

The Experience of Job engagement and Self-care among Ugandan Nurses and Midwives

Pauline Bakibinga

Dissertation for the degree philosophiae doctor (PhD)

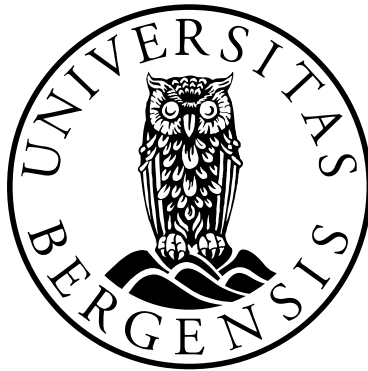
University of Bergen

2012

**The Experience of Job engagement and Self-care among Ugandan Nurses and
Midwives**

Pauline Bakibinga

Dissertation for the degree philosophiae doctor (PhD)



2012

Department of Health Promotion and Development

Faculty of Psychology

University of Bergen

DEDICATION

- i) To my beloved parents Martha Nakirijja Bakibinga and George William Bakibinga (RIP) whose love, dedication and sacrifices, but above all, their faith in me continue to encourage me to reach for the stars.
- ii) The nursing workforce in Uganda; the unsung heroes in ‘the Pearl of Africa’, on whose shoulders the health system functions.

CONTENTS

DEDICATION.....	3
TABLE OF CONTENTS.....	4
ACKNOWLEDGEMENTS.....	7
LIST OF ABBREVIATIONS.....	9
ABSTRACT.....	10
LIST OF PUBLICATIONS.....	14
1. INTRODUCTION	15
1.1 NURSES AND THE HEALTH WORKFORCE IN UGANDA.....	15
1.2 NURSING IN UGANDA.....	17
2. THEORETICAL FRAMEWORK	18
2.1 JOB ENGAGEMENT.....	19
2.1.1 CALLING.....	21
2.1.2 ZEST FOR WORK.....	22
2.1.3 VITALITY.....	22
2.2 SELF-CARE.....	23
2.3 SELF-TUNING MODEL OF SELF-CARE.....	25
2.4 SALUTOGENIC MODEL	26
2.5 RELIGION AND COPING.....	27
2.6 RESEARCH QUESTIONS.....	30
3 METHODS	31
3.1 SETTING	31
3.2 DESIGN	32
3.3 PARTICIPANTS	35

3.4 INTERVIEW GUIDE.....	37
3.5 DATA COLLECTION AND TRANSCRIPTION.....	38
3.6 ANALYSIS.....	39
3.7 RESEARCH QUALITY.....	41
3.7.1 RESEARCHER’S ROLE.....	41
3.7.2 SUBJECTIVITY-REFLEXIVITY.....	42
3.7.3 VALIDITY.....	43
3.7.4 RELIABILITY.....	44
3.7.5 GENERALIZABILITY.....	45
3.8 ETHICAL CONSIDERATIONS.....	46
4. RESULTS.....	47
4.1 PAPER 1- FACTORS CONTRIBUTING TO JOB ENGAGEMENT IN UGANDAN NURSES AND MIDWIVES.....	47
4.2 PAPER 2- SELF-TUNING FOR JOB ENGAGEMENT: UGANDAN NURSES’ SELF- CARE STRATEGIES IN COPING WITH WORK STRESS.....	49
4.3 PAPER 3-THE ROLE OF RELIGION IN THE WORK LIVES AND COPING OF UGANDAN NURSES.....	51
5. DISCUSSION.....	52
5.1 LIMITATIONS-THEORETICAL AND METHODOLOGICAL.....	52
5.2 GENERAL FINDINGS.....	53
5. 3. SEARCH FOR MEANING.....	54
5.3.1 SENSE OF CALLING.....	54
5.3.2 CALLING-VOCATION MATCH.....	55
5.4 SALUTOGENIC PROCESS-JOB ENGAGEMENT; MEANING, ZEST FOR WORK AND VITALITY.....	56
5.5 PATHOGENIC PROCESS-WORK STRESS; WORK OVERLOAD, POOR WORKING CONDITIONS.....	58

5.6 MEDIATING (SELF-TUNING) PROCESS; INTROSPECTION, SENSIBILITY, REFLECTION AND ACTIVE COPING.....	59
5.7.1 SHARING OF EXPERIENCES.....	61
5.7.2 TRUSTING IN GOD’S PROVIDENCE.....	61
5.7.3 ENGAGING IN OTHER ENJOYABLE ACTIVITIES.....	63
5.7.4 LETTING GO.....	63
5.7.5 ADAPTING BASED ON PAST EXPERIENCES.....	64
5.7.6 PRESERVING QUIET TIME.....	64
5.7.7 GUARDING AGAINST WORKPLACE HAZARDS.....	65
5.7.8 SEPARATING WORK FROM PERSONAL LIFE.....	65
5.7.9 RESIGNATION.....	66
6. CONCLUSIONS AND IMPLICATIONS.....	66
6.1 IMPLICATIONS FOR TRAINING INSTITUTIONS.....	67
6.2 IMPLICATIONS FOR HEALTH CARE ORGANISATIONS AND MANAGERS...	68
7. FUTURE DIRECTIONS.....	68
REFERENCES.....	70

ACKNOWLEDGEMENTS

“There is no such thing as gratitude unexpressed. If it is unexpressed, it is plain, old-fashioned ingratitude”- Robert Brault.

This dissertation is a result of efforts from various sources to whom I am grateful and forever indebted.

I am very grateful to the Almighty God for giving me this opportunity to advance in my studies. Great is Thy faithfulness to me-all I have needed your hand has provided, morning by morning, and indeed my cup overflows. To God be all the glory.

To the nurses and midwives in this study: I thank you for accepting to be a part of this study and permitting me to share your experiences. I convey my gratitude to Enid Ashaba Mugarura for her invaluable support during the pilot phase of the study.

To my supervisors Professor Maurice Mittelmark and Associate Professor Hege Forbech Vinje I am very grateful to you for taking me on and contributing intellectually to my training. Your guidance and faith in this project were critical to the successful completion of this project. Without a doubt, your dedication and attention to detail are deeply engraved in my memory.

To the many teachers at the Department of Health Promotion and Development, the Faculty of Psychology and Centre for International Health- University of Bergen; Institute of Health and Society, Faculty of Medicine, University of Oslo and the University of Geneva. I thank you for exposing me to the different perspectives of the world.

To my mentors: Drs. Romano Byaruhanga, Raymond Mwebaze and Pius Okong. I thank you for believing in me as an intern, encouraging me to aim for the highest and later recommending me for further studies. Bishop Lambert Bainomugisha I thank you for being a mentor and good friend. I am grateful to my teachers Dr. Anthony

Mutebi Nsubuga and Mr. Polly Kabiito (RIP) whose faith in me as a student continues to encourage me to strive for greatness.

To the Norwegian State Education Loan Fund (Lånekassen), NORAD, University of Bergen and the University of Geneva I am thankful for the financial support that made this project and related training possible.

I convey my heartfelt gratitude to the librarians at the Faculty of Psychology, staff at HEMIL, members of the MCVenues research group and the GHIG-graduate school for your support, encouragement and feedback during this training. Wenche, Maria, Helga, Marguerite, Elisabeth, Torill, Annegreet, Haldis, Dennis, Camille, Dickson, and others, your support made completion of this project possible.

I am grateful to my former classmates in the International Master's class in Health Promotion-2008/2010 for providing me with enough intellectual stimulation and company that made my stay in Bergen a wonderful experience. My sincere gratitude to the Ugandan students in Bergen 2008-2012 for the moral support rendered.

I am also sincerely grateful to my friends across the globe for the encouragement that saw me through this project. PhD students, past and present, Joseph Rujumba, Martin Atela, Robert Byamugisha, Aminah Nalikka and others, the struggle continues.

And last but not least, my family who always believed in me. Mum and Daddy (RIP)- your unwavering love and encouragement shaped my character and inspired me to attain my fullest potential. My sisters and brothers; Elizabeth, Stella, David M, Jennifer, Angela, John D, Andrew and Joseph, Jaaja Paulina, Uncle Musana, nieces and nephews, cousins and in-laws- your love, support and friendship are the cornerstone for the woman you see today. I extend a special thank you to my sister Elizabeth for helping to illuminate my path. You encouraged me to come to Norway and have supported me through the years with your words and actions. Thank you for editing my papers and dissertation.

List of Abbreviations

HIV/AIDS- Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome.

ICN- International Council of Nurses

MOH- Ministry of Health Uganda

UBOS- Uganda Bureau of Statistics

ABSTRACT

Background:

Nurses, the backbone of health care in sub-Saharan Africa, endure various forms of difficulties while on the job and as a result many choose to migrate in search for better opportunities, or leave the profession. Despite the challenges experienced, there are many nurses who remain on the job in their countries, do thrive and stay engaged while on the job. Earlier empirical evidence from Norway produced a theory, the Self-tuning Model of Self-care, suggesting processes through which nurses' job engagement can be preserved amidst workplace adversity. The main aim of this study was to explore the phenomena of job engagement and self-care among Ugandan nurses known to thrive on the job despite having challenging working conditions, using the model as a guide. This study sought to understand ways in which nurses' job engagement might be enhanced, with the aim to inform training and health care institutions about potential interventions to enhance nurse practitioners' resilience, motivation, and satisfaction on the job.

Methods:

An exploratory qualitative study design using a combination of phenomenology and hermeneutics was conducted, with a purposive sample of 15 nurse practitioners with reputations for thriving despite having difficult working conditions; and currently practising within the public and private sectors in two districts in Uganda. Data were collected through in-depth interviews conducted, between March and May 2010, in either the interviewees' workplaces or at home and lasted from one hour to two hours and 15 minutes. Nurse practitioners were recommended by colleagues for participation in this study. A thematic interview guide was used and modified during the data collection exercise to ensure that major themes of the study questions were captured. As one of the study's aims was to examine, whether or not the nature of job

engagement as experienced by Ugandan nurses relates to Norwegian nurses, the interview guide was adapted from Vinje (2007). In all interviews, nurse practitioners were invited to share their experiences using, ‘Can you please tell-your work life story? One in-depth interview was planned for each participant but with a provision for a repeat, if the need arose. Six interviews were conducted in English (and not repeated). Four were done in English and repeated in the Luganda language because the respondents found it difficult to express themselves in English. The remaining five interviews were done in Luganda. Thus, nineteen interviews were conducted with the 15 nurse practitioners. The interviews conducted in Luganda were transcribed into English. Interview data were analysed using the qualitative content analysis method. The transcripts were analysed using content analysis focusing on the manifest and the latent content. The analytical tool followed a six-step process including multiple reading of the interview transcripts to make sense out of the data, a division of the data into meaning units, condensation of the meaning units, categorisation of the data, and lastly, generation of sub-themes and themes. The analysis was done in two stages, first within cases and then across cases.

Results:

Paper 1 describes the processes that enabled the nurses to thrive on the job in spite of various work-related challenges. A sense of calling to the profession and meaning are critical to the experience of and maintenance of the nurses’ job engagement. A match between calling and profession gives meaning, zest and vitality to the nurses’ work lives. Even among the nurses who joined the profession out of practical necessity, their job engagement experiences did not differ from their colleagues for whom nursing was, for instance, a childhood dream. When workplace adversity threatens one’s job engagement, a self-care process mediated by reflection and introspection about work life and involving nurses’ abilities to use personal and job resources is set into motion enabling nurses to adjust and cope better on the job.

Paper 2 reports on the self-care practices of the nurses. The nurses reported that the serious stressors they experienced in relation to their work included poor pay, having too heavy workloads, trying to make do without vital supplies, struggling to deal with difficult patients, coping with uncooperative workmates, and being distressed by overly demanding and unfair bosses. To mitigate the effects of the various stressors, the nurses engaged in a 'self-tuning' process involving introspection, sensibility and reflection resulting in adoption of several coping strategies. Coping was in the form of sharing of experiences, trusting in God's providence, engaging in other enjoyable activities, letting go, adapting based on experiences, guarding against workplace hazards, preserving quiet time, and or clearly separating work from personal life.

Paper 3 describes the various influences of religiosity on the work and personal values and coping strategies of the nurses. All the fifteen participants were found to be actively religious, a fact unknown at the time of recruitment. Religion was found to influence the lives of the nurses in four different ways including the nurses' choice of profession, their work values, their ability to cope with work stress, and their self-care strategies.

Conclusions:

The Self-tuning Model of Self-care can be used as a model to understand how thriving nurse practitioners experience and can promote their job engagement, amidst challenging working conditions. In the face of adversity, nursing job engagement was a process whose foundation lay in a sense of calling to the profession, and is characterised by the meaningfulness that nurse practitioners attach to their work, which promotes feelings of zest and vitality at work. Even in instances where one's choice of profession is dictated by circumstances beyond the individual, this study demonstrated that nurse practitioners can experience job engagement under difficult working conditions, when their personal values coincide with professional nursing

values. A self-tuning process involving routine introspection, sensibility to and reflection about ones' circumstances enabled thriving, especially when job engagement was threatened. When faced with work challenges that threatened their job engagement, the self-tuning process led to active coping in one or several ways. This study showed that religion played a critical role in the work-lives and the stress coping resources of the nurses. Findings from this Ugandan context suggest that nurse practitioners should be encouraged to practice habitual introspection and reflection about the satisfaction they derive from work, to enable them retain a high level of job engagement despite the adversities of nursing practice. Health care managers need to make work environments conducive to enhance job engagement by ensuring that all nurse practitioners have job resources such as working equipment and social support that they need to thrive on the job. This study supports previous research conducted in Norway that self-tuning is a learnable skill, critical in helping nurses cope with work-related adversity; the skill of self-tuning should be emphasised both during nursing training and on the job.

List of publications

Paper 1: Bakibinga, P., Vinje, H. F & Mittelmark, M. B. (2012).

Factors contributing to job engagement in Ugandan nurses and midwives. *ISRN Public Health*, vol. 2012, Article ID 372573, 9 pages, 2012. doi:10.5402/2012/372573

Paper 2: Bakibinga, P., Vinje, H. F & Mittelmark, M. B. (2012). Self-tuning for job engagement: Ugandan nurses' self-care strategies in coping with work stress. *International Journal for Mental Health Promotion*, 14 (1), 3-12.

Paper 3: Bakibinga, P., Vinje, H. F & Mittelmark, M. B. (revised and resubmitted). The role of religion in the work lives and coping of Ugandan nurses and midwives. *Journal of Religion and Health*

1. Introduction

1.1 Nurses and the Health workforce in Uganda

Nurses are critical members of the health workforce, usually being the first contact that members of a community have with the health system in sub-Saharan Africa (ICN, 2008). Nurses' importance is more marked in many emerging economies, such as, those of sub-Saharan Africa, where they are often responsible for primary health care delivery in areas where other health care cadres are unavailable (Munjanja, Dovlo & Kibuka, 2005). Like other caring professions, nursing is stressful, wherever it is practiced, and even more so in sub-Saharan Africa where nurses are forced to contend with poor remuneration, bad working conditions, lack of opportunities for professional advancement and education, in addition to infection threats, including, HIV/AIDS (Munjanja, et al, 2005, ICN, 2008). These are in addition to the common occupational stressors and causes of burnout in nursing practice, such as work overload, role ambiguity, stressful interpersonal relationships including, dealing with difficult patients (McVicar, 2003; Parikh, Taukari & Bhattacharya, 2004).

Uganda, like many other countries in the global south, suffers from a severe shortage of a trained health work force (Matsiko & Kiwanuka, 2003). The trained health workers are both inadequate in numbers and inappropriately distributed. Whereas more than 80% of the Ugandan population is found in the rural areas, the distribution of trained health workers favours the urban areas (MOH, 2007). In addition to the constant outflow of skilled professionals leaving the country for better prospects abroad, Uganda has a shortage of health workers arising from insufficient training capacity, low remuneration and poor working conditions in the public and private not for profit sectors, making it difficult for the sectors to recruit and retain staff (MOH, 2010a). Low production of health workers by the training institutions, not in tune with the growing demands, and a mismatch between health needs and training are

frustrating the Ugandan health system. For instance, the three public medical schools in Mbarara, Makerere and Gulu, currently produce a total of less than 200 medical doctors annually. This is due, in part, to the fact that training is directed by the Ministry of Education and not the Ministry of Health (Matsiko & Kiwanuka, 2003)

Even for those remaining in the Ugandan workforce, there is a cause for concern. In a recent study about its health workforce, the Ministry of Health in Uganda observed that although nurses were least likely to leave the profession or country, satisfaction was found to be very low as only 37% of the health workers reported that they were satisfied with their jobs (Hagopian, Zuyderduin, Kyobutungi & Yumkella, 2009). Dissatisfaction arose from low salaries, poor working and living conditions, heavy workload and inadequate supervision. A recent survey conducted among Ugandan physicians showed that only 37% reported that they were satisfied with their jobs while 46% reported that they were likely to leave the health sector or the country any time (Luboga, et al, 2010). Another study conducted among nursing students in the country (Nguyen et al, 2008), revealed that the majority planned to work abroad or in urban areas, with only 8% considering working in Uganda. 70% of interviewed students planned to immigrate to the United States of America or the United Kingdom and 80% were considering practice in urban areas. The students' reasons for dissatisfaction are similar to those presented by the nurses in practice. Due to the challenges faced by the health workforce in Uganda, some of them have opted out of the profession while many others take on other jobs to supplement their income.

In spite of all the challenges faced by health workers in Uganda in general, and by nurses in particular, there are professionals who are highly engaged in their work, still manage to remain healthy, and continue to do a good job in the process. However, those that thrive have not been the subject of research; the vast majority of research on the health workforce in Uganda has focused on the causes of shortages and on descriptions of the situation, without illuminating why some health workers choose to

remain in the nursing field and the country, and continue to serve against all odds (Hagopian, et al, 2009; Luboga, et al, 2010; Matsiko & Kiwanuka, 2003).

The need to understand factors that enhance and promote job engagement amongst thriving health professionals in the country is therefore a high priority. The aim of this qualitative study was to explore how and why some nurses in Uganda thrive in spite of the numerous stressors encountered on the job. Research on experiences of thriving nurses in Uganda might be useful to other nurses and health professionals who struggle to deal with work- related adversities and sometimes leave practice.

1.2 Nursing in Uganda

In Uganda, like elsewhere in the sub-Saharan Africa, nurses are usually the first and often the only healthcare professionals that community members requiring medical attention come into contact with. Nurses in Uganda are a special group of interest because they are the majority, as such, in a bid to understand the depth and obtain solutions to the health worker crisis in the country; they can be representative of the health workforce. Furthermore, their perceived powerlessness, in comparison to other cadres such as medical doctors implies that their stressful experiences are characteristically different and more.

Uganda has a shortage of nurses. For instance, in 2011, Uganda's 32.9 million population had only 3, 475 registered midwives and 6,226 enrolled midwives (Minca, 2011; UBOS, 2011). Despite being responsible for the majority of primary health care, especially in the rural areas, the nurses work lives are characterised by poor living and working conditions, involving low financial compensation, having to work without adequate supplies and no or limited career prospects. Quite often there are media reports about nursing malpractice reflecting the general public's displeasure with the quality of services that the nurses render (Breda, 2011). Although health services in the public health units are provided free of charge, quite often supplies are not available to meet the needs of the high patient numbers. It is therefore common to

find health workers (nurses) asking patients or their relatives to buy supplies such as gloves and syringes, in addition to providing their own food and linens. Patients and relatives, disgruntled over the lack of resources blame the nurses for the health system's failures, accusing them of corruption. Therefore, the high work load, low pay and public ridicule are a major source of frustration for the nurses providing clinical services in Uganda (Zuyderduin, Obuni, & Mcquide, 2010). In a report released by the International Council of Nurses in 2010, only 12% of nurses in Uganda were satisfied with their career.

As a result of their work and living conditions, the nurses are compelled to supplement their income through other activities while others either opt out of the profession or leave the country for better economic and career prospects abroad.

Nursing training in Uganda is composed of various programmes leading to different professional nursing levels. The bachelor's degree in nursing is a four year university programme with an additional year of internship. At this level, nurses acquire nursing, midwifery, primary care and research skills. The registered level training with specialisation in nursing, midwifery, paediatrics or psychiatry is a three year course following acquisition of a Uganda Advanced Certificate of Education while the enrolled nurses or midwives training (which has been phased out but the nurses still exist in the system) followed acquisition of a Uganda Certificate of Education and lasted two and a half years. The comprehensive nursing training is a four year programme focusing on community health (Matsiko & Kiwanuka, 2003). The public health nursing programme is open to registered nurses and lasts two years.

2. Theoretical framework

This dissertation focuses on job engagement and self-care practices among nurses and midwives with reputations for doing well on the job in Uganda. Job engagement and self-care provided the main theoretical frames of reference while religion and coping were retrospectively found to be useful based on the data we obtained. We used the

Self-Tuning Model of Self-care to inform the interview guide that we used to explore job engagement and self-care in this study group. I will describe the different theories in the order in which they were used in the three papers.

2.1 Job engagement

Job engagement is the main focus of paper 1. Job engagement is an important concept in organisational psychology; engaged workers are more positive, healthier and more likely to remain on the job (Bakker, et al, 2008). The growing interest in job engagement follows the psychology research community's increasing interest in positive aspects of functioning. Schaufeli, Salanova, Gonzalez-Roma & Bakker (2002), define job engagement as the "positive, fulfilling, work-related state of mind that is characterised by vigor, dedication, and absorption" (p.74). Prior to this, Maslach (1997) conceptualised engagement as the opposite of burnout, consisting of energy, involvement and professional efficacy. Following a review of publications on employee engagement, Shuck and Wollard (2010) provide a more comprehensive definition in which engagement is conceptualised as "an individual employee's cognitive, emotional, and behavioural state directed toward organisational outcomes" (p. 103). Across all definitions there is agreement that job engagement is characterised by energy, dedication, and involvement at work.

Engaged employees are able to express themselves physically, cognitively, and emotionally during their work, while disengaged employees are withdrawn and on the defensive (Kahn, 1990). Empirical evidence on job engagement points to social support, autonomy, and personal strengths, such as, resilience and self-efficacy as critical to reducing the harmful effects of job demands (Hakanen, Bakker & Demerouti, 2005). Furthermore, job resources, satisfaction on the job and intentions to keep working are related to job engagement (Bakker, et al, 2007; Simpson, 2009b).

Nursing engagement is important for the nurses' well-being and performance on the job and has potential to enhance patients' and organisational outcomes (Simpson,

2009a). Interventions to promote nursing engagement need to be supported by empirical evidence on its essence, antecedents and consequences. However, these are poorly understood. Based on empirical work in Norway, nursing engagement has been defined as a process (not a state) originating from a sense of calling to nursing, experienced as the meaning in life that nursing offers, and expressed as zest for one's work and vitality on the job (Vinje, 2007; Vinje & Mittelmark, 2008). The driving force for job engagement involves the search for, the experience and maintenance of meaningfulness.

Job and organisational engagement are differentiated and have been shown to have different antecedents, necessitating the exploration of the two concepts separately (Wollard & Shuck, 2011). Job engagement has individual and organisational-level antecedents. At the individual level, absorption, involvement in meaningful work, vigor, and dedication, among others, have been empirically shown to precede job engagement (Shuck & Wollard, 2010; Wollard & Shuck, 2011). On the other hand, job characteristics, rewards, and perception of work place society are some organisational level antecedents of engagement. More specifically to nursing, trust and autonomy (Bargagliotti, 2011), calling and meaningfulness (Vinje, 2006), social support from colleagues, energy and reward (Simpson, 2009b) are highlighted as key antecedents to engagement of nurses. With antecedents and consequences in mind, Bargagliotti (2011), in a recent concept analysis of work engagement, defined nursing engagement as “the dedicated, absorbing, vigorous nursing practice that emerges from settings of autonomy and trust and results in safer, cost-effective patient outcomes” (p.11).

For purposes of this dissertation, I adopt a nursing engagement definition by Vinje and Mittelmark (2006); a process (not a state) originating from a sense of calling to nursing, experienced as the meaning in life that nursing offers, and expressed as zest for one's work and vitality on the job.

This study explored three job engagement factors calling, zest for work and vitality, as conceptualised in the Self Tuning Model of Self-Care (Vinje, 2008; Vinje & Mittelamrk, 2006), among Ugandan nurses and midwives known to thrive on the job.

2.1.1 Calling

The concept of calling has historically been attached to divine and religious notions. Christopherson (1994) defines it as “a task set by God with a sense of obligation to work for purposes other than one’s own” (p.219). A calling is characterised by a deep desire to devote oneself to serving people according to the high values of a task or profession (Lane, 1987; Raatikainen, 1997).

However, over time, calling has been expanded to accommodate more secular aspects such as the sense of purpose or meaningfulness and fulfilment in one’s work. Dik and Duffy (2009) provide a more comprehensive definition of a calling as, “ a transcendent summons experienced as originating beyond the self to approach a particular life role in a manner oriented toward demonstrating or deriving a sense of purpose or meaningfulness and that holds other oriented values and goals as sources of motivation”(p. 427). In this definition, due consideration is made for one’s motivation originating from an external source(s)-God, needs of society, fate. It also focuses on purpose and meaningfulness of one’s activity-to self, others and or God.

Called professionals find their tasks more meaningful resulting in more satisfaction on the job and a high degree of commitment. They possess a high sense of values, courage, a strong will, and boldness; they do not give up in the face of adversity (Lane, 1987; Raatikainen, 1997).

In this study, calling is defined by “feelings of having a mission or purpose, including commitment to and healthy absorption in one’s vocation and having the feeling of being in the right place and in the right position” (Vinje, 2007, p. 27).

2.1.2 Zest for work

Zest for work is a valued positive trait in occupational health. It involves a deep emotional connection with one's job in which an employee expresses enthusiasm and satisfaction with their work. Zest for work is characterised by energy and excitement leading to a sense of fulfilment in one's role. In this study, "Zest for work is defined by feelings of vocation-related joy, happiness, enthusiasm, and dedication" (Vinje, 2007, p. 27).

Employees who view their work as a calling and not merely as a job or career find their work to be more meaningful and score higher on satisfaction (Peterson, et al, 2009). Although linked to job satisfaction, zest for work transcends job satisfaction, by including not only satisfaction but has employees expressing enthusiasm and a deep emotional connection to one's tasks (Josephson & Vingard, 2007; Peterson, et al, 2009). Research on zest for work has potential to illuminate ways in which enthusiasm and satisfaction is linked to employee health and their subsequent performance. A Swedish study (Josephson & Vingard, 2007) showed that employees with low zest for work experienced more self-reported work-related strain, inadequate collegial support at work, poor health and more work absenteeism due to ill-health.

2.1.3 Vitality

Vitality is a positive affective state characterised by vigour. It is a discrete positive emotion characterised by high levels of activation which also influences the amount of energy an employee expends during a task (Kark & Carmeli, 2009). In this study, vitality is defined by "feelings of vigour, strong life energy, and the will to exert oneself" (Vinje, 2007, p. 27). When an employee experiences vitality, she/he tends to view work as meaningful and purposeful. Vitality is one of the most studied components of job engagement (Wollard & Shuck, 2011). While job resources fuel vitality, work demands such as work overload, shift work, reduce one's work energy, and create and increase stress and chances of burnout. Vitality has also been observed

to enhance workers' creativity (Kark & Carmeli, 2009). Because the state is contagious and affected by one's work environment, employers seek ways to enhance vitality by creating work conditions that foster it.

2.2 Self-care

Self-care is the subject of paper 2. Self-care refers to intentional activities undertaken by an individual to promote and maintain their personal well-being (Kickbusch, 1989). Self-care, an important nursing theory pioneered by Dorothea Orem (Orem, 1991), is distinguished from dependent care, as it stresses the role of the individual in promoting their own health, assisted by nurses and other health professionals (Denyes, Orem & Bekel, 2001). Self-care is a practical strategy aimed at regulating one's functioning within existing and or changing conditions. Prior to commencement of actions to self-care, identification, formulation and expression of the pre-requisite regulations is required (Denyes, et al, 2001). Thus attention to the self and the environment are critical in the self-care process. Although there is disagreement over its definition, there appears to be consensus that self-care is context specific, focuses on individual control, choices and actions and that it is influenced by knowledge, skills and values, among other attributes (Wilkinson & Whitehead 2009). A review of the literature shows that self-care theory and research in nursing is divided into self-care for patients and self-care for nurses (Ablett & Jones, 2007; Rose & Glass, 2008; Wilkinson & Whitehead, 2009). Whereas, the largest body of literature addresses the former, highlighting how nurses can empower patients to self-care, nurses' own self-care is increasingly valued in occupational health promotion, especially in highly stressful practice settings (Ablett & Jones, 2007; Shapiro, Brown & Biegel, 2007). Holistic self-care, which involves meeting the physical, mental, and spiritual needs of an individual, is important for health professionals to enable them to be more available to their clients. Riley (2003) has indicated that when each area physical, mental, social and spiritual is highlighted, one has the opportunity to focus on enhancing their well-being in totality. Holistic self-care begins with an assessment of

one's status; listening to the messages that the body gives. When deficiencies are identified, one is in better position to identify strategies to cater for one's needs (Riley, 2003). Moreover, attention to personal values, priorities and responsibilities serves to enhance holistic self-care.

Nursing scholars have reported the need for nurses to attend to their self-care needs (Riley, 2003; Vinje & Mittelmark, 2006; Ablett & Jones, 2007). Research has shown that nurses understand the importance of their holistic self-care for their ability to provide care to others (Rose & Glass, 2008). Emotional balance, a result of self-care, fosters nurses' ability to meet patients' needs. Self-validation, seeking emotional support and setting emotional boundaries were found to enhance emotional well-being among Australian community nurses involved in palliative care (Rose & Glass, 2008). When professionals engage in self-care, they build personal resilience. Resilience, the pattern of positive adaptation in the context of past or present adversity (Wright & Masten, 2005), involves utilisation of available resources to bounce back from challenges. Because personal resilience enables thriving in the face of work adversity (Jackson, Firtko & Edenborough, 2007), resilient professionals are vital resources to health systems.

Research among community nurses in Norway showed that a self-care process of habitual introspection and sensibility to and reflection about one's situation, enabled nurses to adopt positive coping strategies when their work engagement was threatened (Vinje & Mittelmark, 2006, 2007, 2008). This research led to the development of the Self-Tuning Model of Self-Care (Vinje, 2008, Vinje & Mittelmark, 2006). The Model suggested ways in which nurses in Norway could maintain their job engagement in the face of work-related adversity.

2.3 Self-Tuning Model of Self-care

The Self-Tuning Model of Self-Care (figure 1, hereafter referred to as the ‘model’), formulated from empirical work on nursing job engagement and self-care in Norway (Vinje, 2007, 2008; Vinje & Mittelmark, 2006, 2007, 2008) by providing some key thematic areas pertaining to the Ugandan nurse practitioners’ work-lives that we explored. The model consists of three main processes; salutogenic, pathogenic and mediating, self-care processes that help one to recapture and foster job engagement when it is threatened.

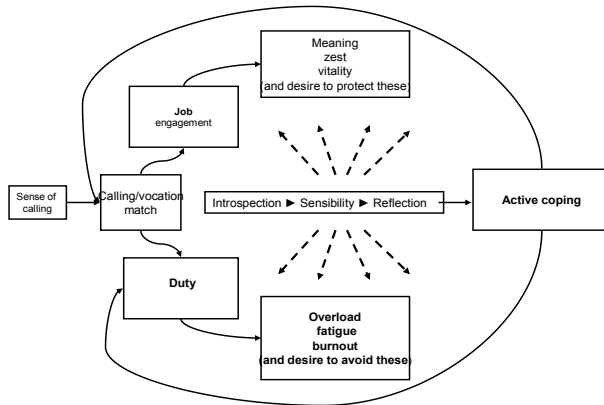
The foundation of the nurses’ job engagement lies in a sense of calling to nursing which all the nurses in the study possessed. Results showed that when the match between calling and vocation was made, the job engagement process was set in motion. The match between calling and vocation promotes both the salutogenic and pathogenic process. In the salutogenic process, job engagement is fostered and preserved by the calling/vocation match. The job engagement process is exhibited as the nurses’ experience of meaningfulness, zest for work and vitality. In the pathogenic process, the nurses’ strong sense of duty may result in work overload, fatigue, moral distress and possibly burnout. A mediating process founded in a nurse’s habitual introspection, sensibility to and reflection about their situation enables the nurse to engage in active coping strategies, serving to mitigate the effects of stressors and preserving job engagement.

Given the potential benefits of the model, in this study, we were compelled to explore whether or not the job engagement and self-care experiences of nurse practitioners in Uganda related to the experiences of the nurses in Norway. Within a qualitative methodology, we explored job engagement and self-care among Ugandan nurse practitioners open to information that was specific to the Ugandan context yet looked out for possible similarities between both study groups. The model served as a theoretical guide by informing the interview guide and the resultant content areas from which the data analysis commenced. From the model, the nurse practitioners’

work-lives were explored by asking them to tell us about their experiences in regard to calling, zest for work, vitality, meaning and self-care.

Figure 1

The Self-Tuning Model of Self-Care



Our literature search did not find studies on self-care experiences of nurses in the Sub Saharan Africa region.

Because self-care involves what professionals can do to ensure thriving on the job, exploring the subject among Ugandan health professionals is important, especially given the amount and extent of the odds they contend with in the course of their work. Paper 2 explored self-care strategies of nurses in the private and public sectors in Uganda, who were known to thrive despite the various challenges they faced in their daily work.

2.4 Salutogenic model

Aaron Antonovsky’s Salutogenic model (Antonovsky, 1979) has a vital connection with the Self-Tuning Model of Self-care. Salutogenesis is concerned with how to live

well with stressors and not how to eliminate the stressors. Within this model, departing from the pathogenic paradigm, Antonovsky (1987) defined health on a continuum; health-ease-dis-ease, with people located somewhere between the imaginary poles of total health and ill-health. The salutogenic model focuses on the use of resources at an individual level and those within one's environment to maintain health. At the core of the salutogenic model are two concepts: a Sense of Coherence (SOC) and generalised resistance resources (GRRs). A sense of coherence entails an individual's ability to view and manage life stresses as comprehensible, manageable and meaningful. The GRRs on the other hand are biological, material, factors that enhance one's ability to deal with demanding situations. A SOC makes it possible for one to use the GRRs that in turn enhance thriving. In line with the basic health promotion principles, salutogenesis has a holistic view of health and life in general and provides a vital way in which health can be maintained and enhanced especially during challenging conditions (Eriksson & Lindström, 2008).

The Salutogenic model and the Self-Tuning Model of Self-care share attributes but have different uses. Whereas the self-tuning process involves introspection, sensibility and reflection through which GRRs enhance the SOC, the Self-Tuning Model is offered as an analytical model to the understanding of job engagement. On the other hand, the Salutogenic model serves as a general model of health. Although it was not the focus of this research project, the salutogenic model's focus on resources for health provides an appropriate frame through which job engagement and self-care experiences of nursing professionals known to thrive on the job against all odds might be understood.

2.5 Religion and Coping

Religion and coping are the subjects of paper 3. As is obvious from the previous sections, this PhD project was founded on earlier work in Norway from which the Self-Tuning Model of Self-care was derived. Two main phenomena in the Norwegian

research were the experience of job engagement and means of coping with the stress of nursing via self-care. The research plan for the present dissertation was to explore these phenomena in a very different context-nursing in Uganda. The motivation was to investigate the relevance of the Self-Tuning Model across contexts. Thus papers 1 and 2 were “pre-ordained” to focus on job engagement and self-care. The genesis of paper 3 was quite different. During the course the interviews and subsequent data analysis for papers 1 and 2, it became overwhelmingly evident that despite many similarities in the Norwegian and Ugandan nurses’ experiences, the theme of religiosity appeared nowhere in the Norwegian data, while religiosity was ubiquitous in the data from the Ugandan nurses. Following the ‘inductive nose’, the decision was made to focus on analysis of religiosity in the work lives of the Ugandan nurses, as reported in paper 3.

The importance of religion and spirituality in the lives of people across the globe is evident from a grown body of research, even if religiosity and health has not been a major theme in health promotion research. (Koenig, 2009; Levin, 1994; Seybold & Hill, 2001).

Koenig (2009) defines religion as ‘beliefs, practices, and rituals related to the sacred’ (p.284). In this dissertation, this broad and multidimensional definition is embraced as it goes beyond the scope of institutional religious practices. Coping is the process of dealing with situations that are seen as exceeding the resources of a person (Lazarus & Folkman, 1984). Coping is a dynamic, multi-dimensional and contextual process involving behavioural and cognitive efforts that enable an individual to deal with stressful conditions (Lazarus & Folkman, 1984; Pargement, 1997).

In coping with challenging situations, Pargement (1997) suggests that an orienting system guides the process. An orienting system, known to be dynamic in nature, has been defined as a frame of reference consisting of material, biological, psychological, social, and spiritual components through which an individual thinks about and deals

with life situations (Pargement, 1997). Religious coping is a process involving the use of religious resources to cope with stressful life events (Pargement, 1997). Religious coping has been associated with better mental and physical health among different subjects and less occupational stress among certain professions and individuals dealing with various challenges (Levin, 1994; Seybold & Hill, 2001; Koenig, 2009; Hodge & Roby, 2010).

Religion as part of an individual's orienting system facilitates the coping process by determining the way in which a stressful event is appraised and the types of coping resources one can draw upon to mitigate the effects of the stressor (Park, 2005).

Although religion and coping share important similarities, the coping process focuses on stressful life experiences while religion focuses on the sacred (Pargement, 1997). While coping can involve religious resources, the significance of religion is not limited to stressful experiences alone (Morgan, 1983; Hodge & Roby, 2010).

In nursing, the role of religion and spirituality is acknowledged with a rich body of literature on nursing's spiritual/ religious and humanitarian origins and the need to empower nurses to cater for the holistic, including the spiritual, needs of their patients (Greenstreet, 1999; Lane, 1987). There is also evidence, most of which is from palliative or oncology settings, illuminating how nurses in practice utilise religious and spiritual coping resources to cope with work-related stress (Ekedahl & Wengstöm, 2010; Shinbara & Olson, 2010).

It is important to understand the different ways through which religion/spirituality might influence nurses' performance in the workplace. However, the majority of the studies that have been undertaken on religiosity and spirituality, with emphasis on coping, in nursing are quantitative in nature often with a simple reference to religion or spirituality as a stress coping resource without describing the mechanisms through which the resource is used. In addition, my literature search did not find nursing studies that have shown how religion affects the work values of nurses in practice.

2.6 Research questions

The principal aim of this study was to explore in-depth the phenomena of job engagement and self-care among Ugandan nurses and midwives with reputations for thriving on the job in spite of challenging work conditions.

The research questions were:

Research question 1:

How do thriving nurses and midwives in Uganda experience job engagement?

Aim 1: To explore the nature of job engagement among Ugandan nurses and midwives.

Aim 2:- To examine, whether or not, the nature of job engagement as experienced by Ugandan nurses and midwives relates to that of Norwegian nurses.

The results are presented in paper 1.

Research question 2:

How do thriving nurses and midwives in Uganda maintain and enhance their job engagement?

Aim 3: To explore the role of self-care in maintaining and enhancing job engagement among thriving nurses.

Aim 4: To examine the coping strategies used by Ugandan nurses and midwives known to thrive on the job.

Aim 5: To explore in what ways the self-care practices of Ugandan nurses and midwives have elements of self-tuning and thus relate to Norwegian nurses' self-care.

The results are reported in paper 2 which also draws on the results reported in paper 1.

Research question 3:

In what ways does religion have a role in the work lives, self-care and coping strategies of Ugandan nurses and midwives?

Aim 6: To explore the role of religion in job engagement and self-care among thriving nurses.

The results are reported in paper 3.

3 Methods

3.1 Setting

The study was conducted in two districts of Uganda, one in the Eastern region (District A) and the other in the Central region (District B). Uganda is a small landlocked country, situated in the eastern part of Africa, sharing frontiers with the Democratic Republic of Congo to the west, Rwanda to the south-west, Tanzania to the south, Kenya to the east and South Sudan to the north. The estimated population of Uganda is 33 million people (UBOS, 2011) occupying an area of 241,038 sq. Km. Uganda has a decentralised system of government and is currently administratively divided into 112 Districts, which are further subdivided into Counties, Sub-Counties, Parishes and Villages. The health service infrastructure follows this pattern.

Map of Uganda (African Safaris, 2005), showing the districts from which the participants were drawn.



In Uganda, the health care delivery services are provided by the public sector, private-not-for-profit (faith-based), private medical practice (private-for-profit), community health workers and traditional herbalists, spiritualists and traditional birth attendants (MOH, 2005, 2007, 2010a, 2010b).

3.2 Design

A qualitative methodology utilising phenomenology and hermeneutic principles was used to obtain rich descriptions of the meanings that the nurses attach to their work experiences. This study was informed by both theory and theory. The Self-Tuning Model of Self-care informed the interview guide (see section 3.4), yet from a phenomenological hermeneutic perspective, we explored Ugandan nurses/midwives' lived work experiences being open to experiences particular to the Ugandan context. Use of qualitative techniques has gained acceptance in nursing research and practice

(Carr, 1994; Fawcett et al, 2001). Qualitative inquiry is a way of discovering the meaning that individuals attach to a phenomenon in context. The assumptions in qualitative research are that human beings socially construct meanings based on their contexts or settings and that reality is created and maintained subjectively (Denzin & Lincoln, 1994). It is interpretative in nature, seeking to provide descriptions and interpretations to the meanings attached to phenomena in context. It is not only flexible, but also rejects a priori classification of data, thus allowing for the emergence of information and interpretations. Very often, qualitative research follows inductive processes resulting in establishment of generalisation unlike deductive processes, frequently used in quantitative methodology that seek to determine whether certain generalisations are applicable to certain instances. Debates between informal and formal use of deductive procedures in qualitative research are on-going. While some researchers argue for adoption of both inductive and deductive processes in qualitative inquiry (Patton, 1991), there are those that advance a case for using either one of the approaches (Yin, 1994). This study was positioned between inductive and deductive processes. The inductive angle sought to describe the work world as seen by the participants, with the aim of illuminating common meanings underlying the nurses' individual work-related experiences. On the other hand, the deductive process followed from the Self-tuning Model of self-care which provided certain areas of the nurse practitioners' work-lives that we explored.

Qualitative research provides a subjective and holistic view of the phenomenon under investigation, as compared to quantitative research (Carr, 1994). It involves active interaction between the researcher and the research participants in their own language, home or workplace. However, these qualitative research attributes are also viewed as potential weaknesses (Yardley, 2000; Malterud, 2001).

Phenomenology lays emphasis on the description and understanding of human conscious experience as it is lived in the world (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009). Husserl maintained that one had to bracket out

foreknowledge in order to ‘see’ a phenomenon clearly, without bias (Dowling, 2007; Lavery, 2003). This bracketing involves identification of one’s prior knowledge about a phenomenon under study and actively attempting to block it in order to see the phenomenon in its ‘pure’ nature.

Heidegger on the other hand differed from Husserl by arguing that one’s consciousness could not be separated from their world (Lavery, 2003). Human beings are products of their history or backgrounds (pre-understanding), which in turn determines their way of understanding the world. This pre-understanding, according to Heidegger, is part of someone and so one could not encounter new phenomenon without referring to their past understanding. Individuals are not passive residents in the world but rather interact with the world affecting each other mutually (Lavery, 2003). At the core of understanding is interpretation. In hermeneutics-the art of interpretation in context, one seeks to obtain a valid and common understanding of the meaning of a conversation or text (Kvale, 1996).

According to Heidegger, we interpret a phenomenon by relating it to the relevant features of our history (past). Every experience is interpreted by an individual based on their background. Gadamer further stressed the inextricable link within language, understanding and interpretation while at the same time arguing against the impossibility of bracketing. There will always be some prejudice in understanding based on our pasts (Lavery, 2003). Openness to these prejudices, through a self-reflective process, helps us understand others and other (new) experiences without unnecessarily filtering them through our own cultural and other biases (Clarke, 1999; Whitehead, 2004). As such, we avoid taking for granted what is said.

This study involved a combination of descriptions and interpretation. From the foregoing presentation, it becomes apparent that it is important for me as a researcher to reflect on who I am in addition to being open to the stories I am listening to as told by my participants. Through reflection, I attempt to obtain meaning attached to their

experiences within their contexts fully aware of our cultural and historical differences. I engaged in a reflective process before and during the interviews, listening to the audio recording, transcribing the interviews and during the analysis. This reflection enabled me to ask such questions as: What biases do I bring to this interview? What is she saying? What does she mean? What am I learning from her? How does she engage in self-care? In what ways does her experience help me to understand the subject better? What else could the themes mean?

I had to try to understand the nurses' experiences within context, fully aware that my understanding of the world might not necessarily be the way the participants view their own world. I was aware that even within a homogeneous or similar group, the subjective world matters. Each participant's story was special. Yet in the spirit of phenomenology, I searched for commonalities across the different participants' accounts in order to obtain the essence of job engagement and self-care among this group of nurses. In the process, I used my interactions with the participants to explore further and reflect on how my own pre-understanding might have impacted on the data collection and analysis processes. (See 'Researcher's role 3.7.1 and 'Ethical considerations' 3.8)

3.3 Participants

The study sample contained fifteen nurses and midwives who were selected using purposive and snowball sampling techniques (Creswell, 2003). While purposive sampling targets a particular group of people, snowball sampling involves participants already in the study suggesting other participants. Purposive and snowball sampling techniques presented the most convenient way to access nurse practitioners with reputations for thriving on the job despite work adversity. In this dissertation 'nurse' is used to refer to either nurse or midwife.

In the first instance, I contacted heads of health units and asked them to nominate nurses or midwives with reputations for thriving on the job. In district A, four nurses

were sampled from different units of a health centre. In district B, three nurses were also sampled from different units of a health centre. By snowball sampling, eight more participants were sampled from district B. As a result nine nurses and midwives from public health units and six from private units were sampled. Fifteen female Ugandan nurses and midwives with reputations for thriving on the job despite working under difficult conditions were nominated by their colleagues based on the following selection criteria;

- i) Known to thrive despite working in difficult working conditions
- ii) Expressed enthusiasm on the job
- iii) Vigorous and highly committed to work
- iv) Nurses or midwives who had been working for over 3 years at their present workplace.
- v) Female nurse or midwife

All participants agreed that they fulfilled the selection criteria. When they fulfilled the inclusion criteria, the nurses had to express willingness to participate in the study. When approached by the researcher, all the nurses in the study agreed to participate in the interviews without persuasion. Female nurses were chosen for comparative purposes with Vinje (2007) and sampled from different geographical and workplaces so as to dampen cultural influences on the sample. I was interested in getting stories from a range of workplaces since I had in mind the differences in work conditions in the different health units. For instance, public health units usually have less access to required equipment and yet have a higher client load. This could mean different exposures to and experiences of stress for different groups of nurses, further adding depth to generated data.

Nine participants were from public (government- aided) health units, three from private-not-for-profit (faith-based) units and the remaining three from private- for-profit health units. All the participants worked in various hospital departments including medicine, gynaecology, maternity, antenatal clinic, outpatients/emergency, neonatal intensive care and surgical departments of different health units in the two districts.

Among the fifteen nurses and midwives who participated in the study, five were double trained-registered nurses/midwives, four were enrolled midwives, three were registered midwives, and one was a registered nurse while two were comprehensive nurses. Within the group, four had training in public health nursing, one in social work and another in counselling.

Participants' ages ranged from 28 to 49 years and years of working experience ranged from three to 29 years.

3.4 Interview guide

An interview guide was used and modified during the data collection exercise to ensure that major themes of the study questions were captured. This structured approach enabled me to get all participants covering the same themes. As one of the study's aims was to examine whether or not the nature of job engagement as experienced by Ugandan nurses relates to Norwegian nurses, the interview guide was adapted from Vinje (2007). The guide contained a list of themes to be covered and suggested questions to be explored. The interview guide was divided into seven main sections: work-life, calling, zest for work, vitality, meaning, self-care, coping and resilience training. Some of the themes overlapped. Work-life, zest for work, vitality, meaning and self-care were inspired by Vinje (2007). Coping and resilience training were inspired by the salutogenic model which suggests that one's ability to cope with stressors is developed from previous experiences.

In all interviews the opening question was: ‘Can you please tell me your work life story?’ (Vinje, 2007, p.40) All subsequent questions, including those seeking clarifications were presented in a conversational style to get the participant to discuss further issues raised in answers. I used open-ended questions such as, ‘What is it that made you choose to study nursing? Do you feel that you are in the right place?’

3.5 Data collection and transcription

Using an exploratory qualitative design, the study’s data were collected through in-depth face-to-face interviews to give the participants an opportunity to share their experiences while on the job. Kvale (1996) argues that when selecting an approach one needs to focus on the research question and issue under study. In this study, the focus was nursing job engagement and self-care experiences. As a qualitative research interview is a way of providing a description of the life world of an individual with respect to interpretation of their meaning (Kvale, 1996), in-depth interviews were deemed an appropriate method for studying the nurses’ lived experiences. In order to answer the research question, I conducted in-depth, one-to-one interviews that were audio recorded. The interviews were open-ended, allowing me to collect as much information as was possible from the participants. After the first 3 interviews, conducted in English, I realised that my participants were struggling to express themselves so I translated the interview guide into Luganda, one of the local dialects. I had someone else (a native speaker of Luganda and fluent in English) check it in comparison to the English version.

One in-depth interview was planned for each participant but with a provision for a repeat, if the need arose. Six interviews were conducted in English (and not repeated). Four interviews were done in English and repeated in the Luganda language because the participants found it difficult to express themselves in English. The remaining five interviews were conducted in Luganda. Thus, nineteen interviews were conducted with the 15 participants.

Data saturation is defined as a point at which no new knowledge is being added with subsequent data collection sessions (Kvale, 1996; Laverly, 2003). I got to this point when I was interviewing the 11th participant. However, at this point I had fewer professionals from the privately run health centres. Since I wanted to have a fairly representative sample of professionals from different settings, I interviewed four more. The interview process stopped after the 19th interview as I realised that new interviews were revealing little new knowledge.

Interview venues were places judged convenient to the interviewee but with limited distractions. The interviews took place between March and May 2010 in either the interviewees' workplaces or at home lasting from 1 hour to 2 hours and 15 minutes.

All the interviews were tape recorded and during the interview sessions I made notes. In the field notes I included my thoughts and initial interpretations regarding my impressions of the interview setting and the non-verbal behaviours of the interviewees.

Transcription of interviews involves a transformation of oral recordings to text (Kvale, 1996). Transcription from one language to another presents a challenge because information is lost in the process. At the end of each day I listened to an entire recording before I transcribed. During the transcription, I replayed the recording and tried to recreate the interview situation. I then wrote by hand as I listened. All the interviews were transcribed verbatim. After all the interviews had been transcribed and field notes typed, I arranged the data into groups (participants from government and private health units).

3.6 Analysis

In order to describe and interpret the nurses' experiences in-depth, qualitative content analysis focusing on the manifest and latent content was conducted using a method adapted from Graneheim and Lundman (2004) and Whitehead (2004). Graneheim and

Lundman's suggestions were the main guiding principles for the analysis supported by Whitehead's suggestions for improving the quality of hermeneutic research. As the nature of qualitative data analysis is largely dependent on the analyst's presuppositions and abilities it was important that I lay bare my biases.

Interviews were analysed through an interpretative comparative process, the hermeneutic circle', involving the moving back and forth between parts of the transcribed text and the whole text in cycles that constitute a spiral. In each cycle I identified meanings in each individual interview, compared a whole interview with others to obtain general patterns of meaning and finally compared all interview accounts to obtain sub-themes and themes. In the analytical process, as I moved from part to the whole, I remained open to alternative interpretations, fully aware of the temporality of truth in light of the text and myself as the interpreter. The interview data was divided into different content areas: work-life experiences, calling, zest for work, and vitality, meaning, and self-care, coping and resilience training as predefined in the thematic guide; religiosity emerged from the data. Under each area, the unit of analysis was the specific text about the nurses' experiences while on the job.

The analytical tool followed a six-stage process.

- i) In the first stage, following transcription of the interviews, I read through each of the transcripts several times to make sense of the data. This was done while I listened to the recording of the corresponding interview.
- ii) In the second stage, I went back to each interview transcript and identified expressions by the nurses that were deemed to be connected to particular themes. These were highlighted and divided into meaning units.
- iii) The third stage involved a process of condensing the meaning units. The aim was to provide descriptions, close to the transcriptions in standard

language. This step served to highlight the manifest content of the interview material.

- iv) In the fourth stage, I made interpretations of the underlying meaning of the identified meaning units. I asked questions like, ‘what did she mean?’, ‘what else could she have meant?’
- v) In the fifth stage, I generated sub-themes from the meaning units.
- vi) Following a reflective process involving systematic search for other possible alternative themes, discussions with my supervisors, and obtaining feedback from participants, themes were generated.

The analysis (*see appendix VI*) was done in two stages, first within cases and then across cases. Later, we compared the results to those of Norwegian nurses (Vinje, 2007; Vinje & Mittelmark, 2006; 2007; 2008).

3.7 Research quality

3.7.1 Researcher’s Role

In qualitative phenomenological hermeneutic inquiry, the researcher is not only an instrument, but also attempts to understand people’s interpretation of a phenomenon. The inquiry process involves a description, reflection, interpretation, and engagement from which the essence of an experience is made (Kvale, 1996). It is therefore important to identify the values and biases that the researcher brings to the study based on their backgrounds, as these shape their interpretation of situations and as such carry implications for research quality (Creswell & Miller, 2000; Kvale & Brinkmann, 2009). I am a female Ugandan medical doctor whose understanding of, and perceptions about the health care system in general and nursing practice in particular arise from personal experiences. Years of training at the medical school and clinical practice that included placements in different health units in Uganda enabled

me to appreciate the context. From my experience, nurses in Uganda carry out their daily work under difficult conditions. I developed interest in discovering and implementing measures to enhance health workers' wellbeing and satisfaction on the job. In the process, I discovered the salutogenic model (Antonovsky, 1979; Antonovsky, 1987) and the Self-Tuning Model of Self-care (Vinje & Mittelmark, 2006; Vinje, 2008) which presented me with an opportunity to explore what can be done to understand and perhaps improve the wellbeing of health workers in Uganda. Having read Vinje's work, I recognise this as a potential source of bias. However, through procedures highlighted below, I hope to mitigate the effects of this bias.

3.7.2 Subjectivity-Reflexivity

Qualitative inquiry is subjective in nature. Many writers argue that qualitative researchers, being instruments, cannot avoid influencing their projects based on their values and experiences. As such, subjectivity ought to be used positively through such steps as self-reflection, discussions with other researchers and or comparison of findings with other studies. In addition, Kvale (1996) stresses that biased subjectivity, which involves researchers avoiding evidence that differs from their own opinions but instead focus on reporting and interpreting their own conclusions, ought to be avoided. Reflexivity, a self-reflective process, demands an appreciation of one's role in the research process based on their values, experiences and interests (Vinje, 2007). As noted in the preceding section ('Researcher's role') I acknowledge that my role in this project is influenced by my past experience, values and interests. Based on my understanding of the Ugandan context, and despite having read Vinje's work, I expected to find something new from Uganda. Noting the importance of contexts, I was open to finding similarities and differences between the nurses in Norway and those in Uganda. I also reflected on my position as a researcher, a medical doctor interviewing nurses about their work experiences. Given the perceived power differences between nurses and doctors in Uganda, I had anticipated reluctance from participants in getting them to open up to me, especially since most of their work

experiences involve interaction with doctors. However, the participants opened up to me, judging from the way some shared very personal experiences while others expressed their gratitude at having someone listen to their ‘story’-the good and the bad, unlike the picture portrayed in the media regarding nurses in service. The fact that I am a female could have had a role in this interaction, possibly downplaying my position as a doctor. In addition to engaging in self-reflection, which I highlight in the ‘Researcher’s role’ I utilised the validity and reliability checks below to ensure that the entire research process attained acceptable quality standards.

3.7.3 Validity

Validity in qualitative research is the extent to which observations indeed reflect the phenomena of interest (Kvale, 1996). It involves checking, questioning and theorising about emergent data (Kvale, 1989). To enhance validity of the current study, I adopted the strategies recommended by Creswell (2009). Primarily, my potential biases were clarified in the ‘Researcher’s role’. In qualitative research, the utility of pilot tests is advanced because these pre-tests enable the researcher to minimise problems during data collection (Kvale, 1996; Sampson, 2004). Kvale (1996) suggests that pilots ought to be conducted with participants with similar attributes to those that will participate in the implemented study. In this study I was aware of the flexible nature of the qualitative study design and the need for openness to new phenomena; I implemented a pilot test in order to determine the ease or difficulty with which participants would find the interview questions.

The interview guide was piloted at one hospital where I interviewed six nurses and midwives, who were not part of the sample analysed for this study, to assess the usefulness of the guide. I discovered that the guide was adequate, only requiring minor adjustments in cases where certain questions did not apply to a particular participant and that the language of some questions needed to be clarified as some of the participants found them to be confusing. The nurses in the pilot were informed

about the nature of the study and prior ethical approval, including a provision for the pilot, had been obtained from the Norwegian Social Sciences Data Services and the Uganda National Council for Science and Technology.

In addition to clarifications that were sought during and after each interview from participants, all the interviews were transcribed verbatim and analysed by the author of this dissertation. As a Ugandan health care professional with seven year experience in the field, my familiarity with health care work helped me to establish trust, and this may have contributed to richer data than might have been collected by an interviewer with less relevant experience.

A validity issue pertaining to this study involves the nature of the subject under study and the way in which the participants were chosen. Because the participants were chosen as success stories, they may have been led to portray their lives in a positive way.

3.7.4 Reliability

Reliability in qualitative inquiry refers to the consistency of the research findings, through the interview process, the data transcription and analysis (Kvale, 1996). This study used some reliability checks, presented below, as suggested by Creswell and Miller (2000). An interview guide was used during the interviews to ensure that all participants' responded to similar questions thus allowing for consistency throughout the interviews. All participants were asked to read the transcript of their interview, all agreed, and all expressed the opinion that the transcripts were correct. Later, I sought and obtained feedback on generated theory and discussed emergent conclusions with participants and colleagues at the faculty (Creswell & Miller, 2000). Following the main fieldwork in October 2009-May 2010, I met with the participants in October 2010. The participants read their transcripts and agreed that they were accurate representations of what had transpired during their interviews. Following the final analysis, in a further feedback field trip in October 2011- January 2012, the

participants received a summary of the emergent conclusions and all expressed satisfaction with the findings.

One aspect of reliability in this study is the fact that the author of the dissertation conducted the interviews, data transcription and analysis. Furthermore, the entire research process may have been affected by my knowledge of the subject. However, in a bid to mitigate the effects of this and thus enhance the study's findings, the supervisors of the project read all the transcripts separately and throughout the entire research, the team engaged in discussions and was involved in the analytical process. Furthermore, I have endeavoured to provide vivid details, through thick and rich descriptions in the various publications (see 'Generalizability').

3.7.5 Generalizability

Generalizability is not the goal of qualitative inquiry and is not a focus of this study. This study sought for similarities and differences in the nature of job engagement and self-care within the studied group of nurse practitioners with the intent of describing the lived experience of practicing nursing under adverse conditions in Uganda. In keeping with qualitative methodology, the findings of this study described the lived experiences of this group of nurses. As such these findings are not intended to be representative of how all nurses in Uganda experience their job engagement and self-care. The value of qualitative inquiry is in highlighting the particularity of a context (Creswell, 2009). In addition, Kvale (1996) argues that through analytical generalisation, a qualitative study's findings might be applied to other situations. Analytical generalisation pertains to a critical assessment of the degree to which one project's findings can be utilised in another setting. As such, the researcher should provide sufficient evidence to allow the readers to make analytic generalisations. I have endeavoured to provide sufficient evidence through rich-detailed descriptions of the nurses' accounts and emergent themes to allow readers to make their own analytical generalisations.

3.8 Ethical considerations

Principles of research ethics demand that researchers uphold the values and moral standards of professional conduct and take due consideration for important obligations towards the protection and respect for the welfare of participants (Kvale, 1996; Kvale & Brinkmann, 2009). In addition, qualitative research involves a sustained and intensive experience with participants and phenomenological inquiry might result in participants sharing sensitive information (Creswell, 2009). Although the study focuses on success stories and damaging information was not expected to be revealed, it was important for me to take certain basic ethical precautions for the safety and wellbeing of participants.

Prior to commencement of the study, ethical approval was obtained from Uganda National Council of Science and Technology and the Norwegian Social Science Data Services. At the start of each interview, each participant was provided with verbal and written information pertaining to the study's purpose and design, their right to withdraw at any time, assurance on confidentiality and anonymity of both the site and the participants and the type of data collection devices. Each participant read and signed an informed consent form prior to commencement of the interview. The participants did not receive any financial incentives. On the interview transcripts the only identifications made were age, district and type of health centre, whether public or private. In the publications, anonymous quotations were used and the names of the districts were replaced by letters A and B.

In an interview study, the researcher weighs between potential harm to the interviewees and the benefits of participating in the study while at the same time reflects on the potential consequences for the participants and the wider group they

represent (Kvale, 1996). I was aware that the interaction between researcher and participant is reciprocal, in that I would learn something new about the participant yet at the same time she would have a voice and possibly learn something new about herself. In the interviews, as I learned, I offered the participants an opportunity to talk about aspects of their work, something they had never had a chance to do. One nurse/midwife, after the interview, stated that the interview had given her a chance to reflect on her professional work and the reason why she worked as a nurse practitioner. It had been a gratifying experience for her.

My interaction with the nurses presented me with a moral and ethical challenge. Some of the nurses spoke of past interactions with doctors and seniors, in which they had been bullied. Even when my inner reaction was, ‘I cannot tolerate that’, I came to terms with the fact that these were individuals working within a system that glorifies certain professional levels and cadres over others. I was also keen to avoid giving false hope to the participants. One midwife expected me to deliver a copy of my report to the national nursing council and the Ministry of Health, with the expectations that their concerns regarding poor working conditions would be addressed.

4 Results

4.1 Paper 1- Factors contributing to job engagement in Ugandan nurses and midwives

The primary aim of this article is to report on the nature of job engagement as experienced by Ugandan nurses and midwives known to thrive on the job amidst various challenging work conditions. In order to illuminate further how job engagement can be maintained and enhanced, this article uses part of the Self-Tuning Model of Self-care as an analytical framework to explore reasons for high levels of job engagement among nurses and midwives known to thrive on the job in Uganda.

The paper addresses the question:

‘How do thriving nurses and midwives in Uganda experience job engagement?’

Our findings showed that the nurses’ job engagement originated from a sense of calling to the nursing profession, which set in motion a process mainly mediated by introspection, sensibility and reflection about their work life. This in turn enabled the nurses to adjust and thrive while on the job. For some the calling was experienced from childhood while for others it was related to a major life-altering experience or in relation to God. Even for the nurses who joined nursing for practical reasons it appeared as if their personal values found a balance with those of nursing, which is a highly value driven profession.

Amidst work challenges such as working without adequate supplies and dealing with demanding clients or bosses, the nurses’ accounts reflected individuals who are passionate about and deeply committed and dedicated to their work. This passion was driven by a search for meaning and meaningfulness in life and reported as a need to be of service to others. The nurses’ job engagement was exhibited as enthusiasm, dedication and vigour, thus supporting prior research on the essence of job engagement.

Overall, the nurses’ accounts revealed individuals with high moral and ethical standards related to personal, including religious and nursing values. Further, the nurses’ job engagement involved use of available resources, both intra- and interpersonal, enabling the nurses to deal with their job demands. When faced with difficult circumstances, through introspection and reflection the nurses reviewed their situations and acted in ways that preserved and fostered their job engagement. Interpersonal relationships in the form of relationships with peers, superiors, and clients were also reported as important factors in the nurses’ job engagement. These were either positive, fostering job engagement or negative, hindering their job engagement. We speculated that the nurses’ ability to thrive despite adversity was

dependent upon having a positive outlook on life rather than on avoidance of stressors. Furthermore, awareness of and one's ability to utilise personal and job resources at one's disposal is critical to reducing the impact of nursing stress thus enabling coping on the job.

As studies have linked personal resources such as reflection, optimism, and self-efficacy, among others, to resiliency and resilience has been suggested as a facilitator of work engagement, we suggested that nurses ought to be supported to build their personal resources (strengths) through self-care. Furthermore, health training institutions and workplaces ought to facilitate nurses to learn the skills for, and practice habitual introspection and reflection about the satisfactions they derive from their work, to enable them maintain high levels of job engagement, especially in difficult work conditions.

4.2 Paper 2- Self-tuning for job engagement: Ugandan nurses' self-care strategies in coping with work stress

This paper explores the self-care practices of Ugandan nurses and midwives with reputations for thriving despite having difficult working conditions. It further sought to examine whether or not the nature of self-care among nurse practitioners in Uganda was similar to that of Norwegian nurses. It addressed the question:

'How do thriving nurses and midwives in Uganda maintain and enhance their job engagement?'

The nurses' expressions revealed them to be highly dedicated, committed and driven individuals with enthusiasm for their work despite the daily work challenges they encounter. In addition to poor pay, the stressors that the nurses reported included working without vital equipment and supplies, having too heavy workloads, struggling to deal with rude or difficult patients, sharing responsibilities with uncooperative workmates and being distressed by overly demanding and unfair

bosses. To counter these challenges, the nurse employed various coping strategies which we in our analysis clustered under nine main themes. These included; sharing of experiences and acting professionally, trusting in God's providence, engaging in other enjoyable activities, letting go, guarding against workplace hazards, preserving quiet time, adapting based on past experiences, clearly separating work from personal life, and finally, resignation.

Their coping was mediated by a dynamic process, centred on the nurses' awareness of their internal and external environment, in which they reflected on their circumstances thus enabling them to adopt various coping strategies that protected and fostered their job engagement when it was threatened. Whereas there were some differences between the Norwegian and Ugandan samples in the nature of stressors experience and coping resources used, our findings provide new evidence for self-tuning as a cognitive process that enables one to cope with stress and adequately maintain job engagement. Our findings on self-care and coping strategies also showed a connection with the salutogenic model. The nurses' experiences revealed individuals who had not only been empowered with skills to deal with work demands, but found their challenges meaningful. Through their upbringing and experiences during training, the nurses reported that they had acquired the skills required to deal with challenges faced during their work. Their nursing roles were meaningful as they used their positions to make their lives and those of the people they served better. In addition, their use of a range of physical, social, spiritual, and mental resources to self-care and cope showed that the nurses found their challenges comprehensible, meaningful and manageable. In light of these findings we speculated that self-tuning enhances sense of coherence that in turn promotes thriving in the midst of adversity.

We concluded that self-tuning for self-care is a key strategy for nurturing nurses' resilience, which in turn fosters thriving in the face of challenging working conditions. Although self-tuning for self-care is an individual mental strategy,

individuals in equally demanding situations could benefit from these nurses' experience.

4.3 Paper 3-*The role of religion in the work lives and coping of Ugandan nurses*

This paper focuses on the influence of religion on the work, coping, and self-care strategies of Ugandan nurses and midwives with reputations for thriving on the job despite work adversity. The focus for this paper was not planned but arose from the data. During the data collection and analysis it became evident that the participants referred to their faith in God and religious values in relation to their work lives.

Paper 3 answers the question:

‘In what ways does religion have a role in the work lives, self-care and coping strategies of Ugandan nurses and midwives?’

In our analysis we found that religion was important in four different ways in the lives of the nurses.

First, religion had a role in the choice of profession. Whereas five of the participants specifically assigned their choice of profession to a call from God, others related their choice to opportunities to be of service to others but often with religious connotations. Second, religion featured in the participants' experiences on the job. This was expressed as either high moral and ethical standards with a link between nursing and personal, including religious values or in the purpose of their work; a religious demand with God as judge of their efforts. Thirdly, the nurses attributed their ability to deal with challenging work conditions to their faith in God. This faith enabled them to find meaning in their circumstances. Coping with job stress was made possible through personal and group prayer activities and sharing of experiences with other colleagues. Religious belief enables individuals to cope with stressful situations.

Finally, having defined their self-care in holistic terms, the nurses' reported the use of various activities including religious ones in their self-care strategies. Prayer and meditation were highlighted as key sources of respite from work-life stress. Holistic self-care through physical, social, spiritual, and mental activities enhances well-being of health care professionals thus enhancing thriving on the job. Given the range of ways in which religion influences the lives of these nurses' we conclude that religion seems to provide a lens through which the participants view their world as coherent. However, since all the participants reported to be actively religious, this does not say anything about nurses who are not.

5. Discussion

The main aim of this qualitative interview study was to explore the nature of job engagement and self-care among nurses with reputations for thriving on the job despite work-related adversity. In this section, some methodological considerations are highlighted before the consolidated findings from the three sub-studies are discussed in the context of the existing literature. Finally implications for and conclusions of the study are stated.

5.1 Limitations-theoretical and methodological

A qualitative study of nursing job engagement and self-care experiences is not without limitations. Limitations of each sub-study are presented in the three papers and will not be repeated here. However, a general consideration for the study worth noting is in the nature of the study design.

As phenomenological-hermeneutic inquiry seeks meaning through understanding and interpretation of an experience, a key limitation of this study of Ugandan nurses' experiences on the job is that the findings present one interpretation of the data. There is no universal understanding of a single phenomenon nor is a particular interpretation superior to another. Besides, seeking to completely understand other people's

experiences is unrealistic. Following from this, I am aware that my horizon cannot be blocked out and yet it cannot at the same time be fully complete or adequately comprehensible to others. I therefore leave the study open to scrutiny by others, cognizant that different findings and or interpretations are possible.

The way participants were recruited through recommendations presents a limitation as the nurses may have been compelled to not only participate, but to also portray their experiences in a positive way, thus masking the negative aspects of their work. Snowball sampling has a potential of having participants recruiting peers they share similar traits with. However, a consistency of responses across the findings and illuminated in the analytical process provided a credible basis for understanding the nature of job engagement and self-care among Ugandan nurses.

5.2 General findings

The current study supports the assertion that the Self-Tuning Model of Self-care is a viable analytical framework in the understanding of job engagement and self-care within the nursing profession (Vinje, 2007; Vinje & Mittelmark, 2006, 2007, 2008). The findings reported in Paper 1 show that the experience of job engagement for the nurses originates from a sense of calling to the profession and is embedded in the meaning that the nursing roles offer to the nurses' lives. The job engagement process is expressed as energy and enthusiasm on the job and is facilitated by intra-and interpersonal resources. Based on the report in Paper 2, the current study has demonstrated that self-tuning, a learnable skill (Vinje & Mittelmark, 2006), can be used by nurses working under difficult conditions and in different contexts to nurture and protect their job engagement, especially when it is threatened. The self-tuning (self-care) process involving introspection, sensibility and reflection is chiefly dependent upon the nurses abilities to use their personal and work resources to adjust and thrive on the job. As reported in Paper 3, religion plays a crucial role in the work lives, self-care and coping experiences of these nurses. As such, the present findings

also demonstrate the importance of context in the study of job engagement and self-care.

5. 3. Search for meaning

5.3.1 Sense of calling

In response to their reasons for choosing nursing as a profession, overall the nurses spoke of a need to be involved in meaningful work. The nurses' accounts reveal passionate individuals driven by a search for meaning and meaningfulness in life. Although the nurses joined the profession following different circumstances, nursing for all offered the opportunity to live their values, to be of service by fulfilling the needs of others and ultimately attending to their own personal needs. For a majority nursing as a choice of vocation was a result of a childhood dream to be part of a health service delivery team. Two of the nurses spoke of nursing as a calling in religious terms-a call from God. Yet for four others their presence within the profession was not an initial choice. This particular group settled for nursing for practical purposes. However this group also spoke of nursing as the opportunity to live out their values through the provision of a necessary service and enabling them with a means of income for their survival. For all the participants, engaging in meaningful work served as a driving force for their job engagement.

The findings support earlier literature on the nature of 'calling' in various ways. First, that a calling is not limited to religious terms (Dik & Duffy, 2009; Duffy & Dik, 2011; Steger et al, 2010). This study shows that a calling can be related to work-related joy and meaning (Vinje & Mittelmark, 2008). Second, the findings show that a calling can be related to a response to a higher voice which could, in some cases, be divine (Dik & Duffy, 2009; Jeffries, 1998). Thirdly, for those who chose nursing out of practical need, a sense of calling can follow a series of events (Jeffries, 1998). Based on the experiences of the participants in regard to their 'calling', the definition of sense of calling by Vinje (2007) is deemed appropriate as it encompasses the

expressions of this study group in regard to their choice of profession. Calling is defined by “feelings of having a mission or purpose, including commitment to and healthy absorption in one’s vocation and having the feeling of being in the right place and in the right position and in the right position” (Vinje, 2007, p. 27). A sense of calling set into motion the job engagement process.

5.3.2 Calling-Vocation match

A match between calling and vocation is critical to the nursing job engagement experience. The findings in this study support an earlier assertion that when a nurse’s search for meaning is matched with nursing roles, their job engagement process is set into motion (Vinje, 2007; Vinje & Mittelmark, 2008). For some, the choice was clear as early as their childhood, yet for others, a series of events in their lives made nursing a practical choice. Even for the group that opted for nursing out of necessity, their job engagement experiences were consonant with those who chose nursing out of realising a childhood dream. It is worth noting that these experiences in this Ugandan context were consonant with those of community nurses in Norway. These nurses also spoke of nursing roles as opportunities to make a difference in their personal lives and also live out their values. It is therefore apparent from these findings that the highly value-driven nature of the nursing profession enabled these nurses to live out their values, thus experiencing the meaning in life that nursing offers. All the nurses in the study came through as a value-driven lot, with high professional and personal ethical standards.

It has been suggested that experiencing a job as a calling rather than just a career or vocation is more beneficial to the individual and the organisation (Duffy et al, 2011). In the current study, the benefits to the individual are evident, as the nurses were able to thrive on the job despite their work challenges. The benefits that health care organisations accrue from having nurses who experience their profession as a calling are beyond the subject of this dissertation. It has also been noted that experiencing

one's job as a calling can have negative consequences. Cardador and Caza (2012) recently noted that employees with a high sense of calling but without a flexible work identity are prone to such conditions as exploitation from co-workers and disillusionment when their values are not supported by their organisations. The findings from this current study attest to this. Some of the nurses spoke of instances when they experienced feelings of frustration when their work environment did not fully meet with their ideals. However through various self-care strategies they had managed to hold on to their job engagement.

5.4 Salutogenic process-job engagement; meaning, zest for work and vitality

This is the main thrust of Paper 1. This health promoting process is set in motion when a nurse's sense of calling is matched with the right vocation.

Findings show that following a calling/vocation match, the nurses' job engagement is a process and not a state characterised by meaningfulness that the nurses attach to their work and expressed as zest and vitality at work. This is in accord with earlier findings from Norway regarding the essence of job engagement among community nurses (Vinje, & Mittelmark, 2008).

Consistently throughout the interviews the nurses came through as highly committed and driven individuals who expressed enthusiasm for their work despite the adversity they had to contend with daily. As in the Norwegian context, in this Ugandan context, nursing engagement in the face of adversity centres on the meaning and meaningfulness their roles provide (Vinje, 2007; Vinje & Mittelmark, 2006, 2007, 2008). Engaging in meaningful work has been said to fulfil the human spirit (Kahn, 1990). For these nurses, nursing placed them in a position to make other people's lives better while at the same time enabling them to survive as a source of income. Some related their work to serving God.

From the nurses' tales this quest for meaning and experience thereof was balanced with high professional and moral standards. With this foundation, they expressed vigour, enthusiasm and dedication while for their work. This study confirms literature on the nature of job engagement as characterised by vigour and dedication (Jenaro, et al, 2011). While meaning is expressed as zest for work, vitality on the other hand enables one to hold on to the meaning. Like the nurses in the Norwegian sample (Vinje, 2007), work for these nurses went beyond the monetary benefits as the majority of the nurses noted that they were willing to fully engage themselves in their roles despite the meagre financial compensation they received for their labour. For these nurses, zest for work was experienced by feelings of being in the right place, being appreciated and through interpersonal relationships and the balance between job demands and resources.

Within this group of nurses, vitality was experienced as inner power possessed or reclaimed after a rest and, like zest for work, subsequently facilitated by interpersonal relationships and the balance between job demands and resources. These findings support earlier reports on the role of job resources and collegial support systems in enabling employees deal with their job demands (Bakker et al, 2007; Hakanen, et al, 2005; Schaufeli & Bakker, 2004). Various scholars have shown that when the work environment is supportive, in the form of job resources and social capital, employees are more inclined to experience job engagement and satisfaction even when the job demands are high (Bakker et al, 2007; Hakanen et al, 2005). The findings from these Ugandan nurses attest to the importance of social support and a positive work environment in fostering employees' thriving on the job.

Self-tuning has a vital connection with the salutogenic model. The salutogenic model's focus on creating positive health is centred on one's view that situations they encounter make cognitive and emotional sense and that resources are available to meet the challenges they encounter. The self-tuning process involves cognitive, emotional and behavioural aspects that enable an individual to not only make sense

out of their situation, but also act in ways that enhance their well-being. Self-tuning, a personal resource, is critical to creation and maintenance of holistic health, both in the workplace and outside work thus facilitating thriving. Findings from this study found evidence for the salutogenic elements-SOC and the GRRs (Antonovsky, 1979, 1987). The nurses reported that their work roles, including the stressful events related to their work, made ‘cognitive’ sense because they had been prepared during their upbringing as children, in their training schools and at work by learning on the job. Nursing roles were regarded as ‘meaningful’ service because they gave them opportunities to make a difference in their individual lives and the lives of others. Furthermore, the nurses regarded their challenges as ‘manageable’ because they knew they had the resources to deal with them. In their self-care processes they utilised a variety of active coping strategies which Antonovsky (1987) identified as GRRs. The assertion as stated in paper 2 is that self-tuning enables one to view their world as coherent as Antonovsky suggested (Antonovsky, 1979). Because self-tuning involves introspection, sensibility and reflection about one’s circumstances and subsequent actions to mitigate the deleterious effects surrounding one’s circumstances, this self-care process enhances an individual’s sense of coherence. As such, when an individual self-tunes, they are in a position to view their world as coherent-comprehensible, manageable and meaningful.

5.5 Pathogenic process-work stress; work overload, poor working conditions

The sense of calling and the resultant calling/vocation match have potential to set in motion a ‘negative’ pathogenic process characterised by stress and possibly burnout (Vinje & Mittelmark, 2007). This is especially eminent when the demands on the individual outweigh their abilities to meet them. The findings on perceived work stressors for the nurses in this study confirm the stressful nature of nursing (Clegg, 2001; McVicar, 2003; Nabirye, 2011) and also present a major difference between nurses in Uganda and those in the West, and particularly in Norway where the Self-Tuning Model developed. Research in the West has shown that a considerable portion

of nursing stress results from either personal demands on the self or from systemic challenges (Sørli, 2004, 2005; Vinje, 2007; Vinje & Mittelmark, 2007). Gibb et al (2010) have indicated that mental health nurses and allied professionals in the United Kingdom found organisational challenges more stressful than direct patient care. Among community nurses in Norway who were thriving at the time they were interviewed, nine out of the eleven nurses had previously come to near-burnout out of the excessive demands they placed on themselves and on others. This led to moral distress, stress, and near-burnout experiences (Vinje & Mittelmark, 2007). However, for the nurses in this study, the sources of stress they reported arose from poor pay, working without necessary supplies, heavy workload, dealing with difficult clients, uncooperative workmates, and overly demanding and unfair bosses made their work lives difficult. In effect, the excessive demands on the Ugandan nurses are placed on them by the health system within which they work. The findings that the nurses are quite often forced to work without necessary equipment have been reported before In Uganda (Nderitu, 2010); a situation that often results in moral distress (Harrowing & Mill, 2010). Moral distress has been reported among nurses providing HIV/AIDS care following from the nurses' realisation that they had to ask patients and their relatives to buy supplies such as gloves, which the health units did not have (Harrowing & Mill, 2010). The nurses in this study reiterated their feelings of frustration, moral distress and mental and physical exhaustion resulting from their work. Whereas these challenges result in moral distress, physical and mental exhaustion, they do not give up and cannot afford to leave. The nurses continue to work because they love their work or for some, because they cannot afford to leave their jobs out of financial necessity.

5.6 Mediating (self-tuning) process; introspection, sensibility, reflection and active coping

When workplace adversity threatens one's job engagement, a self-tuning process involving introspection on, sensibility to, and reflection about their situation enables

the nurses to adjust and cope better on the job (Vinje, 2007; Vinje & Mittelmark, 2006). This mediating process is core to a nurse's ability to thrive, especially under difficult circumstances, as it enables them to detect threats to their job engagement, and make necessary adjustments to their situation, thus avoiding the extreme effects of stress. This self-care process ensures that nurses retain their job engagement even under difficult circumstances. The nurses in this study revealed an active search to hold on to the meaning they find in nursing. Through a dynamic process involving a keen and purposive awareness of their internal and external environments, the nurses reflected on their circumstances, enabling them to adopt coping strategies that enhanced their job engagement when it was threatened.

In nursing and other health care fields, reflective practice is encouraged to enable practitioners redefine their goals in relation to their work roles. This study supports existing theory on the role of reflecting on one's work roles in enhancing practice.

Sensibility is at the core of, and is the most intuitive element of the self-tuning process (Vinje, 2007; Vinje & Mittelmark, 2006). Introspection, sensibility and reflection work as a thermostat of sorts, detecting changes in one's environment and triggering responses which ensure adoption of different active coping strategies. In this study, self-tuning is presented as a personal resource used by individuals to detect threats in their environment serving to set in motion actions to mitigate the deleterious effects of the threats to one's well-being. Self-tuning is a skill that can be acquired through teaching that seems to develop out of one's life experiences. The self-tuning process enables practitioners to identify which conditions they can and cannot control, and ultimately identify those they can alter to ensure their well-being. Thriving is ensured through individual actions or with support from colleagues, peers, family or friends.

For the nurses in this study, coping took several forms. For some, coping was enabled through the sharing of experiences, trusting in God's providence, engaging in other

enjoyable activities, letting go and or adapting based on past experiences. Yet for others coping involved preserving quiet time, guarding against workplace hazards and or clearly separating work from personal life.

Key to the coping process is the ability to view the world as coherent. The nurses' abilities to thrive rested not on avoiding stressors, but on the identification of the threats to their job engagement and mobilisation of resources, personal and job, to mitigate the effects of the stressors.

In the discussion that follows, the specific coping strategies of the Ugandan nurses/midwives are presented.

5.7.1 Sharing of experiences

Several studies on organizational environments and performance have underscored the role of social support in enabling individuals to cope with their work roles (Freeney & Tiernan, 2009). Social capital in the form of positive interpersonal relationships is reported to mitigate the negative effects of challenging work situations (Lewis, 2011). The nurses in this study, too, indicated the role of social support in facilitating them to cope with their challenges at work and ultimately enabling them to thrive on the job. Through sharing of experiences with workmates, friends and or family, they were able to offload various stressful experiences at work and specifically from their workmates, learn from each other's experiences. By learning from other people's experiences, they were empowered to cope better when they were faced with similar situations. This study confirms the importance of social capital in nurturing positive workplaces (Lewis, 2011).

5.7.2 Trusting in God's providence

All the participants indicated their faith in God as a source of sustenance in the face of workplace adversity. As reported in Paper 3, a fact unknown at the time of recruitment was that all the participants were actively religious. While some attributed

their choice of profession to a call from God, all the participants revealed that their work values, self-care and coping strategies were influenced by their faith in God.

Religion and spirituality have been linked to nurses' abilities to cope with work related stress in different contexts (Ekedahl & Wengström, 2010; Shinbara & Olson, 2010). Among caregivers for disabled elders, research has shown that caregivers who utilised religious/spiritual beliefs to cope with care giving had better relationships with their wards, and this was linked with less depression and role depression. Findings from this study support earlier reports in Uganda on nurses' abilities to cope with challenges of providing universal care (Nderitu, 2010). The nurses in Nderitu's study reported that their faith in God not only provided them with protection from hospital acquired diseases, but also enabled them to care for their patients. Pargement's (1997) assertion that religion is a meaning system that serves as a guide to a believer is supported in this study. Indeed for the nurses in this study religion is more than a coping resource, as it also provided a lens through which they viewed their world. Religion provided them with motivation and the ability to cope with their challenges at work and life in general.

Literature on religion and spirituality in the workplace points to challenges that employees face in expressing their beliefs (Grant, O'Neil & Stephens, 2004; Mitroff, 1999). An investigation among nursing staff at a University hospital in the United States of America revealed that although most of the employees perceived their work actions as spiritual in nature, many felt unable to find opportunities to practice their spiritual beliefs (Grant et al, 2004). This was partly due to the perception that discourses about spirituality in the workplace were not desirable. Several nurses in the current study reported that they were able to practice their spiritual beliefs within their workplaces unhindered, with some praying with and for their patients and others praying with work mates with similar beliefs. This was evident in all types of health units, faith based or not. This acceptance of religion/ spirituality in the workplace appears to be a contextual occurrence given that more than 95% of the population in

Uganda actively practices either Christianity (the majority) or Islam (UBOS, 2007). In the Norwegian study where the Self-Tuning model was developed, religion did not feature at all in the nurses' experiences. This study therefore highlights the importance of contexts in the description of lived experiences.

5.7.3 Engaging in other enjoyable activities

Various stress management techniques have been described and found to be useful in enabling individuals cope with stress. These include physical exercises, meditation and pursuing hobbies, among others (Dewe, 1987; Lambert & Lambert, 2008). Among community nurses in Norway, pursuit of other activities alongside nursing was reported as a vital aspect of the nurses' self-care process, enabling to thrive on the job in spite of demanding work conditions (Vinje & Mittelmark, 2006). The nurses in this study also reported that they engaged in other, enjoyable activities outside of nursing. For some, relaxation was achieved through meditation and or prayer, spending time with significant others, listening to music, singing, among others. The current study strengthens the importance of extra-curricular activities in replenishing employees' energy and fostering thriving on the job. The nurses reported a need to undertake other activities alongside nursing as a relaxation tool (hobbies) or as sources of extra income to meet their needs.

5.7.4 Letting go

In coping with life stress, individuals are encouraged to 'let go' of negative emotions and experiences (Pargement & Rye, 1998). First one has to accept the situation at hand and then prioritise pertinent issues to deal with. In the process one is able to let go of unnecessary stress and achieve peace of mind. Religion's principle of forgiveness encourages letting go of negative emotions such as anger (Pargement & Rye, 1998). Outside of religion, letting go ensures that negative emotions following unpleasant situations are forgotten. Several nurses revealed the importance of 'letting go' of situations that were beyond their control as a coping mechanism. Instances

included moments when they knew they had done their best and could not change anything. Some of their experiences with patients, colleagues or superiors placed them in uncomfortable positions, eliciting negative emotions, but by choosing to let go of the situations and emotions, they achieved peace of mind.

5.7.5 Adapting based on past experiences

Learning from one's experiences is a vital resource in the face of nursing adversity (Dewe, 1987; Vinje & Mittelmark, 2006). Lessons learned from past experiences serve as a point of reference enabling one to thrive better in similar or related situations in the future. In the current study, the nurses revealed the importance of learning from past experiences. This took two forms; one was as a result of their professional training and the accrued skills that enabled them to cope with work challenges, and the second followed challenging situations at work, from which they learned to deal with similar situations in the future. The nurses indicated that this form of preparation ensured that when they were faced with certain challenges they had experienced before, it was easier to act in ways that did not worsen the situation. Experiences from the past presented them with options in regard to what they could do and what they ought to possibly avoid when they encountered similar situations in the future.

5.7.6 Preserving quiet time

Mindfulness-based stress reduction techniques have been found to be beneficial in managing various mental and physical disorders in different settings (Irving, Dobkin & Park, 2009; Shapiro et al, 2007). For instance, meditation has been shown to lower stress, improve well-being and enhance coping among students (Beddoe & Murphy, 2004; Oman, Shapiro & Thoresen, 2008). Several nurses in the current study reported the need to find time and a place in which they could meditate and pray. They used their scheduled breaks from work to reconnect with their inner selves away from other people, and some went to the hospital chapels to pray. During this time they reflected

upon their roles and circumstances and also replenished their physical and mental energy.

5.7.7 Guarding against workplace hazards

In the course of their duties, nurses working in the public sector in Uganda often have to work without basic protective gear, such as gloves, due to stock-outs (Bateganya, et al, 2009; Kizza et al, 2011; Nderitu, 2010). As a consequence, they often ask patients and relatives to buy some of the supplies or the nurses have to buy their personal protective equipment (Harrowing & Mill, 2010; Nderitu, 2010). In support of the above reports, in this study, the nurses drawn from the public sector also reported the need to have extra supplies, such as gloves, for when the unit's stock ran-out or asking caregivers to buy what was required. This was to ensure protection from infections.

5.7.8 Separating work from personal life

Because health professionals are prone to mental ill-health in form of compassion fatigue, and moral distress, it is important that they self-care (Ablett & Jones, 2007; Riley, 2003; Sandgren et al, 2005). To this end, a separation of work from personal life is encouraged (Dewe, 1987). The current study supports literature on self-care for professionals regarding the importance of separating work from personal life in dealing with work-related stress. Most of the nurses underscored the importance of striking a work-personal life balance through a clear separation of their work from their personal lives. Separating work from personal life can be difficult and several of the nurses noted that this was not always possible but they strove to attain it with the knowledge that if they did not leave work issues at work, their families suffered. For these nurses, work-life balance was attained through such activities as leaving work issues at work, managing their time better and nurturing themselves outside work by indulging in pleasurable activities including spending quality time with their significant others.

5.7.9 Resignation

On a not so positive note, some nurses revealed tales of despair and apathy following the fact that no matter what they did, they could not change their situation. These nurses reported that they had given up with regard to the way things were run in their health units and in the health system in the country in general. For these nurses the greatest concern was income. Even when they felt that conditions were not right, some of the nurses continued with their work motivated mainly by financial necessity.

These nurses seemed to have resigned to their fate, accepted the frustrations that were part of their work, and continued to function within the system because they had no better options. This finding presents a cause for concern in regard to the quality of the health system and services and welfare of the health workforce in Uganda, as these nurses were recruited because they were known to be ‘thrivers’. If nurses who are known to perform well utilise negative coping strategies, one wonders what happens with the others. Ultimately, this has implications for the health system with regard to the quality of patient care.

6. Conclusions and Implications

In conclusion, the findings from this study illustrate that the Self-Tuning Model of Self-care can be used as an analytical framework in the study of nursing job engagement and self-care, in contexts as diverse as community nursing in Norway and hospital nursing in Uganda. In spite of the challenges they face at work, the nurses in this study demonstrated a determination to hold on to the meaning they initially sought when they joined the profession. Amidst the stressful work conditions they reported to experience, such as dealing with difficult clients, working without adequate resources and a high workload, these nurses exhibited dedication and commitment to their profession and enthusiasm for their work. Although the challenges lead to moral distress and fatigue, they do not give up.

The findings suggest that self-tuning, a learnable skill, can be used by nurses to preserve and enhance their job engagement. The nurses utilised their personal and job resources in order to foster thriving on the job, even when their work circumstances dictated otherwise. A keen awareness of their inner and outer environments gained through a process of introspection, sensibility and reflection, enables the nurses to detect threats to their job engagement. This is then followed by adoption of various health promoting active coping strategies that ensure thriving under difficult circumstances. Although self-tuning is an individual skill, the role of job resources in the nurses' job engagement and self-care experiences implies that it is influenced by one's interaction with the environment. As such, nurses in training and those on the job need to be facilitated to develop and use their self-tuning talents.

6.1 Implications for training institutions

Training institutions have a critical role to play in preparing professionals for practice. Whereas literature has clearly demonstrated the importance of preparing nursing students to provide holistic care to their patients, it is equally important to prepare students to meet the needs of their clients by first caring for themselves. Training institutions are important in the formative years of future professionals. Research on self-care and resilience has shown that these are learnable skills (Shapiro, et al, 2007; McAllister & McKinnon, 2009). Also research on mindfulness-based stress reduction has demonstrated that teaching students meditation skills helps nurture empathy and serves to enhance subjective physical and mental well-being (Beddoe & Murphy, 2004; Oman, et al, 2008; Irving et al, 2009). This study, in accord with prior empirical evidence on the subject, suggests that self-tuning is an important skill that students in nursing training ought to learn and exercise in order to better prepare for the challenges of nursing practice. Findings of this study have shown that these thriving and resilient nurses in part attributed their ability to cope on the job to their experiences in the training institutions. The skills they learned empowered them to deal with challenges they encounter during practice. This study's findings suggest that

by encouraging students to develop and engage in their talents for habitual purposive reflection and introspection about their actions and future roles, they will be able to care for themselves better, and be in a better position to meet the needs of their patients.

6.2 Implications for health care organisations and managers

The finding that job engagement is facilitated by job resources presents a point of consideration for health care managers aiming at retaining an engaged workforce. In line with the healthy workplace settings approach of the World Health Organisation, health care managers are mandated to provide safe and healthy work environments for their employees. Ugandan nurses work under adverse conditions often, without the basic requirements necessary to provide care to their patients and to protect themselves from workplace hazards. Nevertheless, these professionals are able to thrive as a result of the self-tuning self-care process they engage in. The self-care process involves use one's personal and job resources. Although self-tuning for self-care is an individual process, this study has demonstrated that health care organisations and managers have a critical role to play in facilitating health professionals to derive satisfaction from their jobs and thrive in their roles by creating supporting work environments.

In a bid to retain and engaged health workforce, the findings from this study also suggest that health care managers need to encourage their employees to engage in reflective practice. This will enable the employees to identify and derive satisfactions from their jobs.

7. Future Directions

This study contributes to the literature by highlighting the factors that promote and enhance nursing job engagement in Uganda. It presents an important step in understanding the essence of job engagement in a sub-Saharan African context. This

study has demonstrated that nursing job engagement is a process characterised by meaning, zest and vitality and enhanced by personal and job resources

Importantly, it provides evidence that the nature of job engagement as experienced by nurses in sub-Saharan Africa relates closely to experiences of professionals in the West. However, given the methodological concerns raised earlier, future research is necessary to explore job engagement within nursing at a larger scale by including participants from rural settings as the work conditions in these areas present different challenges for nurses in practice. In addition, an exploratory study involving male participants will be vital to examining the nature of engagement among male nurses.

In regard to exploration of job engagement, a particular area of interest is the need to examine the effects of the nurses' engagement on the overall performance of the health institutions and the health system as a whole. Specifically, the way in which the nurses' engagement is related to their training experiences and patient outcomes would better inform nursing research and practice on ways to better prepare practitioners for their demanding but fulfilling roles and also foster retention on the job. This study and research in Norway have demonstrated a link between self-tuning and the salutogenic model by postulating that self-tuning enables an individual to view their world as coherent; comprehensible, manageable and meaningful. Future research integrating the two models is necessary to further demonstrate utility of the same in health promotion programming.

Given the potential use of the Self-tuning Model of Self-care, and the importance of a thriving health workforce in Uganda and elsewhere, research on job engagement among other health care professionals would be beneficial in informing health human resource management policy and practice.

References

- Ablett, J. R., & Jones, R. S. P. (2007). Resilience and well-being in palliative care staff: a qualitative study of hospice nurses' experience of work. *Psycho-Oncology*, *16*, 733-740. doi:10.1002/pon.1130
- African Safaris. (2005). Uganda [Map], Retrieved August 3, 2010, from: http://www.e-gnu.com/country_info/uganda/
- Antonovsky, A. (1979). *Health, Stress and Coping*. New York: Jossey-Bass.
- Antonovsky, A. (1987). *Unraveling the mysteries of health. How People manage Stress and Stay Well*. San Francisco: Jossey-Bass.
- Bakker, A. B., Hakanen, J. J., Demerouti, E., & Xanthopoulou, D. (2007a). Job resources boost work engagement, particularly when job demands are high. *Journal of Educational Psychology*, *99*(2), 274-284. doi:10.1037/0022-0663.99.2.274
- Bakker, A. B., Schaufeli, W. B., Leiter, M. P., & Taris, T. W. (2008). Work engagement: An emerging concept in occupational health psychology *Work & Stress*, *22*(3), 187 - 200 doi: 10.1080/02678370802393649
- Bargagliotti, L. A. (2011). Work engagement in nursing: a concept analysis. *Journal of Advanced Nursing*, *00*(0), no-no. doi:10.1111/j.1365-2648.2011.05859.x
- Bateganya, M., Hagopian, A., Tavrow, P., Luboga, S., & Barnhart, S. (2009). Incentives and barriers to implementing national hospital standards in Uganda. *International Journal for Quality in Health Care*, *21*(6), 421-426.
- Beddoe, A. E., & Murphy, S. O. (2004). Does mindfulness decrease stress and foster empathy among nursing students? *Journal of Nursing Education*, *43*(7), 305-312.

-
- Breda, K. L. (2011), Nursing Contradiction: Ideals and Improvisations in Uganda by *Helle Max Martin*. *Medical Anthropology Quarterly*, 25, 543–544. doi: 10.1111/j.1548-1387.2011.01184.x
- Cardador, M. T., & Caza, B. B. (2012). Relational and Identity Perspectives on Healthy and Versus Unhealthy Pursuit of Callings. *Journal of Career Assessment*, 00(0), 1-16.
- Carr, L. T. (1994). The strengths and weaknesses of quantitative and qualitative research: what method for nursing? *Journal of Advanced Nursing*, 20, 716-721.
- Christopherson, R. W. (1994). Calling and career in Christian ministry. *Review of Religious Research*, 35(3), 219-237.
- Clarke, J. B. (1999). Hermeneutic analysis: a qualitative decision trail. *International Journal of Nursing Studies*, 36, 363-369.
- Clegg, A. (2001). Occupational stress in nursing: a review of the literature. *Journal of Nursing Management*, 9, 101-106. doi:10.1046/j.1365-2834.2001.00216.x
- Creswell, J. W. (2003). *Research design: Qualitative, Quantitative, and Mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2009). *Research design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, 39(3), 124-130. doi: 10.1207/s15430421tip3903_2
- Denyes, M. J., Orem, D. E., & Bekel, G. (2001). Self-Care: A Foundational Science. *Nursing Science Quarterly*, 14, 48-54. doi:10.1177/089431840101400113

-
- Denz-Penhey, H., & Murdoch, C. (2008). Personal Resiliency: Serious Diagnosis With Unexpected Quality Outcomes. *Qualitative Health Research, 18*, 391-404.
- Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the Field of Qualitative Research. In N. Denzin, & Lincoln, Y. S. (Ed.), *Handbook of Qualitative Research* (pp. 1-17). Thousand Oaks, Ca: Sage.
- Dewe, P. J. (1987). Identifying strategies nurses use to cope with work stress. *Journal of Advanced Nursing, 12*(4), 489-497.
- Dik, B. J., & Duffy, R. D. (2009). Calling and Vocation at Work : Definitions and Prospects for Research and Practice. *The Counseling Psychologist, 37*, 424-451. doi:10.1177/0011000008316430
- Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies, 44*, 131-142.
- Duffy, R. D., Dik, B. J., & Steger, M. F. (2011). Calling and work-related outcomes: Career commitment as a mediator. *Journal of Vocational Behavior, 78*, 210-218.
- Ekedahl, M., & Wengstöm, Y. (2010). Caritas, spirituality and religiosity in nurses' coping. *European Journal of Cancer Care, 19*, 530-537.
- Eriksson, M. (2007). *Unravelling the mystery of Salutogenesis: The evidence base of the salutogenic research as measured by Antonovsky's Sense of Coherence Scale*. PhD (DissertationÅbo Akademi University Vasa), Turku.
- Eriksson, M., & Lindström, B. (2008). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International, 23*(2), 190-199.

-
- Fawcett, J., Watson, J., Neuman, B., Walker, P, H & Fitzpatrick, J. J. (2001). On nursing theories and evidence. *Journal of Nursing Scholarship*, 33(2), 115-119.
- Freney, Y. M., & Tiernan, J. (2009). Exploration of the facilitators of and barriers to work engagement in nursing. *International Journal of Nursing Studies*, 46(12), 1557-1565. doi:10.1016/j.ijnurstu.2009.05.003
- Gibb, J., Cameron, I. M., Hamilton, R., Murphy, E., & Naji, S. (2010). Mental health nurses' and allied health professionals' perceptions of the role of Occupational Health Service in the management of work-related stress: how do they self-care? *Journal of Psychiatric and Mental Health Nursing*, 17, 838-845.
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 105-112. doi:10.1016/j.nedt.2003.10.001
- Grant, D., O'Neil, K., & Stephens, L. (2004). Spirituality in the workplace: New empirical directions in the study of the sacred. *Sociology of Religion*, 65(3), 265-283.
- Greenstreet, W. M. (1999). Teaching spirituality in nursing: a literature review. *Nurse Education Today*, 19, 649-658.
- Hagopian, A., Zuyderduin, A., Kyobutungi, N., & Yumkella, F. (2009). Job satisfaction and morale in the Ugandan Health Workforce. *Health Affairs*, 28 (5), 863-875.
- Hakanen, J. J., Bakker, A. B. & Demerouti, E. (2005). How dentists cope with their job demands and stay engaged: the moderating role of job resources. *European Journal of Oral Sciences*, 113, 479-487. doi: 10.1111/j.1600-0722.2005.00250.x

-
- Harri, M. (1998). The sense of coherence among nurse educators in Finland *Nurse Education Today*, 18(3), 202-212. doi:10.1016/S0260-6917(98)80080-4
- Harrowing, J. N., & Mill, J (2010). Moral distress among Ugandan nurses providing HIV care: A critical ethnography *International Journal of Nursing Studies*, 47(6), 723-731. doi:10.1016/j.ijnurstu.2009.11.010
- Hodge, D. R., & Roby, J. L. (2010). Sub-Saharan African Women Living with HIV/AIDS: An Exploration of General and Spiritual Coping Strategies. *Social Work*, 55(1), 11.
- ICN. (2008). Delivering Quality, Serving Communities: Nurses Leading Primary Health Care. Geneva: International Council of Nurses-ICN.
- Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complimentary Therapies in Clinical Practice*, 15(2), 61-66.
- Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *Journal of Advanced Nursing*, 60, 1-9. doi:10.1111/j.1365-2648.2007.04412.x
- Jeffries, E. (1998). Hearing the call to nursing. *Nursing*, 28(7), 34-35.
- Jenaro, C., Flores, N., Orgaz, M. B., & Cruz, M. (2011). Vigour and dedication in nursing professionals: towards a better understanding of work engagement. [Article]. *Journal of Advanced Nursing*, 67(4), 865-875. doi:10.1111/j.1365-2648.2010.05526.x

-
- Josephson, M., & Vingård, E. (2007). Zest for work? Assessment of enthusiasm and satisfaction with the present work situation and health- A 1.5- year follow-up study. *Work, 29*(3), 225-231.
- Kahn, W. A. (1990). Psychological Conditions of Personal Engagement and Disengagement at Work. *The Academy of Management Journal, 33*(4), 692-724
- Kark, R., & Carmeli, A. (2009). Alive and creating: the mediating role of vitality and aliveness in the relationship between psychological safety and creative work involvement. *Journal of Organizational Behavior, 30*, 785-804.
- Kizza, I. B., Tugumisirize, J., Tweheyo, R., Mbabali, S., Kasangaki, A., Nshimye, E., Sekandi, J., Groves, S., & Kennedy, C. E. (2011). Makerere University College of Health Sciences' role in addressing challenges in health service provision at Mulago National Referral Hospital. *BMC International Health and Human Rights, 11*(1).
- Koenig, H. (2009). Research on Religion, Spirituality, and Mental Health: A Review. *Journal of Psychiatry, 54*(5), 283-291.
- Kvale, S. (1989). To validate is to question. In S. Kvale (Ed.), *Issues of Validity in Qualitative Research* (pp. 73-92). Lund, Sweden: Studentlitteratur.
- Kvale, S. (1996). *Interviews: An introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.
- Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative interviewing* (2nd ed.). Thousand Oaks, CA: Sage.
- Lambert, V., & Lambert, C. (2008). Nurses' workplace stressors and coping strategies. *Indian Journal of Palliative Care, 14*(1), 38-44.

-
- Lane, J. (1987). The Care of the Human Spirit. *Journal of Professional Nursing*, Nov-Dec, 333-337.
- Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods*, 2(3), Article 3.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Levin, J. S. (1994). Religion and Health: Is there an association, is it valid, and is it causal? *Soc. Sci. Med*, 38(11), 1475-1482.
- Lewis, S. (2011). *Positive psychology at work. How positive leadership and appreciative inquiry create inspiring organizations*. Chichester, UK: Wiley-Blackwell.
- Luboga, S., Hagopian, A., Ndiku, J., Bancroft, E., & McQuide, P. (2010). Satisfaction, motivation, and intent to stay among Ugandan physicians: a survey from 18 national hospitals. . *The International Journal of Health Planning and Management*, 26(1), 2-17.
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358, 483-488.
- Maslach, C., & Leiter, M. P. (1997). *The Truth about Burnout*. San Francisco, CA: Jossey-Bass.
- Matsiko, C. W., & Kiwanuka, J. (2003). A review of human resource for health in Uganda. *Health Policy and Development*, 1(1), 15-20.

-
- McAllister, M., & McKinnon, J. (2009). The importance of teaching and learning resilience in the health disciplines: A critical review of the literature. *Nurse Education Today*, 29(4), 371-379.
- McVicar, A. (2003). Workplace stress in nursing: a literature review. *Journal of Advanced Nursing*, 44, 633–642. doi:10.1046/j.0309-2402.2003.02853.x
- Minca M. (2011). Midwifery in Uganda: In-depth country analysis. Background document prepared for the State of the World’s Midwifery Report 2011. Unpublished.
- Mitroff, I. I. (1999). A study of spirituality in the workplace. *Sloan Management Review*, 40(4), 83-92.
- MOH. (2005). *Health Sector Strategic Plan II 2005/06 – 2009/2010*. Kampala: Ministry of Health, Uganda.
- MOH. (2007). Annual Health Sector Performance Report 2006/7. Kampala: Ministry of Health, Uganda.
- MOH. (2010a). Annual Health Sector Performance Report 2009/10. Kampala: Ministry of Health, Uganda.
- MOH. (2010b). *Health Sector Strategic Plan III 2010/11-2014/15*. Kampala: Ministry of Health, Uganda.
- Morgan, P. S. (1983). A Research Note on Religion and Morality: Are Religious People Nice People? *Social Forces*, 61, 683-691.
- Munjanja, O. K., Kibuka, S., & Dovlo, D. (2005). *The nursing workforce in sub-Saharan Africa*. Geneva. Retrieved 23.3.09 from <http://www.icn.ch/global/Issue7SSA.pdf>

-
- Nabirye, R. C. (2011). Occupational stress, job satisfaction and job performance among hospital nurses in Kampala, Uganda. *Journal of Nursing Management*, *19*, 760-768.
- Nderitu, E. W. (2010). *The Experience of Ugandan Nurses in the Practice of Universal Precautions*. Masters (Dissertation, Faculty of Nursing, University of Alberta), Edmonton.
- Nguyen, L., Ropers, S., Nderitu, E., Zuyderduin, A., Luboga, S., & Hagopian, A. (2008). Intent to migrate among nursing students in Uganda: Measures of the brain drain in the next generation of health professionals. *Human Resources for Health*, *6*(5). doi:10.1186/1478-4491-6-5
- Oman, D., Shapiro, S. L., & Thoresen, C. E. (2008). Meditation lowers stress and supports forgiveness among college students: A randomized controlled trial. *Journal of American College Health*, *56*(5), 569-578.
- Orem, D.E. (1991). *Nursing: Concepts of practice* (4th ed.). St. Louis, MO: Mosby-Year Book Inc.
- Pargement, K. I. (1997). *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: The Guilford Press.
- Pargement, K. I., & Rye, M. S. (1998). Forgiveness as a method of religious coping. In E. L. Worthington (Ed.), *Dimensions of forgiveness: Psychological research and theological perspectives* (pp. 59-78). Radnor, Pennsylvania: Templeton Foundation Press.
- Parikh, P., Taukari, A., & Bhattacharya, T. (2004). Occupational Stress and Coping among nurses. *Journal of Health Management* 2004, *6*, 115-127.
- Park, C. L. (2005). Religion as a Meaning-Making Framework in Coping with Life Stress. *Journal of Social Issues*, *61*(4), 707-729.

-
- Patton, M.Q (1991), *Qualitative Evaluation and Research Methods*, 2nd ed, Sage Publications, Newbury Park, CA.
- Peterson, C., Park, N., Hall, N., & Seligman, M. E. P. (2009). Zest and work. *Journal of Organizational Behavior*, 30, 161-172.
- Riley, J. (2003). Holistic self-care: strategies for initiating a personal assessment. *AAOHN Journal*, 51(10), 439-447.
- Rose, J., & Glass, N. (2008). Enhancing Emotional Well-being Through Self-care: The Experiences of Community Health Nurses in Australia. *Holistic Nursing Practice*, 22(6), 336-347. doi:10.1097/01.HNP.0000339345.26500.62
- Raatikainen, R. (1997). Nursing care as a calling. *Journal of Advanced Nursing*, 25, 1111-1115.
- Sampson, H. (2004). Navigating the waves: the usefulness of a pilot in qualitative research. *Qualitative Research*, 4 (3) 383-402.
- Sandgren, A., Thulesius, H., Fridlund, B., & Petersson, K. (2005). Striving for Emotional Survival in Palliative Cancer Nursing. *Qualitative Health Research*, 16(1), 79-96.
- Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior*, 25, 293-315.
- Schaufeli, W. B., Salanova, M., Gonzalez-Roma, V., & Bakker, A. B. (2002). The measurement of engagement and burnout: A two sample confirmatory factor analytic approach. *Journal of Happiness Studies*, 3, 71-92.
- Schaufeli, W. B. (2007). Work engagement: An emerging psychological concept and its implications for organizations. In S. W. Gilliland, Steiner, D. D. &

-
- Skarlicki, D.P. (Ed.), *Research in social issues in management* (pp. 135-177). Greenwich, CT: Information Age Publishers.
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, *55*(1), 5-14.
- Seybold, K. S., & Hill, P.C. (2001). The Role of Religion and Spirituality in Mental and Physical Health. *Current Directions in Psychological Science*, *10*, 21-24.
- Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, *1*(2), 105-115. doi:10.1037/1931-3918.1.2.105
- Shinbara, C. G., & Olson, L. (2010). When Nurses Grieve: Spirituality's Role in Coping. *Journal of Christian Nursing*, *27*(1), 32-37.
- Shuck, B., & Wollard, K. (2010). Employee Engagement and HRD: A Seminal Review of the Foundations. *Human Resource Development Review*, *9*(1), 89-110.
- Simpson, M. R. (2009a). Engagement at work: A review of the literature. *International Journal of Nursing Studies*, *46*(7), 1012-1024 doi:10.1016/j.ijnurstu.2008.05.003
- Simpson, M. R. (2009b). Predictors of work engagement among medical surgical registered nurses. *Western Journal of Nursing Research*, *31*, 44-65.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51-80). London: Sage.

-
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Thousand Oaks, CA: Sage.
- Steger, M. F., Pickering, N. K., Shin, J. Y., & Dik, B. J. (2010). Calling in work: Secular or Sacred. *Journal of Career Assessment*, 18(1), 82-96.
- Sørli, V., Kihlgren, A. & Kihlgren, M. (2004). Meeting ethical challenges in acute care work as narrated by enrolled nurses. *Nursing Ethics*, 11(2), 179-188.
- Sørli, V., Kihlgren, A. & Kihlgren, M. (2005). Meeting ethical challenges in acute nursing care as narrated by registered nurses. *Nursing Ethics*, 12(2), 133-142.
- UBOS. (2007). *Uganda Demographic and Health Survey 2006*. Kampala, Uganda and Calverton, Maryland, USA: Uganda Bureau of Statistics and Macro International Inc.
- UBOS. (2011). *Statistical Abstract*. Kampala: Uganda Bureau of Statistics. Retrieved 24.10.2011 from www.ubos.org
- Vinje, H. F. (2007). *Thriving despite adversity: Job engagement and self-care among community nurses*. PhD (Dissertation, Faculty of Psychology, University of Bergen), Bergen.
- Vinje, H. F. (2008). Spenningsfylt omsorgspraksis og selvomsorg: Hvordan kan jobbengasjement bevares og stimuleres i sykepleien? *Tidsskrift for Kreftsykepleie*, 24(4), 6-13.
- Vinje, H. F., & Mittelmark, M. B. (2006). Deflecting the path to burnout among community health nurses: How the effective practice of self-care renews job engagement in the face of adversity *International Journal of Mental Health Promotion*, 8, 36-47.

-
- Vinje, H. F., & Mittelmark, M. B. (2007). Job engagement's paradoxical role in nurse burnout. *Nursing and Health Sciences, 9*, 107-111.
- Vinje, H. F., & Mittelmark, M. B. (2008). Community nurses who thrive: the critical role of job engagement in the face of adversity. *Journal of Nurses in Staff Development, 24*(5), 195-202.
- Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advanced Nursing, 45*, 512-518.
- Wilkinson, A., & Whitehead, L. (2009). Evolution of the concept of self-care and implications for nurses:A literature review. *International Journal of Nursing Studies, 46*, 1143–1147. doi:10.1016/j.ijnurstu.2008.12.011
- Wollard, K. K., & Shuck, B. (2011). Antecedents to Employee Engagement:A Structured Review of the Literature. *Advances in Developing Human Resources, 13*(4), 429-446.
- Wright, M. O., & Masten, A.S. (2005). Resilience processes in development: Fostering positive adaptation in the context of adversity. In S. Goldstein, & Brooks, R. B (Ed.), *Handbook of resilience in children* (pp. 17-37). New York: Springer.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215-228. doi:10.1080/08870440008400302
- Yin, R.K (1994), *Case Study Research: Design and Method*,, 2nd ed, Sage Publications, Thousand Oaks, CA.
- Zuyderduin, A., Obuni, J.D., & Mcquide, P.A. (2010). Strengthening the Uganda nurses' and midwives' association for a motivated workforce. *International Nursing Review, 57*, 419–425.