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ORIGINAL ARTICLE

The role of motivation in the initiation and maintening mentoring relationships among nurses and midwives

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Abstract

Aim: To understand clinicians' motivations to engage in mentoring to support newly graduated nurses and midwives working in hospital settings.

Background: Nursing and midwifery literature has established the benefits of mentoring and challenges that affect the effectiveness of formal mentoring programmes. No studies have explored hospital nurses' and midwives' motivations to mentor in the absence of the obligatory status and associated rewards of institutionalised mentoring.

Methods: A qualitative descriptive study with 35 nurses and midwives working in three public hospitals in the western, northern and northwestern parts of Uganda. Data were collected using semistructured interviews. Reflexive thematic analysis was applied to interpret the data. We have adhered to COREQ reporting guidelines.

Results: The study revealed three salient themes that capture nursing and midwifery professionals' mentoring perspectives. Participants expressed confidence in their inherent mentoring capacities and were often motivated by a desire to reciprocate prior mentoring experiences. Their mentoring approaches varied between self-focused and other-focused motivations, with some overlap in perspectives on hierarchical versus relational mentoring. Across the board, there was a strong consensus on the need of mentoring for individual clinicians, healthcare institutions and the broader profession. The study highlights five opportunities that can be harnessed to design future mentoring programmes.

Conclusions: The findings delineate a complex interplay between self-centred and altruistic mentoring motivations, aligning with hierarchical or mutually beneficial mentoring paradigms.

Implications for nursing policy: Nurse managers should tailor mentoring programmes to align with these intrinsic motivations, affirm the enduring need for mentoring, and leverage existing institutional resources to create both acceptable and efficient mentoring frameworks.

KEYWORDS
Hospital nurses and midwives, mentoring beliefs, mentoring need, mentoring opportunities

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INTRODUCTION

The nursing/midwifery workforce faces several challenges: many experienced nurses opt for early retirement, and those who remain often exhibit signs of demoralisation and burnout (World Health Organisation, 2020). New nurses are often overwhelmed by the complexity of clinical practice, heavy workloads, and strained collegial relationships (Hunter & Warren, 2014). This has often resulted in a noticeable trend of new graduates transitioning to other professions or non-clinical roles. These factors can contribute to the high attrition rates observed in hospitals (Jun et al., 2021). These workforce issues affect both the developed and developing countries at varying levels (Australian Institute of Health & Welfare, 2022; Bryant et al., 2022).

Mentoring as a professional development strategy enables workplaces to tap into the expertise of senior clinicians to ease the transition of newly graduated nurses and midwives (Mullen & Klimaitis, 2021). In the fields of nursing and midwifery, mentors are generally experienced clinicians with expertise in their respective areas, while mentees often include nurses and midwives who are either new to clinical practice or re-entering the workforce (Hoover et al., 2020). These mentoring processes result in outcomes related to career development, psychosocial support, and reduced turnover rates (Gayrama-Borines & Coffman, 2021; Horner, 2020). Through mentoring, senior clinicians share their wealth of knowledge, granting novice nurses and midwives invaluable opportunities to enhance their clinical skills. This mentor–mentee dynamic plays a pivotal role in guiding the professional development trajectory of novices (Voss et al., 2022). Furthermore, mentoring relationships also provide a means of psychosocial support to novice nurses to cope with challenges and issues in the workplace.

To enhance the quality of mentoring, hospitals often rely on establishing formal mentoring programmes to recruit and retain nurses/midwives (Djiovanis, 2022; Zhang et al., 2016). Formal mentoring programmes are initiated and supported by the organisation/hospital management processes (Giacumo et al., 2020). The hospital provides the resources necessary to provide instrumental rewards and recognitions as the extrinsic drive to encourage senior clinicians to support new graduates. Previous research has shown that structured mentoring programmes have been used to adapt evidence-based practice, enable skill mix in the management of HIV, and build the resilience of staff nurses (Hoover et al., 2020; Ojemeni et al., 2017). Furthermore, the literature shows that formal mentoring programmes face challenges such as incompatibilities between the mentors and mentees (Kakyo et al., 2022; Wissemann et al., 2022). These incompatibilities have been attributed to differences in personalities, generational gaps and workplace factors, such as mentors and mentees working in different hospital units (Coventry & Hays, 2021; Devey et al., 2020). In addition, workplace challenges such as workload and the lack of time dedicated to mentoring in complex and dynamic clinical environments often affect the mentor's ability to initiate and commit to these mentoring relationships (Rohatinsky et al., 2018).

In health care settings where resources are limited, the implementation of structured mentoring programmes often becomes infeasible. As a result, clinicians are compelled to seek and rely upon informal mentoring relationships to bridge the gap. Informal mentoring relationships arise spontaneously, are organic, self-initiated, and sustained (James et al., 2015). These relationships arise based on a shared need for mentoring, shared goals, and similar personalities (Janssen et al., 2016). Although informal mentoring relationships are the most common supportive workplace relationships, their unstructured nature poses challenges for systematic study, making them difficult to monitor and evaluate (Mohtady et al., 2016). In the absence of instrumental rewards and the presence of workplace challenges, there is a need to understand why nurses and midwives have continued to initiate and engage in mentoring to support newly qualified nurses and midwives in hospital settings. This study seeks to fill the gap in the literature on intrinsic motivations to mentor among nurses/midwives.

The theoretical understanding of the motivations in mentoring has often viewed mentoring as a transactional relationship using the social exchange theory (Majiros, 2013). In other words, nurses/midwives internally evaluate the benefits of engaging in mentoring against the cost before fully committing to mentoring activities. Compared to informal mentoring, formal mentoring programmes provide benefits like protected mentoring time, promotions for senior nurses, and the recruitment of newly graduated nurses and midwives (Wissemann et al., 2022). These benefits have encouraged nurses to engage in mentoring despite the workplace challenges that affect mentoring. When mentoring is informal, such as that happening in resource-limited settings, mentoring activities are not explicitly supported by hospital management (Mohtady et al., 2016). Therefore, nurses and midwives often rely on their intrinsic motivation to mentor and are compelled to look into available opportunities within the hospital setting that can be harnessed to provide support for newly graduated nurses and midwives.

METHODS

Aim

The aim of the study was to understand clinicians' motivations to engage in mentoring to support newly graduated nurses and midwives working in hospital settings. This study is part of a larger study that explores mentoring for nurses and midwives working in hospital settings.

Study design

This study applied a qualitative descriptive study design. This study design enabled the researchers to remain grounded in

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the data (Sandelowski, 2000). We have adhered to COREQ reporting guidelines.

Settings and participants

The study was conducted in hospital settings across Uganda, focusing on nurses and midwives. The participants were recruited from three public hospitals situated in the western, northern and northwestern regions of Uganda. Among these, two served as referral hospitals, while the third functioned as a teaching hospital. All these hospitals were regionally based, situated over 300 km away from Uganda's capital, Kampala. The referral hospitals were comparatively large, with nursing and midwifery staff numbers between 110 and 170 (Department of Human Resource Management, 2021).

Upon obtaining ethics approvals from both institutional and local ethics committees, and permissions from hospital management, poster advertisements were placed on hospital notice boards inviting individuals to participate in the study. Inclusion criteria were self-identification as being in a mentoring relationship or having participated in mentoring activities.

Data collection

Data were collected between June and September 2022 using a semistructured interview guide. The interviews were conducted by the first author, who has previous experience with qualitative studies. Given that the initial literature review did not retrieve mentoring literature from Uganda, the researchers thought it wise to use a vignette in the data collection process (see Figure 1). The vignette provided a brief idea of the phenomenon of mentoring (Erfanian et al., 2020). This was done to distinguish mentoring relationship experiences from other workplace relationships such as workplace friendships or supervisor-subordinate relationships. The interview guide was made up of two sections. The first section was used to obtain information about the demographic characteristics of the participants (Table 1). The subsequent section consisted of questions relating to participants' understanding of the concept of mentoring and how they identified their mentors/mentees, what motivates them to mentor others, how their current mentoring experiences have influenced their decisions to mentor others, and current enablers of mentoring within the hospital. Probing questions were used to moderate the interview and obtain a deeper understanding of their mentoring motivations. The development of the interview guide together with the vignette was informed by literature. Interviews were conducted within the hospital premises in the ward offices or hospital board rooms. Interviews were audio recorded and later transcribed by the first author.

Data analysis

Transcripts were de-identified and imported into Nvivo software for data management and coding. Data were analysed inductively using reflexive thematic analysis to identify themes that were sometimes explicit and other instances latent representations of the data (Braun & Clarke, 2019). Reflexive thematic analysis acknowledges the researcher as an active entity in this process of analysis (Braun & Clarke, 2019). The researcher made the deliberate choice to transcribe the data as opposed to obtaining transcription services. This allowed for the first step in reflexive thematic analysis which is about familiarisation with the data. The subsequent steps in the analysis were about coding. The codes were initially mainly descriptive and later the researcher adapted focused and pattern coding to identify categories and patterns within the data. The emerging codes and patterns in the data were discussed in the team meetings where similar codes were grouped and the codes that were different were split. This iterative process of organising and reorganising continued until subthemes, and overarching themes were derived from the codes as shown in Table 2.

Rigour and trustworthiness

To ensure credibility, the researcher collected the data and transcribed the data herself. The process of data analysis was carried out by the entire research team in which codes were generated by the first author and checked by second and third authors. The process of identifying themes was done in team meetings. The data have been presented with extracts from the data to reflect the consistency between interpretations of the data and the raw data (Guba, 1981). In qualitative research, maintaining a comprehensive audit trail is required to substantiate rigour of the research process (Cypress, 2017). An example of how codes were grouped into categories and then into subthemes and themes is shown in Table 2.

Ethical considerations

The study was approved by the Flinders University Research Ethics Committee (Approval no. 5313). Approval to conduct the study in Uganda was obtained from The AIDS Support Organisation (TASO) Research Ethics Committee (Approval no. TASOREC/056/2021-UG-REC-009 [AMEND]). Permission to access the study participants was obtained from hospital management. Participants were provided with a participant information sheet that contained details of the study. Upon reading the details related to the study, participants provided signed informed consent prior to commencing with the data collection.

FINDINGS

Participant characteristics

The study recruited 35 participants consisting of 10 males and 25 females. Participants had worked in clinical settings for

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The vignette

Asikidi is a senior midwife who doubles as a nurse in-charge of labor ward. Asikidi is a mentor to Kamuli who works on the medical ward. The two met ten years ago when Kamuli was newly employed in the hospital and was doing orientation at Asikidi's ward. Asikidi was impressed by Kamuli's passion to care for the mothers and seemed eager to learn. Kamuli occasionally approached Asikidi for help managing the complex cases as she felt overwhelmed. Kamuli admired Asikidi's midwifery skills and how she kept the ward running as she made midwifery practice seamless. Asikidi likewise learned a lot about evidence-based practice from Kamuli. The two often had brief discussions regarding nursing & midwifery practice, workplace politics, relationships with colleagues and peers. Asikidi felt helpful to Kamuli and always looked forward to their interactions. At the end of the Kamuli's orientation, she moved to the medical ward where she had been posted. Kamuli maintained contact with Asikidi, and they often exchange phone calls. They discussed both personal and professional development issues. Asikidi has recommended Kamuli for many hospital trainings. Kamuli has gone on to further her studies and is now pursuing a postgraduate diploma in health service management. Kamuli is now a mentor to new graduates within the hospital and some of her mentees work in different hospitals. Kamuli has kept in touch with Asikidi, and both feel satisfied that their influence in the nursing and midwifery profession has gone on to generations of new nurses.

FIGURE 1 Showing the vignette used during data collection.

TABLE 1 An extract of the interview guide used during data collection.

Demographic characteristics
Please tell me about yourself.
Gender
Qualification
Type of facility work for
Registration identity
Number of years worked as nurse/midwife.
Previous experience in formal mentoring

Reflecting on a workplace relationship similar to the case of Asikidi and Kamuli (vignette):
Context of mentoring:
From your experience, how would you define mentoring?
What roles do mentors/mentees play?
Mentor identification:
How did the mentoring relationship with your mentor/mentee start?
What motivated you to mentor other nurses/midwives in your workplace?
Mentoring influence
How has your experience of mentoring influenced your future decisions to mentor other nurses/midwives?
Factors for or against mentoring
What factors enabled you to learn most from your mentor in the workplace?
What factors enabled you to provide mentoring activities to nurses/midwives?

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TABLE 2 Showing an example of the coding process.

Quotes from transcripts	Codes	Subthemes	Themes
'You know medicine changes.' P19 'And mentorship I would encourage people should read, you can't be mentoring people what you studied over 10 years back. No, so you should be up-to-date with the new guidelines, new protocols.' P33.	Clinical practice is dynamic and complex	Mentoring for adaptability in clinical setting	The need for mentoring in the clinical settings
'aaah the biggest challenge would be the older generation. These are people who went through the system [clinical practice] before computers were around before internet was prevalent. Now if you are telling them about an online meeting, you have to tell them press [click] here, something you look at as being basic, to them it's not basic at all.' P3	Changes in principle over generations		
'We feel these people [new graduates] coming to the field they are not getting the teachings we got from their tutors; you know also the tutors are dot com generation. Or it is a personal feeling that I cannot work thoroughly. Most times when mentoring you realise there are many gaps from these students, somebody is about to finish school, but they are going out raw; you don't have the basics in nursing.' P17	Changing nursing education trends	The growing importance of mentoring in contemporary nursing	
'But these young ones, they come on duty when they reach here, they tell you sister, let me reach here [going away from workstation], let me do this, they keep on tossing you. And also, you expect them to do the work, at the end of the day they don't do it. You don't know if it's because they don't have the knowledge or skill may be doesn't know the procedure or it's his own attitude, he wants to dodge the work.' P27 'There are things we don't have to do, the professional conduct, the ethics and things we should do more.' P7	Declining professional and ethical standards within the profession		
'You know these days because someone wanted to go for medicine [to be doctor] but their points [high-school scores] are not as high as to secure an admission into medicine. so, the parent says now you go for nursing. Yet their major aim was up in medicine, they will go complete the nursing school, they give them jobs but that is not where wanted to be. For me …wondering why this person behaves like this., Then you realise that for this person, this is not where he belongs. That is not what they wanted. Even after qualifying and after going through all the ethics … they still feel they wanted to be the doctors not the nurses. Especially with the gents[males].' P1	Dwindling passion for the profession		

periods ranging from 3 months to 32 years. This range highlighted a diversity in expertise: 21 participants were senior, with over 5 years of experience, while the remaining 14 had less than 5 years of experience working in hospital settings. Six of the participants had a postgraduate degree, which was either in midwifery and women's health, or critical care nursing. The rest of the participants had a bachelor's degree in nursing or midwifery ($n = 15$), or a diploma in nursing or midwifery ($n = 13$), while one participant had a nursing certificate. Regarding their registration, the majority of the participants were nurses ($n = 20$), while others were midwives ($n = 6$), and others were registered both as a nurse and midwife ($n = 9$). Three themes were identified from the data that represented the nurses' and midwives' motivations to engage in mentoring to support newly graduated nurses and midwives working in hospital settings: beliefs about mentoring, the need for mentoring in clinical settings, and opportunities for mentoring in the workplace.

Beliefs about mentoring

This theme relates to the participants' beliefs about mentoring in clinical settings and consists of seven subthemes: Mentors are born, reciprocating the favour, the focus is on the patient and the community, mentoring for self, there are givers and receivers in mentoring, mutuality and fluidity in mentoring, and organisational responsibility in the initiation and support of mentoring.

Mentors are born

Participants had an interesting belief that *mentors are born*. They used words like 'instinct', 'we have been chosen', 'it's in my nature', 'out- [of the goodness] of the heart', 'calling', and 'heart for it' to describe their innate abilities to mentor others. These beliefs got them through mentoring even without mentorship training and in the absence of external drives to mentor others as participant one states:

> *'I think, mine was an instinct. Once you are already a nurse and a midwife there is that instinct really. I want to see you do it like a nurse. I want to see you do it like a midwife. Aaaaa I think it was just in-built in me that a nurse is supposed to do like this. And I just want to see them moving in the way that.'* (P1, female, postgraduate, senior nurse)

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Reciprocating the favour

Comparatively, mentoring was viewed by many participants as beneficial only to the other. The other was usually the junior staff. To most of the participants ($n = 22$), mentoring was believed to be one of the many ways to aid the transition of novices to ensure the continued growth of the profession. Participants stated that professional standards and ethics could only be taught and maintained through mentoring activities such as role-modelling best standards. Mentoring was a way to correct past wrongs within the profession that impacted the societal image of nursing and midwifery practice. To these participants, at the core of mentoring was the profession. Therefore, it was expected that the nurses and midwives mentor others for the sake of the growth and continuity of the profession as one participant clearly stated: 'Then you put in your mind, these are the future nurses, or these are the future leaders in the time to come like some of us when we retire those ones will be the ones who step in our shoes' (P16, female, diploma, senior nurse). Nurses and midwives in clinical settings see mentoring as a way to *pay it forward*, primarily aiming to support newcomers in the profession. This was specially emphasised by a midwife:

> *'If someone had not mentored me, would I have gone through this system well? You say ok let me also mentor someone, let me also do good to someone, and then as you do it. For the first time, you are doing it because someone mentored you.'* (P3, female, postgraduate, senior nurse and midwife)

The focus is on the patient and the community

More important was the focus on the patient and the larger community from which they hailed. Participants were aware that at the end of the mentoring, the benefits chain was the patient. The patient was the beneficiary of good mentoring practices: 'Because our main core here is to make the patients who are sick to recover; that is the main reason I mentor' (P17, female, diploma, senior nurse), or the victim of bad mentoring: 'They don't do the right thing. Life is going to be lost but you don't know which life is this one [will be]' (P1, female, postgraduate, senior nurse). Mentoring was therefore done to ensure that the patient and general community received the utmost quality of care when they showed up at the hospital because 'a good nurse is one who can offer quality care to the patient' (P29, female, certificate, senior, nurse).

Mentoring for self

Another important belief regarding mentoring held by the participants centred around *mentoring for self*. These nurses and midwives ($n = 15$) saw themselves as the beneficiaries of the outcomes of mentoring. They engaged in mentoring for two reasons. Firstly, because they needed to be mentored: 'For the human being it means you don't know and yet you must know, and you must have someone to guide you so that you know about it' (P33, female, graduate, senior, nurse). Secondly, mentoring was important to protect oneself. They stated their concern:

> *'As I mentioned that at some point you might land in the hands of that person you were supposed to mentor but either ignored or you didn't want to share knowledge and this person is practicing their bad skills on you and you can't do anything about it.'* (P24, male, graduate, senior, nurse)

There are givers and receivers in mentoring

This mentoring belief portrayed mentoring as a one-way process in which it was the responsibility of the mentor to provide mentoring activities to the benefit of the mentee. This meant that the mentor was the giver, and the mentee was the receiver at all times in the mentoring relationship. This subtheme reflected hierarchical relationships in the workplace where the mentor was viewed as the parent and the mentee as the child: 'If someone is your mentor, they will be like the second parent. What do parents do? They solve problems from home or work' (P13, female, graduate, junior, nurse). This had implications for the overall experience of mentoring in clinical settings. The emphasis was that there was nothing in it [mentoring] for the mentor. The goal was to help the mentee meet their expectations in clinical settings. Mentoring was viewed as a one-way phenomenon.

Mutuality and fluidity in mentoring

A subtheme on mutuality in the mentoring relationship and fluidity in mentoring roles was evident in the data. Participants acknowledged that mentoring was about imparting knowledge from a senior colleague to a less experienced nurse/midwife. However, seniority was multifaceted which meant that the giver of knowledge could also be the receiver upon circumstance as one participant warned: 'It's not always that mentors are experts you have to be careful with that. You have to be willing to learn and adjust accordingly' (P22, female, diploma, senior, nurse). Seniority was based on age but also on clinical experience. Specifically, the more years one had spent working in the hospital the more senior they were considered to be. Seniority was also dependent on the level of education. For example, a nurse who was master's prepared was more senior than the one with a bachelor's degree. The Ugandan health system also deemed registered nurses as senior to enrolled nurses making seniority vary within the cadre of the nursing/midwifery profession. Sometimes, seniority was about possessing a very specific skill set compared to those who struggled with it:

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> *'For a nurse who did a certificate, has been in the hospital more than somebody who has done BSN [Bachelor of Science in Nursing]. Let me just continue with example of cannulation, so this enrolled nurse has seen all kinds of patients from the dehydrated ones whose veins have collapsed, she has worked through them.'* (P13, female, graduate, junior, nurse)

The fluidity in seniority made mentoring a two-way phenomenon: 'And actually mentoring is either way, even me a junior there are somethings that I know that I can try to mentor your supervisor or so-called experienced person' (P9, male, graduate, junior, midwife).

Strong personal bonds were valued as the centre of productive mentoring. In fact, for these participants ($n = 12$), mentoring was viewed as a relationship as opposed to a process or a set of activities. To them, mentoring was about creating trusting relationships and cultivating relational bonds between oneself and the other. Having good communication was important, and neutrality was desirable. It was important to build a good foundation for the trusting relationship such as creating a good rapport with the other colleague: 'First of all, it is to create a good rapport with the mentee because without a good relationship we can never mentor' (P19, female, diploma, senior, nurse). Some level of similarity was necessary for these bonds to stay strong. Participants felt that mentoring was best to occur between people in the same profession, working in the same geographical area: 'Me I would think mentoring is ahh getting someone in the same field' (P1, female, postgraduate, senior nurse). In case the dyad differed in professions, they at least had a similar work ethic: 'I have an experience of an obstetrician I worked with, I come ask for consultation on a patient I have done a clerkship. When it's me, he does not take it lightly because he knows I can do better' (P2, male, graduate, junior, midwife).

Organisational responsibility in the initiation and support of mentoring

The final subtheme of participants' beliefs about mentoring centred on whose responsibility mentoring was. Mentoring only existed if the organisation or hospital administration showed some level of commitment. Mentoring started with the initiation by the organisation. They needed to set the ball rolling: 'Actually, if there is to be something [mentoring], it should be done right from the ministry, … because it starts from there' (P1, female, postgraduate, senior nurse). If no mentoring existed in the organisation, then it had everything to do with the organisation's capacity to support mentoring: 'Once the management is on board that is like 50% achieved; the other nitty-gritty would be, what is the structure of mentoring? how can we make it fit your organisation?' (P24, male, graduate, senior, nurse).

Most of the subthemes relating to the beliefs about mentoring were more common among the senior nurses and midwives who were more likely to believe in the internal instincts surrounding mentoring. Furthermore, the senior nurses and midwives more commonly believed in a hierarchical nature of mentoring, emphasising that mentoring was done with the goal of the 'other' in mind; the 'other' being a novice nurse/midwife, the patient or the community. Comparatively, junior nurses and midwives believed that mentoring was mutual and fluid, stating more clearly that mentoring was a two-way phenomenon.

The need for mentoring in clinical settings

Participants indicated that their motivation to serve as mentors to fellow nurses and midwives was driven by an identified need for sustained mentoring initiatives as well as the establishment of future formal mentoring programmes. The need for mentoring was expressed in three subthemes: mentoring for adaptability in clinical settings, the growing importance of mentoring in contemporary nursing, and the bridge from a state of overwhelm to empowerment.

Mentoring for adaptability in clinical settings

The participants highlighted the need for mentoring within clinical settings. They acknowledged that even though expertise was built over the years of practice, a clinician cannot know it all. Clinical practice was considered a complex system, managing a complexity of patients that could quickly get overwhelming:

> *'I remember one time, there is time we lost a mother. She was having postpartum haemorrhage and it wouldn't stop she had been referred from a health centre 3 to health centre 4 to a regional referral and then it was at round midnight, we had to run around looking for blood [for transfusion], prepare her for theatre, she died before reaching theatre table. It was overwhelming.'* (P7, female, graduate, junior, midwife)

The complexity in practice meant the nurse/midwife could rely on the mentor for psychosocial support when overwhelmed or on the mentee when the complexity meant a need for more hands. Clinical practice was also described as being dynamic: '*I may be somebody who knows many things, but since medicine keeps changing; there are new things they learn from their institution*' (P17, female, diploma, senior nurse). Further, technology was evolving. This required nurses and midwives to continuously learn from each other and support one another.

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The growing importance of mentoring in contemporary nursing

Participants felt that the profession needed continuous mentoring in the clinical area. Firstly, participants were worried about the changing trend in nursing education in which student numbers were overwhelming, clinical placements were shorter and nursing school programmes were more theoretical than practical in their orientation. The advancement of technology has led to students gaining knowledge in a simulated environment, reducing their direct patient interactions. This meant that many nurses and midwives were entering practice without the full set of clinical competencies and these nurses needed mentoring:

> *'…because now the schools are so many you find someone qualified, and they cannot even cannulate they cannot pass a catheter cannot pass an NG [nasogastric] tube and yet someone has trained for 3 years. So, I would like to see someone qualifying when he or she has achieved or knows what she supposed to do at the end of the day for the good of the patient.'* (P25, female, graduate, senior, nurse and midwife)

Secondly, the profession was faced with a set of new nurses who did not really want to be nurses or midwives and had become so purely by circumstance:

> *'And it's like they came to nursing as last resort they are not 'called' as our ethics says…They wanted to be people higher than nurses but since they didn't get the chance they came to nursing with less interest in nursing, that is our challenge, it's very dangerous. We are scared of the future once we are retired, we don't know what the service will be in the future.* (P17, female, diploma, senior nurse).

It was a genuine worry that these new colleagues were at the verge of leaving the vocation due to very low passion for the profession. Without mentoring interventions, the profession would lose these skilled nurses to other professions, further affecting the staffing levels at the hospitals. A good example of dwindling passion for the profession came from one of the newer nurses:

> *'…one can go back to school for basic sciences without necessarily doing [nursing] internship but it's one advantage when you are registered with the [nurses'] council because the [job] adverts can be specific that someone must be registered with the board. So, I am here [for internship] for a mission. It's not that I don't like it [nursing] totally … but the other part [basic science] weighs more interest compared to this [nursing].'* (P14, male, graduate, junior, nurse)

Thirdly, participants were worried about the declining professional standards in clinical practice. Participants felt that some nurses/midwives were unempathetic, which was contrary to the professional and ethical code of conduct. This was best described by one participant, who was a new nurse to the hospital:

> *'There was this guy, came through emergency while I was on medical ward. He had hypertension and left side stroke. I don't know what transpired through the night. In the morning I was the first to arrive with a student from [names the school], when reached she told me there is a patient who needs suctioning, … The staff on duty came. I told her we have this patient, where can we find wheelchair or trolley to transfer him to a place where we can take care of him. She simply said 'I don't know'. You know that response, oh my God, this could be your father, this could be someone's ….'* (P13, female, graduate, junior, nurse)

Fourthly, nurses and midwives did not relate well with each other in clinical settings: 'We don't have a nurse's culture that nurses help fellow nurses. We don't have the tradition that nurses help nurses. Everyone is on their own' (P12, female, graduate, junior, nurse). The nurse-to-nurse, midwife-to-midwife relationship at work was complicated with quarrelsome individuals and rudeness, with some colleagues describing it as being tough and difficult. These relational dynamics created fear and intimidation within the workplace environment:

> *'The work environment is such that when this person steps in even people who were discussing and talking to each other stop and start to pretend to be busy just to impress that person. The work environment is already dead. It's not good people don't enjoy what they are doing.'* (P24, male, graduate, senior, nurse)

The other professional issues to demonstrate a need for mentoring practices were related to the increased professional turnover: 'Many nurses have opted to leave nursing go for a different thing where you know you can be promoted. Those small issues affect' (P22, female, diploma, senior, nurse), and the worrying image of nursing in society: 'Before people thought nurses were school dropouts that were just trained on job but now it's a profession, it has a registration [licensure] process. So, when the patient was explained to what it entails to be a nurse' (P11, male, diploma, senior, nurse).

The bridge from a state of overwhelm to empowerment

The participants alluded to the individual need for mentoring. Nurses/midwives felt the clinical practice could be

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overwhelming with emotions that only a fellow nurse/midwife could understand:

> *'It's a very tasking profession it's very energy draining profession. I have seen people break down, people get so weighed down from work and stress. One thing about mentorship is that you don't feel the heat of work or the stress of work that much because you have someone you can always talk to.'* (P6, female postgraduate, senior, nurse and midwife)

Some participants felt nurses and midwives in the clinical area were not assertive and lacked confidence expressing themselves, particularly within the interprofessional practice:

> *'You see when someone comes in the hospital, there is that issue people saying that the doctors know it all and yet there are so many nurses who have actually so much to offer. You ask, can someone contribute? They say but the doctor has said, what else can we say?'* (P3 female, postgraduate, senior nurse and midwife)

All these personal issues were more apparent if the nurse/midwife was new to the profession or to the organisation. Furthermore, nurses and midwives had personal non-work-related problems that had the potential to affect their work in the clinical settings. All of these issues pointed to the need for mentoring for nurses and midwives:

> *'They don't want to be on ground [at work]. They feel they have a lot of commitments; their minds are on other things; they are torn between…. they have personal issues that are interfering with work.'* (P26, female, graduate, senior, nurse and midwife)

There was a fairly equal agreement regarding the dynamic and complex nature of clinical practice, requiring continuous mentoring across the lifespan of one's clinical career. Likewise, both senior and junior nurses/midwives acknowledged the personal issues that require mentoring to help individuals cope with the stress of working in the clinical area. However, senior nurses and midwives believed more in the potential for mentoring to address the professional issues in nursing and midwifery.

Opportunities for mentoring in the workplace

There were opportunities present within the workplace that provided a gateway for the initiation and nurturing of mentoring relationships. The hospital runs a human resource appraisal system. During this process, each nurse or midwife made goals that were both career and practice related. Practitioners would have a discussion with their immediate supervisors about these goals and they would identify ways to achieve these goals. These goals were evaluated by both parties at the end of the financial year. Participants in this study identified the appraisal system as an opportunity for mentoring between senior and junior colleagues:

> *'eeeh you know you made a workplan with your supervisor so after a given period of time you are going to be appraised, in your workplan there are going to be various things to be implemented and those things, most of them you will need mentorship from your supervisor and accountability to your supervisor. So that alone, having that at the back of your mind helps you keep on track, run to them for solutions, keep engaging with them like that.'* (P7, female, graduate, junior, midwife)

The hospitals and the Uganda Nurses and Midwives Council (UNMC) also had Continuous Professional Development (CPD) guidelines which could be harnessed and used to enhance mentoring experiences. The hospitals had schedules for CPD sessions on a monthly basis. The UNMC mandated that nurses and midwives accumulate a specified number of CPD points before renewing their practice licences. The CPD system could be used by mentors to help mentees meet their learning needs. But also, CPD sessions could be used to encourage senior nurses and midwives to engage in mentoring especially if CPD points were attached to mentoring:

> *'Every week we have CPDs we discuss some procedures and conditions, we be updating. So, people be updated about what is current. I think that the main thing.'* (P12, female, graduate, junior, nurse)

> *'You see how CPD points are added on doctors to get licences? It pushes them to actually do CPD. But if also in nurses we could have some things attached to CPD, to make people mentors one or two people this year.'* (P3, female, postgraduate, senior nurse and midwife)

The hospitals also run partnerships with non-government organisations (NGOs), universities and other implementing partners. These organisations provided training opportunities within the hospital for staff. In fact, some universities offered training about mentoring to hospital staff.

> *'But we have institutions like [names a university] whose students we train from here, they also organise special training for preceptors who will train their students. And any other organisation who think that their people can get training or mentorship from here they can pick staff from here and train them.'* (P23, female, graduate, senior, nurse and midwife)

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The hospitals that participated in this study were regional referral hospitals, which by virtue of their status were training institutions. They received students from nursing and medical schools and universities. Internship nurses and nurses returning to practice often did their short-term placements at these hospitals. These interactions provided opportunities for senior colleagues to interact with novice practitioners, hence an opportunity to initiate mentoring relationships:

> *'Also, our mandate as a regional referral hospital is to oversee the lower health facilities. It's actually a key role of the staffs working in this hospital that they mentor not only student but also counterparts working in the lower health facilities. So, we consider it as for the students, it offers a teaching [learning] opportunity to them and for counterparts… it serves as an opportunity to share experiences with them in terms of equipment, procedures. There are some complicated cases we do at regional level which the lower health facility people may not have an opportunity to do then we can transfer that knowledge to them.'* (P23, female, graduate, senior, nurse and midwife)

The employment structure consisted of health workers at various levels of seniority, including physicians. These professionals could serve as mentors for the nurses and midwives, offering an opportunity for interprofessional mentoring:

> *'This is a referral hospital, there are so many consultants they can learn from. Me I think they have suitable environment for mentoring. We have different cadres you can't miss someone who can help out.'* (P16, female, diploma, senior nurse)

Other cadres of nursing and midwifery were also represented, providing human resources for mentoring. The participants also highlighted that although employees described a few colleagues with bad attitudes and difficult personalities, most of the nurses and midwives were approachable and willing to help others to learn. The hospitals had employees with the attitude and attributes for effective mentoring: 'Not really but when I work together with other people some people are easy to approach so I know who to approach for what' (P12, female, graduate, junior, nurse).

A pattern analysis for the theme of opportunities for mentoring in the workplace showed that junior nurses and midwives seemed more optimistic about mentoring than their senior colleagues. They believed in harnessing the existing mentoring opportunities within the hospital. The opportunities ranged from the existing staffing structure and the human resource appraisal systems to partnerships with NGOs and universities. These opportunities, if tapped into, could provide a good foundation for initiating, sustaining and supporting mentoring relationships in the hospitals.

DISCUSSION

Our study identified motivations that nurses and midwives had when engaging in mentoring within acute care settings. In contexts with limited resources and the absence of established formal mentoring programmes, mentoring lacks both obligatory status and associated rewards. This study indicates that mentoring is driven by personal beliefs and the perceived need for it. Mentoring leverages workplace opportunities to foster support from senior clinicians to junior nurses and midwives. Organisational research shows that perceptions about mentoring predict intentions to engage in mentoring from formal mentoring programmes (Małota, 2019). Despite the known mentoring perceptions, they have not been explored in hospital nurses and midwives. Our study detailed motivations for nurses and midwives to engage in informal mentoring through interactive dialogues with them.

Our study reflects on the 'self' versus the 'other' approaches to mentoring with implications for building a hospital culture of mentoring (Janssen et al., 2016). Nurses and midwives who mentor novices with the 'self' in mind, engage in mentoring to meet their own personal goals and needs. In such a relationship, mentoring presents benefits for the mentor and the clinician being mentored (Kakyo et al., 2022). In such circumstances, mentoring is viewed as a two-way relationship, viewing both the mentor and mentee as active entities in the mentoring relationship. This relationship is based on reciprocity, where relational attributes of trust and respect form the foundation of the relationship (Ragins, 2012). Such a relationship is characterised by mutual benefits and fluidity in mentoring roles. Conversely, one-way mentoring is characterised by a mentor who is an active giver and a mentee who is a passive receiver. In this relationship, the mentor engages in mentoring to the benefit of the 'other', who is usually the novice nurse or patient/community. This relationship coincides with hierarchical language in which the mentor is viewed as a parent, and the mentee as a child (Jacobs, 2018). The power imbalance in this relationship is associated with behaviours such as manipulation, overdependence and limited autonomy, giving room for a dysfunctional relationship (Kow et al., 2020; Washington & Cox, 2016).

Previous research shows that whether mentoring is one-way or two-way, self-focused or other-focused, it forms the individual beliefs that are important in cultivating a mentoring culture within acute care hospitals (Janssen et al., 2016; Liu et al., 2021). Our study shows that these beliefs are important in the initiation and sustaining of the relationship both in formal and informal mentoring relationships. A clinician whose orientation is towards a hierarchical type of mentoring would conflict with the nurse/midwife that believes in reciprocal principles. These foundational beliefs regarding mentoring play a crucial role in establishing how, for example, respect and trust are defined and demonstrated within a mentoring relationship. Trust is an important foundational principle in effective mentoring (Chong et al., 2020; Sawatsky et al., 2016). Such instances of mismatch between the mentor and mentee

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have been the sources of conflict, particularly present in formal mentoring programmes (Kakyo et al., 2022; Washington & Cox, 2016)

Organisational commitment to mentoring is demonstrated by fostering a heightened awareness of its benefits. Organisational commitment in previous studies is demonstrated through imparting knowledge about the advantages of mentoring, including its role in building resilience and adaptability (Davey et al., 2020). Furthermore, the organisation recognises that each clinician enters a mentoring relationship with a unique set of personal beliefs that influence their predisposition toward mentoring. Organisational commitment is seldom explicit in informal mentoring relationships. However, there are a number of ways that middle and top management can demonstrate their commitment to mentoring. Bally (2007) identifies individualised influence, where top leadership models good mentoring practices. Other ways to demonstrate commitment include availing mentoring opportunities such as delegation, promoting accountability by incorporating mentoring goals into performance evaluations and professional development plans (Giacumo et al., 2020). Our study extends the existing literature on organisational commitment and concurrently identifies five distinct opportunities which hospitals and professional bodies can demonstrably commit to in order to foster a mentoring culture: (1) Nurses and midwives at various career stages looking for or providing mentorship; (2) the yearly performance review in the human resource management system; (3) external collaborators like universities and NGOs working with these hospitals and providing mentorship initiatives; and (4) existing CPD standards endorsed by the UNMC. These prospects demonstrate an organisational climate that is consistent with a positive mentoring culture. These expectations are in line with other regulatory bodies. For example, the International Council of Nursing (ICN) and the International Confederation of Midwives (ICM) have mentoring as an explicit expectation of their nurses and midwives, respectively (International Confederation of Midwives, 2014; International Council of Nurses, 2021).

Our study shows that nurses' and midwives' motivations to engage in mentoring were based on the need for it within the hospital, in the profession and among the nurses and midwives. The hospital's need for mentoring was centred on the complexity and dynamic nature of the clinical practice. These findings replicate previous findings in the literature that acknowledge nursing and midwifery practice is complex and dynamic, requiring continuous learning and support (Barker & Kelley, 2020). In the context of clinical practice, we are witnessing the advent of new technologies alongside the emergence of novel diseases and care models. These complex care systems necessitate a diverse skill set among clinicians. Furthermore, the dynamic nature of these systems engenders evolving care models and disease patterns. This study, in line with other studies, acknowledges the role of mentoring in sharing knowledge and expertise. Mentoring is essential in advancing the call for quality and consistent practice in hospitals (Hoover et al., 2020; Schwerdtle et al., 2017).

Our study also highlighted the professional need for mentoring. Current trends and issues in nursing and midwifery affect the profession in several ways. The student-to-instructor ratios can be overwhelming in nursing schools (Younas et al., 2019) with high turnover rates. Specifically, senior nurses retiring and young nurses changing professions for various reasons. Workplace hostility is characterised by horizontal violence (Bambi et al., 2018) and negative portrayals of the profession in media and the public (López-Verdugo et al., 2021). Our study indicates the potential for the use of mentoring in addressing these professional issues. This study agrees with previous findings that the goal of mentoring should be focused on issues of importance to the profession (Jacobs, 2018).

The personal need for mentoring underscores the emotional intensity inherent in the professions of nursing and midwifery (Delgado et al., 2017). Literature indicates a high prevalence of burnout (Dall'Ora et al., 2020). Nurses and midwives have previously shown that mentoring is one way to cope in an environment that can weigh down the clinician. Adding to the various goals of mentoring, our study shows that mentoring is needed by the individual clinician to cope with the emotions in the workplace and find the balance between personal and workplace-related issues.

The findings as a collective show that the engagement in mentoring activities and processes within acute care settings is built both from policy and the individual's beliefs about mentoring. For example, the belief that mentoring benefits the other may result in a hierarchical type of relationship while believing that mentoring benefits self may result in a reciprocal relationship. Nurses and midwives, in the absence of organisational commitment to mentoring, look to their personal beliefs to initiate and sustain informal mentoring relationships.

Limitations

As with the context of qualitative research, the findings of this investigation illuminate the nuanced perceptions and experiences related to mentoring among nurses and midwives working in acute care hospitals in Uganda. Given the specific sociocultural and institutional conditions in Uganda, findings may not be applicable to other settings with judicious consideration of contextual differences. Secondly, although the initial coding process was conducted by a single researcher, steps were taken to preserve the fidelity of the emergent codes and themes. This was accomplished through iterative dialogues and reflective consultations with the rest of the research team.

IMPLICATIONS FOR NURSING AND HEALTH POLICY

Nurses' and midwives' foundational beliefs concerning mentoring serve to shape the overarching culture of mentoring

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within the healthcare setting. Therefore, gaining insights into the motivational factors and perceptions that underlie the engagement of nurses and midwives in mentoring roles is crucial. Such understanding is not only instrumental for unravelling the complex dynamics that facilitate the initiation and longevity of mentorship relationships but is also vital for the development of mentoring programmes. Designing such programmes in alignment with the prevailing mentoring culture enhances their acceptability and efficacy within the hospital environment. Hospital nurse managers need to scrutinise the perceptions and attitudes that nurses and midwives hold towards mentoring. Such an analysis is foundational to any attempt to integrate and enhance mentoring programmes effectively.

CONCLUSIONS

Our study established that in the absence of institutionalised mentoring frameworks, which are indicative of organisational commitment to mentoring, alongside the presence of routine challenges that may impede effective mentoring, nursing and midwifery professionals often default to innate, intuitive practices. These perceptions encapsulate both self-oriented and other-oriented approaches to mentoring. Importantly, these clinicians consistently endorse the individualised value of mentoring, not just as a professional development tool, but as a requisite component for personal and organisational growth.

AUTHOR CONTRIBUTIONS

All authors have equally contributed to the design and writing of the manuscript as follows: Study design: TAK, LDX, DC; data collection: TAK; data analysis: TAK, LDX, DC; manuscript writing: TAK, LDX, DC.

CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

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ETHICS STATEMENT

The study was approved by the Flinders University Research Ethics Committee (Approval no. 5313) and the AIDS Support Organisation (TASO) Research Ethics Committee (Approval no. TASOREC/056/2021-UG-REC-009 [AMEND]).

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