involve the following eight steps:

1. To get a sense of the storyline, by reading carefully through all the transcriptions and field notes to obtain background information. The researcher jotted down ideas as they came to mind.
2. The researcher then selected one most interesting and shortest document and asked herself what the interview was all about. Focusing on the underlying meaning of the text the researcher wrote down her thoughts in the margin. Repetition of this process was followed throughout all generated data. As there was transition from one topic to another, the researcher distinguished content from topic. Identified topics were then written in the margin of the document.
3. The researcher paid attention to the underlying meaning rather than the content. As topics emerged, they were written down in the margin, clustering similar

topics together. A connection was made between similar topics by using highlighters. Topics with the same colour were clustered together. All topics were arranged into columns on one sheet of paper; one column per each data document. The best fitting name that captures the substance was chosen for the clustered topics. These topics are then further arrayed as major topics, unique topics and leftovers.

4. Abbreviated topics were written in codes. The clustered major topics as well as the unique topics were abbreviated as codes. These codes were written next to the appropriate segment of the text. This process showed how well the topic descriptions corresponded with what was found in the data. It also led to the discovery of new topics that were not previously identified.
5. At this stage the researcher was ready for refinement of the organised data; the most descriptive wording for the topic was found and the topics were turned into categories and sub-categories. Coding refers to the process whereby data will be divided into finer parts, conceptualised and then synthesized in a new way (de Vos 1998: 271).
6. A final decision was then made on the abbreviated category name and each code was alphabetized. Subsequently a coding session was done.
7. The data material belonging to each category was assembled in one place and a preliminary analysis was performed and the commonalities, uniqueness, confusions and contradictions, as well as the missing information with regard to the research topic were then identified. This led to some of the data being discarded, as it was not relevant.
8. Tesch (cited in Creswell 1994: 154) suggests the re-coding of existing data will be done only when absolutely necessary.



CONFIDENTIALITY CLAUSE

Research Title: Development of a wellness programme for nurses working in an anti-retroviral clinic to prevent and manage compassion fatigue



Researcher: M. J. Tellie

The research code of Ethics mandate that confidentiality be maintained throughout data collection, data analysis and report writing.

The co-coders of the qualitative data collected hereby need to commit themselves to maintaining of confidentiality when co-coding the data.

I..... and commit myself to keep all information confidential during the course of analyzing the qualitative data for the above stated research study.

Co-coder:

1. Signature:		Date:	<u>5 / 8 / 2011</u>
2. Signature:		Date:	<u>5 / 8 / 2011</u>

CLIENT/STUDENT

Mercia Tellie

THIS IS TO CERTIFY THAT

Dr. Jeanette Maritz and Dr. Retha Visagie have co-coded
the following qualitative data:

7 Semi-structured Individual Interviews

For the study

A wellness programme to prevent and manage
compassion fatigue amongst nurses working in an anti-
retroviral clinic

We declare that we have reached consensus on the major themes of the data during a consensus discussion. The client/student has been provided with a report.

Dr. Jeanette Maritz (D.Cur; M.Cur; B.Cur (Ed.et.Adm); Advanced Research Methodology)

jeanettemaritz@gmail.com

Retha Visagie (D.Cur;M.Cur; B.Cur (Hons); BACur; Advanced Research Methodology)

rgvisagie@mweb.co.za

Appendix I: Editor's Declaration



STUDENT

Mercia Jane Tellie

THIS IS TO CERTIFY THAT

Ms. Anna Catharina Baird edited the study

A wellness programme to prevent and manage compassion fatigue amongst nurses working in an antiretroviral clinic in a public tertiary hospital

Ms Anna Catharina Baird (B Cur (I et A), Hons Communication, M A Ancient Languages and Cultural Studies)

annab@netactive.co.za

Signature: _____

AC Baird

Date: _____

11/11/2016

**Appendix R: A wellness programme to identify, prevent and manage compassion
fatigue amongst nurses who work in ARV clinics**



List of appendices on CD-ROM

Appendix J: Study summary sheet

Appendix K: Field notes

Appendix L: Qualitative data analysis worksheet

Appendix M: Job description: Professional Nurses

Appendix N: Job description: Enrolled/staff Nurses

Appendix O: Interview transcripts

Appendix P: The e-Delphi questionnaire

Appendix Q: Employee Health and Wellness Strategic Framework for the Public Service

**A wellness programme to identify, prevent and manage compassion fatigue
amongst nurses who work in antiretroviral clinics.**



Mercia Tellie

University of Pretoria: 2016

“Every one of us needs to show how much we care
for one each other and in the process
take care of ourselves”

Princess Diana

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A wellness programme to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics

Introduction

In this section the reader is orientated regarding the purpose and objective as well as the target group for whom the wellness programme was developed.

The interventions focus on the organization and on the individual nurses to create awareness on their risk to develop compassion fatigue, and strategies to manage existing compassion fatigue and prevent future compassion fatigue. On organizational level interventions focus on the development of policies, guidelines and protocols to create a supportive environment that enhance the health and well-being of employees. The individual interventions focus on increasing a sense of satisfaction, restoring empathetic caring, nurturing of the self and living a balanced work/life. The interventions focus on three levels, namely: awareness of risk, management and prevention.

Interventions for identification of risk and signs and symptoms of compassion fatigue focus on creating a programme on awareness of compassion fatigue; provision of education on death and grief and bereavement support to nurses; regulation and mitigation of work-related stress; establishment of work/life balance and desensitize nurses to traumatic events exposed to. Interventions that focus on strategies to prevent and manage compassion fatigue includes compile and implement a self-care programme; building of resilience, maintaining of work/life balance; establish support networks for nurses; build and strengthen nurses' resilience; practice mindfulness; increasing a sense of compassion satisfaction. Interventions that focus on preferred support that will help to prevent and manage compassion fatigue include creation of a network of support, promoting managerial support in the form of provision of debriefing service.

The wellness programme was developed based on the premise that the organisation would enable management to appoint a person that will facilitate the implementation of the wellness programme for nurses who work in the antiretroviral clinics to prevent and manage compassion fatigue.

Objective of the wellness programme

The objective of the wellness programme is to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics who are at risk to develop compassion fatigue or who already suffer from compassion fatigue.

For whom is the wellness programme intended

The wellness programme is intended for nurses who work in antiretroviral clinics who are at risk of developing compassion fatigue or who suffer from compassion fatigue.

THE WELLNESS PROGRAMME

The wellness programme consists of five interventions with 12 sub-interventions with a rationale and actions to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics.

Theme 1: The risk to develop compassion fatigue

The researcher identified two main interventions with related sub interventions under this theme.

Intervention 1:

Enhance nurses' ability to overcome work environmental factors that contribute to compassion fatigue

This intervention aims to provide ways of addressing the challenges nurses face in the work environment in order to minimise their risk of developing compassion fatigue.

Intervention 1a: Foster an atmosphere that is supportive of work/life balance

Rationale:

Frank and Karioth (2006:10) state that working extended hours and experiencing personal life disruption may cause nurses to be more vulnerable to compassion fatigue. According to Kulesa (2014:27) time away from direct patient care lessen the symptoms of compassion fatigue. Therefore, Bessinger (2006:19) recommends that healthcare professionals maintain a good balance between work and home life in order to defuse the tension they experience. Balancing work/life enables nurses to invest time and energy into nurturing themselves so that they are able to nurture and care for others (Boyle 2011:4). Thus, maintaining a balance between work and home life will help to decrease the risk of nurses developing compassion fatigue Zander (cited in Walker, Morin and Labrie 2012:14; Boyle 2011:7; Maytum, Heiman and Garwick 2004:177). Putting up boundaries protect nurses from experiencing negative feelings and help them to compartmentalize their experiences moving on with the day-to-day caring of their patients (Gerow et al. 2009:126-127).

Actions:

The person appointed by the organisation to run the wellness programme will be responsible to implement identified interventions and actions that will help to minimise the risk of nurses developing compassion fatigue.

- Emphasise the need for nurses to maintain a balance in their life. Encourage them to include a break for meals and physical activities or time to rest in each work day.
- Educate nurses on how to delineate and maintain professional boundaries and how to maintain emotional distance from troubling situations.
- Encourage nurses to spend time with family and engage in activities that the family can do together that will assist them to disengage from work-related issues when at home.
- Establish a system that monitor nurses' work schedules that limit the number of overtime in order reduce exposure to traumatic stressors and increase their job satisfaction.

Intervention 2

Lessen the negative effect of the cost of nurse-patient relationship

The aim of this intervention is to provide ways of ensuring that the cost of the nurse-patient relationship does not contribute to compassion fatigue.

Intervention 2a: Modulate nurse' response to the exposure to patients' traumatic events

Rationale:

According to Loolo (2016:32-34) long term exposure to patients' traumatic events can bring alterations in healthcare professionals' imaginary system of memory, negatively affecting nurse-patient relationship, resulting in reduced empathy towards patients. Ray et al (2013:255) state that being pre-occupied with traumatised patients increase vulnerability to compassion fatigue. Portnoy (2011:50) states that healthcare professionals should learn to modulate their responses to the stressors they face. According to Figley (2002:438-1439) healthcare professionals need to be desensitised from traumatic stressors by enabling themselves to face and work through various feelings and issues associated with traumatic experiences.

Actions:

The person appointed by the organisation will be responsible to implement intervention and actions to desensitize nurses' response to the traumatic stressors that they are exposed to in ARV clinics:

- Create awareness amongst nurses of any destructive behaviour, such as over-identification with traumatized patients. Encourage nurses to reach out for help when needed in order to minimise the effect of compassion fatigue on their well-being.
- Provide professional supervision and educate nurses to identify scenarios that are most difficult and exhausting to them. Nurses should identify and review potential reactions they use when those situations arise.
- Encourage nurses to recognise and accept the realities of working in an antiretroviral clinic, accepting that HIV/AIDS is a life-threatening condition and there is no cure for it. Emphasise the importance to concentrate on the positive features of own and their patients' experiences.

- Decrease exposure to traumatic events. Ensure that nurses have a balanced patient load and that a nurse does not consistently deal with extremely difficult patients and their families.
- Educate nurses on how to identify personal stressors in the workplace and be aware of factors that may cause compassion fatigue. Nurses should be encouraged to keep a journal on any traumatic or meaningful encounters that they have had during the day and share with colleagues at meetings, or they can practice meditation daily.

Intervention 2b: Create a culture of compassion at organisational level

Rationale:

Compassion in organisations can take place at all levels and can be encouraged by managers. Compassion in an organisation makes employees to feel recognised and they feel supported and this will foster resilience and organisational commitment (Hoffman 2009 cited in Slatten, Carson and Carson 2011:329; Kanov et al. 2004:809).

Actions:

The person appointed by the organisation will be responsible to implement intervention and actions to desensitize nurses' response to the traumatic stressors that they are exposed to in ARV clinics:

- Create a culture in the organisation that allows compassion to be expressed towards patients, colleagues, managers and supervisors.
- Recognise employees as human beings and ensure that support systems are in place that will help them to cope in the workplace.

Theme 2

Manifestation of compassion fatigue

Four subcategories were identified under this theme that covers the physical, psychological, and spiritual presentation of compassion fatigue as well as the behavioural manifestation of compassion fatigue.

Intervention 3

Enhance understanding of the manifestation of compassion fatigue

This intervention aims to raise awareness on the manifestation of compassion fatigue to ensure early identification of the development of compassion fatigue.

Intervention 3a: Raise awareness on compassion fatigue

Rationale:

Braunschneider (2013:16; 17) states that compassion fatigue is becoming very prevalent in the healthcare profession. Awareness of how compassion fatigue present is important because self-awareness and early recognition of signs and symptoms are key to the prevention thereof (Hesselgrave 2014:3; Panos 2010:3; Joinson 1992:118). However, Hooper et al. (2010:426) argue that the warning signs and symptoms of compassion fatigue often go unrecognised by nurses. Therefore, creating awareness on compassion fatigue should be the first step in any wellness programme, in order to enable healthcare professionals to consciously use the right coping skills, take appropriate action in seeking help to deal with it and practice self-care that will help to prevent the occurrence thereof (Smart et al. 2013:9; Lombardo and Eyre 2011:3; Tunajek 2006:24-25). According to Kelly, Runge and Spencer (2015:526) addressing compassion fatigue is beneficial for both nurses and the organisations they work for.

Actions:

The person appointed by the organisation to run the wellness programme will implement the following actions to create awareness on compassion fatigue amongst nurses who work in ARV clinics.

- Create awareness amongst new recruits during interviews of the possible risk of them developing compassion fatigue and the effect that it could have on their well-being, due to exposure to patients who are HIV positive while working in antiretroviral clinics.
- Include a module on compassion fatigue in the induction and orientation programme of new staff, in order to create awareness on compassion fatigue. Emphasis should be on educating the new recruits on how to recognise and manage compassion fatigue and informing them of the resources available to help them cope with the challenges they face working in ARV clinics.

- Acknowledge the presence of compassion fatigue in a proactive way and educate managers and supervisors on identification of risk factors in antiretroviral clinics that may trigger compassion fatigue that could affect patients' care negatively.
- Provide written handouts and articles on compassion fatigue to nurses and include compassion fatigue as a topic on the in-service training schedule as means of continuous personal development.

Intervention 3b: Assess the manifestation of compassion fatigue

Rationale:

Doing the compassion fatigue self-test (ProQOL Stamm 2010), the Compassion fatigue Scale, Compassion Satisfaction and Fatigue Test and/or Compassion Fatigue Self-test can help nurses to become aware of their own compassion fatigue symptoms (Bride, Radey and Figley 2007:156). Firstly it can serve as an important tool for healthcare professionals to understand their feelings of unhappiness and dissatisfaction, and secondly it can help them to develop a warning system for themselves that will indicate when they are going into the danger zone of developing compassion fatigue (Mathieu 2007:2). These compassion fatigue tests can be used as a basis for planning self-care strategies (Stamm 2010:11). According to Panos (2010:4) unrecognized compassion fatigue will result in people to leave their professions, and/or fall into addictive behaviour such as drug abuse and gambling. Nurses can decide which test they would like to use, and access to these compassion fatigue self-tests is free of charge on the internet from: www.compassionfatigue.com or www.sidran.org; or www.proqol.org/Proqol_Test.html.

Actions:

The person appointed by the organisation will be responsible to implement intervention and actions to modulate nurses' response to the traumatic stressors that they are exposed to in ARV clinics:

- Provide access to different compassion fatigue self-tests and encourage nurses to do a self-assessment using the self-report questionnaire that will assist them in identifying any triggers and recognise the signs as well as symptoms of compassion fatigue.

Theme 3

Strategies to prevent and manage compassion fatigue

Based on participants' responses the researcher identified strategies that nurses were using to manage compassion fatigue, as well as preferred support from management that can help nurses to prevent and manage compassion fatigue. Under preferred support from management the researcher identified debriefing, managerial and psychological support as strategies to prevent and manage compassion fatigue. Personal strategies used by nurses to prevent and manage compassion fatigue included collegial support, self-care and celebration of patients' lives.

Intervention 4

Provide workplace support that will prevent and manage compassion fatigue

This intervention aims to provide support to nurses to prevent the occurrence of compassion fatigue as well as management of existing compassion fatigue.

Intervention 4a: Establish on-site debriefing and counselling services

Rationale:

Debriefing with supervisors, consultants or colleagues is regarded as being very important in the prevention of compassion fatigue (Killian 2008:37). Louw et al. (2011: 656) argue that debriefing is a highly important part of any wellness programme whereby nurses are given the opportunity to express their emotions and experiences in a controlled environment. It can be used to relieve tension, as well as relieve the emotional adverse effects. Debriefing techniques can be used to prevent compassion fatigue (Pickett et al. 1994:250). Goga and Thomson (2012:15) argue that the purpose of debriefing is to provide support to individuals in managing challenges and demands within the context of their work. Good debriefing support results in an improvement in staff attitude and improvement in services delivery. According to Dominguez-Gomez, Rutledge, Hemet, and Fullerton (2009:203) formal or informal debriefing can provide opportunities to talk about work-related issues and provide relief from distress.

Actions:

The organization should provide the necessary resources and support to the person who run the wellness programme to establish debriefing and counselling services.

- Institute debriefing systems that are available and accessible to nurses when needed with a psychologist/social worker appointed for this purpose.
- Encourage nurses to attend debriefing sessions especially after exposure to traumatic events.

Intervention 4b: Provide workplace support

Rationale:

According to Boyle (2011:5-6) managing and preventing compassion fatigue requires more deliberative attention from managers. Work-related support alleviates work-stress from caring for sick and traumatised patients, promotes compassion satisfaction and in turn prevents compassion fatigue (Ray et al. 2013:257; King et al. 1998 cited in Sabo 2006:140). Support in the workplace indirectly reduces the negative effect of stressors and help to maintain the health and well-being of healthcare professionals. Providing support to those in need outweigh the difficulties experienced at work (Loolo 2016:106; Hunsaker et al. 2015:191; Sheppard 2015:57; Kulesa 2014:25). Hunsaker et al. (2015:192) argue that positive, supportive managers is more likely to have nurses with high levels of compassion satisfaction and in turn less compassion fatigue resulting in retention of knowledgeable, caring and experienced nurses. According to Inbar and Ganor (2003:111; 112) management should design an organizational culture that prevents or moderates the risk of compassion fatigue.

Actions:

Management should provide workplace support to nurses to help prevent and manage compassion fatigue.

- Implement a mentoring programme that places emphasis on enhancing professional skills and competencies of nurses and identifies nurses to be mentored and links them up to a mentor. The mentoring programme should include clinical case review sessions held once a week that focus on discussing difficult HIV/AIDS cases, the correct use of HIV/AIDS policies and guidelines as well as correct drug regimen decisions.
- Promote the establishment of a relaxation centre where staff may go for brief periods of respite, where they can get a light massage or just relax in a quiet comfortable setting.
- Establish a network of collegial support systems to provide support and guidance that will help nurses cope with work demands and addressing emotional issues of working

in ARV clinics. This can be achieved by regular discussions amongst teams where team members are encouraged to participate in making decisions regarding the care and management of difficult patients. Articles on latest research findings in the HIV/AIDS field and compassion fatigue can contribute to the recognition of compassion fatigue, discussion of its implications and formulation of a team approach to address compassion fatigue.

- Diversify nurses' workload – lessen professional time spend on providing care to the most distressed patients. Mix nurses' caseload, share acute and stable HIV positive patients. Have clear limits regarding time on duty, encourage engagement in research, teaching or other activities to round off clinical service. Rotation of nurses out of the antiretroviral clinic on a regular basis will help to prevent over-exposure to patients' trauma and work-related stress.

Intervention 4c: Enhance nurses' sense of job satisfaction

Rationale:

Kelly, Runge and Spencer (2015:527) state that meaningful recognition and increase in job satisfaction can help to prevent compassion fatigue because highly satisfied nurses experience less compassion fatigue. Compassion satisfaction act as a buffer against compassion fatigue by having a protective influence upon individuals' risk levels, balancing the negative effects of caring for traumatised patients and stressful events, resulting in healthcare professionals to be less vulnerable to compassion fatigue (Smart et al. 2013:5; Figley 2002:1437). Malatjie (2010:10) argues that reward and recognition act as a buffer against stress as it helps in the promotion of a positive work environment. Thus, healthcare professionals should focus on finding ways to increase their sense of achievement and sense of compassion satisfaction in order to lower or prevent compassion fatigue (Smart et al. 2013:5; Figley 2002:1437).

Actions:

Actions should aim at improving nurses' sense of self-fulfilment and compassion satisfaction level. The following actions are suggested to increase nurses' sense of achievement and their compassion satisfaction level; the actions can be used by management and/or the person appointed to run the wellness programme to enhance nurses' job satisfaction:

- Institute a reward system that acknowledges outstanding accomplishment of staff e.g. best nurse of the month in order to increase sense of compassion satisfaction.

- Create an environment that allows nurses to achieve optimal performance and productivity. Provide opportunities for personal growth and development.
- Organise social events- such as annual retreats that allow team members to interact with each other.
- Encourage nurses to focus on the successes of the day and the sense of appreciation from patients, e.g. recognition of the psychological successes of care that contribute to the well-being of patients and their families.

Intervention 4d: Enhance the use of positive coping skills

Rationale:

Positive coping skills are associated with lower levels of secondary traumatic stress and compassion fatigue Hollingsworth (1993 cited in Jacobson 2006:146). Bessinger (2006:29) argues that stress cannot be completely eliminated from our lives. However, coping strategies can assist in decreasing stress to a more healthy level, thus preventing the harmful emotional and physical effects. Tunajek (2006:25) agree that the use of appropriate coping skills improve harmony and lead to congruence of mind, body and spirit. It makes life to be fun, improves the quality of life, and provides a feeling of happiness and j.

Actions:

The person appointed to run the wellness programme will implement the actions to enhance nurses' coping skills.

- Encourage nurses to keep a journal on experiences that will help to manage feelings and reflect on life-events. Identify scenarios that are most difficult and exhausting and identify and review potential responses that can be used when those situations arise.
- Provide opportunities where nurses can debrief informally with colleagues, where they talk about their feelings and fond memories of their patients.
- Encourage nurses to utilize relaxation techniques such as meditation, yoga, physical exercise and recreation. They should also be encouraged to use faith and religion to become more spiritual, in order to make sense of the meaning of life and can use prayer and also pray for patients.
- Create awareness in nurses regarding the appropriate use of humour in the workplace as a coping strategy in harsh circumstances.

Intervention 4e: Provide bereavement support programmes

Rationale:

Being exposed to multiple deaths within a short space of time cause nurses to be traumatised resulting in an increase in their risk to develop compassion fatigue (Gerow et al. 2009:127; Abendroth and Flannery 2006:354; Figley 2002:1437). According to Bennett and Kelaher (1993 cited in Rapp 2012:6) nurses who work in the HIV/AIDS field are at an increased risk of experiencing grief due to the many deaths they face that may prevent them from providing quality care. Bereavement support programmes help nurses to find closure by allowing them to talk about their thoughts and feelings and in so doing reduce the risk of compassion fatigue (Fetter 2012:560; Macpherson 2008:148). According to Parry (2011 cited in Ek, Westin, Pahl, Osterling, Strang, Bergh et al. 2014:509) nursing students lack sufficient skills to cope with end-of-life care. Therefore, understanding nurses' experiences of death and dying can help the health care system to prepare and educate nurses on how to deal with issues relating to end-of-life care.

Actions:

The person appointed to run the wellness programme can link with a palliative care association and request training for all nurses who work in ARV clinics.

- Facilitation of end-of-life training provided by palliative association that incorporate: personal fears and phobias around death dying and loss, impact of bereavement and benefits of supported workforce; manifestations of grief in the workplace; listening and communication skills; helping models as well as loss and trauma in the workplace. Managers and supervisors should be encouraged to also attend the training to enable them to deal with employee's grief.

Additional actions for bereavement support:

Management should provide the necessary resources and support to provide education on death, grieving and bereavement that include the following action steps that will provide guidance to nurses on the path of healing:

- Provide written handouts about death and bereavement to raise awareness on feelings and fears and to provide ongoing coping tips to nurses.
- Encourage nurses to find closure on the death of their patients and allow them adequate personal time to grieve the inevitable death of their patients.

- Institute multidisciplinary ward rounds to improve team work, allowing healthcare workers to share their emotional experiences caring for patients who are HIV positive and other members empathizing with colleagues.
- Encourage nurses to create a remembrance tree or memory board in the unit, in a staff-only area that is changed with each passing season and they can also create sympathy cards to send to the patients' family and encourage nurses to keep a journal to write fond memories of patients, funny anecdotes and well wishes to patients' loved ones and mail it to the family.
- Provide counselling for nurses who work in paediatric ARV clinic following the death of a child patient.
- Establish a referral system for pastoral care for debriefing and bereavement counselling to support nurses during bereavement. Allow nurses to participate in caring rituals and if possible, to attend patients' funerals to help them find closure.

Intervention 4f: Build and strengthen nurses' resilience

Rationale:

Resilience is a personality trait that enables a person to overcome adversity and within a work situation enable a person to remain task-focused and productive during tough times (Warner 2012:n.p.) Comfort, Boin and Demchak 2010:14). Resilience can be viewed as a dynamic process that allows people to successfully adapt to challenges, stress and adversity (Deshields et al 2015, n.p; Norris et al. 2008:129). Resilience acts as a buffer against compassion fatigue because it provides protection against the harmful effects of caring for traumatised patients by enhancing greater job satisfaction, lessen anxiety and improve quality of life (Hegney et al. 2014:516-517; Potter et al. 2013:180;186). The goal of a resilience training programme is to strengthen internal coping mechanisms to build resilience and to build a healthier work environment by empowering nurses to become mentally stronger individuals. Thus, it is to enable nurses to perform more effectively in a stressful situation resulting in improved patient outcomes and staff satisfaction (Sullivan and Bissett 2012:3).

Actions:

The person appointed to run the wellness programme will implement actions to build and strengthen nurses' resilience.

- Establish a resilience training programme on a monthly basis that focuses on reinforcement of content to build and strengthen nurses' resilience. The programme will

focus on seven elements of resilience, namely: connection and support, self-validated care giving, self-efficacy, self-regulation, positivity and self-care.

- Provide additional strategies that can be used to build resilience including cognitive reframing, toughening up, grounding connections, work/life balance and reconciliation.

Intervention 5

Build personal strategies to manage compassion fatigue

With this intervention the researcher aims to enhance and strengthen strategies that individual nurses can use to prevent and manage compassion fatigue.

Intervention 5a: Create an organisational culture that encourages self-care

Rationale:

Compassion fatigue affects individuals in the caring profession, therefore healthcare professionals must learn to care for themselves, participate in self-care activities that replenish their energy during the day and in their personal life in order to overcome the negative effects of compassion fatigue (Najjar et al. 2009:274). Self-care is the cornerstone in preventing compassion fatigue (Wentzel and Brusiewics 2014:96; Bush 2009:27) because it enables healthcare professionals to replenish their energy during the day, refuelling and revitalizing the physical, emotional, psychological, spiritual, relational and professional dimensions (Gentry and Baranowsky 2013:n.p.; Kearney, Weininger, Vachon, Harrison and Mount 2009:1162). Self-care promotes a sense of compassion satisfaction that acts as a buffer against compassion fatigue, since it allows the individual to take care of interests outside of work (Loolo 2016:57; Berg and Nilsson 2015:13; Parsons 2014:13;14; 33; Eastwood and Ecklund 2008:116).

Actions:

The person who runs the wellness programme should implement actions that encourage the practice of self-care by nurses.

- Provide education to nurses on self-care techniques that will improve their resourcefulness and coping techniques.
- Encourage nurses to say 'no' without feeling guilty when feeling overwhelmed.
- Create time for social interaction with other staff members, and participate in team building exercises.

- Encourage nurses to develop and maintain a healthy lifestyle and build resistance to stress through healthy eating habits, adequate rest and sleep and regular exercise.
- Encourage nurses to nurture themselves and to take time pursuing non-work related activities that they enjoy, such as walking, listening to music or reading. Emphasise the importance of inclusion of self-soothing activities in the self-care plan such as relaxing, reading a book or watching a movie.
- Educate nurses on the use of mindfulness exercise. Nurses to do mindful meditation, quiet their mind and educate them to be present in the moment.
- Encourage nurses to engage in healing activities. Nurses can bring into the office signs of life and beauty such as a plant that remind them of life. Start a garden, paint or take a walk to enjoy nature.
- Educate nurses on how to practice positive mind skills intentionality. Celebrate and remember even minor successes. They should honour nursing as the spiritual, spirit-filled practice, using difficult situations as lessons for growth.





Appendix J: Study Summary Sheet



Appendix C Study Summary Sheet

Study Summary Sheet

A wellness programme to prevent and manage compassion fatigue amongst nurses working in an anti-retroviral clinic in public tertiary hospital

The objectives of the study will be to:

1. Explore and describe the manifestation of compassion fatigue amongst nurses caring for HIV positive patients.
2. Develop a wellness programme to care for nurses working in an anti-retroviral clinic that will aid in screening, prevention and management of compassion fatigue.
3. Implement and evaluate the implementation of a wellness programme to screen, prevent and manage compassion fatigue of nurses working with HIV/AIDS patients.

Back ground:

Compassion fatigue can lead to poor clinical work. Professional errors cost the organization and the nursing profession. It leads to absenteeism and high staff turnover. Nurses who are protecting themselves are likely to be motivated, open to new learning, and doing their job well. Addressing compassion fatigue does not have to be an expensive venture, teaching nurses to take care of themselves through a wellness programme can achieve this.

Study Design:

The researcher will address the nurses in each anti-retroviral clinic with the help of the unit manager during their tea break and hand out the study summary sheets explaining details about the study. Appointments would then be made with nurses that show interest in the study on an individual basis, at a time that suite the clinic. If you agree to take part in the study, you will be asked to participate in an one-on-one interview that would be tape recorded and to also complete a questionnaire.

• **Interview :**

Nurses will be interviewed on a one-on-one basis using the interview guide. Interviews will last approximately one hour.

Benefits:

The benefit of your participation in the study will contribute to the researcher understanding the manifestation of compassion fatigue amongst nurses working in an anti-retroviral clinic and the implementation of a wellness programme that will aid in the prevention and management of this phenomenon.

Participation is voluntary. Information gathered will be kept confidential



Appendix K: Filed Notes

Appendix K: Filed notes

REGISTERED NURSE

(The researcher included one example)

FIELD NOTES INTERVIEW 1

Participant: Registered nurse working in adult antiretroviral clinic
Department of Health, Charlotte Maxeke Tertiary Hospital

October 2009

Time: 09:00

The researcher had an initial meeting with the participant to establish contact and to decide on a date and time for the interview that was convenient for the participant and the unit.

Role in antiretroviral clinic: Participant is a registered nurse working in adult antiretroviral clinic and does counselling of adult patients referred from other departments as well as patients admitted in different wards within the hospital. Counselling includes pre- and post-test counselling for HIV testing and giving of HIV test results. The participant is stationed in the adult antiretroviral clinic.

The interview took place in the participant's consulting room. There was background noise from patients chatting in the waiting area and from the adjacent vital sign room.

The purpose of the interview was to obtain data on how working in an antiretroviral clinic impacts on the participant's well-being. The data obtained during the interviews will aid in a wellness programme that identifies, prevents and manages compassion fatigue amongst nurses working in antiretroviral clinics. The participant will benefit from the wellness programme.

The participant gave consent that the interview may be recorded. The research assistant conducted the interviews while the researcher took down field notes. The research assistant was in control of the interview. The participant was reassured, appeared relaxed and eye contact was maintained during the interview.

The participant has years of experience working in an antiretroviral clinic and answered all questions confidently. She showed passion for her work in the antiretroviral clinic, her voice was clear and the tone of her voice was raised when she spoke about her work. The participant was at ease and the interview went well with no interruptions.

My impression:

- Her non-verbal communication clearly sends a message of her passion and her belief in a higher being gives her strength and helps her to cope working in an antiretroviral clinic for such a long time.
- Working in antiretroviral clinics does negatively impact on the health of nurses
- Nurses are emotionally involved with their patients and seeing them suffer does affect nurses.

Shortcomings of the interview:



- The participant answered all questions and probes were adequate, thus the researcher did not have to do any follow up interview.



Appendix L: Qualitative Data Analysis Worksheet



Appendix L: Qualitative data analysis worksheet

Themes	Categories	Subcategories
Trust and confidence	<ul style="list-style-type: none"> • Health care system • Leaks and gaps 	<ul style="list-style-type: none"> • Meaning of confidence ▪ Finding a cure for HIV/AIDS ▪ Applaud for progress made ▪ ARV initiation ▪ Patients being missed by system ▪ HIV/AIDS services in rural areas ▪ Prevention strategies ▪ Termination of pregnancy ▪ Resources and equipment ▪ Remuneration policies ▪ Role of nurses in anti-retroviral clinic ▪ Workplace support systems
Challenges faced by health care system	<ul style="list-style-type: none"> • HIV/AIDS programme 	<ul style="list-style-type: none"> • Consistency implementing policies • Access to ARV clinic • ARV initiation • Side effects • No cure for HIV/AIDS • Staff shortage • Nurses attitude • Decision making
Anti-retroviral therapy	<ul style="list-style-type: none"> • Availability of anti-retroviral treatment ▪ Hope and faith 	<ul style="list-style-type: none"> ▪ Prolong life ▪ Hope ▪ Patient's fear to commence anti-retroviral clinic ▪ Doubt about the effectiveness of anti-retroviral clinic ▪ Patients response to treatment ▪ Defaulting treatment ▪ Progress made regarding the knowledge on anti-retroviral treatment ▪ Anti-retroviral guidelines • Believe in anti-retroviral treatment • Believe will find a cure for HIV/AIDS in future



		<ul style="list-style-type: none"> ▪
Human Immune Virus epidemic	<ul style="list-style-type: none"> ▪ Knowledge ▪ HIV prevention strategies ▪ Discordant couples 	<ul style="list-style-type: none"> ▪ Study the virus ▪ Research and evidence base practice ▪ Conferences and workshops ▪ Training needs ▪ HI/AIDS epidemic ▪ Negotiation of condom use ▪ Non-disclosure ▪ Contraceptive methods ▪ Prevention of mother-to-child transmission programme ▪ Awareness campaigns ▪ Patient education ▪ Multiple partners ▪ Fighting a losing battle ▪ Concerns most mothers are HIV positive
HIV testing programme	<ul style="list-style-type: none"> ▪ Patient's response to HIV diagnosis ▪ Family response to HIV diagnosis ▪ Nurse's response to HIV diagnosis 	<ul style="list-style-type: none"> ▪ Suicidal ▪ Access anti-retroviral programme too late ▪ Disclosure issues ▪ Experience fear ▪ Go through grieving process ▪ Origin of virus ▪ Face challenges ▪ Negative behaviour ▪ Feeling of hopelessness ▪ Blamed for bringing the virus into the house ▪ Fear person is dying ▪ Partner refuse to use condoms ▪ Effect on nurse when giving a HIV positive test result
Traumatic experiences of patients	<ul style="list-style-type: none"> ▪ Nurse's response to patient's hurt 	<ul style="list-style-type: none"> ▪ Empathetic response ▪ Negotiation of condom use ▪ Being compassionate ▪ Emotional attachment ▪ Affected by listening to patients traumatic stories ▪ Pre-occupation with a patient ▪ Need boundaries to separate work and home



	<ul style="list-style-type: none"> ▪ Cost of caring for HIV positive patients ▪ Physical fatigue 	<ul style="list-style-type: none"> ▪ Nurse's emotional well-being ▪ Emotional fatigue ▪ Something trigger the memories ▪ Express passion for work in anti-retroviral clinic ▪ Emotional exhaustion experienced by nurses ▪ Loss of passion for work ▪ Disturbance in sleep pattern ▪ Pre-occupation with patients ▪ Trigger of memories ▪ Causes of compassion fatigue ▪ Signs and symptoms of compassion fatigue ▪ Low energy levels at the end of the day
The nurse's work environment in an anti-retroviral clinic	<ul style="list-style-type: none"> ▪ Workplace support Systems ▪ Work related stress ▪ Strategies to distress 	<ul style="list-style-type: none"> ▪ Lack of debriefing ▪ Managerial support ▪ Collegial support ▪ Support systems identified by nurses that they need ▪ Addressing training needs ▪ Resources and equipment ▪ Long queues in clinic ▪ Not getting through to patients ▪ Patients negative behaviour ▪ Lack of managerial support ▪ Lack of knowledge on HIV and anti-retroviral treatment ▪ Unco-operative parents ▪ Patient perception of HIV ▪ Disengage when at home ▪ Talking about experience ▪ Believing in a higher being ▪ Praying ▪ Going to the gym
Caring for HIV positive patients	<ul style="list-style-type: none"> ▪ Role of the nurse in anti-retroviral clinic 	<ul style="list-style-type: none"> ▪ Identify with the HIV positive patient ▪ Holistic care ▪ Contributing to make a difference in the lives of HIV positive patients ▪ Change perception of patients



	<ul style="list-style-type: none"> ▪ Tasks and functions ▪ Challenges and difficulties experience 	<p>on HIV</p> <ul style="list-style-type: none"> ▪ Workload ▪ Long queues in clinic ▪ Energy levels at end of a work day ▪ HIV positive patients need more psychological support ▪ Rendering quality nursing care ▪ Nurses emotional well-being ▪ Change perception of patients on HIV ▪ Heavy workload ▪ Long queues in clinic ▪ Energy levels at end of a work day ▪ Emotional exhaustion felt by nurse ▪ HIV positive patients need more psychological support ▪ Not getting through to patient ▪ Desire to make a difference in the lives of HIV positive patients ▪ Patients feel stigmatized ▪ Patients direct negative emotions towards health care workers ▪ Patients are scared ▪ Suicidal tendencies of patients ▪ Disclosing HIV status to family member or friend ▪ Fear of dying ▪ Fear of commencing anti-retroviral treatment ▪ Patients lifestyle the cause of HIV status ▪ Serving a mobile community ▪ Enter health care system when very sick ▪ The emotional and financial cost of caring for HIV positive patients
<p>Caring for HIV positive children and adolescents</p>	<ul style="list-style-type: none"> ▪ Challenges and difficulties faced 	<ul style="list-style-type: none"> ▪ Pre-occupation is worse when dealing with HIV positive children ▪ Nurses are very protective over the children ▪ Parental involvement in caring



		<p>for HIV positive children</p> <ul style="list-style-type: none"> ▪ Support given to mothers ▪ Parental negligence ▪ Effect of unco-operative parents on continuity of care ▪ Causes of babies born HIV positive ▪ Will child cope when informed of HIV diagnosis ▪ Orphans in care of grandmothers ▪ Concern when child hear that mother died from HIV/AIDS ▪ Loss of a nation ▪ Referral of mothers for anti-retroviral treatment
Response of the nurse to the death of a patient or family member	Bereavement/mourning process	<ul style="list-style-type: none"> ▪ Grieving after the death of a patient ▪ Coping with the death of a patient or family member ▪ Cause of death of a family member ▪
Nurses affected by the HIV epidemic	<ul style="list-style-type: none"> ▪ Nurse's family member diagnosed HIV positive 	<ul style="list-style-type: none"> ▪ Memories of family member refusal to start anti-retroviral treatment ▪ Perception of HIV services in rural areas where family member lived ▪ Share experience of family member with other patients ▪ How nurses cope with the death of a family member ▪ Nurse feel guilty for not being there for family member who died without having commenced anti-retroviral treatment ▪ Family member not disclosing HIV status ▪ Cause of death of family member ▪

Appendix M: Job Description – Professional Nurses



ANNEXURE B

JOB DESCRIPTION

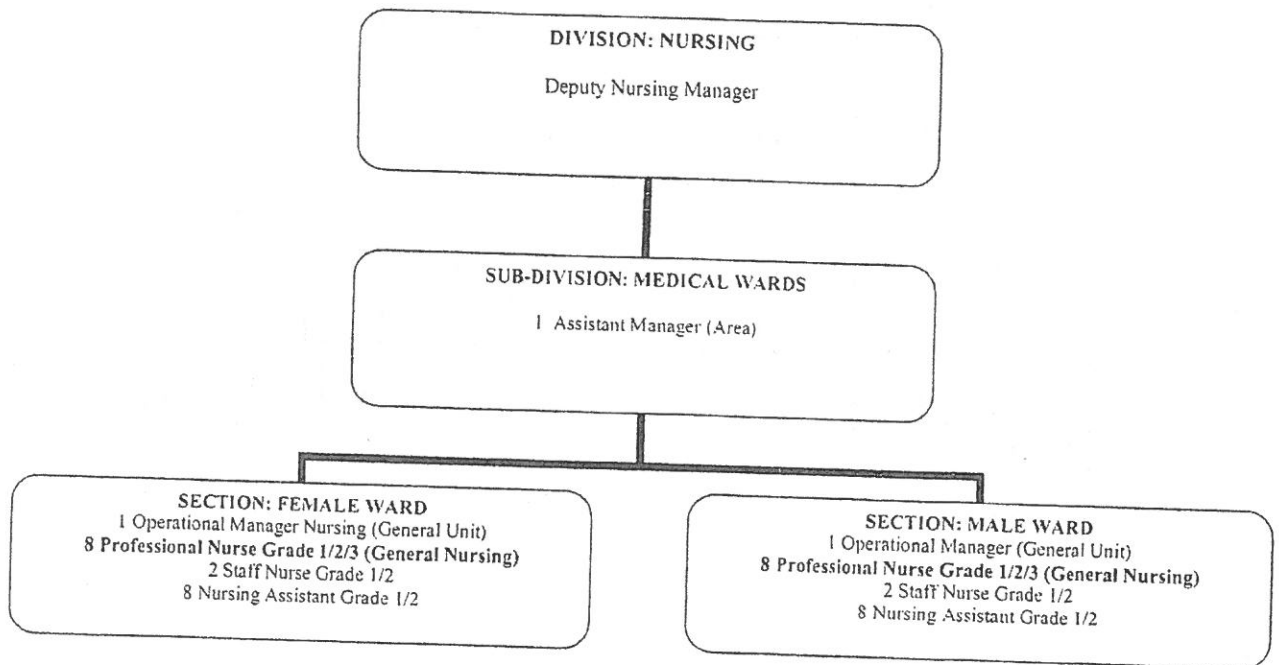
Name	Persal Number

A. JOB INFORMATION SUMMARY

Job Title	Professional Nurse (General Nursing)
Occupational Specific Dispensation	Professional Nurse
Job Level	PN-A2, PN-A3, PN-A4
Date	1 July 2007
Location	Various Institutions
Component	Nursing
Post report to	Operational Manager Nursing (General Unit)
Job Classification Code	



B. HIERARCHICAL POSITION OF POST



C. JOB PURPOSE (Linked to Strategic Plan)

To provide holistic nursing care to patients in a cost effective, efficient and equitable manner.

D. MAIN OBJECTIVES (Key Performance Areas (KPA's))

MAIN OBJECTIVES		%
1.	<p>Provide direction and supervision for the implementation of the nursing plan (clinical practice/quality patient care):</p> <ul style="list-style-type: none"> Implement a comprehensive nursing care plan/program for the promotion of health, self-care, treatment and rehabilitation of patients. Administer treatment plan of common or minor primary health conditions presented at primary care facilities in accordance with prescribed norms and standards, guidelines and treat conditions of patients as prescribed. Screen health problems and diseases in accordance with prescribed norms and standards. Maintain a therapeutic relationship and environment in which health care can be provided optimally and safely. Report and communicate on the continuity of care to the caregivers and members of the health team. Create and maintain a complete and accurate nursing record for individual health care users. Audit clinical records by analyzing data. Participate in health promotion and illness prevention initiatives and contribute to their evaluation. Demonstrate and understand traditional healing practices within the health care user's belief. 	40%



MAIN OBJECTIVES		%
2.	<p>Implement standards, practices, criteria and indicators for quality nursing (quality of practice):</p> <ul style="list-style-type: none"> • Maintain a plan to improve the quality of nursing and health care. • Implement quality improvement plan. • Participate in the auditing of quality of nursing and health care. • Assist in the development of nursing and improvement of standards of care through research. • Create an environment and learning opportunities that foster professional growth and improvement in nursing and health care. • Actively engage in the education and training of students in the health care system. • Perform or carry out interventions ranging from personal care with active involvement of patients and other members of the team. • Develop and document interventions and progress of patients to facilitate continuity of care. • Participate in the formulation and review of nursing interventions through comprehensive and on-going assessment. • Identify health indicators and risk factors and conduct client satisfaction surveys 	25%
3.	<p>Practice nursing and health care in accordance with the laws and regulations relevant to nursing and health care:</p> <ul style="list-style-type: none"> • Maintain a professional and ethical practice as well as an enabling environment for ethical practice. • Protect and advocate rights of patients regarding health care. • Implement patient care standards, policies and procedures. • Compliance and adherence to the relevant acts/prescripts applicable within the nursing environment. • Contribute to the education and professional development of students. • Apply the principles of nursing care in service rendering, for the maintenance of professional excellence. • Implement nursing care management activities according to the Standards of Practice and Scope of Practice and act upon breaching of laws relating to nursing practice and professional code of conduct and practice standards. • Implement quality improvement plan, the Nursing Act and Regulations, the Code of Ethics and Professional Practice of the South African Nursing Council. • Implement procedures that maintain effective infection control and occupational and safety measures in accordance with Occupational Health & Safety legislation. 	15%
4.	<p>Maintain a constructive working relationship with nursing and other stakeholders:</p> <ul style="list-style-type: none"> • Collaborate with members of the health and social care teams and assist in decision-making pertaining to health care delivery. • Communicate with the multi-disciplinary health teams, organizations and special interest groups when dealing with community health issues and needs. • Disseminate information on epidemics, nutritional disease, maternal and infant morbidity and mortality and other common diseases. • Participate in health promotion and illness prevention initiatives. • Implement nursing interventions to achieve expected outcomes. 	10%



MAIN OBJECTIVES		%
5.	Utilize human, material and physical resources efficiently and effectively: Human <ul style="list-style-type: none"> • Contribute to the training and professional development of students and sub-ordinates • Maintain the duty roster, leave schedules and attendance register • Maintain accountability and responsibility for nursing care activities Material and Physical Resources <ul style="list-style-type: none"> • Order stock • Report maintenance of equipment 	10%

A. DIMENSIONS OF THE POST

Equipment Budget

- Tens of thousands

Stores Budget

- Tens of thousands

F. DELEGATIONS

LABOUR RELATIONS DELEGATIONS	HUMAN RESOURCES DELEGATIONS	FINANCIAL DELEGATION	SIGNING AUTHORITY	PROCUREMENT DELEGATIONS
Managing workplace discipline	All other powers and duties delegated in terms of the acting capacity	None	Procurement delegations: Approval of expenditure up to R.....per case	



G. PERFORMANCE STANDARDS & INDICATORS (Based on main objectives)

MAIN OBJECTIVES (measurable outputs/end results)	INDICATORS (indicating how well standards were achieved)
<p>1. Provide direction and supervision for the implementation of the nursing plan (clinical practice/quality patient care)</p>	<ul style="list-style-type: none"> • Nursing care plan/program • Patient assessment reports • Continuity of care report • Norms and standards guidelines available • Treatment evaluation report • Treatment and prescription plan • Health care information assessment report • Audited clinical records • Patient care communication plan • Nursing care plan • Nursing data and information (health indicators) available • Confidential patient reports
<p>2. Implement standards, practices, criteria and indicators for quality nursing (quality of practice)</p>	<ul style="list-style-type: none"> • Nursing and health care improvement plan • Nursing care audit report • Health research report • Student assessment programs and reports • Continuity of care plan • Continuity of care interventions and progress plan and report • Continuity of care assessment report • Client satisfaction survey • Health indicators and risk factors report • Health promotion program
<p>3. Practice nursing and health care in accordance with the laws and regulations relevant to nursing and health care</p>	<ul style="list-style-type: none"> • Professional and ethical practice guidelines • Policies and legislation available • Policies, protocols and guidelines available • Patient Rights Charter • Patient care standards, policies and procedures available • Acts/prescripts compliance/ adherence report • Standards of Practice and Scope of Practice available • Professional and nursing care guidelines • Quality nursing care principles • Nursing care management plan • Nursing intervention revised/reviewed • Nursing intervention assessment report • Nursing care intervention measures • Quality assurance monitoring indicators and tools • Infection control procedures • Occupational and safety measures



MAIN OBJECTIVES (measurable outputs/end results)	INDICATORS (indicating how well standards were achieved)
4. Maintain a constructive working relationship with nursing and other stakeholders	<ul style="list-style-type: none"> • Attendance register • Reports of meetings • Circulars and Minutes • Nursing professional guidelines • Peer review reports • Health improvement plan • Quality assurance report
5. Utilize human, material and physical resources efficiently and effectively	<ul style="list-style-type: none"> • Monthly allocation lists • Duty schedules, attendance/time registers • Leave schedules • Personal Development Plan • Performance instruments and evaluation reports • Inventory registers • Stock register • Scheduled drug register

H. OUTPUT PROFILE

KEY CUSTOMERS	REQUIREMENTS	OUTPUTS
1. Public (community, patients)	Service delivery, advice, health education, care and support	Recommendations, well informed patients, acceptable service, complaints and suggestion boxes and reports
2. Nursing Manager	Patient care, support and general advice	Recommendations, advice, information in the form of reports, letters, memos
2. Deputy Manager	Patient care, support and general advice	Recommendations, advice, information in the form of reports, letters, memos
3. Assistant Manager	Patient care, support and general advice	Recommendations, advice, information in the form of reports, letters, memos
3. Operational Manager	Patient care, support and general advice	Recommendations, advice, information in the form of reports, letters, memos
4. Clinical Manager/Multi-disciplinary team	Nursing care support, service delivery improvement	Recommendations, advice, information in the form of reports, letters, memos, assist in decision-making process
5. Colleagues	Nursing care, administrative advice, support, liaison, information-sharing	Recommendations, advice, information in the form of reports, letters, memos, assist in decision-making process.
6. NPO's and other stakeholders (Traditional Healers Association, etc)	Patient care support, liaison, networking	Recommendations, advice, information in the form of reports, letters, assist in decision-making process



KEY CUSTOMERS	REQUIREMENTS	OUTPUTS
7. South African Nursing Council	General support, networking, liaison, customer care and negotiations	Recommendations, advice, information in the form of reports, letters, assist in decision-making process
8. Governance structures (Clinic Board, etc)	General support, improved service delivery, liaison, customer care and negotiations	Recommendations, advice, information in the form of reports, letters, assist in decision-making process

I. COMPETENCY PROFILE

KNOWLEDGE	SKILLS	PERSONAL	EXPERIENTIAL COMPETENCY
Knowledge of nursing care processes and procedures, nursing statutes, and other relevant legal frameworks such as: Nursing Act, Health Act, Occupational Health and Safety Act, Patient Rights Charter, Batho-pele principles, Public Service Regulations, Labour Relations Act, Disciplinary Code and Procedure, Grievance Procedure, etc	Good Communication skills Report writing skills Facilitation skills Co-ordination skills Liaison skills Networking skills Problem solving skills Information Management Knowledge Management Planning & Organising Computer Literacy	Responsiveness Pro-activeness Professionalism Accuracy Flexibility Initiative Cooperation Team player Supportive Assertive	Basic R425 qualification i.e. diploma/degree in nursing or equivalent qualification that allows registration with the South African Nursing Council as a Professional Nurse Current registration with the South African Nursing Council (SANC) as a Professional Nurse Where applicable completion of community service

J. INDIVIDUAL/DEVELOPMENT PROGRAMME (PRIORITY)

To be determined by individual jobholder (this should be linked to the performance management system).

K. CAREER PATHING

Promotion to next higher grade

1. Professional Nurse Grade 2 (General Nursing)
2. Nature of work in next higher grade:
As required in the higher grade



Appendix N: Job Description – Enrolled Nurses



ANNEXURE A

JOB DESCRIPTION

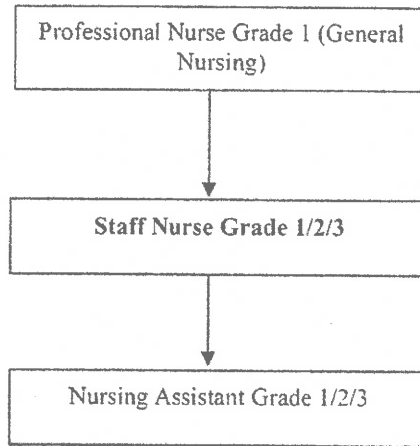
Name	Persal Number

A. JOB INFORMATION SUMMARY

Job Title	Staff Nurse
Occupational Specific Dispensation	Staff Nurse
Job Level	SN 1
Date	1 July 2007
Location	Various Institutions
Component	Nursing
Post report to	Professional Nurse Grade 1 (General Nursing)
Job Classification Code	



B. HIERARCHICAL POSITION OF POST



C. JOB PURPOSE (Linked to Strategic Plan)

To provide quality basic nursing care services under the supervision of a Professional Nurse within the scope of practice as defined by the South African Nursing Council (SANC) and Charter of Nursing Practice.

D. MAIN OBJECTIVES (Key Performance Areas (KPA's))

	MAIN OBJECTIVES	%
1.	Development and implementation of basic patient care plans: <ul style="list-style-type: none"> • Ensure maintenance of patient hygiene; • Sustain nutritional status of patients; • Facilitate the mobility of patients; • Facilitate the elimination processes. 	30%
2.	Provide basic clinical nursing care: <ul style="list-style-type: none"> • Measure, interpret and record vital signs; • Operate all relevant apparatus and equipment; • Assist professional nurses with clinical procedures (i.e. administering of intramuscular injections); • Preparation of patients for diagnostic and surgical procedures. 	55%
3.	Effective utilisation of resources: <ul style="list-style-type: none"> • Order stock and equipment in a cost effective manner; • Report loss or damage immediately. 	10%



	MAIN OBJECTIVES	%
4.	<p>Maintain professional growth/ethical standards and self development:</p> <ul style="list-style-type: none"> To maintain the code of conduct as required in the Public Service and by the Professional Body; Seek learning opportunities, i.e. in-service training, courses. 	5%

E. DIMENSIONS OF THE POST

Equipment Budget

- None

Stores Budget

- None

F. PERFORMANCE STANDARDS & INDICATORS (Based on main objectives)

MAIN OBJECTIVES (measurable outputs/end results)	INDICATORS (indicating how well standards were achieved)
1. Development and implementation of basic patient care plans	<ul style="list-style-type: none"> Quality provision of care; Positive feedback from patients and families; Complete nursing care plans and progress reports.
2. Provide basic clinical nursing care	<ul style="list-style-type: none"> Quality provision of care; Positive feedback from patients and supervisors.
3. Effective utilisation of resources	<ul style="list-style-type: none"> Appropriate care and use of equipment and consumables; Availability of stock register; Updated inventory list.
4. Maintain professional growth/ethical standards and self development	<ul style="list-style-type: none"> Positive feedback from supervisors; Evidence of self development.



G. OUTPUT PROFILE

KEY CUSTOMERS	REQUIREMENTS	OUTPUTS
1. Public (community, patients)	Service delivery, advice, health education, care and support	Recommendations, well informed patients, acceptable service, complaints and suggestion boxes and reports
3. Assistant Manager	Patient care, support and general advice	Recommendations, advice, information in the form of reports, letters, memos
3. Shift Manager	Patient care, support and general advice	Recommendations, advice, information in the form of reports, letters, memos
4. Colleagues	Nursing care, administrative advice, support, liaison, information-sharing	Recommendations, advice, information in the form of reports, letters, memos, assist in decision-making process.
5. South African Nursing Council	General support, networking, liaison, customer care and negotiations	Recommendations, advice, information in the form of reports, letters, assist in decision-making process
6. Governance structures (Clinic Board, etc)	General support, improved service delivery, liaison, customer care and negotiations	Recommendations, advice, information in the form of reports, letters, assist in decision-making process

H. COMPETENCY PROFILE

KNOWLEDGE	SKILLS	PERSONAL	EXPERIENTIAL COMPETENCY
<p>Knowledge of nursing care processes and procedures, nursing statutes, and other relevant legal frameworks such as:</p> <p>Nursing Act, Health Act, Occupational Health and Safety Act, Patient Rights Charter, Batho-pele principles, Public Service Regulations, Labour Relations Act, Disciplinary Code and Procedure, Grievance Procedure, etc</p>	<p>Basic communication skills</p> <p>Basic writing skills</p> <p>Ability to function as part of a team</p> <p>Basic interpersonal skills</p> <p>Elementary facilitation skills</p>	<p>Responsiveness</p> <p>Pro-activeness</p> <p>Professionalism</p> <p>Accuracy</p> <p>Flexibility</p> <p>Initiative</p> <p>Cooperation</p> <p>Team player</p> <p>Supportive</p> <p>Assertive</p>	<p>Grade 12 or equivalent qualification, plus two year Staff Nurse Certificate that allows registration with the South African Nursing Council</p> <p>Current registration with the South African Nursing Council (SANC) as a Staff Nurse</p>



I. INDIVIDUAL/DEVELOPMENT PROGRAMME (PRIORITY)

To be determined by individual jobholder (this should be linked to the performance management system).

J. CAREER PATHING

Promotion to next higher grade

1. Staff Nurse Grade 2/3
2. Nature of work in next higher grade:
As required in the higher grade

K. AMENDMENTS TO THE JOB DESCRIPTION

The Head of Department or his/her nominee reserves the right to make changes and alterations to this job description, as he/she deems reasonable in terms of changes in the job content in line with the strategic objectives of the Department, after due consideration with the postholder.

L. PERFORMANCE INSTRUMENTS

The performance instrument of the postholder, should be read as an extension to the job description.

M. JOB DESCRIPTION AGREEMENT

We, the undersigned, agree that the content of the completed job description provides an accurate outline and picture of the job as expected from the incumbent in the job:

Supervisor:	Job Incumbent:
Rank:	Rank:
Date:	Date:
Accepted	Signature:
Additional comments/proposed time of revision of the job description, only if there are changes in the job content.	
Date of revision:	



Appendix O: Interview Transcripts

PARTICIPANT WORKS IN ADULT ARV CLINIC

SPEAKER	COMMENT	CODING
Interviewer	Thank you for joining us today sister. Our study today is basically looking at compassion fatigue and how it manifests among nurses working in adult, antenatal and paediatric anti-retroviral clinic. The questions that we are going to ask today will be under thematic form. We have a number of themes and under each theme we've got questions. So the first question or theme is around trust and despair. Do you have confidence in the healthcare system?	
Nurse	I do, I do have confidence on the healthcare system. (answered very confidently)	
Interviewer Probe:	Ok, would you care to elaborate on that? What is it would you find as making you confident? Or what is it that makes you have confidence in the health care system?	
Nurse	I'd say I have confidence in this healthcare system because this healthcare system comes from very far in terms of taking care of patients. Even if they get challenges they go on, but the healthcare system even with challenges its still trying to do its best to take care of its patients.	
Interviewer	In terms of yourself as a nurse, having confidence in the system and how that relates to you instead of the patients?	
Nurse	Well as a nurse having confidence means different things because there are people who think to trust the healthcare system is to see non..... and with the other's like myself it is not about that. Its about being there to give care and to help the patient. So it means alot of things to alot of people, but to me it means being there and being able to sustain and being able to give the care no matter what the circumstances.	
Interviewer	Do you believe you can make a difference in the lives of HIV positive patients?	
Nurse	Yes, very much so. (uses her hands to express her passion for working with these patients)	

PARTICIPANT WORKS IN ADULT ARV CLINIC



Interviewer Probe:	Can you elaborate further?	
Nurse	Because when you deal with HIV positive people you have to be very passionate, in other words if you are not passionate about it you wont go far. But if you are passionate and you want to make a difference you need to because you meet such alot of people, different characters and even different views regarding the HIV itself. At the time you feel challenged when meeting with different people, it is for you to know that each and every person is an individual and you approach the person according to the level in which you find or see the patient to be in. You need that difference because you can change the perception of the people.	
Interviewer	In relation to hope, can you explain your feeling regarding the fact that there is no cure for HIV AIDS?	
Nurse	There is no cure at the moment and we are still waiting for the findings, because I think the cure will come, I have hope.	
Interviewer	Do you have hope that one day scientists will find the cure, as you've just said and how will it come about?	
Nurse	Knowing and having being with HIV patients for some time and so far having had that knowledge of where we come from where this HIV Virus is concerned, I think there is hope and I think scientists will, although one cannot actually say how soon, but I am really hopeful. Because to start with there was nothing, they couldn't understand what was happening, and now they understand and have developed some drugs which can actually try to make the virus to be not that much powerful to destroy the victims. So to me there is hope.	
Interviewer	In terms of caring for HIV positive patients, how would you define caring?	

PARTICIPANT WORKS IN ADULT ARV CLINIC



Nurse	<p>Blinking her eyes, touch her heart to express how she feels</p> <p>Caring, caring, love, compassion; to care for a person for me is to love that person in what condition that person is. You have to have that love because as human beings unless you have some understanding; I have to have that understanding of a person in another perspective, because I would say I am too religious, that is one thing that tries to help me, because when I look at a person, I see that person, I take that person to have been created in the image of God; and so when I look at the person, something else comes into me and says I have to take care of this person and not be judgemental, I must just be there to try and help the person try and understand in order for that person to have that hope, that courage to go on living.</p>	
Interviewer	<p>So would you say then, that that would be your definition of the term "a caring nurse?"</p>	
Nurse	<p>A caring nurse is to be there for the person, try and respect the person, from where the person comes from, don't judge that person. Be there and help that person; that is caring. You're not supposed to, when you say you're caring, try to carry the burdens of that person, but you have to understand what that person is going through so that you can try and help that person to come out from whatever he is in; but not actually having to suffer with that person. But understand the person.</p>	
Interviewer	<p>And how do you express caring towards HIV positive patients in your clinic?</p>	
Nurse	<p>Well, I think in our clinic we are caring for the HIV positive patients because we counsel them, we give them medication. We are always monitoring them; those are the things that each and every nurse does wherever he/she is. We monitor them and see to it that you always talk to the patient, you are open to the patient so that if they are undergoing any form of strain, you are there, and you can be open and approachable, so that they can come to you and sit down and talk to you. There is such a lot in caring that on cannot stop or decide to do just a compartment of caring. Each and every person is an individual.</p>	

PARTICIPANT WORKS IN ADULT ARV CLINIC

<p>Interviewer</p>	<p>Would you say caring for HIV positive patients is different from caring for any other patient</p>	
<p>Nurse</p>	<p>I wouldn't say it's different.... Caring is caring no matter what the patient is suffering from. But with the HIV patients, what can sort of maybe make it a little bit different is because of that thing of saying that an HIV patient, most of them, they are still suffering from denial and stigmatisation and so they sort of place themselves in a little corner. So that's when you have to go and dig them to come out. So that is where maybe one can say it is different from the other patients because you go deeper. Like a patient with sugar diabetes, a patient will simply say I am suffering from sugar diabetes, but with HIV its not like that, you have to sort of go in deep for a person to see that I am suffering from another type of disease which you don't have to be ashamed of. So it's where one can say maybe its different, otherwise caring it's the same.</p>	
<p>Interviewer</p>	<p>Do you find caring for HIV patients difficult or challenging</p>	
<p>Nurse</p>	<p>It is challenging, it is challenging because of the very reasons that I have said, (the denial?) yes... and stigmatisation. It becomes so difficult because now you are that stage where you try and advise a person to say NO!!, this is not different from any other. You take some effort until that person can actually admit and say yes, and see the result after taking treatment and feel I'm my self again; and so it's challenging, it really is challenging. (laughing.....)</p>	
<p>Interviewer Probe</p>	<p>Just to clarify are you saying then its difficult to care for HIV patients who are approaching it from different angles?</p>	
<p>Nurse</p>	<p>Yes that is why in caring you don't have to have a blanket approach you have to approach each</p>	

PARTICIPANT WORKS IN ADULT ARV CLINIC



	patient as an individual.	
Interviewer	Could you describe what is meant by the term "there is a cost to caring for HIV positive patients' Nurse	
Nurse	There is a cost I can say. I don't know whether you want the cost where there is money involved or cost regarding?	
Interviewer	Everything	
Nurse	Well both ways, moneywise yes because the patients have got to be monitored. The laboratory as you know today is costing alot of money. The many drugs; some of us who started with patients when they had no medication can actually see this because..... until the government decided that ok they will try and give the people medication, so I think it is an expensive programme. Even emotionally it is very costly.....because as you look at this client who is at the verge of crying or even bursting or even wants to commit suicide because of the diagnosis of HIV. If you are not emotionally balanced you can find yourself tilting so it is costly.	
Interviewer	In terms of when experiencing stress, what causes the most stress in your work environment?	
Nurse	I think what causes the most stress; ... it's just the emotional involvement in the whole thing. Otherwise I wouldn't say there is anything; because I have already told you that I am coming from a background where I am not looking at money as a first factor. I am looking at it as I am here trying to change lives in different people and that counts more. So stress to me is when I'm trying to help this person and this person does not understand what I'm trying to give to him/her. Then that is one thing that actually causes stress to me as an individual. Then it's where you find me going deeper and deeper trying to win this person.	
Interviewer	How do you cope with the stress in your daily work life?	

PARTICIPANT WORKS IN ADULT ARV CLINIC

Nurse	To give a smile, to give a smile. That is how I cope with stress and as I've already said, I'm a praying woman. (look up to heaven) Prayer helps me alot.... I go to church on Sunday after experiencing all the stress during the week trying to help people, and then I go to church on Sunday. Monday I'm as fresh as ever beginning another week and waiting for the stresses of that very week.	
Interviewer	How do you cope with hearing about patients who have died that you have nursed?	
Nurse	Its painful, it's hurtful; (sadness in voice, talks softer) because when you are nursing patients you're always looking at wanting to see them stand up and believe. But we are not in control because somewhere somehow others throw in the towel and die. It's a painful thing,.... you always want your patients to live.	
Interviewer	Do you allow yourself to grieve your patients who have passed on?	
Nurse	It's just a pity that sometimes others you don't even know about their deaths, but those that you know about their death, you do have time to sit and think about them, even if you are not going to grieve in such a way that you lose your mind. But you do sympathise with their relatives, children, if they are leaving children behind or whatever. You allow your emotions to feel whatever they are feeling at that particular time. You cannot suppress even if you're feeling; there are those patients who sometimes you attach to emotionally and then when they die you grieve.	
Interviewer	What strategies do you use to distress, like the grieving as you have mentioned, like going to church. What other strategies do you use or you have other than those?	
Nurse	Hayi, except maybe sometimes organising some things here in the clinic which we can enjoy, like celebrating world AIDS day with our patients and having that moment of feeling ok. And just mingling with the people and talking to people about how you feel at times, just being	

PARTICIPANT WORKS IN ADULT ARV CLINIC

	open with your friends if you're feeling you're not ok, you talk about it.	
Interviewer	In terms of the theme Compassion Fatigue; What is your understanding of the term compassion?	
Nurse	Compassion? The term compassion to me it's a feeling for somebody who can, I don't know how to put it.	
Interviewer	Have you ever heard of the term compassion fatigue?	
Nurse	No....	
Interviewer	You've spoken about compassion earlier, the way you've spoken about compassion, what is your understanding of compassion?	
Nurse	Compassion if I'm to give it one word; Is feeling Pity.	
Interviewer	Then Fatigue?	
Nurse	It's being tired of feeling pity.	
Interviewer	So, would you say that is how you would define compassion fatigue? Being tired of feeling pity?	
Nurse	I think that is how I can define it, when you are feeling tired of feeling pity for somebody.	
Interviewer	Then, do you think you suffer from compassion fatigue?	
Nurse	I don't think so because I never feel tired of feeling pity for somebody..... But I don't know, feeling pity in which way, to the extent of what. The pity, I would say is in different levels, because if you exercise too much pity you don't make a difference. So somewhere somehow you do feel pity but you have to be in such a way that this person does not start pitying himself to an extent that he/she finds himself dropping because of what you have made them feel. I	

PARTICIPANT WORKS IN ADULT ARV CLINIC

	don't know if I'm explaining myself well.	
Interviewer	I understand, I get what you mean, so would you say then that maybe instead of the term pity, maybe empathy?	
Nurse	Yes, empathy yes.. You feel for the person, but you don't want them to drag you, because your main aim is to bring them up.	
Interviewer	Can you describe how a person suffering from compassion fatigue would feel?	
Nurse	A person who suffers from compassion fatigue is a person who sometimes you'll find that when a person is crying, she also starts crying. You just find yourself being taken by what the next person is feeling to an extent that now you are no longer yourself, you want to suffer with that person who is suffering....	
Interviewer	So would you say then that that person shows signs and symptoms of someone who is suffering from compassion fatigue?	
Nurse	I would say that that thing that is affecting the person is the thing that makes you feel you suffering yourself and now you need help yourself. So you are not a candidate to be trying to help people because you also need help too and you need to help yourself	
Interviewer	What would be the signs, like definite signs and symptoms of someone suffering from compassion fatigue?	
Nurse	I think some of the signs would be the ones that I've already mentioned the emotional like the crying, and maybe even sometimes you don't want to work in that very department you'd want to change and go somewhere or now you start maybe not having the love that you're supposed to give to those people that you are caring for. You start now maybe being irrational,..... angry and you start just having behavioural changes towards the people that you say you want to help	

PARTICIPANT WORKS IN ADULT ARV CLINIC

	and care for.	
Interviewer	Do you think there is a difference between burnout and compassion fatigue?	
Nurse	I think it's the same thing. I think when you showing the signs of compassion fatigue you are just showing signs of burnout syndrome. I would say it's almost the same.	
Interviewer	Now coming to working with HIV positive patients, how do you feel towards HIV Positive patients?	
Nurse	I love them, I love them.. (hand movement)	
Interviewer	Can you just describe the relationship you have with them	
Nurse	I always maintain a carer and client relationship, but one thing for sure is that having dealt with these people, .. I've learnt that you must always understand each and every individual in order to be able to help. You cannot just because they are all suffering from HIV take HIV out of them and just blanket them as they come, you have to all the time remember that each and every individual when you meet that person, is a totally different person all together. In other words you're learning yourself everyday because people act differently, they behave differently, they take things differently.	
Interviewer	How do you feel at the end of a very busy day after having worked with very sick HIV positive patients?	
Nurse	It's tiring, it's tiring and you always feel when you go to bed, those very patients that you have left for that particular day tomorrow morning you're looking forward to seeing them still there and see them pick up, and see them come right. So... that is the one thing that should hold you and attract you to come to work and give the care that you supposed to give. Never throw in the towel.	
Interviewer	And how are your energy levels at the end of the day	

PARTICIPANT WORKS IN ADULT ARV CLINIC

Nurse	I'm always bouncy, very energetic (laughing)	
Interviewer	What makes you energetic?	
Nurse	It's because it's me.... I think having accepted the condition of HIV and not having any queries or any thing beside having to say, I am here and I'm here to make a difference in somebody else's life, because you are working there and you know you are there to bring a change in those people. So if you always feel bouncy and want to come to work and if you have helped one person that particular day to the fullest. That is a payment more than any other money, I don't know, that is how I think about the HIV people.	
Interviewer	And how many HIV positive patients do you care for on average every month?	
Nurse	None over a 1000	
Interviewer	How does your experience at work affect you at home?	
Nurse	When I'm at work, I'm at work. When I'm at home, I'm at home. These things are two different places. When I leave my work, its finito..... when I reach my home now I am in a different environment. I cannot carry things from here otherwise their going to disturb my children there or maybe my things from home coming to disturb the patients. I need boundaries.	
Interviewer	Do you ever feel disconnected to your HIV positive patients?	
Nurse	That is a difficult one, I don't know how to approach it because each time you see a person you have seen you always feel connected and there are things that you have done or things that this person has said or where this person comes from, so I think I, maybe can feel disconnected if I am not seeing them. Because we are seeing a lot of patients, when they are not there you cannot be thinking about so and so, and so and so; otherwise that is going to give your mind a lot to think about. But once you see them, there are things that come that connect you with that particular person. Because there are activities which took place between you and that person,	



DRAFT TRANSCRIPT: CF_P001

PARTICIPANT WORKS IN ADULT ARV CLINIC

	and so they remind you and then you sort of connect.	
Interviewer	In some cases the patient's lifestyle is the cause of HIV positive status. Does that bother you and how do you respond in such cases?	
Nurse	I try not to be judgemental and the issue of confidentiality plays a major role because patients can actually tell you what they cannot tell the next person when you're sitted with them as an individual and they can say things which they cannot say wherever they are. So if a person says something to me, I keep it to myself, I try and sit down with that person and help that person to work out the issues that make the person feel I was wrong by doing this and this, but I try not to be judgemental at all times, but as long as the person can actually see that I went wrong here and did this and this and this and how best can I try to help myself to deal with the situation. Because in some cases you find that the person will always feel guilty about what they have done and that becomes a stumbling block when caring for that patient. So if the person can try and work it out and remove the stumbling blocks then that person will respond better to the treatment. But as long as you as a person do not become judgemental as if you are a perfect someone. You look at that thing.	
Interviewer	So in cases when your patients express the fear of dying how do you deal with this situation?	
Nurse	Alot of patients do express the feeling of the fear of dying because one thing they have in their minds is HIV; that being HIV means death. Now you have to work steadily with that person to try and advise or even educate that being HIV does not mean death. Being HIV is just being diagnosed and there is help out there. Try and make that person to change their perspective towards linking HIV with death because whether you suffer from a painful finger, if your day is here you'll die. So HIV does not mean death.	
Interviewer	Do you ever at some point feel guilty with regards to the way you respond to HIV patients?	
Nurse	I've never experienced ever feeling guilt.	
Interviewer	Can you briefly explain what a nurses day looks like in an antiretroviral clinic.	

PARTICIPANT WORKS IN ADULT ARV CLINIC



Nurse	It looks tiring.	
Interviewer Probe:	Just from morning, would you take us through the process?	
Nurse	<p>Its tiring because if patients come and a lot of them they have this thing of wanting to go back. I think that is one thing that actually sometimes tires nurses because you push them from one level and when you are sure that they are somewhere and they understand and they do things correctly, then some issues crop up, then they go back, they retreat. Now you have to go back and start again, start again, its tiring. HIV patients, one would say that much as we try and tell them that they are not different from other people, they always feel they are different. So emotionally some of them go to and fro, to and fro. So as a nurse at the end of the day you become mentally tired. Because what you said maybe a week ago or two weeks ago, you have to start again and jack this person up again. And its tiring emotionally.</p>	
Interviewer	What has motivated you to work in an antiretroviral clinic? How many years have you been here?	
Nurse	<p>In fact I started working with HIV patients in 2002. Long before the ARV's, because they came in 2004. Like any other person I was afraid to nurse HIV patients, but I was motivated by certain doctors with whom I was working with in casualty because of my experience being a primary health care nurse. Those are the people who motivated me to start working with HIV patients, to counsel, take bloods, and that was in 2002 and that's when I started actually now experiencing working with HIV patients, and from then I gained the passion and the love to work with HIV people. Now that I'm seeing them improve with the ARV's it even makes my hope to go higher and higher.</p>	

PARTICIPANT WORKS IN ADULT ARV CLINIC

Interviewer	What would make your work in the antiretroviral clinic easier?	
Nurse	If patients were doing the right thing every time, I think that would really ease our task.	
Interviewer Probe:	Nothing else other than patients?	
Nurse	I can't think of anything else.	
Interviewer	In terms of psychological support, how do you relate to your colleagues in the clinic and does this help you to cope with your work?	
Nurse	I think working with colleagues it helps because sometimes when you care for people and you feel there is something that has disturbed you or what, we discuss about it and that brings upon relief to you. Communication and working harmoniously and if there is a problem, sit down and sort it out so that you do not carry it to the next day, otherwise it becomes a burden and you don't feel like coming to work because you are fighting with a colleague. I think working together harmoniously as a team. (talk intensely, leaning forward).	
Interviewer	What support systems are in place in this clinic?	
Nurse	There are no support systems.	
Interviewer	There are no support systems? What support systems would you want to see?	
Nurse	Support systems like a person coming and sitting down and doing a debriefing. So that people can talk about their issues and a professional person by the way.....	

PARTICIPANT WORKS IN ADULT ARV CLINIC

Interviewer	Probe:	Like a?
Nurse		Like a social worker or a psychologist. Just come in and say I'm here, come let's talk about your issues.
Interviewer		Rating scale: In terms of empathy, from a scale of 1 to 5, emotional involvement in HIV positive patients how would you rate yourself?
Nurse		I would say rarely = 1
Interviewer		Empathetic response to HIV positive patients, how would you rate yourself?
Nurse		I would say always = 4
Interviewer		Your ability to separate work from home?
Nurse		Always = 4
Interviewer		In terms of personal factors, have you recently lost a close family member?
Nurse		Right now I'm going home on Saturday to go and bury my brother, my aunts' son. (sad look in eyes)
Interviewer		How was the personal relationship with the person you've lost?
Nurse		We were buddies, very close
Interviewer		What was the cause of d do death if you don't mind sharing?

PARTICIPANT WORKS IN ADULT ARV CLINIC

Nurse	I'm suspecting because he was living in Pretoria,.... and them I'm suspecting that HIV could have been the cause of death.	
Interviewer	And this is the recent loss that you've experienced?	
Nurse	Yes, yes.....	
Interviewer	Are you currently caring for a terminally ill family member?	
Nurse	No not now	
Interviewer	Thank you very much for participating in this study, it was very informative.	
Session ends.		



Appendix P: The e-Delphi Questionnaire



Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Section 1 of 5



Delphi Method:

Refinement of a wellness programme to identify, prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics.

Section A: Introduction to the study

Title: A wellness programme to prevent and manage compassion fatigue amongst nurses working in an antiretroviral clinic in a public tertiary hospital.

The research study was conducted in two phases and took place in the adult, ante-natal and paediatric antiretroviral clinics in a public tertiary hospital. Nurses who worked in these antiretroviral clinics that are based in hospital out-patient departments render basic nursing care related to out-patient care. In phase one of this study the researcher used a single embedded case study design which had three sub-units situated within the case, namely: nurses who work in the adult, ante-natal and paediatric ARV clinics in a tertiary public hospital. Phase two of the study covers the development and refinement of the wellness programme to prevent and manage compassion fatigue amongst nurses who work in antiretroviral clinics.

The aim of the study was firstly to explore and describe the extent of the manifestation of compassion fatigue amongst nurses working in antiretroviral clinics; and secondly to develop a wellness programme to aid in the identification and management of episodes of compassion fatigue as well as the prevention of future occurrences of such episodes of compassion fatigue amongst nurses working in antiretroviral clinics.

After section 1 **Go to section 2 (Section B:)**

Section 2 of 5



Section B:





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

In addition the cost of the nurse-patient relationship contributed to them being at risk of compassion fatigue. Aspects that were identifies included caring for traumatised patients, vicarious exposure to traumatic experiences of their patients, and the influence caring for patients who are HIV positive have on their personal lives and their families. These aspects place nurses at risk of developing compassion stress, compassion discomfort and ultimately compassion fatigue.

Manifestation of compassion fatigue:

The nurses presented with physical, psychological and spiritual signs and symptoms of compassion fatigue. Their behaviour also changed as they progressed towards compassion fatigue. Physically they presented with fatigue, low energy levels, insomnia and dizziness. Psychologically they presented with depression, fear, despair, higher stress levels and feeling emotionally drained. In addition nurses also experienced a sense of satisfaction that they are making a difference in their patients' lives. Spiritually they presented with doubt in themselves as they felt the need for major change, such as a new job. The behaviour they exhibited included being irrational aggressive, impatient, irritable and angry. They also disengaged from their patients and started to neglect their own appearance.

Strategies used by nurses to manage compassion fatigue:

Various strategies to prevent and manage compassion fatigue were identified: both what nurses can do and what they expect from management. Debriefing, and managerial and psychological support were deemed important in managing compassion fatigue and as a way to prevent it from recurring. Nurses regarded collegial support as important and revealed that they need to pay more attention to self-care to prevent and manage compassion fatigue. Celebrating the lives of patients who passed away helped nurses to find closure

After section 2 [Continue to next section](#)

Section 3 of 5



Section C:

Development of the interventions and actions for the wellness programme

Kindly read through this section to get an understanding of how the interventions and actions for the wellness programme were developed





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

should be taken. The interventions are based on four levels namely: communication and awareness; screening and assessment; education, lifestyle and behaviour change support systems (Baun, Horton & Storlie 1992 cited in Bessinger 2006, p. 61). The wellness programme interventions and actions focus on creating awareness through a process of self-consciousness that will lead to early recognition of signs and symptoms of compassion fatigue. To educate nurses on how to change their lifestyle and behaviour as well as providing of support systems at individual and professional level for nurses. Nurses should be educated on how to manage their time and how to restructure their daily routine and at professional level the support provided should include interventions at the cognitive-behavioural and social-organisational level. The cognitive-behavioural interventions should address the way nurses perceive and interpret reality and social-organisational interventions should assists nurses in dealing with crises and traumatic situations (Inbar &

After section 3 Continue to next section

Section 4 of 5



Section D

Delphi Questionnaire: Kindly choose one appropriate answer for all questions

Demographic Information:

Gender *

1. Male
2. Female

Age group *

1. 25 - 30





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Country of origin *

Short answer text

Professional

1. Nurse
2. Medical Officer
3. Social Worker
4. Psychologist
5. Other:

If other, provide detail

Short answer text

Occupation

1. Nurse
2. Medical Officer
3. Social Worker
4. Psychologist





Delphi questionnaire: Refinement of wellness progr



QUESTIONS

RESPONSES 3

- HIV/AIDS
- Compassion fatigue
- Traumatology
- End-of-life-care
- Other...

Number of year working in field of



Short answer text

After section 4 **Continue to next section**

Section 5 of 5



Section E:

This section covers the rating of interventions and comments on actions:

Kindly follow the guidelines to complete the Delphi:

Criteria for rating interventions and





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

This intervention aims to provide ways to addressing the challenges nurses face in the work environment to minimise their risk to develop compassion fatigue

Intervention a: Foster an atmosphere that is supportive of work/life

Rationale:

Frank and Karioth (2006, p. 10) state that working extended hours and experiencing personal life disruption may cause nurses to be more vulnerable to compassion fatigue. According to Kulesa (2014, p. 27) time away from direct patient care lessen the symptoms of compassion fatigue. Therefore, Bessinger (2006, p. 19) recommends that healthcare professionals maintain a good balance between work and home life in order to defuse the tension they experience. Balancing work/life enables nurses to invest time and energy into nurturing themselves so that they are able to nurture and care for others (Boyle 2011, p. 4). Thus, maintaining a balance between work and home life will help to decrease the risk of nurses developing compassion fatigue (Zander cited in Walker, Morin & Labrie 2012, p. 14; Boyle 2011, p. 7; Maytum, Heiman & Garwick 2004, p. 177). Putting up boundaries protect nurses from experiencing negative feelings and help them to compartmentalize their experiences moving on with the day-to-day caring of their patients (Gerow et al. 2009, pp. 126 - 127).

Kindly indicate on whether you agree or disagree with inclusion of this intervention using the Likert scale *

1. Strongly agree
2. Agree
3. Strongly disagree
4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Row 4. Reliability: Under the same circumstance, another wellness clinician would apply the interventi

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The intervention is precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention

The person appointed by the organisation to run the wellness programme will be responsible to implement identified interventions and actions that will help to minimise the risk of nurses developing compassion fatigue.

- Emphasise the need for nurses to maintain a balance in their life. Encourage them to include a break for meals and physical activities or time to rest in each work day.
- Educate nurses on how to delineate and maintain professional boundaries and how to maintain emotional distance from troubling situations.
- Encourage nurses to spend time with family and engage in activities that the family can do together that will assist them to disengage from work-related issues when at home.
- Establish a system that monitor nurses' work schedule that limit the number of overtime in order reduce

Please comment regarding actions for intervention

Long answer text

Intervention 2: Lessen the negative effect of cost of nurses-patient

The aim of this intervention is to provide ways to ensuring that the cost of the nurse-patient relationship does not





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

work through various feelings and issues associated with traumatic experiences.

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

- 1. Strongly agree
- 2. Agree
- 3. Strongly disagree
- 4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventio

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigue

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly







Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Actions for intervention ▾

The person appointed by the organisation will be responsible to implement intervention and actions to desensitise nurses to the traumatic stressors that they are exposed to in ARV clinics:

- Create awareness amongst nurses of any destructive behaviour, such as over-identification with traumatized patients. Encourage nurses to reach out for help when needed in order to minimise the effect of compassion fatigue on their well-being.
- Provide professional supervision and educate nurses to identify scenarios that are most difficult and exhausting to them. Nurses should identify and review potential reactions they use when those situations arise.
- Encourage nurses to recognise and accept the realities of working in an antiretroviral clinic, accepting that HIV/AIDS is a life-threatening condition and there is no cure for it. Emphasise the importance to concentrate on the positive features of own and their patients' experiences.
- Decrease exposure to traumatic events. Ensure that nurses have a balanced patient load and that a nurse does not consistently deal with extremely difficult patients and their families.
- Educate nurses on how to identify personal stressors in the workplace and be aware of factors that may cause compassion fatigue. Nurses should be encouraged to keep a journal on any traumatic or meaningful encounters that they have had during the day and share with colleagues at meetings, or they can practice

Please comment regarding actions for intervention ▲ *

Long answer text

Intervention 2b: Create a culture of compassion at organisational ▾

Rationale:

Compassion in organisations can take place at all levels and can be encouraged by managers. Compassion in an organisation makes employees to feel recognised and they feel supported and this will foster resilience and organisational commitment (Kanov et al. 2004, p. 809; Hoffman 2009 cited in Slatten, Carson & Carson 2011,

Kindly indicate whether you agree or disagree with the inclusion of the intervention *

1. Strongly agree

2. Agree





Delphi questionnaire: Refinement of wellness progr



QUESTIONS

RESPONSES 3

Kindly indicate the validity, reproducibility, cost-effectiveness, applicability and clarity of the intervention usinf Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree

*

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventio

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigue

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The interventions should be precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention

The person appointed by the organisation will be responsible to implement intervention and actions to desensitise nurses to the traumatic stressors that they are exposed to in antiretroviral clinics:

- Create a culture in the organisation that allow compassion to be expressed towards patients, colleagues, managers and supervisors.
- Recognise employees as human beings and ensure that support systems are in place that will help them to





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

This intervention aims to raise awareness on the manifestation of compassion fatigue to ensure early identification of the development of compassion fatigue.

Intervention 3a: Raise awareness on compassion

Rationale:

Braunschneider (2013, p. 16, p. 17) states that compassion fatigue is becoming very prevalent in the healthcare profession. Awareness of how compassion fatigue present is important because self-awareness and early recognition of signs and symptoms are key to the prevention thereof (Hesselgrave 2014, p. 3; Panos 2010, p.3; Joinson 1992, p. 118). However, Hooper et al. (2010, p. 426) argue that the warning signs and symptoms of compassion fatigue often go unrecognised by nurses. Therefore, creating awareness on compassion fatigue should be the first step in any wellness programme, in order to enable healthcare professionals to consciously use the right coping skills, take appropriate action in seeking help to deal with it and practice self-care that will help to prevent the occurrence thereof (Smart et al. 2013, p.9; Lombardo & Eyre 2011, p. 3; Tunajek 2006, pp. 24-25). According to Kelly, Runge and Spencer (2015, p. 526) addressing

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree
2. Agree
3. Strongly disagree
4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly *





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The interventions should be precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention ▾

The person appointed by the organisation to run the wellness programme will implement the following actions to create awareness on compassion fatigue amongst nurses who work in ARV clinics.

- Create awareness amongst new recruits during interviews of the possible risk of them developing compassion fatigue and the effect that it could have on their well-being, due to exposure to patients who are HIV positive while working in antiretroviral clinics.
- Include a module on compassion fatigue in the induction and orientation programme of new staff, in order to create awareness on compassion fatigue. Emphasis should be on educating the new recruits on how to recognise and manage compassion fatigue and informing them of the resources available to help them cope with the challenges they face working in ARV clinics. .
- Acknowledge the presence of compassion fatigue in a proactive way and educate managers and supervisors on identification of risk factors in antiretroviral clinics that may trigger compassion fatigue that could affect patients' care negatively.
- Provide written handouts and articles on compassion fatigue to nurses and include compassion fatigue as a topic on the in-service training schedule as means of continuous personal development.

Please comment regarding actions for intervention ▾ *

Long answer text

Intervention 3b: Assess the manifestation of compassion ▾





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree
2. Agree
3. Strongly disagree
4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

- Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r
- Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventic
- Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigue
- Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven
- Row 5. Applicability: The target population for whom the wellness programme as intended are clearly





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Actions for intervention ▾

The person appointed by the organisation will be responsible to implement intervention and actions to desensitise nurses to the traumatic stressors that they are exposed to in ARV clinics:

- Provide access to different compassion fatigue self-tests and encourage nurses to do a self-assessment using the self-report questionnaire that will assist them in identifying any triggers and recognise the signs as well as symptoms of compassion fatigue.

Please comment regarding actions for intervention ▾ *

Long answer text

Intervention 4: Provide workplace support that will prevent and manage compassion fatigue

This intervention aims to provide support to nurses to prevent the occurrence of compassion fatigue as well as management of existing compassion fatigue.

Intervention 4a: Establish on-site debriefing and counselling ▾

Rationale:

Debriefing with supervisors, consultants or colleagues is regarded as being very important in the prevention of compassion fatigue (Killian 2008, p. 37). Louw et al. (2011, p. 656) argue that debriefing is a highly important part of any wellness programme whereby nurses are given the opportunity to express their emotions and experiences in a controlled environment. It can be used to relieve tension, as well as relieve the emotional adverse effects. Debriefing techniques can be used to prevent compassion fatigue (Pickett et al. 1994, p.250). Goga and Thomson (2012, p. 15) argue that the purpose of debriefing is to provide support to individuals in managing challenges and demands within the context of their work. Good debriefing support results in an improvement in staff attitude and improvement in services delivery. According to Dominguez-Gomez et al. (2009, p. 203) formal or informal debriefing can provide opportunities to talk about work-related issues and

Kindly indicate whether you agree or disagree with the inclusion of this intervention *





Delphi questionnaire: Refinement of wellness progr



QUESTIONS

RESPONSES 3

If you responded strongly agree or strongly disagree kindly motivate your answer

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventio

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigues

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The interventions should be precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Intervention 4b: Provide workplace

Rationale:

According to Boyle (2011, pp. 5-6) managing and preventing compassion fatigue requires more deliberative attention from managers. Work-related support alleviate work-stress from caring for sick and traumatised patients, promotes compassion satisfaction and in turn prevents compassion fatigue (Ray et al. 2013, p. 257; King et al. 1998 cited in Sabo 2006, p. 140). Support in the workplace indirectly reduces the negative effect of stressors and help to maintain the health and well-being of healthcare professionals. Providing support to those in need outweigh the difficulties experienced at work (Loolo 2016, p. 106; Hunsaker et al. 2015, p. 191; Sheppard 2015, p. 57; Kulesa 2014, p. 25). Hunsaker et al. (2015, p. 192) argue that positive, supportive managers is more likely to have nurses with high levels of compassion satisfaction and in turn less compassion fatigue resulting in retention of knowledgeable, caring and experienced nurses. According to Inbar and Ganor (2003, p. 111, p. 112) management should design an organizational culture that prevents or

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree
2. Agree
3. Strongly disagree
4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly *





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The interventions should be precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention

Management should provide workplace support to nurses to help prevent and manage compassion fatigue.

- Implement a mentoring programme that places emphasis on enhancing professional skills and competencies of nurses and identifies nurses to be mentored and links them up to a mentor. The mentoring programme should include clinical case review sessions held once a week that focus on discussing difficult HIV/AIDS cases, the correct use of HIV/AIDS policies and guidelines as well as correct drug regimen decisions.
- Promote the establishment of a relaxation centre where staff may go for brief periods of respite, were they can get a light massage or just relax in a quiet comfortable setting.
- Establish a network of collegial support systems to provide support and guidance that will help nurses cope with work demands and addressing emotional issues of working in antiretroviral clinics. This can be achieved by regular discussions amongst teams where team members are encourages to participate in making decisions regarding the care and management of difficult patients. Articles on latest research findings in the HIV/AIDS field and compassion fatigue can contribute to the recognition of compassion fatigue, discussion of its implications and formulation of a team approach to address compassion fatigue.
- Diversify nurses' workload – lessen professional time spend on providing care to the most distressed patients. Mix nurses' caseload, share acute and stable HIV positive patients. Have clear limits regarding time on duty, encourage engagement in research, teaching or other activities to round off clinical service. Rotation

Please comment regarding actions for intervention

Long answer text





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree
2. Agree
3. Strongly disagree
4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventio

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigue

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Actions for intervention

Actions should aim at improving nurses' sense of self-fulfilment and compassion satisfaction level. The following actions are suggested to increase nurses' sense of achievement and their compassion satisfaction level; the actions can be used by management and/or the person appointed to run the wellness programme to enhance nurses' job satisfaction:

- Institute a reward system that acknowledges outstanding accomplishment of staff e.g. best nurse of the month in order to increase sense of compassion satisfaction.
- Create an environment that allows nurses to achieve optimal performance and productivity. Provide opportunities for personal growth and development.
- Organise social events- such as annual retreats that allow team members to interact with each other.
- Encourage nurses to focus on the successes of the day and the sense of appreciation from patients, e.g. recognition of the psychological successes of care that contribute to the well-being of patients and their

Please comment regarding actions for intervention *

Long answer text

Intervention 4d: Enhance the use of positive coping

Rationale:

Positive coping skills are associated with lower levels of secondary traumatic stress and compassion fatigue (Hollingsworth 1993 cited in Jacobson 2006, p. 146). Bessinger (2006, p. 29) argues that stress cannot be completely eliminated from our lives. However, coping strategies can assist in decreasing stress to a more healthy level, thus preventing the harmful emotional and physical effects. Tunajek (2006, p.25) agree that the use of appropriate coping skills improve harmony and lead to congruence of mind, body and spirit. It makes life to be fun, improves the quality of life, and provides a feeling of happiness and joy.

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree
2. Agree
3. Strongly disagree





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

KINDLY indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventio

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigue

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The interventions should be precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention

The person appointed to run the wellness programme will implement the actions to enhance nurses' coping skills.

- Encourage nurses to keep a journal on experiences that will help to manage feelings and reflect on life-events. Identify scenarios that are most difficult and exhausting and identify and review potential responses that can be used when those situations arise.
- Provide opportunities where nurses can debrief informally with colleagues, where they talk about their feelings and fond memories of their patients.
- Encourage nurses to utilize relaxation techniques such as meditation, yoga, physical exercise and recreation. They should also be encouraged to use faith and religion to become more spiritual in order to





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Being exposed to multiple deaths within a short space of time cause nurses to be traumatised resulting in an increase in their risk to develop compassion fatigue (Gerow et al. 2009, p. 127; Abendroth & Flannery 2006, p. 354; Figley 2002, p. 1437). According to Bennett and Kelaher 1993 (cited in Rapp 2012, p. 6) nurses who work in the HIV/AIDS field are at an increased risk of experiencing grief due to the many deaths they face that may prevent them from providing quality care. Bereavement support programmes help nurses to find closure by allowing them to talk about their thoughts and feelings and in so doing reduce the risk of compassion fatigue (Fetter 2012, p.560; Macpherson 2008, p. 148). According to Parry 2011 (cited in Ek et al. 2014, p. 509) nursing students lack sufficient skills to cope with end-of-life care. Therefore, understanding nurses' experiences of death and dying can help the health care system to prepare and educate nurses on how to deal with issues

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree
2. Agree
3. Strongly disagree
4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventic





Delphi questionnaire: Refinement of wellness progr

M

QUESTIONS

RESPONSES 3

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention ▾

The person appointed to run the wellness programme can link with a palliative care association and request training for all nurses who work in ARV clinics.

- Facilitation of end-of-life training provided by palliative association that incorporate: personal fears and phobias around death dying and loss, impact of bereavement and benefits of supported workforce; manifestations of grief in the workplace; listening and communication skills; helping models as well as loss and trauma in the workplace. Managers and supervisors should be encouraged to also attend the training to enable them to deal with employee's grief.

Additional actions for bereavement support:

Management should provide the necessary resources and support to provide education on death, grieving and bereavement that include the following action steps that will provide guidance to nurses on the path of healing:

- Provide written handouts about death and bereavement to raise awareness on feelings and fears and to provide ongoing coping tips to nurses.
- Encourage nurses to find closure on the death of their patients and allow them adequate personal time to grieve the inevitable death of their patients.
- Institute multidisciplinary ward rounds to improve team work, allowing healthcare workers to share their emotional experiences caring for patients who are HIV positive and other members empathizing with colleagues.
- Encourage nurses to create a remembrance tree or memory board in the unit, in a staff-only area that is changed with each passing season and they can also create sympathy cards to send to the patients' family and encourage nurses to keep a journal to write fond memories of patients, funny anecdotes and well wishes to patients' loved ones and mail it to the family
- Establish a referral system for pastoral care for debriefing and bereavement counselling to support nurses during bereavement. Allow nurses to participate in caring rituals and if possible, to attend patients' funerals to ▾

Please comment regarding actions for intervention ▾ *

Long answer text





Delphi questionnaire: Refinement of wellness progr



QUESTIONS

RESPONSES 3

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

- 1. Strongly agree
- 2. Agree
- 3. Strongly disagree
- 4. Disagree

If you responded strongly agree or strongly disagree kindly motivate your answer *

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventic

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatigue

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly





Delphi questionnaire: Refinement of wellness programme

M

QUESTIONS

RESPONSES 3

Actions for intervention

The person appointed to run the wellness programme will implement actions to build and strengthen nurses' resilience.

- Establish a resilience training programme on a monthly basis that focuses on reinforcement of content to build and strengthen nurses' resilience. The programme will focus on seven elements of resilience, namely: connection and support, self-validated care giving, self-efficacy, self-regulation, positivity and self-care.
- Provide additional strategies that can be used to build resilience including cognitive reframing, toughening

Please comment regarding actions for intervention

Long answer text

Intervention 5: Build personal strategies to manage compassion

With this intervention the researcher aims to enhance and strengthen strategies that individual nurses can use to prevent and manage compassion fatigue.

Intervention 5a: Create an organisational culture that encourages self-

Rationale:

Compassion fatigue affects individuals in the caring profession, therefore healthcare professionals must learn to care for themselves, participate in self-care activities that replenish their energy during the day and in their personal life in order to overcome the negative effects of compassion fatigue (Najjar et al. 2009, p. 274). Self-care is the cornerstone in preventing compassion fatigue (Wentzel & Brusiewics 2014, p. 96; Bush 2009, p. 27) because it enables healthcare professionals to replenish their energy during the day, refuelling and revitalizing the physical, emotional, psychological, spiritual, relational and professional dimensions (Gentry & Baranowsky 2013, n.p.; Kearney et al. 2009, p. 1162). Self-care promotes a sense of compassion satisfaction that acts as a buffer against compassion fatigue, since it allows the individual to take care of interests outside of work (Loolo 2016, p. 57; Berg & Nilsson 2015, p. 13; Parsons 2014, p. 13, p. 14, p. 33; Eastwood and Ecklund 2008,

Kindly indicate whether you agree or disagree with the inclusion of this intervention *

1. Strongly agree





Delphi questionnaire: Refinement of wellness progr



QUESTIONS

RESPONSES 3

Long answer text

Kindly indicate the validity, reproducibility, cost-effectiveness, reliability, applicability and clarity of the intervention using Likert scale 1=Strongly agree, 2=Agree, 3=Strongly disagree, 4=Disagree *

Row 1. Validity: The interventions are evidence based and will enhance identification, prevention and r

Row 2. Reproducibility: Given the same evidence another researcher would produce similar interventio

Row 3. Cost-effectiveness: The interventions should identify, prevent and manage compassion fatig

Row 4. Reliability: Under the same circumstances, another wellness clinician would apply the interven

Row 5. Applicability: The target population for whom the wellness programme as intended are clearly

Row 6. Clarity: The interventions should be precise, unambiguous and user-friendly

Column 1. Strongly agree

Column 2. Agree

Column 3. Strongly disagree

Column 4. Disagree

Actions for intervention





Delphi questionnaire: Refinement of wellness progr



QUESTIONS

RESPONSES 3

- Educate nurses on the use of mindfulness exercise. Nurses to do mindful meditation, quiet their mind and educate them to be present in the moment.
- Encourage nurses to engage in healing activities. Nurses can bring into the office signs of life and beauty such as a plant that remind them of life. Start a garden, paint or take a walk to enjoy nature.
- Educate nurses on how to practice positive mind skills intentionality. Celebrate and remember even minor successes. They should honour nursing as the spiritual, spirit-filled practice, using difficult situations as

Please comment regarding actions for intervention *

Long answer text



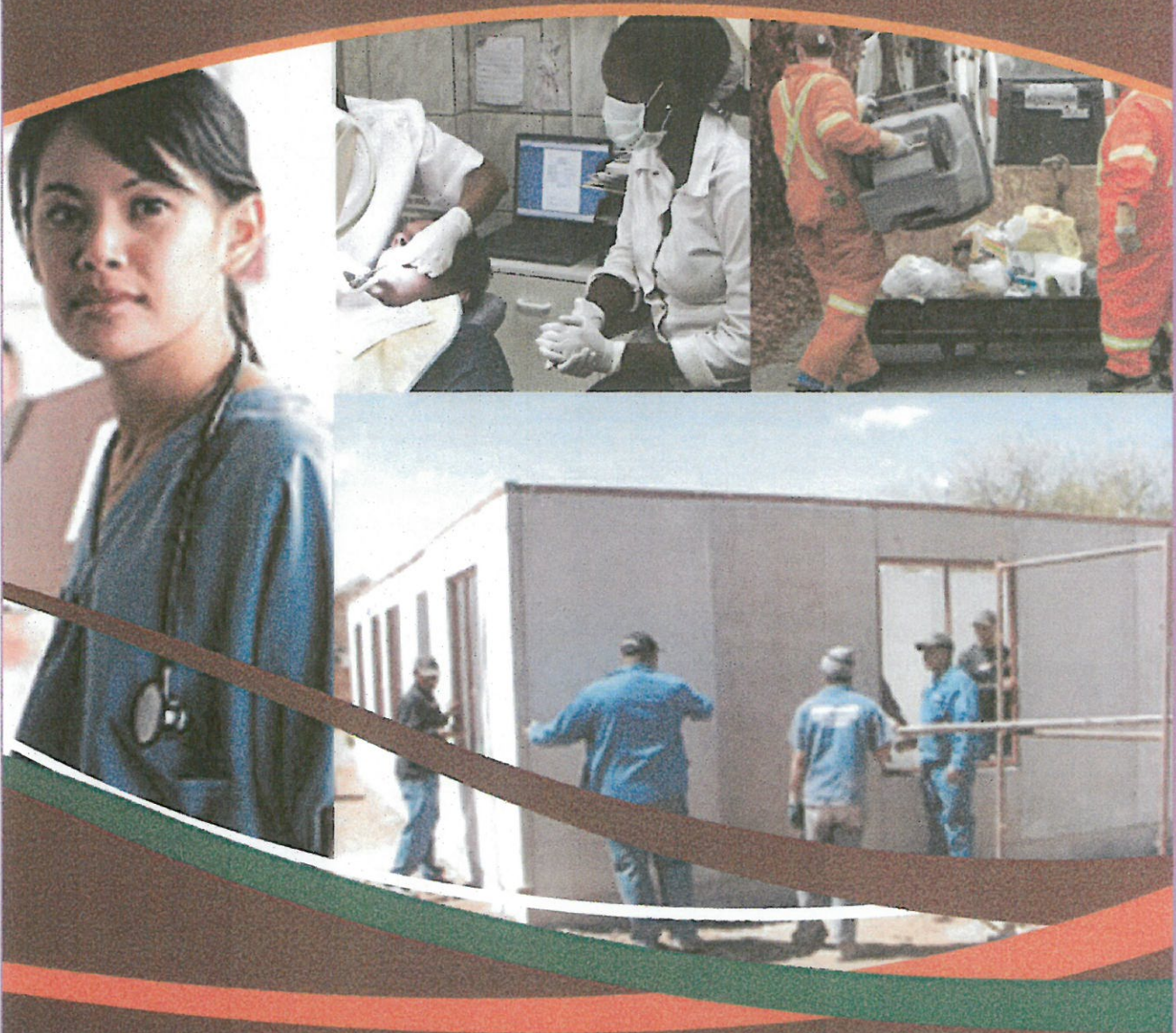


APPENDIX Q

EMPLOYEE HEALTH AND WELLNESS STRATEGIC FRAMEWORK FOR THE PUBLIC SERVICE



EMPLOYEE HEALTH AND WELLNESS STRATEGIC FRAMEWORK FOR THE PUBLIC SERVICE



FINAL DRAFT:
NOVEMBER 2008





FOREWORD

Historical approaches to solving challenges of employee health and wellness within the public service, given tomorrow's complex environment, are inadequate. The high-value Public servant of the future will be characterised by a capacity for balanced and healthy living to ensure efficient service delivery.

Current approaches to the business as usual approach, where it relates to public servant's health and wellness, including the quality of their working life and the appropriate environments are still based on a model that has become increasingly inexcusable in terms of maintaining employee human dignity. Bridging the gap between these challenges of the past and the complex problems of the immediate

future require focused initiatives and interventions. What is required is an innovative solution which the Employee Health and Wellness Strategic Framework attempts to address.

This integrated model is responsive and pre-emptive to employee and employer health rights and responsibilities, as it provides a platform for implementation and co-ordination in a synergistic manner by stressing the virtues of health as a priority for our workforce.

The Employee Health and Wellness Strategic Framework was developed following the research and benchmarking of international and local best practices and by obtaining inputs from stakeholders from previous Employee Health and Wellness Indabas.

This framework takes cognisance of the reality that HIV and AIDS and TB, chronic diseases and occupational injuries and diseases, environmental and quality management as some of the main challenges facing South Africa today. It seeks to represent an integrated, needs-driven, participative, and holistic approach to Employee Health and Wellness in the Public Service. The integrated approach to employee health and wellness recognises the importance of individual health, wellness and safety and its linkages to organisational wellness and productivity in the Public Service.



Mr. Masenyani Richard Baloyi
Minister: Public Service and
Administration





Purpose of Document

Title of the Document:

The Employee Health and Wellness Strategic Framework for the Public Service (EH&WSF)

Objective of this document:

The key objective of this document is to communicate the Strategic Framework, which provides for an integrated, needs-driven, participative, and holistic approach to Employee Health and Wellness in the Public Service. The integrated approach to employee health and wellness recognises the importance of linking individual health, safety and wellness, organisational wellness, environmental sustainability, quality management to productivity and improved service delivery outcomes. This will be effectively achieved through critical common strategic interventions in priority areas of:

- HIV&AIDS and TB Management
- Health and Productivity Management
- Safety, Health, Environment, Risk and Quality Management (SHERQ)
- Wellness Management

Goal of this document:

The ultimate goal is to provide a common strategic direction and platform for operational policies in line departments by providing guidelines through principles and practices for the health and wellness of public servants, their families and citizens. It interprets the legislative and political intent in a strategic manner that allows for commonality of application across different line and sector organisations.

Overview

The array of priorities, as addressed in the conceptual framework, has been derived through a national consultative process with stakeholders and through a review of international and local best practices. The consultation and review sought to highlight the core issues and take note of exemplary practice in responding to the issues and challenges of the EH&W field.





Targeted Audience

The target is all Public Servants in government departments and other relevant government entities; as well as Employee Health and Wellness line managers and practitioners responsible for implementation of EH&W programmes, top managers and political leadership.

Structure of this document:

This document comprises various distinct sections. Each section illuminates a key element of the Framework: the context, the strategic thrusts, principles, and objectives, the legal framework, the implementation plan, and the monitoring and evaluation framework. The Framework also amplifies the functional and process pillars on which the Framework is based, as well as the national priority items which provide direction to the Public Service.

These specific functional support areas impact directly on the roles and responsibilities of managers and health and wellness practitioners in government. The last section of the document is a generic implementation plan, which will be fully developed into policies for each one of the four strategic areas.

Consultation Process

There has been an extensive consultative process leading up to the compilation and approval of this document, from 2006-2008. This is not a static document it will be reviewed in line with future developments in the EH&W field, which will be communicated through regular EH&W steering committee meetings and the annual EH&W Indaba.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
AU	African Union
COIDA	Compensation for Occupational Injuries and Diseases Act
COPD	Chronic Obstructive Pulmonary Disease
DPSA	Department of Public service and Administration
EAP	Employee Assistant Programme
EH&W	Employee Health and Wellness
EH&WMSF	Employee Health & Wellness Management Strategic Framework
GEMS	Government Employee Medical Scheme
HAART	Highly Active Anti-Retroviral Therapy
HPM	Health & Productivity Management
HIV	Human Immunodeficiency Virus
HRMD	Human Resource Management Development
HR	Human Resource
IEC	Information Education and Communication
ILO	International Labour Organisation
IR	Industrial Relations
KPA	Key Performance Area
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MTCT	Mother to Child Transmission
NEPAD	New Partnership for Africa's Development
NSP	National Strategic Policy Framework 2007-2011
NWHA	National Employees Health Agenda
OLAP	On line Analytical Processing
OHS	Occupational Hygiene and Safety/Occupational Health and Safety
PMTCT	Prevention of Mother to Child Transmission
PDP	Personal Development Plan
PILIR	Policy and Procedure on Incapacity Leave& Ill-Health Retirement
PSC	Public Service Commission
PSR	Public Service Regulations
QWL	Quality of Work Life
SADC	South African Development Community
SITA	State Information Technology Agency
SMS	Senior Management Service
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nations
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation





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SECTION 1: INTRODUCTION

1.1 BACKGROUND

Employee Health and Wellness Programmes in the Public Service are rapidly transforming the nature of holistic support provided to employees to ensure risk management, occupational health, safety, productivity and wellness of government employees and their families and the safety of citizens in the Public Service world of work. Following extensive investigation of international and local best practices and obtaining inputs from internal stakeholders and discussions at several Employment Health and Wellness INDABA Conferences specific areas of focus have been identified as the key components of EH&W, which have informed the outline and contents of the proposed public service strategic response. A clear need for a common approach, understanding and uniformity of implementation programmes emerged, hence the need for this EH&W Strategic Framework for the Public Service.

This strategy is influenced by but not limited to the World Health Organisation (WHO) Global Plan of Action on Workers Health 2008-2017, the International Labour Organisation's (ILO) Decent Work Agenda in Africa 2007-2015 and the recommendations of the report of the WHO's Commission on Social Determinants of Health released in August 2008. It is based on what is currently considered national priority as guided by current disease burden in the South African Worker Population of which the Public Service constitutes 10%. It is also based on what is considered priority issues to be addressed in so far as employee's health is concerned.

1.2 OBJECTIVES

The fundamental objective of this Strategic Framework is to facilitate the development of strategies, mechanisms and interventions by government departments and provincial administrations for the implementation of HIV&AIDS and TB Management, Health and Productivity Management; Safety, Health, Risk and Quality Management; and Wellness Management in the Public Service.

1.3 SITUATIONAL ANALYSIS

Part Six of the Public Service Regulations, 2001 affirms the principle of improvement of the working environment to ensure efficient service delivery to include among others employees' health, disability, HIV&AIDS and other health conditions for the benefit of employees and their families. New developments in the fields of Occupational Health and Safety, HIV&AIDS and TB Management, Chronic Disease management and productivity management are some of the issues raised covered in this framework. The newer developments in Safety, Health, Environment, Risk, and Quality management are also addressed in this framework. The Wellness Pillar addresses psychosocial stressors in a proactive fashion integrating all aspects of wellness of public servants and their families.





a) HIV&AIDS and TB Management: HIV and AIDS is one of the major challenges facing South Africa today. Of the 48 million South Africans estimated in the last census, 5 700 000 estimated to be HIV infected (UNAIDS/WHO 2008) with a prevalence rate (15-49 yrs) of 18, 1%. Most of these are women 3 200 000, are in urban and rural informal environments (SA National HIV Prevalence, HIV Incidence, Behaviour Communication, Survey 2005). South African HIV epidemic is both generalized and concentrated. The knowledge of the epidemic and modes of transmission are important to inform all interventions in a mainstreamed fashion to address both internal and external responses to HIV&AIDS.

South Africa is one of the 22 High Burden Countries that contribute approximately 80% of the total global burden of all TB cases. It has the seventh highest TB incidence in the world. During the past ten years the incidence of tuberculosis has increased, in parallel to the increase in the estimated prevalence of HIV in the adult population. This has resulted in increasing recognition of the problems posed to public health by TB. Generally TB control is facing major challenges. Co-infection with Mycobacterium Tuberculosis and HIV (TB/HIV), and multi-drug-resistant (MDR) and extensively drug-resistant (XDR) tuberculosis in all regions, make prevention and control activities more complex and demanding

TB and HIV infections are so closely connected that the term "co-epidemic" or "dual epidemic" is often used to describe their relationship. Each disease speeds up the progress of the other, and the two diseases represent a deadly combination, since they are more destructive together than either disease is alone. Tackling HIV should therefore include tackling tuberculosis, while preventing tuberculosis should include prevention and management of HIV.

The greatest challenge is to prevent new infections (primary and secondary), accelerate access to treatment for those clinically eligible for treatment, reduce stigma and discrimination, with special focus on TB stigma, and accurately monitor and evaluate all interventions for both the workplace and the external responses in accordance with the HIV&AIDS and STI National Strategic Plan 2007-2011 and Tuberculosis Strategic Plan for South Africa, 2007-2011

The recent Mexico HIV Conference emphasized the importance of three (3) I's for TB management. The Three I's are activities to reduce the burden of TB in people with HIV, including intensified case finding (ICF), isoniazid prophylaxis (IPT) and TB Infection Control (IC). Studies have shown that a person with TB who is coughing without covering his or her mouth poses a greater risk to someone



close by than someone sitting across the room. Even so, tiny droplets that could contain infectious bacilli can remain in a room without good ventilation for a very long time. This is a critical aspect to consider in preventive efforts to reduce the TB transmission in the workplace

WHO has developed a new six point Stop TB Strategy which builds on the successes of DOTS (Directly Observed Treatment, Short-course) while also explicitly addressing the key challenges facing TB. Its goal is to dramatically reduce the global burden of tuberculosis by 2015. Furthermore the new toolkit on management of TB in the workplace launched by World Economic forum, and the South African Bureau of Standards' (SABS) new standard on workplace management of South African National Standard (SANS 16001) will give specific guidance on occupational interventions of HIV&AIDS and TB management also in the Public Service.

b) Health and Productivity Management: Non communicable diseases including Chronic Diseases of lifestyle, occupational injuries and diseases, are increasingly becoming main contributors to high burden of disease in many developed and developing countries. This elevates the challenge of addressing the double burden of infectious and chronic diseases. Cardiovascular disease, cancer, chronic respiratory disease, and diabetes are responsible for more than 60% of death globally and projected to account for two thirds of deaths globally for the next 25 years. The World Health Organisations Global Strategy on Diet, Physical Activity and Health together with the National Departments of Health's Healthy Lifestyle Campaign will inform the workplace health education and promotion interventions prescribed by this framework. Traditional disease management programmes, health education and promotion programmes and productivity improvement and Public Service delivery improvement in particular have not been integrated thus far. This framework puts all these interventions together to form a comprehensive health and productivity management programme to be implemented in the public service.

c) Safety, Health, Environment, Risk and Quality Management: (SHERQ). This pillar deals with the intangible and tangible factors of safety, health environment, risks and quality management for purposes of optimal occupational health and safety of employees, the safety of citizens and also the sustainability of the environment, the management of occupational and general risks and quality of government products and services. It is in response to international instruments, National legislation and generally accepted standards of international Organisation of Standards and other standard generating authorities. This include but not limited to the OHSAS 18001 for Occupational health and safety, ISO 14001 for Environmental Management, ISO 9001 for Quality Management.

The report on the survey conducted following the public sector strike of 2006, the January 2008 Cabinet Lekgotla decision of improve the working environment in government front and back office environment , and the Parliament noting of ILO Convention 187 Promotional Framework for Occupational Safety and Health, 2006 are all events and documentation that adds to the rationale for this pillar. At the end of 2007, South Africa noted the ILOs Convention 187





Promotional Framework for Occupational Safety and Health, 2006 for ratification. This promotional framework provides for:

- the development of national policy on occupational safety and health and the working environment developed in accordance with the principles of Article 4 of the Occupational Safety and Health Convention, 1981 (No. 155);
- the development of national system for occupational safety and health or national system i.e. infrastructure which provides the main framework for implementing the national policy and national programmes on occupational safety and health;
- national programme on occupational safety and health or national programme which is a national programme that includes objectives to be achieved in a predetermined time frame, priorities and means of action formulated to improve occupational safety and health, and means to assess progress;
- a national preventative safety and health culture which is a culture in which the right to a safe and healthy working environment is respected at all levels, where government, employers and workers actively participate in securing a safe and healthy working environment through a system of defined rights, responsibilities and duties, and where the principle of prevention is accorded the highest priority

This ILO convention 187 and the Occupational Health and Safety Policy of 2005 developed by the Department of Labour will form the basis of this Pillar and will address even risk , environment, and quality management in line with January 2008 Cabinet Lekgotla's decision for development of a plan on improvement of working environment in the work place. The SHERQ Pillar will constitute the Public Sectors response to ILO Convention 187 of 2008 and Department of Labour's OHS Policy of 2005.

d) Wellness Management: This pillar addresses the individual and organisational wellness in a proactive manner. This development is a radical departure from the Employee Assistance Programme which was limited in scope and practice and was reactive and not strong on prevention. This is against the analysis done by many epidemiological and health information and medical aid cost driver trend reports like the Key Health trends from the Government Employee Medical Scheme (GEMS) and other medical aid schemes which confirm the trends of psychosocial problems, organisational climate assessments of hostile working physical and psychosocial working environments.





SECTION 2: OUTLINE OF THE CONCEPTUAL FRAMEWORK

2.1 STRUCTURE OF THE FRAMEWORK

The overall Employee Health and Wellness Strategic Framework, which circumscribes the strategy for employee health and wellness within the Public Service, is represented in terms of a "Parthenon House" founded on the legislative and policy framework. There are three critical components of the strategy:

- a) The vision and mission for the strategy and the manner in which these are communicated, institutionalized and managed
- b) The four functional or key pillars for achieving this vision, or the primary arenas of action in implementation for creating a health and safe working environment in the public service, and the four process pillars for implementation:
- c) The ten core principles for implementing the strategy, which serve as a set of guidelines to organize and manage interventions for employee health and wellness in the workplace.

The four functional pillars or strategic programmes of action comprise:

Occupational Health

Pillar 1: HIV&AIDS and TB Management

Pillar 2: Health and Productivity Management.

Quality of Work Life (QWL)

Pillar 3: SHERQ Management

Pillar 4: Wellness Management

Cutting transversally across these four functional pillars are the four process pillars which drive implementation of the Framework:

- Capacity development initiatives
- Organisational support initiatives
- Governance initiatives
- Economic growth and development initiatives



The Parthenon house (Conceptual Framework) for Employee Health & Wellness (EH&W) is illustrated below:

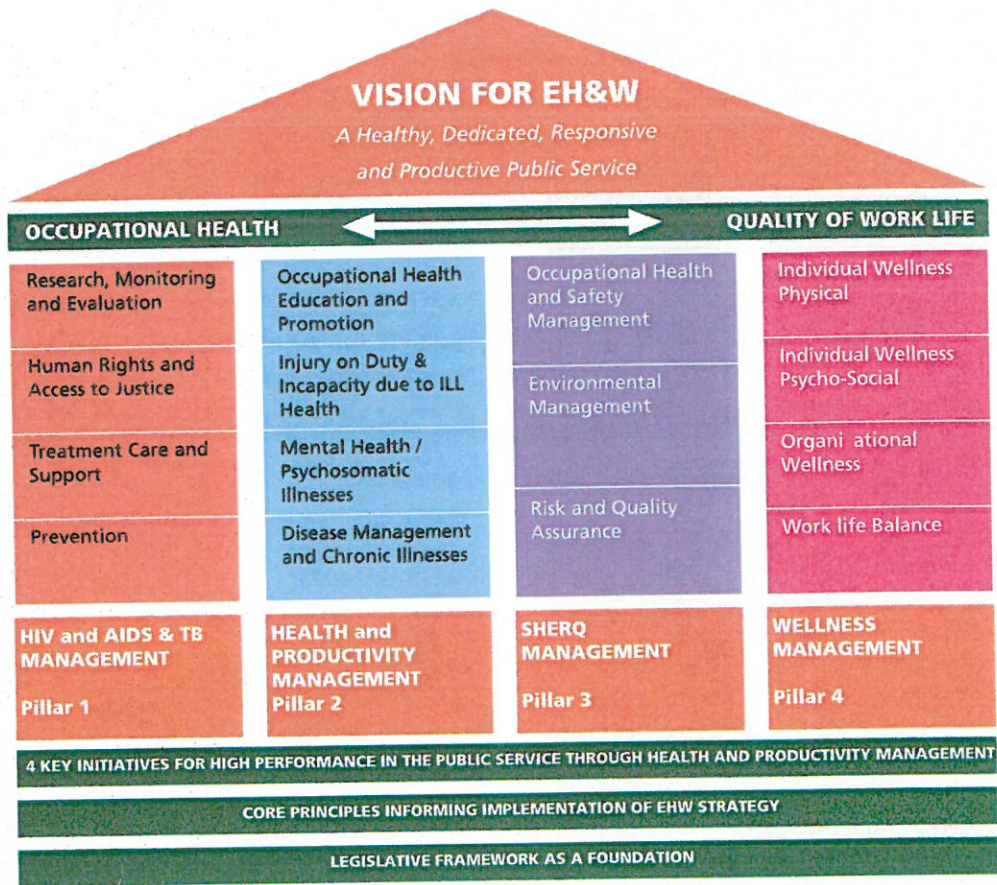


Figure 1: Conceptual Framework for the Employee Health & Wellness (EH&W) in the Public Service

2.2 VISION

The vision for the EH&W Strategic Framework is to provide programmes that can develop and maintain healthy, dedicated, responsive and productive employees within the public service who can add value within public service organisations. This vision is articulated as follows:

"A healthy, dedicated, responsive and productive public service".



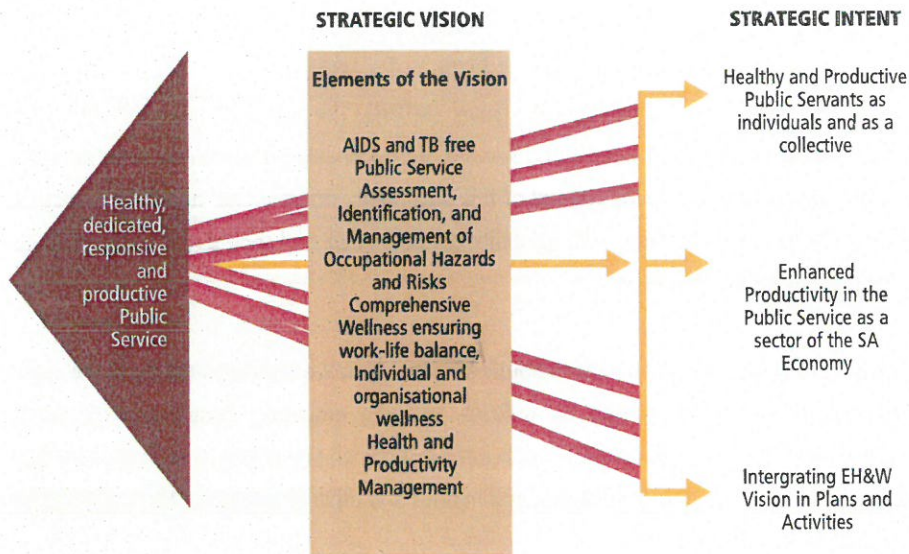


Figure 2: Diagrammatic illustration of the Vision of the EH&W Strategic Framework

3.3 MISSION

The mission of the EH&W strategic framework is to ensure the management of comprehensive health and wellness programmes and services in public service organisations. The mission is:

"To build and maintain a healthy workforce for increased productivity and excellent service delivery for the benefit of employees and their families"

2.4 LEGAL AND POLICY FRAMEWORK

This political commitment to the health and wellbeing of the nation is also enshrined in the South African Constitution, Act 108 of 1996 and its Bill of Rights. It is expressed as "Everyone has the right- to an environment that is not harmful to their health or well-being "and "Everyone has the right to have access to health care services, including reproductive health care"

The Employee Health and Wellness Strategic Framework taking into consideration all international instruments that form part of international law that are relevant to the health and wellbeing of workers for improved Occupational Health and Safety, Gender equality in health, and the human rights bases of health. These includes among others the WHO workers health plan of 2007-2015, the ILO Convention 187 of 2006 which provides for a promotional framework for occupational health and safety. These instruments build on the WHO Global Strategy on Occupational Health for All of 1994 and affirm the need to have a national occupational health related strategy base in what is considered as priorities in that country.





The other international instruments and plans like United Nations Convention on the Rights of People with Disabilities, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), The Beijing Declaration and its Platform for Action, 1995 (+10), United Nations Millennium Declaration and its Development Goals (MDGs), The International Convention on Population Development 1994 (+10) and World Summit on Sustainable Development, Johannesburg 2002 are assert that health and in the context of this document, occupational health in particular, should address needs of people living with disability, gender-based, and should recognise health as a contributing factor to development.

This framework is also a response to various South African legislative requirements that is relevant to occupational health. These provide for policies, systems, programs, compliance measures, monitoring and evaluation of occupational health interventions on prevention, treatment, care and compensation of occupational health diseases and injuries and other diseases like HIV and AIDS, TB and chronic diseases of life style.

Beyond the legislation this EH&WSF responds to the relevant National strategic plans and policies related to employee and wellness that this strategic framework seeks to respond to. This includes but is not limited to the National Strategic Plan on HIV&AIDS 2007-2011, the draft National Strategic Framework on Stigma and Discrimination, the National occupational health policy of 2005.

The last level of the legislative and policy framework responded to through this document are economic and social policy, programmes and strategy including Integrated Development Plans (IDPs), Medium Term Strategic Framework, National Spatial Development Strategies, and annual Presidential pronouncements and Cabinet Makgotla decision.

INTERNATIONAL INSTRUMENTS UNDERPINNING EHW MANAGEMENT

- WHO Global Strategy on Occupational Health for All
- WHO Global Worker's Plan 2008-2017
- ILO Décent Work Agenda 2007-2015
- ILO Promotional Framework for Occupational Safety Convention 2006
- United Nations Convention on the Rights of People with Disabilities
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- The Beijing Declaration and its Platform for Action, 1995 (+10)
- United Nations Millennium Declaration and its Development Goals (MDGs)
- The International Convention on Population Development 1994 (+10)
- World Summit on Sustainable Development, Johannesburg 2002
- World Economic Forum-Workplace TB and HIV Toolkit
- WHO Global Strategy on Prevention and Control of non communicable diseases (April 2008)
- Recommendations of the Commission on Social determinants of Health (August 2008)





LEGAL FRAMEWORK FOR EHW MANAGEMENT WITHIN THE PUBLIC SERVICE

Constitution of the RSA, Act 108 of 1996	Occupational Health and Safety Act 85 of 1993	Labour Relations Act, 66 of 1995	Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000	Public Service Act, 1994 as Amended & Regulations	The Medical Schemes Act, No. 131 of 1998
Disaster Management Act, No. 57 of 2002 and Basic Conditions of Employment Act 75 of 1997	Employment Equity Act (55 of 1998; 97 of 1998; 9 of 1999)	National Disaster Management Framework		Compensation for Occupational Diseases and Injuries Act, No.130 of 1993	Health Care Act Tobacco Products Control Amendment Act No. 12, 1999

STRATEGIC FRAMEWORKS APPLICABLE TO EH&W WITHIN THE PUBLIC SERVICE

National Strategic Plan on HIV&AIDS 2007-2011	National Strategic Framework on Stigma and Discrimination	National Occupational Health and Safety Policy of 2005
National Strategic Framework on Stigma and Discrimination	National TB Infection Control Guidelines, June 2007	Management of Drug Resistant Tuberculosis in South Africa, Policy Guidelines, June 2007

ECONOMIC AND SOCIAL POLICY, PROGRAMMES AND STRATEGY

Presidential Pronouncements and Budget Speech	Integrated Development Plans (IDPs)	Medium Term Strategic Framework	National Spatial Development Strategies	Provincial Growth and Development Strategies
	Occupational Health Policy 2005 (Department of Labour)			

Table 1: Legal and Policy Framework

The Strategic Framework for Employee Health and Wellness within the Public Service must be aligned with Government's priority areas and national action plan for the various government clusters. The key priority areas are summarised in Table 2 below:

1. Transforming our country into a genuinely non-sexist society
2. Eradicating poverty and underdevelopment, within the context of a thriving and growing first economy and the successful transformation of the second economy
3. Securing the safety and security of our people
4. The further entrenchment of democracy in our country
5. Building a strong and efficient democratic state that truly serves the interests of the people
6. Transforming our country into a genuinely non-racial society
7. Opening the vistas towards the spiritual and material fulfilment of each and every South African
8. Contributing to the victory of the African renaissance and the achievement of the goal of a better life for the people of Africa and the rest of the world

Table 2: Government's Key Priority Areas



2.5 CORE PRINCIPLES

This set of core principles been derived through a consultative process with relevant stakeholders during the period 2005 – 2007, on a review of available documents and international instruments pertaining to employee health and wellness. The policy priorities of Government were always the focus point of discussions in all consultation sessions as they provided the key strategic point of reference.

The EH&W strategic framework is based on core principles which are value-based to create an understanding and promote unity of focus in guiding our public service employee behaviour, interactions and strategic choices for implementation. The principles are set out in Figure 3 below:

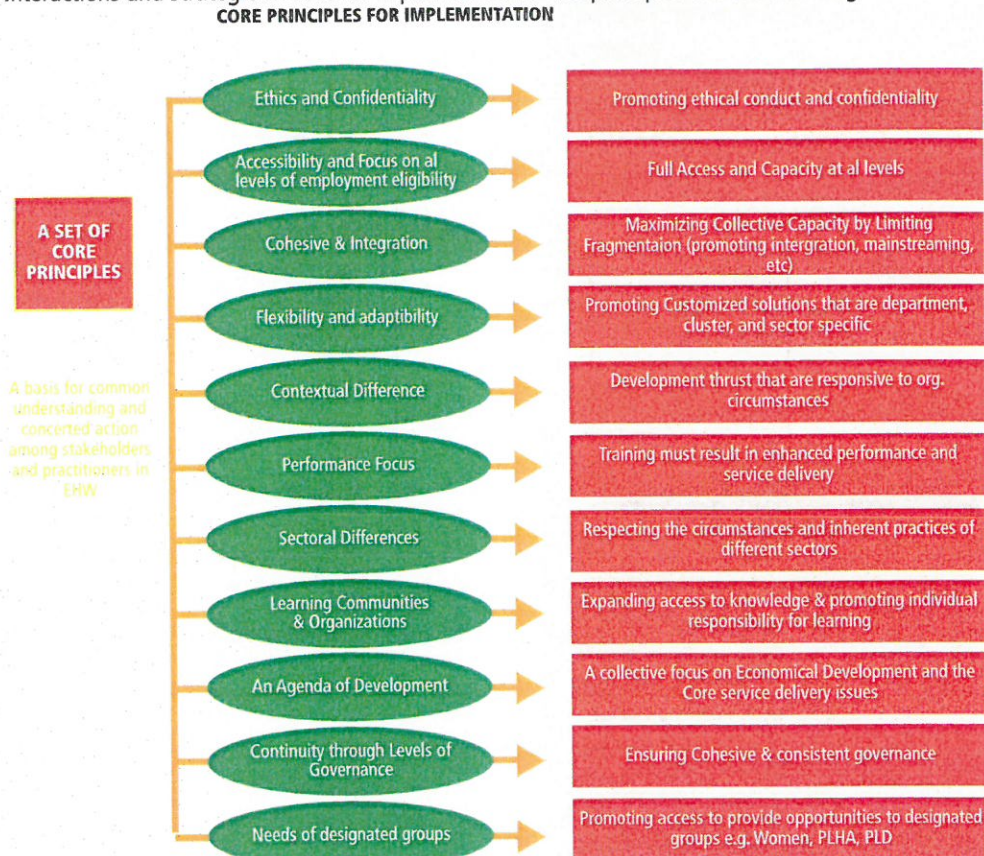


Figure 3: Core Principles for Implementation of the EH&W Strategic Framework

The two principles that are the cornerstone for the EH&W programmes, practices, and services are confidentiality and ethical behaviour.





Confidentiality

Employees utilizing the EH&W programme are assured of confidentiality, except in cases of risk to self and others or in terms of legislation. Strict confidential records and information outside the personnel records should be maintained at all times. The Departments will ensure the confidentiality of all medical and personal information of employees. The employees within the Public Service have a constitutional right to confidentiality about their HIV and AIDS status, in particular; should an employee reveal his/her HIV status, this information shall not be disclosed to any other party including other employees, union member or management. Consent for disclosure should be in writing.

Ethical Behaviour

The EH&W units shall ensure professional and ethical behaviour as well as the protection of the client's confidentiality. Only registered professionals will be allowed to provide therapeutic interventions. EH&W/ EAP professionals who are registered with their respective professional bodies will have to adhere to codes of conduct of such bodies as well as the code of conduct of the departments. The EH&W/ EAP professional will therefore be held responsible for the consequences of their actions should they behave in an unethical manner such as breaching confidentiality. As far as possible the generic principles of respect for autonomy, non-maleficence, beneficence, and distributive justice will guide the actions of policymakers, programme managers, researchers and all professionals working in the field of employee health and wellness.

The rest of the core principles are a set of value-based understandings which guide our behaviour and interactions, and are geared towards an understanding of the achievement of a transformed Public Service. They seek to establish a common set of beliefs and understanding among practitioners and stakeholders, so that programme interventions are not based on different stakeholder assumptions. Realising the established vision and ensuring that all will act to ensure progress is predicated on this common set of principles. The most highly prioritized principles which affect the application of the strategic framework are presented and explained below. These principles are by no means exhaustive. They may, however, represent the foundation of a process through which consensus is derived about additional principles that may be appropriate and relevant for promoting implementation success.

The core principles indicated in Figure 3 are detailed below:

a) Focus on all Levels of employment: Any organization has to operate at maximum performance and fulfil demands that are spread across a wide spectrum of complexity levels. The reach and influence, as well as the time spans of responsibility and consequence differ markedly from level to level. The Framework must be inclusive of all employees in the Public Sector. In this respect, it must focus on senior and executive management, middle managers, operational and technical staff as well as staff at the lowest level of the occupational ladder. Each employee has a role to play in the enhanced performance and service delivery in their respective departments, and each has a right to opportunities





for development. Consideration of the needs of employees at different levels and in occupational categories has to be emphasized. Competencies and skills commensurate with job descriptions become critical to ensure effective individual performance and ultimately improved overall organizational performance and service delivery.

b) Responding to the needs of designated groups: An important dimension of any diversity development must be the self-reflection and introspection with regard to one's values, beliefs and behaviours related to how one perceives designated groups such as women, older persons, people with disabilities and people living with HIV and AIDS. This awareness is crucial to the manner in which a Public Service official responds to the needs of individuals within designated groups, with particular importance to persons with disabilities and women. Stereotyping, ill-conceived perceptions and negative attitudes become insurmountable barriers to the advancement and development of designated groups, whether as Public Service employees or as the clients of the services of the government departments. The Public Service must endeavour to address disparities in respect of race, gender and background, promote equal opportunity and create a culture that embraces diversity. This is primarily a social-economic imperative to normalise society and achieve sustainable and embedded transformation.

c) Representation of targeted groups: Fundamental to the creation of a non-sexist, non-racist and fully inclusive Public Service is the process of achieving equity, parity, representation and participation of the designated groups in the employ of the Public Service. It is imperative that any strategy that aims to promote and protect human rights and human dignity of all people, must ensure that it first gets the "numbers game" right. Concomitantly, affirmative action measures and special measures to empower women, people with disabilities and blacks are critical in order to increase their participation in all occupational categories and levels. Furthermore it is essential to ensure that processes of policy and programme generation that are aimed at advancing designated groups include participation by members belonging to such groups. Participation in key decision-making that concerns designated groups cannot take place outside of those it concerns and those it seeks to address.

d) Equality and non-discrimination: The principles of equality and non-discrimination are the cornerstones of democracy upon which the South African constitution is based. Any discrimination based on any grounds such as sex, race, ethnicity, language, religion or belief, political or any other opinion, disability, age or sexual orientation contravenes such constitutional imperatives.



Pivotal to the transformation of the Public Service is the principle of non-discrimination and upholding the value that discrimination on any unfair grounds should be eliminated. While this is the case, it should be remembered that a core principle adopted by government in the promotion of the interests of, and access to opportunities, by women, people with disabilities and blacks, is constituted as “fair discrimination”. The basic notion which belies this thinking is the pressing need to “level the playing fields” and fast track the achievement of both de jure and de facto equality. The Public Service upholds, promotes and disseminates the values and practices underlying the fight against discrimination, including through the use of awareness-raising campaigns and diversity management interventions. Equality and the right to non-discrimination warrant the creation of an environment within which individuals are protected against unreasonable or unacceptable differential treatment.

e) Healthy integration and embracing change: In order to successfully facilitate a healthy integration among employees, the organizational culture needs to be built on honest feedback and should be supported by a system where change is embraced at all levels. Such an approach needs to be supported by means of open and transparent performance and feedback within the context of non-discrimination. Cultural phenomena and traditional value systems, including issues such as race, language, ethnicity and religion, need to be addressed in order to achieve progressive integration that is free of prejudice. Culture change therefore requires a paradigm shift. If the organizational ethos, culture, beliefs and values do not incorporate flexibility and innovation, then it is critical to ensure that it strives to become flexible and innovative in order to survive the challenges of an ever-evolving workplace and competitive global markets. In a highly evolving Public Service, the manner in which organizations are able to adopt change, and adapt to it effectively, will impact on their ability to become high performing learning organizations.

f) Building Government capacity: An effective and efficient Public Service is central to South Africa as a developing State, and therefore the issue of development is always core to its agenda. These developmental imperatives are pressing and demand urgent redress, particularly for those issues that impact directly on the lives and welfare of people. It is therefore always a “call to action” in and for the Public Service. This context therefore merits comprehensive and multi-sectoral approaches and responses that combine both the capacity and unique strengths of all sectors of the Public Service. Any agenda for diversity management in the Public Service must, therefore, always take cognizance of the developmental agenda of the State and must be responsive to the capacity development needs of the State in terms of advancing growth and development.

g) Addressing diversity of needs: A thorough understanding of the ways in which environmental pressures impact on organizational life is essential to the effective management of diversity. In order to improve the organization’s overall effectiveness, it is essential to recognize and acknowledge the different needs of all employees.

h) Human dignity, autonomy, development and empowerment: The implication of human dignity is that every employee





should be acknowledged as an inherently valuable member of the Public Service who brings a unique contribution to the workplace. There is a need to provide space for mutual respect and esteem in order for every individual to be empowered and for them to grow within the organisation.

i) Barrier-free Public Service: There is a need to maintain an inclusive, barrier-free work environment that is accessible to all. Respect for an individual's right to privacy and confidentiality should be maintained at all times. The Public Service is mindful of these factors in terms of the planning and design of work-related events so that events and opportunities are accessible to all employees. Professional barriers (e.g. lack of advancement, mentoring, and training opportunities) and psychological barriers (e.g. issues related to balancing family/work expectations and sexual discrimination/ harassment) that affect the progress and well-being of individuals in the workplace need to be eliminated. The removal of these barriers will, ultimately, result in departments improving their service delivery levels.

j) Collaborative Partnerships: The need for partnerships between the Public Service and organizations like Disabled People's Organizations, the National Gender Machinery and NGOs is becoming increasingly important as needs, trends, and issues are identified. The essential elements that are associated with successful collaborative partnerships are those of networking and visioning. The establishment and sustainability of these collaborative partnerships should ideally be built on mutual strengths and help create innovative services and processes for the Public Service and communities. There should be coherence in policy and programmes between the government departments and sectors.

2.6 PROCESS PILLARS OF ACTION

The four process pillars (operational) of the Strategic Framework for promoting employee health and wellness cut across all functional pillars (which will be discussed in paragraph 2.7 below). It is the basis on which the implementation of the strategic framework is premised. These four key initiatives are the defining pillars on which the Public Service Human Resource Development Strategy is build and to which the EH&W Strategic Framework had been linked. They serve as the underlying basis on which the employee health and wellness must be founded. Each of the four key initiatives is briefly described below:

- *Capacity development Initiatives*
- *Organisational Support System Initiatives*
- *Governance and Institutional Development Initiatives*
- *Economic Growth and Development Initiatives*





(a) Capacity Building Initiatives: Capacity building initiatives are represented in those activities which add value in strengthening our ability to build human capital. Human capital must be built efficiently and effectively, with the infrastructure put in place to promote ease of access. These capacity building initiatives are implementable in order to promote employee health and wellness. The capacity development initiatives are set out below:

- *Promote competence development of EH&W practitioners*
- *Improve capacity development of auxiliary functions (OD, HR, IR, Skills Development, Change Management etc.) to assist with wellness promotion at an organisational level*
- *Establish e-Health and Wellness information systems*

(b) Organizational Support Initiatives: The success of the Strategy for promoting employee health and wellness in the Public Service depends on the extent to which pertinent organizational support structures and systems in place are properly utilized. The strategy cannot function effectively without proper structures and processes for allocating and managing assigned responsibilities and resources, and without proper operational systems for promoting effectiveness and efficiency. This organizational support is essential to the success of this strategy. These organizational support measures and strategic activities are implementable in order to promote employee health and wellness. These initiatives are set out below:

- Establish an appropriate organisation structure for EH&W
- Ensure Human Resource planning and management
- Develop integrated EH&W information management system
- Provide physical resources and facilities
- Ensure financial planning and budgeting
- Mobilise management support

(c) Governance and Institutional Development Initiatives: Refers to the manner in which the strategy will be promoted, governed and supported in the Public Service. Governance here refers to the manner in which strategic leadership, monitoring and evaluation of policies and programmes, compliance with scientific and ethical guidelines, standards, protocols, will be provided in order to ensure successful implementation of the Strategic Framework. It also entails the interventions that will be made to monitor and evaluate all interventions of functional pillars that in line with the 12 components of an effective the EH&W M&E system. This will be in fulfilment of all oversight structures at national and international level including SADC, AU, WHO, ILO, and other relevant structures. Good governance is included as one aspect in the strategy because health issues in general and EH&W in particular are governance issues in line with the SA legislature, recommendations of international legal instruments, SADC and ILO Codes of Good practice and other strategic documents like WHO's Closing the Gap, Health equity through action on social determinants of health report of the WHO Commission on Social Determinants of Health, the WHO Workers Health





Plan 2008-2017, ILO Decent Work Agenda for Africa 2007-2015, and others indicated in the legal and policy framework. These governance and institutional development measures and strategic activities are implementable in order to promote employee health and wellness and are set out below:

- Establish an EH&W Steering Committee
- Obtain Stakeholder commitment and development
- Develop and implement an ethical framework for EH&W
- Develop the management of wellness care
- Develop and implement management standards for EH&W (ISO standards, SANS, etc)
- Develop and maintain an effective communication system
- Develop and implement a system for monitoring, evaluation, and impact analysis
- Regularly report to Portfolio Committee on Public Service and Administration, Public Service Commission, SADC, AU, ILO, WHO, ECOSOC and other oversight structures

(d) Economic Growth and Development Initiatives: In its overall agenda Government seeks to build an economically vibrant state and simultaneously address the many challenges which affect the welfare of its people, in particular, designated groups. These include: poverty and its consequences; unemployment (especially among rural women and women with disabilities); lack of housing; the impact of HIV and AIDS on individuals, households, communities and the society at large; crime and corruption. Many Government programmes and initiatives are undertaken in skills development in response to driving the development agenda forward, to increase employability and, in turn, increase the chances of economic growth to the country. Government also fosters and forges effective partnerships which the aim of empowering such organizations and providing them with information on services and opportunities that are available. These economic growth and development measures and strategic activities are implementable in order to promote employee health and wellness and are set out below:

- Mitigate the impact of HIV and AIDS and Other Diseases on the economy
- Ensure responsiveness to the Government's Programme of Action
- Ensure Responsiveness to Millennium Development Goals
- Integrating SADC, NEPAD, AU and Global programmes for the economic sector



SECTION 3: BUILDING BLOCKS OF THE FUNCTIONAL PILLARS

The EH&W Strategic Framework is based on four functional pillars, which represent the recommended core functions of the EH&W Units in line departments, and identify a critical set of initiatives to be undertaken by the health and wellness practitioners in carrying out their roles and responsibilities. EH&W initiatives in the Public Service embrace the occupational health of employees and to promote the quality of work life within the Public Service.

These four functional pillars prescribe the minimum standards that needs to be covered as part of the EH&W scope of program focus, for which accounting officers will be accountable, notwithstanding other provisions of South African and International law. They also serve to inform the basis of transactional relations between Public Service organisations and Service Providers. They are the basis for the management of human and material resource demand for an integrated EH&W programme. They don't prescribe a specific profession, but indicate the basic health, safety, and wellness functions that need to be covered in every Government Department.

This component of the conceptual framework is essentially the core of the EH&W strategic framework for the public service. It embodies four (4) pillars of strategic functions and building blocks that represent the content or "the what" of areas of action in implementation and is described below:

- HIV and AIDS and TB Management
- Health and Productivity Management
- SHERQ Management (Safety, Health, Environment, Risk, Quality)
- Wellness Management

3.1 PILLAR 1: HIV AND AIDS and TB MANAGEMENT

The rationale and intended outcome related to HIV and AIDS management and health promotion are the mitigation of the impact of the HIV&AIDS epidemic and improvement of Public Service delivery to reduce the number of infections and the impact on individual employees, families, communities and society.

The TB epidemic is galloping, significantly driven by the HIV and AIDS epidemic and is a major cause of death. The time bomb of low cure rates, drug resistance and weakened immune systems is exploding.

HIV and AIDS is one of the major challenges facing South Africa today. Some two decades since the introduction of this disease in the general population, the epidemiological situation is still characterized by very large numbers of people living with HIV and a disproportionate effect on particular sectors of society, viz.; young women, the poor, as well as those living in underdeveloped areas in the country. HIV infection and AIDS disease however, affects the lives of all South Africans in many different ways.





Based on the Department of Health's National Strategic Plan for HIV and AIDS and STI 2007-2011, initiatives and interventions in the Public Service embrace four broad objectives:

- prevention to reduce the rate of HIV incidence;
- provision of treatment, care and support to infected employees;
- to protect human rights and access to justice; and
- to have a research agenda in the Public Service and the world of work in South Africa.

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP) seeks to reduce the number of new HIV infections by 50% and reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV.

The Stop TB National Plan based on International Standards for Tuberculosis Care indicates that TB is preventable and curable. Therefore, Health systems should ensure, as a first priority that individuals suspected of having TB have universal access to rapid diagnosis, appropriate treatment, and adequate support systems to ensure treatment completion. Of particular importance are infection control operations in all settings, to prevent transmission of TB, in line with the National TB Infection control policy, June 2007

This Framework serves as a broad guide for government public service organisations in responding to HIV & AIDS and STIs, and TB in the Public Service world of work.

This pillar consists of the following four sub-objectives:

- Prevention
- Treatment, care and support
- Human and legal rights and access to justice
- Monitoring, research and surveillance.

Each of the above-mentioned sub-objectives consists of constituent components which form the essence of the relevant focus areas and is illustrated in Figure 4. Each sub-objective will have critical success factors and proposed activities which will be included in the Generic Implementation Plan (Annexure A).



Medical Assistance for Treatment and Care of Public Servants Living with HIV AND AIDS is provided by GEMS. As far as possible Government Departments should encourage all government employees to be members of the Government Employee Medical Scheme (GEMS) to access the benefits of health care in relation to treatment Care and Support in all HIV&AIDS interventions. Treatment and Care could also be accessed at Government hospitals and clinics, which have extensive health care programs and services.

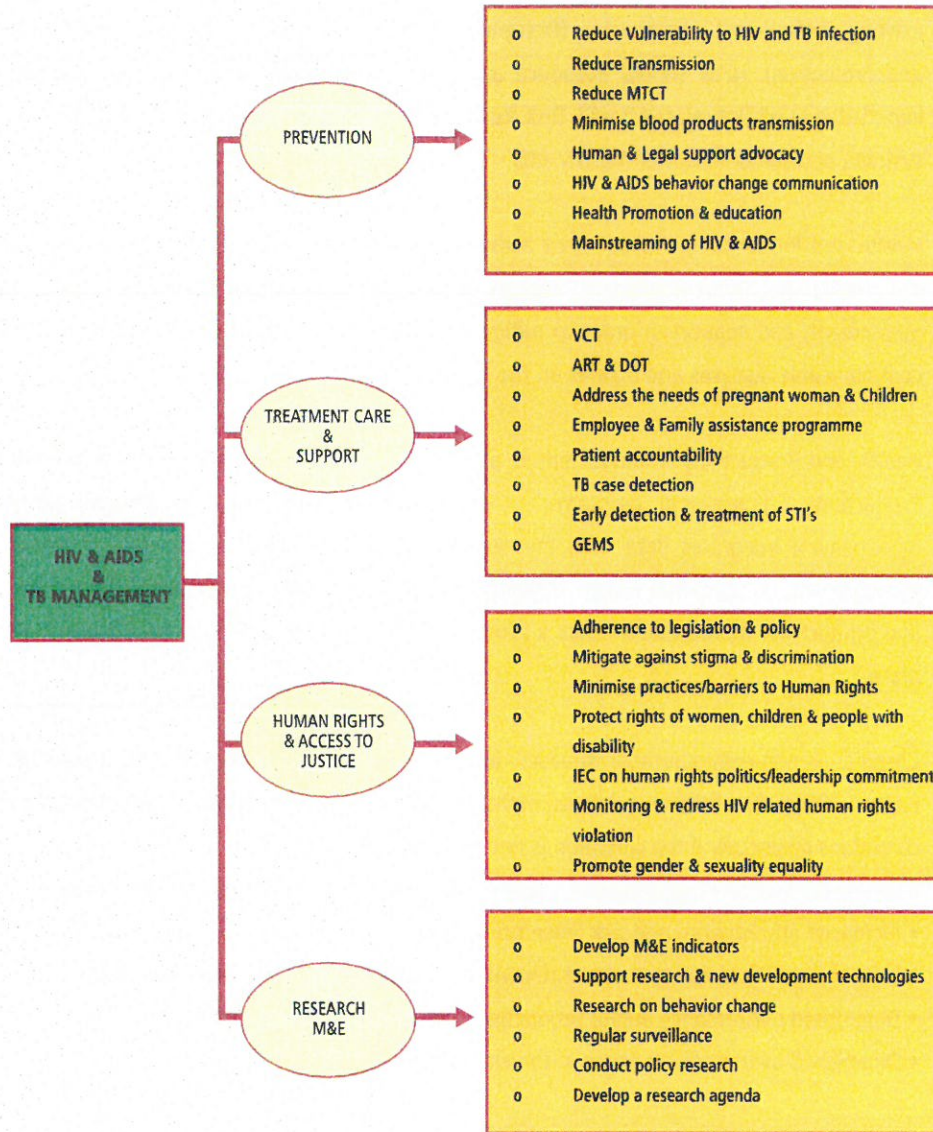


Figure 4: Framework for operationalising PILLAR 1: HIV and AIDS & TB Management





3.2 PILLAR 2: HEALTH AND PRODUCTIVITY MANAGEMENT (HPM)

Health and Productivity Management (HPM) in the work place is defined as “the integrated management of health risks for chronic illness, occupational injuries & diseases, mental diseases and disability to reduce employees’ total health-related costs, including direct medical expenditures, unnecessary absence from work, and lost performance at work - also known as “presenteeism.” in the Public Service world of work. HPM is also meant to strengthen and improve the efficiency of existing services and infrastructure (Occupational Health Services, Occupational Health Education and Promotion). HPM should introduce additional interventions based on recent advances in knowledge in HP (Integrated Health Risk Assessment and Management IT Systems with, classification systems, occupational cancer registry, etc)

Health and Productivity Management activities are convergent efforts to promote and maintain the general health of employees through prevention, intervention, awareness, education, risk assessment, and support in order to mitigate the impact and effect of communicable and non-communicable diseases and injuries on the productivity and quality of life of individuals.

Health and Productivity Management is also often known as: Care management, Health and Productivity Management programs, or disease self-management. Health and productivity management integrates data from the domains of health promotion, disease prevention, care management, occupational health, disability management, and organizational dynamics. Health and productivity management offers a process through PILIR to managed healthcare in the work place.

Chronic, or non-communicable diseases, account for three out of five deaths worldwide (WHO Report, 2005). The following effects might be characteristic of employees suffering from chronic conditions (especially if the condition is not well controlled):

- Increased medical costs (hospitalization, medicine usage, and other healthcare costs);
- Increased absenteeism and sick leave utilization;
- Loss of experience due to early retirement and/or premature death due to ill health;
- Diminished performance and/or productivity due to physical incapability; and
- Diminished overall effectiveness of the employee.

Formal disease management programmes driven by the Employee Health and Wellness programme should be in place for the management of all non-communicable and communicable diseases (the latter includes HIV&AIDS) in the workplace.



As already alluded to above this pillar consist of the following four sub-objectives:

- *Disease Management*
- *Mental Health and Productivity Management*
- *Injury On Duty & Incapacity due to Ill-Health*
- *Occupational Health Education and Promotion.*

Each of the above-mentioned sub-objectives consists of constituent components which form the essence of the relevant focus areas and is illustrated in Figure 4. Each sub-objective will have critical success factors and proposed activities which will be included in the Generic Implementation Plan (Annexure A).

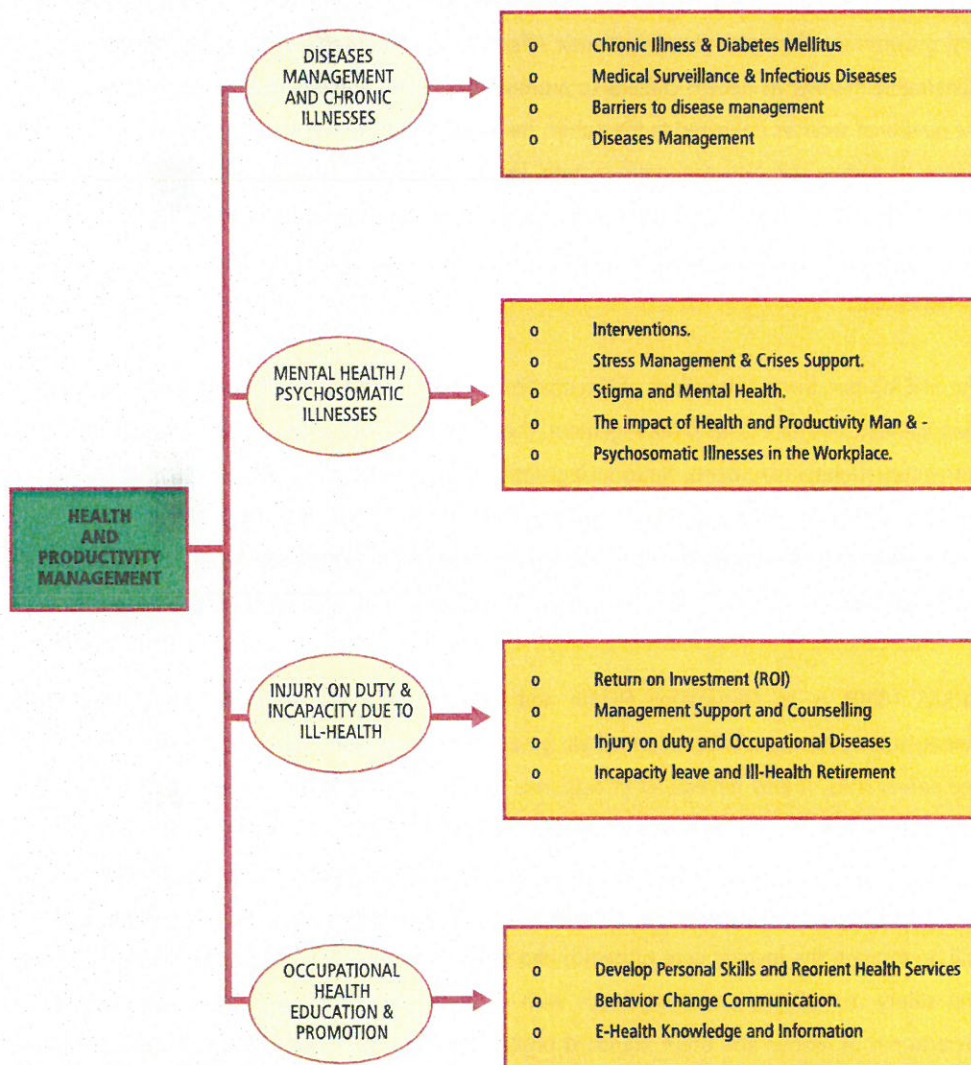


Figure 5: Framework for operationalising PILLAR 2: Health and Productivity Management





3.3 PILLAR 3: SHERQ MANAGEMENT (Safety, Health, Environment, Risk, and Quality)

New developments in Governance indicate that juristic persons like government department and other private sector companies are integral to wellbeing of individuals and their families. There is international consensus that issues of Safety, Health, Environment, Risk and Quality are issues that must be addressed as governance issues. The EH&WSF affirms through this pillar the strategic importance of SHERQ in enhancing governance of government departments in general and improvement of public servants health and wellness in particular.

This SHERQ pillar provides for increased responsibility of political and executive leadership to ensure that government department conduct their affairs in an accountable, responsible, transparent and sustainable manner as decent citizens to promote the health and wellness of their employees and the quality of services delivered to the public, the sustainability of the environment for the long term effects of adding value to economic growth. Implementation of both the intangible and tangible aspects of SHERQ are to be implemented by guided by human rights culture that impacts on health environment and also the practice of quantitative measurements sciences applied in risk and quality management.

The SHERQ has three sub pillars of Occupational Health and Safety Management, Environment Management and Risk Quality Management. These sub pillars are to be implemented in compliance with international instruments, National legislation, National policies and other strategic documents mentioned that form the legal and policy framework for EH&W. The implementation will be in accordance with the standards identified by the international Organisation of Standards OHSAS 18001 for OHS, ISO 14001 for Environmental Management, ISO 9001 for Quality Management.

OHSAS 18001 is an Occupation Health and Safety Assessment Series for health and safety management systems. It is intended to help government departments to control occupational health and safety risks. It was developed in response to widespread demand for a recognized standard against which to be certified and assessed. The sub pillar of occupational health and safety is meant to ensure occupational health and safety, (occupational hygiene included) based on risks and hazards identified, programmes to mitigate against and control of these risks. Its implementation will be through the involvement of health and safety representatives and establishment of health and safety committees and compliance with occupational health and safety standards set by department of labour and other standard organisation and the South African Bauer of Standard (SABS) in line with the principle of tripatism.



ISO 14001 basically establishes a co-coordinated and formal framework of controls with which to manage environmental protection. It is an internationally accepted standard for an Environmental Management System, specifying requirements for establishing an environmental policy, determining environmental aspects and impacts of products, activities and services. It requires that environmental objectives and measurable targets are planned and that defined programs are implemented to meet the objectives and targets.

With respect to EH&W in particular the environmental pillar seeks to ensure that optimal architectural, special facility designs and internal working environment designs for optimal health, safety and productivity of public servants and safety of citizens. In so far as it is possible natural eco-friendly systems of lighting, ventilation and sanitation should be used to mitigate against environmental hazards and risks related with the use of machinery.

Special facilities for designated groups like women, children and people living with disability should be specifically included in workplace and architectural designs e.g. breast feeding and child care facilities. Other facilities for physical wellness e.g. canteens, gyms and organisational wellness e.g. counselling rooms, boardroom and adequate office space should also be catered for.

The ISO 9001 standard provides a framework around which a quality management system can effectively be implemented and focus on the process model as a system platform with continual improvement being the driving force to enhance customer satisfaction. This standard gives new opportunities for government departments to use the quality management system as a strategic tool which can help them to exceed "compliance to requirements" and move towards public service excellence in general and EH&W in particular.

This sub pillar of SHERQ provides for assessment of risks and attainment of good quality of products and services, and the implementation of processes to manage risks, quality through establish disciplines that include but not limited to disasters management, implementation of emergency preparedness plans and others guided by relevant standards.

In line with all the standards and guideline related to this the SHERQ pillar should be implemented include the provisions of ILO Convention 187 of 2006. This promotional framework provides for:

- the development of national policy on occupational safety and health and the working environment developed in accordance with the principles of Article 4 of the Occupational Safety and Health Convention, 1981 (No. 155). For EH&W SHERQ pillar this will also include environment risk and quality management.
- The development of national system for occupational safety and health or national system i.e. infrastructure which provides the main framework for implementing the national policy and national programmes on occupational safety and health. For EH&W SHERQ pillar this will also include environment risk and quality management.



- national programme on occupational safety and health or national programme which is a national programme that includes objectives to be achieved in a predetermined time frame, priorities and means of action formulated to improve occupational safety and health, and means to assess progress. For EH&W SHERQ pillar this will also include environment risk and quality management.
- a national preventative safety and health culture which is a culture in which the right to a safe and healthy working environment is respected at all levels, where government, employers and workers actively participate in securing a safe and healthy working environment through a system of defined rights, responsibilities and duties, and where the principle of prevention is accorded the highest priority. For EH&W SHERQ pillar this will also include environment risk and quality management.

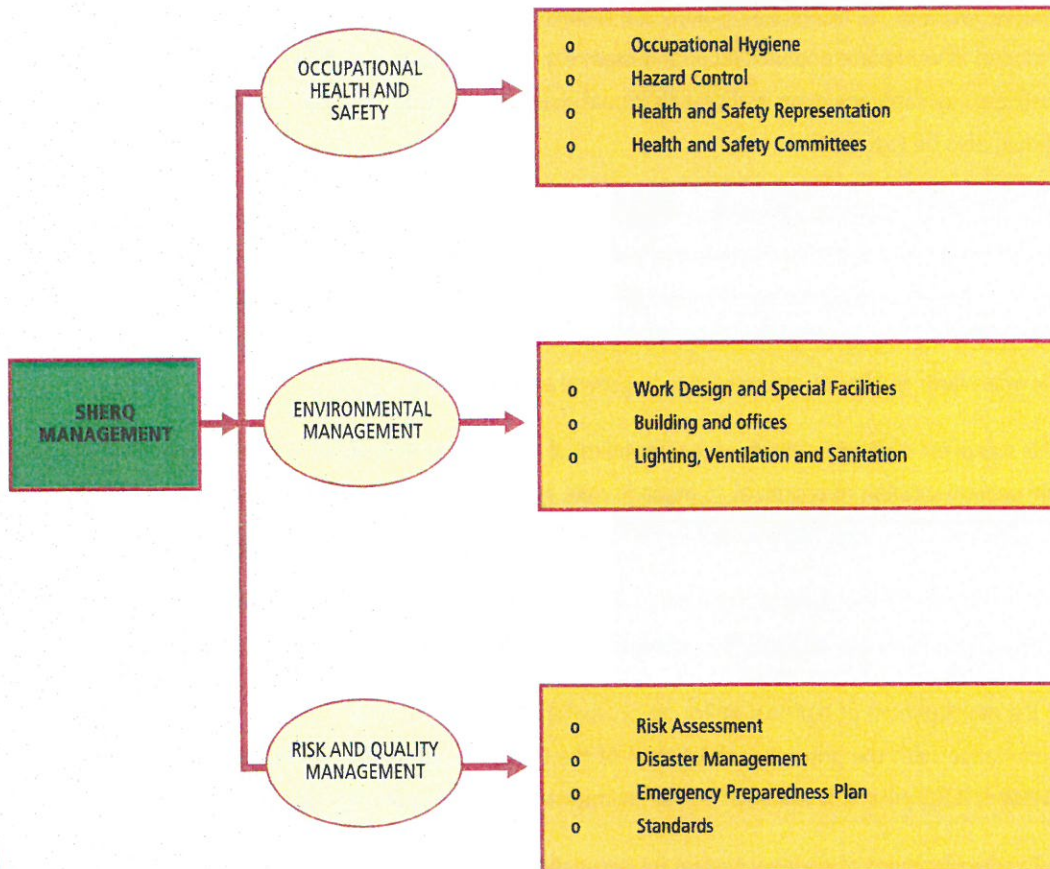


Figure 6: Framework for operationalising PILLAR 3: SHERQ



3.4 PILLAR 4: WELLNESS MANAGEMENT

Individual and organisational wellness is represented by this pillar. Individual wellness is the promotion of the physical, social, emotional, occupational, spiritual, and intellectual wellness of individuals. This is attained by creating an organisational climate and culture that is conducive to wellness and comprehensive identification of psycho-social health risk. Evidence-based practices could also be used to ensure individual and organizational wellness in the Public Service.

Organisational wellness promotes an organizational culture that is conducive to individual and organizational wellness and work-life balance in order to enhance the effectiveness and efficiency of the Public Service. The intended outcome of wellness management is to maximise and sustain the potential of human capital and an effective and efficient Public Service that is positively responsive to the needs of the public.

Wellness Management emerged as a priority due to increasing recognition that the health, safety and wellness of employees directly impact on the productivity of the entire organization. As employees are the life-blood of the organization it is vital to help them produce at their optimum levels. Both personal and workplace factors influence overall wellness and employee performance.

Wellness is regarded as the optimal state of the health of individuals and groups of individuals with two main focal points of concerns, namely: the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfilment of one's role expectations in the family, community, place of worship, workplace and other settings

The Workplace Wellness Management programme grew out of the Employee Assistance Programmes (EAP) and Work-Life Balance Programmes. Historically the EAP mainly supported individual wellness, through counselling and such educational efforts as stress management, managing change, and other wellness promotion strategies. The Work- Life Balance Program promotes flexibility in the workplace to accommodate work, personal and family needs; which can result in benefits to organizations due to higher levels of employee satisfaction and motivation.

Wellness Management strives to meet the health and wellness needs of the Public Servants through preventative and curative measures by customizing those aspects from traditional programmes such as EAP, Work life Balance and, Wellness Management programmes that are most relevant and fit the uniqueness of the Public Service and its mandate.





As already alluded to above, this pillar consists of the following four sub-objectives:

- Individual Wellness(Physical Wellness)
- Individual Wellness (Psycho-Social Issues: Social, Emotional, Spiritual, Intellectual and Financial/ Economical Wellness)
- Organizational Wellness
- Work Life Balance

Each of the above-mentioned sub-objectives consists of constituent components which form the essence of the relevant focus areas and is illustrated in Figure 4. Each sub-objective will have critical success factors and proposed activities which will be included in the Generic Implementation Plan (Annexure A).

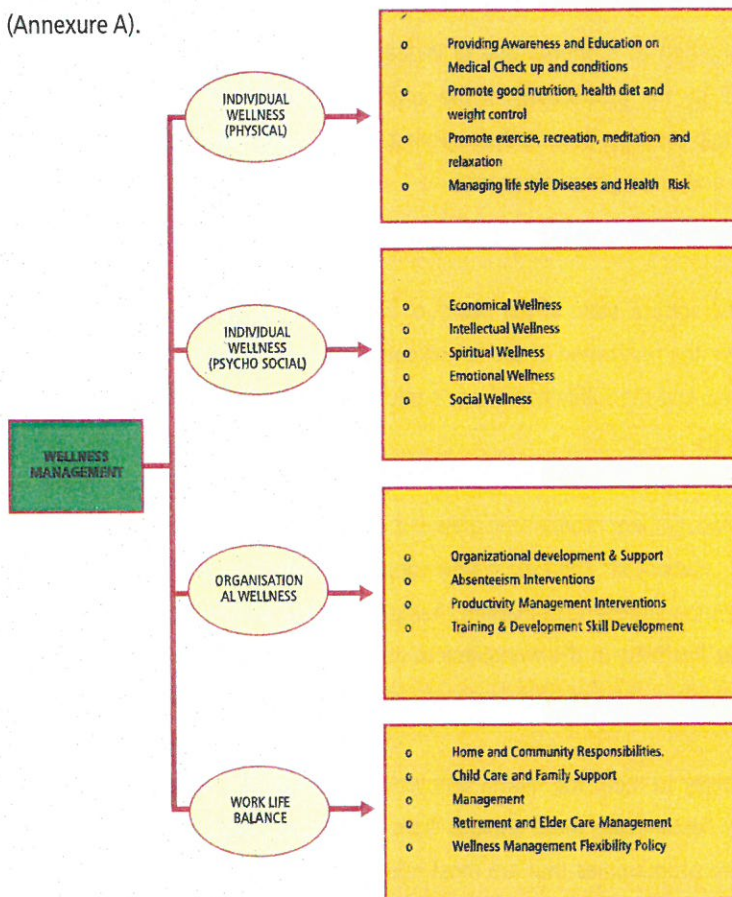


Figure 7: Framework for operationalising PILLAR 4: Wellness Management



SECTION 4: KEY INITIATIVES TO ENSURE IMPLEMENTATION OF THE FRAMEWORK

As the South African Public Sector shifts towards results-based programming, the Framework is a strategic means to incorporate the integration of employee health and wellness perspectives into Government's National Programme of Action. This framework thus advocates that integrating employee health and wellness considerations in the National Plan of Action and the government-wide results-based system are mutually reinforcing processes.

The Implementation of the EH&W Strategic framework will be realised through development and implementation of specific policies, programs, and monitoring and evaluation plans to ensure optimal health and wellness of government employees.

The main tools for the implementation of the Employee Health and Wellness Strategic Framework are as follows:

- Policies
- Generic Implementation Plan
- An Implementation Step-by-step Guide (Policies, Protocols, Standards, Handbooks etc)
- An Annual Implementation Plan (with operational plans for EH&W programmes)
- A Monitoring and Evaluation Framework, plan, and tools to provide public service organisations with the opportunity to report on progress in implementation at the Steering Committee meeting (Meso, Micro, Macro levels)
- An Annual Employee Health and Wellness Indaba (both provincially and nationally) to track Progress on Implementation
- An Annual Performance Progress Report

Implementation Strategy for the EH&W Strategic Framework

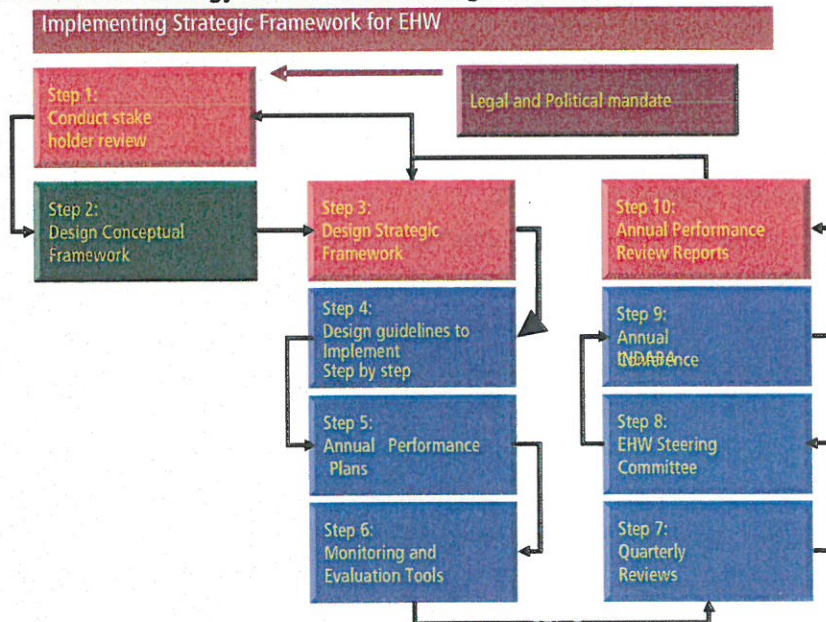


Figure 8: Implementation Strategy for the EH&W Strategic Framework





The above figure represents the steps that need to be taken to implement the EH&W strategy and is further explained below. The approach taken in promoting implementation success is one that seeks to ensure that there is a balanced application of support with the promotion of accountability through monitoring and evaluation. In the end, successful implementation is the reward for good governance at all levels.

4.1 STEPS FOR IMPLEMENTING EH&W STRATEGIC FRAMEWORK

STEP 1: Conduct Stakeholder Review

- Investigation of international and local best practices
- Obtaining inputs from internal and external stakeholders
- Review specific areas of focus
- Alignment with international instruments; legislation and other relevant policies

STEP 2: Design the Conceptual Framework

- Alignment of international instruments; legislation and other relevant policies to the local needs as reflected in surveys, research, situational analysis, reports etc.
- Obtain inputs from a diverse sectors, professions, institutions, stakeholders, practitioners, policymakers, researchers
- The design must be responsive to the environmental needs and follow a logical framework to yield objectives, implementation guides, and M&E tools
- Follow a consultative process with stakeholders and through a review of international and local best practices

STEP 3: Design the Strategic Framework

- Consists of a logical framework with set objectives, success indicators, activities and resources needed for implementation
- Forged partnerships with relevant stakeholders to design an integrated framework.
- Conduct workshops with national and provincial government departments, as well as the private sector and experts in the relevant field to discuss and adapt the framework according to latest developments in the field
- Communication and alignment with best practice and evidence derived from research
- EH&W framework informs formulation of objectives and sub-objectives, which can be used as a basis of planning and strategic action.
- In turn this should be monitored and evaluated to demonstrate effectiveness and evidence of impact through improved individual wellness, organisational wellness and improved service delivery.



STEP 4: Design step-by-step Guidelines for Implementation

Step-by-step guidelines for each of the strategic objectives must be developed. These guidelines will give detailed direction for implementation and will seek to provide background information and references, implementation ideas and best practice suggestions related to each strategic objective of the EH&W framework.

The central theory of implementation is the logical frame of implementation of policies, programmes, projects inherent in the results-based model of management. This implies dividing programme components in manageable short term medium term and long-term stages of implementation.

These components of implementation include: inputs (all resources, human, financial, material, and time) that are necessary to implement all activities and processes that are meant to ensure short term and intermediate effects like outputs and outcomes of programmes. All these are done for the purpose of determining long term effects in the form of changes in the population of interest.

It could be designed as an easy reference handbook, electronic device, Policies, Protocols, Standards, Handbooks etc that will provide the EH&W practitioners with guidelines to successfully implement the framework. The implementation guidelines could also be designed as an activity workbook or workshop manual, which has established interventions and consultative processes for developing and implementing EH&W strategies within the respective departments. This will be designed on an ongoing basis by DPSA in consultation with line departments and other stakeholders based on results-based management model.

STEP 5: Annual Performance Plans

Every EH&W unit has a responsibility to ensure that annual performance plans are developed, which are aligned with the PMDS, which clearly indicates the work that is done in EH&W and the progress made. Such plans must be based on this EH&W Strategic framework, line department's strategic and operational plans, as well as the skills development plans. These must also be expressed in the form of the results based management model. An important element in the feedback loop of organisational management involves monitoring and evaluation outcomes and impact as measured against strategic and operational plans and annual performance plans indicating inputs and processes invested in various EH&W programmes.

STEP 6: Develop a Monitoring and Evaluation Framework

The DPSA EH&W component is responsible for the designing of a Monitoring and Evaluation Framework to measure the progress made with the implementation of the EH&W framework. This also is based on the theoretical base of a results based logical framework for management. The implementation of the M&E framework will be through the





12 components of an effective M&E system for EH&W. Implementation success will be gauged through monitoring and evaluation processes that are linked to continuous feedback, and adds value through support for taking corrective measures and sharing lessons learnt. The key channel of monitoring, inputs, outputs and processes, will be quarterly and annual consultative meetings among stakeholders and with the respective departments to discuss progress and challenges, and to collectively seek solutions that could work. Evaluation will in so far as possible be conducted by outside stakeholders for purposes of measuring outcomes and impact of the EH&W interventions.

STEP 7: Quarterly Reviews

Regular reviews of progress on EH&W programmes should be conducted. These EH&W reviews will be conducted quarterly with all departments. These reviews will inform implementation, monitoring and what future evaluation studies should be conducted for future planning. The quarterly reviews will mostly focus on building an effective M&E system, and those aspects of monitoring related to measurements of data reflecting inputs and related outputs and processes.

STEP 8: EH&W Steering Committee

The dpsa has established Steering Committees for all components of Human Resource Management and Development, including EH&W, which have quarterly meetings. These are at provincial and national levels. The Steering Committee is a vehicle of coordination, communication, collaboration, consultation, which seeks to establish harmonised communication of the EH&W Framework; build commitment for its implementation and create avenues through which collaborative initiatives can be forged. Senior managers and EH&W practitioners are the representatives on the Steering Committees.

Through the Steering Committee the following could be achieved:

- Draw lessons from policy implementation, monitoring and evaluation
- Asses the impact of EH&W on the ongoing transformation of the Public Service
- Consistent measurement of the impact of EH&W on productivity of the Public Service
- The dpsa must be seen as a strategic overall coordinating partner in the efforts of Departments to address strategic and EH&W related issues.
- A communication strategy must be undertaken in Provinces and in the Departments, in Directorates and in Institutions as well as with stakeholders and supporters to ensure that information is cascaded to all levels.

STEP 9: Annual Employee Health and Wellness indaba (conference)

The annual EH&W Indaba's also serve as forums for coordination, communication, collaboration, consultation on matters of EH&W in the Public Service. Further more it is also a forum where



monitoring and evaluation of the implementation of EH&W policies is deliberated on, policy analysis studies are presented, new developments based on cutting edge research, legislative and policy gaps are assessed and new ways of improving EH&W policies and programmes are addressed annually. It also creates an opportunity for departments and stakeholders to participate and share best practices in the field.

STEP 10: Annual Performance Review Report

An Annual Performance Review Report will be created from reports of the Indaba, Quarterly reviews, Quarterly Steering Committee meetings, Monitoring and Evaluation reports, as well as individual departmental progress reports. The combined EH&W Annual Performance Review Report will form the basis for future planning and implementation. It will also be a vehicle account to oversight structures like Cabinet, Portfolio Committee on Public Service and Administration, Public Service Commission and any other relevant oversight structure regarding issues of EH&W in the Public Service.

4.2 ORGANISATIONAL STRUCTURE FOR IMPLEMENTATION OF EH&W STRATEGIC FRAMEWORK

To further support and streamline the implementation an organisational structure is proposed in Figure 8 for facilitating implementation of the framework. The structure reflects the key pillars of the framework, and outlines the drivers of implementation at the National, Provincial, Departmental and Institutional levels. The key features of the structure are as follows:

- It details the continuity of implementation between different levels of Government
- It depicts the requirements for "top down" and "bottom up" engagements
- It notes the necessity of defining responsibilities and outcomes at each level
- It highlights the need to customise strategic provisions with contextual and organisational circumstances
- It places in its relative institutional role the institutions, programmes and processes which constitute the field of practice for EH&W

Responsibilities and engagements are defined at the macro, Meso and micro levels – or at National, Provincial and Departmental levels. The aim here is to highlight the role at each level and to note the relationship to existing policy frameworks and structures at these respective levels.

Figure 8 essentially maps the core considerations for the effective governance of the implementation process for the EH&W Strategic Framework. Of critical importance here are the responsibilities to be undertaken at each level of Government and the importance of managing implementation within existing policy frameworks and institutional arrangements.



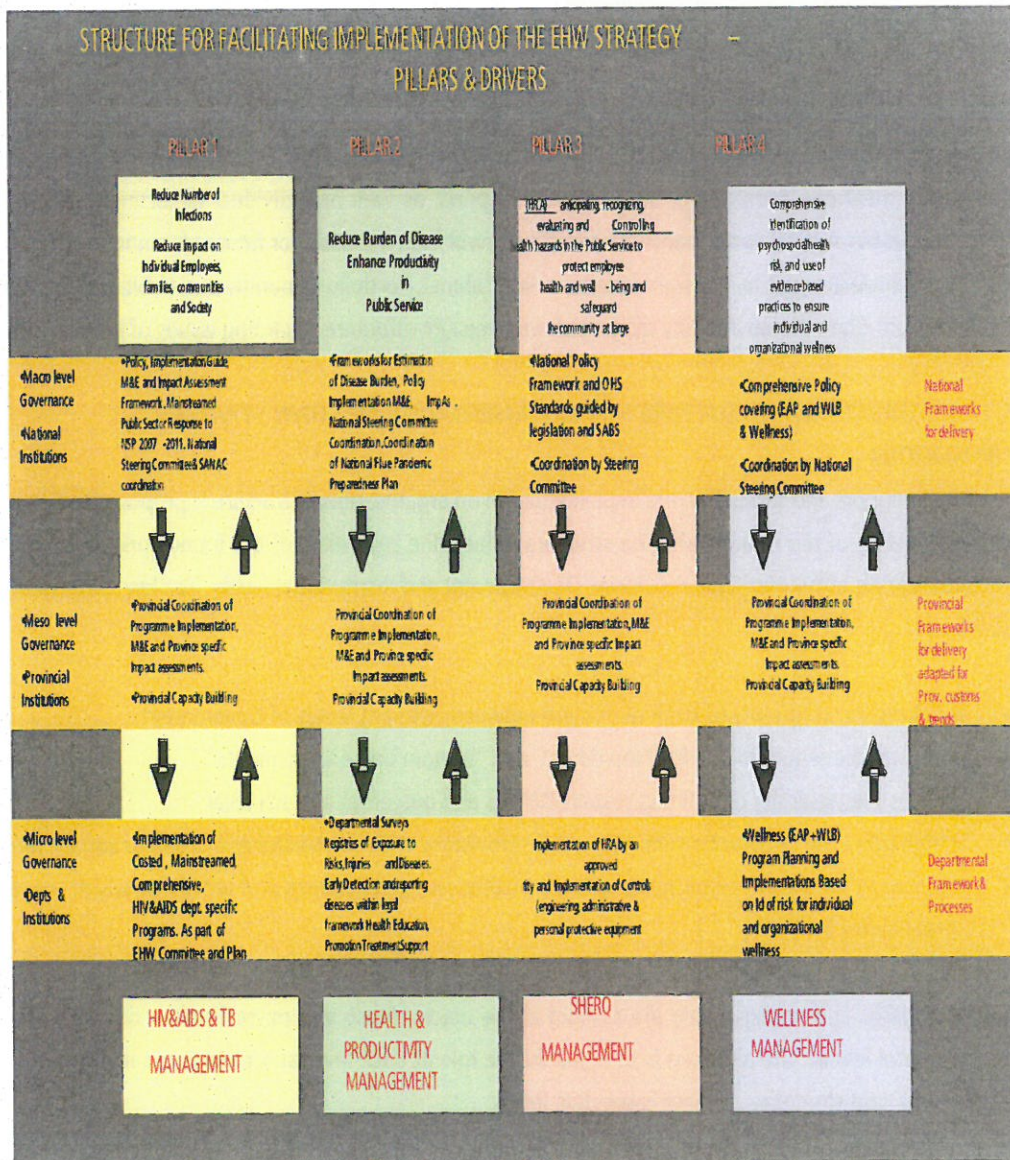


Figure 9: Implementation Structure for EH&W Strategic Framework



SECTION 5: GENERIC IMPLEMENTATION PLAN, RESULT-BASED MODEL & MONITORING AND EVALUATION SYSTEM

The Generic Implementation plan for EH&W is the alignment of the logical framework commonly used in policy, programme and project management (inherent in the result-based model) and the 12 components of an effective M&E system and the organisational structure for implementation of the EH&W as described in paragraph 4.2. An effective, efficient and implementable monitoring and evaluation system is required if this Public Service Strategy is to be successful in measuring achievements of EH&W Strategic Framework objectives. Such a system must align M&E interventions at the micro, meso level of governance as indicated in figure 8. Departments would be expected to develop indicators as appropriate for micro and meso levels of governance. The implementation of this framework will follow the result-base model described in paragraph 5.2. The organisational structure for M&E is the same as the organisational structure for implementation of the EH&W Strategic Framework. M&E data generated at all levels should in so far as possible be used at the level at which it is collected.

Monitoring is viewed as routine, daily assessment of ongoing activities and progress; whilst evaluation is seen as the episodic assessment of overall achievements. Of importance are the core components and identification of indicators. The 12 Components of an effective EH&W M&E System will be operationalised through the Steering Committees at different levels as indicated in Figure 8 above.

In an environment where departments struggle with maintaining commitment to the EH&W programme, reporting, monitoring and evaluation fulfill a more basic function of determining whether EH&W policies and programmes are being implemented at all. Monitoring and evaluation have a significant role to play in any EH&W intervention as it assists in assessing whether a programme is appropriate; cost effective and meeting the set objectives. The basic components that should be included in the EH&W M&E System are indicated in Figure 9 below.

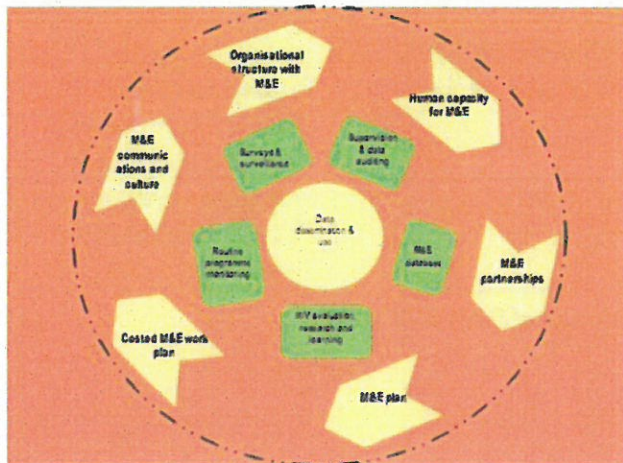


Figure 10: Twelve Components of an effective EH&W M&E System



The outer ring in Figure 9 (12 M&E components) represents the human resources, partnerships and planning to support data collection and data use. It includes individuals, analyzing of data, functions/actions, and the culture that are fundamental to improving and sustaining M&E system performance. The middle ring focuses on the mechanisms through which data are collected, verified, and transformed into useful information. The centre of the diagram represents the central purpose of the M&E system: using data for decision-making. These 12 components are linked to the Generic Implementation Plan and will be operationalised as stated in Table 3 below.

Component levels	Components	Linkages with Generic Implementation Plan (GIP)
People, partnerships and planning	<ol style="list-style-type: none"> 1. Organisational structures with EH&W M&E functions 2. Human capacity for EH&W M&E 3. Partnerships to plan, coordinate, and manage the M&E system 4. National multi-sectoral EH&W M&E plan 5. Annual costed national EH&W M&E work plan 6. Advocacy, communications, and culture for EH&W M&E 	Meso, Micro, and Macro levels should work together in a coordinated way to ensure appropriate human capacity, partnerships, annual planning according to the GIP
Collecting, verifying, and Analyzing data	<ol style="list-style-type: none"> 7. Routine EH&W programme monitoring 8. Surveys and surveillance 9. National and sub-national EH&W Databases 10. Supportive supervision and data auditing 11. EH&W evaluation and research 	Stakeholders should ensure that all data processes and practices are in place to produce data that is valid, reliable, has integrity, and is precise
Using data for decision-making	<ol style="list-style-type: none"> 12. Data dissemination and use 	Data collected must inform policy formulation and program operations at different levels. Data should be used at level of generation

Table 3: Operationalising of 12 Components of EH&W M&E System



The 12 components described above are not 12 steps intended to be implemented sequentially; rather, these 12 components all need to be present and work to an acceptable standard for the national M&E system to function effectively. Departments may need to focus on a few of the components at the outset, building the system up over time. Not all components need to be implemented at all levels of the system; what is relevant at the national level, for example, may not be relevant at the service delivery level.

5.2 Results-based Model (RB-M)

The Results-based Model (RB-M) is well known in government departments and is the basis of the implementation of most policies and by implication Strategic Frameworks and M&E Tools. It is a model through which the EH&W M&E System will produce M&E data with specific indicators.

- In developing and implementing a monitoring and evaluation (M&E) framework appropriate indicators should be identified.
- An indicator is a variable that measures one aspect of a program/project
- An appropriate set of indicators includes at least one indicator per significant element of the program or project (input, output/ process, outcome and/or impact). These indicators are identified and categorised in the Generic Implementation Plan (5.3 Annexure A).

Indicators should not just measure inputs and processes but also outcomes and impact. Thus, the Results-based Model (RB-M) could be used to identify indicators as set out below in Figure 10.

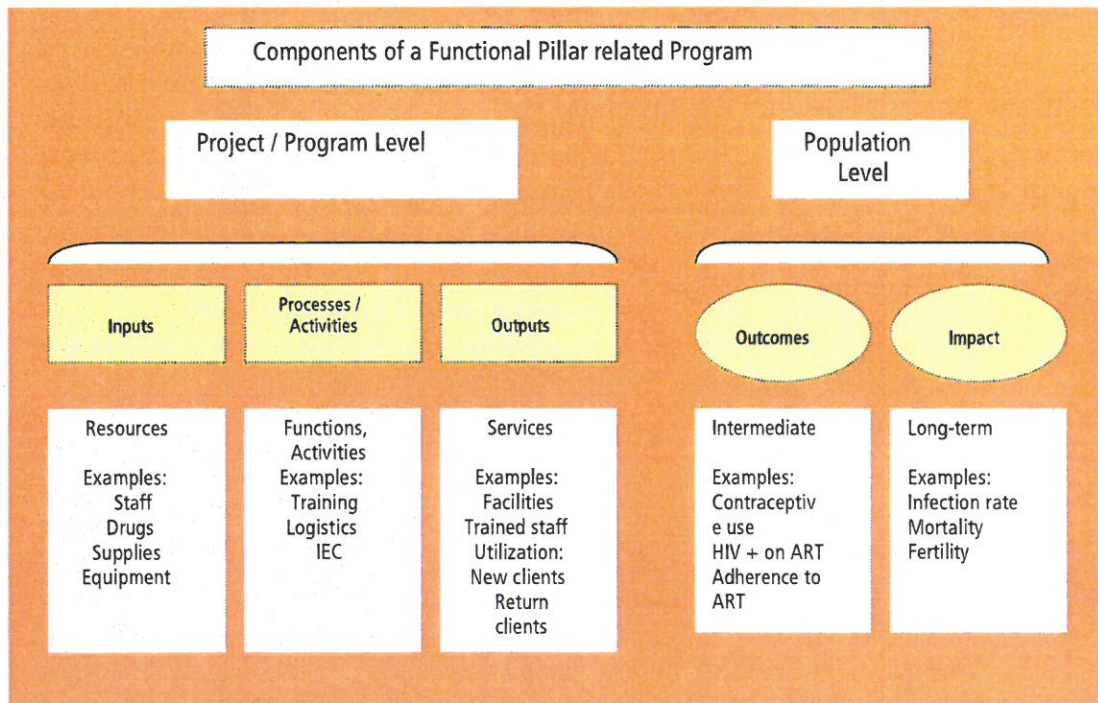


Figure 11: Results-based Model (RB-M)





3.3 GENERIC IMPLEMENTATION PLAN FOR EMPLOYEE HEALTH AND WELLNESS

(ANNEXURE A):

Based on the concepts and principles set forth in the EH&W Strategic Framework, a generic outline of a EH&W Implementation Plan is presented in this section of the document to provide guidance to government departments. However, this implementation plan will be further developed to include all process and functional pillars in a Comprehensive Generic Implementation Plan that will be attached to the EH&W policies. Clear guidelines for implementation will be provided.

AREA OF PRESENTATION	INTENT AND DESCRIPTION
1. Strategic Objective	The strategic objectives are the objectives noted to represent each pillar of the strategy as presented in the conceptual framework diagram. There are four strategic objectives – one to represent each pillar of the strategy. The strategic objective is identified on the outline of each sub-objective. The impact indicators will be measure of attainment of the strategic objectives
2. Sub-objective	Each pillar of the strategy is divided into the interventions or initiatives which are embodied in that pillar. Each intervention or initiative is presented as a sub-objective. These sub-objectives are the focal points of the strategic framework and the basis of the activities to be undertaken. The sub-objectives are analysed and presented to ensure that the practical implications of each is clear. The output indicators will be measures of attainment of the sub-objectives
3. Success Indicators	Success indicators are the performance expectations for each sub-objective. They seek to identify exactly what outcomes are expected as a result of the intervention made. Input indicators are a measure of the resources required for all processes, activities, outcomes, processes envisaged.

Table: 4 Outline of a generic implementation plan





The Strategic Objectives of the EH&W Strategic Framework, with their related sub-objectives and success indicators are outlined in the following matrices:

Strategic Objective 1: HIV and AIDS & TB Management		
To mitigate the impact of the HIV&AIDS and TB epidemic and improvement of Public Service delivery to reduce the number of infections and the impact on individual employees, families, communities and society (Impact to be measured)		
Strategic Objective 1 To mitigate the impact of the HIV&AIDS and TB epidemic and improvement of Public Service delivery to reduce the number of infections and the impact on individual employees, families, communities and society.	Sub-Objective 1.1 (Output indicators)	Success Indicators (Outcomes indicators)
	1.1 To provide prevention Programmes.	<ul style="list-style-type: none"> • Reduced Vulnerability to HIV and TB infection • Reduced sexual transmission of HIV and new TB infection cases • Reduced MTCT of HIV • Minimised blood products transmission • Human & Legal support advocacy implemented • Improved HIV & AIDS behavior change communication • Increased Health Promotion & education • Mainstreaming of HIV & AIDS • TB infection control programmes implemented • Early detection and treatment of STI
	Activities for Strategic Objective 1.1 (Basis for process indicators as indicated in R- B Model)	
	1.1.1	Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty; Accelerate programmes to empower women and educate men and women, (including the boy and girl child), on human rights in general and women's rights in particular; Develop and implement strategies to address gender based violence; Create an enabling environment for HIV testing; Build and maintain leadership from all sectors of society to promote and support (The NSP goals); Support national efforts to strengthen social cohesion in communities and support the institution of the family; Build AIDS competent communities through tailored competency processes.
	1.1.2	Strengthen behaviour change programmes, interventions and curricula for the prevention of sexual transmission of HIV customised for different groups with a focus on those more vulnerable to and at higher risk of HIV infection.
	1.1.3	Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services; Develop a comprehensive package that promotes male sexual health; develop and integrate interventions for reducing recreational drug use in young people with HIV prevention efforts; increase the accessibility and availability of comprehensive sexual assault care including PEP and p sychosocial support.





<p>Strategic Objective 1 To mitigate the impact of the HIV&AIDS and TB epidemic and improvement of Public Service delivery to reduce the number of infections and the impact on individual employees, families, communities and society.</p>	<p>Sub-Objective 1.2 (Output indicators)</p>	<p>Success Indicators (Outcomes indicators)</p>
	<p>1.2 To provide TREATMENT CARE AND SUPPORT</p>	<ul style="list-style-type: none"> • Increased VCT coverage • Increased ART & DOTS coverage • Addressed needs of pregnant woman & Children • Employee & Family assistance programme implemented • Treatment adherence counselling <ul style="list-style-type: none"> • Patient accountability increased • TB prophylaxis, TB screening, TB and STI case detection and treatment improved and defaulter rate reduced • GEMS disease management Programmes accessed early in the disease process
	<p>Activities for Sub-Objective 1.2 Basis for process indicators as indicated in R- B Model)</p>	
	<p>1.2.1 Create a referral mechanism with VCT providers; Recruit and train peer counselors and ensure confidentiality; Train VCT staff on pre- and post-test counselling. Promote uptake of VCT; Promote on-site or off-site VCT supported by consistent supplies of testing materials and information on test protocols; Provide space for workplace counselling and testing, and ensure that counselling is always provided; Assure privacy and confidentiality.</p>	
	<p>1.2.2 Encourage support for people living with or affected by HIV and AIDS; Encourage early enrolment with GEMS through wellness programmes; Ensure increased number of early enrolment with disease management programmes.</p>	
	<p>1.2.3 Support DOT and treatment adherence; Increase access to VCT through workplaces and trade unions; Investigate community based VCT strategies (outside of health facilities) For continuum of care, special and unmet needs.</p>	
<p>1.2.4 Increase the number of employees who have never had an HIV test with focus on men; Increase the number of employees tested in the last 12 months; Increase the proportion of newly HIV positive diagnosed employees.</p>		





<p>Strategic Objective 1 To mitigate the impact of the HIV&AIDS and TB epidemic and improvement of Public Service delivery to reduce the number of infections and the impact on individual employees, families, communities and society.</p>	Sub-Objective 1.3 (Output indicators)	Success Indicators (Outcomes indicators)
	1.3 To promote HUMAN RIGHTS AND ACCESS TO JUSTICE.	<ul style="list-style-type: none"> • Adherence to legislation & policy • Stigma & discrimination mitigated • Minimised practices/barriers to Human Rights • Protected rights of women, children & people with disability • IEC on human rights politics/leadership commitment demonstrated • Monitoring & redress HIV and TB related human rights violations • Gender & sexuality equality promoted
	<p>Activities for Sub-Objective 1.3 (Basis for process indicators as indicated in R- BModel)</p>	
	<p>1.3.1 Develop a national framework on HIV and AIDS in the Workplace; Revise the DOL Code of Good Practice on HIV and AIDS and Employment; Assist SMEs to implement workplace policies; Ensure protection of rights of casual, contract and/or poorly organised (such as domestic workers); Ensure protection of rights of employees expressly excluded from the ambit of labour legislation; Develop and distribute human rights guidelines and information on: Voluntary HIV testing and disclosure.</p>	
	<p>1.3.2 Develop and disseminate information on HIV prevention, treatment and support that responds to the special needs of: sex workers children and adults with disabilities, Drug users, Prisoners, MSM, gay and lesbian people, Orphans and vulnerable children (including children in self-care) Refugees, undocumented migrants and immigrants Older persons; Monitor HIV-related human rights violations and develop enforcement mechanisms for redress; Establish and offer training programmes to PLWHAs in all districts on HIV treatment and prevention literacy, and on human rights and the law</p>	
<p>1.3.3 Develop mainstreamed HR policies that address barriers to human rights Conduct campaigns to promote human rights; Design and implement competency audits of current HIV and AIDS staff; Protect rights of women, children & people with disability; IEC on human rights politics/leadership commitment; Monitoring & redress HIV related human rights violation; Promote gender & sexuality equality; Mitigate against stigma & discrimination</p>		





Strategic Objective 1
To mitigate the impact of the HIV&A infections and the impact on individual employees, families, IDS and TB epidemic and improvement of Public Service delivery to reduce the number of communities and society.

<p>1.1 To promote the conduct of RESEARCH, MONITORING AND EVALUATION.</p>	<ul style="list-style-type: none"> • M&E indicators developed and reporting regularly done • Research & new development technologies supported • Research on behavior change conducted • Regular surveillance conducted • Policy research conducted • Developed research agenda • Know Your Epidemic and Mode of Transmission Studies conducted and or reports used to inform prevention programmes
<p>Activities for Sub-Objective 1.4 (Basis for process indicators as indicated in R- B Model)</p>	
<p>1.1.1</p>	<p>Develop an M&E system ; Provide training on M&E system for departmental officials; Develop Intervention strategies to support departments which face challenges; Put in place Mechanisms to share lessons learnt and best practice; Use M&E data to identify the barriers to implementation of the HIV and AIDS framework; Support and monitor research to develop and implement HIV prevention technologies; Keep records of the results of the periodic evaluations; Establish, implement and maintain procedures for dealing with actual and potential nonconformities and for taking corrective action and preventive action.</p>
<p>1.1.2</p>	<p>The department shall investigate nonconformities, determine their causes and take actions in order to avoid their recurrence; The department shall evaluate the need for actions to prevent nonconformities and implement appropriate actions designed to avoid their occurrence; The department shall record the results of corrective actions and preventive actions taken; Review the effectiveness of corrective actions and preventive actions taken; The department shall ensure that internal audits of the HIV and AIDS management system are conducted at planned intervals in order to determine whether the HIV and AIDS management.</p>
<p>1.1.3</p>	<p>System conforms to planned procedures for HIV and AIDS management including the requirements of this standard, and has been properly implemented and is maintained.</p>
<p>1.1.4</p>	<p>The DPSA in consultation with SITA, GEMS, PILIR and external experts investigates the accessibility of relevant data; The DPSA in consultation with relevant internal and external experts develop guidelines and SOPs pertaining to data inputs and collection, the assimilating of information, and reporting mechanisms; DPSA in conjunction with SITA (and external experts) develop guidelines for an integrated operational information management system that includes security directives; DPSA in conjunction with SITA (and external data warehousing experts) develops a suitable data warehousing methodology to assimilate information throughout the HIV and AIDS function, in order to ensure a standardised, updated data warehouse.</p>
<p>1.1.5</p>	<p>The HIV and AIDS steering committee in departments establishes a sub-committee to oversee and monitor activities related to the information management system. Each department by means of the HIV and AIDS sub-committee and all relevant stakeholders develop a customised implementation plan and action plan for the development of an integrated information system. Action plans should include information management SOPs, and budgets as well as roles and responsibilities of relevant stakeholders Communication to executive management regarding the benefits and reporting schedules of the integrated HIV and AIDS; information management system.</p>
<p>1.1.6</p>	<p>To develop a research agenda (Support research & new development technologies, Research on behavior change, Conduct policy research).</p>
<p>1.1.7</p>	<p>To conduct regular surveillance.</p>





Strategic Objective 2: Health and Productivity Management		
To manage communicable and non-communicable diseases, mental health /psychosomatic illnesses, injury on duty and incapacity due to ill health and occupational health education and promotion in order to enhance productivity (impact to be measured)		
Strategic Objective 2 To manage communicable and non-communicable diseases, mental health /psychosomatic illnesses, injury on duty and incapacity due to ill health and occupational health education and promotion in order to enhance productivity	Sub-Objective 2.1 (Output indicators)	Success Indicators (Outcomes indicators)
	2.1 To promote diseases and chronic illnesses management.	<ul style="list-style-type: none"> Departments have conducted awareness programmes and employees use disease management programmes Departmental Health and Productivity Management policy developed in all departments Co-operation between specialists, general practitioners and patients are achieved to reduce barriers of disease management at the work place Structures are established for disease management and behaviour change communication Chronic Illnesses management is improved and the impact can be seen in employee health; stress levels; turnover; conflict; absenteeism; and organizational culture Strategies are implemented to prevent the risk of employees contracting infectious diseases Comprehensive risk assessment which covers prevention, control, protection, monitoring and health surveillance conducted Awareness programmes on the functions and purpose of health surveillance and the relevant laws and regulations conducted
	Activities for Strategic Objective 2.1 (Basis for process indicators as indicated in R-B Model)	
	2.1.1	Development of a Health and Productivity Management Policy; Compile an operational plan for the roll out of comprehensive disease management package in the workplace: Ensure disease management awareness programmes to staff and training of all managers regarding disease management.
	2.1.2	Promote co-operation between general practitioners and patients; Provide funding; education materials and management support.
	2.1.3	Develop programmes for effective communication; knowledge of disease management; attitude and behaviour change; advocacy; reducing of stigma and discrimination; care and support of vulnerable employees.
	2.1.4	Develop programmes for improvement of employee health; reduction of workforce turn over; improving employee decision making ability; reducing organisational conflict and absenteeism.
	2.1.5	Identify, assess and control the risk to employees of infectious diseases in the workplace; provide suitable information and training in the avoidance of risk, including work methods, use of equipment and hygiene; advise members that they are entitled to withdraw their labour in order to protect themselves.
2.1.6	Assessing workers Health; conduct tests, surveys, other investigations; and monitoring sicknesses; voluntary programmes and inspections	





Strategic Objective 2

To manage communicable and non-communicable diseases, mental health /psychosomatic illnesses, injury on duty and incapacity due to ill health and occupational health education

Sub-Objective 2.2 (Output indicators)	Success Indicators (Outcomes indicators)
<p>2.2 To promote the management of Mental health and psychosomatic illnesses:</p> <ul style="list-style-type: none"> • Interventions. • Stress Management & Crises Support • Stigma and Mental Health • The impact of Health and Productivity Man & Psychosomatic Illnesses 	<ul style="list-style-type: none"> • A Toolkit is developed and implemented for Mental Health Promotion in the workplace which looks at practical steps for addressing mental health • The impact of programmes that reduce the psychosocial and physical demands of the work place that trigger stress are measured • Plans to create a low stress public service are developed and implemented • Increased number of public servants who are not stigmatized and disadvantaged, who will be able to manage their lives effectively and who are able to sustain positive relationships with others • Interventions are made to involve groups of employees that are formed based on person-environment relationships, and which contribute to the generation or reduction of psychosomatic disorders
<p>Activities for Sub-Objective 2.2 (Basis for process indicators as indicated in R-B Model)</p>	
2.2.1	Develop programmes which recognise mental health needs; Raise awareness of self and other mental wellbeing; identify and address factors affecting mental health in the workplace; Provide support options which are confidential and non-Stigmatizing.
2.2.2	Develop programmes that reduce depression and anxiety; reduce general mental distress symptoms; deal with post traumatic distress: have a balanced approach to addressing work stress.
2.2.3	Identify the causes of stress and take steps to remove; develop a stress management approach; reduce toxin intake; explore and use relaxation.
2.2.4	Develop programmes that promote a culture of respect and dignity; train staff to be sensitive to mental distress; encourage awareness of mental issues; make employees aware of the danger signs and understand the importance of seeking help early; Make sure that no one is refused employment on the grounds of mental illness.
2.2.5	Take safety precautions: ensuring the safety of self and others; ensuring privacy, but ask one or two individuals to stay for support and safety; calling emergency services immediately if unsure of course of action; Giving background information to police and ambulance services; Involving Security until emergency services arrive.
2.2.6	Alter working conditions so that they are less stressful or more conducive to effective coping; Help individuals with coping strategies for conditions that are impossible or difficult to change; Identify stressful relationships between individual or group and the work setting; Teach coping strategies for individuals who share common coping deficits; Include individual counselling services for employees.





Strategic Objective 2 To manage communicable and non-communicable diseases, mental health /psychosomatic illnesses, injury on duty and incapacity due to ill health and occupational health education and promotion in order to enhance productivity	Sub-Objective 2.3 (Output indicators)	Success Indicators (Outcomes indicators)
	To manage injury on duty and incapacity due to ill health <ul style="list-style-type: none"> • Injury on duty and Occupational Diseases • Incapacity leave and Ill-Health Retirement • Return on Investment (ROI) • Management Support and Counselling 	<ul style="list-style-type: none"> • A system to manage employee conditional leave and investigate the application with the assistance of a Health Risk Manager, in terms of PILIR is implemented • A process to report any injuries sustained by workers in the workplace is established • Programme to establish a supportive environment is created through a champion to assist departments and to improve productivity, increase morale • Reduction of on the job accidents and injuries and retained employees • Procedures are established for protecting employees, as well as complying with the law • Counselling and support services are established • Return on investment (ROI) best practice is used to develop cost effective health care programmes
	Activities for Sub-Objective 2.3 (Basis for process indicators as indicated in R-B Model)	
	3.3.1	Implement a system to manage injury on duty and incapacity due to ill health; Assist the employee to complete ILL Health retirement specific forms if necessary; Granting injury on duty leave according to COIDA.
	3.3.2	Treat injuries immediately if serious refer to hospital; investigate accidents or exposure and institute remedial measures to prevent similar incidents; Ongoing education on reporting of injuries and illnesses.
	3.3.3	Ensure that targeted employees must attend training on Health Management Programmes and provide support to employees who truly need such support through EH&W programmes.
	3.3.4	Take firm action and disciplinary action where health issues are abused. Have onsite Assistance; counselling; critical incident response; Workshops; seminars; Professional Supervision/Mentoring/Coaching; EAP programmes.
3.3.5	Implement programmes to identify hazards; Decide who might be harmed and how; Evaluate the risk and decide on precautions; Record findings and implement them; review assessments and update if necessary.	





<p>Strategic Objective 2</p> <p>To manage communicable and non-communicable diseases, mental health /psychosomatic illnesses, injury on duty and incapacity due to ill health and occupational health education and promotion in order to enhance productivity</p>	<p>Sub-Objective 2.4 (Output indicators)</p> <p>To promote occupational health education and promotion</p> <ul style="list-style-type: none"> • Develop Personal Skills and Reorient Health Services • Behavior Change Communication. • E-Health Knowledge and Information Management. 	<p>Success Indicators (Outcomes indicators)</p> <ul style="list-style-type: none"> • The impact of health policies and health systems on public health practice and on broad, population-based health outcomes within a historical, political and economic framework is evaluated • Occupational Health standards are developed, and monitored for, to ensure continuous improvement • Technology is used to engage employees in managing their health, accessing quality and pricing information, and changing behaviour • Health education and promotion programmes for employees to exercise more control over their own health and over their environments, and to make choices conducive to health. • Health Services are shared among individuals, community groups, health professionals, health service institutions and governments • Systems are strengthened for workplace learning in health management





<p>Strategic Objective 2</p> <p>To manage communicable and non-communicable diseases, mental health /psychosomatic illnesses, injury on duty and incapacity due to ill health and occupational health education and promotion in order to enhance productivity</p>	<p>Activities for Sub-Objective 2.4</p> <p>(Basis for process indicators as indicated in R-B Model)</p>
	<p>2.4.1 Evaluate the impact of health policies and health systems on health Practices; implement and manage public health systems; advocate for policy environmental change</p>
	<p>2.4.2 Apply fundamentals of budgeting and financial management to government health services facilities: carry out leadership and management roles in health services organisations such as public health departments, health care facilities etc.</p>
	<p>2.4.3 Develop strategic management plans for public health and health services organisations that balance competing and conflicting interests as well as factors beyond managerial control</p>
	<p>2.4.4 Understand the legal ethical and cultural environments in which health systems operate and identify and apply the essential components for the provision and management of health services for a defined population</p>
	<p>2.4.5 Apply evidence-based principles of community assessment, mobilization, engagement and advocacy to the management of local health services and Public health organizations.</p>
	<p>2.4.6 Identify risk management and safety priorities at the workplace: develop, and maintain effective and effective and efficient processes for the management, and investigation of serious incidents</p>
	<p>2.4.7 Ensure that there is a consistent approach to reporting and investigating incidents, not forgetting the values, Ethics and Professional Code of Practice; Prepare quarterly and annual Audits for the Department; Manage the budget</p>
	<p>2.4.8 Develop communications department and an employee safety communication strategy; Ensure that all stakeholders are informed of relevant health managing policies planning frameworks and implementation guidelines; Ensure all employees have sufficient knowledge and understanding of the learning networks</p>
	<p>2.4.9 Address the gap between existing and necessary skills and capacity to fulfill identified roles and functions; engage in identifying training needs; build on making effective use of the knowledge and skills that participants bring to the training situation; drive methodologies by both content and outcome that are to be achieved.</p>
	<p>2.4.10 Embracing and expanding mandate which is sensitive and respects cultural needs; support the needs of individuals and communities for healthier life; increasingly in a health promotion direction that is beyond providing for clinical and curative services.</p>
<p>2.4.11 Improving the quality of health management in the work place; Upgrading national training capabilities in health management and finance ; Providing access to online medical resources and Internet-based tools; develop workshops on leadership development management strategies on issues relating to health care; harmonise all stakeholders for the attainment of objectives of certain developmental imperatives</p>	
<p>2.4.11 Improving the quality of health management in the work place; Upgrading national training capabilities in health management and finance ; Providing access to online medical resources and Internet-based tools; develop workshops on leadership development management strategies on issues relating to health care; harmonise all stakeholders for the attainment of objectives of certain developmental imperatives</p>	





Strategic Objective 3: SHERQ Management		
To ensure Public Service to be a healthy and safe work environment (Impact indicator)		
Strategic Objective 3: To ensure Public Service to be a healthy and safe work environment	Sub-Objective 3.1 (Output indicators)	Success Indicators (Outcomes indicators)
		3.1 To provide Occupational Health and Safety management
Activities for Strategic Objective 3.1 (Basis for process indicators as indicated in R-B Model)		
3.1.1 Establish an Occupational Health and Safety team and Engage an agronomist or an equivalent practitioner		
3.1.2 Develop, maintain and update an anthropometric data base (Maintain South African Standards e.g. SA Military Standards, International Documentation for Standard e.g. International Standard Organization 7250)		
3.1.3 Design Biomechanics Assessments (Use Ergonomics); Use Biomechanics measurements to determine physical work performance tolerance; Set accommodation and accessibility standards for individuals using mobility aids		
3.1.4 Ergonomics & Accidents (Conduct regular accident prevalence and incidence Conduct investigations whenever accident prevalence and incidence increases)		





Strategic Objective 3: To ensure Public Service to be a healthy and safe work environment	Sub-Objective 3.2 (Output indicators)	Success Indicators (Outcomes indicators)
	3.2 To provide Environmental Management	<ul style="list-style-type: none"> • A policy for Workplace Design and Special Facilities developed and implemented • Developed appropriate work place design for individual comfort and organisational productivity • Developed and implemented appropriate Ergonomic Program which will yield productivity in the workplace • Improved attention and effective and good quality work is evident in maximised productivity and individual comfort and safety • Promote Work Life Balance and individual wellness programmes are implemented
	Activities for Sub-Objective 3.2 (Basis for process indicators as indicated in R-B Model)	
	3.2.1 Design of Machines, interfaces of control rooms, and Standard Operational Procedures etc (Document the task of the operators of equipment; Fit task to human and not human to task; Workplace strategies should be developed; Effectiveness of the work environment should be constantly monitored)	
	3.2.2 Computerisation and use of visual displays (Use of visual displays for people with visual disability; Conduct ergonomics program for appropriate ergonomic prescriptions for computerised systems)	
	3.3.3 Visual Abilities and optimal acuity (Identify user population; Design for functional comfort and ease; Design appropriate rest pauses during a work period)	
3.3.4 Worker Capability, Work appropriateness and Balance (Use standards and other verified scientific information and ergonomics data; Building standards and facility planning standards should be developed and maintained; Furniture standards for office, office support and amenity spaces, adapting as needed to site-specific furniture inventory)		
Strategic Objective 3: To ensure Public Service to be a healthy and safe work environment	Sub-Objective 3.3 (Output indicators)	Success Indicators (Outcomes indicators)
	3.3 To provide Risk and Quality Assurance Management	<p>Health risk assessment plan with clear objectives to guide assessment processes is in place</p> <ul style="list-style-type: none"> • Developed interventions for disaster management • Developed Post Disaster Recovery Plan <p>Produce annually a Disaster Management Analysis report. A Disaster Preparedness Plan is accessible and available</p>
	Activities for Sub-Objective 3.3 (Basis for process indicators as indicated in R-B Model)	
	3.3.1 Health Risk Assessment design and planning (Identify the hazards; Determine harm and damage; Evaluate the risks and decide on precaution; Record your findings and implement them; Review your assessment and update if necessary)	
	3.3.2 Hazard Identification (Conduct "Walk through" Survey; Consult with workers; Measure possible hazards; Identify effects of hazards on employees)	
	3.3.3 Hazards Analysis and Evaluation (Analyse health risks; Measure number of exposed employees; Record effects of current control measures and personal protective equipment; Risk rating: To be performed by an occupational Hygienist)	
3.3.4 To control effects of hazards in the workplace (Demarcate enclose and isolate dangerous work areas; Minimise hazardous substances and their source, and Substitute toxic substances with less toxic ones; Improve ventilation and extract fumes and vapours; Modify working environment through engineering, maintenance of machines)		





Strategic Objective 4: Wellness Management		
To provide individual wellness and organizational wellness and to improve work life balance (Impact indicator)		
Strategic Objective 4 To provide individual wellness and organizational wellness and to improve work life balance	Sub-objectives (Output indicators)	Success Indicators (Outcomes indicators)
	4.1 To promote Individual Physical Wellness of Employees in order to promote fitness and healthy lifestyle	<ul style="list-style-type: none"> Established and quality assured fitness, exercise, and recreation facilities and programs that shows a high utilisation rate. Increased access to centralised wellness centres as negotiated by different provincial departments Management awareness and education programs are in place for nutrition, weight control, medical check-up, life style and chronic diseases Established database that indicate Public servants with lower stress levels; better focus; less accidents and less absenteeism Systems are in place for dissemination of medical information electronically and in print to all employees
Activities for Strategic Objective 4.1 (Basis for process indicators as indicated in R-B Model)		
4.1.1 Establish facilities such as communal lounges, canteens, gyms, wellness centres which offers a variety of health and wellness programmes such as aerobic classes, and work-based sport and fitness activities		
4.1.2 Invite health professionals such as dieticians, nurses, doctors to wellness days to provide Information and education on health and wellness issues		
4.1.3 Provide education, awareness, and prevention programmes		





Strategic Objective 4 To provide individual wellness and organizational wellness and to improve work life balance	Sub-Objective 4.2 (Output indicators)	Success Indicators (Outcomes indicators)
	4.2 To promote the management of Individual Psychosocial wellness	<ul style="list-style-type: none"> Preventative and curative programmes for managing emotional wellness are in place to enhance emotional intelligence, self-esteem, optimism, sense of coherence, and resilience of employees Programmes are established to promote social, financial, and spiritual wellness Continuous professional development programmes that encourages studying and reading are developed Electronic information about learning opportunities and programmes are easily available and accessible A monitoring system is implemented that shows that debt rate in the Public Service is decreasing
	Activities for Sub-Objective 4.2 (Basis for process indicators as indicated in R-B Model)	
	4.2.1 Develop self-development skills programmes such as effective listening, communication, conflict management, financial and debt management	
	4.2.2 Develop and implement curative programmes such as stress management; grief counselling, trauma defusing and trauma debriefing, fear management skills; depression and anxiety	
	4.2.3 Establish an internal/ outsourced, or combination model counselling service with referral systems and ongoing training	
	4.2.4 Develop and establish crisis management committees, training of marshals, and first aid kit management	
	4.2.5 Develop and implement effective workplace prevention programmes and policies for violence, substance abuse, values and belief systems, professional development	
	4.2.6 Develop and implement effective workplace prevention programmes and policies for violence, substance abuse, values and belief systems, professional development	
	4.2.7 Develop systems and ensure that electronic information about psycho-social wellness are easily available and accessible	





Strategic Objective 4 To provide individual wellness and organizational wellness and to improve work life balance	Sub-Objective 4.3 (Output indicators)	Success Indicators (Outcomes indicators)
	4.3 To promote the organisational culture that is conducive to individual and organisational wellness in order to enhance the effectiveness and efficiency of the Public Service	<ul style="list-style-type: none"> Prevention, education and awareness productivity management and organisational development programmes and policies are in place
	Activities for Sub-Objective 4.3 (Basis for process indicators as indicated in R-B Model)	
	4.3.1 Develop and implement Productivity Management; Absenteeism & Presenteeism Management Programmes	
	4.3.2 Prevention programmes to deal with burnout, stress, discrimination, victimization, harassment, and workplace violence and bullying (Clearly communicate the definition of rights of employees and channels to follow for reporting incidents; Encourage employees to break the silence; Develop complaints procedures; Sensitise managers to the signs of abuse)	
	4.3.3 Develop Organisational Development & Support programmes (working in collaboration with other Functions in the department)	
4.3.4 Develop and implement programmes to train and develop employees and private sectors on organisational development and other relevant current and cross cutting issues regarding Health and Wellness		





<p>Strategic Objective 4 To provide individual wellness and organizational wellness and to improve work life balance</p>	<p>Sub-Objective 4.4 (Output indicators)</p>	<p>Success Indicators Outcomes indicators)</p>
	<p>To promote work-life balance in order to assist employees in meaningful daily achievement and enjoyment in each of the four life quadrants namely work, family, friends, and self.</p> <p>To motivate employees to make use of their gifts, skills and talents in order to gain purpose, enrichment and happiness in life</p>	<ul style="list-style-type: none"> • Flexible Wellness Management Policies are developed and implemented • Implemented support programmes to assist employees in meaningful daily achievement and enjoyment in their work • Developed support programmes to assist employees in their family, friends and community lives and responsibilities • Developed support programmes to assist employees in self development • Developed a culture of acknowledgement and appreciation for hard work; coping strategies to address work over load; • Created a conducive work environment with a prevention-oriented mission at the top and bottom of the organisation and a marketing strategy that promotes work life balance through newsletters, training, educational seminars, and Web resources
	<p>Activities for Sub-Objective 4.4 (Basis for process indicators as indicated in R-B Model)</p>	
	4.4.1 Coordinate training and monitoring of implementation of policy	
	4.4.2 Conduct diagnostic surveys that measure trends in the Public Service (individual, team and organisation)	
	4.4.3 Implement training and development of managers and supervisors in transformation leadership and engagement management	
	4.4.4 Develop Time Management Skills and provide support to employees to balance the demands of their work and personal life	
	4.4.5 Do life skills training programmes like assertiveness and interpersonal Communication.	
	4.4.6 Ensure the training of all staff and managers regarding Quality of work life management in the workplace	
	4.4.7 Encourage supportive supervisory relationships and supportive co-worker relationships through effective communication and support	





<p>Strategic Objective 4 To provide individual wellness and organizational wellness and to improve work life balance</p>	<p>Sub-Objective 4.4 (Output indicators)</p> <p>To promote work-life balance in order to assist employees in meaningful daily achievement and enjoyment in each of the four life quadrants namely work, family, friends, and self.</p> <p>To motivate employees to make use of their gifts, skills and talents in order to gain purpose, enrichment and happiness in life</p>	<p>Success Indicators Outcomes indicators)</p> <ul style="list-style-type: none"> • Flexible Wellness Management Policies are developed and implemented • Implemented support programmes to assist employees in meaningful daily achievement and enjoyment in their work • Developed support programmes to assist employees in their family, friends and community lives and responsibilities • Developed support programmes to assist employees in self development • Developed a culture of acknowledgement and appreciation for hard work; coping strategies to address work over load; • Created a conducive work environment with a prevention-oriented mission at the top and bottom of the organisation and a marketing strategy that promotes work life balance through newsletters, training, educational seminars, and Web resources
	<p>Activities for Sub-Objective 4.4 (Basis for process indicators as indicated in R-B Model)</p>	
	<p>4.4.1 Coordinate training and monitoring of implementation of policy</p>	
	<p>4.4.2 Conduct diagnostic surveys that measure trends in the Public Service (individual, team and organisation)</p>	
	<p>4.4.3 Implement training and development of managers and supervisors in transformation leadership and engagement management</p>	
	<p>4.4.4 Develop Time Management Skills and provide support to employees to balance the demands of their work and personal life</p>	
	<p>4.4.5 Do life skills training programmes like assertiveness and interpersonal Communication.</p>	
	<p>4.4.6 Ensure the training of all staff and managers regarding Quality of work life management in the workplace</p>	
	<p>4.4.7 Encourage supportive supervisory relationships and supportive co-worker relationships through effective communication and support</p>	





SECTION 6: CONCLUSION

6.1 SUMMARY STATEMENT

The intended EH&W Strategic Framework for the Public Service as outlined herein is presented as the basis upon which all Health and Wellness practitioners in various roles can promote a common vision and strategic thrust. It is presented here as a platform for a cohesive and concerted effort, and as a call to action for all those whose role may contribute to the transformation of the Public Service through building capability and capacity. Ultimately, the Framework must be effective, not in meeting technical targets, but building more elaborate delivery systems, ensuring enhanced performance and service delivery, which ensures people, are well served with humility, integrity and professionalism, secures the attainment of the welfare of individuals and their communities.

The EH&W Strategic Framework for the Public Service is presented as a statement of the manner in which the DPSA intends to manage and support the continued refinement of EH&W in the Public Service. The framework seeks to build on the gains of the past, confront the issues which currently affect our performance and lay the cornerstones of a new future for EH&W in the Public Service.

The framework offers a menu of EH&W functions, which cover health, safety, and wellness issues for the individual as well as for the organisation. It is challenging and motivates the public service to think in an integrated and pro-active way. It combines already existing thinking, practices, and services and thus urges a change in mindset. It shows that issues of EH&W went through a process of evolution from a narrowly focused support program to a holistic EH&W field.

Notwithstanding, these ideas are the considerations which will take us forward into a more responsive and performance oriented EH&W Public Service. These are the ideas that will add the most value to our current operations and practise in EH&W and these are the ideas which have the highest potential for making the most significant difference in the shortest time. Time is of the essence and demands and expectations are great.

We believe that the framework is responsive to our current circumstances because it was formulated based on latest research and input from stakeholders, and moved from the Management of HIV and AIDS in the workplace 2002-2006 to an Integrated EH&W in 2008 and beyond. We hope that the focus and content of the framework duly reflects the input and priorities expressed by stakeholders and participants in the review process. We hope that practitioners and stakeholders in EH&W see the strategic framework as a mandate that they have crafted to seek their interest as professionals and advance the cause of EH&W in the Public Service as a viable field of practice. The goal, eventually, is healthy, dedicated employees; safe and healthy organisation enhanced performance and improved service delivery. We hope that the strategic framework puts EH&W in the forefront as a measure which will, in the end, ensure the realisation of the Public Service envisioned in the Constitution

6.2 ACKNOWLEDGEMENTS

The design and development of the Strategic Framework for EH&W in the Public Service would not have been possible without the sincere and detailed constitution and comments provided by stakeholders and by members of the EH&W community in the Public Service and in the private sector.

It is not possible to honour here the richness of the ideas shared and the importance of contributions made.

The quality of the contributions made is indicative of a future of accomplishment in EH&W that is truly transformational. We wish to recognize the institutions and individuals who have been part of the process of engagement for the development of the EH&W Strategic Framework.

Because of the number of people and institutions who have participated in the process, we are unable to always provide the names of participants. However, we wish to note that we have thoroughly reviewed your input and your individual contributions have been invaluable.

