UTS UNIVERSITY OF TECHNOLOGY SYDNEY

An Ethnographic Study of Nursing on a Surgery Ship Providing Humanitarian Care

by Sonja Dawson
RN, BN, MN (Hons), GCertICUNurs, GCertHigherEd, MACN

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of

Professor Doug Elliott and Professor Debra Jackson AO

University of Technology Sydney
Faculty of Health

January 2021

CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Sonja Ann Dawson, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy (PhD) in the Faculty of Health (Nursing) at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research is supported by the Australian Government Research Training Program.

Signature:

Production Note:
Signature removed
prior to publication.

Date:

15 January 2021

ACKNOWLEDGMENTS

My PhD candidature has been a substantial personal journey, one which was birthed much further back than my initial enrolment into the academic program. Yet, on reflection, the PhD candidature is a defined season that is one leg of a journey. To use nautical imagery, this ‘leg’ has been a voyage through unchartered waters, one that has required frequent recalibration to ensure I remained on the right course. At times, it felt like I could easily be drifting at sea. However, feelings are a poor guide to the truth. I consider it a privilege to have had this opportunity to illuminate a unique aspect of humanitarian nursing and provide in-depth guidance for nurses choosing a similar journey.

The rippling effects of COVID-19 have pushed aside all familiar routines, and we have all had to deviate and adapt significantly from the familiar ways we understood. Nurses, at increased risk to themselves, have made necessary adjustments and have continued to offer humanitarian care in various ways and in ‘out-of-the-way’ places. It is just what nurses do. It is hard to predict the longer term impact COVID-19 will have on the future of international volunteering; however, one thing is certain. Mercy Ships’ mission and vision remain constant—to provide hope and healing in its various forms.

I acknowledge and offer my heartfelt thanks to my fellow travellers who have accompanied me in various ways and means on this research voyage. They are:

- My husband, for aligning with my vision to complete the PhD and for his never-ending encouragement through the numerous life events that have occurred during my candidature;

- My parents, who returned to Australia from Europe by cruise ship while 7 months pregnant with me, sowing a wanderlust for travel and love of the ocean in my spirit before I was born. Sadly, my mother passed before I finished the thesis, but I sensed her encouragement from beyond;
- My family and friends, including Richard and Anne for their advice;
- Mercy Ships' family around the world, many of whom have contributed to the shaping of my character and passion for seeing lives changed. Particular recognition goes to Dr. Gary Parker, who has been and always will be my 'hero' in the faith, modelling extraordinary compassionate care to every soul he met;
- My nursing colleagues, including those who generously participated in this study and those who have gone before me, changing hearts and lives. May I have accurately represented their collective voice, professionalism, and nursing skill as they have loved and served humanity;
- My employer, for supporting a period of research leave in the data collection phase;
- My research supervisors, Professor Doug Elliott and Professor Debra Jackson AO, for their academic guidance in developing my research and writing skills;
- Professional editor Pam Firth of The Detail Devil, who provided copyediting and manuscript formatting services according to the guidelines laid out in the university-endorsed national *Guidelines for Editing Research Theses* (Institute of Professional Editors [IPEd], 2019).

DEDICATION

I dedicate this work to Don and Deyon Stephens, founders of an exceptional life-changing organisation, who, through their remarkable faith and willingness, have left a legacy impacting the lives of so many people, including donors, volunteer crew, patients and their families, and the global community.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ALNAP	Active Learning Network for Accountability and Performance
CASP	Critical Appraisal Skills Programme
CoF	Community of faith
CoP	Community of practice
CoNP	Community of nursing practice
COREQ	Consolidated Criteria for Reporting Qualitative Research
CT	Computerised tomography
FBO	Faith-based organisation
FN	Fieldnotes
IPC	Infection Prevention and Control
IRB	Institutional Review Board
ICU	Intensive care unit
ISC	International Support Center
LMIC	Low- to middle-income country
MCB	Medical capacity building
MeSH	Medicine medical subject heading
MSF	Médecins Sans Frontières
NGO	Nongovernmental organisation
NTEU	National Tertiary Education Union
NCFI	Nurses Christian Fellowship International
ODI	Overseas Development Institute
PACU	Post anaesthesia care unit
PPM	Professional practice model

RN	Registered nurse
STMM	Short-term medical mission
STMT	Short-term medical team
SDGs	Sustainable Development Goals
TD	Transformational development
UNHCR	United Nations High Commissioner for Refugees
VMT	Visiting medical team
YWAM	Youth With A Mission

GLOSSARY

The glossary provides definitions for the following terms that are embedded in this thesis.

Acculturation: Individuals that assume changed behaviour and attitudes (psychological and cultural adjustment) when immersed into a multicultural society, live in close contact with an international team, or who have encountered a different culture (J. W. Berry, 2004).

Humanitarian actors: Those responding to a humanitarian need are described as humanitarian actors (Harvey, 2013). They can be either paid or voluntary. *Actors* is a generic term for people responding to an urgently felt need to relieve suffering and improve health outcomes, usually within the confines of a given role (Beaglehole & Bonita, 2010; Dawson & Homer, 2013).

Humanitarian response: A humanitarian response commonly involves the act of helping others to alleviate suffering and prevent death, where the assistance rendered goes beyond the usual obligations of the responders (Stevermer, 2012). It includes a sense of compassion and assumes an inability of governments and/or society to provide the necessary resources to their citizens (Käpylä & Kennedy, 2014).

Low to middle-income country (LMIC): The World Bank classifies 189 member countries plus 28 other economies into four income groups—low, low-middle, upper-middle, and high—where income is measured in U.S. dollars, using the World Bank Atlas Method of gross national income per capita (The World Bank, 2021). These classifications are updated each fiscal year. The classification provides a broad grouping. Further, it aligns with other indicators such as the Human Development Index, which evaluates the distribution of

education, health, and living standards (United Nations Development Programme, n.d.). Literature also uses the term *developing nation* and a number of alternative terms such as *resource-poor*, *low-resource*, *third world*, and *global south* (Doane, 2014). The terms, often used interchangeably, describe the instability of governance; a high level of debt, poverty; low levels of literacy, education, and technological advancement; poor health infrastructure/outcomes; and dependence on industrialised nations for extra support (Strasser et al., 2016). The common denominator is the inequality of people accessing available global resources (United Nations Development Programme, 2019).

Mission/medical mission: The U.S. National Library of Medicine medical subject heading (MeSH) defines medical missions as “travel by a group of physicians to a foreign country to undertake a special study of short-term duration” (Langowski & Iltis, 2011, p. 71). *Mission* is used in the context of international medical service trips that have neither religious nor military objectives (Mitchell et al., 2012), and the term is now becoming more generic in describing a concept of offering global health. Historically, however, the term *medical mission* has been connected with extending mercy and compassion through health care and simultaneously sharing a message of faith (Panosian & Coates, 2006). It may still be associated with a faith-based (or religious) sense or in a military sense—for example, where the U.S. Navy has provided peacekeeping and medical assistance described as *missions of mercy* (Agazio, 2010; Lagrew et al., 2012; Smith & Smith, 1995; Wegner et al., 2010). The absence of nursing within the definition of medical mission is noted, despite the likely involvement of nurses within service offered through medical mission

projects. The most common acronym for short-term medical teams participating in a medical mission was found to be “STMT” (Lasker et al., 2018, p. 1).

Proselytism: This term refers to sharing the good news of the gospel message from the Bible. Although Mercy Ships is a faith-based organisation, they do not engage in proselytism or recruit those receiving service with manipulation or any contractual agreement. Goods and services are given freely and are not dependent on any response from an individual to believe what they say.

Transformation: A fundamental change used within the confines of this thesis to describe a process of modification, physically or in belief, so that the situation of a patient’s health or functional participation in their family, community, or society achieves a more favourable result. Used in the context of a nurse’s transformation, it relays a change to the nurse’s perspective, leading to a modification—personally, professionally, or both (Boykin & Schoenhofer, 2001).

Transformational development: Transformational development is a framework that focuses on restoring wholeness, not only to individuals but families, communities, and society (C. Roche & Madvig, 2016). Originating from the World Vision organisation, many of the protestant Christian faith-based organisations operate from this theoretical perspective (Myers, 2011), including Mercy Ships.

Volunteer: This term describes people who willingly contribute their knowledge and professional skill without payment of a salary or wage (Sherraden et al., 2008). The concept, as used in this study, may extend to

advocacy, fundraising, and increasing the social profile of organisations through social and/or professional circles.

NOTES ON STYLE

This thesis is presented as a conventional style, formatted to the recommended American Psychological Association's *Publication Manual* (seventh edition).

Key to Transcripts and Fieldnotes

Findings are presented with the following abbreviations and formatting.

Verbatim quotations: Interviewees are deidentified by number (#)—for example, "There is such a spirit of teamwork here (#10)".

Fieldnotes (FN): These are indicated as FN with # diary entry date—for example, "The dayworker moved around the ward delivering food to each of the patients (FN #14 Oct)". On occasion, I summarise observations into a table that originated from fieldnote diary entries without noting every individual date.

Explanation of Terms

Participant: Refers to any nurse who was present in the ethnographic field site during the period of data collection.

Interviewee: Refers to those participating nurses who provided written consent to be formally interviewed during the period of data collection. Interviewees were allocated a number rather than a pseudonym name due to the large number of them.

Nurses: At times, I use the term generically to describe volunteer nurses that work with Mercy Ships.

ABSTRACT

Less than half the world's population has access to essential health services (United Nations, 2020), the majority of whom live in low- to middle-income countries (LMICs; Meara et al., 2015). The inability to access health services denies people a life of dignity. To bridge this current gap in the provision of health care, nongovernmental organisations are responding by deploying specialist, short-term healthcare teams (Ng-Kamstra et al., 2016). Nurses, as the largest group of health professionals, provide care within those teams. Substantial literature is linked to nurses deployed in a disaster response situation, However, there is limited research into nurses' roles within teams meeting a humanitarian response outside that urgent disaster context, and what their contribution brings.

The purpose of this ethnographic study was to explore nursing involvement within humanitarian healthcare provision to generate insight into the area of humanitarian nursing in an acute, short-term, nondisaster context and to extend the research literature surrounding this topic. The study was framed within the context of a faith-based nongovernmental organisation delivering specialist surgery on a civilian hospital ship. The aim was to advance the mission and purpose of humanitarian (nondisaster) nursing, providing a detailed description of the culture of nursing care in that setting.

An interpretivist standpoint, influenced by a social constructivist theoretical position, was taken. Data were collected over 6 months, using participant observation, a reflection of artefacts, and the collective voice of volunteer nurses. Thematic analysis was conducted considering Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. Findings

elucidated nursing within the context of a community of nursing practice (CoNP), revealing four major themes: (1) “What drew us here?” (expressions of motivation), (2) “Who we are and how we do what we do” (expressions of engagement), (3) challenges (embracing change), and (4) development (expressions of transformation).

This study contributes new knowledge by describing the culture of nursing and how nurses enact their care in a previously undescribed humanitarian context. Based on the analysis of findings, a professional practice model (PPM) named HHEALED was proposed. An in-depth application of the model was made to the specific organisational context framing the study. Recommendations arising from this study address nurses’ social and professional roles within humanitarian care that could further validate and strengthen policies and programs for the delivery of humanitarian health care for a mobile platform providing specialist surgical care.

DISSEMINATION OF FINDINGS

Peer-Reviewed Publications

Dawson, S., Elliott, D., & Jackson, D. (2017). Nurses' contribution to short-term humanitarian care in low- to middle-income countries: An integrative review of the literature. *Journal of Clinical Nursing, 26*(23–24), 3950–3961. https://doi.org/10.1111/jocn.13816

Dawson, S., Jackson, D., & Elliott, D. (2019). Challenges and reflections from an international, humanitarian, short-term surgical mission on collecting ethnographic data in a remote environment. *Nurse Researcher, 27*(2), 21–25. https://doi.org/10.7748/nr.2019.e1627

Dawson, S., Elliott, D., & Jackson, D. [Manuscript submitted for publication]. Understanding the motivation of nurses volunteering for humanitarian service.

Dawson, S., Elliott, D., & Jackson, D. [Manuscript submitted for publication]. Participation to transformation: Recognising personal and professional growth in nursing through humanitarian service.

Scholarship

Recipient of the 2020 Joan Hardy Post Graduate Nurses Scholarship from National Tertiary Education Union (NTEU).

Nursing Conferences

2020 *A professional practice model (PPM) for nurses working in a faith-based humanitarian nondisaster setting* [Paper presentation]. Nurses Christian Fellowship International (NCFI) World Congress, Colorado, United States (postponed until 2021 due to international travel restrictions).

2018 *Sailing through ethnographic data collection on a hospital ship* [poster presentation]. Sigma 29th International Research Congress, Melbourne, Australia.

2017 *Introducing Mercy Ships* [oral presentation]. Day Surgery Nurses Association Annual Conference, Sydney, Australia.

Seminars

2018 *Sailing through ethnographic data collection* [Doctoral Award Category 5-minute e-poster]. HDR Research Student Forum, University of Technology Sydney (UTS), Australia.

2018 *Qualitative data collection in a remote context* [RAPP Seminar Series]. Avondale University College, Sydney, Australia.

2018 *The love boat* [Joint Faculty 3-minute thesis competition]. Research Student Forum, University of Technology Sydney (UTS), Australia.

2017 *"The love boat": An ethnography of nursing onboard Mercy Ships* [3-minute thesis competition]. Research Student Forum, University of Technology Sydney (UTS), Australia. Awarded first place.

2017 *An ethnography of nursing on Mercy Ships: A report on my research study* [RAPP Seminar Series]. Avondale University College, Sydney, Australia.

2016 *An ethnography of nursing on Mercy Ships* [Africa Mercy crew meeting]. Benin, West Africa.

2015 *"All at sea": An ethnographic study of nursing on Mercy Ships.* Research Student Forum, University of Technology Sydney (UTS), Australia.

Media Interviews

2017 (4 February). *Foxtel Magazine* interview with Helen Vnuk https://www.foxtel.com.au/whats-on/foxtel-insider/nat-geo-people/surgery-ship.html

2017 *The Surgery Ship* (Season 2 premiere). National Geographic People Channel, 8-part series airing weekly, S. Dawson included in Episodes 1 and 7.

2017 (11 April). *Question and Answer Panel, Preview,* Episode 1 of The Surgery Ship series, Australian Museum, Sydney.

2017 (13 April). ABC Radio National, Amanda Smith [15 min 06 sec] http://www.abc.net.au/radionational/programs/lifematters/why-i-volunteered-as-an-overseas-medic/8441610/

2017 (27 April). Hope 103.2 Radio, *Laura and Duncan Breakfast Show* [7 min 23 sec]. https://hope1032.com.au/stories/culture/guests-and-artists/2017/surgery-ship-brings-hope-healing-forgotten/

2017 (27 April). ABC Radio Perth, Gillian O'Shaughnessy [7 min 44 sec]. https://www.abc.net.au/radio/perth/programs/wa-afternoons/working-as-a-volunteer-on-a-mercy-ship/8477216

CHAPTER 1. INTRODUCTION

Preface

This thesis investigates humanitarian nursing care through a nongovernmental organisation (NGO) that provides surgical care and capacity building of local health infrastructure in low- to middle-income countries (LMICs) via a mobile (ship) platform. My interest in this investigation stemmed from my involvement in international health work, volunteering as a registered nurse (RN) with an NGO in Africa for almost 12 years. My varied roles during that time included the direct provision of clinical care and education, and planning for and management of various health programs. I also learned from, oriented, supported, and debriefed international nursing colleagues and others, giving holistic health care in a faith-based mission context.

While volunteering in Africa, it became clear to me that this setting was unique, and many nurses arrived enthusiastic yet possibly underprepared for the experience. Moreover, many nurses I spoke to about my journey on my return from the volunteer role were curious of the concept of a hospital ship delivering surgical care and wanted to know more. The opportunity to volunteer was commonly shared via word of mouth but was not easily seen in the research literature or professional publications. I considered that a well-conducted research study could contribute to further advance the visibility of nursing for nurses and others in this humanitarian, faith-based mission context and aid their understanding of “how” they nurse.

On my return to Australia 12 years ago, I obtained a role as nursing faculty in a faith-based tertiary setting. In that capacity, I have been directly involved in organising and leading international, clinically focused

service-learning trips for cohorts of senior nursing students. These students often express their interest in participating in humanitarian global health work after graduation. These service-learning trips have involved close collaboration with a foreign nursing school and a remote acute hospital run by a faith-based institution in the South Pacific.

I remain passionate about preparing, teaching, and empowering both nursing students and RNs to fulfil their desire to interact in this vital area of global health need. I believe a well-conducted research study in this area will add to the body of nursing knowledge and benefit future participants in the humanitarian nursing space.

Introduction

A recent report by the World Bank and the World Health Organization stated that half the world's population lacked basic access to health care (World Health Organization, 2017). Despite advances over the past few decades, sizeable gaps remain in the availability of services in particular geographical areas, namely Sub-Saharan Africa and parts of Asia, which fall into LMICs (World Health Organization, 2017). Within the world's population, five billion people do not have access to safe, affordable, and timely surgery, the majority of those being in LMICs, and there is a significant shortage of health professionals to meet the burden of need (Meara et al., 2015). In beginning to address this urgent need, NGOs provide humanitarian assistance through relief initiatives and the development of sustainable programs to assist local providers in improving health outcomes for their people.

Literature gives some attention to nurses working with NGOs to address these health needs, but most publications fall within a disaster response

context. Much less has been published about nurses' contributions in a broader (nondisaster) humanitarian role. A robust description of nursing in a nondisaster humanitarian context is needed.

The field of research for this study is, therefore, international nursing, with an emphasis on charitable, surgical care provided by a visiting medical team (VMT) in a nondisaster humanitarian context. This exploration illuminates nurses' expectations of working for an NGO providing surgical care in an LMIC. This research study will be an authentic guide for those seeking involvement in humanitarian nursing projects. It may also inform and guide human resource managers when selecting and maintaining nurse volunteers.

This qualitative study straddles a traditional immersive ethnographical approach with focused ethnography (Cruz & Higginbottom, 2013; Wall, 2015). Focused ethnographic studies within nursing have typically described an explicit setting, with data collection being more often episodic. Conversely, the data in this study were collected over 6 months of immersive research in the field setting, purposely aligning with more traditional anthropological approaches (Bernard, 2006). Adopting an active participant–observer position provides for an in-depth analysis of the culture and narrative of this cohort of nurses.

The research is seen through the framework of social constructivism. Nurses work in social contexts, and therefore their reflection and understanding of their experience are integral to forming a culture of care. This study is a highly documented exploration of an international nursing team with diverse backgrounds and their interaction within the community of nursing practice (CoNP) to which they are connected. A growing body of knowledge is

constructed from their work context, their experiences, and the global influences of the environments with which they have engaged.

This chapter presents the context and background to this research, which includes a description of the current situation, outlines the research study aims and expected outcomes, states the significance of the study, and gives an overview of the thesis structure.

Context and Background

Globally, inequities exist in the availability and provision of health care services for those in need. Humanitarian crises, whether acute or prolonged, are a major contributing factor to a nation's inability to provide adequate health care to its people (Global Humanitarian Assistance, 2015). The resulting shortfall in the provision of care is pronounced in countries where inherent poverty exists and may be coupled with sudden-onset natural disasters or ongoing human conflict. This interruption of an already fragile health system worsens health issues for citizens and increases their risk of death (Gordon, 2010).

Although global poverty rates have been in decline over the past two decades, 10% of the world's population live on less than US$1.90 per day. That figure indicates a significant reduction from 42% in 1990. However, in Sub-Saharan Africa, the rate of poverty remains at 30% (The World Bank, 2021). Only three of the 40 lowest places listed in the Human Development Index rankings are not geographically placed in Sub-Saharan Africa (United Nations Development Programme, 2020).

In 2020, it is estimated that of the 7.8 billion people in the world, 168 million people will require humanitarian assistance (The Lancet, 2020). Sadly,

one child still dies every 20 seconds from a lack of clean water in developing countries (Troeger et al., 2018). Emerging and re-emerging infectious disease, such as HIV/AIDS, Ebola virus (Buseh et al., 2015), tuberculosis, and most recently, the COVID-19 pandemic (World Health Organization, 2020f) continue to threaten people's quality of life. In 2017, despite a vast improvement in the mortality rate, there were 830 child-bearing-related deaths per day worldwide, with 99% of those deaths in LMICs (World Health Organization, 2020d). LMICs experience a critical shortage of health infrastructure (Dywili et al., 2012; Naiker et al., 2009; World Health Organization, 2015). Increasingly concerning predictions by the World Health Organization help outline a worldwide shortage of 18 million healthcare professionals by 2030 (World Health Organization, 2020c). To further exacerbate the problem, an increasing number of LMIC domiciled healthcare professionals are migrating to more developed nations (World Health Organization, 2020c).

Africa, in particular, has a rising concentration of the world's poor, mainly due to its population growth (Beegle & Christiaensen, 2019). Globally, Africa holds 22% of the burden of disease yet accesses only 3% of available health workers (World Health Organization, 2020b). Civil war (Garry & Checchi, 2020), epidemics (Briand et al., 2014), and violence to healthcare staff put people at further risk of being unable to access care around the African continent (Hawkins & Pérache, 2017).

This underprovision of health services in developing countries continues to be a philanthropic concern (Koplan et al., 2009). The humanitarian charter and minimum standards set out in the humanitarian response in the *Sphere Handbook* mandate that people should have access to "integrated quality

healthcare that is safe, effective and patient-centred″ (Sphere Association, 2018, p. 298). A positive change in global health outcomes is therefore imperative. First, a significant increase in the number and quality of healthcare professionals is needed (Cancedda et al., 2015). International health equity is being addressed through the collaboration of highly resourced countries, rendering global humanitarian assistance to lower resourced countries within health care (M. C. White et al., 2020). Such aid has led to a significant rise in reports on the scale and impact of improvement to equity (Australian Council for International Development, 2014). International humanitarian actors contribute significantly to reducing the inequality gap between various nations' healthcare needs and the delivery of care (VanRooyen et al., 2001; Walsh, 2004). Second, goals towards reversing contributing causes are vital. The United Nations Sustainable Development Goals (SDGs) reaffirm a global commitment to focus on ending poverty and inequality, protecting the planet, and providing all people with the opportunity to enjoy safety and prosperity by 2030. That is, all people should be able to access preventative, curative, rehabilitative, and palliative health care (World Health Organization, 2018a) This study highlights one of the contributing factors towards the achievement of universal health coverage (United Nations, n.d.).

A variety of activities fall under the global health umbrella. Agencies can work across broad domains or they may focus on one particular aspect. The Lancet Commission on Global Surgery identified safe, affordable, and timely surgery as "indivisible and dispensable part of health care" (Meara et al., 2015, p. 3). Further, the Commission recognised that NGOs are one of many vital contributors to the provision of health support necessary to bring both

immediate and long-term health solutions (Alkire et al., 2015). Within this surgical response, nurses are a vital and significant component of those volunteers who respond to humanitarian needs through participating in short-term medical team (STMT) assignments (Rosa et al., 2017).

Humanitarian Response: Who and How?

The World Health Organization monitors and commonly coordinates international responses to humanitarian health inequities. More commonly found in literature is the deployment of teams in a humanitarian *crisis* response.

Assistance in the form of *relief* helps to meet immediate and urgent needs. Relief is most often referred to as the urgent provision of care after disasters or complex emergencies that may be the result of human-manufactured crises, either intended or unintended (armed conflict, transportation incidents such as aeroplane crashes, or explosions) or natural disasters (Breakey et al., 2015). *Natural* refers to geophysical (earthquakes, tsunamis, or volcanic eruption), climatological (droughts, cyclones), or biological disaster (epidemics and plagues). Governments of high-income countries, independent not-for-profit organisations, charities, or NGOs are significant contributors to implementing healthcare-focused responses (United Nations, 2015). It may be provided through the deployment of a military disaster medical assistance team (Agazio, 2010; Kenward & Kenward, 2015; Timboe & Holt, 2006) or large multisectoral organisations sending urgent humanitarian assistance (Cameron, 2011; Fedele, 2015; Laleman et al., 2007; Trelles et al., 2015).

However, when related to health needs, the depiction of humanitarian assistance in the traditional sense, delivered in response to an emergency,

does not accurately reflect the whole spectrum of reality. The malnourished child that breaks a leg in infancy, yet survives, learns to walk on a leg that has healed in malalignment and must then manage through life with a gross deformity. That child, unable to access specialist care, is not able to reach normal developmental milestones, is wrought with physical and emotional pain, is unable to thrive, and develops chronic mobility issues and comorbidities such as arthritis in the hip caused by poor posture. Urgent acute health care, vital at the initial injury stage, may or may not have been provided. However, the appropriate level of care, although maybe lifesaving, was not provided to prevent the development of chronic complications. Consequently, the child suffers the ongoing impact of the initial injury. The complex, individualised care needed in the situation of the child described above does not fall neatly into the humanitarian care spectrum. It may be categorised as *relief*, yet in published literature, humanitarian assistance is heavily weighted on describing the provision of short-term essential services to ensure immediate survival (K. Schneider, 2012).

When considering the whole spectrum of humanitarian care, a developmentalist, primary care approach to health welfare programs is situated at the opposite end to relief and focuses on ongoing structural issues, typically found to be working with communities to improve economic, social, and political development (Darcy & Hofmann, 2003). A long-term presence by agencies provides partnerships to stabilise and improve the delivery of health care, focusing on empowerment, advocacy, logistics, fundraising, and ongoing management (Jacobsen, 2014). Often described as primary health care, it

encompasses care necessary to prevent, prepare, and restore health from crisis situations (World Health Organization, 2018b).

A precise definition related to humanitarian response addressing urgent, nondisaster care in LMICs combining both relief and development aims is missing. In part, this is explained by the complex environments in which NGOs work—environments that are not immediately war affected and do have a national government in place that provides health care under certain circumstances—yet many in need fall through the gaps, developing conditions that severely impair their quality of life (Darcy & Hofmann, 2003).

Further, within this spectrum of global health response between relief and development, there is a significant overlap in the various humanitarian organisations' roles. Many health services provided by international NGOs are implemented in conjunction with host countries' national governments. Organisations that attempt to relieve the suffering of marginalised peoples consist of three main groups (Pezzella, 2006):

1. International government organisations address global issues such as trade, development, human rights, and poverty and bring together member states with an international scope and presence. Multilateral organisations, such as the United Nations High Commissioner for Refugees, World Bank, World Food Programme, and the World Health Organization, rely on funding from multiple governments and external programs.
2. Bilateral organisations are government agencies that give aid to LMICs directly from a single country. One example is the U.S. Agency for International Development (USAID).

3. NGOs, sometimes referred to as private voluntary organisations, consist of both faith-based organisations (FBOs) such as Samaritan's Purse and not-for-profit, secular organisations such as Médecins Sans Frontières (Werker & Ahmed, 2008). The response from this sector focuses on urgent relief, capacity building, and the development of programs for disaster preparedness (Australian Civil-Military Centre, 2015). Collaboration with governmental organisations provides the required financial assistance (Mahn et al., 2008). The provision of care is complex, and these organisations overlap in role and definition.

A category of humanitarian healthcare response integrating both relief and development purposes is provided by some mobile platforms, including *fly-in fly-out* teams (Pfeiffer, 2003). These teams may be deployed in response to a complex emergency; however, some NGOs deploy teams to provide ongoing specialist surgical care in a humanitarian response because the governments of LMICs may not have prioritised or have the capacity to provide that care (McGowan et al., 2020). The ongoing inability of marginalised people to access the basic care they need increases the risk of chronic illness and leads to a critical threat to their health and wellbeing (DuBois et al., 2015). Some examples of health-focused NGOs offering acute surgical care through mobile self-contained hospitals involve planes (Orbis Flying Eye Hospital), trains (Smile Train), and ships (Mercy Ships). Other teams such as Open Heart International transport the necessary equipment and supplies. Nurses function within these teams that provide both lifesaving and life-changing surgical procedures (Dawson et al., 2017).

Since this research exposes nursing within a specific and unique context belonging to mobile platforms (in this instance, a civilian hospital ship), the next section situates Mercy Ships within the framework of organisations using ships to deliver care.

Ships as Specialised Platforms

When this study commenced in 2015, there were several different organisations using ships to provide global health care. Using ocean-going vessels to deliver health care has both benefits and limitations; however, it is essential to note that vessels are usually docked in port and not sailing when delivering health care. It is argued that ships are self-sufficient mobile platforms that can reach regions where clean water, electricity, and medical services are limited or non-existent (Shrime et al., 2015). In contrast, yet dependant on their size, ships are usually only accessible at the coastline, are expensive to maintain, and require ongoing fuel and maintenance.

The first known charitable ship platform was run by Project HOPE, founded in 1958 (Project HOPE, n.d.). It started when a medical doctor serving on a navy warship during World War II witnessed poor health conditions and unaddressed health needs in the South Pacific. Discussions with the U.S. Navy led to the charter of a U.S.-based Naval hospital ship to serve vulnerable populations. Through private and corporate fundraising, the *SS Hope* was deployed 11 times between 1959 and 1974. In 1974, the organisation swapped to land-based programs and continued to work in 26 countries, meeting the healthcare needs of vulnerable people in crisis (Project HOPE, n.d.). The U.S. Navy hospital ships *USNS Comfort* and *USNS Mercy* are 1,000-berth floating hospitals, working in partnership with NGOs such as Project HOPE to give

humanitarian assistance and disaster response for global health diplomacy purposes (Larter, 2020; Licina, 2013).

Other charitable organisations operating ships to deliver health care are recognised. Youth With A Mission (YWAM) ship equipped ministries use ocean-going vessels, yachts, and riverboats in Colombia, the Amazon, Micronesia, and Panama (YWAM Ships, n.d.). Medical Ships Australia serves Papua New Guinea, offering eye surgeries, dental care, primary health care, and community health education (YWAM Medical Ships, n.d.). Other organisations such as Sonship (Sonship, n.d.) and Sea Mercy (Sea Mercy, 2018) are deployed by FBOs to deliver primary health care to the South Pacific Islands.

This study focused on nurses volunteering with the NGO Mercy Ships, which operates the largest civilian hospital ship, the Africa Mercy. The NGO represents a sector of the industrialised “north”, delivering compassionate health care in the form of specialist surgery to those suffering from abject poverty in LMICs, with volunteer crew receiving no remuneration. For the past several decades, the organisation has been situated in Sub-Saharan Africa. Although considered “elective” by definition, some surgical procedures offered are lifesaving, such as for patients with large head and neck tumours impeding on their oesophagus or trachea (Mercy Ships, n.d.-e).

As an NGO, Mercy Ships also incorporates local staff, employed to assist with cultural assimilation and translation. Mercy Ships’ aim, to support and contribute to the effectiveness of local healthcare capacity, is as important as the surgical care rendered. Mercy Ships works in collaboration with the host country’s local system and other partners for referral of patients and provision of

care. Empowerment is encouraged with the addition of programs to bolster the local healthcare system. In that capacity, Mercy Ships exchanges knowledge with local healthcare providers, shares resources, and helps to strengthen policies (Close et al., 2017; M. C. White et al., 2017). Anecdotal stories and documentaries such as *The Surgery Ship* (Hetherton-Miau, 2017) and *Mighty Ships* (Nielsen & McCairley, 2010) have provided information about charitable health care through Mercy Ships. However, there has been no formal nursing research documented about the nature and experience of nurses as key actors in healthcare delivery through charitable ship platforms.

Problem Statement

To date, the provision of humanitarian nursing practice and the challenges experienced by nurses have not always been well understood. While the experience of nurses delivering humanitarian care in a disaster is somewhat known, nursing practice delivered in the context of a short-term medical context in an LMIC with ongoing humanitarian need remains hidden. There is a lack of standardised, accepted definitions for humanitarian response (Kohrt et al., 2019), and a conceptual framework to conduct research into a humanitarian context considered acute nondisaster relief was not located. Further, there seems to be a disconnect between NGOs and others conducting research into humanitarian nursing; however, if consequential changes are to be made in nursing practice, education, and research, a coordinated effort is vital to access data and information (Weiner, 2011). As an educator in global health, it is clear that more understanding of a nurse's role in nondisaster care in an LMIC is needed to provide appropriate education and support to nurses choosing to engage in this environment. As this study undertook to understand the

experiences of humanitarian nurses and how they perceived their practice, an ethnographic approach offered the best way to establish fundamental insights into the role of nurses participating in this type of humanitarian care.

Purpose of Study

The purpose of this study was to explore how nurses involved in short-term nondisaster humanitarian care perceive and manage their experiences of working in a volunteer nursing capacity in an LMIC.

Aim

The aim was to advance the mission and purpose of humanitarian nondisaster nursing to provide insight and understanding to support a volunteer nurse choosing to work in a humanitarian setting. Therefore, this study aimed to enhance understanding of the role of nurses in volunteer service, working within a remote environment in a noncrisis mobile setting, and while engaging with other cultures in the humanitarian nursing context.

Objectives guiding this study were

1. to interpret the culture of nursing practice delivered through an FBO using a hospital ship to provide care;
2. to establish nurses' perceptions of participating in international humanitarian work;
3. to evaluate any specific nursing skills developed while volunteering in a ship-based setting;
4. to analyse factors that may contribute to, or hinder, nurses' practice in this humanitarian response context.

Significance of Study

Nurses' experiences, and the culture of nurses volunteering in a nondisaster, short-term surgical context, are made prominent. Analysis of findings draws conclusions and provides recommendations for nurses choosing to volunteer in a humanitarian, nondisaster nursing context.

Culture is described by renowned nurse anthropologist Leininger (1995) as ″the learned, shared and transmitted knowledge of values, beliefs, norms and lifeways of a particular group that guides an individual or group in their thinking, decisions and actions in patterned ways″ (p. 60). Culture, therefore, impacts individual, family, social group, and community domains. The concept of culture, as applied to nursing, relates to one's perception of illness, assumptions of physical and psychological needs, and communication. Although it is possible to find quantitative information about the numbers and types of surgeries completed, or the number of health professionals trained, there is a lack of relevant research evidence confirming and describing nursing within humanitarian nondisaster projects.

The International Council of Nurses and other professional bodies mandate the importance for nurses to reflect on their values and beliefs when delivering ethically and culturally competent care to others in a vastly different cultural context (Williamson & Harrison, 2010). As one way to prepare themselves for humanitarian work, nurses may seek out published literature to guide them in the process of engaging in the sector and therefore learn from those who have gone before them (Almonte, 2009). International volunteering in health care is receiving considerable scholarly attention, but there is a gap in published literature for nurses' involvement and impact (Dawson et al., 2017).

While nursing within a disaster response situation is widely reported (Downes, 2015; Hamlin, 2010; Sloand et al., 2012; Yan et al., 2015), less research is available for nurses involved in acute need in nondisaster humanitarian aid response situations. Because published research literature is a valuable resource to ensure nurses' contribution to humanitarian work is understood correctly, and to inform, equip, and empower nurses to work to their full potential, this study aimed to extend the available literature meaningfully.

Study Outcomes

The results of this qualitative enquiry reveal essential aspects of the nursing culture within a specific humanitarian nursing context—that is, promoting social justice and addressing health disparity through the delivery of compassionate surgical care. The study's findings aid in informing future nursing volunteers as well as providing nurse managers, educators, preceptors, and human resource personnel with more understanding as to nurses' experiences and perceptions of volunteering in a humanitarian environment. The research findings may influence the orientation, mentoring, and debriefing of future nurses. Research findings may also lead to positive outcomes in the recruitment of nurses and the development of programs and processes to aid their experiential learning. The study has provided a means for self-examination for nurses choosing to work in this or similar contexts and gives opportunity to contrast and appreciate social and cultural differences through a shared identity. Aspects of nursing leadership, policy development, and future curriculum development for nurses in this and similar nursing contexts have emerged.

Beyond the study's setting of one hospital ship, its findings make an original contribution to knowledge about the role of volunteer RNs in a combined humanitarian aid and NGO context. This articulation of knowledge provides a firm foundation on which to develop nursing-related activities and further strategic planning. Although generalising the study's findings may not be appropriate, there are currently several charitable and government organisations offering healthcare services from a mobile ship platform. As there is limited knowledge about nursing in that context, findings from this study contribute to a broader understanding when considering similar mobile platforms offering global health care. A gap in the literature is made evident in Chapter 2.

Thesis Structure

I present the research in seven chapters, with associated documents as appendices.

Chapter 1 describes the core concepts aligned with this qualitative study and the central problem the study addresses: that humanitarian nondisaster nursing is hidden within the research literature. Background about the chosen organisation provides a lens through which the study is framed. It presents my interest in the topic, and the purpose and scope of the study, and states the research objectives that scaffold the study.

Chapter 2 situates the context for the thesis, critically analysing relevant published research literature. An integrative literature review was published from this work (see Dawson et al., 2017). I discuss and justify the need for further research to contribute to a greater understanding of the culture of

nursing within a volunteer, nondisaster humanitarian nursing context. An updated literature search was completed covering the years from 2017 to 2020.

Chapter 3 situates the work within a philosophical and methodological framework in which the key theoretical concepts that underpin ethnography provide a rationale for the study's design. A core focus of this research was to understand the culture of nursing by describing the experiences of participating nurses. In this chapter, I justify the methodology used and declare my position as an active participant–observer.

Chapter 4 describes the research methods I used as focused ethnography. I discuss ethical considerations and describe the setting. Methods of data collection and analysis, including reflections and challenges of data collection in a remote location are presented. A methods paper was published from this work (see Dawson et al., 2019).

Chapter 5 presents the research findings in four overarching themes which align with the study's objectives. Twelve related subthemes elucidate the topics.

Chapter 6 presents a discussion of the study's findings, emphasising the salient features, and situates the findings within published literature. I discuss holistic care within the framework of nursing theorist Jean Watson and as situated learning in a CoNP. I then present a professional practice model (PPM) for humanitarian nursing as it relates to the organisational context.

Chapter 7 contains recommendations for further research, policy development, and nursing practice and provides a concluding reflection.

Chapter Summary

Mercy Ships is an organisation through which nurses volunteer in a nondisaster humanitarian response, promoting social justice and addressing health disparity through the delivery of compassionate surgical care. While there are anecdotal stories and media presentations about this charitable work, to date, there has been no formal nursing research documented about humanitarian nursing through a hospital ship setting. A deeper understanding of how the culture of nursing care affects delivery may help with recruitment of prospective volunteers. Articulation of the culture of care through this research will inform and strengthen nurses' resolve to align themselves with this work. Chapter 2 offers an extensive and systematic search of the literature to situate the research study within the humanitarian space.

CHAPTER 2. LITERATURE REVIEW

Introduction

This chapter reviews the published research surrounding nurses' involvement in humanitarian nursing to provide insight into the context and rationale for this study. An integrative review was published as an integral component of this thesis (Dawson et al., 2017). The integrative review method and synthesis are presented here verbatim in Microsoft Word format, although tables have been renumbered to match the thesis format. As the literature review connected with this study was published in 2017, a more recent literature search using the same criteria as the initial review was performed in 2020. A relevant, updated critique is provided to incorporate literature published since the initial review.

Published Integrative Review

An integrative review approach was selected to enable inclusion of a broad range of study designs and data collection processes for this topic area. This framework incorporates a defined review question, an explicit search strategy across a range of study designs, quality appraisal of study methods, and synthesis of study findings (Whittemore & Knafl, 2005). Selection of a broad sample of designs allows a comprehensive and rigorous analysis of the available literature (Tavares de Souza et al., 2010).

Aim

The aim was to review published research literature with a specific focus on the provision of nursing care in the international, voluntary, humanitarian short-term context and to synthesise selected publications to describe the

involvement and relevance to clinical practice that nurses have in the context of international volunteer work. The research question was developed to guide the review: ″What role and activities do nurses perform in visiting medical teams (VMTs) administering professional health care in low- to middle-income countries (LMICs)?″

Search Methods

Based on the review question, an electronic bibliographic search of publications indexed in seven medical and social science scholarly databases was performed: ProQuest Health and Medicine, Academic Search Complete (EBSCO), PubMed, MEDLINE, Embase, ScienceDirect, and Scopus. The search dates spanned from 1995 to 2015.

The four major keywords searched were nursing, humanitarian, international, and volunteer. Subject headings were expanded to encompass short-term medical mission/trip/team, surgical brigade, humanitarian organi* (organisation/organization), humanitarian aid/assistance, development agency, NGO, faith-based, charity, healthcare provision, altruism, developing country, low-middle income country and marginali* (marginalised/marginalized). Search results were imported into a bibliographic database, EndNote (Thomson Reuters, New York, NY, USA), and duplicate citations were removed. Titles and abstracts were assessed for eligibility for inclusion in the review. Handsearching of articles for reference lists to identify additional publications that were not initially located was used.

Selection of Papers for Inclusion

Papers were included for review if they met the following inclusion criteria:

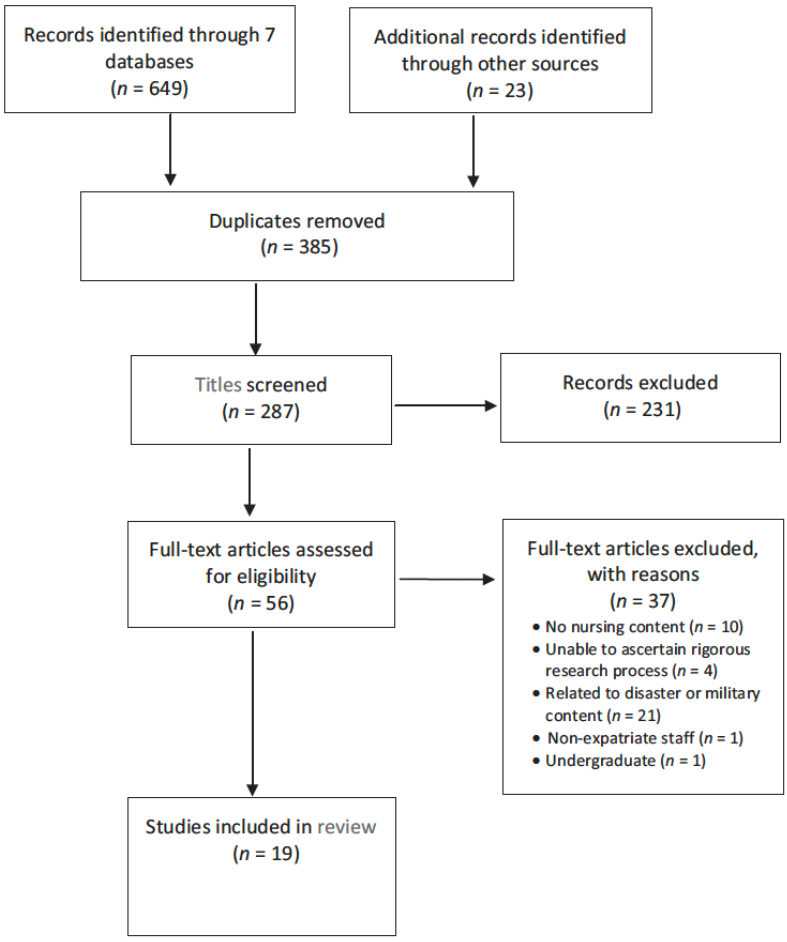
- Primary research related to charitable healthcare provision in an LMIC, including medical capacity building;
- Peer-reviewed papers of primary research related to short-term medication missions (STMMs);
- Published between 1995 and 2015 in the English language;
- Assistance was short term (< 2 years' duration);
- Participants were qualified international health professional volunteers that specifically included nurses as part of the STMM team.

Studies were also excluded that reported a response to an acute disaster, including military efforts for terrorism or war, or focused on team learning with undergraduate and/or postgraduate teams rather than serving or teaching the recipients.

A PRISMA flow diagram (Moher et al., 2009) was used to document each stage of the study selection process (see Figure 1).

Figure 1

PRISMA (2009) Flow Diagram



Quality Appraisal

The rigour, credibility, and relevance of the selected studies were appraised for retention in the review. Qualitative, quantitative, and mixed-methods research papers were assessed according to the Critical Appraisal Skills Programme (CASP UK, 2013) tool. Systematic reviews were assessed according to the PRISMA guidelines (Moher et al., 2009). Twenty-five papers were critically appraised; six were excluded as they did not meet the accepted criteria for detailing the research process, research method, or ethics requirements. Nineteen papers were therefore retained following critical

appraisal: eight qualitative, four quantitative, and three mixed-methods studies, and four systematic reviews.

Data Analysis

Whittemore and Knafl's (2005) framework was used to guide the analysis and synthesis of data extracted from the studies. A thematic analysis framework (Whittemore & Knafl, 2005) enabled the inclusion of a diversity of study findings from a range of designs to be grouped into categories (Z. Schneider & Whitehead, 2013). A matrix was developed to identify and compare common topics. Findings emerged through repeated readings of the studies to identify similarities between studies until categories and issues were identified (Torraco, 2016). For the quantitative studies, key narrative findings from the study authors were examined by a constant comparative approach, with findings from the other designs incorporated where appropriate into the synthesis.

Findings

Included literature comprised a combination of reviews and qualitative, quantitative, and mixed-methods studies. Table 1 summarises the papers included in the review. Key findings from the review papers are initially reported separately to provide context for the evidence base and subsequent synthesis of findings. A brief description of the primary studies is also provided, before presenting identified issues.

Of the 19 articles included, four were systematic and/or integrative reviews, two of which reported the participation of health professionals via short-term trips to LMICs and the impact on and quality of their involvement in health systems (Martiniuk et al., 2012; Sykes, 2014). These reviews identified a lack of satisfactory reporting, including limitations in conceptual or theoretical

analysis (Martiniuk et al., 2012). Furthermore, as these STMMs were likely to increase in the future, the authors urged organisations to ensure they report more specifically on the work they are doing to enable a more accurate picture of team geographical placements, the roles and responsibilities of team members, and the anticipated impact of these trips on both volunteers and those facilitating and receiving the care.

From a primary research perspective, eight articles included some aspects of expatriate health professional staff experiences (including nurses) while working in the described context (S. Adams et al., 2012; Asgary & Lawrence, 2014; Bjerneld et al., 2004; Busse et al., 2014; Chapin & Doocy, 2010; Chiu, Weng, Chen, Yang, Chiou, et al., 2012; Lal & Spence, 2016; Withers et al., 2013), and 14 described the evaluation of a particular program while serving on an STMM, which included varying aspects of team dynamics and nursing involvement within those teams (Bido et al., 2015; Busse et al., 2014; Chiu, Weng, Chen, Yang, Chiou, et al., 2012; Chiu, Weng, Chen, Yang, & Lee, 2012; Compton et al., 2014; Dawson et al., 2014; Dawson & Homer, 2013; Elnawawy et al., 2014; Green et al., 2009; Haglund et al., 2011; Laleman et al., 2007; Martiniuk et al., 2012; Sykes, 2014; Withers et al., 2013). There was an overlap of the two categories in three articles (Busse et al., 2014; Chiu, Weng, Chen, Yang, Chiou, et al., 2012; Withers et al., 2013).

Issues

A number of issues were identified from the chosen articles: a description of demographic data (demographics of volunteers), the reasons health professionals offered their services (motivation for involvement), how effective the work was (assessing how sustainable the services of particular

organisations or programs might be in the longer term, i.e. sustainability), and issues related to cultural safety and ethical or moral obligations of foreign health professionals volunteering in an LMIC (cultural, ethical, and moral obligations).

Table 1 summarises the aims, methods, and findings of papers included in the review.

Table 1

Identified Literature

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
S. Adams et al., 2012	To report on the experience of a surgical team offering humanitarian assistance via STMM	Some; describes nursing as preoperative assessment, postsurgical clinical care, and education to local nursing staff; experience	Descriptive qualitative; case study	*N* = 54 (including 40 nurses) in two visits of a cardiac surgical team from Canada to Peru	Demographic data about number of patients treated and types of cardiac conditions managed; relationship between visiting and host teams discussed, along with challenges in managing environment and resources
Asgary & Lawrence, 2014	To explore experiences and perspectives of *experienced* humanitarian actors	Minimal; unable to differentiate as to specific nursing involvement in results; experience	Descriptive qualitative; interviews	*N* = 44 career humanitarian workers > 3 years' involvement, including six nurses	Values and beliefs of humanitarian actors strongly linked to personal/ organisational ideologies and influenced by shared experiences
Bido et al., 2015	To obtain humanitarian actors' perspectives on their effectiveness of participation in STMM and sustainability of changes	Nonspecific; brief description about autonomy of U.S. nurses and clinical education skills offered; evaluation of team	Descriptive qualitative; interviews	*N* = 21 STMM health professional participants to one orthopaedic NGO in Dominican Republic including one expat U.S. nurse	Dominican Republic (host) nurses positively influenced by exposure to visiting team structure; continuing education and cultural exchange increased sensitivity of both visiting and host teams to each other

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
Bjerneld et al., 2004	To assess impact on recipient and professional behaviour of volunteer after participation on return to home country	More nursing than medical; experience	Descriptive qualitative; interviews	*N* = 20 Swedish health professionals working with national and international NGOs, including 15 nurses	Six themes including both positive and negative thoughts and unexpected nature about work, feelings about other 'actors', role of recruiting organisations. and factors affecting success
Busse et al., 2014	To quantify and evaluate personal and professional impact on STMM participants	Some; description of improved clinical nursing skills; experience and evaluation	Survey questionnaire and open-ended questions	*N* = 63 healthcare professional participants to one health NGO in Ethiopia, including 19 nurses	Participants rated personal and professional impact from involvement as high, with 83% accomplishing goals of trip(s); included being positively changed by experience
Chapin & Doocy, 2010	To quantify the current practices of STMM trips from United States conducted by a range of organisations	Nonspecific; very brief description about capacity building related to local nurses; experience	Survey questionnaire and open-ended questions	*N* = 40 experienced STMM volunteers (not specified as nurses, however stated 40% other health professionals likely including nurses, therefore up to 16)	Demographics of participation, including types of medical and surgical involvement, donations, and collaboration with local health providers

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
Chiu, Weng, Chen, Yang, Lee, et al., 2012	To measure efficiency and perception of participants of STMM	Although nurses included in sample, unable to differentiate any further specific nursing-related data from results; evaluation	Retrospective data analysis; questionnaires	*N* = 71 reports of STMM activity from Taiwan to Central America and South Pacific *N* = 253 participants, including 75 nurses	Cohort analysis of health professionals STMM involvement to two geographical areas (Central America and South Pacific) and comparison of services showed visits to Central America were primarily communities, while in South Pacific, mainly to hospitals with no significant difference in demographic data or expectations of those participating in STMM to different geographical locations
Chiu, Weng, Chen, Yang, Chiou, et al., 2012	To quantify participants of STMM and explore motives and perceptions of them	Nonspecific; although nurses were included in sample, results did not differentiate any further specific nursing-related data; experience and evaluation of program	Survey questionnaire	*N* = 278 participants in Taiwan International Cooperation + Development Fund, including 86 nurses	Demographic data about numbers and types of health professionals, as well as destination of STMM trips, motivation, and expectations

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
Compton et al., 2014	To assess a particular organisation's effectiveness from participants' perspectives	Nonspecific; unable to discern specific nursing activity evaluation of program	Survey questionnaire and in-depth interviews	*N* = 500 + *N* = 18 interviews, including 69 nurses	Cohort analysis; number of trips, trips, countries visited and estimated costs; results reflected overall satisfaction by participants in trips
Dawson et al., 2014	To explore literature related to collaboration of midwifery services supporting education and professional activity in LMICs	Specific to midwives and clinical nurse educators' evaluations of program	Systematic integrative review	Ten nonresearch articles and five research articles included in meta-synthesis	Identified activities instrumental in building capacity, including education training and research programs
Dawson & Homer, 2013	To identify the needs and experiences of international health workers	Nonspecific; unable to discern specific nursing activity evaluation of program	Integrative narrative review	*N* = 11 studies	Identified eight themes, including skills needed, challenges, motivations, identity, ethical dilemmas, cultural issues, and personal health needs
Elnawawy et al., 2014	To obtain international medical volunteers' experiences and expectations of participation	Minimal; development focus of primary health care; clinical skills teaching program; midwives; evaluation of team	Grounded theory; interviews	*N* = 13 British health volunteer placements with one organisation to Nepal, including five auxiliary nurse midwives	Themes included motivation of volunteers, contextual naivety, relationship between volunteers and local health workers, expectations

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
Green et al., 2009	To assess local (Guatemalan) and foreigner perceptions of short-term medical volunteer work provided by foreigners	Minimal; unable to discern specific nursing activity; evaluation of team	Ethnography; interviews	*N* = 72 (23 Guatemalan healthcare providers, 2 of whom were nurses and 21 foreign medical providers, parents of recipients of care, government officials and nonmedical personnel)	Themes identified healthcare needs of Guatemalan communities, their perceptions of dependence on foreign providers, and the burden on host community, community needs, perceived quality of care, and the sharing of resources
Haglund et al., 2011	To determine if a twinning partnership via training camps could improve capacity and efficiency of neurosurgical services in an LMIC (Uganda)	Minimal; continuing education offered by nurses in post-neurosurgical clinical care, sterile technique, and surgical equipment preparation; evaluation of program	Case study approach	Demographical data collected for 2 years after commencement of program on productivity and efficiency of neurosurgical cases	Capacity building accomplished and maintained through twinning training camps

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
Lal & Spence, 2014	To explore the lived experiences of New Zealand nurses participating in aid work within surgical settings and war zones	Specific; clinical/ surgical role experience	Interpretive phenomenology; interviews	*N* = 4 nurses in surgical STMM teams	Three themes included participants' thoughts on (a) anxiety, (b) different practice (c) re-entry to life on return
Laleman et al., 2007	To quantify the contribution of STMM international health volunteers in Africa	Nonspecific; evaluation of team	Survey questionnaire	*N* = 13 questionnaires plus *N* = 8 in two focus groups (not delineated to nursing)	Demographical data, including contribution of 5,000 FTE international health volunteers to Africa in 1 year (2005), with 1,500 being doctors
Martiniuk et al., 2012	To quantify and highlight potential advantages and disadvantages of STMM from literature (1995–2009)	Nonspecific; evaluation of team	Systematic review	*N* = 230 articles reviewed (9% of total articles located according to their criteria)	Lack of common definition of medical mission trips; poor reporting; room for improvement
Sykes, 2014	To quantify impact of STMM (in medical literature 1993–2013)	Nonspecific; evaluation of team	Systematic review	*N* = 67 articles included (< 6% total articles, low-level evidence)	Diversity of terms (> 45 identified to describe STMTs); majority of articles represent low-level evidence related to reliable and consistent research evaluation tools and > 80% reported on trips with a surgical focus

Author/Date	Aims/Objectives	Context Related to Nursing	Design/Method	Sample	Results
Withers et al., 2013	To explore motivation and importance of individuals' participation to one dental health NGO in Mexico	Minimal; experience and evaluation of team	Descriptive qualitative case study; interviews	*N* = 30 including five nurses plus 4 days' observation	Themes emerged regarding personal motivation and positive professional benefits of participation; recommendation to facilitate first-time volunteers service ensuring definite roles and responsibilities to improve satisfaction and to sustain volunteerism

Demographic Data of Volunteers and Trips

The term “short-term medical mission” (STMM) is not clearly defined in the literature, has no internationally agreed upon definition, and is therefore problematic to compare studies (Martiniuk et al., 2012). Laleman et al. (2007) proposed that no known framework had been developed to analyse the contribution of global health volunteers. There is also no known global body or register that records all international NGO participants and activities.

Although a nursing focus was sought, data were sparse. In calculating the number of nurses identified in the chosen articles, approximately 14% of health professionals involved were described as having a nursing role. A range of other health professionals, including anaesthetists, generalist doctors, kinesiologists, physiotherapists, paramedics, pharmacists, psychologists, radiologists, and surgeons, were identified as participating volunteers within teams.

Collective results suggested health volunteers completed assignments within broad and varied timeframes, with up to 2 years the longest (Martiniuk et al., 2012) and just 5 days the shortest (Chiu, Weng, Chen, Yang, Chiou, et al., 2012). A large proportion of volunteers tended to go on multiple trips and felt optimistic about their contributions (Bjerneld et al., 2004; Busse et al., 2014; Compton et al., 2014). One systematic review determined that over the past 25 years, 230 accounts of STMMs to LMICs had been identified within the literature, with the United States, Canada, Australia, and the United Kingdom being the top four sending countries (Martiniuk et al., 2012).

Another study identified 2,300 participants’ involvement in a minimum of 949 trips over a 5-year period to 45 countries (Compton et al., 2014). Results of

a further survey study noted that over 2,000 volunteers had been deployed to Sub-Saharan Africa in 1 year (2005), suggesting it could be as many as 5,000 (Laleman et al., 2007). As data cannot be pooled from these studies, the picture remains incomplete as to a realistic prediction of the number of people deployed or the number of trips being made globally.

Findings revealed that nurses were underrepresented, with only one study in this review reporting a purely nursing focus (Lal & Spence, 2014). Eight papers included nurses within the context of health care, and the remaining 11 had varying degrees of a description of STMM teams and roles, albeit either very limited or no discussion about any specific nursing roles. If specified, nurses' involvement covered clinical practice areas such as midwifery in Nepal (Elnawawy et al., 2014), cardiovascular care in Peru (S. Adams et al., 2012), clinical skill assessment in Ethiopia (Busse et al., 2014), generalist nursing in Mexico (Withers et al., 2013) and Guatemala (Green et al., 2009), assisting in orthopaedic surgery in the Dominican Republic (Bido et al., 2015), part of a neurosurgery team in Uganda (Haglund et al., 2011), acute surgical nursing in LMIC hospitals generally, and primary healthcare nursing in more remote communities (Lal & Spence, 2014). A common thread that runs through these articles is an expectation for volunteers to pass on knowledge through teaching and mentoring of local healthcare staff.

Motivation and Experiences

Global health volunteers more often than not had participated with the altruistic objective of addressing unmet needs to improve the health of less fortunate individuals and communities (Asgary & Lawrence, 2014; Dawson & Homer, 2013; Elnawawy et al., 2014; Withers et al., 2013). They also declared

motives for adventure, to contribute to diplomatic relations, and a desire and willingness to travel (Chiu, Weng, Chen, Yang, Chiou, et al., 2012).

Overall, volunteers expressed satisfaction in their participation and recommended the experience to others, noting significant growth in personal and professional development through challenges, including character building and strengthening of confidence (Asgary & Lawrence, 2014; Bido et al., 2015; Compton et al., 2014; Dawson & Homer, 2013; Lal & Spence, 2016; Withers et al., 2013). Many participated in multiple trips over a number of years, reporting reward to themselves as participants and perceived benefits to the recipients of their care (Asgary & Lawrence, 2014; Bido et al., 2015; Chapin & Doocy, 2010; Chiu, Weng, Chen, Yang, & Lee, 2012).

Responses gave insight into the humanitarian workers' perceived identity. That is, although participants had idealistic intentions, and sensed the stress of their ongoing need to fight for justice and equity, they were driven by an overwhelming need fuelled by adrenaline in response to the urgency of the situations they were presented with and had noble aspirations to *rescue* those in need. Sometimes, the outcomes led to unfulfilled expectations, as volunteers did not always witness a change to the overall situation (Asgary & Lawrence, 2014; Bido et al., 2015; Dawson & Homer, 2013; Elnawawy et al., 2014).

Further issues raised by nurses included stress in adapting to humanitarian settings, the different scope of practice, challenges faced when trying to understand the health disparity, and re-entry adjustment on return home after an assignment (Lal & Spence, 2016).

Effectiveness

Articles evaluating the NGO sending teams on STMM trips were generally positive about the involvement or work accomplished. Several studies examined the effectiveness of a particular medical or surgical program by numbers of surgeries completed, patients treated, and commitment to follow-up care (S. Adams et al., 2012; N. S. Berry, 2014; Bido et al., 2015; Elnawawy et al., 2014; Green et al., 2009).

A common thought among volunteers was that doing something is better than doing nothing (Elnawawy et al., 2014). However, at the date of review, there was a lack of published guidelines and measures to evaluate programs and people involved with providing medical care (Chapin & Doocy, 2010), and especially no nursing-related literature associated with the assessment of care given in this context. Sykes (2014) concluded that although STMMs are becoming more popular, trips to LMICs are mostly underevaluated and raised serious ethical concerns given that internal self-review by organisations was common, with little published data from external or independent sources on the quality of care delivered (Chapin & Doocy, 2010). The development and implementation of an assessment tool to measure effectiveness of such trips for their accountability to donors and recipients is important (Sykes, 2014). In relation to the overall care provided by the healthcare team, understanding the nursing contribution as a separate role within the team is important.

Sustainability and Accountability

Although humanitarian-focused STMTs have provided essential surgical procedures for many patients in LMICs who would not otherwise have had access to care, much greater opportunity for volunteer teams to engage with the

local healthcare community to give training and resources for more sustainable outcomes into local systems was noted (S. Adams et al., 2012; Chapin & Doocy, 2010). An exploration of the effectiveness of an individual surgical program in Guatemala, from both participant and recipient perspectives, identified a desired collaboration between NGOs and the local health services but also reported that trust was a vital part in the partnership to strengthen sustainability (Green et al., 2009). Success should therefore be measured within a commitment to build a stable relationship between hosts and those on STMTs, earmarked by genuine sharing of ideas, resources and knowledge, and good communication (Dawson et al., 2014; Elnawawy et al., 2014). With an identified gap in the literature about how STMMs interact with the communities they serve and the healthcare systems that support them, there is opportunity for greater research into the sustainability of programs delivering short-term medical care, and especially the specific nursing involvement in mentoring and building capacity for ongoing care.

Cultural, Ethical, and Moral Obligations

Experiences embodied various challenges that included confusion of roles and feeling stretched to involve themselves in things they had not intended or expected or without adequate training (Bjerneld et al., 2004; Dawson & Homer, 2013; Lal & Spence, 2016). Furthermore, worthy aspirations of contributing do not necessarily mean it will bring benefit to the recipient (Elnawawy et al., 2014). Volunteers described experiencing an ethical dilemma when in the situation of being expected to provide leadership and mentoring of locals when they felt ill equipped and therefore reluctant (Dawson & Homer, 2013). Some volunteers felt it was morally important to gain a deeper

understanding of the local system before giving advice (Lal & Spence, 2016) and developing a greater understanding of cultural differences.

Another issue identified some volunteers' realisation that their presence may be causing dependence on foreign aid by locals that could have a detrimental effect on the government's ongoing support and development of services (Green et al., 2009). Corruption and inability to trust were further issues that caused a moral predicament, leading to anxiety (Dawson & Homer, 2013).

Discussion

This review highlighted short-term, health-focused volunteer teams' involvement in charitable humanitarian efforts in selected international contexts, which included some nurses. Data related to the nursing discipline specifically were indiscriminate: however, three categories of data could be drawn—that is, data related to health professionals' contribution, preparation, and experience. The goal of the review was to quantify the roles and responsibilities of nurses in the described context, but limited data highlighted that further research was necessary to support findings. Findings brought to the forefront that nurses and other health professionals are highly motivated to involve themselves in voluntary service in LMICs, even to the extent that they are willing to put themselves at higher risk and forgo their own comfort, but this does not give voice to the potential for distress and exposure to trauma, and their needs of subsequent emotional support and re-entry strategies on return to their home countries.

Identifying the importance of the nurse's role and function in health-related humanitarian service is important as nurses currently work in a

wide variety of roles, including those in a volunteer capacity outside their normal country of residence and often outside their usual practice areas. Sustainability of care by involvement of short-term medical trips is underresearched, and nursing involvement within deployed teams requires further research to clarify the nursing workforce impact.

As there is a growing emphasis on nursing competency standards (Halcomb et al., 2017), there is little acknowledgment of educational and support needs for nurses in preparing them to take on these roles, while they are there, or even after they return. This identifies the need for further empirical evidence of nurses' involvement within this context to validate the charitable, somewhat hidden, work of nurses and their experiences and to inform both prospective volunteers and recruiters to allow for better preparation for such work. It also highlights the opportunity to give voice to nurses' experiences in the wider global clinical nursing community and the benefits and challenges of working in broader practice environments. Furthermore, there is a responsibility for those recruiting nurses to participate in volunteer service to educate and prepare them for and manage the higher risks of working internationally (Asgary & Junck, 2013).

The concept of care, intricately interwoven into nursing, fundamentally seeks to improve the quality of life by extending compassion, promoting dignity, and nurturing and empowering both individuals and communities (Rytterstrom et al., 2009). The nurse's ability to dedicate themself to others' welfare, coupled with selfless compassion, are altruistic traits attributed to the nursing profession (Gormley, 1996). Embracing that responsibility, many nurses have risen to the challenge in collaboration with other healthcare professionals within short-term,

health-focused teams to provide some level of this care (Upvall & Leffers, 2014). Most often, nurses are required to function in conjunction with other healthcare team members in a multidisciplinary team, so literature within this realm is well situated. However, as there are many anecdotal accounts where nurses are also being called upon to function autonomously (Arbon, 2004), function outside their scope of practice, and give holistic care to patients in the context of their experience and environment, further research into specific unique environments and CoNPs within the context of charitable health care in STMTs is warranted. Furthermore, those engaging nurses in voluntary service have a responsibility to prepare, follow, and support nurses before, during, and after their service.

A limitation to this review is that searched articles were in English only.

Recommendation and Conclusion

Further research in nurses fulfilling short-term healthcare placements related to humanitarian care is long overdue. The integrative review identified various contexts and aspects of health care offered outside disaster and military nursing contexts. However, the lack of literature specific to nurses' participation and the lack of consistency in terminology give justification for further research in this field to inform the professional bodies related to the nursing discipline. As it seems likely that nurses are highly motivated to continue volunteering for such service, it is important for sending agencies to provide adequate preparation and follow-up care to nurses placed in these positions. There is a definite chasm in research knowledge that describes the unique environments nurses are volunteering in outside their home countries, the roles they are fulfilling, the quality of care given including nurses' competency within their assigned roles,

factors that motivate or deter their willingness to serve, and the lack of preparation and educational programs to support them in deciding to become involved in this service.

Updated Literature Review

The initial literature review search for this study spanned 1995 to 2015. As several years have now passed, the initial search was repeated in 2020, using the same criteria and allowing inclusion of any related, newly published literature. Updating the literature review provides an opportunity to argue the current study under discussion against what is currently published on the topic (J. R. Gray et al., 2016). Peer-reviewed research literature was critiqued using the same inclusion criteria as previously used and according to the CASP tool (CASP UK, 2013).

Three published research articles met the criteria to add to the initial review findings (Gilday et al., 2018; Hargreaves & Golding, 2017; Tjoflat et al., 2016). Gilday et al.'s (2018) qualitative study evaluated nurses' and caretakers' perspectives of care given in a paediatric department in a humanitarian setting facilitated by the NGO Médecins Sans Frontières (MSF). Relevant findings identified that a lack of teamwork impacted the delivery of care and how participants believed a more focused patient- and family-centred care model could improve the quality of care given.

Hargreaves and Golding (2017) undertook an oral history study of seven nurses who worked with MSF. The results provided a detailed description of their motivations and experiences during and after the humanitarian mission. Results and discussion focused on the connection between their nursing

identity and their commitment to bring positive change. Resilience, flexibility, and self-awareness were qualities evident in contributing nurses.

Last, Tjoflat et al. (2016) conducted a descriptive, explorative, qualitative study, highlighting seven expatriate nurses' experiences working with local nurses in a low-income country for an average period of 6 months. Findings identified that the nurses found cultural challenges in communication, mentoring local nurses, and working under the local system, which could affect the overall collaboration with their nursing colleagues and reduce the potential improvement in the quality of care given.

Four articles were discounted as not meeting the inclusion criteria as initially applied as they were focused on disaster response and nor did they meet the guidelines for the appraisal tool used.

Given the scarcity and heterogeneity of results related to nursing research in online databases, it could be possible that the information sought may lie elsewhere in grey literature and related organisational databases. Searches targeting the keywords health, nursing, humanitarian, international, and volunteer were made through the websites of ReliefWeb (https://reliefweb.int/updates) and the Overseas Development Institute's Active Learning Network for Accountability and Performance (ALNAP), which is an international humanitarian network comprising international humanitarian organisations (https://www.alnap.org/). The sites had limited search ability, with no date parameters. However, 424 entries from ReliefWeb and 109 entries from the ALNAP sites were generated consecutively, mostly comprising organisational manuals, situation field reports, guidelines, and press releases.

These searches did not yield any further appropriate research that had not already been found in the academic databases.

Chapter Summary

Research with nurses fulfilling short-term healthcare placements in a voluntary LMIC humanitarian context is long overdue. This integrative literature review identified various contexts and aspects of health care offered outside disaster and military nursing contexts. However, the lack of literature specific to nurses' participation and inconsistency in terminology justify further research in this field to inform the professional bodies related to nursing. As it seems likely that nurses are highly motivated to continue volunteering for such service, it is essential for sending agencies to provide adequate preparation and follow-up care to nurses in these positions. There is a definite void in research knowledge that describes the unique contexts that nurses are choosing to volunteer in outside their home countries.

CHAPTER 3. METHODOLOGY

Introduction

This chapter outlines philosophical enquiry in the nursing context. Defining the philosophical framework relevant to this qualitative research study enables an understanding of abstract ideas and beliefs that informed the research process and contributes to the research rigour (Crotty, 1998). It explains the ontological, epistemological, and theoretical positions and justifies the chosen methodology—ethnography—to achieve the study's objectives. Ethnography allows interpretation of meaning and significance that, in this study, informs the cultural milieu of nursing practice within the context of offering humanitarian surgical care. I explain my position as a researcher, discuss researcher safety, and identify assumptions. The chapter concludes with a summary. Following, Chapter 4 describes the study design, ethical considerations, trustworthiness and methodological rigour, and the methods used to collect and analyse the data.

Philosophical Framework

Ontology is the overarching framework for understanding "what" is known (Guba & Lincoln, 1982) about nursing on a hospital ship. The ontological belief as applied to this study is relativism, where reality is considered true to the individuals experiencing it in any given place and time (Denzin & Lincoln, 2011). Reality is co-constructed to highlight phenomena shared by a group that participates in a commonly shared experience (Creswell, 2013).

Epistemology is the philosophical study of the concept and origin of knowledge (Kikuchi & Simmons, 1994); in other words, it is "how" something is

known. Social constructivist philosophy frames this study as it accommodates nurses' prior learning as a foundation from which to identify assumptions, expand current knowledge, modify, and then build new knowledge (Creswell, 2013; Prawat & Floden, 1994). This framework allows the synthesis of knowledge to interpret the "culture" of nurses identifying with and volunteering for a faith-based humanitarian organisation (Engebretson & Littleton, 2001).

The theoretical perspective used in this study is interpretivism as it becomes the lens through which the set beliefs guide the study's framework, making evident the embedded philosophical assumptions (Creswell, 2013). The interpretive aim is to understand how a particular group of people interact together and how they assign meaning to their social action.

Ethnography as a Mode of Enquiry

Ethnography as the chosen methodology supports an inductive, naturalistic approach. The term ethnography can describe both a method and a methodology (Brewer, 2000) but when applied as a methodology, there are distinct views about the subtle differences between an ethnography and an ethnographic study (Hammersley & Atkinson, 2007). An ethnography uses theoretical underpinnings founded in anthropology to study a community, while an ethnographic study uses that same framework as applied to a subsection of that community (Buscatto, 2018). The studied phenomena are derived from people, artefacts, space, and organisational functions (Talamo et al., 2017). Therefore, the ethnography approach enables the researcher to explore unique patterns and symbols that reflect the group's characteristics and consequent meaning (Creswell, 2013).

Ethnographers seek to articulate what makes one group distinct and unique from another group and, with a holistic perspective, analyse meanings (Roper & Shapira, 2000). Ethnography within the health sciences has produced knowledge that has both generated and influenced health-related interventions (Rashid et al., 2015).

Historically, the term ethnography originates from the Greek root words *ethnos*, meaning race or people group, and *graphis*, meaning writing. In the early 1900s, classic ethnographies were considered descriptive accounts of discrete and often distant communities or cultures (Reeves et al., 2008), where the researchers were often travellers or missionaries. In anthropology, classical ethnography describes the study of foreign or native populations (Fetterman, 2010), where the population being studied is typically different from that of the researcher's cultural background (O'Reilly, 2012; Pole & Morrison, 2003).

Since that time, ethnography has evolved to embrace disciplines other than anthropology, allowing a refined focus while maintaining the study of human behaviour, values, and their belief systems' influence on a particular culture (Bruni, 1995). Subsequent studies applied ethnographic principles to the character and behaviour of groups, embracing age, social status, role, and institutional and more focused environments outside ethnicity (Roper & Shapira, 2000). Subcategories of ethnography have emerged in contemporary ethnographical studies as conventional principles were applied to different situations (Lambert et al., 2011).

Subcategories of Ethnography

Published literature identifies various subcategories of ethnography: autobiographical, critical, feminist, focused, institutional, and online. Brief

descriptions of the subcategories are presented in Table 2, and then further discussion aligns this study as focused ethnography within the broader, more conventional ethnography.

Table 2

Summary of Subcategories of Ethnography

Subcategory	Description
Autobiographical	An analysis of culture as seen through personal, subjective experience and perspective, where the researcher is the centre of focus and inquiry (Fetterman, 2010)
Critical	Investigates and reflects on power imbalance within political policy and seeks to address injustice (Harrowing et al., 2010)
Feminist	A research perspective with the intent to remove sexist imbalance (Reeves et al., 2013)
Focused/rapid	Data collection occurs within a more focused timeframe and context than conventional ethnography (Cruz & Higginbottom, 2013)
Institutional	With the perspective of connecting people with the institutional and social processes that may rule them (S. Adams et al., 2015)
Online/virtual/netography	Data are gathered from online chat rooms, forums, online texts, and virtual communities (Reeves et al., 2013)

Focused Ethnography

Focused ethnography explores a particular issue or shared experience within a subculture or specific setting (Draper, 2015). Fieldwork is described as the ″collection of specific data that relate to a narrower research question than traditional ethnography″ (de Chesnay, 2015, p. 9), where the researcher enters and leaves the field regularly during data collection. Focused ethnography developed, therefore, as a modified form of traditional immersive ethnography, the latter requiring prolonged, uninterrupted immersion in the research field (Knoblauch, 2005).

Since Madeline Leininger, a nursing theorist, first introduced ethnography into the nursing research space in 1970 (de Chesnay, 2014), ethnography has been adopted by nurse researchers to investigate how nurses deliver health care within healthcare settings, including emergency departments (Fry, 2012) and intensive care units (Storesund & McMurray, 2009). Other examples of ethnography being applied to health care include the investigation of quality and safety (Leslie et al., 2014), the use and meaning of artefacts (Talamo et al., 2017), and hospital culture in general (van der Geest & Finkler, 2004). Findings from a systematic literature review of nursing spanning over 40 years and 13 countries capture the proliferation of ethnographic nursing in nursing education, prison nursing, inpatient, community, and long-term care (Keen & de Chesnay, 2015). Given that the nature of this study centres on a unique cohort of nurses delivering humanitarian surgical care through a hospital ship, it can be considered a focused ethnography. However, the prolonged immersion of data collection more suits the description of a classic ethnography. When related to this study, ethnography captures how nurses know and learn about the phenomena connected with their professional practice in that context, their common identity, and attributes.

Theoretical Underpinnings

Theoretical underpinnings of ethnography are based on naturalism, holism, and culture (Laugharne, 1995; Savage, 2000; Wolcott, 1999). Each of these three concepts are outlined in the next section.

Naturalism

A characteristic of ethnography as a naturalist paradigm is that research occurs in the natural environment rather than in an experimental setting

(Hammersley & Atkinson, 2007). It embraces both the researcher and participants' interactions in the "field" (Hammersley & Atkinson, 2007). The natural "field" in this study were the nurses and their nursing activities connected with the *Africa Mercy* hospital ship, which was docked in an LMIC. Data collection was facilitated by undertaking "fieldwork" in that natural setting (J. L. Whitehead, 2005), thereby allowing me, as the researcher immersed in the environment, to provide a detailed and thick description of data (Geertz, 1973). The paradigm allowed me to portray more accurately the salient views of participants volunteering on board at that time, which contributed to methodological rigour.

Holism

The concept of holism crosses different disciplines and is commonly accepted in nursing as referring to the whole person as a complete sum of the parts, as opposed to reductionism when individuals are viewed as consisting of separate systems or components (Mariano, 2007). Nursing practice is influenced by culture, and practice is likely to appear different in changing contexts (Draper, 2015). In this study, the framework of holism describes more fully the way nursing was practised and valued within the organisation at the centre of the research. It encompasses an integrated approach, incorporating physical, emotional, social, and spiritual realms.

Culture

The study aimed to understand the way culture influences the way nurses function in a particular humanitarian service context. As a central concept of anthropology, culture describes a collective set of characteristics, beliefs, ideas, customs, and behaviour of a particular group of people, which

identifies that group as being socially connected in some way. It can embody such phenomena as sociopolitical norms (P. Gray & Thomas, 2006) and values, dress, language, rituals, ceremonies, traditions, artefacts, and symbols (Holden & Littlewood, 2015). Kroeber and Kluckhohn (1952), when compiling concepts and definitions of culture, noted over 160 variations. The basic premise is that culture comprises explicit and implicit patterns of behaviour, learned or created, that set apart the members of the group as distinct from another group.

Shein (1990) explained culture manifesting in three broad and observable constructs: artefacts, values, and assumptions. They identified artefacts as both physical and abstract phenomena. Examples include a smell, a sense of emotional intensity, layout of the environment, the way people dress or are organised, and material objects such as equipment, records, or documents. The presence of artefacts can be noted; however, it can be more complex to determine the meaning behind their use or presence. Values governing behaviour are linked to belief systems and can be observed as written statements (e.g., in organisational documents) or action but are likely identified verbally by interviewing those in the relevant group. Assumptions are challenging to identify as they are often unconsciously embedded in behaviour. Meaning lies in the interpretation of those making a particular assumption (Hofstede et al., 2005).

Understanding Shein's (1990) cultural construct is vital for this study because culture influences the way nurses interact with each other and with their patients and healthcare personnel of the host countries the ship visits. An awareness of the way nurses portray health and wellness will add to their cultural sensitivity in those interactions. The mandate in the first element of the

International Council of Nurses' (2012) Code of Ethics is that nurses ″promote an environment in which the human rights, values, customs, and spiritual beliefs [of all] are respected″ (p. 2).

A traditional essentialist perspective of culture (P. Gray & Thomas, 2006) typically describes phenomena surrounding the ethnicity, traditions, beliefs, habits, customs, and morals of a particular group of people, which are passed from one generation to the next (Spradley, 1979; Wolcott, 1999). This view is commonly seen as static, rather than actively being produced, and hides the creation and recreation of processes necessary for representation (P. Gray & Thomas 2006). The art of seeing and interpreting culture is a subjective process and, given the multiple dynamics, will always be subject to revision. Therefore, in this study's context, "culture" is represented as an amalgam of complex social interactions that happen between patients, health professionals, and others. A robust definition of culture within nursing embraces more than rituals, values, and any material phenomena. It describes a way of being and understanding within an organisational framework that leads a collective group of people to think, feel, and act (Frey, 2018). Meaningful learning takes place by interactions between nurses and the environment. Therefore, culture is both meaning and an expression of that meaning during practice (Hobart, 2000).

Patients and their families also have their own unique culture, characterised by both who they are and what they do (Fetterman, 2010). Culture determines how people interpret their health and how health consequently affects them. Nurses caring for people with different worldviews and values to their own must be aware of the way these factors interact with their patients' recovery. Differences are displayed in values surrounding health

and illness, beliefs, and ways of behaving. The social, geographical, religious, and political environment will influence how culture is enacted, and since culture influences health, the delivery of health care must be appropriate for the target population (Leininger, 1985).

Nursing, as a profession, has embraced cultural competence as an essential skill (Leininger, 1995). This skill—caring for patients in a manner that aligns with their respective cultures—is known as transcultural nursing. Leininger's (1988) theory of culture care diversity and universality, also known as the cultural care theory, was introduced to the nursing space in the early 1980s. Her theory is based on the premise that one's health is defined and valued by a set of beliefs (Butts & Rich, 2015). Leininger's Sunrise Model is based on the relationship between anthropological and nursing domains that presents a systematic way of holistically assessing a patient's needs.

The critical work of Ramsden (2002), who advocated for cultural safety among Indigenous people, must also be acknowledged. As it relates to this study, cultural safety embodies the construct that there is a genuine risk of power imbalance between the nurse and the patient. Culturally safe care empowers patients to determine how they would expect and prefer care. For nurses to deliver culturally safe care, it requires self-reflection, recognition of values inherent in the culture of care, and purposeful action to deviate from the usual way the nurse may have learned to deliver care. The findings from this study will inform nurses in their respective roles of the assumptions they may hold. Knowledge of how these assumptions impact healing can encourage nurses to ensure the environment they are constructing, and their professional relationships, are based on individuality and respect. Culturally safe care

recognises the patient for who they are and what they need (Papps & Ramsden, 1996). Understanding nursing culture in the delivery of care on a hospital ship is the first step to examine work practice and evaluate the effectiveness of care offered.

Organisational Culture

Organisational culture is another phenomenon that influences the distinctive nature of nursing tradition (Hancock, 2018). It can be understood by studying an organisation's written vision, mission, and value statements and evaluating how committed and effective employees are in reflecting the organisation's stated intentions. There are commonalities to be found in organisational culture, including language, dress, rules, and rituals (Suominen et al., 1997). Rituals within the nursing profession, for example, can describe repeated and everyday activities, such as handover, report writing, accountability in medication administration, and professional development sessions. Many of these rituals or processes are essential factors in delivering safe, quality nursing care.

The research documented in this thesis presents a subculture of professional nursing within the humanitarian aid sector, where the culture and context define nurses as having a set of distinct characteristics. These cultural characteristics are found in multiple layers: the nurses' cultures, the cultures of the patients in their care, and the organisational cultures influencing nurses' practice. The chosen methodology—ethnography—provides a deep and rich layering of information to construct reality (Fetterman, 2010), and justification for its use is discussed in the next section.

Justification of Methodology

As focused ethnography has been applied to nursing research as a practical and effective means to interpret specialised clinical practice areas, (Higginbottom et al., 2013), in this study's context, a focused ethnographic approach emerged as being the most appropriate method. The focus was a defined setting and group of nurses (Rashid et al., 2015) given the context of exploring nursing practice on a hospital ship berthed in an LMIC for humanitarian surgical services. Roper and Shapira (2000) identified the reason for using focused ethnography was to understand the practice of nursing as a cultural phenomenon. As the practice of nursing comprises complex layers, gaining a comprehensive understanding of the context and description of this social interaction was warranted. This approach meets the stated aims of the study, which were to explore nursing involvement within humanitarian health care provision, to generate insight into the area of humanitarian nursing in a short-term nondisaster context, and to extend the research literature surrounding the topic.

Further, the study intends to communicate the mission and purpose of humanitarian nursing in a meaningful manner and illuminate any skill sets and learning that might transfer to professional nursing contexts in other settings on completion of service. As a result, answers to questions such as "What is it like to be a member espousing nursing culture?" and "What are the rules guiding social behaviour within this context?" were sought. The cohort identified a set of core values and beliefs while giving nursing care through a charitable hospital ship context. Nursing within this ship environment is a unique setting and community of practice (CoP). As this research study has a specific contextual

background of an FBO, a focused ethnography methodology enabled insight into the experiences of nurses embedded in this organisational culture within a humanitarian aid setting (de Chesnay, 2015). The emphasis was on drawing out the meaning of those who were actively living and working within this context.

Researcher Position

A researcher can adopt varying levels of participation. A common criticism is that researcher boundaries can often be blurred (Abdulrehman, 2017; Sandiford, 2015), and it is common to move between observation and participation at different times of the study. Gold (1958) elucidated four commonly accepted positions as a researcher in social observations. Table 3 briefly summarises these positions.

Table 3

Researcher Positions

Assumed Position	Characteristics	Challenges
Complete participant	The researcher is fully immersed into the activities, acts as a "native", may conceal the role (covert), or may declare the role.	Covert: Participants are not informed of the data collection process, and the researcher is not identified as such.
Participant as observer	The researcher is a member of the group being studied and as such is fully engaged in group activity. Participants are aware that the researcher's observation in a participatory role will generate data.	The participant as observer may become so assimilated that important observations are missed or assumptions are made.
Observer as participant	The researcher has brief contact with the participant but is seen as an outsider. The primary role is to collect data but is peripheral to group activity.	It becomes more difficult to develop trust and respect when acting in this role.
Complete observer	The researcher has no participation (outsider). Considered as unobtrusive, participants are unaware they	The complete observer may succumb to role

Assumed Position	Characteristics	Challenges
	are being observed (covert) approach.	pretence/deception and seem detached.

Spradley (1979) described the same concepts in field observation and data collection above but as a continuum, explaining a starting point at nonparticipation and then migrating from less to more participation, capturing the concept of overt (open) and covert (undercover) data collection. Continuum markers are “nonparticipation”, “passive”, “moderate”, “active”, and eventually “complete” participation. Nonparticipation means observation from afar: not being present (e.g., watching a video). Passive explains the researcher as being present in the room or context but observing only, taking fieldnotes from a distance, without apparent interaction. Moderate participation is when the observer takes a moderate stance in participating in an activity (e.g., occasional social engagement by helping). Active participation describes the situation where a researcher is fully engaged in the group as a member, and the participants often forget that the researcher’s objective is to observe the activity as the researcher. Complete participation is to conduct the research covertly (Spradley, 1979).

An “emic” perspective describes participant observations from within the cultural setting, using fieldnotes, reflection, and informal conversation. I positioned myself as an active participant–observer, seeking to understand the group’s behaviours, beliefs, and culture and ascribing significance to those factors while identifying as a group member. This acceptance of *belonging* by fellow group members allowed me to gain an insider perspective of beliefs and practices; it was also a requirement by the organisation for me to take on a

position as a nurse throughout data collection. I sought consent, and data were collected overtly, being considered an insider by the group and having an active role in the community (Allen, 2004). As an active participant–observer, trust was built and rapport more firmly established, while reducing the stigma attached to an outsider role (Johnson et al., 2006).

Concurrently, I sought to bring balance by gaining an “etic” perspective. Objective observation allowed consolidation and interpretation of data by interviewing participants and examining associated documents (Roper & Shapira, 2000). This combination of both emic and etic perspectives gave rise to data triangulation, as it was not just about what the participants said they did or believed, but confirmation by observing interactions in the participants’ “natural” setting. The researcher becomes intertwined in the everyday functioning of the environment for a necessary time to gain an ability to attribute meaning to the cultural practices, both spoken of and observed (Kawulich, 2005).

Reflexivity describes the relationship between the researcher, the group being researched, and the research process. Credible research practice expects neutrality as much as possible when collecting data. However, personal belief can influence interpretation and introduce bias into study outcomes (LeCompte, 1987). The researcher, as the instrument for data collection, should be cognisant of any bias influencing the research and results (Roper & Shapira, 2000). Recognising familiarity with my prior involvement, declaring assumptions to mitigate bias and increase the credibility of the research, is common practice (Atkinson & Hammersley, 1994).

I affirm that due to my previous involvement in volunteering for the same NGO that was the host organisation for this study, and in a similar humanitarian aid context, it was not possible for me to be entirely objective when making observations and reflections. Having dual roles as Infection Prevention and Control (IPC) nurse and researcher, I made my position explicitly known to all the nurses in the research field. My knowledge of the way things functioned on the ship was an advantage; however, it also put me at risk of making assumptions. After I declared my previous 12-year history of serving with Mercy Ships, I experienced a general openness and social acceptance by most of the nursing cohort. However, a small amount of data pointed to newly appointed nurse leaders indicating a feeling of insecurity around me at times. Observation and reflection were heightened as consistent access to both verbal and more subtle nonverbal exchanges took place. Measures were subsequently taken to minimise discomfort; I chose not to write fieldnotes of participant observations in the open, electing instead to complete fieldnotes as soon as possible after leaving the space.

Participants were also verbally reassured that they held the most recent working knowledge of current systems and procedures. Withdrawal from the area became necessary at times to demonstrate compliance with a noninvasive presence. There were rare occurrences when no clinical understanding in complex situations was expected from me due to my prior involvement.

Although at the time of entering the research field for this study, it had been 10 years since I had last volunteered with Mercy Ships—this study's host organisation—I understood that my history would undoubtedly contribute to some level of subjectivity. Being mindful of how potential sources of bias may

influence the research process is essential; however, there remains no set framework or construct to eliminate that bias systematically (Cudmore & Sondermeyer, 2007). Further, assumptions were derived from areas such as my identity as an experienced clinician, and as an academic practising in an industrialised nation, and my Christian worldview were identified and scrutinised. My prior and ongoing involvement with humanitarian care and my longstanding relationship with the host organisation was declared throughout the study. Engagement with humanitarian literature and strong advocacy for social justice helped me to identify with an emerging belief that nurses who are willing to offer resources such as time, money, and energy are altruistic, yet they remain variably equipped to adapt to an environment outside their usual country and place of work. My opinion is that many were exceptionally enthusiastic but underprepared.

Humanitarian health care involves more than an emergency relief response, but the “more” is not as clearly described in the literature. In that literary space, STMTs have been heavily criticised, with questions asked about whether they are doing more harm than good. An initial intention to volunteer short term two decades ago stretched into a lifelong commitment as knowledge grew. My understanding changed over time. Consequently, I support STMTs involved in humanitarian aid contexts as being an effective means to influence change.

Nevertheless, the position I have taken is not to critique the usefulness, or lack of, of the work of any particular organisation in the relief and development space. Instead, I describe the nursing contribution and situate the culture of humanitarian nursing through the lens of one faith-based

(interdenominational Christian) organisation. The potential for further research to broaden the topic of humanitarian (nondisaster) nursing is discussed in Chapter 6.

Other aspects of bias within the study can come from the participants themselves. The concept known as social desirability recognises that participants want to put forward their best selves (Bergen & Labonte, 2020). They may feel pressure to respond in a particular way, so their response may be distorted from the truth. If they are assured their responses will be truly anonymous, judgement free, and answers kept confidential, they will likely be more honest (Huberman & Miles, 2002). Using a larger number of participants across a broad range of subdepartments also helped mitigate this potential for bias. I ensured I had a balanced representation of participants with a cross-section of time, volunteering in weeks, months, and years of commitment, to gain a balanced view to mitigating a "honeymoon"[1] response. Finally, triangulation by gathering data from multiple means (e.g., interviews, observations, documents, artefacts), was another purposeful way to reduce the potential for bias.

Dual Role: Nurse and Researcher

A Mercy Ships requirement for the research project included my acceptance of a new, full-time position of IPC nurse, a 6-month engagement of 45 hours per 5-day working week. The role included developing the position and creating and formalising associated policies and procedures with each of the

[1] Honeymoon response alludes to the first stage of falling in love and describes a moment of elation, joy, excitement, and admiration (Gottman, 2018). The term is used within the confines of the thesis to describe the joy volunteers often experience in their initial weeks of their arrival to serve on board.

teams. Simultaneously, I undertook a 3-month online postgraduate certificate in IPC. The IPC role required me to advise and assist in all hospital areas and off-ship programs, providing flexibility for observation and collection of data both during and outside working hours (R. M. Emerson et al., 2011).

When undertaking participant observation, it is essential to navigate and balance the researcher and nurse roles (Aberese-Ako, 2016; Spradley, 1979). I needed to develop rapport and trust with the participants and to “fit in” so that my presence would not disrupt daily activities. Participant observation and analysis involves understanding participants’ roles, using an immersive technique, gathering impressions of behaviour (Bonner & Tolhurst, 2002). Recording descriptive accounts as a participant–observer required a variety of lenses through which to reflect on, frame, and represent the activities observed, rather than habitually documenting copious amounts of information. As the researcher, my focus remained on immersion and objectivity. It is recognised that limitations may be placed on the researcher as an “outsider” when recognised as having a dual motivation: to work and research at the same time (Allen, 2004).

In this study, I straddled the role of insider and outsider sufficiently to be accepted within the group, while simultaneously observing with objectivity (Dwyer & Buckle, 2009). Balance was more achievable because I was Mercy Ships alumna. However, my previous service had been on a different ship. A decade had passed since that last service, and so returning to conduct the research meant I was somewhat removed from more recent organisational changes. Fundamentally, the vision and mission of the mobile surgical team had remained the same over that time, but as the organisation had also grown

and changed, processes had been refined, the mobile team worked in new countries, and the surgical scope of practice had increased, therefore allowing for a more objective lens through which the setting could be viewed.

Researcher Safety

A safeguard to protect the researcher from potentially vulnerable situations is known as researcher safety (Dickson-Swift et al., 2007). Safety remained paramount throughout the research project and was the dual responsibility of both the researcher and those in the leadership of the host organisation. Both parties agreed to a standard set of guidelines related to work and safety practices and security policies, which aligned with the operating environment. Permission was granted for me to intervene should a situation be presented during the collection of this study's data that required me to inform nursing leadership of the need for alternative nursing practice to prevent potential harm to patients. Participants were advised of this possibility and were asked to give their consent in that unlikely event. Similarly, a situation may have occurred related to data collection, possibly harming the reputation of the researcher or the Mercy Ships organisation. Neither situation arose.

Researcher Bias

Credible research practice requires the researcher to adopt a neutral stance when collecting data (Spradley, 1979). In learning about the interactions and environment in which the researcher is studying as a participant–observer, it is impossible to become detached and unbiased in a neutral and independent role (R. M. Emerson et al., 2011). During the process of data collection, I engaged with specific activities and became exposed to various perspectives. Worldview, belief systems, values, and knowledge of self during data collection

can influence the process, so bias must be declared and considered at each step of the process. It is the researcher's role to ″reveal the multiple truths apparent in others' lives″ (R. M. Emerson et al., 2011, p. 4); in doing so, researcher blind spots may prejudice the collection of data and promote a view of what the researcher wants to show rather than the complete picture. Being aware, honest, and accountable in data collection is necessary (Roper & Shapira, 2000). Several techniques were used to reduce bias. In qualitative research, as the researcher, I had to develop a personal awareness of values and views, and identify possible prejudices (Morse, 1994), including prior experience, knowledge, beliefs, and values related to service, humanitarian work, volunteerism, and a passion for fighting against injustice. In identifying and declaring these biases, the research is considered somewhat more credible. However, while it was relatively easy to identify potential sources of bias, there is no set framework or construct to eliminate that bias systematically. Table 4 provides identified researcher assumptions.

Table 4

Researcher Assumptions

Description	Assumption
Professional role	• People everywhere have the same right to treatment, including health care, despite status, religion, behaviour, culture, race, or belief. • In my role as a health professional, caring for and interacting with all people deserves equal attention and effort. • I can influence and mentor those in my circle of connection to become involved in this cause. Still, I must not abuse the privilege of contact and power in any present or future relationships.
Personal belief and values	• As a Christian, I aspire to interact with people according to biblical principles—in other words, the way Jesus would. • My past involvement with Mercy Ships, and with the developing world, has influenced who I am, and I believe it has shaped my

	character and desire to see humanity live at peace with each other and with God. • I have an ongoing desire to see less-resourced communities empowered to take hold of an improved quality of life, which includes health care. I live out those values by my involvement in advocacy and administering practical help.
Researcher	• As a researcher, I am aware that I have a personal connection to the research site and some potential participants. Believing in the work delivered by Mercy Ships and having invested over a decade of my career volunteering for this organisation has both positive and potentially negative aspects for this research project. It gives me both access to the site for research with prior knowledge of how things work, but also a potential bias in data collection and analysis. There is a danger that as the researcher, my interpretation of participants' perceptions of the environment will be positively skewed.

Chapter Summary

Defining the foundational framework about philosophical concepts is critical for research to be meaningful and rigorous. This chapter positioned the study concerning ontological, epistemological, and theoretical constructs for the chosen methodology—namely, ethnography. Ethnography was discussed concerning naturalism, holism, and culture and applied to the nursing discipline. A brief history of ethnography was outlined, providing a summary of the types of ethnography that have evolved. Justification for the use of focused ethnography was argued. The chapter also included describing my position as an active participant–observer in this study. The next chapter describes the study's design, ethical considerations, trustworthiness, and methodological rigour and the methods used to collect data.

CHAPTER 4. METHODS

Introduction

Having presented the conceptual framework that guided this study in Chapter 3, this chapter explains the methods employed. This study aimed to describe and understand the culture of humanitarian nursing delivered in the context of a faith-based STMT volunteering on a hospital ship. The organisational context and ethical considerations are discussed, along with the setting. The data collection process included accommodating the inherent challenges of collecting data in an immersive hospital ship setting. A methods paper was also published from this work (Dawson et al., 2019).

Defining the Context: *Africa Mercy* Community

Mercy Ships is an international faith-based charity, operating since 1978. It deploys the largest civilian hospital ship globally, called the *Africa Mercy*. The vessel has 474 crew berths and an approximate gross tonnage of 16,500 (Mercy Ships, n.d.-a). *Faith based* refers to acting on a set of beliefs or placing confidence in a common understanding founded on a particular set of values (Ferris, 2005). At a conceptual level, faith-based NGOs can encompass a range of faith identities that have differing degrees of willingness and ability to embrace humanitarian assistance. Motivation to identify with a particular faith may include a desire to further organisational objectives (Jacobsen, 2014). In the context of this thesis, faith based refers to the set of values and understanding of a worldview through the Christian religion.

Foundational values of Mercy Ships embrace an integrated biblical worldview of service to others and a personal relationship with Jesus (Mercy

Ships, n.d.-b). All employees (day workers) and volunteers (staff) are expected to abide by a set of organisational values that describe a desire to follow the model of Jesus and in doing so seek to (1) love God, (2) love and serve others, (3) be people of integrity, and (4) strive for excellence in all they say and do.

Most of the crew are from multiple denominations of the Christian faith. Not all crew profess a belief in Christianity; however, it is an expectation for volunteers to align with the organisation's mission, ethos, and lifestyle principles. Mercy Ships' imperative is to encourage the growth of all serving crew in faith, love, character, skills, and competence.

At the time of data collection in 2016, an average of 450 volunteer crew (singles, couples, and families with children) served on the *Africa Mercy*. Approximately 45 children of the long-term crew attended the ship's internationally accredited school on board. Volunteers held passports from 35 countries, with English the primary spoken language on board. On average, 100 berths were dedicated to hospital and medical programs. During the 6 months data were collected for this study, 180 nurses served on board for varying periods, and 294 nurses in total for the 10 months the ship was docked in the field service location (Human Resource Manager, personal communication, 13 July 2020). Those living on board, considered crew, were required to sign on and off *articles* in keeping with maritime law processes. These articles were a set of documents that represented the ongoing contract between the crew and the master of the vessel, containing a set of rules. All crew members (except primary caregivers and children of the long-term crew) were expected to work an average of 45 hours per week (Mercy Ships, n.d.- c). Depending on the position filled, a short-term crew member could volunteer for as little as 2 weeks

or the duration of the field service (up to 10 months). Long-term crew positions (such as the managing director, captain, chief engineer, or medical director) were usually filled by persons committing to service for 2 years or more. The long-term crew members attended a 5-week preparatory course to join in that capacity, called *onboarding*. Long-term crew provided leadership stability, forming the community of faith (CoF). A proportion of the crew was transient, regularly returning to volunteer for specific seasons. Alumni status was conferred after one service trip. All Mercy Ships volunteers provided funds to cover crew fees (food and board), travel insurance, and transportation to and from the ship. Mercy Ships covered visa arrangements and healthcare personnel's professional registration certification for permission to practise in the host country.

At the time of data collection, 220 African citizens, known as *day workers*, were employed by Mercy Ships for the 10 months the ship was docked. They did not sleep on board but covered all shifts in support of the ship community's needs. Day workers were assigned various roles in maintenance, translation, and accompaniment of patients between the dock and the ships healthcare department. Other day worker roles included preparing patient meals, laundry, and cleaning.

Mercy Ships partners with host nations to fill gaps within resource-poor healthcare systems, attending to immediate needs through surgery as well as offering ongoing capacity-building programs. The core mission is to address neglected trauma, disease, and congenital conditions through surgery and other interventions (M. C. White et al., 2020). Surgical procedures range from simple to complex, in maxillo-facial, ophthalmological, plastic reconstructive,

orthopaedic, gynaecological, and general surgery areas. In recent years, Mercy Ships leadership has made a strategic shift by strengthening their focus on offering training programs to host country providers, intended to improve effectiveness, increase access to specialty surgical care, and build local capacity (M.C. White & Close, 2016). In recent years, training has expanded to incorporate departments such as sterilisation, biomedical engineering, and hospital administration and health professionals such as surgeons, anaesthesia providers, and nurses.

An *advance* team of up to 10 crew is deployed 3 months ahead of the ship's arrival to make necessary arrangements; local partners are also involved in that process. Nurses are often included in an advance team, with responsibilities involving liaison with health officials and the dissemination of information, including the patient selection processes.

Several support services are vital to facilitating Mercy Ships functioning in Africa, including the International Support Center (ISC) in Texas, United States, Mercy Ships' global association headquarters in Switzerland, and 16 offices globally. Annually, approximately 1,600 volunteers assist the organisation's mission worldwide, including 900 volunteers from 45 nations serving in Africa (Mercy Ships, n.d.-d).

Research Process

Ethical Considerations

Adherence to ethical principles in research was an essential part of ensuring integrity and merit in the quality and rigour of this study (Lincoln & Guba 1985). The study was approved by the University of Technology Sydney, Human Ethics Committee (UTS HREC ETH16_0426; see Appendix A).

Permission was granted in accordance with the *Australian Code for the Responsible Conduct of Research* (National Health and Medical Research Council, 2018), and the University of Technology Sydney *Research Ethics and Integrity Policy* (University of Technology Sydney, n.d.). Ethics approval was ratified by the Institutional Review Board (IRB) of Mercy Ships (see Appendix B).

I agreed to abide by the ethical code and followed its principles throughout the research study. These principles embrace scientific quality and respect, dignity, and safety of all participants (Flick, 2014). The four concepts of autonomy, privacy and confidentiality, beneficence, and justice are addressed with application to this study next.

Autonomy

Participants were assured that they could make an independent and informed decision, free from coercion (National Health and Medical Research Council, 2018). Participant Information forms were distributed to those showing interest in the study's research aims. Participants were encouraged to ask questions and clarify their involvement. Ethics committee contact information was provided so that prospective participants had an autonomous avenue for enquiry.

Privacy and Confidentiality

Participants were assured of the confidentiality of demographic information collected and any data associated with observations, interviews, and fieldnotes. Interviews were held in a safe, confidential space. Participants were able to access confidential counsel by ship chaplains if any personal concerns surfaced during the research process. Numbers were assigned to

report quotations in findings and the dissemination of data anonymously. Signed consent forms and demographic data forms were digitally scanned and stored as digital files, with paper copies destroyed by incineration. Audio recordings of interviews were saved as digital files. All digital files connected with the research were stored securely on a password-protected computer in a locked room accessible only to me.

Beneficence

Sensitivity to the welfare of those participating, and assessing their risk of harm, was necessary to determine whether the research was justified; the benefits of research must outweigh the risks of discomfort or potential harm (National Health and Medical Research Council, 2007). Nurses were verbally introduced to the research study in their first orientation session on arrival to the ship, and they were additionally provided with printed information at that time (see Appendix C) outlining the risks and benefits of participation in the study. There was potential that the discussion of nursing services provided during the research study could cause some distress in recounting or processing certain situations (e.g., not being able to select every patient presenting for medical or surgical intervention). However, the risk was assessed as being no greater than for those choosing not to participate in the study. Counselling services ordinarily available to the ship's volunteers from its Chaplaincy Department were available to participants throughout the study period. Participants were free to raise concerns and were given instructions on how to arrange further discussion if needed.

Gaining written consent from each nurse for inclusion in observation for the study was viewed as too labour intensive due to the volume of nurses (*n* =

180) arriving and leaving over the 6 months planned for data collection. However, verbal consent was sought from each nurse volunteering during the research period. Nurses were advised that they were free to opt out; however, none chose to do so. Each interviewed participant provided their written consent for inclusion in the study. It is important to recognise that consent, obtained at the start of the project, could be rescinded by a participant at any time. In ethnography, where observation forms a large part of the data, ongoing negotiation is required (Roper & Shapira, 2000). While there was unlikely to be overt coercion, there may have been subtle pressure from leadership or peers to participate. A strategy to minimise this risk was to ensure participants were reminded of their freedom to withdraw at any stage, without any discrimination or foreseeable risk to themselves. Withdrawal from this study would not preclude receiving counselling if sought, and nor would it have any consequence for their volunteer service. No high risk or vulnerable populations were included in the research (National Health and Medical Research Council, 2007), and although patients were present in the research environment, no interviews were sought from patients; therefore, their consent was not necessary. The relevant ethics committee received no complaints during or after the onboard data collection phase.

Justice

Justice encompasses the concept of fairness in recruiting participants and ensuring no exploitation throughout the research (Shenton, 2004). Participants were selected by convenience. All nurses volunteering on the *Africa Mercy* between 18 July and 18 December 2016 could participate in an interview. Research outcomes will be made accessible to participants and the

organisation in a confidential manner as soon as practicable. In appreciation for participants' time, each was provided with a thank you note and a coffee voucher.

Setting

The study was performed on the *Africa Mercy*, docked in a port city of an LMIC in West Africa. Although anchored in a large port city (population 650,000), the ship is considered to be in a remote location. However, in Mercy Ships' and therefore this study's context, "remote" refers to the ship being physically removed from support services on which other hospital settings in main centres might be dependent. For example, personnel were limited to those who were present, and in the event of an outbreak of illness among the crew, there was no nursing agency to call on to send replacement staff easily. Similarly, if the computerised tomography (CT) scanner needed a replacement part that was not on hand, the ship was remote in the sense that it could take an extended time before the CT scanner could be effectively serviced. Technology allows for communication with support offices around the world. However, at times, the ship may have prolonged delays in accessing the support that a land-based hospital located in an industrialised nation may have. These delays are often due to the host country's bureaucratic processes; examples include customs and border control, necessary governmental permissions, or the physical distance of replacement supplies to be flown.

The onboard hospital was approximately 1,200 m^2, holding five operating rooms (with six operating tables), a recovery room, a two-bed intensive care unit, two hospital isolation rooms, one ward accommodating higher acuity patients, and several low-dependency wards. The hospital was located on Deck

3, sitting just below the waterline with no portholes. There were 84 in-patient beds. The hospital space included some services being provided on the dock, whereby some mobile army-style pop-up tents were erected for the duration of the field service and located within the ship compound. The tents served as patient waiting, patient screening and admission areas, rehabilitation space for physiotherapy, and space for postoperative visits.

The hospital was supported by services that included radiology, a medical laboratory, a hospital laundry, food dispensary, and biomedical engineering. Offices onboard provided coordination for off-ship programs and teams such as screening, palliative care, and healthcare mentoring. The crew working in off-ship teams slept on board at night but travelled to varying locations around the port city and, except for the dental team, contained RNs. Approximately 20 or more ship vehicles were used to transport those teams around the country. Most hospital supplies were stored in a cargo hold and delivered to the wards and operating theatres daily. Cargo holds were stocked with supplies that were shipped via container from Mercy Ships' support offices in the United States and Europe every 6 weeks. The operating theatres usually functioned to full capacity 5 days per week and were available on call for emergencies. Approximately 75 to 80 nurses were connected to healthcare services at any one time.

Sampling

Nurses formed a significant component of the workforce, and working as a nurse in this humanitarian aid context involved travel to the international location for periods of between 2 weeks and 10 months or longer, volunteering in service without remuneration. Qualitative research uses the term *participants*

(Creswell, 2013). In general, there are no absolute specified criteria for an acceptable sample size in qualitative research, although 30 to 50 participants are suggested for an ethnography (Richards & Morse, 2013). All nurses present during the data collection phase of the study were unavoidably included in my observations but were not study “participants” unless they had provided their written consent and were subsequently interviewed. The host organisation, Mercy Ships, had specific criteria for the acceptance of volunteer nursing crew. These criteria required current licensure as an RN and a minimum of 2 years’ postgraduate experience. A risk assessment was made of each applicant’s health and wellbeing before being accepted to ensure they were fit and safe to join the team. I did not turn any nurses away, as although 49 might be considered a large number for a qualitative study, it provided an appropriate cross-section of nursing roles and length of service with the organisation. One nurse agreed to an interview but was unable to be interviewed before leaving the ship, so they subsequently answered the interview questions via email.

The crew, including nurses, were housed on board the ship in very close proximity to their workplace. Cabins had different numbers of berths, and short-term hospital crew could share a cabin with up to eight people. The living quarters for single nurses were separated from the hospital by a fire door, and patients were unable to access the area. Couple and family cabins were located elsewhere around the ship. Occasionally, there was a necessity for off-ship housing—for example, when specific medical teams such as Screening or Medical Capacity Building teams were required to travel around the host country (M. White & Close, 2016). Eight-hour shifts were expected for nurses in a rotating roster with morning, evening, and night duty shifts. General ward

nurses cared for five to seven patients during the day and evening shifts and up to 10 patients at night. Those contracted with intensive care qualifications cared for ventilated patients when necessary. Required clinical skills for pre and postoperative nursing care (adults and children) included patient assessment, wound management, surgical drains, nasogastric tubes, nasopharyngeal airways, tracheostomies, urinary catheters, intravenous lines, and the administration of medication.

Qualifications specific to nursing roles outside the ward areas were commensurate with the position filled: operating theatre or recovery room experience, education, palliative care (counselling and communication), and advanced wound care skills.

The individuals presenting for health screening, surgery, and care were from a different cultural background to the international team of nurses. A team of interpreters was therefore integral to facilitate communication with patients and their families.

Privacy could be contentious for some, as patients were encouraged to go for a walk (accompanied) and spend time in the fresh air outside on the deck. There could be little demarcation between “time on” and “time off” for nurses working and living in the same location, and as security was paramount, working in such an environment meant living on site with less than a minute commute from accommodation to the workspace. Although appropriate from service and safety viewpoints, while participating in data collection, this proximity provided a limited ability to be distanced from the hospital and to be separate from colleagues and patients, with the discipline required to maintain a professional distance.

Although the sample size in ethnographic research usually involves the whole subculture or group under investigation, there was a need to limit the number of participants interviewed for practical reasons. Convenience sampling was employed so I could discover, understand, and gain more in-depth insight into the culture of nursing. A cross-section of nurses from each of the smaller departments was gained. I sought a mix of both short-term and long-term nursing staff, and similarly, both first-time volunteers and return volunteers. Nurse managers, educators, screening and admission nurses, postoperative ward nurses, recovery room, operating theatre, and palliative care nurses were all included to gain a complete picture of the nursing care given. This cross-section could provide data to look for any differences in perception or experience unique to a particular team.

Data Collection

R. M. Emerson et al. (2011) outlined four phases of data collection. These phases are summarised in Table 5 and provide a systematic representation of how the data collection phase of this study took place. Each of the four phases are expanded next.

Table 5

Phases of Data Collection

Phase	Method
1	Gain entry, identify key informants, define researcher role, develop trust
2	Recruit and gain the consent of participants, collect data, fieldwork observations, arrange and conduct interviews, source documents and artefacts
3	Transcription of interviews, participant check of transcripts, reflection on observations, artefact/document analysis
4	Resolve ambiguities and withdraw from the site

Phase 1

Social circumstances must be in place to allow for the collection of data in qualitative research. Before ethics approval was sought from Mercy Ships' IRB, I sent an informal letter to the founders, informing them of my desire to undertake formal nursing research within the organisation and asking for their initial thoughts before proceeding with the ethics application. They provided an enthusiastic and positive reply. A formal request was then sought from the organisation's IRB. The process of ethics approval is outlined in the section "Ethical Considerations".

Once ethics approval was granted, plans were made to travel to the location. Negotiations were made that suited the research aims and my availability. Phase 1 included entering the setting, defining my role as a researcher with key informants to verify their understanding (Creswell, 2013), and orienting myself to where the research would take place. I arrived at the ship in its preoperating phase in South Africa, shortly before the ship was to sail to West Africa for the field service. The sail to the new host nation took approximately 2 weeks, during which days were filled with an orientation to the field location, team building, cleaning, and preparatory activities for the medical work ahead.

The deputy and chief medical officers, medical capacity building director, hospital director, and nursing supervisor jointly verified their willingness to give access to the group being studied. The deputy chief medical officer expressly agreed to informal supervision of my research activities while onboard.

In ethnographic research, the researcher needs to establish rapport and build trust with participants. Although there was an established level of respect

and trust by individual leaders of Mercy Ships, based on my previous interaction and service, this trust needed to be re-established and respect gained with current team members. However, this happened in a way that I did not expect. Within a week of being on board in the shipyard phase, I heard a public address broadcast asking for all medical personnel to report to the cargo hold. By the tone of the receptionist's voice, I sensed this was a serious issue requiring immediate intervention. Nearly all the healthcare services crew were still on leave; at that time, there was no doctor on board, and the hospital was not available. There was a crew clinic space that could receive a patient with minimal supplies. I had not yet been oriented to the cargo hold space but met the crew dentist in the hallway and asked how I could help. He directed me to follow him. We collected the emergency backpacks and stretcher and arrived at the cargo hold to find a seriously injured crew member. He was conscious, and a short-term nurse I had not yet met was supporting his head, speaking to him. Several technical crew members were standing by with radios (walkie talkies) and allowed us to proceed with caution. I checked for further danger and then asked the patient what hurt the most, and to what extent. He pointed to his leg and suggested it was 10/10 pain. During an assessment to establish that he had a clear airway, was breathing, and had circulation, two nurses who had been working in another department and who had not yet re-joined the health care services department arrived at the scene. As a matter of priority to establish experience among us, we quickly paused to introduce ourselves to each other and arranged ourselves according to our skills. We proceeded to manage the injury together in collaboration with the captain and others. An ambulance was called, and the patient was eventually taken off the ship under

the medical care of local authorities. As is typical following critical incidents, a debriefing session was held immediately afterwards. Under the circumstances, the situation was dealt with as best as possible. The patient underwent surgery and returned to the ship briefly for a farewell before being medically evacuated to his home country for ongoing treatment.

I perceived that my involvement in this incident accelerated team building and trust between me and the healthcare staff present, the operations manager and the captain. The immersion into this critical incident tested skill and communication and built camaraderie. The strategic and purposeful building of trust that typically occurs over a long time happened immediately amid a critical incident requiring crew who were strangers to each other to work together.

While developing trust, keeping the two roles of clinician and researcher separate was not realistic given the full immersion into the community, professionally and socially. The period of 2 weeks before the sail and then a further 2 weeks of the sail allowed development of rapport and trust before everyone became so busy and immersed in their responsibilities that learning about a research project could be seen as an unnecessary extra on their to-do list. I was also in regular communication with the leadership team on board and provided regular updates.

Phase 2

The data collection began when the ship arrived at the field service location in West Africa. Within 10 days of arriving, the short-term crew were flying in to join, and long-term crew were returning from personal leave, allowing for the hospital environment set-up and initial patient selection (screening). Gradually, as nurses returned or joined for the first time, I introduced myself to

each and discussed the research study. After the ship docked, there was an urgency to get the hospital space cleaned, equipment offloaded and put in place (e.g., dock space tents), and cleaning and sterilising supplies. A team-building session provided a nonthreatening space for me to begin sharing the project.

The beginning of field service required the establishment of many processes that considered factors unique to the host country's context. Orientation was provided to the newly arriving crew, during which I was invited to share my intended research project with the nursing crew, who were enthusiastic and supportive. Each time new nurses arrived, I had the opportunity to introduce myself in both roles, as IPC nurse and as a researcher. I shared my Mercy Ships' history and my dual purpose for being on board. A verbal explanation was given for the study, and information leaflets were made available. Nurses were instructed on how to opt out of my observation and provided details on how to do that. I asked all nurses to express their interest in a semistructured interview during the time they were on board if interested and made appointments with those who wanted to discuss further.

Information about the study was posted on Mercy Ships' intranet page (see Appendix D), and posters advertising the study were placed within the ship's hospital areas I attended each Monday morning orientation when nurses were present and shared the research purpose. Written consent for participation in an interview was gained. Before consent, any clarification or questions were encouraged and addressed. Although nurses were given the opportunity to opt out of the study (that is, researcher observation), none chose to do so.

Fieldwork: Observation

Approaches to observation can be structured or unstructured. A structured approach may involve the use of a tool, such as a checklist to focus the data, and an unstructured approach gives the researcher freedom to make notes on conversations and observations in a less formal way (Atkinson, 2015). In general, positivist research typically involves the use of structured observation, whereas interpretivist (naturalistic) paradigms are considered unstructured.

The approach taken in this research study was the unstructured style of recording fieldnotes in response to my observations. My observations were as an active participant throughout data collection, including full immersion in the environment while living on board and participating in a nursing role. Approximately 5 months of 10 hours per day amounted to 1,500 hours. Fieldwork commenced when I arrived at the location on 25 June 2016 and concluded on 18 December 2016. Immersion was during waking hours and typically covered morning and evening shifts from 7.00 a.m. to 10.00 p.m. on all days of the week (including weekends). I was asked to care for a ventilated patient throughout the night on two occasions, which provided a convenient opportunity for observation of the clinical activities during a night shift in the high acuity ward. Notes were written by hand into a journal after the event took place (such as on patient screening days, working a shift in the ward, interacting with day workers and patients, or while participating in meetings and other day-to-day routines on board). It was impractical to write everything down, but as best I could, I recalled artefacts in the area, processes, and nursing-relevant conversations. I identified my thoughts and reactions during observation for

further processing (Brewer, 2000); handwritten notes were then transferred into MS Word for Mac (v16) files for importation to the qualitative data management program NVivo for Mac (v11). Other reflections were made during that process of recall and analysis (Roper & Shapira, 2000). Various rituals were documented as a “day in the life of a nurse on board” in individual diary entries. Reflections on these observations continued well after I left the research field.

Semistructured Interviews

Semistructured interviews were held in a private location at a time when the participant was not required on shift. All participants provided written informed consent before the audio recording of interviews. Each interviewee was given a demographic data page to complete (see Appendix E). The required data included the name, age, gender, years of nursing experience, nursing area they worked in on board, the number of field services they had participated in, and the amount of time of their service.

Interviews lasted from 30 to 65 minutes, with an average of 40 minutes (see Appendix F). Interviews were audio recorded. Appropriate collection of data included communicating with the participants in the language they were most comfortable using. English was the language used on board; however, some nurses spoke English as their second (or other) language, and it was necessary to recognise that they might feel self-conscious expressing themselves in English. I was aware that nuances and communication styles might be different for native English speakers compared to those speaking English as a second language. The interviewees were a mix of speakers of English as their first or other language. I explicitly looked for additional nonverbal cues and validation of my own and the interviewees’ understanding

when data were recorded and asked for extra clarification during interview if necessary or when the audio recordings were subsequently transcribed.

In addition to individual interviews, I aimed to complete focus groups of nurses in respective teams (such as patient selection, admissions, and theatre); this was expected to contribute to a deeper understanding and create a synergy of discussion between participants. Practically, although attempted, this was too great a challenge to organise; nurses from one work team, although willing, were rarely off shift and available at the same time. Only one focus group with two nurse participants was achieved.

Collection of Artefacts and Documents

In addition to observational fieldnotes and interviews, the third source of data came from artefacts and supporting documents (O'Reilly, 2012). The nursing supervisor gave access to important nursing documents such as shift schedules, orientation and continuing education notes, and written updates communicated to all nurses. This documentation provided crucial contextual information related to expected preparedness of nurses before their arrival, orientation to professional processes on board, and the debriefing practice as nurses completed their service. There were also general crew documents and orientation processes, as well as weekly continuing education sessions that occasionally had handouts attached. Finally, there were several anecdotal articles published by nurses and health professionals describing the medical work on board over the years. Appropriate documents were sourced and applied to the chosen online tool NVivo for Mac (v11) for analysis.

Phase 3

Interpretation of data was validated with study participants; a minimal delay between the completion of the interviews and transcription would allow verification before the participant or I left the field (Spradley, 1979). However, due to the ship's ongoing operational requirements, this was not realistic, and therefore most of the transcription was not completed until after I had left the field. Necessary verification was achieved by email communication.

To maximise the richness of the data, and validate findings, a nominated on-site supervisor allowed discussions of emerging conclusions. Meetings were less frequent and less formal than I had anticipated, as they prepared to leave Mercy Ships after 5 years of continuous service.

Typically, during this phase, reflections on observations would occur. I found that the pace of professional and social interactions did not allow significant analysis of data until after I had left the field.

Phase 4

In this final phase, my strategy to leave the field and withdraw from the study site included informing leadership and nurses that the study had ended, communicating outcomes to date, and farewelling participants. The process was made more difficult as I was also leaving my role as IPC nurse, and there had not yet been a replacement instated. Documentation for handover to the next IPC nurse was left in situ, and verbal reports were made to various leaders. I was satisfied that I had obtained data saturation. The anticipated timeframe for transcription of interviews and fieldnotes was not fully met. Further discussion with supervisors and colleagues proved more difficult than

expected due to a variety of factors; therefore, data analysis was more protracted.

Challenges of Immersive Data Collection in Practice

As described by T. L. Whitehead (2005), the process of data collection is a cyclical process that requires the researcher to move between collection, observation, reflection, and discovery. Reflexive dialogue is a necessary component. Undertaking fieldwork in a confined location far from home is vastly different from being a nurse researcher in one's familiar home country territory. Imposed security measures in communal living and working spaces provide a limited ability to withdraw. Furthermore, it was commonplace to spend time off in the community with the same colleagues, near patients with little or no downtime or capacity to withdraw from the tasks at hand, blurring boundaries considerably.

During the study, the wider nursing cohort displayed an admirable sense of responsibility and willingness to go above and beyond the usual expectations of their roles; this blurred the notional start and end of shift boundaries somewhat and contributed to my authentic, immersive experience. Ethnography is an open-ended, inductive, and reflexive process that requires critical thinking, flexibility, and adaptability to collect data as a participant–observer by full immersion. As both the researcher and nurse, it was vital that I remained sensitive to the needs of colleagues; to retain their respect and trust required a high level of flexibility within the work and research space. Other constraints included difficult access to the research team not on site due to time difference, challenges in technology, and less instruction or debriefing than might have otherwise occurred.

Data Management

Fieldnotes and observations were recorded in personal diary notebooks, rewritten into Word documents, and saved on my laptop computer. These files were stored securely and not shared. Audio files were also stored on my laptop when not being used. During the data collection phase, the computer was securely stored in a locked cabin and was not accessible to anyone else. Data were backed up on both a secure “cloud” server and on a hard drive and stored in a secure space. The participants’ signed consent forms were scanned and saved as computer files and then shredded before I left the site. Audio interviews were transcribed verbatim and, along with fieldnotes and documents, were uploaded into the qualitative data management software program NVivo for Mac (v11), which allowed the appropriate storage, classification, and management of data. Files were deidentified, saved, and then shared with the supervisory research team. Interviews were transcribed by me (22 files) and an independent contractor through a transcription service (27 files). The independent transcriber signed a confidentiality agreement. All transcribed data were checked against the audio recordings by me for accuracy and edited accordingly. If there were any ambiguities, the relevant participant was consulted by email for accuracy; there were fewer than 10 audio recordings that had to be clarified in this manner. This process allowed immersion in the data and gave the ability to reflect deeply on the content (Brewer, 2000). All data files will be destroyed after 7 years from completion of the study.

Thematic Data Analysis

Data analysis began at the time of data collection from three aspects—description, analysis, and interpretation—and continued after I left the study

setting. All data (interview transcriptions, fieldnotes, and reflections) were viewed as one set once uploaded to the online data management tool. I used the thematic analysis method described by Braun and Clarke (2006), which they characterised in six nonlinear steps. They are to (1) become familiarised with the data, (2) generate initial codes, (3) search for themes, (4) review themes, (5) synthesise and rename themes, and (6) produce the report.

First, I read all transcribed interviews, fieldnotes, and documents. Codes are descriptive topics assigned to sentences or paragraphs. Sentences or phrases were given a code to facilitate matching with one of the research aims (e.g. motivation, learning, holistic care). Codes were sorted into sets. I coded the individual lines several times to compare, contrast, and categorise until I saw specific categories emerge. After each file was coded, a discussion with the research team allowed further clarification and theme development. I then synthesised categories into themes and subthemes. This method of inductive thematic analysis continued by identifying themes and patterns of data. There was no initial framework used. I used tables to represent quotations, and further discussion with research team members caused me to reassign and rearrange quotations and excerpts to formulate the findings (Thorne, 2000). Eventually, individual sets were combined to form abstract concepts and broader categories to group and explain phenomena (Roper & Shapira, 2000). After comparing codes, three themes, with subthemes, were synthesised.

Quality of Research

The qualitative study satisfied the criteria for trustworthiness through the evaluation of research within the paradigm of naturalism; four concepts were

used: credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985).

Credibility represents how “truthfully” data have been presented (e.g., do the findings match what the participants thought and said?). These included triangulation by using different data gathering methods, prolonged engagement at the study site, persistent observation, extended connection with participants allowing the development of rapport, and member checking, especially with those for whom English was a second language (Holloway & Wheeler, 2013). Finally, an iterative data analysis process was undertaken jointly with my research supervisors.

Dependability refers to the accurateness of the study. By describing the context in detail and the process I took as the researcher, readers can make a judgement on how consistent the research process has been and how dependable the findings are (Roper & Shapira, 2000). Transparency was achieved by outlining all the steps taken from data collection through to analysis and reporting of findings. Data have been kept securely as a record of the research.

Transferability refers to whether study findings can be applied to a similar situation in a different context (Lincoln & Guba, 1985). A thick description of behaviour and experiences surrounding the nursing culture provided background and detailed contextual data to allow comparisons (Shenton, 2004). In judging transferability, it is the reader who confirms this concept, not the researcher, as it is the reader who understands the intricacies of the alternative environment to know if it is applicable or not (Korstjens & Moser, 2018). Examples include that the findings of this study could be generalised to a

setting where nurses are providing similar nursing care on a different ship with the same organisation, or with another organisation that has a similar faith-based ideology and care approach in a humanitarian aid setting.

Confirmability promotes the inclusion of strategies to ensure findings are correctly represented as the ideas of participants, rather than the researcher's preferences or prior assumptions (Shenton, 2004). Researcher-declared bias has been reflected on and included, and beliefs and assumptions connected with research aims are stated.

Beyond Lincoln and Guba's (1985) four concepts, reflexivity, which was discussed in Chapter 3, provides another level of trustworthiness as I examined the research process through the lens of my worldview, preconceived ideas, and conscious and unconscious assumptions.

Chapter Summary

In this chapter, an overview of the methods employed for data collection and analysis was presented. Challenges in the process of data collection in the field were outlined, with collection requiring full immersion over an extended period. Ethical considerations were discussed, along with strategies to ensure quality and trustworthiness of data. Chapter 5 presents the findings.

CHAPTER 5. FINDINGS

Introduction

This study used ethnographic methodology, which included immersive observations and interviews. Data were gathered to address the four aims of the study. A synthesis of the study's findings is presented, beginning with a description of the participants' characteristics, followed by an explanation of the four overarching themes: (1) "What drew us here?" (expressions of motivation), (2) "Who we are and how we do what we do" (expressions of engagement), (3) challenges (embracing change), and (4) development (expressions of transformation). The study's objectives and corresponding themes and subthemes are shown in Table 8. Each theme's meanings are extended by subthemes and illustrated with selected quotations from deidentified interviewees, together with reflections on field observations.

Participant Characteristics

Approximately 180 nurses volunteered on the hospital ship throughout the 6-month data collection period, with an average of 76 nurses at any one time. Participants had varied experience in service, from newly graduated RNs to nurses with specialist postgraduate training in critical care areas, public health, and tropical medicine.

Fifty nurses offered to participate in formal interviews, 49 of whom completed a face-to-face interview on the ship. One focus group was conducted, with two interviewees (others involved in that team were not RNs and therefore not interviewed), and one participant had to leave unexpectedly

but subsequently responded to the interview questions by email. Of the 49 interviewees, 12 did not have English as their first language.

Table 6 summarises the country of origin for interviewed participants.

Table 6

Interviewees' Country of Origin

Country of Origin	*N* = 51
Australia	5
Canada	6
England	8
Germany	2
Ireland	2
Netherlands	8
New Zealand	2
Singapore	1
Switzerland	2
United States	15

The average age of the interviewed participants was 35 (range: 22–66 years), with a time of continued service with Mercy Ships ranging from 3 weeks to more than 15 years. Interviewees included those volunteering with the organisations for the first time (*n* = 16), those with previous experience on a short-term placement and those returned for second field service (*n* = 12), those who had been on board for more than 1 year (*n* = 5) and 2 years or more (*n* = 14), and those with up to 15 years of service (*n* = 2).

More than half the participants had volunteered with Mercy Ships previously and had therefore been to more than one field location in an LMIC (*n* = 33). There was a balanced mix of ages; young single participants with few social ties or financial commitments; married couples, some with children; and others who had retired from working in their home countries but had retained

registration, including some who had adult children in their home countries.

Table 7 differentiates the number of participants enacting specialised roles.

Table 7

Interviewees' Nursing Practice Roles

Nursing Practice Roles on Board	Number of Participants
Admission nurse	1
Treatment room nurse (dressings team)	1
Ward educator	3
Manager	1
Medical capacity building nurse	3
Operating theatre nurse	3
Outpatients nurse	1
Post anaesthesia care unit (PACU) nurse	2
Palliative care nurse	2
Patient selection (screening) nurse	5
Ward nurse	29
Paediatric nurse	10
Intensive care nurse	8

Objectives

The study had the following objectives:

1. To establish nurses' perceptions of participating in international humanitarian work;
2. To interpret the culture of nursing practice;
3. To analyse factors that may contribute to, or hinder, nurses' practice in this humanitarian response context;
4. To evaluate any specific nursing skills developed while volunteering in the ship-based setting.

Table 8 represents the four themes and 12 subthemes that emerged from the data.

Table 8

Representation of Findings in Themes and Subthemes

Theme 1 **"What Drew Us Here?"** **(Expressions of Motivation)**	**Theme 2** **"Who We Are and How We Do What We Do"** **(Expressions of Engagement)**	**Theme 3** **Challenges** **(Embracing Change)**	**Theme 4** **Development** **(Expressions of Transformation)**
In the right place; enacting perceived identity	Common unity; cohesive team	Professional role clarification and expectation	Personal revelation
Realising potential to facilitate change	Bridge builders; instilling hope, promoting empowerment, advocating for justice	Constrained independence	Professional evolution
Searching for meaning and purpose	Nurturing wholeness; holistic care	Acculturation	
	Healing environment; hospitality		

Theme 1: "What Drew Us Here?" (Expressions of Motivation)

Theme 1 encapsulates the participants' expressions of motivation and is elucidated by three subthemes, depicted in Table 9.

Table 9

Subthemes of Theme 1

Subtheme 1	Subtheme 2	Subtheme 3
In the right place; enacting perceived identity	Realising potential to facilitate change	Searching for meaning and purpose

Under this theme, findings revealed the complexities and emotions around the decision by nurse volunteers to enter humanitarian work. Participants' motivations for humanitarian work reflected a deep connection with their values, their identity, their purpose and meaning through service, and their desire to contribute to making a difference to others' quality of life. Reasons for actively pursuing volunteer service included a strong connection to spirituality or personal faith, a confidence in their ability to make a difference in individual lives, and to escape mundane routines in pursuit of an adventure. The study's ethnographic approach found a correlation between what participants perceived to be true for themselves, as stated in interviews, and how they were observed in their voluntary roles. Each subtheme is further elaborated.

Subtheme 1: In the Right Place; Enacting Perceived Identity

Participants found that their commitment to humanitarian work facilitated a means to enact and develop their perceived identity within a belief system and worldview and one with which they strongly resonated. Many spoke of being "called", "led", or "drawn" to volunteering to fulfil a particular purpose, one with

which they were passionate to align. As one participant described, “The thing that motivates me is because I know this is where my heart is. That is the only way I can describe it” (#16).

Participants were explicit and diligent in researching the humanitarian organisation with which they intended to volunteer. Spending time researching online, and speaking with or learning about previous participants who knew of the organisation, was typical. Numerous participants were aware of the potential to volunteer at a much earlier stage than they were either ready for or had the professional experience required to apply. Participants’ views aligned with the goals of the organisation, and its patient outcomes resonated with them. One participant stated, “As a nurse . . . I just felt drawn into being a part of [this work]; I just knew that it is what I wanted to do” (#14).

Admiration for the espoused organisational culture prompted volunteers to be able to demonstrate their values practically, within an environment that accommodated their ideals: “I wanted to do some charity nursing for quite a long time. I guess that’s rooted in my faith” (#08). Participants were motivated by working within a team of people with the same vision and values that were beneficial to the patients and themselves. Teamwork did not refer to a social uniformity but rather to share a common purpose for wellbeing among individuals and communities. One participant said, “It’s just the whole ethos, everything about it . . . I respect the organisation, and therefore, I want to be part of it” (#02).

Subtheme 2: Realising Potential to Facilitate Change

A decisive motivating factor was the desire to see a positive change to individuals’ situations, coupled with the participants’ perceived confidence in

their ability to facilitate that change: “I have a big dream of working more in-depth in global health and addressing infant mortality issues . . . that is really, really important to me and part of my future” (#30). Participants stated their conviction to “give back” came from a sense of having been privileged to a high standard of education and with sufficient access to resources that allowed them to work effectively in their home countries. They thought they had a responsibility to assist in producing positive outcomes elsewhere. For example, “I feel a sense of responsibility for not taking [my education] for granted, and for sharing that with others who don’t have those opportunities” (#06).

Participants were confident that they were “in the right place at the right time”, seeing themselves equipped professionally and having the required emotional and financial support. They considered support offered from family, friends, their wider community, or nursing colleagues instrumental in helping them decide to volunteer. Prior experience in short-term humanitarian projects in a school or university service-learning capacity or other nursing experience contributed to their confidence. One participant stated, “I was encouraged by both a professor and by a family friend to pursue this work. I know the preparation I had as a burns ICU [intensive care unit] nurse was really helpful here. It’s amazing how much has transferred over” (#31).

The ship hospital provided clean water, a constant electricity source, and access to reliable resources such as monitoring equipment, which participants understood to be ordinarily unreliable or not guaranteed in a local LMIC setting. The knowledge that resources were likely to be dependable empowered volunteers with the expectation that their involvement could make a positive difference. One participant shared, “Working in this [ship] context offering

high-quality care and taking the skills I learned as a nurse at home to benefit another country, but still having the resources and access to things that I needed [was attractive]" (#11). That participant had previously perceived that working in local contexts would not be as beneficial due to the limited resources. She was attracted to this context, expecting that her effort with perceived adequate support would not be in vain. However, participants coming from a highly resourced country were also keen to learn how to be resourceful in managing with fewer supplies. Participants who were part of the medical capacity building (MCB) teams, working with their nursing colleagues from LMICs, learned to be creative and elevated their perceptions of the developing nations' practitioners.

Furthermore, participants had a robust sense of advocacy for those patients who presented as vulnerable. They held the firm resolve that the underserved patient, deprived of a reasonable quality of life, deserved more. Participants had a desire to restore dignity to individuals and perceived that they could be effective change agents through their actions: "I love that people get access to surgery that they literally couldn't otherwise access . . . this is what love and hope look like, and I can be a part of delivering that" (#20a). Therefore, participants were altruistically motivated to action: "There are so many different things that prevent people from getting health care that is a right. That's what drives me to want to bridge that gap of injustice and unfairness" (#27).

Subtheme 3: Searching for Meaning and Purpose

Participants expressed a desire to help address areas of great need, which revealed validation of their individual needs. One said, "Working [in my home country], I didn't feel important. If I quit my job, someone else would be

there to take my place. But here, well, it's not the case" (#11). Volunteer humanitarian nursing was seen to be a credible cause; however, for some, it satisfied an underlying need to validate personal worth. As one participant noted, "Here you have people who have had no other choice. We can offer them what they can't have. I just feel like I am doing so much more good here" (#14). One participant suggested that her involvement in the volunteer mission was more satisfying than work in her home country, saying, "I wanted to go to a place, to people who really need help, where no others are coming to help them" (#46).

Another said, "I started feeling like what I was doing [at home] wasn't enough" (#09). An expectation that surgery delivered on board the ship would positively transform the quality of a patient's life fuelled a nurse's sense of purpose and intrinsic reward. Much of this expectation came from exposure to others who had worked on board or via media shared, including websites, newsletters, or presentations. Further, for a portion of participants, working at home was becoming less satisfying. Participant #27 felt her patients were ungrateful for the care they received: "People back home are very self-centred. It's more about me, me, me, me, me. That whole attitude is just really so ungrateful" (#27). Participants, at times, judged their participation in humanitarian work as having more meaning to them than their nursing roles at home: "But, when I think about the work that we're doing and how—it's not only more meaningful for me, but it's meaningful for the patients" (#28).

Participants had a sense of accomplishment that they were contributing to the welfare of others while working in a like-minded team that pushed their boundaries, affording both personal and professional growth. One participant

stated the incentive to begin and then continue her volunteer nursing role arose from witnessing patients' transformations, which she described as "addictive". Many alluded to thinking that once they had done this type of work, it would be impossible to go back to their usual or ordinary way of doing things. Their worldview had been expanded, and they had grown to serve "against all odds".

Furthermore, their service encompassed more than aiding patients' physical healing; it included psychological and emotional contexts by allowing the nurse to instil hope in patients who had none. Hope is a thought, but emotional perceptions of comfort, joy, and calm often follow that hope. That hope extended beyond postsurgery outcomes and often changed nurses' perceptions of their patients' trajectories. That is, hope became palpable; patients felt accepted by nurses and others, which participants believed empowered patients to engage in their community again. The organisation espoused the aspect of "transformational development". One participant contemplated, "It is the patients that keep me coming back. Seeing the changes in them . . . seeing the difference in their demeanour when they leave the ship. I feel that's what really makes being here worth it" (#23).

Theme 2: "Who We Are and How We Do What We Do" (Expressions of Engagement)

Theme 2 unmasks the core of the culture of humanitarian nursing, describing who these nurses are, what they do, and how they engage with patients in delivering nursing care. It explains the characteristics of nurses providing tangible hope in those seeking compassionate, humanitarian care, the practice of nurturing wholeness, and restoring dignity. This provision of care is

embedded in a purposeful hospitable and healing environment. Table 10 summarises the subthemes.

Table 10

Subthemes of Theme 2

Subtheme 1	Subtheme 2	Subtheme 3	Subtheme 4
Common unity; cohesive team	Bridge builders; instilling hope, promoting empowerment, advocating for justice	Nurturing wholeness; holistic care	Healing environment; hospitality

Subtheme 1: Common Unity; Cohesive Team

Participants revealed nursing in this humanitarian hospital ship context felt like being part of a collective cultural entity: a strong and cohesive team of people who had sought and made substantial efforts to volunteer their skills. Despite the high turnover of volunteers, there was a sense of community and importance placed on passing knowledge from one team member to the next. As one participant said,

> Because someone is leaving, but someone is always coming . . . there is an environment of really depending on each other . . . one day you're new and you need help and tomorrow someone else needs help, so you need to help them. You have that environment of always supporting and teaching people. (#04)

The international environment was new for most participants; training and experiences within the volunteer group of RNs were diverse. Participants fostered camaraderie as they fully invested in opportunities available through volunteering service. Embedded values of the humanitarian organisation included faith, love, excellence, and integrity (Mercy Ships, n.d.-a) and the

volunteer nursing application process clearly stated the outworking of those expectations for potential volunteers. Those values were embedded in nurses' personal lives and professional roles, guiding their actions. Attitudes reflected both personal choice and a determination to work well together as a team, putting aside differences to the benefit of the patients. One participant expressed this sentiment:

> You've definitely got a calibre of nurses who have a real desire to be here, a real heart to be here and a calling. I think that makes it a very unique team, because of that unity in working together, I think that's a really special thing, and that overcomes many of the difficulties in working with so many international people. (#16)

A camaraderie developed, despite frequent staff turnover, due to an absolute commitment to the cause for the duration of time they volunteered. Nurses felt an allegiance to each other and were well supported by their team and others on board. An operating theatre nurse explained,

> We have a very tight-knit group, and everyone works together so well, it's like they are family, there to support you . . . especially during the [medical] emergency. Even nurses who weren't working that day just showed up to help, to ask if you were okay, or did you need anything or to check on the patients. You feel much more supported here than you do back home because people really do, honestly care about you, and their patients. (#23)

A nurse that had been on board for several months said,

> I think everybody just kind of learns that there's a type of nursing that exists on the Africa Mercy that's really different . . . everybody comes to that same

> conclusion, that it's always a teamwork thing over an individual nurse [role]. (#30)

This theme, depicting the culture of nursing for this cohesive team, held numerous factors: spirituality, humility, love and authenticity, and compassion and kindness. Each factor was demonstrated yet overlapped conceptually from the way one nurse interpreted and therefore expressed it to another nurse.

Spirituality

The nursing care model on board integrated a traditional, faith-based ideology with professional excellence and clinical expertise. A shared belief system based on a Christian worldview was embodied in the hospital and throughout the whole community. There was a strong emphasis on rituals. One of the older nurses who had arrived to work in an ICU position for the first time reflected on the work:

> [Mercy Ships is] dominated by Christian culture, which at the base it's about a commitment to others, preferring others to yourself. It isn't mumbo jumbo, but really, you see this operating daily, so it profoundly affects the work culture, because there is cooperation and a gluing of the team that I've never experienced anywhere else, in any other place. Hence, it is very different. (#48)

Spirituality was seen in a few rituals within the nursing routine. At the beginning of each shift, it was common practice for nurses and translators to gather in a time of prayer. Prayer time was held openly in the ward, where patients and family members could hear and observe the ritual. The nursing team leader would usually suggest several, so-called, *praise and prayer points*, pertinent for that moment. They thanked God for those patients who had had

successful outcomes and were going home, prayed for patients who might have had slower than expected healing, those patients having surgery that day, and for other challenging ship situations, such as waiting for customs clearance of a shipping container with needed medical supplies. Nurses and translators were free to pray or not to pray aloud, in English or their language. Not all chose to pray aloud but seemed to remain connected with the process. At times, patients were seen kneeling or sitting on their beds with their heads bowed or joining into the shared spiritual activity.

At the end of the prayer time (lasting on average 5–15 minutes), nursing handover would take place. A template with names of patients and details had been printed at the end of the previous shift and completed by team leaders to facilitate handover, which was found especially helpful for those whose primary language was other than English. Handover sheets passed to the next shift were often adorned at the edges with notes, bible verses, and stickers for encouragement purposes.

Prayer was also incorporated into other working contexts. On the vessel's arrival to the host nation, the chief medical officer publicly asked all crew to stop for a few moments, gave thanks for the safe arrival of the vessel, and asked for a blessing on opportunities to serve the host country and its people. During serious medical emergencies, it was common for ship crew to be made aware via the overhead paging system that the medical team were needing support, and crew were asked to stop for a few moments and participate in corporate prayer to see a beneficial outcome. Immediately before a patient was to have surgery, the crew members involved (surgeon, anaesthetist, operating room nurses) would pray together with the patient.

Patients were often asked if they would like prayer, and there was no obligation to submit to that process.

Africa is known for vibrant singing, dancing, and drumming. Many of the patients and their families found solace in hearing familiar songs and joining in when they could. During certain times throughout the day, a team of translators and chaplains would move through various hospital spaces and lead patients and crew in a short time of singing songs in the local dialects. After checking with the charge nurse to ensure it was appropriate timing, a moment of joyous music would ensue—often requiring all other activity in the ward to be put on hold while that occurred. At times, it was loud and lively, with clapping, drumming, instruments, and dancing. Other times, it was quieter and more reverent. Patients and caregivers spoke of it being a highlight in their day. Nurses found this practice helped cheer their patients, and although at times it felt they needed to rearrange their work around these moments, they considered the benefits outweighed the inconvenience of an interrupted task. One nurse commented,

> We do certain things that are culturally important for the people. Like, they love music. It makes them feel more at home, I think, when we have their local music and their own people leading the praise time. Then [the hospital environment is] not quite as foreign for them. (#15)

These times of music seemed to build relationship, by connecting patients and nurses (all service providers and others who joined in). When patients heard songs in their mother tongue, it connected them to the otherwise foreign hospital environment, and their body language showed that the

connection with the words, melodies, and instruments penetrated their hearts, honouring their familiar world.

Humility

A shared understanding of values fostered an ethic of strong camaraderie and a willingness to prefer others over self. A ward nurse explained,

> This is by far the most gracious work environment I've ever been in. When I was new, I was trained to be a charge nurse. Of course, there's nerves . . . but I had the confidence of knowing that even if I made a mistake, or forgot something, no one would scream at me [like at home]. They were just going to help me understand . . . to teach me how to do it . . . this is just such a nice place to be, and it's very peaceful. (#28)

In describing nursing, another participant highlighted an absence of competitiveness, a different experience from her home country. She said, "Nobody is out to be better than everybody else here . . . there is no competition. People are working together and really want to help each other" (#49).

Another participant stated,

> Here, the attitude of the nurses is very different to what I have experienced elsewhere . . . everyone wants to be here . . . that means working well together. Even if you have different personalities and clashes, it doesn't affect the way that you work as a team. Everything works well here because everyone has the right attitude. (#13)

One of the nurses assigned to the operating theatre team expressed, “Patients are in the middle, they are centre . . . it’s not about the self-centredness of nurses or what pay rise or promotion they’re going to get. That levels everyone out. It’s only about the patient then” (#31). Observations regularly revealed the humility of nurses in the operating theatre space, as they willingly worked well past their scheduled shift duties to clean and prepare equipment ready for the following day (FN #14 Aug). It was noted that whether the participant professed Christianity or not, an environment following biblical values brought a depth of unity and a healing balm to an otherwise stressful environment.

Love and Authenticity

On sharing the aim of nursing on board, participants described love and philosophical foundations as essential factors: “The focus is about genuinely loving the patients, which I’m not used to back home” (#42). A nurse manager said, “You just get used to seeing [nurses] going that extra mile . . . they do it just because they want to, and they want to make things better for patients . . . It’s an outflowing of their love” (#31). Many nurses reported that they were enabled to be more “loving” in this environment. One said, “I think there’s way more of an emphasis on being compassionate and loving people here than at home. I mean, you just need to get the task done [at home]” (#49).

Nurses spoke about what it was to “love on” their patients. It seemed to be a phrase commonly used by the U.S. nurses, but “sharing God’s love” with patients and their caregivers was a familiar phrase most nurses employed. Participant (#47) explained, “There is a special culture on the ship that we do really try to promote loving people”. When discussing how organisational values

were incorporated into her work, a ward nurse stated, “When [patients are] here, they see faith in action. Like they see us saying, ‘We are here because God loves you and because we love you’. They see that actually happening. It’s not just like some random idea” (#28).

These participants’ comments amplified statements contained in the Mercy Ships’ Philosophy of Service documentation available on the *Africa Mercy’s* intranet, depicting that the main message to be communicated is one of God’s love and compassion. Further to this concept, however, nurses not only spoke of love for their patients, they also loved and cared for each other. Preferring the other person was also perceived as love, and this is commonly found in reflections within fieldnotes on observations. Observations extending this concept of nurses loving and caring for another are depicted in Table 11.

Nurses displayed behaviours in the delivery of nursing care that were congruent with their expressed beliefs. An observed incident that highlighted authenticity was when a screening team nurse needed to convey the news to a patient that they were not a candidate for surgery. The primary communicating nurse expressed the difference between the expectation not to show an emotional response when working in her home cultural context and the permission she felt to be her true self in her role on board. The nurse, unable to fulfil the patient’s expectations to offer a surgery slot, sat with the patient in their grief and resolved to be authentic with the patient, who she felt was likely experiencing abandonment and confusion. The nurse felt vulnerable, and the raw emotion she displayed was costly to her, yet she did it knowingly and with freedom, understanding she was acting out of a deep value base. She said,

> Back home, they would say ″Don’t cry in front of the patient; don’t show your emotion″. But . . . loving people for me in this place is about being vulnerable . . . here you are faced with such obnoxious poverty, and you are desperate to hold any shred of yourself together. But . . . a tear was all a patient needed to see, to understand that you are trying your best. Because to them, when they look at you, you have everything. They don’t get why you can’t help them. Then, I think they realise if you could, you would. But the fact that you are not means you can’t, not because you don’t want to. (#41)

Alternatively, for some participants, love was exchanged as a gift; they were giving and receiving instead of seeing it as “cost”. To be able to be real and to connect genuinely was a gift they believed they received and saw themselves giving to each other in their team, within their community, and to their patients or those they connected with (such as translators or other local health providers).

Compassion and Kindness

A significant aspect of participants’ nursing care included thoughtful, purpose-driven behaviour conveying respect, dignity, and acceptance to patients, most of whom had perceived as not receiving before their ship encounter. Nurses felt the workload allocation allowed time to go the extra mile to honour their patients, to show kindness in small but meaningful transactions that most felt unable to provide in their home countries due to time constraints. A ward nurse shared,

> One of the things I think is quite startlingly different is that we do have more time to care, to love, whatever that might mean . . . I think one of the beautiful things is that it can be more about really taking that time to hold people’s hands

> and, even if you don't speak the same language, connect with people in a nonverbal way, a way that conveys their value. (#20a)

The perception that Mercy Ships nurses were considerate and kind to each other was also present:

> So, there's a lot of grace . . . if I don't know how to do something or if I run out of time and I don't get things done, people are not looking down on you. They just say, "It's okay, we'll do it". It's a very kind team; they'll pick up where you left off. (#06)

The perception was also expressed by local nurses observing the way Mercy Ships nurses interacted with patients. In a mentoring session from the medical capacity team nurses at a local hospital, one of the local nurses was asked, "What can we, as Mercy Ships nurses, teach you"? Their response: "Teach us kindness. We don't know how to be kind to our patients" (FN #2 Dec).

Table 11 is a collection of observations I made in fieldnotes supporting Theme 2, Subtheme 1.

Table 11

Observations Supporting Care and Teamwork

Observed Incidents Within the Ward Setting
Two nurses were asking how each other slept.
One nurse was inviting another nurse to watch how to do a particular procedure.
When the ships café was open, off duty nurses would ask their colleagues in the ward to ask they would like them to bring them a coffee.
Nurses were supporting one another by doing work tasks for each other if they were unfamiliar with them (lung sounds/heart sounds, inserting a cannula).
Helping each other do wound dressings, mostly when unfamiliar with the styles of dressings.
Nurses updated each other on the progress of patients outside of team handovers.
Nurses were arranging social activities and invited those that had only just joined the team.
Nurse A offered to save meals for Nurses B + C before the food line was taken down in the dining room.
A nurse giving handover to another nurse in their shared native language after the handover had been heard in English.
Day nurses offering night nurses their cabin to sleep in for the day, if they were going off the ship, and it was expected to be particularly noisy.
Crazy Scrub Friday (wearing mismatched/African cloth scrubs) as a form of team building.
Nurse A (going off duty) telling Nurse B (coming on duty) to call her cabin in the night if she was unsure and needed help with a fresh post-op patient whose surgery took longer than expected.
A nurse that was leaving offered to take any mail to her home country, to mail internally as the local postal service was unreliable.
Nurses were praying together for other individual nurses.

Subtheme 2: Bridge Builders; Instilling Hope; Promoting Empowerment, Advocating for Justice

Nurses felt the desire and the ability to instil hope in their patients, and that gave them much joy. That sentiment was shared across most areas of

nursing: nurses involved in patient selection, those caring for patients in the surgical wards pre and postoperative, nurses involved with rehabilitation (postoperative dock visits), palliative care nurses, and in the mentoring teams. A postoperative team leader shared, “It is so much more; not only taking the tumour away, but also to give back that lost hope. It’s really the heart of the nurses. We came here to serve the patients in that way” (#19).

One of the medical capacity building nurses said, “The fact is you are able to offer something that people otherwise wouldn’t have. That is the truth, we can offer that hope, I mean, real tangible hope” (#20a). Further, a palliative care nurse shared her perspective when discussing a patient in their care that could not breastfeed her newborn child due to her deteriorating health from a fungating breast tumour. She reflected on a patient’s perspective:

> The help we give is also very practical . . . I can only imagine being at the very end of not being able to get help, and then someone says, “I can help you with powdered milk for six months”. It fills their hope that there actually is a way around this . . . in the palliative care program, we do give hope—there is hope. Hope even in suffering, and it’s quite amazing what God can do. (#25)

In an interaction I had with a surgical ward nurse on an evening shift, I wrote fieldnotes on my observations and our discussion during a clinical shift. The nurse (Participant #48) was confessing she did not really know how to explain to those at home what she was doing and that deeper level of connection but felt strongly that it was about helping the poorest of the poor and bringing hope to people. She spoke insightfully about how she thought bringing hope to people really affected the culture of care positively and how she interacted with her patients. She said,

> As nurses, we have to navigate the patient's anxiety and the newness about the unfamiliar, you know, these people know nothing about first world medicine, they've never been on a ship, they walk up the gangway, and we're all uniformed, everything is likely to be beyond their experience, so I think the people are amazing that they can just do that. In my culture, if there was that much change and that much newness, patients would be needing to see their psychiatrist. Sometimes I don't really know what I'm looking at. Maybe it is just an acceptance, something about being poor, and having no other option that pushes people to come here. They just do whatever it takes. So, I don't really know what I am looking at, but it's very impressive and it certainly affects the culture of the nurses, as the nurses are very sensitive to that anxiety. (#48)

The conversation reminded me of a patient that had travelled for several days from the interior of the country and had never seen the ocean. On her arrival to the dock, it took many hours for the translators and caregiver to coax her up the gangway as she relayed her fears of walking over the water. When she courageously trusted and finally got to the top of the gangway, she was required to walk down a flight of stairs to the hospital. However, not only had she never walked on stairs before, when she initially refused, further discussion revealed she also feared she would drown if she had to walk down the stairs into the water. The promise of hope gives extraordinary courage. The desire to understand what it might be like for patients to experience such an unfamiliar and foreign environment requires a nurse's great patience and sensitivity, as reflected by Participant #48.

Given the patient cohort, participants were strong advocates for righting injustice. They wanted to provide the highest quality of care while the patient was in hospital but were just as concerned about the patient's social and

emotional situations after discharge, therefore putting plans in place to mitigate adverse circumstances to their healing. Nurses made frequent assessments of their patients in conjunction with translators as to the ongoing care and protection of the treatment they had been given. For example, can a patient be discharged safely from the hospital and return for postoperative care, or do they sleep on a dirt floor with no clean running water, not within reasonable walking distance, therefore may need some interim accommodation? Do they need money for transportation home? Negotiations were required for patients that lived in a situation likely to pose a risk to their successful recovery, and they were offered solutions.

Nurses were often concerned with the patient's postoperative needs on discharge, predicting risk and making plans to protect their patients from harm. Patients were given holistic health education beyond the surgical procedure they had. When necessary, nurses connected patients with local charities, local day workers, churches, or local missionaries, and if needed and agreed, plans were often put in place for ongoing social, emotional, or spiritual care. One nurse working in the general ward reflected on sending patients home and her responsibility in that process. One charge nurse said,

> You know they are going home by *Zemidjan* [motorbike transport]. If it were in [my home country], their wives would have them pushed down to the front door [in a wheelchair] to a waiting car. Here [West Africa], it's so different. They're on their own . . . as soon as they are discharged, they have to look after themselves . . . it's all related to survival. At home [European country], we have a doctor's letter, and you can get sick benefits for a couple of weeks and most don't really have to worry about work, most people have some sort of savings.

> Here [West Africa], it's just completely different. I need to be much more aware. (#33)

Resources were gifted to patients, and nurses were personally quite often involved in helping to improve the quality of life beyond the medical treatment given. Shoes were provided to the father of a paediatric patient who walked in without any. At other times, nurses would connect patients and their families with finance, such as to pay school fees so the child would not be excluded from school attendance. Another participant had donated some money to the palliative care team that was visiting a young mother with breast cancer. Their patient was unable to produce enough breast milk due to her cancer, and they were worried that her baby was not thriving. The palliative care team were able to help the mother buy milk powder to feed her baby until he was 6 months old. This advocacy extended beyond a clinical procedure to teaching skills that may assist in a future income stream; these measures were indicative of the holistic care reaching beyond a medical procedure and the ongoing care and responsibility for patients' welfare. When urgent patient financial needs became obvious, chaplaincy was informed, and further assessment was made; if appropriate, the community was given an opportunity to donate financially to a particular need.

Nurses perceived that empowerment was a goal and a gift they could deliver to patients. Participants reported that they loved seeing the small and large transformations in their patients' lives and hearing in conversations how patients saw their future: regaining their self-confidence, finding their voice, and being able to see the future differently. A dressings team nurse relayed her joy

as she recounted following one of her paediatric patients' healing journey. She said,

> To see them at first, so timid, out in the screening tent when they see the surgeon, hiding behind their mum and just not looking at you, then after a few days being in the ward, making eye contact, but looking up so scared at the beginning of dressing changes, then to the end, marching in and walking towards the bubbles and picking them up before they go sit down on the table like they own the dressing room. They pick out the toys that they want. And finally, to seeing them on discharge leaving the hospital with their head held higher and to see them with personality and sass again. It's precious. (#31)

Participant #20b, who had been on board for many years, relayed her thoughts about vulnerable patients who had been disempowered:

> It's so hard for them; and the reality is that it's a long process and it takes a lot of relationship building and loving and coming alongside people and working alongside them but when you witness the change it is worth it.

Participants understood empowering people meant restoring their means for survival in a physical sense, but for others, the emotional aspect of healing was just as important. Nurses were rewarded by patients having improved mobility or function that gave a means to work and earn money again, but the restoration of dignity was seen in many circumstances in addition to the physical realm. Nurses reported witnessing that transformation was a strong motivating factor. Women with obstetric fistula regained the possibility to become a mother again, which was clearly physical, but it held strong cultural ties to a women's identity and being a valuable member of society in bearing children. Culturally, having children was also a means to ensure one would be

cared for in old age. A plastic reconstructive nurse recounted some of the positive experiences of caring for her patients. She said,

> There's a seamstress that had contractures on her hands from a burn. She hasn't been able to sew for years now; couldn't do what she loves but now she will, because she's had surgery. I think a huge part of this work is just making people be able to look at themselves and feel human again. Another patient had his face burned in an electrical accident and lost his nose and a good part of his face, and he was able to have a nose reconstruction. Giving a person back their dignity and to not feel like they have to hide from the world is so great . . . the people that we are reaching have a true need and we can really offer them new life, where they wouldn't have had otherwise. (# 22)

Again, another nurse said,

> It starts with the physical. You know, those with the massive tumours, it means their face is fixed, but then there is the layer of self-esteem. They feel beautiful again. One of these boys that had a repair due to noma, he was about 18 years old, and it was really touching, because he said, "Well, I can get married now, I can finally get a girlfriend". Seeing someone feel good about themselves is such a wonderful thing. Then they can fit, they're no longer deemed to be possessed by something like an evil spirit, they're not outcasts, and they're integrated back into society. (#48)

That empowerment reaches beyond patients and caregivers to the local healthcare system by reaching local nurses involved in the mentoring program. A sentiment was shared by one of the nurse managers. He said,

> The goal of working [in an LMIC] is to empower the local people that actually live here, so that we can slowly somehow impact their health care system. My

> favourite part is when the local nurses come on board and see the care we give. We aim to empower those nurses so hopefully patients can start to see hospital in West Africa as not being the end of the road for them, but as an affordable and safe place to access before it is too late; like, when needed, and it would be something that can actually help their lives rather than hinder them. (#27)

Subtheme 3: Nurturing Wholeness; Holistic Care

This subtheme embodies holistic, person-centred care; the nurses held equally important patients' physical, emotional, social, and spiritual aspects. There were numerous examples provided by participants of having the time and opportunity to make patients feel special, and they alluded to a style of nursing more elevated than the expected norm in their home countries. For example, a nurse stated,

> It is in taking the extra time; like, [the ship] has regular patient gowns, same as at any hospital [in the nurse's home country]. But on board we also have a select 10 to 15 more girly children's gowns. They're brightly coloured, with puffed sleeves and nice necklines. Nurses take the time to find those and make sure the kids here longer get one of those. So, they can feel just a little bit special. Just a little bit more like a girl. (#24)

Commonly, surgical patients were asked to wear a hospital gown (which was culturally unfamiliar to them), so nurses chose to take extra time and effort to sift through the clean laundry to locate a gown they believed their patient may feel more comfortable in.

While translators helped healthcare personnel communicate with patients, on occasion, a patient may only speak a remote dialect. Despite this verbal language barrier, nurses expressed their understanding of holistic care

as engaging meaningfully with patients, believing that their actions promoted more than physical care. As one of the surgical ward nurses shared,

> One of our patients spoke a tribal dialect which distanced her from other patients. But we [nurses] really connected with her, and rubbed her back, and listened to music together. When it was time for discharge, she was upset that she was leaving . . . we knew she didn't want to go home. She felt loved and accepted here. (#23)

The culture of holistic care pervaded all nursing teams. A palliative care nurse shared about forming relationships and the importance of maintaining regular contact with the family of a former patient who had died a few weeks earlier at home. She explained from the family's perspective:

> The family said, "You really care because you follow up with us, you call us, and you still come and visit us, even now". They said, "When we went to the [local] hospital, we got told, no—we can't help you" for an answer, and that's it. They often don't get any explanation; they don't even know what [illness] they have; they're just left abandoned. (#25)

Promoting dignity was an important aspect identified as a cultural characteristic of nursing in the hospital as so many of the patients shared stories of being treated in an undignified manner, from their social networks and when seeking care from their local health providers. Disfigurement and cultural belief systems put patients in a position of being shunned from their social networks. Patients physically covered their protruding facial disfigurements with tea-towels or scarves. They had not been touched for years by family or others due to inherent fear that their condition was maybe infectious or that a curse

could be transmitted. Nurses and others made intentional efforts to restore dignity by taking time to sit with patients despite foul odours, explain carefully in terms they could understand, and use therapeutic and culturally appropriate touch and invest time to show the patient their worth. Fatu,[2] a woman with a vesicovaginal fistula leaking urine for 7 years, was suffering from paralysing shame but had given everything to courageously present to the Mercy Ships screening, seeking help. In that moment of connection, a nurse validated her as a person, aided her practically (giving her some incontinence pads and disposable underwear to keep her dry), and started the process of restoring some dignity. A tear rolled down Fatu's cheek, as she told the translator that she had not been able to get on public transport for many years, due to her horrible smell, and was so relieved she had found the ship's location after walking many days. At that moment, the nurse asked her if she could hug her and set the process in motion for further assessment and possible surgical repair (FN #19 Jul).

A ward nurse reflected on the practice of integrated care from a holistic perspective in the humanitarian setting and compared it to her home country (England). She said,

> I think from a nursing point of view which we could learn in the UK is the importance placed on nutrition here . . . like the food they get given here is way richer in vitamins and minerals than it is in the UK hospitals; and then, the way we give additional vitamins and minerals too—it's so important to get back to

[2] Name changed to protect identity.

> what is helping the wound to heal . . . like, you shouldn't use a £50 expensive dressing when you're not even thinking about the nutrition needs. (#08)

The higher nurse-to-patient ratio meant that caring for fewer patients gave freedom to deliver holistic care and was very welcomed by nurses. Participant #46 said,

> It feels like coming back to what nursing should be. In Germany, we have so little time for each person. Here it's quite the opposite, you have time to get to know them, to take care of their mental health, and of their spiritual life . . . more than just the medical things. That's a great experience. That is what makes nursing so unique on the ship that you don't have to take care of 20 patients.

Moreover, Participant #13 said,

> Definitely the biggest difference is the more holistic approach to nursing on board the ship, as back at home you don't tend to have as much time to do anything but your tasks which is just the physical things. But here on board it's really rewarding. I feel like you have more opportunity to get to know the patients more personally, so then you can obviously cater to the spiritual and emotional side of things as well which is very different to at home.

In offering nursing care, one nurse reflected on her thoughts about the difference in care given between the ship team and the local hospital situation:

> I've been in Africa a long time. But [that visit] just reminded me again, the hopelessness of what the hospital is here versus the hope we can offer on the ship . . . I can see a huge difference just even in the way that we interact with our patients. It's just that love and that care and that kindness we give that is

missing . . . I think that they lap up and that contributes to their healing as much as the physical surgery or the wound care. (#14)

Table 12 reports on observed interactions evidencing aspects of holistic care provided by nurses. The table of interactions were summarised from my fieldnotes. These were regular and frequent occurrences over the course of the 6 months of observation.

Table 12

Observed Holistic Interventions

Holistic Interventions
Asking what the patient believed about their illness, seeking to understand cultural and spiritual beliefs, without judgement.
Dressing team nurses spending time blowing up gloves as toys, and spending time playing with and allowing children to become familiarized with area before providing treatment.
Being sensitive to patients' caregivers needs and acting on them (e.g., washing the fathers one set of clothes after they had travelled for days from upcountry).
Discharge planning: providing money for transportation to get home if necessary, asking patients if they had a relative to stay with in town and if not, arranging intermediary accommodation at the HOPE Centre until full discharge.
Connection activities for children (and adults); such as colouring in activities, craft, time spent teaching children to hold a pen and to write their name, learning words of the patients' dialects, learning songs in the local language, fingernail painting.
Health education; the importance of handwashing, breastfeeding, nutrition, family planning, prevention of conditions such as scabies, worms, etc.
Playing music and encouraging patients to dance; nurses learning to clap and dance African style, often facilitating great bouts of laughter by patients.
Nurses accompanying patients out to Deck 7 or to the dock for a walk to get fresh air and exercise, or to facilitate use of their mobile phone (reception was dull at certain points on the hospital deck).
Spending extra time connecting with patients; to learn how to braid hair, playing with toys, nurses showing patients how to do a jigsaw puzzle.
Asking about their patients' needs and acting when possible to help meet those needs (e.g., providing a pair of shoes when the patient did not own any).

Holistic Interventions
Arranging for a special meal from the kitchen for a particular patient need.
Language learning, time spent to understand where the patients came from. This extended to some nurses having the opportunity to visit patients in their home (accompanied by translators) if invited.
Using therapeutic touch for pain relief and physical connection (foot massage on dry cracked feet).
Numerous nurses visiting their patients in the ward on their days off to greet them and follow their progress.
Facilitating floor space in the ward for a patient's prayer mat (Muslim prayer).
Discussing childbirth and the challenges of raising children in Africa (not connected with patients' reason for admission).
Asking patients if they would like prayer, and praying for them with translators.
Inviting patients to join in with crew celebratory activities such as a Carols by Candlelight service on the dock at Christmas.

Subtheme 4: Healing Environment; Hospitality

Within the philosophy of holistic care, participants worked hard to create an environment where comfort and inclusivity were imperative for patients and families. The ship hospital setting is a very different environment to local African hospitals, both in the physical space and the cultural practice. It was important to participants that patients felt welcomed and comfortable in body and spirit, and this contributed to their healing process. Efforts were made to ensure the environment was physically, emotionally, and culturally conducive to healing. Although compact, patient care areas were well maintained and clean and filled with light, laughter, decorations (patients' and nurses' artwork), coloured blankets, intact mattresses, with pillows and fresh linen, in contrast to local hospital environments. Good nutrition was provided in three meals a day (designed with a dietician and prepared by local cooks), and a hygiene pack, including a towel, soap, toothbrush, and toothpaste, was gifted to each patient.

Children were often gifted a knitted soft toy to take home, and there was a genuine welcome conveyed by all. Ship nurses understood that such items could not be easily acquired due to port restrictions. Therefore, needs were met on board to ensure that patients had what would help make them comfortable. There was no cost to patients for care received.

One of the ward nurses explained,

> I think like it's amazing if you walk on the wards and just hear the chatter and the laughter. I really feel we're doing such a good job. It might look very different than at home because it's messy and sometimes looks really disorganised. But at the end of the day, we give really good care. I'm very proud of what we accomplish. (#01)

As one of the nurses reflected on the vast difference in workflow priorities between her nursing position in her home country and nursing on the ship, she said,

> It is politically incorrect to sit down and play a game with a patient at home. If you're doing that, there is the expectation you should be doing something else more important. Whereas here, it's a requirement that you do that as part of your job. That's the social and the spiritual and the emotional part of nursing here. (#44)

Wards were organised in surgical specialities and held 12 hospital beds each that were separated by privacy curtains. Patients of all ages with the same or similar conditions were located together in the same space, enabling people to share common experiences and encourage one another during recovery. Some patients may have never seen another person with their same

disfigurement, or with a similar condition. Participants believed the layout of the wards suited the culture, and the strategy of placing patients with similar conditions together was conducive to patients' families supporting each other, bringing emotional support and healing. One of the paediatric nurses stated,

> It's good for the kids [with disfigurements] to be around a whole bunch of other kids that are just like them . . . they form really deep bonds. They've spent most of their life feeling very isolated, and then all of a sudden, all these other kids around them are just like them, and everyone is friendly, and they see past the deformity because they have the same. (#09)

All ship wards were connected by one corridor, allowing for recovering children to visit easily with others and play together in the hospital space on that deck. Patients were also given opportunity daily to gather outside for fresh air in the designated deck space together.

Participants sought feedback from patients and each other to cultivate an environment that was kind, positive, and promoted healing. Patients regularly conveyed their gratefulness at the environment and the services offered, their satisfaction in the services provided, and the outcomes of surgery. One nurse described the satisfaction she received in hearing patients were grateful. She said,

> I like hearing how thankful patients are . . . it's encouraging to hear [them express] what they are actually thinking . . . the translators and day crew [too] . . . and sometimes you don't really think you're doing that much as a nurse, and then you hear patients speak of what little thing they are thankful for. (#38)

On occasion, despite their poverty, patients offered a gift in appreciation for their positive experience: produce (oranges, eggs, and even a live chicken) or an offer to help sweep or clean. The following is an excerpt of a fieldnote entry.

> Today, I helped out scheduling patients for eye surgery with the Eye Screening team at the local hospital. Before we got started, I was greeted by our translator, telling me there was a man who urgently needed to see me. I was about to say he should wait in the queue along with everyone else, when the translator added, “He wants to measure you”. I said “Pardon—I don’t understand?” in my best broken French . . . as I was faced with a man with a tape measure around his neck, and a grin from ear to ear. I didn’t recognise this man and certainly could not remember enlisting him for his tailoring services. Finally, after some confusion and some more dialogue, an explanation came. He was a tailor, and so grateful for the kindness and genuine care I had shown his father last week in his eye exam, that he insisted on making me a dress, and therefore was asking my permission to take my measurements. (FN #29 Oct)

One translator shared that having a dress made as a gift was regarded as a high honour in their culture.

Rituals were purposefully arranged to provide hospitality and contributed to patient comfort and familiarity. Nurses attempted to learn local phrases (making patients laugh at their mispronunciation at times) and set necessary tasks around extracurricular activities to bridge the gap and to make patients feel at ease. Primary healthcare education about common ailments (such as lethargy and dehydration, malnutrition, and parasitic infections) and healthy behaviours such as handwashing, infection prevention, and breastfeeding were communicated with song, picture boards, and at times puppets. Craft activities

kept both children and adults occupied and aided with rehabilitation. Basic writing and mathematics skills were nurtured where appropriate. Singing and drumming sessions encouraged movement, with upbeat music and dance. Times where patients could openly share their stories were arranged, and selected movies were shown in the wards. A paediatric nurse shared about her patient interaction by playing an African bead game called Owari:

> We made this whole tournament in the ward, and that was really fun. So that kind of stuff you wouldn't do back at home, to play games [at work] . . . you do get an excellent connection with the patients . . . even though you can't speak their language, it doesn't matter. But you know they're trying to just let you win because they feel bad for you. (#07)

These activities all served to bring cheerful ambience to the environment for nurses, patients, and their caregivers. One participant said,

> The music is really uplifting, and you get caught by it, and the longer you stay here, the longer you are affected by it. I'm not quite sure how that happens . . . or what's actually going on, but it is everything . . . [patients] that can get up, and dance will get up and dance, they'll move, and their joy is so readily expressed. (#48)

Nonhealthcare crew members were encouraged to visit and connect with the patients and the patients' families as a form of social engagement. Daily, for able patients and caregivers, time was spent on the outside deck where there was more space for children to run around and expend energy, to interact with other crew and patients, and to get fresh air and sunshine. For less mobile patients, there was a stores lift that facilitated the movement of patients to the

upstairs deck. These activities were an essential part of providing an environment for healing and required organisation as safety and security was paramount. Off-duty nurses and others regularly joined this daily afternoon occurrence. Tables and chairs on the deck were dedicated to this afternoon activity, so groups could play card games, Jenga, and paint each other's fingernails. This social connection between nurses, patients, and others was an essential part of the culture of nursing on board, indicating the provision of holistic care (FN #15 Sep).

Celebrations were encouraged, including dress ceremonies for patients with a repaired vesicovaginal fistula. A ceremony was held where women were given a new dress, adorned with makeup, to celebrate their physical healing. This ceremony also symbolised new hope in returning to their community, no longer marked by the smell of urinary incontinence that stole their dignity and tainted them as an outcast. This sentiment was expressed by one participant who felt the healing environment was an essential factor in the transformation of patients:

> You see it in the transformation of the patients. Those core values that go into the love and the care put into every patient . . . the classic stigma that patients come in with, and then they leave with much less [of the stigma], not just because their physical deformity has gone, but because of the respect and things that are conferred by the staff here during their time onboard. There are countless examples of that. (#37)

As part of various mentoring programs, local healthcare professionals worked alongside the Mercy Ships team, providing transparency and credibility for both the local healthcare teams and patients receiving services on board.

One nurse reflected on an interaction she had with a local visiting surgeon, which indicated an outcome nurses sought to convey not only to patients but to local health professionals. She said,

> One [local] surgeon commented about what she saw here . . . She said, “I see that you really care for our people”. That brings tears to my eyes, because I think wow, if we can model that to the local people, in ward rounds, like the way we speak to people, and the way that we take the time for that, that we actually care . . . this is what love looks like. (#20b)

Theme 3: Challenges (Embracing Change)

This overarching theme describes the challenges participants felt and the process they entered to embrace change. It concerned defining their professional roles, feeling somewhat constrained in their independence, both professionally and personally. There was a process of adapting to a complex cultural environment with layers of cultural difference: living on a ship docked in a shipping port, working in an international team of nurses, and living in a community of faith and in a country with vastly different cultural traditions to participants’ home countries. Each subtheme is explained further.

Table 13

Subthemes of Theme 3

Subtheme 1	Subtheme 2	Subtheme 3
Professional role clarification and expectation	Constrained independence	Acculturation

Subtheme 1: Professional Role Clarification and Expectation

Common nursing procedures (such as medication administration) led nurses to think critically and reassess their beliefs due to the somewhat unique processes employed in the hospital ship environment. For example, ward nurses were required to transcribe a doctor's orders onto a patient's medication chart when standing orders were applicable. This was an uncommon task for most RNs as it was different to their home country nursing process and was therefore questioned frequently. Standard care pathways adapted to each patient's situation were commonly used to avoid mistakes being made by nurses new to the environment; that is, they were not yet familiar with a patient's trajectory or a surgeon's particular instructions that may deviate from the expected norm and were adapted to a West Africa context.

Differences in caring for paediatric patients versus adults was another task that nurses initially found challenging. A nurse, who was used to caring for adults and had been allocated to care for a child, said,

> I had a child being sick [vomiting] and it's not something I feel comfortable with . . . with the adults I just know what I need to do . . . not so with children, but it's comforting that there is always someone working with you that is able to help you. (#45)

Although working in a cohesive team was positive, there was a realisation of the differences in the way nursing was practised around the world, and therefore it was a learning process as nurses became more culturally aware of other colleagues. Nurses were led to question the way they did things, and they had ample opportunity to evaluate their own processes when they witnessed alternative ways of doing things by nurses from other countries. One

participant reflected, “So you don’t really realise how different [it is] until you come in contact with another nurse from another country . . . At first, it’s like, a little rough” (#10). The environment provided a rich exchange of knowledge yet also caused stress for some nurses. Different terminology was used internationally for the same procedure. Even between the English-language-speaking countries, equipment or procedures may have different terms. For example, when referring to disconnecting an intravenous line and closing it off without removing the cannula from the patient, a U.S. nurse would *hep lock* a cannula, an Australian nurse would refer to that same procedure as *capping* the cannula, while a British nurse may *bung it*. This caused confusion for some participants, particularly those with English as a nonprimary language. There were many conversations about differences in language between nurses who could usually laugh about the idiosyncrasies they discovered. Another participant saw working outside her home country as positive and an opportunity for increased professional awareness. She said, “I think that’s really good because it just jolts you out of your zone where you think everything’s a certain way” (#15). Flexibility and learning to adapt was a common part of nurses embracing professional differences and clarifying their roles. One participant expressed, “On the ship . . . they manage patients a little bit different. So, getting our head around it, yeah . . . you’ve got to get used to it” (#13).

Conversely, there is a greater possibility to think or act in a judgemental way, as although nurses said they were accommodating to different cultures, sometimes their nursing colleague completed a clinical procedure another way to how they had been taught. Participant #16 understood that judgement of colleagues’ practice could happen easily; it was a challenge that required a

level of emotional intelligence and maturity to respond in an attitude of humility and negotiation. Nurses did not automatically accept different practices, and although the principle was the same, nurses may have felt more comfortable doing a procedure in a different way and therefore required good leadership to navigate through that process to ensure the patient received the most appropriate treatment.

Subtheme 2: Constrained Independence

In general, the team leader did a “doctor’s round”, communicating directly with the surgeon or physician about each patient’s progress, and then individually conveyed those medical orders to each nurse caring for the particular patient. This process had developed over time to reduce the potential for miscommunication due to language barriers. Experienced nurses who were used to a more autonomous way of communicating directly with the medical staff about the patients in their care felt constrained by that routine practice. Once nurses understood the reasons behind the seemingly complex communication process, they accepted the routine as better practice. Further to that, documentation (e.g., nursing care pathways) was used on board to provide guidance to nurses that were unfamiliar with certain patient trajectories after specialist surgery. To some very experienced nurses, the mandatory use of those nursing care pathways felt like their critical thinking skills were undervalued.

Participants perceived communication with patients to be a challenge, with some more frustrated than others. The non-English language context required navigating how to nurse without direct verbal communication. There were many hand actions, attempts at speaking words in the local dialects, and

translators, although there to bridge the gap, were sometimes not as forthcoming as they could have been in admitting they did not understand. These communication challenges presented a learning opportunity for nurses: to develop critical thinking strategies to achieve the desired outcome. One nurse, sensing the translator had not understood, asked,

> ‘Do you understand [my] English?’ He said yes. He nodded his head because they all nod their heads . . . but he didn’t really [understand]. It is just learning to be patient in mentoring and teaching medical vocabulary to day workers . . . for our ward to work. (#38)

Another common challenge for participants was helping patients understand what they needed in relation to their health trajectory, considering their health literacy was much lower than the nurses were accustomed to when dealing with patients in their home countries. A general ward nurse, when speaking of his role in postoperative education, said,

> It takes twice as long to do here. Sometimes more, because you often have to go through two different translators to get to the patient’s language. First, you have to trust the translators are actually translating everything you say to the patient. But then, does the patient really understand? They don’t have that luxury of a GP or internet or TV where they can [learn] what it means. (#33)

Another issue was having to tell patients that treatment was not possible or available for their situation, and it was a particularly emotionally draining situation for those working with patient selection in the screening team. One nurse said,

> After a while, you almost hit a wall because you can't say no anymore. It's really hard; people are coming full of hope. Then if you have to say no because you can't help them, they fall down, and they wail. (#01)

The counselling team, including palliative care nurses, saw those patients that had not been offered a surgical procedure, and there were debriefing sessions available for crew to process emotions. Nevertheless, being faced with overwhelming numbers of patients seeking help, and patients often presenting with conditions the medical teams did not deal with (e.g., diseases that could not be cured by a surgical procedure), required much emotional energy and caused stress for nurses. Nurses that were passionate about helping those that had a problem did not find any joy having to say, "No—we cannot help you". The communication with patients surrounding the selection process for treatment, day in and day out for extended months, required persistent resilience and support.

Subtheme 3: Acculturation

This subtheme embraces the cultural change that occurs because of exposure and connection between many different cultural contexts. Nurses needed to gain an understanding of their place within an international team, of the unique nursing culture present within the organisation, and of the culture of where they were in Africa.

African culture incorporates a greater awareness of the whole person in everyday life, holistically. Participants sensed that the opportunity to embrace differences in worldview and cultural practice was both a challenge and a learning opportunity. Participant #48 said,

> You studied holistic nursing at university, wrote all the essays and read all the literature [about holistic care] but then at home you walk into situations that are so strongly demarked. But here, it really is holistic nursing in every sense, because there is no other option but to holistically nurse here . . . if we had private rooms, I don't think the hospital would work, you know? There is literally 30 cm between the beds, and a mattress under the bed for the caregiver. There is lots of loud noise, and the place rocks . . . but healing is taking place somehow.

For this participant and many others, the many people in a limited space, the noise, and the cultural beliefs of African people were a chaotic challenge. However, after some weeks, the participant was taken by surprise at how she grew to embrace and adapt to what was initially so foreign to her. Recognising that her patients had to deal with an equally difficult adaptation as the nurses did, she went on to explain,

> They've never been on a ship . . . we are all uniformed, they know nothing about first world medicine, and everything is likely to be beyond their experience. I think these people are amazing. I don't know what I am looking at sometimes, but it certainly affects the culture of nursing here, and the nurses are very sensitive to that. We get great teaching. We have to learn how to chill and how to deal with people. You don't get that sort of exposure or teaching at home. (#48)

Participants were challenged by the differences between what was known as warm-climate and cold-climate cultural beliefs, and it was a source of frustration or challenge for some nurses that had not previously experienced the stark difference between the two (Lanier, 2000). However, the longer nurses

spent in the environment, the easier they felt they adjusted, became acculturated, and accepted the new normal.

Theme 4: Development (Expressions of Transformation)

Theme four contains two subthemes that represent the intersection of participants' personal and professional growth. Components are depicted in Table 14.

Table 14

Subthemes of Theme 4

Subtheme 1 Personal revelation	Subtheme 2 Professional evolution
Emotional intelligence and insight	Critical thinking to strengthen clinical acumen
Communication and cultural competency	Leadership skills

Subtheme 1: Personal Revelation

When confronted with difficulties, individuals became acutely conscious of an authentic connection between their value system and how their beliefs impacted themselves and others. For the participants in this study, there was an opportunity to grow their emotional and social competence, and those who had returned on multiple occasions felt there was always more to learn. These perceptions became evident to participants and their managers. When explaining her involvement in debriefing nurses who had finished their service, a nurse manager stated, "This experience does something significant in the hearts of the nurses . . . they don't come thinking they are going to receive. But they leave saying, 'I've learned this and that from the patients . . .' and it really moves them" (#40).

Emotional Intelligence and Insight

The environment elevated contributing factors to recognising emotional responses in participants and how these might affect others. Participants reported gaining insight; the sudden realisation or new understanding of an idea was born from working intensely with nurses of different social and cultural backgrounds. Those who had left their country and culture for the first time were confronted with colleagues, patients, translators, and local health professionals who had varying ideas or belief systems. To reconcile these differences, participants used discussion, reflection, and debriefing measures. Furthermore, they were required to process emotions while engaging in work that challenged their ways of understanding. A nurse involved in patient selection who had participated in more than one field service reflected, “I definitely think this work is changing me. I don’t think you notice the change until later . . . when you look back. I know for sure I’m not the same person I was this time last year” (#27).

Further to this growth mindset theme, a ward nurse serving for the first time understood how her behaviour had impacted the mother of her patient, which gave new insight into a cultural aspect of patient care that she had previously not considered. Her initial motive was to give a child some stickers as a gift. She said,

> I was giving stickers to her child, and the mother wasn’t happy about it. I hadn’t experienced that reaction before. The mum said, “It’s hard for us because we come on the ship and our children get rewarded, except at home I don’t have [stickers] to reward her with. It’s hard for us to see them so happy here, and then we go home, and she’s just not going to be happy” . . . I had never looked at that aspect from the parent’s perspective. (#13)

One screening team nurse pondered the potential affect the experience would have when she returned home:

> I realise their comorbidities are things that we never consider in the west . . . and now having been exposed to people experiencing trauma and conflict, children born out of that adversity . . . my mindset is so different . . . When I go back home, I will be that so much more holistic. (#41)

Communication and Cultural Competency

Participants' work and living contexts were culturally distinctive from their usual environments. It was intense, busy, and noisy, and there was ample opportunity to gain insight into both their own and others' cultural behaviour. A participant reflected**,**

> Living all together makes you look at your own culture differently, and you think, oh wow, we are sometimes kind of rude or very direct in things or other things that I just didn't realise when I was living in [my home country], but I've noticed that being here now. (#18)

Another participant contemplated,

> You're going to be with people from all nations and having to get along . . . it kind of jolts you out of that egocentric kind of life you live . . . whereas here, well, everyone does things very differently. And I like that . . . it just jolts me out of my little rut. It really makes me think. (#15)

Participants situated and compared their new work environment to their home contexts. Witnessing limitations in access to health care and resources led to an appreciation for the health systems in their home countries. An

operating room nurse, reflecting on what she might take home after her experience, said,

> I'll be so much more appreciative of things back at home. I always say we moan so much about the health system in [my home country]. When you look at what people have here, it's like how can you even moan? (#35)

Further, participants expected to communicate effectively with each other despite cultural and linguistic difference. Knowledge and skill were enriched when functioning within an international team, but patience and persistence were developed when working through untrained translators who were from many different language groups. Therefore, increased tolerance, and an expanded worldview, benefited them by seeing through the eyes of nurses from vastly different cultural contexts. The off-ship collaboration with local African nurses allowed for expansion in nurses' thinking, with a rich exchange of knowledge, reflection on principles, and altered practice. With the participants' newly acquired context of global humanitarian aid, an increase in flexibility and relevancy occurred. One of the nurses who had been on board for 1 year said,

> We interact with local hospitals, and we get local nurses on our wards. So, they see how we work, we will work together and [some of our nurses] go to their wards and watch how they work. There is an exchange of knowledge. We see the way they do it, and if it is really good, maybe we can use it for our nursing context. (#46)

Subtheme 2: Professional Evolution

Professionally, the study setting provided an opportunity for new clinical experiences. Selection criteria for acceptance to nursing roles on the ship

demanded competence in English but having French as a language skill was a bonus. Completion of a checklist of competence in nursing skills was mandatory, and managers then placed nurses within the most appropriate areas matching their experience. However, that was balanced by an acknowledgement that the ship's context was unique, and therefore, there was accompanying freedom to be legitimate learners. There was an expectation that even highly experienced nurses needed to develop and apply their understanding to gain insight within a different context.

The partnership between nurses and the organisation was seen to be beneficial, as one participant described:

> What a win-win. I have nursing skills that are needed, but here I get back how to be more human, how to be soft, how to stay with people in their sorrow, disappointment. Oh my gosh, I am a better human being for [this experience] . . . to give people back a life is beyond words, rewarding. (#48)

Critical Thinking to Strengthen Clinical Acumen

In a professional sense, nurses perceived learning in the clinical understanding of disease processes and presenting conditions, in gaining a better understanding of the roles of nurses in other countries, and in advancing and gaining more flexibility with clinical reasoning. Consequently, their critical thinking became more creative. Furthermore, some nurses shared certain clinical skills they had grown, including venepuncture and cannulation, suturing, eye blocks, and advanced assessment skills.

Nurses were involved in triage and initial stages of patient selection. In the beginning, most had not seen the gravity of clinical presentations, and despite being mentored with firm guidelines for screening and patient selection,

nurses were tested in their clinical reasoning and justifications. Their ability to identify significant clinical symptoms and patient history-taking skills were consolidated. This participant when discussing her role noted, “You see things here that you would never see back home. Every day is a learning day . . . that can be exhausting, but it is excellent to learn” (#27).

Some participants found their assigned position afforded role expansion in clinical skills when compared to their home country positions. A perioperative nurse said, “There’s definitely a lot of things that I’ve been taught here . . . I feel like I’m really extended in my scope of practice here, and it’s nice to have the support for that” (#36).

Another nurse specialist working with the ophthalmic team explained her involvement with preoperative cataract patients: “I’ve learned a huge amount. Being here has certainly made me much more comfortable [in ophthalmic nursing] and has increased my skill set” (#05).

Given the context of mixed adult and paediatric presentations in each specialty ward, many nurses who were more familiar in caring for adults said they felt underprepared when they were assigned to care for children. They sought help from team leaders and were mentored in the paediatric-related nursing skills they thought they lacked (e.g., giving oral medication to infants). Moreover, nurses educated in different countries did not all practise the same way. On witnessing a nasogastric tube exiting the neck of a patient who had maxillofacial surgery, one participant said, “I was so not used to seeing that. It’s not something we would ever do back home” (#18). Further, theoretical concepts such as respiratory assessment (e.g., auscultating lung sounds) may have been included in undergraduate degrees for nurses in some countries but

were underpractised, so those nurses valued having the support to consolidate such underpractised or unfamiliar skills. A ward nurse reflected on clinical skills that had been enhanced while on board: “Checking NG [nasogastric tube] placement, bowel sounds or lung sounds . . . I don’t have those skills down . . . because we just never really do those things at home. So, I learnt [that], and I was quite excited” (#39).

Once per week, a didactic-style in-service health-related lecture was provided to all interested crew. The aim was to deliver a contextual understanding of conditions, treatment, and specific considerations to new volunteers. A ward nurse stated, “The in-services have been so educational. It is so helpful hearing from the perspective of others, especially the surgeons . . . it impacts you and changes your understanding” (#22). Nurses developed pragmatism considering the need to function in an expanded role:

> I think here, we are actually everything . . . we are the social worker, and the discharge planner . . . there is a dietician and a speech therapist, but we’re still [reinforcing] those skills when they are not around. We’re doing physiotherapy. We’re doing almost everything . . . at home, you would have that other person [in that role] to sort that problem out. The roles are much more comprehensive for nurses here. (#21)

In contrast, a small number of very experienced nurses felt their skill set was not being optimally used. A nurse located in a plastic reconstructive ward said, “At times, I feel like I’m more like a babysitter than a nurse. Some days you don’t do a single clinical skill, other than take vital signs on someone and give them some vitamins” (#15). A small number of highly skilled and experienced participants who were deployed in slower paced areas (e.g., skin-

graft patients where protocols required wound dressings to be in place for extended periods) found their clinical skills were used less than they expected. However, they found the opportunity to reflect on how other skills, such as relational and communication skills, were strengthened in the process.

Some nurses visited patients in their homes, providing further contextual understanding. Seeing patients' living conditions, and their lack of access to health services and other resources, helped the nurses to make the connection between the burden of disease and causative environmental factors.

Leadership Skills

The volunteer cohort often aspired to work long term in humanitarian contexts, whether with the current service or to move to a more permanent land-based situation. Nurses who had been working for a more extended period in humanitarian work mentored new arrivals, giving perspective and insight to both cultural competence and global health needs. A practical and typical example was when a nurse new to the environment tended to want to pick up a crying baby to comfort them, despite not being the baby's assigned nurse and did so without asking the mother's permission. The mothers politely obliged without comment as culturally, it would be considered rude to object, given they were receiving free health care. Nurses needed to put themselves in the situation of a stranger clutching their baby out of bed and walking off with them to the other side of the room. This situation required diplomacy and instruction by the team leader or others who had a more in-depth insight into what effects a nurse's behaviour was having on a mother. Further, leadership skills were developed in learning the art of managing people and in communicating the

appropriate practice of specific actions with nurses from different nationalities to ensure they adopted a more culturally competent behaviour.

Problem-solving and critical-thinking skills were accelerated within the study's environment. As supplies were procured from a variety of countries and were often unfamiliar, ample opportunities arose to learn about new products and the adaptations required for the unique environment. On a shift where wound care was being performed, two nurses from different nations were observed working together. One assumed a mentoring role. The nurse attending to the dressing was about to place the Jelonet dressing on the wound without removing the protective paper layer; she had never seen it before. Her mentor told her to peel off the paper, and she said, "Oh thank you so much for saying that . . . if you were not here, I would have just put that on and then it would not have helped the wound at all". The nurse, who had the potential to be embarrassed at her lack of knowledge about the dressing, added, "Being really able to adapt to different environments is an excellent skill to take home because, in nursing, things are always changing" (FN #6 Nov). Other participants noted appreciating the use of limited resources and learned to be more frugal, while gaining the confidence to question the necessity of specific interventions. Participants were therefore encouraged about the likelihood that they would consider changing their previous practices on their return to their usual working environments in their home countries. One participant said,

> You don't have as much stuff as you would at home, and you have to utilise your resources well here . . . like re-using the little plastic temperature probe covering [for the same patient] . . . I'm just not used to that . . . and not doing something that's not necessary . . . like, at home I would probably just put up

> some [intravenous] fluids. But does that patient really need these fluids? At home we start things too easily . . . but here they consider everything really well, which I think works much better than at home. You can over-care for the patients at home. (#13)

Chapter Summary

This chapter presented the study's findings as they related to the study's four main objectives. A demographic description of participants was given, and then the four overarching themes were highlighted by participant quotations and field observations: (1) "What drew us here?" (expressions of motivation), (2) "Why we do what we do" (expressions of engagement), (3) challenges (embracing change), and (4) development (expressions of transformation). Some concepts were placed under individual headings yet crossed over multiple categories. Chapter 7 provides an analysis of the findings, situating them in relation to current published literature, and proposes a PPM to guide nursing within the nondisaster humanitarian space.

CHAPTER 6. DISCUSSION

Introduction

The study's overall aims were to describe the roles and practices of nurses participating as volunteers, underpinned by their experiences working within an international team in global health, providing nondisaster humanitarian care in an LMIC. Key findings were arranged into four themes that aligned with the study's objectives, as presented in Chapter 5: (1) "What drew us here?" (expressions of motivation), (2) "Who we are and how we do what we do" (expressions of engagement), (3) challenges (embracing change), and (4) development (expressions of transformation). Significant retooling of embedded themes produced a codification to outline the LMIC humanitarian nursing context, leading to the development and articulation of a generic PPM named HHEALED. This generic model was reapplied to the study's representative CoNP, and a graphic figure for considered use by the NGO is presented below. The final chapter (Chapter 7) outlines methodological strengths and limitations and recommendations related to nursing education, policy, practice, and research.

Provision of Nursing Care

The nursing profession can be generally described as a gathering of people who, having been trained in a specific set of skills and behaviours, demonstrate *care* for others, purposing to bring health, healing, and wholeness (World Health Organization, 2020e). The World Health Organization explains *health* as a state of complete wellbeing that embraces holistic domains: physical, mental, spiritual, and social spheres. Nurses, in fulfilling their given

role, have a mandate to plan both preventative and restorative caring interventions in alignment with the World Health Organization's definition of holistic health (World Health Organization (2020a).

Despite unique representations and differences between countries, cultures, and contexts, caring behaviour exists in some form in every society. There are varying expressions of caring in practice. The expression of care is vital for survival, human development, and the maintenance of health and is best placed when it is person centred (Watson, 1979). The expression of person-centred care is based on a therapeutic interpersonal relationship between the nurse and patient (Watson, 2013), where the relationship rather than the service is central (Drury & Hunter, 2016).

It can be argued that nurses inherently follow the same creed of service today as they have done throughout history and will likely continue throughout time. That creed is the essence of nursing practice: being *present* to deliver compassionate care (Kim, 2015). However, nurses interpret that creed through many lenses; one such lens is cultural, and consequently, how they administer that care is often influenced by each lens (Goldman & Trimmer, 2019). It is important to acknowledge that globally, the profession of nursing is unlikely to be standardised for that very reason. Moreover, because governments of low-, middle-, and high-income countries have different priorities, goals, resources, and agendas, expressions will inevitably vary between them (Rosa, 2017).

When considering a cohort of nurses trained in high-income countries volunteering in LMICs, an instinctive expectation might be for nurses to evaluate the health context using criteria drawn from their own cultural context's health training (Long, 2000). Through ignorance or bias, this may result in an inability

to penetrate the values and worldviews of those they are attempting to serve and subsequently reduce the effectiveness of care (Fountain, 1989). Discernment is essential when identifying traditional beliefs and practices, to differentiate between those that are beneficial and can therefore be affirmed and those that may place the patient in harm and therefore need to be contested (Long, 2000).

Although the International Council of Nurses (2012) provides a framework to underpin the delivery of appropriate nursing care through the *International Code of Ethics for Nurses*, it remains generic. Initially developed in 1953, the last revision was in 2012. In 2019, the code is once again under review to “maintain safe, equitable, social and economic working conditions as well as the interprofessional relationships with co-workers” (Stievano & Tschudin, 2019, p. 155). Nurses working within countries that subscribe to the International Council of Nurses are bound by the *International Code of Ethics for Nurses* in whichever context of practice they find themselves.

The first of four elements within that code describes the responsibility that nurses must meet the health and social needs of patients in their care and, applicable to this study context, those identified as vulnerable. Among other things, the code mandates that nurses advocate for equitable resource allocation in social justice, being respectful, compassionate, and trustworthy as they do so (International Council of Nurses, 2012).

However, despite good intentions to practise ethical, culturally appropriate, person-centred care, nurses are subject to forces that, at times, impose challenges and obstacles to intended delivery. Healthcare organisations, including charitable ones, can make financial and managerial

decisions that lead to poor outcomes, such as overwhelming and unrealistic workloads, resource constraint, and less provision of support than nurses need. These decisions, in turn, may lead to less effective delivery of care for patients and place nurses at risk of moral distress, fatigue, and professional disengagement (Duffy, 2016). The use of a contextual nursing model can provide a valuable framework from which to integrate specific values with desired professional practice and therefore minimise the risk of encountering those negative effects (Mensik et al., 2011).

Nursing Models

The term *theoretical nursing model* is synonymous with the conceptual framework and describes a set of complex abstract phenomena that, when configured, helps nurses organise their understanding in a more simplified manner (McKenna et al., 2014).

Models hold assumptions and concepts that provide principles underpinning a particular worldview (Theofanidis & Fountouki, 2008) and can be represented by either words, graphic illustration, or both. When theoretical concepts are applied to specific contexts, it results in a PPM. Within nursing literature, several different terms are employed to illustrate the concept of a PPM. Similarly identified terms include patient care delivery model, professional care model, contemporary care delivery model, and integrated care delivery system (Chamberlain et al., 2013).

Professional Practice Models

A PPM is a framework developed from theories, values, and clinical processes that further incorporates professional development, communication, and collaboration (Chamberlain et al., 2013). The purpose of a PPM is to guide

nurses in an exemplary practice of their profession within a uniquely defined context (Hoffart & Woods, 1996). Further, a PPM serves as a beacon for nurses, articulating unique and distinguishing factors of the intended culture of nursing and enabling them to have professional influence over the care they provide (Ortiz, 2016).

Developing a New Professional Practice Model

The central tenet of a PPM consists of core professional values underlying nursing practice, based on a theoretical framework. It is likely to also include organisation-specific values illustrating the overarching mission (Slatyer et al., 2016). Hoffart & Woods (1996) described a PPM as a rope with five intertwined strands incorporating professional values, professional relationships, a patient care delivery system, a management approach, and compensation or rewards. Models addressing all five areas are the most useful in demonstrating improved outcomes when applied (Silverstein & Kowalski, 2017).

Implications

Organisations using a professional model to align nurses' contributions with organisational and theoretical priorities prove beneficial to patient safety, quality, and efficiency (Dubois et al., 2013). A summary representing the components is a useful way to organise thinking around the complexities of nursing practice and may or may not be represented by graphic figures (Duffy, 2016).

A published integrative review synthesised results from 69 articles relating to aspects of PPMs in low-income countries (Ng'ang'a & Byrne, 2015). The review indicated organisational systems using PPMs increased the performance of the nursing workforce. As a PPM typically aligns with an

organisation's mission, values, and goals, the incorporation of a PPM establishes a measure for performance and can encourage consistency across the team (Basol et al., 2015). PPMs have the potential for minimising risk of functioning outside those boundaries when nursing expectations are clarified (Bachman & Malloch, 1998).

A multitude of PPMs have been designed for use in various nursing and midwifery contexts. A PPM representative of Jean Watson's caring theory incorporates four elements: "caritas process, transpersonal caring relationship, caring moment and caring healing modalities" (Lukose, 2011, p. 27). However, the model provides specific considerations related to a humanitarian LMIC context, such as the key features of transcultural aspects and the significance and influence of the way environment impacts healing.

A recently published literature review focused on disaster nursing response synthesised findings and presented the HOPE model (Hugelius & Adolfsson, 2019). Disaster nursing shares many similarities with humanitarian nursing as it incorporates an altruistic intent to meet the needs of vulnerable populations yet does not provide the key aspects of education and development necessary for the cross-cultural or LMIC context. The HOPE model presents the importance of "holistic health assessment and promotion as the first construct, as well as organizing and managing the response, professional adaption, endurance and recovery" (Hugelius & Adolfsson, 2019, p. 7). Interestingly, the construct of hope is presented as a "trust, both in the nurse and in the disaster-affected individuals' ability to cope and manage" (p. 7) rather than as something to be instilled or given.

The CHANNGE model has been applied to humanitarian nursing in LMICs, specifically aimed at increasing the quality of care by visiting neonatal nurse practitioners. The model focuses on the delivery of culturally sensitive, holistic, global education (Muskett, 2019) to improve neonatal care in LMICs but was applied to nurse practitioners who had an extended scope of practice. The CHANNGE model did not highlight the importance of a healing environment.

A new model was sought to identify, encapsulate, and further develop the findings and analysis of this study and is illustrated next.

LMIC Humanitarian Nursing Model: HHEALED

HHEALED is a PPM drawn from the context of the ethnographic focus and is representative, having been derived from focused research and practice.[3] The PPM emerged to aid understanding of nurses working in humanitarian care settings, serving both acute surgical and primary healthcare aims. As with all PPMs, it follows that HHEALED may be uniquely adapted by individual NGOs to incorporate their specific organisational aims and values. It accommodates those aspects of other models and allows for the expression of love (charity), the gift of hope, and the importance of the provision of a healing environment where other professional practice models applied to the LMIC humanitarian context do not.

[3] Nurses in the study understood a contextualised version of the HHEALED model and its individual concepts. This model may be a helpful tool to minimise disjointed or fragmented care, which is a possibility when considering the likely high turnover of nurses in organisations facilitating relatively STMTs. It was observed that they were more likely to perform in a more collaborative way to achieve common goals. Further, these teams often consist of international nurses from different nations and backgrounds, with varied nursing experiences and cultural nuances. Eventually, a formal implementation of this model could be materialised through nursing orientation, professional development programs, mentoring, reinforcement, and ongoing evaluation.

The PPM encapsulates the constructs of **H**olistic care, **H**ope, **E**mpowerment, **A**gape **L**ove, **E**nvironment, and **D**evelopment, which forms the scaffold of nursing philosophy when delivering humanitarian care in an LMIC. Figure 2 shows the acronym and provides a description of each element.

Figure 2

HHEALED Professional Practice Model

H	**H**olistic care
H	**H**ope
E	**E**mpowerment
A L	**A**gape Love
E	**E**nvironment
D	**D**evelopment

Drawing from, and synthesising, the embedment of a PPM in daily nursing practice upholds the vision of exemplary humanitarian nursing care in LMICs (Duffy, 2016). The model points to the opportunity for the philosophy and culture of humanitarian nursing to be highlighted to others, intending to offer humanitarian nursing care in the previously undefined space between acute relief and longer term development projects. It can be used as a beginning framework for unique adaptation to the specific context in which implementation is needed. In the following section, each of the concepts listed in the HHEALED model are explained and evaluated in relation to existing published literature.

Holistic Care: HHEALED

Findings articulate the importance of the culture of care given as holistic. That is, there is an interconnectedness and significance placed on caring for the person's body, mind, and spirit. The connection includes social and cultural

considerations, the geographical and environmental context they are in, and the relationships between all aspects.

A recent integrative review on the topic identified a significant overlap in the terms “holistic nursing”, “integrative health care”, and “integrative nursing” (Frisch & Rabinowitsch, 2019, p. 260). Holistic nursing is defined as *whole-person care*, where the nurse’s goal is focused on interactions towards healing the whole person, acknowledging their body, mind, and spirit (Dossey, 2013).

Participants in this study reported their understanding to deliver what they termed *holistic* care as of utmost importance and could do so with ease and freedom in an LMIC context. They were adamant that despite their intentions to offer that same holistic care in their home countries (Western), their attempts were more constrained and therefore less likely to be authentically holistic. They justified their reasoning with explanations of heavier workloads, budget limitations, perceived changes in priorities, and cultural impositions encountered in their home countries.

One explanation for this perception of participants is likely due to the model of nursing care experienced within the study context being quite different to what participants were used to in their home countries. Differences included a higher ratio of nurses to patients, the surgical patients selected being likely to have fewer comorbidities, and having local day workers present at each shift to assist in translation. The day workers were also available to help nurses with tasks such as restocking supplies, accompanying patients, hospital laundry, and other housekeeping duties. Further, patients’ worldviews in the LMIC incorporated holistic ideals more naturally than patients in nurses’ Western home countries (Lanier, 2000). The recognition of the contextual importance

and benefit of holistic nursing care is therefore the central construct of the *HHEALED* model.

Nursing theorist Jean Watson (1988) proposed how nurses could meet the health needs of vulnerable patients through a holistic framework in her theory of human caring (Clarke et al., 2009). Watson posited that nursing is an intersubjective and interpersonal process that places a high value on the caring relationship between the nurse and recipient; she made caring central to her theory. Watson (1988) explained that her model, in stark contrast to the medical model of "curing", was a framework where "caring" took precedence (p. 175). Watson's (1999) theory contains 10 "carative" factors contributing to "the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity" (p. 29). Those carative factors relate to values of altruism, support, faith, hope, sensitivity, and trust, expressing feelings, teaching/learning, problem-solving, gratifying human need, and allowing for *caritas*, an expression between love and care. The culture of nursing care as being holistic, given within a context of LMIC humanitarian surgical care, fits well within Watson's theory.

Being present, and taking time to sit with and listen to patient stories, beliefs, and concerns, is vital to providing a healing environment (Covington, 2003). Further, building a relationship through a caring connection is a key concept to restoring dignity and hope to someone who is suffering (Baillie & Gallagher, 2011; Remen, 2002). The recipients of humanitarian care are generally present with vulnerability and discouragement. Vulnerability is multidimensional and complex (Agampodi et al., 2015); however, in the LMIC setting in which nurses function, patient vulnerability is attributed to poverty and

inequality, social exclusion, discrimination, disability, and psychological trauma. That is, patients have often received the message in multiple ways that they are not of worth or value due to their ongoing, chronic inability to secure necessary health care, leading to physical disfigurement and emotional discouragement. In a holistic environment, a sense of trust is extended towards patients and, with empathy and compassion, relationships are built with verbal communication and caring, nonverbal body language (Ellis, 1999).

When considering how holistic nursing can be applied to the LMIC humanitarian context, a recently published article (Rosa et al., 2019) attested that holistic nursing principles demonstrate the opportunity to connect theory with practice within the United Nations SDGs agenda. The authors argued holistic nursing is a pragmatic and well-considered means to address the multidimensional global health needs positioned in the 2030 agenda. They suggest nurses practising holistic care are best able to uphold principles of health equity when delivering global health care. Moreover, the five core values of the framework *Holistic Nursing: Scope and Standards of Practice* (American Holistic Nurses Association & American Nurses Association, 2019) provides a further guide on how to provide holistic care within a global health setting. The core values cover areas of philosophy and theories, self-reflection and development, the holistic nursing process, holistic communication, and healing environments. However, Rosa (2017) claimed that holistic nursing may not be implemented in resource-poor settings as easily as it can be in high-resource settings where holistic nursing has a more central status and higher academic and praxis prospects. This study's setting as a mobile, self-contained hospital, despite it being in an LMIC, was seen to be a "First World" hospital, with access

to a high standard of functioning equipment and resources such as clean water and constant electricity.

Another vital aspect in the implementation of holistic care is the consideration of cultural safety. Volunteers providing humanitarian assistance in LMICs by means of STMTs are predominantly from industrialised nations (S. D. Roche et al., 2017). It is important that volunteer nurses are aware of differences between patients' worldviews and their own, and the challenges patients have faced in their healthcare journey. Volunteer nurses need to provide holistic nursing care in a culturally safe manner (Leininger, 1995; Spence, 2003). A consideration to be highlighted is that participants from high-income countries reported less hindrance in delivering *holistic* care in an LMIC context than in their home countries. Considering the cultural milieu, where an African worldview is associated with a greater depth of awareness related to the associations between biopsychosocial and spiritual realms and health, this is not surprising (Long, 2000). The delivery of holistic nursing care advocates strongly for healing with a caring presence and commitment to cultural safety within the physiological, psychological, social, spiritual, and environmental constructs of healing. The combination of nurses that purposefully extend holistic care with a more central focus, as Rosa (2017) claimed, with a cohort of people with a cultural worldview more nuanced to understanding holism than dualism seemed to be an ideal situation to see authentic holistic care realised.

Hope: H**H**EALED

Hope is an abstract idea that philosophical, theological, psychological, and sociological schools of thought have attempted to conceptualise. As a verb, hope describes an "anticipation, accompanied by desire and expectation, of a

positive, possible future" (Stephenson, 1991, p. 1457). As a noun, hope is something to be possessed. Parse (1999), who studied the lived experience of hope, employed a cohort of participants stretching across nine different countries and found that hope was a universal phenomenon. Scholars have explored and described hope in relation to the delivery of nursing care in diverse contexts (Rees & Joslyn, 1998), and several nursing authors have conceptualised the term over time (Cutcliffe & Herth, 2002; Haas Stavarski, 2018; Herth & Cutcliffe, 2002; Morse & Doberneck, 1995; Tutton et al., 2009).

Hope has been attributed to sustaining both nurses (Penz & Duggleby, 2011; Peter et al., 2015) and patients through difficult circumstances, and when hope is lost, death is accelerated (Broadhurst & Harrington, 2016). There is overwhelming evidence that hope influences positive health trajectories. Benzein and Saveman (1998) reported that good nurse–patient relationships impacted patient hope positively. Nurses are therefore well placed to offer interventions within the healthcare setting in relation to hope. Furthermore, the holistic framework by Watson included *instilling faith and hope* as one of the 10 caritas processes outlined in her theory (Watson & Turkel, 2010). Although some measurement tools for hope expressed in specific conditions were located (e.g., mental health and palliative care), given that hope in a marginalised population holds many variables and is therefore a vastly abstract concept, evaluating hope as an outcome of nursing care in a humanitarian setting remains a challenge.

Nevertheless, participants within the study repeatedly spoke of their ideology to instil hope as a desired and important aspect of the care they were delivering. The presence of hope counteracted despair. The cohort of patients

typically seen in an LMIC humanitarian context present with some level of hopelessness. Their vulnerability and presence of debilitating conditions due to their chronic inability to access timely or appropriate health care often renders them powerless. Their despair grows from countless unsuccessful attempts to secure help. Whether the hope is offered in curative surgery, rehabilitation, or palliative care, participants believed in the importance of the practice of encouraging patients to hope for positive change.

The recognition of hope in psychological healing after a physical change to body image has been documented (Grogan, 2016). Positive self-image is connected with feelings of capability (Juth et al., 2008) and often dictates if a person is able to recognise their value. It is not automatic that a 50-year-old with a facial cleft deformity, having suffered the brunt of cruel seclusion by society for many years and who has surgery to repair the deformity, receives an immediate psychological effect and feels comfortable to interact with their community again. The extension of hope, and nurses' advocacy to empower and instil dignity and value, is as necessary to bringing holistic healing as the physical, surgical repair.

Nursing interventions offering hope may include active listening, offering empathy and emotional support, goal setting with patients, positive reinforcement of functional ability, building rapport, and engendering trust.

Empowerment: HH**E**ALED

Empowerment, in the context of this study, describes a process where a nurse's actions contribute to an individual gaining greater control over decisions and actions affecting their health and overall wellbeing. A recommendation in the most recent operational report to transform vision into action in primary

health care urges priority to engage those experiencing an inability to reach health services (World Health Organization and the United Nations Children's Fund [UNICEF], 2020).

Participants heard repeated stories from their patients suffering from debilitating conditions, who had been unable to secure health care over a protracted period, and who felt disempowered. That sense, which at its root is a lack of control, stems from and perpetuates limitations in pursuing education, a vocation, and meaningful social engagement.

Participants desired to bring holistic healing through positively influencing a patient's trajectory by *empowering* them to have greater control over their health and life. For example, once a patient has increased mobility or restored eyesight, such opportunities to attend school or gain employment are likely increased but not automatic. Psychological processes contribute to the ability for patients to embrace change. Patients who have been shunned from their community due to disfigurement may have grown to accept a devalued sense of self-worth (Saran et al., 2019), and therefore holistic care entails empowerment from multiple angles. Purposeful intervention by nurses to empower a person with psychological and spiritual encouragement can be a positive influence to help patients regain more control over their health and their overall wellbeing on discharge. Nurses' attitudes favoured the inclusion of actions promoting patient dignity and encouragement, which can positively influence patients' self-esteem (J. Whitehead & Wheeler, 2008). Participants believed that healing the mind and spirit was just as important as the physical realm, and spent extended time communicating with patients to understand their patients' needs.

Empowerment in the context of the HHEALED model involved both structured and unstructured moments of connection by nurses with patients. Practical application may include education sessions to promote increased health literacy, health-promotion activities, community health education, and advocacy such as patient referral to programs and ongoing health care after they are discharged or after the team departs. Social activities can have multiple purposes (e.g., doing craft, colouring in, numeracy games, learning to write their name). Empowering moments may occur during physical rehabilitation or the facilitation and encouragement of social interaction with others, thereby lifting a patient's mood by sense of accomplishment. Empowerment may come in the form of nurses facilitating the obtainment or provision of unique resources, such as a wheelchair or teaching a new skill such as crocheting, leading to an increase in a patient's ability to generate an income. A literature review by S. D. Roche et al. (2017) identified only three instances that suggested referral of patients to the local health system when care was outside the capacity of the visiting team, but study participants advocated for and arranged referral through the appropriate channels of the organisational structure when appropriate.

Participants spoke of sensing fulfilment and gaining reward in moments of empowering connection with patients and their families, so it was bidirectional. The nurse–patient relationship is complex (Leininger, 1995). There is often a power differential between the two; patients may feel vulnerable and dependent, and nurses may have particular suggestions about what the patient should do to regain health, which may or may not be in alignment with the patient's reality. For example, a nurse may suggest to a patient with

hypertension that they need to see a medical doctor for ongoing management when, in fact, that reality is not necessarily enacted by that patient. Reasons the patient may not prioritise that advice may include unavailability of the required service, an inability to pay for the service, or patients not prioritising that action as the symptoms (or lack of) may not be an accurate indicator of the urgency. Instilling or promoting dignity is one of the central tenets of holistic caring. As such, it cannot be isolated, but dignity is encapsulated by recognising a patient's intrinsic value. Nurses respect patients' uniqueness despite their circumstances. Within this environment, loving, nonjudgemental care was the main focus. Nurses thrived in delivering that nonjudgemental care, but they also needed to remain sensitive and respectful to patients regarding their beliefs, especially concerning any treatment they may have sought (either intentionally or unintentionally) that had brought them to that place of need.

Agape Love: HHE**AL**ED

The study captures an element of culture depicting the way nurses engaged with a patient's environment and the wider healthcare team. Through the multitude of cultural beliefs, attitudes, values, and behaviours, an emergent shared identity aided in identifying participants as a collective group working together in love, which is identified as a positive value to be upheld in humanitarian care.

Ancient Greek philosophers described love in three contexts: agape, eros, and philia (Moseley, n.d.). The model applies to the concept of selfless love, or *agape*. Agape love is often referred to as divine love, as the Greek translation aligns with the typical love that a god may have for humankind. Agape love is also known as *caritas*, or *charity*, by Christian believers and

describes an altruistic and unselfish concern for the welfare of others (Burton, 2020; Robbins, 2016). Jean Watson's use of the term caritas in a humanistic sense further captures the heart of the nurse's care for others (Newbanks et al., 2018; Persky et al., 2008). The nurse–patient relationship holds agape love and is seen as central, with the patient receiving healing and often experiencing transformation. That connection extends to the relationship enabled in the medical capacity-building context as nurses engaged by the organisation form an engaging, mentoring relationship with local nurses. It further extends to the collegial atmosphere within nursing, caring for each other in their CoNP and those in the wider community.

Participants spoke of being wholly immersed in the work and pushed past the typical boundaries of commitment they were used to in their home countries to purpose positive change. Their service and response were often demonstrably above and beyond what they were initially scheduled to or expected to do. Being highly "engaged" in work meant being connected to the patients and *loving* them. Participants consistently acknowledged and thrived in empowerment nurtured by the team of health professionals working together for one purpose: to contribute to the tangible improvement in their patients' quality of lives. However, this was not found in extant nursing literature. Zinsli and Smythe (2009) found a work ethic between aid workers did not always align with the same motivating goals. Participants in this study were tenacious to enact ethical principles of beneficence and justice: doing good to those who were vulnerable and had specific, unmet health needs. Further, the purpose of the care—to relieve suffering and do no harm, which was provided to patients through this organisation—was seen as an important attraction to the work for

nursing participants. While this attraction is not unique to nurses that volunteer in an LMIC humanitarian context, it was specifically highly elevated through regular conversation and organisational cultural expectation. Broadly, all nurses were expected to have a desire to relieve suffering and do no harm. At the very least, nurses were asked to follow the ethical mandate (International Council of Nurses, 2012), and therefore, unless observed otherwise, the assumption was that all nurses did. The HHEALED model imprints and elevates these mandates collegially and as a cultural capstone.

Another organisational objective was to deliver capacity-building programs. Nurses strongly aligned with the desire to leave an ongoing legacy in the host country and was a compelling factor that contributed to the decision-making of participants to not only volunteer but to do so displaying that commitment to service with altruistic ideals. The second core value of Mercy Ships is to love and serve others. Research literature suggests that the more substantial the links between an organisation's policies and individual values, the more likely the individual's sense of mission will be enacted (Moody & Pesut, 2006). That is, volunteers who were satisfied with the way they were managed and had good professional relationships with their colleagues led to higher levels of commitment to the organisation they served (Agostinho & Paço, 2012; Campbell & Yeung, 1991).

Environment: HHEAL**E**D

In the early 19th century, Florence Nightingale (1993) identified that the patient's surrounding environment influenced healing. Patients are already vulnerable due to their condition, and that vulnerability is potentiated when they enter a foreign environment for surgery while in a partially or fully dependent

state. In the context of LMIC humanitarian care, and particularly in a mobile context, patients face additional challenges as they interact with the environment. The context of a civilian hospital ship for those patients receiving surgery was foreign. Patients may have never experienced showers, electricity, ship noises, or even stairs. Some had never seen the ocean before they arrived or had never walked up a gangway. Patients were also being cared for by what they may have interpreted as *foreigners*. Therefore, nurses needed to grow in their understanding of how to be culturally appropriate and provide safety in their nursing care for those patients, keeping those things in mind (Caruso et al., 2008). The hospital environment offered was warm, open, colourful, and hospitable. Physical needs were provided. The space, although small, was clean and bright and in direct contrast to the local hospital, which local citizens spoke of as having a negative reputation that they only went to as their last resort.

Sociologically, nurses typically perceived a vast difference between their own cultural nuances and the patients they were caring for. Nurses understood clearly that they needed to make adjustments. Common factors related especially to differences in perception of time, worldview, and therapeutic communication. This was especially relevant when patients expected communication to involve more than their immediate circle and allowed or even invited other bystanders to overhear conversations regarding their medical treatment. For a nurse having worked in a Western country paradigm and used to speaking with patients with a high level of confidentiality, that concept was found to be challenging and abnormal when others not seemingly connected with the patient were invited to listen. However, regardless of cultural

expectation of medical systems, delivery of health care, or societal support, nurses delivered care in an environment that was person centred and communicated, culturally appropriately, the value of the person and the promotion of their dignity, which satisfied the human need for belonging and acceptance.

The healing environment nurses created provided acceptance and an avenue for disclosure. Stories were shared; people met others with the same disfigurement or illness. In West Africa, a common understanding of healing is embedded within the conceptual framework of their worldview (Asante & Mazama, 2009; Idehen & Oshodin, 2007). An African definition of health, as defined by Kofi Appiah-Kubi outlines “the wellbeing of mind, body and spirit; living in harmony with one’s neighbour, the environment and oneself and all levels of reality . . . physical, social, spiritual, natural and supernatural” (Berinyuu, 1988, p. 31). It can be argued that the love, acceptance, kindness, provision of care, gentleness, encouragement, positiveness, and joy all contribute to the restoration of body, mind, and spirit (Craffert, 1997). However, an awareness that nurses cannot realistically address the whole spectrum of possible needs experienced by the patient and their family is essential.

Development: HHEALE**D**

The HHEALED model promotes *development* as a concept, valuing nurses being involved in the ongoing educational support and professional development exchange with the local nursing community where appropriate. To do this, nurses need an understanding of the factors related to the burden of disease within the unique context, an ability to address preventative health

education, and appropriate cultural response as vital factors in effecting change (World Health Organization and UNICEF, 2020).

Transformational development (TD) principles, commonly employed by faith-based NGOs, are central to the study's organisational context (Myers, 1999) and are incorporated into the HHEALED model. C. Roche and Madvig (2016) proposed a working definition for TD, stating that it "encompasses genuine, lasting improvements in people's lives that are enabled and sustained by the creation of just, equitable, accountable and environmentally sustainable social, economic and political systems" (p. 5). Nurses are encouraged to embrace those TD principles and use the framework to contribute and exchange knowledge at whatever point they are engaged, whether it be with individual patients or with local nurses in a professional development capacity. This context of development considers holistic solutions to the cause of poverty and encourages implementation to bring lasting change to individuals, their families, communities, and society (Offutt, 2012). *Transformational* development, as opposed to just development, has a more holistic stance (Myers, 2011). Development is often associated with materialistic improvement or industrialisation. The TD framework upholds positive change in the whole of human life and incorporates everyone. Myers (2011) recognised that TD is a lifelong journey for all stakeholders: the patients, their families and communities, the volunteer nurses and other staff, and the national nurses in this context. Working together towards TD requires humility. The aim is to arrive at a place of wholeness together, not expecting that one group has all the right answers or needs to *train* those they are reaching out to. It is about choice and experiencing life and wholeness as the true identity it was intended to be. The

ideology of faith and spirituality, from whichever tradition it stems, (e.g., Christian, Muslim, Buddhist, Hindu, agnostic, atheist, or other), is centred on core values that shape an understanding of how people see and interact with the world. Development within the HHEALED model is to accompany those with whom we journey to find wholeness, whether that be in meeting basic needs to sustain life and promote equity, justice, and reciprocity, freedom from oppression, or increase our sense of dignity and self-worth (Myers, 2011).

Nursing a patient involves both the science and art of care (Watson, 2013), and the culture of nursing within humanitarian care focuses on achieving equity and equipping patients to gain greater control over actions affecting their health. Low levels of health literacy have been shown to be linked to less participation in health-promotion activities, poor adherence to health-focused treatments, increased morbidity, and premature death (World Health Organization, 2013). Health education given to patients and their caregivers by nurses enables and empowers patients to become more health literate and therefore has the potential to improve patient health outcomes. Additionally, collaboration, mentoring, and professional development programs between Mercy Ships nurses and local nurses equip both cohorts to become more culturally aware, enable learning, and empower all involved in the provision of holistic patient-centred care.

Rasori (2019) suggested nurses involved in VMT humanitarian projects use educational strategies to promote empowerment and sustainability, including the implementation of a “train the trainer model” (p. 137). To guide nurses’ partnerships, the ethics framework of engaged presence by Hunt et al. (2014) highlights the need for cultural humility by clinicians in partnership with

others in development aid work. The key aim is to partner with and identify ways to assist and augment nurses' practice within an extant system of culture, rather than impose change through a Western viewpoint (Walsh, 2004).

Nurses working together in an international and dynamic team across geographic and unconventional contexts creates an environment where critical thinking and problem-solving are fostered and enhanced, resulting in the emergence of innovative techniques. Reflective practice has also been identified as a necessary component by nurses intending best practice within the context of humanitarian holistic care (Rosa et al., 2019).

Sample Application of HHEALED PPM for Mercy Ships

Implementation of a PPM has the specific purpose of creating a culture where a particular ethos is upheld, and nursing practice is embedded within the model (Arford & Zone-Smith, 2005; Girard et al., 2005). A conceptual model gives nurses the ability to gauge how they are practising according to the espoused structure (Duffy, 2016). This study's findings were applied to the five components that Hoffart and Woods (1996) suggested and are briefly summarised in Table 15.

Table 15

Application of Components to PPM

Components Forming the PPM	Application
Professional nursing values	Integrity, authenticity, altruism (agape love), clinical excellence
Professional nursing relationships	Respect, open and honest communication, humility, commitment, and service to others
Patient care delivery system	Caring is based on culturally appropriate, holistic, person-centred care in a hospitable, safe environment, with advocacy and measures to elevate patients' dignity prioritised
Nursing management approach	Supportive, inclusive, empowering
Compensation and rewards	Includes affirmation, professional development, the likely development of strong and ongoing international friendships, and intrinsic reward through the satisfaction of practising authentic holistic care and contributing to tangible improvements in patients' quality of life

(Hoffart & Woods, 1996)

Figure 3 has been developed as a graphic representation of the HHEALED PPM with relevance to the distinct context of this study's findings. The expression of a PPM within an organisation gives foundation to how nursing is "considered, conveyed and claimed" (Duffy, 2016, p. 20). A heart, an anchor, and a circle are conceptual symbols to illustrate and form the model for LMIC humanitarian nursing as administered by the nursing team of Mercy Ships.

Figure 3

Suggested Professional Practice Model (HHEALED) for Mercy Ships

Heart

The core of the model depicts two people forming a heart-based figure; the nurse (left) connects meaningfully with a patient (right). The heart symbolises person-centred care, which is focused and holistic. Within that person-centred care, the nurse connects with patients in humility, love, kindness, and compassion and imparts hope with the aim of contributing to the restoration of patients' dignity and wholeness.

Anchor

In the figure, the heart is pierced by the anchor. The anchor is symbolic in the figure foremost because it is representative of an organisational service delivery context of nurses volunteering on a hospital ship. The anchor

symbolises hope, steadfastness, and strength. An anchor's description, as a noun, is a heavy object with a chain or rope attached, typically used to moor a vessel to the seabed. Used as a verb, however, its meaning is to secure an object firmly or to provide a foundation (Cambridge Dictionary Online, n.d.). To the seafarer, an anchor functions to temporarily hold a ship in place and stop the ship from drifting. If a vessel is not securely anchored, it does not have much hope of staying where it intends or surviving intact through a storm. The anchor also represents security. Therefore, when used as a metaphor in this PPM, it is the grounding force on which nursing values, relationships, and practice are founded. Despite having a clear function, the anchor is not designed to secure a ship permanently, as a ship's purpose is usually to sail from one destination to the next. The results of this study were applied to a develop a generic PPM that may need slight adaptation and change for embedment in the unique organisational mission and vision in which it is used.

A cross was used to supply the organisation's proclivity for its own religious iconography. The iconic cross was extended to show an anchor representing the sea-faring context, the Christian faith, and nursing the *spirit* (spirituality). Within this FBO, faith was a central part of the organisational framework, reflecting TD and personally motivating many study participants to volunteer. A deeper analogy to the anchor metaphor is made for the Christian nurse who holds the *Bible* central to their faith as the anchor can be taken a step further to be representative of hope. Hope is an emotion that is often

described as synonymous with optimism (Bloeser & Stahl, 2017), but in the Christian faith, an anchor symbolically represents hope.[4]

When applied to this PPM of nursing care, the concept of extending hope, symbolised by the anchor, is multidimensional (Snyder et al., 2017). In one sense, it is the offer of physical healing. Patients receiving transformative surgery are given hope that their figurative *physical tomorrow* will be different. Multidisciplinary care with surgical intervention means that for patients accepted for surgery, a certain outcome is expected; the blind will see (ophthalmology), the lame will walk (orthopaedics), the mute will speak (head and neck surgery), and women suffering incontinence from an obstetric fistula will no longer experience shame and despair. Patients with a palliative need are included by the extension of hope, with the provision of resources that may make their tomorrow more comfortable (e.g., pain relief, perhaps a new mattress to lie on, or a peaceful death). At a deeper level, within this FBO, all patients were freely extended hope in a realm beyond the physical (spiritual hope), with the offer of prayer and conversations about their understanding of life and their future. Within many African cultural traditions, the concept of blessing and cursing is common (Long, 2000). Prayer can include "blessing" or wishing someone well.[5]

Hope can be further described as an attitude that consists of both desire and belief. Hoping for the desired outcome requires a belief in that outcome's

[4] Christian literature often cites Hebrews 6:19 in describing the anchor as being a sure and steadfast hope for one's soul. Figuratively, the anchor refers to the hope generated by faith that enables a believer to stand firm. Hope in this context represents the certainty of the promise of God. God's promise is for salvation, or rescue, from darkness, which is freely given through the gift of God's grace through His Son, Jesus, who provides entry into eternity and gives *perfect peace* (Isaiah 26:3). While hope can be thought of as an *eager anticipation*, to the believer in Christ, that hope is securely anchored and firmly grounded in faith (Denton, n.d.).

[5] The hope of the Christian message is said to be eternal life without pain, suffering, and death. This future (spiritual) hope is promised, though not yet possessed.

possibility. Dr. Gary Parker, Chief Medical Officer and maxillo-facial surgeon who has dedicated his career life to serving within the study's NGO, reminds those in the ship's healthcare team regularly that "for hope to be credible in the future, it must be tangible in the present" (Rickard, 2013). People tend not to be able to hope for what they believe to be impossible. Anything *hoped for* is uncertain. By virtue of the meaning of the word hope, things hoped for are not usually guaranteed, so they may not eventuate, which therefore leads to great disappointment.[6]

In this study, nurses (and others) purposefully extended culturally appropriate "hope" through their practice as encouragement. That hope was for healing in a holistic sense: physically, emotionally, and spiritually. Even when a patient was not accepted for a surgical procedure, all patients were offered hope beyond their immediate physical situation. That hope was presented in a culturally safe way. There was no pressure to decide to accept that hope, but for patients resonating with that offer, and who wished to pursue investigating hope in a deeper spiritual sense, it was extended freely.

Further, hope was extended by nurses involved in the medical capacity-building programs. National nurses involved in the MCB program were given an opportunity to identify with professional development and ongoing professional connections. Recognition and extension of hope so that they could offer something more to their patients was intended by those instilling that hope.

[6] Yet, the Christian faith offers a confident assurance that hope is not only desiring something good for the future, but to those who choose to adopt that belief, they can expect what is promised will be fulfilled. That biblical promise, as understood and communicated by Mercy Ships, is that at the heart of the universe is a God of love who has made provision for the transformation of lives both here in this world and into eternity.

Outer Circle

Mercy Ships has developed a distinctive healthcare response to deliver their views on hope, bring physical and psychological restoration, and instigate aspects of empowerment. Restoration means the establishment of conditions that favour the return of wellbeing and a return to one's God-given potential. The PPM's outer circle encompasses the organisational mandate and depicts the wider environment of family, community, society, and the global world. Within that circle, the biblical worldview is the foundation on which the nature of reality is based, and it guides the interpretation and understanding of the culture of nursing. Within this circle, nurses aim to be as culturally sensitive and appropriate as possible both in the delivery of nursing care to their patients and by the extension of their profession through the medical capacity-building programs that Mercy Ships delivers. Those people that Mercy Ships serves will have shaped beliefs according to their culture, geographical locations, and ethnicity to which they belong. Some beliefs will be common for West Africa, and other beliefs will be specific to each individual. Therefore, nurses must adhere to broad principles of cultural safety and make unique adjustments and application of cultural safety principles each day, within the circle, being symbolic of wholeness. As the patient receives healing, they will likely return to their wider community, and with that healing, the process of transformation may occur. The impact of an encounter with Mercy Ships nurses (and others) has a broader purpose, aiming to bring restoration and wholeness to all that lies within the circle. For some individuals, this may extend to the reconciliation of broken relationships and ultimately to the restoration of a relationship with God as an integral expression of healing.

Inner Circle

The inner circle represents the core nurse–patient relationship as one of love and hope. Institutional core values are upheld and expressed as (1) love God, (2) love and serve others, (3) be people of integrity, and (4) strive for excellence in all that is said and done. These values are reflected in the inner circle, in the nurse–patient relationship; however, just as vital is the expression of those values with oneself and community, including fellow crew members, day workers, and all those on the nurses' journeys. Just as the outer circle represents holism, so, too, does the inner circle. The concept of holism is a state of mind: how one views the world, believes, and acts. Encased in the circle are characteristics shown by the nurse of care, compassion, and kindness.

The culmination of this framework is a model for healing. The goals of transformation are holistic. Relationship is the central construct, and those engaged work towards bringing physical, emotional, social, and spiritual wholeness to themselves and others.

Influence of Organisational Values on Culture of Nursing Care

The findings revealed that nondisaster humanitarian global experiences in an LMIC can be linked to enriching a participating nurse's knowledge of practice. Nurses reported a strengthening of resolve and an increased capability in delivering holistic nursing care, leading to greater personal and professional fulfilment.

An essential concept that study participants found most enriching and sustained them through difficult moments was building solid professional relationships. They felt their team was there as much for each other as for the

patients they were serving. A strong sense of community within the health professionals was present, as well as within the whole ship community. The model of recruitment was such that there was a constant turnover of volunteer crew. Interestingly, research studies indicate a high nursing turnover as a reason for decreased nurses' satisfaction (Nolan et al., 1995; Strachota et al., 2003), yet this was not the same for this context. Collaboration and camaraderie were present, despite that high turnover, which demonstrated the core aspect of cohesiveness, despite the shorter length of service, and motivated participants' commitment to return for further periods of service.

This positive teamwork experience was purposefully built and featured in individual nursing teams, as well as within the whole nursing community. Managers focused on inclusivity, expressing gratefulness, and promoting activities to generate belongingness and build morale. Briefings and debriefings (both formal and informal) unpacked volunteers' expectations, and they were offered specific tools to manage an emotional response. These aspects of involvement brought cohesiveness to the nursing team overall. The spirit of camaraderie reflected a shared commitment to each other and loyalty to the organisation's aims (Gagné, 2014).

Choosing to volunteer within a specific context, such as the CoP described above, has been shown to provide positive health benefits for individuals in the form of enhanced mental health, including feeling needed and being involved in something bigger than themselves (Stukas et al., 2014). Maslow (1943) proposed a theory of human motivation to describe five levels of human need and organised them into a hierarchy. Low-level needs are the fulfilment of physiological factors such as food and basic safety, antecedents to

the gratification of higher order needs such as love, belonging, self-esteem, and self-actualisation. Reaching self-actualisation is the ideal position; however, levels do not necessarily need to be moved through in a profoundly linear progression. Participants were confident that the organisation they were signing up to would provide an environment as safe and secure as possible; with these needs satisfied, there was freedom to have their identity and belonging needs fulfilled, which led to the right conditions for progression to self-actualisation. Participants spoke of authentic satisfaction, and the understanding they had contributed to positive patient outcomes brought them great enjoyment. Volunteering in a nondisaster setting therefore provided an opportunity for Maslow's self-actualisation (Benson & Dundis, 2003) with less perceived risk than a more dangerous project in a disaster response humanitarian situation.

Further to Maslow's theory, participants' satisfaction in their involvement can be expanded by Csikszentmihalyi (2000) research. He introduced the term *flow*, which describes the essence of enjoying satisfaction by being voluntarily stretched to achieve something perceived as difficult yet worthwhile. Participants were motivated by the ideology of being involved in something complex and challenging that benefited another. When in flow, nurses had an enhanced integration of body, mind, and spirit. Csikszentmihalyi described this as being in a state of focused productivity where engagement is easy, where a person is fully immersed in an activity that then produces a state of wellbeing and satisfaction. Participants expressed their motivation for being in the *right place* and the *right time*, doing the *right things*. As they had the opportunity to enact their perceived identity, they were focused entirely *in the moment*, and *became* what they felt was right (Nakamura & Csikzentmihalyi, 2009).

Further to this concept, there is credible evidence that those who help others sustain a benefit themselves.[7] Gratitude for the opportunity of education and experience led to a sense of responsibility to share with the underprivileged. Further, the opportunity to network with and invest in the local health personnel was a strong incentive in offering their services to others. The often dramatic and visible differences in improved quality of their patients' lives brought enhanced satisfaction. Other studies in humanitarian healthcare volunteering found personnel had a similar appreciation in missions abroad (Bjerneld et al., 2004; Hunt et al., 2014). A study by Withers et al. (2013) involving volunteers in Mexico found the work empowered their participants, and this study's results also resonated with a study of older adults volunteering (Omoto et al., 2009), even though that study was not about nurses volunteering overseas. The study by Sloand et al. (2012) reported paediatric nurses had positive experiences when responding to a humanitarian disaster, although they observed that researchers more commonly reported on the difficulties nurses encountered in humanitarian care.

A nurse's vocation encompasses more than the concept of a "role"; there is a personal engagement with the values and ideals of a chosen profession (Raatikainen, 1997). As nurses identify and take ownership of these values, they are drawn into a "moral pull" (K. White, 2002). What motivated the nurses in this study to volunteer was reported to be a genuine feeling that they were in the right place, along with their internal belief system that demonstrated

[7] This concept was seen to be encapsulated by those aligning with the Christian faith: Proverbs 11:25: "Whoever brings blessing will be enriched, and one who waters will himself be watered". The concept was not seen as a primary motivation for people to do something for others in order that they may receive, but rather, it was seen as an undeserved gift or blessing that is received by the one that helps another.

alignment with one's values to carry out a perceived mandate (Carter, 2014). Regardless of age or situation, a firm conviction for participating in making a difference to individuals' circumstances was evident. Conviction is a strong belief in something; for these participants, it was a driving force that included their values and commitment to action (Shelly & Miller, 2009; Shrubsole, 2010). Within the volunteer literature (not necessarily nursing), there is a consistent link between personal belief or religiosity and one's willingness to volunteer (Bennett, 2015; Paxton et al., 2014; Ruiter & De Graaf, 2006).

Community of Practice

Mercy Ships nurses provide holistic nursing care to a particularly marginalised group of people of a vastly different ethnicity to the nurses themselves. The delivery of this holistic care happens within a "community of practice", a group of likeminded people who join in developing shared learning (Wenger et al., 2002). As nurses share their knowledge both formally and informally, passing on "tips and tricks of their trade", a synergy of working solutions is formed, appropriately suited to the context.

For a CoP to be cultivated, three elements (domain, community, and practice) are required. The first element "domain" refers to the identity or shared interest. There is an interdependence on those with more experience and a willingness to participate in the community. An agreement was made between the NGO and the volunteer nurse before the nurse embarks. There was a shared expectation that the individual was one part of a larger team that worked together for the benefit of others. The second element "community" explains the formation and ongoing connection of a group of people, whether it is in physical proximity or not. Despite nurses being situated together physically when

working on board, they often sought to extend that learning process via an ongoing connection (e.g., internet) between return visits. The third element "practice" involves sharing a repertoire of skills and knowledge unique to that crafted group. Members shared a common purpose to bring health to a group of patients they encountered and advance the capacity of local health workers and professionals. Their goal was to apply knowledge and healthcare tools to the advancement of a person's quality of life in those they were seeking to serve (Wenger & Traynor, 2015).

Challenges

Another of the study's objectives was to analyse factors that may contribute to, or hinder, nurses' practice in this humanitarian response context. Challenges reported by study participants encompassed ethical, moral, and practical difficulties, which mirrored similar challenges by other humanitarian actors identified in the published integrative literature review (Dawson et al., 2017). Further, participants' willingness to step into an unfamiliar environment they could not easily retreat from required an increased measure of resilience and courage (C. Emerson, 2017). Nurses enacted their convictions despite a sense of the unknown (Cleary & Horsfall, 2014), also demonstrating courage to go beyond their comfort zone (Crigger & Godfrey, 2011; Gallagher, 2011).

Referring to a *comfort zone* encompasses more than physical comfort. Adaptation to a hospital environment on a ship included adjusting to limitations regarding space: both in the nurses' immediate working environment and their personal living space. Living where one worked for the duration did not allow for much separation between work and social time. Living on a ship required adjustment; nautical terminology was used daily (e.g., listing, bulkheads,

midships, galley, stern, aft, etc.). It also alluded to restrictions on personal freedoms due to being in a high-security risk area. Organisational guidelines were necessary to provide safety, which meant crew members were unable to leave the ship compound without being in a group, providing little or no alone time. There were frequent fire and safety drills, much more frequent than nurses may have been accustomed to in their home environments. This constrained independence was seen as a challenge but also as a sacrifice participants were ready to embrace and overcome. There were other characteristics about living and working in a ship environment that nurses found positively unique and jokingly wished they could introduce back at home. The ship's steel walls meant magnets could be used to secure equipment such as intravenous flasks from the ceiling instead of using intravenous (IV) poles.

Challenges further represented going from the known to the unknown. It encompassed professional discomfort and moral distress that arose from being faced with the situation of being unable to offer needed surgical treatment to all patients. Witnessing an overwhelming need with large numbers of patients, and for some, the severity of patients' conditions not witnessed in the nurses' previous work experiences, also caused some level of initial distress. A study conducted by Harrowing and Mill (2010) identified that Ugandan nurses, who were unable to implement skills and who experienced limitations in both infrastructure and resources, experienced moral distress. Although not directly related to a VMT in a humanitarian nursing context, under similar conditions of being unable to offer solutions, nurses experienced that same distress. Further, a study of U.S. Navy nurses responding to humanitarian efforts identified similar challenges when ethical conflicts arose. Not being able to meet all presenting

patients' needs was a cause for nurses' moral distress, mainly caused by finite resources in time, inadequate infrastructure, or lack of available skill (Almonte, 2009).

Interestingly, the mobile, self-contained hospital provided an environment that meant some participants did not need to interact with the local government and health system. In comparison to several previous studies, participants were sheltered from the corruption and frustration with local health services that had caused a moral dilemma to healthcare providers in other STMTs (Dawson & Homer, 2013; Lal & Spence, 2016).

Limited numbers of participants reported being inadequately prepared in knowing how to address the health conditions of patients where they had no prior experience. However, those participants found that the challenge of working in those conditions also presented an opportunity for growth. Resolution of distress for study participants came in debriefing with colleagues or the chaplains on board. Participants found they developed resilience when processing emotions raised by injustice and suffering and learned how to respond in limitations to addressing a patient's health care. In comparison, published nursing literature reports nurses who stepped into emotionally challenging positions outside their usual professional comfort zone were likely to develop leadership skills that could be transferable to their practice in their home countries (Clancy, 2003).

It was apparent that study participants worked with a disempowered cohort of patients who had little hope and low health literacy (Truter, 2007). Despite a different context, similar ethical challenges have been identified in the humanitarian disaster response literature (Bjerneld et al., 2004; Hunt, 2008;

Michael & Zwi, 2002; Shields, 2005). Patients presenting for health care craved encouragement that they could and would heal. In other words, the absence of healing, whether that be in physical, emotional, social, or spiritual realms, mobilised nurses to deliver holistic care. The way nurses provided care within this study described a context focused on attempting to meet the felt needs of vulnerable people in a holistic framework. The provision of relational dignity and restoring hope was visible and dominant in their holistic nursing practice.

Despite some identified challenges, participants spoke of the great sense of fulfilment as they participated in their roles, which, as identified earlier, pointed towards achieving a sense of flow or reaching self-actualisation within this context. Participants who had multiple instances of involvement in humanitarian missions, either with Mercy Ships or similar work with other organisations, spoke about experiencing some level of difficulty when transitioning back to a nursing role in their home countries.

The literature identifies adjustment challenges for those who had participated in transcultural transitions (Sussman, 2000; Thorne, 1997; Zinsli & Smythe, 2009). One reason for this difficult adjustment is when participants compared their fulfilling nursing experience abroad with their workplaces at home. Participants' priorities, compared to their nursing colleagues who had not participated in such work, may have changed (Thorne, 1997). Another reason is that those who had participated in a humanitarian context found it challenging to dialogue meaningfully with their nursing colleagues on their return home about their experiences. There was a reinforced feeling of anticlimax and disappointment for nurses who wanted to share yet found others could not relate and therefore showed disinterest (Albuquerque et al., 2018). Therefore,

volunteers needed to be not only advised of this possibility but also given tools of empowerment to move through that needed adjustment with the support of others having achieved that process already.

Participants identified working within a dynamic and rapidly changing international team, which was different from their experiences of working in their home countries (Gazaway et al., 2019). Multiple opportunities to reflect and incorporate meaningful learning into their practice was encouraged (Burden, 2016; Field, 2004). Further to the dynamic team, the intense and vastly different environment of working where one lives may not leave adequate time to process these new experiences. For meaningful learning to occur, sufficient time and knowledge of how to reflect, and an opportunity to apply their experience to a new context, is necessary (Wallace, 1996). Johns (2017) supported the position that, although a recent encounter has the potential to lead to personal and professional growth, only after the experience is analysed does that learning lead to beneficial changes in nursing practice.

Other challenging dynamics included language barriers, stemming from interactions with patients and translators and nursing colleagues with English as another language. Host countries contained a diverse number of people groups and dialects, which often meant communication required three or four people to facilitate some understanding. Nurses needed to develop a cultural sensitivity to communication and recognise African cultural practices may cause misunderstanding and preclude truth-telling (Matua & Locsin, 2016). For example, an African patient may hold the cultural belief that to admit pain may be a weakness and lead to fear of retribution. The result might be stoicism or denial of that pain (Albertyn et al., 2009). Identifying cultural nuances in

communication and belief systems is an essential strategy in offering holistic, culturally safe nursing practice (Leffers & Plotnick, 2011).

Published literature highlights a concern of short-term mission trips being too short a timeframe for health workers to learn cultural competence. Despite good intentions, they may naively display paternalistic tendencies and be tempted to function outside their scope of practice (Nilsson et al., 2011). An example that illustrates this point in the study findings is a nurse manager identifying newly arrived nursing volunteers' desire to comfort crying babies. Their cultural tendency was to pick up the crying baby and walk around, cuddling them, often not considering the mother in that process. The use of therapeutic touch in one culture may not be as welcome in another, and such behaviour may be considered insensitive or even unethical. This faux pas may be averted through comprehensive orientation and the integration of short-term volunteers into a CoP. It is essential to understand the guidelines within the practice setting.

A study by Murphy and Clark (1993) found that nurses caring for patients of an ethnic minority may not be aware of their cultural differences. Therefore, nurses experienced challenges in communication, which led to their frustration and withdrawal from offering holistic care. Participants were, on occasion, somewhat naive about the cultural effects they had on patients, but they took extraordinary measures in communicating effectively, using translators and others to ensure they provided culturally appropriate holistic care. Team leaders who have been enculturated are suitable role models for nurses who are new to the transcultural setting (Spence, 2001).

Humanitarian Nursing Skills

One of the study's aims was to identify new skills that participants felt they had developed or current skills they believed had strengthened. As nursing competency was not evaluated, the findings report on participants' perceptions only. Global health nursing describes nurses intervening to achieve health equity outside their home country and in partnership with other healthcare professionals and communities. It is done "with a spirit of cultural humility, deliberation, and reflection" (Upvall et al., 2014, p. 6). When nurses are presented with an alternate worldview, they are open to engaging in critical thinking. Interpersonal skills are tested and, together with the expanded experience, provide an opportunity to become more globally aware and less ethnocentric (Crigger & Holcomb, 2007; Smith-Miller et al., 2010). However, it is important to deliver culturally safe and appropriate care to meet a person's healthcare needs, as defined by the care recipient, in alignment with their cultural and social identity (Papps & Ramsden, 1996).

Participants had the opportunity to reflect on the social and ethical contexts, embracing transcultural learning through their practice (Dean, 2005; Tschudin & Davis, 2008). These reflections can contribute to becoming global citizens where diversity in society today embraces more than ethnicity. That diversity presents in values, belief systems, social class, religious affiliations, lifestyle choices, and linguistic variations (Foronda et al., 2016). Nurses can become more inclusive by growing in competence and understanding of other cultures and their worldviews. This type of service may lead to career advancement by qualifying participants for new clinical and leadership positions in global health. These positions may be in both public and private sectors or

equip them for longer term leadership positions within their current NGO. Hudson and Inkson (2006) proposed that an organisation selecting potential employees would likely see global development work as favourable and expect they would exhibit enhanced cross-cultural competence, advanced problem-solving skills, and heightened self-awareness due to constant challenges in a foreign setting.

Healthcare systems may pressure nurses to be expert practitioners, providing more services with fewer resources (All-Party Parliamentary Group on Global Health, 2016). A review on expert nursing practice identified as essential factors positive role models, intention and recognition, supportive leadership, positive nurse–physician and nurse–patient relationships, autonomy, and a model of holistic practice (Morrison & Symes, 2011). Nurses intend to deliver the most appropriate person-centred care. However, good intention does not always equate with good practice (Kim, 1999). Participants integrated experiential learning with strong clinical reasoning skills and an ability to justify resource allocation and enact evidence-based, resourceful care (Crigger et al., 2006). Interpersonal skill is an attractive attribute for employers—that is, to have nurses who can deal with the ever-increasing challenges of a rapidly changing healthcare environment (Jackson et al., 2007; McAllister & McKinnon, 2009). Leadership skills, emotional intelligence, and an ability to enact change are further desirable attributes of employers when considering the skill mix of potential nursing employees (Akerjordet & Severinsson, 2010).

This study's results indicated that participants immersed in a humanitarian nondisaster context believed they gained experiential multifaceted personal and professional growth. A significant proportion developed specific

clinical skills, while a few very experienced nurses (*n* = 4) felt they were not using known clinical skills to advantage their patients yet reported developing in other ways. Crossing borders and nursing in a humanitarian context is to develop knowledge and praxis, fostering growth in both cognitive and functional domains (Parfitt, 1994). Engagement and reflection expand compassionate, nursing practice, which can benefit current and future applications (P. Gray & Thomas, 2006). Learning outcomes for participants included growth in personal development, work experience, and skills; clinical and leadership development; intercultural competence and language skills; international knowledge and understanding; and civic and global engagement. Similar outcomes were identified in studies by Sherraden et al. (2008), who studied international volunteers in general, and by Lal and Spence (2016), who conducted a small (*N* = 4), nursing-specific study of nurses involved in humanitarian work abroad.

Working together within a diverse international team was an opportunity to stay current with advanced or emerging nursing practice around the world. Further, it was a valuable opportunity to increase nursing knowledge about nursing in other countries because collaboration between team members gave rise to ongoing discussions about commonalities and differences in nursing practice. Nurses were exposed to a broad range of nursing practice through their colleagues. Over time, this appeared to develop a sense of collective wisdom and led to increased self-examination about nursing practice, encouraging professional accountability and justification of rationales related to specific interventions within the patient and environmental contexts. Generous staffing also allowed time for encouraging discussion and reflection among nurses. For some nurses, working within an international team challenged

longstanding values and beliefs, and they modified their practice to suit the setting. In turn, that process encouraged emotional insight and intelligence.

Learning is situated in an authentic environment and embedded within the context and culture of where it happens (Lave, 1991). The theory is based on a constructivist stance, where collaborative learning is integrated with social engagement in a professional nursing practice environment.

The CoP had a distinct purpose and blended individuals' experiences from around the world into a diversified team, where ideas were exchanged and a dynamic learning environment was created. This CoP shared that common imperative to exchange information between a professional group of healthcare volunteers that strived to give the best care in an initially unfamiliar context. Given the high turnover of volunteers, this pervasive culture was communicated by longer serving volunteers. Nurses became integrated into their role within the CoP that represented certain beliefs and behaviours. Despite the fact they may be very experienced nurses, they moved from being a newly arrived nurse to one that had served within the unique context. Over time, the process allowed them to move from novice to expert for that context and they then mentored others (Benner, 1984). It appears that nurses involved in the delivery of nursing care within this cultural context expanded their understanding of how to serve on a diverse international team.

Volunteer Service and Motivation in Global Health

Research on the motivation of health-related workers participating in volunteer international humanitarian work was found (Bjerneld et al., 2006; Hudson & Inkson, 2006; Momani & Alzaghal, 2018; Oberholster et al., 2013; Tassell & Flett, 2011); however, no articles were located when applied

specifically to nurses in that context. While some individuals choose to enter into humanitarian work as a long-term career choice, more choose to be deployed on a short-term basis and in response to an immediate need (Tassell & Flett, 2011). Volunteer choices to participate in humanitarian work includes both intrinsic and extrinsic motives that elicit and sustain behaviour, often at a higher risk to themselves. This study found that nurses self-reported their motives to volunteer were based on a strong connection with the organisational values and their personal belief systems. They also reported a high level of personal and professional satisfaction working within a likeminded and motivated team. When collaboration and team dynamics are perceived as positive, workplace satisfaction is evident, and retention or return volunteering increases (Mickan, 2005). Team members were spurred on by understanding their contribution was highly appreciated and valued by immediate coworkers and their team leaders. Further, they received positive affirmation from the patients they were serving and other stakeholders from their support network, including financial supporters, which in turn motivated them to continue and, in this instance, to contribute financially as was required by the organisation.

The question may then be posed: What causes a nurse not only to volunteer in a higher risk setting than usual, without financial remuneration, but also to go a step further and pay the organisation they are serving for the privilege to work?

Bassous (2014) looked at the factors affecting worker motivation with faith-based nonprofit organisations. Qualitative findings from that study revealed the meaningfulness of the job along with personal faith, high connections with altruistic values, and donation as the main intrinsic factors motivating a person

to volunteer. Further, Bassous's study was not applied to humanitarian workers as such; the participants in this study were guided by the same ideals, with the majority stating they had motives related to their personal faith.

Chapter Summary

This chapter discussed concepts of the delivery of holistic care within a CoNP and the challenges and skills learned concerning existing published literature. Because there is scant literature related to a nondisaster humanitarian context, research literature was drawn from broader contexts and refined into the new PPM modelling. A new PPM was therefore identified from within the research and discussed as a synthesis of the ethnographic study. The substance of HHEALED as a model relies on a culture driven by both organisational values and the nurses delivering humanitarian care. Methodological strengths and limitations and further research in an LMIC humanitarian nursing context are discussed in the final chapter.

CHAPTER 7. CONCLUSIONS AND RECOMMENDATIONS

Introduction

This final chapter includes a summary of the previous chapters' arguments and the methodological strengths and limitations of the study. Recommendations related to nursing education, policy, practice, and future research are suggested. A final reflection of the thesis is presented.

Summary of Arguments Presented in Previous Chapters

Chapter 1 presented background about the need for humanitarian care, nurses' involvement in that health care, and the lack of definition of a particular space in nursing care between acute relief in response to a humanitarian crisis (disaster) and assistance focused on long-term development projects. I presented the context of nurses working within STMTs, specifically on mobile, self-contained platforms, using the Mercy Ships organisation as an exemplar and declared that the primary study objective was to interpret the culture of nursing practice delivered. Further objectives were to establish nurses' perceptions of participating in international humanitarian work, to evaluate any specific nursing skills developed while volunteering in a ship-based setting, and to analyse factors that may contribute to, or hinder, nurses' practice in this humanitarian context.

Chapter 2 completed an integrative review of published literature to situate nurses' contributions to humanitarian care within an LMIC nondisaster context. Results found a lack of standardised, accepted definitions for humanitarian response. There was a clear gap in research knowledge that

described the unique environments, roles, and possible education programs that nurses were involved with in LMIC humanitarian nondisaster care.

Chapter 3 introduced the study's methodology and conceptual framework, arguing that ethnography was an appropriate means to understand the nature of nurses' contributions within a charitable organisation delivering humanitarian care.

Chapter 4 outlined the methods. A qualitative, immersive ethnographic approach was used to collect data over a 6-months period at one study site in its natural setting (a civilian hospital ship in an LMIC). The study sample consisted of 1,500 hours of active participant observation and the collective voice of 49 nurses who consented to a semistructured interview to augment the observations and reflections I made of their nursing activities. Analysis of appropriate and related nursing documents was included.

Chapter 5 reported key findings organised into four themes and subsequent subthemes, which matched the stated objectives. The four themes were (1) "What drew us here?" (expressions of motivation), (2) "Who we are and how we do what we do" (expressions of engagement), (3) challenges (embracing change), and (4) development (expressions of transformation).

In Chapter 6, a more in-depth synthesis of the thematic findings led to the articulation of a new PPM: HHEALED. An examination of literature surrounding current nursing models relating to the humanitarian context was presented and the underpinnings of the HHEALED model emerged. This model lends itself to broader applications through customisation within similar contexts, particularly those that incorporate relevant organisational values. A

graphic and applied representation of the HHEALED model was used to exemplify the model within the NGO it was drawn from (Mercy Ships).

Methodological Strengths and Limitations

Strengths

Findings from this study provide rich insight into a previously undescribed context of nursing within an LMIC nondisaster humanitarian care response. Within the domain, the study focuses on surgical, curative short-term missions delivered from a self-contained mobile hospital platform. The vigorous research process yielded a detailed description of nursing administered within a global charity. The use of focused ethnography fostered a depth of research that would not have been reached with surveys or interviews alone, as new insights emerged into nursing practice delivery through a unique civilian hospital ship context.

Qualitative research requires the development of a strong bond of trust between participants and researcher, often requiring extended time; 6 months of full immersion was given. Therefore, trust was established, as described in Chapter 4.

Participants from a broad range of Western countries represented extensive international nursing experience. There was a large range in the diversity of interviewees as reflected in age, gender, nationality, time, type, and repetition of service with the organisation, and within the nursing roles. There was a robust set of data, voicing 49 nurses' opinions, participant–observer notes, and document analysis, reaching data saturation at 6 months. Trustworthiness was established in the key informant interviews and observation in-practice phases, supporting data validity, value, applicability, and

consistency. Observation of nursing behaviour was undertaken in the natural context. Data were collected and analysed by me, as the primary researcher, and the doctoral supervisory team gave support for further triangulation. The results suggest an in-depth understanding of the culture and interpretations, with validity and rich description.

The research findings provide a framework for nurses participating in a short-term humanitarian experience in the form of a PPM called HHEALED. Moreover, the study provides a lens through which those outside the culture can view what nursing entails within a civilian hospital ship context.

Limitations

The ethnographic method is seen as both a strength and a limitation; the large amount of data made it more challenging to contain within the confines of a structured thesis. The large amount of data also meant systematic data analysis required an extended amount of time to process. The data collection process was immersive and spanned 6 months.

A research design stipulation was that the study be conducted simultaneously with working as an IPC nurse. The consistent collection of data meant my time was divided between the two corequirements. As a qualitative study, some concepts were abstract and more difficult to objectively measure. For example, describing who someone is, and not just what they do, increased the potential for researcher bias as I brought my own experience, prejudice, and culture to the study. Therefore, minimising the impact I could have on influencing the study's outcomes was applied routinely. The process required ongoing awareness protocols and continued disclosure techniques to retain as objective data collection as possible.

Further to data collection, the interviewees may have filtered their responses through researcher assumptions. Triangulation of data was employed to scrutinise and minimise any potential to skew results. Finally, study results were interpreted at one point in time and in one context, limiting large-scale transferability.

Reflections on My Contribution to Knowledge

Philanthropy within the health sector is growing (Fanelli et al., 2020); however, well-meaning intentions to contribute to holistic change is not always enough to make lasting change. Taking an opportunity to volunteer in an LMIC context facilitates nurses who are motivated to care for those experiencing profound marginalisation and social inequity.

Nurses are an essential cohort of workers involved in meeting the 2030 United Nations SDGs, especially related to individuals', families', and societies' improved health. However, nurses (and others) have a moral and ethical responsibility to align with others that do good and not harm (Bauer, 2017; N. S. Berry, 2014).

This thesis extends knowledge in the field of international nursing within an LMIC humanitarian context. I further extend what was previously known by investigating the culture of nursing care within a previously undisclosed nursing context (a civilian hospital ship). Results also identify with and extend previous descriptions of nurses' involvement within humanitarian care and highlight meaningful nursing care through the newly created HHEALED PPM.

NGOs have facilitated nurses contributing to both relief and development projects with a capacity-building priority over many decades. Despite the ease of travel and technology steadily increasing, the globalised world endures

ongoing limitations and obstacles, requiring frequent evaluation and recalibration of ways to address felt need. As a nursing profession, embedded values of empathy, compassion, and service place nurses in a suitable position to meet the humanitarian need. Mercy Ships is one such organisation that has facilitated nurses' motivations to change patients' health outcomes, yet there are many others.

Nurses within this study favoured work environments with characteristics that promoted healing through holistic care, the instillation of hope, empowerment, and the restoration of dignity, love, and development when giving care to patients who had not been previously afforded safe, timely, or accessible health care. Gaining insight into humanitarian nursing culture holds value for future volunteer nurses wishing to align themselves with this type of work. It also offers an opportunity for other nurses working in different humanitarian contexts to compare and evaluate their experiences. The development and incorporation of the HHEALED PPM for nurses working in LMIC humanitarian projects is a framework intended as a tool in nurses' hands, to ignite passion and equip them for service.

Recommendations for Nursing Education

There are multiple implications for nursing education from this study. Professional development activities currently available to the nurse wishing to volunteer in a humanitarian setting are limited. Individual organisations may offer predeployment courses with limited accessibility to those nurses who have not yet been engaged in this type of service. Organisations such as Red Cross, Medair, and MSF focus on preparing those intending to serve in a humanitarian

disaster setting as a career, but access to such courses for those intending involvement in short-term service is limited.

Further, criteria for employment or voluntary service by organisations in the humanitarian setting often include the requirement of prior experience. The challenge of offering a generic professional development course in preparation for humanitarian nondisaster service is the multiple and varied contextual milieus: geographically, organisationally, and ethnically. The development of a global health nursing professional development course, with the freedom to apply knowledge related to a specific and intended nursing role, could be beneficial to nurses seeking a way to prepare themselves for short-term international humanitarian assignments. Suggested application of the HHEALED model by NGOs or academic programs teaching global health topics could highlight the culture of nursing care embedded within the model and ultimately streamline nursing practice, enhancing the quality of care provided.

Cultural awareness training related to specific LMIC contexts and applied information about the host country's healthcare system and available services are warranted. It may also include the practical application of capacity-building principles specific to the host country, build holistic knowledge surrounding specific conditions targeted in the patient population, information related to communicating effectively with translators, and mental health and trauma counselling principles relating to both the patient and volunteer cohorts. This professional development would be particularly pertinent to nurses intending to volunteer but who have not yet had nursing experience in an LMIC setting.

Recommendations for Policy

Nurses are a much-needed voice when considering future policy development and strategies to ensure equitable global health care. Currently, there are suggested guidelines for STMTs working in humanitarian settings, but they lean towards preparation before deployment, direct involvement in disaster response (Elsharkawi et al., 2010), or teams with service-learning motives (Andrews, 2020; Chapin & Doocy, 2010; Costa et al., 2015; Lasker et al., 2018). Some individual NGOs were found to provide a guide for workers joining STMTs. One article providing ethical guidelines for service was identified with nurses as the focal point (McDermott-Levy et al., 2018), but targeted policies aligning specifically with the profession of nursing within the context of the identified gap of literature describing both relief and developmental nursing care in a humanitarian context, while aiming to meet the United Nations 2030 SDGs, is warranted.

Recommendations for Clinical Practice

The HHEALED PPM was developed from research findings from a single study site. Testing the model in similar contexts with nurses deployed for service would bring further validity to the model's content and confirm the attributes in other global health settings.

The study highlights substantial evidence of participants having a positive experience rather than factors deterring involvement. The requirement to raise finance and the loss of salary while participating in an international volunteer opportunity were identified as potential hindrances. At least one nurse identified she would have volunteered for a more extended period except for the expense involved. Since data collection was completed, the COVID-19

pandemic has surfaced and with it, a heightened risk to nurses' health and international travel challenges. The inclination and subsequent commitment of nurses to volunteer for humanitarian work under pandemic circumstances is an area for further development and research.

Testing of the graphic model specifically created for the Mercy Ships organisation is suggested, along with a further discussion with leadership to incorporate the model in an organisation-specific professional development online module hosted by Mercy Ships for nurses to complete before they embark.

Recommendations for Future Research

Beyond the study's findings relevant to the participating NGO, Mercy Ships, research into volunteer nursing in different LMIC humanitarian nondisaster contexts would add to the current limited knowledge. Research describing nurses' involvement in meeting the United Nations SDGs through similar organisations is important to highlight, and therefore the impact nursing has on both the nurse and recipients is warranted.

To date (2020), published research has generally revolved around expatriate volunteers working and volunteering in LMICs. Ascertaining how many national nurses are volunteering in LMICs to provide humanitarian care in their own country or beyond their borders is suggested and to describe their experiences. Further research is also suggested to investigate how volunteers from LMICs may view the experience for a comparison between expatriate and national nursing cohorts.

Further research to establish the subsequent impact short-term international volunteering may have on participating nurses' professional

standing is recommended. This would identify whether nurses have incorporated learning from the *field* into their position's home country practice. That is, are nurses more likely to enter mentoring or leadership positions than others who have not volunteered? Have their experiences of working in an international team in an LMIC increase their cultural competency or social justice advocacy?

Future research projects addressing topics highlighted in the HHEALED PPM would be beneficial as published humanitarian nursing research related to the culture of care is scant. Questions to be asked could include "How do nurses interpret and deliver dignity and the nursing practice of instilling hope and love in a humanitarian context?", "What are humanitarian nurses' specific clinical learning needs when considering a nondisaster environment?", "Which countries embrace global health in their nursing curricula, and which topics may serve as a catalyst for nurse volunteerism, locally or abroad?", "What skills do nurses need for successful reintegration into their own culture and professional roles after within global humanitarian health projects'?, "How can a stronger connection be made to support local nurses with more resourced nurses from industrialised countries in the future?", "Is a stronger long-term connection appropriate, and how can nurses maintain the relationship and strengthen the connection to support colleagues internationally?", "Within a holistic nursing care framework, is it realistic to expect as great a connection in a Western context as was achieved in an LMIC context, with vastly different cultural norms?" Evidence-based clinical research should be done to support the anecdotal evidence of successful procedures and use of various techniques in a

specific patient population and context of surgical curative care. Would those identified techniques be as applicable or appropriate in other contexts'?

Conclusion

Volunteering may become less attractive going forward than it has been in the past considering safety, security, and health concerns. Organisations depending on volunteers will likely need to adjust processes to ensure necessary positions are filled. By April 2020, COVID-19 had significantly changed the healthcare landscape (Rohrich et al., 2020), and international travel has subsequently become less attractive or permissible. Many mobile STMTs administered by NGOs, including Mercy Ships, have been required to withdraw their physical presence from service for a season and readjust and re-evaluate delivery of care considering personnel safety issues, international travel restrictions, and ongoing costs of service. In May 2020, executive leadership made the difficult decision to pause the *Africa Mercy*'s medical work in response to the emerging COVID-19 pandemic, which meant relocating from West Africa. That pause in direct medical services allowed time for a programmatic reassessment of how vital and ongoing support to LMICs could be offered. Technology facilitates change to medical capacity-building programs, which have been recently instituted through partnerships with other not-for-profit organisations (World Telehealth Initiative, 2020). As understood in November 2020, plans are in place to recommence the *Africa Mercy* programs by April 2021. That timing may need to be further readjusted due to the ever-changing nature of the pandemic, and yet it is the very countries with poor infrastructure and access that may need targeted support and assistance with resources within the pandemic period by humanitarian NGOs.

Some years ago, Mercy Ships initiated plans for another vessel to be added to the fleet, increasing its capacity. China Shipbuilding Industry Corporation has contracted an additional purpose-built ship, and the anticipated delivery of the *Global Mercy* is for deployment in 2021. The new Mercy Ship is planned to have five operating theatres, 180 in-patient beds, and 600 crew, with the capacity increasing to house 950 people when the ship is in port. With these expansion plans well underway; it is vital that a greater understanding of the needs and function of nursing with Mercy Ships is gained. Moreover, a significant increase in the number of volunteer nurses will be required to staff this new venture.

Finally, in undertaking this research, I have had ample opportunity to broaden my understanding of global need. While reflecting on my involvement with humanitarian nursing in LMICs, I have considered with fresh eyes the responsibility I have; as a nurse academic, I am entrusted to inspire and mentor nurses in a professional capacity. I consider it a privilege to highlight and expand a growing body of knowledge within the field of humanitarian nursing, albeit a small piece of the jigsaw puzzle in meeting the SDGs. I remain convinced that nurses are well placed to share the burden of bringing light to dark places, through who they are and what they do. Therefore, I remain committed to inspiring and equipping those nurses I am privileged to mentor and educate as they consider how they might expand their borders to love and serve humanity.

REFERENCES

Abdulrehman, M. S. (2017). Reflections on native ethnography by a nurse researcher. *Journal of Transcultural Nursing, 28*(2), 152–158. https://doi.org/10.1177/1043659615620658

Aberese-Ako, M. (2016). “I won’t take part!”: Exploring the multiple identities of the ethnographer in two Ghanaian hospitals. *Ethnography, 18*(3), 300–321. https://doi.org/10.1177/1466138116673380

Adams, C., Kiefer, P., Ryan, K., Smith, D., McCabe, G., Allen, P., Sridhar, K., Torres, P., & Chu, M. W. (2012). Humanitarian cardiac care in Arequipa, Peru:
Experiences of a multidisciplinary Canadian cardiovascular team. *Canadian Journal of Surgery, 55*(3), 171–176. https://doi.org/10.1503/cjs.029910

Adams, S., Carryer, J., & Wilkinson, J. (2015). Institutional ethnography: An emerging approach for health and nursing research. *Nursing Praxis in New Zealand, 31*(1), 18–26. https://doi.org/10.1177/1049732310375435

Agampodi, T. C., Agampodi, S. B., Glozier, N., & Siribaddana, S. (2015). Measurement of social capital in relation to health in low and middle income countries (LMIC): A systematic review. *Social Science & Medicine, 128*, 95–104. https://doi.org/10.1016/j.socscimed.2015.01.005

Agazio, J. (2010). Army nursing practice challenges in humanitarian and wartime missions. *International Journal of Nursing Practice, 16*(2), 166–175. https://doi.org/10.1111/j.1440-172X.2010.01826.x

Agostinho, D., & Paço, A. (2012). Analysis of the motivations, generativity and demographics of the food bank volunteer. *International Journal of Nonprofit and Voluntary Sector Marketing, 17*(3), 249–261. https://doi.org/10.1002/nvsm.1427

Akerjordet, K., & Severinsson, E. (2010). The state of the science of emotional intelligence related to nursing leadership: An integrative review. *Journal of Nursing Management, 18*(4), 363–382. https://doi.org/10.1111/j.1365-2834.2010.01087.x

Albertyn, R., Rode, H., Millar, A. J., & Thomas, J. (2009). Challenges associated with paediatric pain management in Sub Saharan Africa. *International Journal of Surgery, 7*(2), 91–93. https://doi.org/10.1016/j.ijsu.2009.01.005

Albuquerque, S., Eriksson, A., & Alvesson, H. M. (2018). The rite of passage of becoming a humanitarian health worker: Experiences of retention in Sweden. *Global Health Action, 11*(1), 1417522. https://doi.org/10.1080/16549716.2017.1417522

Alkire, B. C., Raykar, N. P., Shrime, M. G., Weiser, T. G., Bickler, S. W., Rose, J. A., Nutt, C. T., Greenberg, S. L., Kotagal, M., Riesel, J. N., Esquivel, M., Uribe-Leitz, T., Molina, G., Roy, N., Meara, J. G., & Farmer, P. E. (2015). Global access to surgical care: A modelling study. *Lancet Global Health, 3*(6), e316–323. https://doi.org/10.1016/S2214-109X(15)70115-4

Allen, D. (2004). Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry, 11*(1), 14–24. https://doi.org/10.1111/j.1440-1800.2004.00201.x

All-Party Parliamentary Group on Global Health. (2016). *Triple impact: How developing nursing will improve health, promote gender equality and support economic growth.* http://www.appg-globalhealth.org.uk/

Almonte, A. L. (2009). Humanitarian nursing challenges: A grounded theory study. *Military Medicine, 174*(5), 479–485. https://doi.org/10.7205/milmed-d-01-7908

American Holistic Nurses Association & American Nurses Association. (2019). *Holistic nursing: Scope and standards of practice* (3rd ed.). American Holistic Nurses Association & American Nurses Association.

Andrews, S. (2020). Identification of current best practices for short-term medical mission trips and adherence to current common principles and guidelines. *Christian Journal of Global Health, 7*(2), 67–82. https://doi.org/10.15566/cjgh.v7i2.341

Arbon, P. (2004). Understanding experience in nursing. *Journal of Clinical Nursing, 13*(2), 150–157. https://doi.org/10.1046/j.1365-2702.2003.00861.x

Arford, P. H., & Zone-Smith, L. (2005). Organizational commitment to professional practice models. *Journal of Nursing Administration, 35*(10), 467–472. https://doi.org/10.1097/00005110-200510000-00008

Asante, M. K., & Mazama, A. (2009). *Encyclopedia of African religion* (Vol. 1). Sage. https://doi.org/10.4135/9781412964623

Asgary, R., & Junck, E. (2013). New trends of short-term humanitarian medical volunteerism: Professional and ethical considerations. *Journal of Medical Ethics, 39*(10), 625–631. https://doi.org/10.1136/medethics-2011-100488

Asgary, R., & Lawrence, K. (2014). Characteristics, determinants and perspectives of experienced medical humanitarians: A qualitative approach. *British Medical Journal (BMJ) Open, 4*(12), e006460. https://doi.org/10.1136/bmjopen-2014-006460

Atkinson, P. (2015). *Working with ethnographic fieldnotes: Learning tango*. SAGE Publications. http://doi.org/10.4135/9781412962056

Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248–260). Sage.

Australian Council for International Development. (2014). *Humanitarian action for results: Strengthening Australia's approach to preventing and responding to disasters and conflict overseas*. ACFID. https://acfid.asn.au/sites/site.acfid/files/resource_document/HAFR-Policy-Paper.pdf

Australian Civil-Military Centre. (2015). *Same space—Different mandates: A civil-military-Police guide to stakeholders in international disaster and conflict response*. Australian Council for International Development. https://apo.org.au/node/57835

Bachman, J. P., & Malloch, K. M. (1998). Developing a common nursing practice model. *Nursing Management, 29*(1), 26–27.

Baillie, L., & Gallagher, A. (2011). Respecting dignity in care in diverse care settings: Strategies of UK nurses. *International Journal of Nursing Practice, 17*(4), 336–341. https://doi.org/10.1111/j.1440-172X.2011.01944.x

Basol, R., Hilleren-Listerud, A., & Chmielewski, L. (2015). Developing, implementing, and evaluating a professional practice model. *Journal of Nursing Administration, 45*(1), 43–49. https://doi.org/10.1097/NNA.0000000000000153

Bassous, M. (2014). What are the factors that affect worker motivation in faith-based nonprofit organizations? *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations, 26*(1), 355–381. https://doi.org/10.1007/s11266-013-9420-3

Bauer, I. (2017). More harm than good? The questionable ethics of medical volunteering and international student placements. *Tropical Diseases, Travel Medicine and Vaccines, 3*(1), 5. https://doi.org/10.1186/s40794-017-0048-y

Beaglehole, R., & Bonita, R. (2010). What is global health? *Global Health Action, 3*, 5142. https://doi.org/10.3402/gha.v3i0.5142

Beegle, K., & Christiaensen, L. (2019). *Accelerating poverty reduction in Africa*. The World Bank. https://openknowledge.worldbank.org/handle/10986/32354

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Addison-Wesley.

Bennett, M. R. (2015). Religiosity and formal volunteering in global perspective. In L. Hustinx, J. Von Essen, J. Haers, & S. Mels (Eds.), *Religion and volunteering* (pp. 77–96). Springer. https://doi.org/10.1007/978-3-319-04585-6_5

Benson, S. G., & Dundis, S. P. (2003). Understanding and motivating health care employees: Integrating Maslow's hierarchy of needs, training and technology. *Journal of Nursing Management, 11*(5), 315–320. https://doi.org/10.1046/j.1365-2834.2003.00409.x

Benzein, E., & Saveman, B. I. (1998). Nurses' perception of hope in patients with cancer: A palliative care perspective. *Cancer Nursing, 21*(1), 10–16. https://doi.org/10.1097/00002820-199802000-00002

Bergen, N., & Labonte, R. (2020). "Everything is perfect, and we have no problems": Detecting and limiting social desirability bias in qualitative research. *Qualitative Health Research, 30*(5), 783–792. https://doi.org/10.1177/1049732319889354

Berinyuu, A. A. (1988). *Pastoral care to the sick in Africa: An approach to transcultural pastoral theology* (Vol. 51). Peter Lang Publishing.

Bernard, H. R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches* (4th ed.). Rowman & Littlefield.

Berry, R. W. (2004). Acculturation. In C. D. Spielberger (Ed.), *Encyclopedia of applied psychology* (pp. 27–34). Elsevier. https://doi.org/10.1016/B0-12-657410-3/00384-6

Berry, N. S. (2014). Did we do good? NGOs, conflicts of interest and the evaluation of short-term medical missions in Solola, Guatemala. *Social Science & Medicine, 120*(0), 344–351. https://doi.org/10.1016/j.socscimed.2014.05.006

Bido, J., Singer, S. J., Diez Portela, D., Ghazinouri, R., Driscoll, D. A., Alcantara Abreu, L., Aggouras, B. M., Thornhill, T. S., & Katz, J. N. (2015). Sustainability assessment of a short-term international medical mission. *Journal of Bone and Joint Surgery American Volume, 97*(11), 944–949. https://doi.org/10.2106/JBJS.N.01119

Bjerneld, M., Lindmark, G., Diskett, P., & Garrett, M. J. (2004). Perceptions of work in humanitarian assistance: Interviews with returning Swedish health professionals. *Disaster Management Response, 2*(4), 101–108. https://doi.org/10.1016/j.dmr.2004.08.009

Bjerneld, M., Lindmark, G., McSpadden, L. A., & Garrett, M. J. (2006). Motivations, concerns, and expectations of Scandinavian health professionals volunteering for humanitarian assignments. *Disaster Management Response, 4*(2), 49–58. https://doi.org/10.1016/j.dmr.2006.01.002

Bloeser, C., & Stahl, T. (2017). Hope. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy.* Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/spr2017/entries/hope/

Bonner, A., & Tolhurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher, 9*(4), 7.

Boykin, A., & Schoenhofer, S. O. (2001). *Nursing as caring: A model for transforming practice.* National League for Nursing (Ed.). Jones & Bartlett Learning.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Breakey, S., Corless, I. B., Meedzan, N. L., & Nicholas, P. K. (2015). *Global health nursing in the 21st century*. Springer.

Brewer, J. D. (2000). *Ethnography*. Open University Press.

Briand, S., Bertherat, E., Cox, P., Formenty, P., Kieny, M. P., Myhre, J. K., Roth, C., Shindo, N., & Dye, C. (2014). The international Ebola emergency. *New England Journal of Medicine, 371*(13), 1180–1183. https://doi.org/10.1056/NEJMp1409858

Broadhurst, K., & Harrington, A. (2016). A mixed method thematic review: The importance of hope to the dying patient. *Journal of Advanced Nursing 72*(1), 18–32. https://doi.org/10.1111/jan.12765

Bruni, N. (1995). Reshaping ethnography: Contemporary postpositivist possibilities. *Nursing inquiry, 2*(1), 44–52. https://doi.org/10.1111/j.1440-1800.1995.tb00062.x

Burden, M. (2016). Working internationally: Challenges and opportunities. *British Journal of Nursing, 25*(20), 1108–1109. https://doi.org/10.12968/bjon.2016.25.20.1108

Burton, N. (2020, June 26). *These are the 7 types of love*. Psychology Today. https://www.psychologytoday.com/au/blog/hide-and-seek/201606/these-are-the-7-types-love

Buscatto, M. (2018). Doing ethnography: Ways and reasons. In U. Flick (Ed.), *The Sage handbook of qualitative data collection* (pp. 327–343). SAGE Publications. https://doi.org/10.4135/9781526416070

Buseh, A. G., Stevens, P. E., Bromberg, M., & Kelber, S. T. (2015). The Ebola epidemic in West Africa: Challenges, opportunities, and policy priority areas. *Nursing Outlook, 63*(1), 30–40. https://doi.org/10.1016/j.outlook.2014.12.013

Busse, H., Aboneh, E. A., & Tefera, G. (2014). Learning from developing countries in strengthening health systems: An evaluation of personal and professional impact among global health volunteers at Addis Ababa University's Tikur Anbessa Specialized Hospital (Ethiopia). *Globalization & Health, 10*(64), 64. https://doi.org/10.1186/s12992-014-0064-x

Butts, J. B., & Rich, K. L. (2015). *Philosophies and theories for advanced nursing practice* (2nd ed.). Jones & Bartlett Learning.

Cambridge Dictionary Online. (n.d.). Anchor. In *Cambridge Free English Dictionary*. Retrieved 12 January 2021. https://dictionary.cambridge.org/dictionary/english/anchor

Cameron, A. (2011). Working life: Taking the road less travelled. *Australian Nursing Journal, 19*(5), 30–33.

Campbell, A., & Yeung, S. (1991). Creating a sense of mission. *Long Range Planning, 24*(4), 10–20. https://doi.org/10.1016/0024-6301(91)90002-6

Cancedda, C., Farmer, P. E., Kerry, V., Nuthulaganti, T., Scott, K. W., Goosby, E., & Binagwaho, A. (2015). Maximizing the impact of training initiatives for health professionals in low-income countries: Frameworks, challenges, and best practices. *PLoS Medicine, 12*(6), e1001840. https://doi.org/10.1371/journal.pmed.1001840 (e1001840)

Carter, M. (2014). Vocation and altruism in nursing: The habits of practice. *Nursing Ethics, 21*(6), 695–706. https://doi.org/10.1177/0969733013516159

Caruso, E. M., Cisar, N., & Pipe, T. (2008). Creating a healing environment: An innovative educational approach for adopting Jean Watson's theory of human caring. *Nursing Administration Quarterly, 32*(2), 126–132.

CASP UK. (2013). *CASP qualitative checklist*. https://casp-uk.net/casp-tools-checklists/

Chamberlain, B., Bersick, E., Cole, D., Craig, J., Cummins, K., Duffy, M., Hascup, V., Kaufmann, M., McClure, D., & Skeahan, L. (2013). Practice models: A concept analysis. *Nursing Management, 44*(10), 16–18. https://doi.org/10.1097/01.NUMA.0000434465.90084.eb

Chapin, E., & Doocy, S. (2010). International short-term medical service trips: Guidelines from the literature and perspectives from the field. *World Health Population, 12*(2), 43–53. https://doi.org/10.12927/whp.2010.22009

Chiu, Y. W., Weng, Y. H., Chen, C. F., Yang, C. Y., Chiou, H. Y., & Lee, M. L. (2012). A comparative study of Taiwan's short-term medical missions to the South Pacific and Central America. *BMC International Health and Human Rights, 12*(1), 37. https://doi.org/10.1186/1472-698X-12-37

Chiu, Y. W., Weng, Y. H., Chen, C. F., Yang, C. Y., & Lee, M. L. (2012). Perceptions and efficiency of short-term medical aid missions among key groups of health professionals. *Evaluation & the Health Professions, 37*(3), 379–393. https://doi.org/10.1177/0163278712461503

Clancy, T. R. (2003). Courage and today's nurse leader. *Nursing Administration Quarterly, 27*(2), 128–132. https://doi.org/10.1097/00006216-200304000-00006

Clarke, P. N., Watson, J., & Brewer, B. B. (2009). From theory to practice: Caring science according to Watson and Brewer. *Nursing Science Quarterly, 22*(4), 339–345. https://doi.org/10.1177/0894318409344769

Cleary, M., & Horsfall, J. (2014). Nursing and enacting the courage of one's convictions. *Issues in Mental Health Nursing, 35*(9), 724–726. https://doi.org/10.3109/01612840.2014.938965

Close, K. L., Baxter, L. S., Ravelojaona, V. A., Rakotoarison, H. N., Bruno, E., Herbert, A., Andean, V., Callahan, J., Andriamanjato, H. H., & White, M. C. (2017). Overcoming challenges in implementing the WHO Surgical Safety Checklist: Lessons learnt from using a checklist training course to facilitate rapid scale up in Madagascar. *British Medical Journal (BMJ) Global Health, 2*(Suppl 4), e000430.

Compton, B., Lasker, J. N., & Rozier, M. (2014). Short-term medical mission trips: Phase I research findings. *Health Progress, 95*(6), 72–77.

Costa, M., Oberholzer-Riss, Hatz, C., Steffen, R., Puhan, M., & Schlagenhauf, P. (2015). Pre-travel health advice guidelines for humanitarian workers: A systematic review. *Travel Medicine and Infectious Disease, 13*(6), 449–465. https://doi.org/10.1016/j.tmaid.2015.11.006

Covington, H. (2003). Caring presence. Delineation of a concept for holistic nursing. *Journal of Holistic Nursing, 21*(3), 301–317. https://doi.org/10.1177/0898010103254915

Craffert, P. (1997). Opposing world views: The border guards between traditional and biomedical health care practices. *South African Journal of Ethnology, 20*(1), 1–9.

Creswell, J. W. (2013). *Qualitative inquiry and research design* (3rd ed.). Sage.

Crigger, N. J., Brannigan, M., & Baird, M. (2006). Compassionate nursing professionals as good citizens of the world. *Advances in Nursing Science, 29*(1), 15–26. https://doi.org/10.1097/00012272-200601000-00003

Crigger, N. J., & Holcomb, L. (2007). Practical strategies for providing culturally sensitive, ethical care in developing nations. *Journal of Transcultural Nursing, 18*(1), 70–76. https://doi.org/10.1177/1043659606294198

Crigger, N. J., & Godfrey, N. (2011). Of courage and leaving safe harbors. *Advances in Nursing Science, 34*(4), E13–22. https://doi.org/10.1097/ANS.0b013e3182356c04

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Cruz, E. V., & Higginbottom, G. (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 46–43. https://doi.org/10.7748/nr2013.03.20.4.36.e305

Csikszentmihalyi, M. (2000). Flow: The psychology of optimal experience. Harper and Row. https://mktgsensei.com/AMAE/flow_the_psychology_of_optimal_experience.pdf (1990)

Cudmore, H., & Sondermeyer, J. (2007). Through the looking glass: Being a critical ethnographic researcher in a familiar nursing context. *Nurse Researcher 14*(3), 25–35. https://doi.org/10.7748/nr2007.04.14.3.25.c6030

Cutcliffe, J. R., & Herth, K. (2002). The concept of hope in nursing 1: Its origins, background and nature. *British Journal of Nursing, 11*(12), 832–840. https://doi.org/10.12968/bjon.2002.11.12.10307

Darcy, J., & Hofmann, C.-A. (2003). *According to need? Needs assessment and decision-making in the humanitarian sector* [Report 15]. [Humanitarian Policy Group Discussion Paper]. Overseas Development Institute. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/285.pdf

Dawson, A., Brodie, P., Copeland, F., Rumsay, M., & Homer, C. (2014). Collaborative approaches towards building midwifery capacity in low income countries: A review of experiences. *Midwifery, 30*, 391–402.

Dawson, A., & Homer, C. (2013). Managing the international humanitarian and development health workforce: A review of experiences and needs. *Asia Pacific Journal of Health Management, 8*(1), 14–23.

Dawson, S., Elliott, D., & Jackson, D. (2017). Nurses' contribution to short-term humanitarian care in low- to middle-income countries: An integrative review of the literature. *Journal of Clinical Nursing, 26*(23–24), 3950–3961. https://doi.org/10.1111/jocn.13816

Dawson, S., Jackson, D., & Elliott, D. (2019). Challenges and reflections from an international, humanitarian, short-term surgical mission on collecting ethnographic data in a remote environment. *Nurse Researcher, 27*(2), 21–25. https://doi.org/10.7748/nr.2019.e1627

de Chesnay, M. (2014). *Nursing research using ethnography: Qualitative designs and methods in nursing*. Springer Publishing Company.

de Chesnay, M. (Ed.). (2015). *Nursing research using data analysis: Qualitative designs and methods in nursing*. Springer.

Dean, P. (2005). Transforming ethnocentricity in nursing: A culturally relevant experience of reciprocal visits between Malta and the Midwest. *Journal of Continuing Education in Nursing, 36*(4), 163–167. https://doi.org/10.3928/0022-0124-20050701-07

Denton, D. R. (n.d.). The Biblical basis of hope [online commentary]. Themelios. https://www.thegospelcoalition.org/themelios/article/the-biblical-basis-of-hope/

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research*. Sage.

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: What challenges do qualitative researchers face? *Qualitative Research, 7*(3), 327–353.

Doane, D. (2014, September 1). *Global development: What's so bad about development?* The Guardian. http://www.theguardian.com/global-development/poverty-matters/2014/sep/01/development-ngos-third-world-global-south#comments

Dossey, B. M. (2013). *Holistic nursing: A handbook for practice*. Jones & Bartlett Publishers.

Downes, E. (2015). Nursing and complex humanitarian emergencies: Ebola is more than a disease. *Nursing Outlook, 63*(1), 12–15. https://doi.org/10.1016/j.outlook.2014.11.010

Draper, J. (2015). Ethnography: Principles, practice and potential. *Nursing Standard, 29*(36), 36–41. https://doi.org/10.7748/ns.29.36.36.e8937

Drury, C., & Hunter, J. (2016). The hole in holistic patient care. *Open Journal of Nursing, 06*(09), 776–792. https://doi.org/10.4236/ojn.2016.69078

Dubois, C. A., D'Amour, D., Tchouaket, E., Clarke, S., Rivard, M., & Blais, R. (2013). Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals. *International Journal for Quality in Health Care, 25*(2), 110–117. https://doi.org/10.1093/intqhc/mzt019

DuBois, M., Wake, C., Sturridge, S., & Bennett, C. (2015). *The Ebola response in West Africa: Exposing the politics and culture of international aid* [Humanitarian Policy Group Discussion Paper]. Overseas Development Institute. https://www.odi.org/publications/9956-ebola-response-west-africa-exposing-politics-culture-international-aid

Duffy, J. R. (2016). *Professional practice models in nursing: Successful health system integration*. Springer Publishing Company.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Dywili, S., Bonner, A., Anderson, J., & L, O. B. (2012). Experience of overseas-trained health professionals in rural and remote areas of destination countries: A literature review. The *Australian Journal of Rural Health, 20*(4), 175–184. https://doi.org/10.1111/j.1440-1584.2012.01281.x

Ellis, S. (1999). The patient-centred care model: Holistic/multiprofessional/reflective. *British Journal of Nursing, 8*(5), 296–301. https://doi.org/10.12968/bjon.1999.8.5.6677

Elnawawy, O., Lee, A. C., & Pohl, G. (2014). Making short-term international medical volunteer placements work: A qualitative study. *British Journal of General Practice, 64*(623), e329–335. https://doi.org/10.3399/bjgp14X680101

Elsharkawi, H., Sandbladh, H., Aloudat, T., Girardau, A., Tjoflat, I., & Brunnstrom, C. (2010). Preparing humanitarian workers for disaster response: a Red Cross/Red Crescent field training model. *Humanitarian Exchange Magazine 46*, 45–47.

Emerson, C. (2017). Calling to nursing: Concept analysis. *Advanced Nursing Science, 40*(4), 384–394. https://doi.org/10.1097/ANS.0000000000000185

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2011). *Writing ethnographic field notes* (2nd ed.). The University of Chicago Press.

Engebretson, J., & Littleton, L. Y. (2001). Cultural negotiation: A constructivist-based model for nursing practice. *Nursing Outlook, 49*(5), 223–230.

Fanelli, S., Salvatore, F. P., De Pascale, G., & Faccilongo, N. (2020). Insights for the future of health system partnerships in low- and middle-income countries: A systematic literature review. *BMC Health Services Research, 20*(1). https://doi.org/10.1186/s12913-020-05435-8

Fedele, R. (2015). Mission possible: Australian nurses and midwives strengthening developing countries [online]. *Australian Nursing and Midwifery Journal, 23*(1), 17–21.

Ferris, E. (2005). Faith-based and secular humanitarian organizations. *International Review of the Red Cross, 87*(858), 311–312.

Fetterman, D. M. (Ed.). (2010). *Ethnography: Step by step* (3rd ed., Vol. 17). Sage.

Field, D. E. (2004). Moving from novice to expert: The value of learning in clinical practice: A literature review. *Nurse Education Today, 24*(7), 560–565. https://doi.org/10.1016/j.nedt.2004.07.009

Flick, E. (2014). *An introduction to qualitative research* (5th ed.). Sage Publications.

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210–217. https://doi.org/10.1177/1043659615592677

Fountain, D. E. (1989). *Health, the Bible and the Church*. Billy Graham Centre, Wheaton College.

Frey, B. B. (Ed.). (2018). *The SAGE encyclopedia of educational research, measurement, and evaluation.* SAGE Publications, Inc. https://doi.org/10.4135/9781506326139

Frisch, N. C., & Rabinowitsch, D. (2019). What's in a definition? Holistic nursing, integrative health care, and integrative nursing: Report of an integrated literature review. *Journal of Holistic Nursing, 37*(3), 260–272. https://doi.org/10.1177/0898010119860685

Fry, M. (2012). An ethnography: Understanding emergency nursing practice belief systems. *International Emergency Nursing, 20*(3), 120–125. https://doi.org/10.1016/j.ienj.2011.09.002

Gagné, M. (2014). *The Oxford handbook of work engagement, motivation, and self-determination theory*. Oxford University Press.

Gallagher, A. (2011). Moral distress and moral courage in everyday nursing practice. *Online Journal of Issues in Nursing, 16*(2), 8.

Garry, S., & Checchi, F. (2020). Armed conflict and public health: Into the 21st century. *Journal of Public Health, 42*(3), e287–e298.

Gazaway, S., Gibson, R. W., Schumacher, A., & Anderson, L. (2019). Impact of mentoring relationships on nursing professional socialization. *Journal of Nursing Management, 27*(6), 1182–1189. https://doi.org/10.1111/jonm.12790

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In Y. S. Lincoln & N. K. Denzin (Eds.), *Turning points in qualitative research: Tying knots with a handkerchief*, (pp. 143–168). AltaMira Press. http://bit.ly/38EtNJh

Gilday, J., Chantler, T., Gray, N., Treacy-Wong, V., Yillia, J., Pascal Gbla, A., Howard, N., & Stringer, B. (2018). The role of pediatric nursing in the provision of quality care in humanitarian settings: A qualitative study in Tonkolili District, Sierra Leone. *Innovational Journal of Nursing and Research, 4*(4), 240–249.

Girard, F., Linton, N., & Besner, J. (2005). Professional practice in nursing: A framework. *Journal of Nursing Leadership, 18*(2).

Global Humanitarian Assistance. (2015). *Humanitarian assistance from non-state donors*. http://www.globalhumanitarianassistance.org/wp-content/uploads/2014/05/Humanitarian-assistance-from-non-state-donors-2014.pdf

Gold, R. L. (1958). Roles in sociological field observation. *Social Forces, 36*(3), 217–213.

Goldman, N., & Trimmer, K. (2019). Towards a culturally inclusive model of care: Quality practice and care through the lens of a practising nurse. In K. Trimmer, T. Newman, & F. F. Padró (Eds.), *Ensuring quality in professional education* (Vol. 1, pp. 123–149). Springer.

Gordon, D. (2010). Determinants of health equity in developing nations. *Social Alternatives, 29*(2), 28–33.

Gormley, K. J. (1996). Altruism: A framework for caring and providing care. *International Journal of Nursing Studies, 33*(6), 581–588. https://doi.org/10.1016/s0020-7489(96)00013-2

Gottman, J. (2018). *The seven principles for making marriage work*. Hachette UK.

Gray, J. R., Grove, S. K., & Sutherland, S. (2016). *Burns and Grove's the practice of nursing research-e-book: Appraisal, synthesis, and generation of evidence*. Elsevier Health Sciences.

Gray, P., & Thomas, D. J. (2006). Critical reflections on culture in nursing. *Journal of Cultural Diversity, 13*(2), 76–82.

Green, T., Green, H., Scandlyn, J., & Kestler, A. (2009). Perceptions of short-term medical volunteer work: A qualitative study in Guatemala. *Global Health, 5*, 4. https://doi.org/10.1186/1744-8603-5-4

Grogan, S. (2016). *Body image: Understanding body dissatisfaction in men, women and children*. Taylor & Francis.

Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. *Educational Technology Research and Development, 30*(4), 233–252.

Haas Stavarski, D. (2018). A descriptive study of how nurses can engender hope. *MEDSURG Nursing, 27*(1).

Haglund, M. M., Kiryabwire, J., Parker, S., Zomorodi, A., MacLeod, D., Schroeder, R., Muhumuza, M., & Merson, M. (2011). Surgical capacity building in Uganda through twinning, technology, and training camps. *World Journal of Surgery, 35*(6), 1175–1182. https://doi.org/10.1007/s00268-011-1080-0

Halcomb, E., Stephens, M., Bryce, J., Foley, E., & Ashley, C. (2017). The development of professional practice standards for Australian general practice nurses. *Journal of Advanced Nursing, 73*(8), 1958–1969. https://doi.org/10.1111/jan.13274

Hamlin, L. (2010). Australian perioperative nurses' humanitarian activities in Banda Aceh. *American Operating Room Nurses Journal, 91*(5), 594–598. https://doi.org/10.1016/j.aorn.2010.02.011

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). Taylor and Francis.

Hancock, K. (2018). Factors that influence organizational culture. In A. M. Beauvais (Ed.), *Leadership and management competence in nursing practice: Competencies, skills, decision-making* (pp. 229–244). Springer Publishing Company.

Hargreaves, J., & Golding, B. (2017). Humanitarian nursing with Médecins Sans Frontières: The dream job. *Health Emergency and Disaster Nursing, 4*(1), 49–56.

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. https://doi.org/10.1016/j.ijnurstu.2009.11.010

Harrowing, J. N., Mill, J., Spiers, J., Kulig, J., & Kipp, W. (2010). Critical ethnography, cultural safety and international nursing research. *International Journal of Qualitative Methods, 9*(3), 240–251.

Harvey, P. (2013). International humanitarian actors and governments in areas of conflict: Challenges, obligations, and opportunities. *Disasters, 37 Suppl 2*, S151–170. https://doi.org/10.1111/disa.12019

Hawkins, V., & Pérache, A. H. (2017). Humanitarian medicine is more than a technical exercise. *The Lancet, 390*(10109), 2226–2228.

Herth, K. A., & Cutcliffe, J. R. (2002). The concept of hope in nursing 6: Research/education/policy/practice. *British Journal of Nursing, 11*(21), 1404–1411. https://doi.org/10.12968/bjon.2002.11.21.12277

Hetherton-Miau, M. (Executive Producer). (2017). *The surgery ship*. [TV Documentary Series 1]. Media Stockade.

Higginbottom, G., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report, 18*(9), 1–6.

Hobart, M. (2000). *After culture: Anthropology as radical metaphysical critique*. Duta Wacana University Press.

Hoffart, N., & Woods, C. Q. (1996). Elements of a nursing professional practice model. *Journal of Professional Nursing, 12*(6), 354–364. https://doi.org/10.1016/s8755-7223(96)80083-4

Hofstede, G. H., Hofstede, G. J., & Minkov, M. (2005). *Cultures and organizations: Software of the mind* (Vol. 2). McGraw-Hill.

Holden, P., & Littlewood, J. (2015). *Anthropology and nursing* (Vol. 1). Routledge.

Holloway, I., & Wheeler, S. (2013). *Qualitative research in nursing and healthcare* (3rd ed.). John Wiley & Sons.

Huberman, M., & Miles, M. B. (2002). Understanding and validity in qualitative research. In A. M. Michael Huberman & M. B. Miles (Eds.), *The qualitative researcher's companion* (pp. 36–64). SAGE Publications, Inc. https://doi.org/10.4135/9781412986274.n2

Hudson, S., & Inkson, K. (2006). Volunteer overseas development workers: The hero's adventure and personal transformation. *Career Development International, 11*(4), 304–320. https://doi.org/10.1108/13620430610672522

Hugelius, K., & Adolfsson, A. (2019). The HOPE model for disaster nursing: A systematic literature review. *International Emergency Nursing, 45*, 1–9. https://doi.org/10.1016/j.ienj.2019.03.007

Hunt, M. R. (2008). Ethics beyond borders: How health professionals experience ethics in humanitarian assistance and development work. *Developing World Bioethics, 8*(2), 59–69. https://doi.org/10.1111/j.1471-8847.2006.00153.x

Hunt, M. R., Schwartz, L., Sinding, C., & Elit, L. (2014). The ethics of engaged presence: A framework for health professionals in humanitarian assistance and development work. *Developing World Bioethics, 14*(1), 47–55. https://doi.org/10.1111/dewb.12013

Idehen, C., & Oshodin, O. (2007). Insights into Benin traditional methods of disease prevention. *Journal of Pan African Studies, 1*(8), 114–119.

Institute of Professional Editors. (2019). *Guidelines for editing research theses*. http://iped-editors.org/About_editing/Editing_theses.aspx

International Council of Nurses. (2012). *The ICN international code of ethics for nurses*. https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf

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), 1–9. https://doi.org/10.1111/j.1365-2648.2007.04412.x

Jacobsen, K. H. (2014). *Introduction to global health*. Jones & Bartlett Publishers.

Johns, C. (Ed.). (2017). *Becoming a reflective practitioner* (5th ed.). John Wiley and Sons.

Johnson, J. C., Avenarius, C., & Weatherford, J. (2006). The active participant-observer: Applying social role analysis to participant observation. *Field methods, 18*(2), 111–134.

Juth, V., Smyth, J. M., & Santuzzi, A. M. (2008). How do you feel? Self-esteem predicts affect, stress, social interaction, and symptom severity during daily life in patients with chronic illness. *Journal of Health Psychology, 13*(7), 884–894. https://doi.org/10.1177/1359105308095062

Käpylä, J., & Kennedy, D. (2014). Cruel to care? Investigating the governance of compassion in the humanitarian imaginary. *International Theory, 6*(2), 255–292. https://doi.org/10.1017/s1752971914000025

Kawulich, B. (2005). Participant observation as a data collection method. *Forum: Qualitative Social Research, 6*(2).

Keen, D., & de Chesnay, M. (2015). State of the art in nursing research using ethnography. In M. de Chesnay (Ed.), *Nursing research using ethnography* (pp. 15–36). Springer.

Kenward, L. J., & Kenward, G. (2015). Experiences of military nurses in Iraq and Afghanistan. *Nursing Standard, 29*(32), 34–39. https://doi.org/10.7748/ns.29.32.34.e9248

Kikuchi, J. F., & Simmons, H. (1994). *Developing a philosophy of nursing*. Sage.

Kim, H. S. (1999). Critical reflective inquiry for knowledge development in nursing practice. *Journal of Advanced Nursing, 29*(5), 1205–1212. https://doi.org/10.1046/j.1365-2648.1999.01005.x

Kim, H. S. (2015). *The essence of nursing practice: Philosophy and perspective*. Springer Publishing Company.

Knoblauch, H. (2005). Focused ethnography. Forum: *Qualitative Social Research 6*(3). https://doi.org/10.17169/fqs-6.3.20

Kohrt, B. A., Mistry, A. S., Anand, N., Beecroft, B., & Nuwayhid, I. (2019). Health research in humanitarian crises: An urgent global imperative. *British Medical Journal (BMJ) Global Health, 4*(6), e001870. https://doi.org/10.1136/bmjgh-2019-001870

Koplan, J. P., Bond, T. C., Merson, M. H., Reddy, K. S., Rodriguez, M. H., Sewankambo, N. K., Wasserheit, J. N., & Consortium of Universities for Global Health Executive, B. (2009). Towards a common definition of global health. *Lancet, 373*(9679), 1993–1995. https://doi.org/10.1016/S0140-6736(09)60332-9

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Kroeber, A. L., & Kluckhohn, C. (1952). Culture: A critical review of concepts and definitions. *Papers. Peabody Museum of Archaeology & Ethnology, Harvard University, 47*(1), 223.

Lagrew, J., Lujan, E., Nelson, S. C., Hauff, N. M., Kaesberg, J. L., Lambert, M. E., Riffenburgh, R., Provencher, M. T., & Douglas, T. D. (2012). Pacific partnership 2010: Anesthesia support aboard the USNS Mercy humanitarian civic assistance. *Military Medicine, 177*(8), 939–946. https://doi.org/10.7205/milmed-d-12-00044

Lal, S., & Spence, D. (2016). Humanitarian nursing in developing countries: A phenomenological analysis. *Journal of Transcultural Nursing, 27*(1), 18–24. https://doi.org/10.1177/1043659614536585

Laleman, G., Kegels, G., Marchal, B., Van der Roost, D., Bogaert, I., & Van Damme, W. (2007). The contribution of international health volunteers to the health workforce in sub-Saharan Africa. *Human Resources for Health, 5*, 19. https://doi.org/10.1186/1478-4491-5-19

Lambert, V., Glacken, M., & McCarron, M. (2011). Employing an ethnographic approach: Key characteristics. *Nurse Researcher, 19*(1), 17–24. https://doi.org/10.7748/nr2011.10.19.1.17.c8767

Langowski, M. K., & Iltis, A. S. (2011). Global health needs and the short-term medical volunteer: Ethical considerations. *HEC Forum, 23*(2), 71–78. https://doi/10.1007/s10730-011-9158-5

Lanier, S. A. (2000). *Foreign to familiar: A guide to understanding hot-and cold-climate cultures*. McDougal Pub.

Larter, D. (2020, April 1). *The US Navy's hospital ships in the COVID-19 fight badly need replacing*. Defense News. https://www.defensenews.com/naval/2020/04/01/the-us-navys-hospital-ships-in-the-covid-19-fight-badly-need-replacing/

Lasker, J. N., Aldrink, M., Balasubramaniam, R., Caldron, P., Compton, B., Evert, J., Loh, L. C., Prasad, S., & Siegel, S. (2018). Guidelines for responsible short-term global health activities: Developing common principles. *Global Health, 14*(1), 18. https://doi.org/10.1186/s12992-018-0330-4

Laugharne, C. (1995). Ethnography: Research method or philosophy? *Nurse Researcher, 3*(2), 45–54.

Lave, J. (1991). Situating learning in communities of practice. In J. Lave & E. Wenger (Eds.), *Situated learning: Legitimate peripheral participation.* Cambridge University Press.

LeCompte, M. D. (1987). Bias in the biography: Bias and subjectivity in ethnographic research. *Anthropology & Education Quarterly, 18*(1), 43–52.

Leffers, J., & Plotnick, J. (2011). *Volunteering at home and abroad: The essential guide for nurses*. Sigma Theta Tau International.

Leininger, M. (1985). *Qualitative research methods in nursing*. Grune and Stratton.

Leininger, M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly, 1*, 152–160. https://doi.org/10.1177/089431848800100408

Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research and practices* (2nd ed.). McGraw-Hill.

Leslie, M., Paradis, E., Gropper, M. A., Reeves, S., & Kitto, S. (2014). Applying ethnography to the study of context in healthcare quality and safety. *British Medical Journal (BMJ) Quality & Safety, 23*(2), 99–105. https://doi.org/10.1136/bmjqs-2013-002335

Licina, D. (2013). Hospital ships adrift? Part 1: A systematic literature review characterizing US Navy hospital ship humanitarian and disaster response, 2004–2012. *Prehospital Disaster Medicine, 28*(3), 230–238. https://doi.org/10.1017/S1049023X13000149

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 75). Sage.

Long, W. M. (2000). *Health, healing and Gods kingdom*. Regnum Books International.

Lukose, A. (2011). Developing a practice model for Watson's theory of caring. *Nursing Science Quarterly, 24*(1), 27–30. https://doi.org/10.1177/0894318410389073

Mahn, M., Maung, C., Shwe Oo, E. K., Smith, L., Lee, C. I., Whichard, E., Neumann, C., Richards, A. K., Mullany, L. C., Kuiper, H., & Lee, T. J. (2008). Multi-level partnerships to promote health services among internally displaced in eastern Burma. *Global Public Health, 3*(2), 165–186. https://doi.org/10.1080/17441690801942821

Mariano, C. (2007). Holistic nursing as a specialty: Holistic nursing—scope and standards of practice. *Nursing Clinics of North America, 42*(2), 165–188.

Martiniuk, A. L., Manouchehrian, M., Negin, J. A., & Zwi, A. B. (2012). Brain Gains: A literature review of medical missions to low and middle-income countries. *BMC Health Services Research, 12*(1), 134. https://doi.org/10.1186/1472-6963-12-134

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396.

Matua, G., & Locsin, R. (2016). Like a moth to a flame: Ebola and the culture of caregiving in Sub-Saharan Africa. In M. A. Ray (Ed.), *Transcultural caring dynamics in nursing and health care* (2 ed., pp. 352–373). FA Davis.

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. https://doi.org/10.1016/j.nedt.2008.10.011

McDermott-Levy, R., Leffers, J., & Mayaka, J. (2018). Ethical principles and guidelines of global health nursing practice. *Nursing Outlook, 66*(5), 473–481. https://doi.org/10.1016/j.outlook.2018.06.013

McGowan, C. R., Baxter, L., Deola, C., Gayford, M., Marston, C., Cummings, R., & Checchi, F. (2020). Mobile clinics in humanitarian emergencies: A

systematic review. *Conflict and Health, 14*(1), 4. https://doi.org/10.1186/s13031-020-0251-8

McKenna, H., Pajnkihar, M., & Murphy, F. (2014). *Fundamentals of nursing models, theories and practice, with Wiley e-text*. John Wiley & Sons.

Meara, J. G., Leather, A. J. M., Hagander, L., Alkire, B. C., Alonso, N., Ameh, E. A., Bickler, S. W., Conteh, L., Dare, A. J., Davies, J., Mérisier, E. D., El-Halabi, S., Farmer, P. E., Gawande, A., Gillies, R., Greenberg, S. L. M., Grimes, C. E., Gruen, R. L., Ismail, E. A., Kamara, T. B., & Yip, W. (2015). Global Surgery 2030: Evidence and solutions for achieving health, welfare, and economic development. *The Lancet, 386*(9993), 569–624. https://doi.org/10.1016/s0140-6736(15)60160-x

Mensik, J. S., Maust Martin, D., Scott, K. A., & Horton, K. (2011). Development of a professional nursing framework: The journey toward nursing excellence. *Journal of Nursing Administration, 41*(6), 259–264. https://doi.org/10.1097/NNA.0b013e31821c460a

Mercy Ships. (n.d.-a). *Ships of mercy. Floating hospitals. Vessels of hope.* Mercy Ships. http://www.mercyships.org/who-we-are/our-ships/

Mercy Ships. (n.d.-b). *Who we are. Our mission.* Mercy Ships. https://www.mercyships.org/who-we-are/our-mission/

Mercy Ships. (n.d.-c). *Volunteer guidebook*. Mercy Ships. https://mercyships.org.au/wp-content/uploads/2017/03/Mercy-Ships-Volunteer-Guidebook.pdf

Mercy Ships. (n.d.- d). *Who we are. Our ships. Africa Mercy.* Mercy Ships. https://www.mercyships.org/who-we-are/our-ships/the-africa-mercy/

Mercy Ships. (n.d.-e). *Surgical procedures.* Mercy Ships. https://www.mercyships.org/what-we-do/surgical-procedures/

Michael, M., & Zwi, A. B. (2002). Oceans of need in the desert: Ethical issues identified while researching humanitarian agency response in Afghanistan. *Developing World Bioethics, 2*(2), 109–130. https://doi.org/10.1111/1471-8847.00045

Mickan, S. M. (2005). Evaluating the effectiveness of health care teams. *Australian Health Review, 29*(2), 211–217. https://doi.org/10.1071/ah050211

Mitchell, K. B., Balumuka, D., Kotecha, V., Said, S. A., & Chandika, A. (2012). Short-term surgical missions: Joining hands with local providers to ensure sustainability. *South African Journal of Surgery, 50*(1), 2.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Journal of Clinical Epidemiology, 62*(10), 1006–1012.

Momani, N., & Alzaghal, M. (2018). Volunteers in disaster relief in zones of armed conflict: The case of Syrian refugee camps in Jordan. *Information & Security: An International Journal, 40*(2), 181–188. https://doi.org/10.11610/isij.4013

Moody, R. C., & Pesut, D. J. (2006). The motivation to care: Application and extension of motivation theory to professional nursing work. *Journal of Health Organization and Management, 20*(1), 15–48. https://doi.org/10.1108/14777260610656543

Morrison, S. M., & Symes, L. (2011). An integrative review of expert nursing practice. *Journal of Nursing Scholarship, 43*(2), 163–170. https://doi.org/10.1111/j.1547-5069.2011.01398.x

Morse, J. M. (Ed.). (1994). *Critical issues in qualitative research methods*. Sage Publications.

Morse, J. M., & Doberneck, B. (1995). Delineating the concept of hope. *Image: the Journal of Nursing Scholarship, 27*(4), 277–285. https://doi.org/10.1111/j.1547-5069.1995.tb00888.x

Moseley, A. (n.d.). Philosophy of love. In J. Fieser & B. Dowden (Eds.), *The internet encyclopedia of philosophy.* Retrieved 20 December 2020 from https://www.iep.utm.edu/love

Murphy, K., & Clark, J. M. (1993). Nurses' experiences of caring for ethnic-minority clients. *Journal of Advanced Nursing, 18*(3), 442–450. https://doi.org/10.1046/j.1365-2648.1993.18030442.x

Muskett, S. (2019). *CHANNGE: A professional practice model for neonatal nurse practitioners who provide short-term humanitarian aid in low-to-middle income countries.* Creighton University. http://dspace.creighton.edu:8080/xmlui/handle/10504/121431

Myers, B. L. (1999). *Walking with the poor: Principles and practices of transformational development.* Orbis Books.

Myers, B. L. (2011). *Walking with the poor: Principles and practices of transformational development* (2nd ed.). Orbis Books.

Naiker, S., Plange-Rhule, J., Tutt, R., & Eastwood, J. B. (2009). Shortage of health care workers in developing countries: Africa. *Ethnicity and Disease, 19*(S1), 60–64.

Nakamura, J., & Csikszentmihalyi, M. (2009). Flow theory and research. In S. J. Lopez & C. R. Snyder (Eds.), *The Oxford handbook of positive psychology* (2nd ed, pp. 195–206). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195187243.013.0018

National Health and Medical Research Council. (2007, 2015). *Australian national statement on ethical conduct in human research*. NHMRC.

https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research

National Health and Medical Research Council. (2018a). *Australian code for the responsible conduct of research*. Australian Government. https://www.nhmrc.gov.au/about-us/publications/australian-code-responsible-conduct-research-2018

National Health and Medical Research Council. (2018b). *Section 1: values and principles of ethical conduct*. Australian Government. https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018#toc__95

Newbanks, R. S., Rieg, L. S., & Schaefer, B. (2018). What is caring in nursing? Sorting out humanistic and Christian perspectives. *Journal of Christian Nursing, 35*(3), 160–167. https://doi.org/10.1097/CNJ.0000000000000441

Ng-Kamstra, J. S., Riesel, J. N., Arya, S., Weston, B., Kreutzer, T., Meara, J. G., & Shrime, M. G. (2016). Surgical non-governmental organizations: Global surgery's unknown nonprofit sector. *World Journal of Surgery, 40*(8), 1823–1841. https://doi.org/10.1007/s00268-016-3486-1

Ng'ang'a, N., & Byrne, M. W. (2015). Professional practice models for nurses in low-income countries: An integrative review. *BMC Nursing, 14*(44), 44. https://doi.org/10.1186/s12912-015-0095-5

Nielsen, C. (Executive Story Editor) & McCairley, K. (Producer). (2010). *Mighty ships Africa Mercy* (Season 3, Episode 5) [TV Series]; Exploration Productions

Nightingale, F. (1993). *Notes on nursing: What it is, and what it is not* (1st ed.). Lippincott Williams & Wilkins.

Nilsson, S., Sjöberg, M., Kallenberg, K., & Larsson, G. (2011). Moral stress in international humanitarian aid and rescue operations: A grounded theory study. *Ethics & Behavior, 21*(1), 49–68, Article Pii 933045037. https://doi.org/10.1080/10508422.2011.537570

Nolan, M., Nolan, J., & Grant, G. (1995). Maintaining nurses' job satisfaction and morale. *British Journal of Nursing, 4*(19), 1149–1154. https://doi.org/10.12968/bjon.1995.4.19.1149

O'Reilly, K. (2012). *Ethnographic methods* (2nd ed.). Routledge.

Oberholster, A. J., Clarke, R., Bendixen, M., & Dastoor, B. (2013). Expatriate motivation in religious and humanitarian non-profit-organizations. *Journal of Global Mobility: The Home of Expatriate Management Research, 1*(1), 7–27. https://doi.org/10.1108/jgm-09-2012-0007

Offutt, S. (2012). New directions in transformational development. *The Asbury Journal, 67*(2), 35–50. https://doi.org/10.7252/Journal.01.2012F.03

Omoto, A. M., Malsch, A. M., & Barraza, J. A. (2009). Compassionate acts: Motivations for and correlates of volunteerism among older adults. In B. Fehr, S. Sprecher, & L. G. Underwood (Eds.), *The science of compassionate love: Theory, research, and applications* (pp. 257–282). Blackwell Publishing https://doi.org/10.1002/9781444303070.ch9

Ortiz, M. R. (2016). Professional practice models: A way to guide the leading-following process. *Nursing Science Quarterly, 29*(4), 334–335. https://doi.org/10.1177/0894318416662927

Panosian, C., & Coates, T. (2006). The new medical "missionaries": Grooming the next generation of global health workers. *The New England Journal of Medicine, 354*(17), 1771–1773.

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal of Qualitative Health Care, 8*(5), 491–497. https://doi.org/10.1093/intqhc/8.5.491

Parfitt, B. (1994). Value orientations of expatriate nurses in the developing countries. *International Journal of Nursing Studies, 31*(3), 279–288. https://doi.org/10.1016/0020-7489(94)90054-x

Parse, R. R. (1999). *Hope: An international human becoming perspective*. Jones and Bartlett.

Paxton, P., Reith, N. E., & Glanville, J. L. (2014). Volunteering and the dimensions of religiosity: A cross-national analysis. *Review of Religious Research, 56*(4), 597–625.

Penz, K., & Duggleby, W. (2011). Harmonizing hope: A grounded theory study of the experience of hope of registered nurses who provide palliative care in community settings. *Palliative and Supportive Care, 9*(3), 281–294. https://doi.org/10.1017/S147895151100023X

Persky, G. J., Nelson, J. W., Watson, J., & Bent, K. (2008). Creating a profile of a nurse effective in caring. *Nursing Administration Quarterly, 32*(1), 15–20. https://doi.org/10.1097/01.NAQ.0000305943.46440.77

Peter, E., Mohammed, S., & Simmonds, A. (2015). Sustaining hope as a moral competency in the context of aggressive care. *Nursing Ethics, 22*(7), 743–753. https://doi.org/10.1177/0969733014549884

Pezzella, A. T. (2006). Volunteerism and humanitarian efforts in surgery. *Current Problems in Surgery, 43*(12), 848–929. https://doi.org/10.1067/j.cpsurg.2006.09.002

Pfeiffer, J. (2003). International NGOs and primary health care in Mozambique: The need for a new model of collaboration. *Social Science & Medicine, 56*(4), 725–738. https://doi.org/10.1016/s0277-9536(02)00068-0

Pole, C., & Morrison, M. (2003). *Ethnography for education*. Open University Press.

Prawat, R. S., & Floden, R. E. (1994). Philosophical perspectives on constructivist views of learning. *Educational Psychologist, 29*(1), 37–48.

Project HOPE. (n.d.). *Our history*. Project HOPE. https://www.projecthope.org/about-us/history/

Raatikainen, R. (1997). Nursing care as a calling. *Journal of Advanced Nursing, 25*(6), 1111–1115. https://doi.org/10.1046/j.1365-2648.1997.19970251111.x

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu.* Victoria University of Wellington.

Rashid, M., Caine, V., & Goez, H. (2015). The encounters and challenges of ethnography as a methodology in health research. *International Journal of Qualitative Methods, 14*(5). https://doi.org/10.1177/1609406915621421

Rasori, A. (2019). The role of nurses in humanitarian medicine: Three educational strategies for sustainable short term medical volunteer trips. *International Journal of Nursing, 6*(1), 135–140.

Rees, C., & Joslyn, S. (1998). The importance of hope. *Nursing Standard, 12*(41), 34–35. https://doi.org/10.7748/ns.12.41.34.s37

Reeves, S., Kuper, A., & Hodges, B. D. (2008). Qualitative research methodologies: Ethnography. *British Medical Journal, 337*, a1020. https://doi.org/10.1136/bmj.a1020

Reeves, S., Peller, J., Goldman, J., & Kitto, S. (2013). Ethnography in qualitative educational research: AMEE Guide No. 80. *Medical Teacher, 35*(8), e1365–1379. https://doi.org/10.3109/0142159X.2013.804977

Remen, R. N. (2002). *Kitchen table wisdom: Stories that heal* (2nd ed.). Pan Macmillan.

Richards, L., & Morse, J. (2013). *Read me first for a users guide to qualitative methods* (3rd ed.). Sage.

Rickard, D. (2013). Los Angeles native, Dr. Gary Parker, honored by the AAOMS for 25+ years of service on the world's largest private floating hospital ship [announcement]. *Oral Surgery, Oral Medicine, Oral Pathology and Oral Radiology, 115*(1), 140–141. https://doi.org/10.1016/s2212-4403(12)01720-8

Robbins, B. D. (2016). The heart of humanistic psychology: Human dignity disclosed through a hermeneutic of love. *Journal of Humanistic Psychology, 56*(3), 223–237.

Roche, C., & Madvig, A. (2016). *Working towards transformational development and the Sustainable Development Goals.* ACFID National Conference.

https://acfid.asn.au/blog-post/working-towards-transformational-development-and-sustainable-development-goals

Roche, S. D., Ketheeswaran, P., & Wirtz, V. J. (2017). International short-term medical missions: A systematic review of recommended practices. *International Journal of Public Health, 62*(1), 31–42. https://doi.org/10.1007/s00038-016-0889-6

Rohrich, R. J., Hamilton, K. L., Avashia, Y., & Savetsky, I. (2020). The COVID-19 pandemic: Changing lives and lessons learned. *Plastic and Reconstructive Surgery, 8*(4), e2854-e2854. https://doi.org/10.1097/GOX.0000000000002854

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Sage.

Rosa W. E. (2017). Exploring the global applicability of holistic nursing. *Journal of Holistic Nursing, 35*(1), 7–9. https://doi.org/10.1177/0898010117692672

Rosa, W. E., Dossey, B. M., Watson, J., Beck, D. M., & Upvall, M. J. (2019). The United Nations sustainable development goals: The ethic and ethos of holistic nursing. *Journal of Holistic Nursing, 37*(4), 381–393. https://doi.org/10.1177/0898010119841723

Ruiter, S., & De Graaf, N. D. (2006). National context, religiosity, and volunteering: Results from 53 countries. *American Sociological Review, 71*(2), 191–210.

Rytterstrom, P., Cedersund, E., & Arman, M. (2009). Care and caring culture as experienced by nurses working in different care environments: A phenomenological-hermeneutic study. *International Journal of Nursing Studies, 46*(5), 689–698. https://doi.org/10.1016/j.ijnurstu.2008.12.005

Sandiford, P. J. (2015). Participant observation as ethnography or ethnography as participant observation in organizational research. In K. D. Strang (Ed.), *The Palgrave handbook of research design in business and management* (pp. 411–446). Palgrave Macmillan.

Saran, A., White, H., & Kuper, H. (2019). PROTOCOL: Effectiveness of interventions for people with disabilities in low- and middle-income countries—an evidence and gap map. *Campbell Systematic Reviews, 15*(1–2). https://doi.org/10.1002/cl2.1006

Savage, J. (2000). Ethnography and health care. *British Medical Journal, 321*(7273), 1400–1402. https://doi.org/10.1136/bmj.321.7273.1400

Schneider, K. (2012). International disaster relief: The Haiti experience. *Clinical Pediatric Emergency Medicine, 13*(1), 6–11. https://doi.org/10.1016/j.cpem.2011.12.006

Schneider, Z., & Whitehead, D. (Eds.). (2013). *Nursing and midwifery research: Methods and appraisal for evidence based practice* (4th ed.). Mosby Elsevier.

Sea Mercy. (2018). *2020 FHCC Program (South Pacific).* SeaMercy.org. http://www.seamercy.org/FHCC

Shein, E. (1990). Organizational culture. *American Psychologist, 45*, 109–119.

Shelly, J. A., & Miller, A. B. (2009). *Called to care: A Christian worldview for nursing*. InterVarsity Press.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63–75.

Sherraden, M. S., Lough, B., & McBride, A. M. (2008). Effects of international volunteering and service: Individual and institutional predictors. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations, 19*(4), 395–421. https://doi.org/10.1007/s11266-008-9072-x

Shields, L. (2005). The nursing shortage and developing countries: An ethical dilemma. *Journal of Clinical Nursing, 14*(7), 787–788. https://doi.org/10.1111/j.1365-2702.2005.01257.x

Shrime, M. G., Sleemi, A., & Ravilla, T. D. (2015). Charitable platforms in global surgery: A systematic review of their effectiveness, cost-effectiveness, sustainability, and role training. *World Journal of Surgery, 39*(1), 10–20. https://doi.org/10.1007/s00268-014-2516-0

Shrubsole, J. (2010). A call to Christian health ministry: Being God's agent. *International Journal of Human Caring, 14*(3), 21–27.

Silverstein, W., & Kowalski, M. O. (2017). Adapting a professional practice model. *American Nurse Today, 12*(9), 78–83.

Slatyer, S., Coventry, L. L., Twigg, D., & Davis, S. (2016). Professional practice models for nursing: A review of the literature and synthesis of key components. *Journal of Nursing Management, 24*(2), 139–150. https://doi.org/10.1111/jonm.12309

Sloand, E., Ho, G., Klimmek, R., Pho, A., & Kub, J. (2012). Nursing children after a disaster: A qualitative study of nurse volunteers and children after the Haiti earthquake. *Journal for Specialists in Pediatric Nursing, 17*(3), 242–253. https://doi.org/10.1111/j.1744-6155.2012.00338.x

Smith, S. D., & Smith, K. A. (1995). Perioperative perspective of a United Nations humanitarian mission. *American Operating Room Nurses Journal, 62*(6), 875–883. https://doi.org/10.1016/s0001-2092(06)63555-2

Smith-Miller, C., Leak, A., Harlan, C., Dieckmann, J., & Sherwood, G. (2010). "Leaving the comfort of the familiar": Fostering workplace cultural

awareness through short-term global experiences. *Nursing Forum, 45*(1), 18–28.

Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2017). Hope theory: A member of the positive psychology family. In M. W. Gallagher & S. J. Lopez (Eds.), *The Oxford handbook of hope.* Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199399314.013.3

Sonship. (n.d.). *MEDISONSHIPS: Who we are*. Sonship. https://www.sonship.org.au/what-we-do/

Spence, D. G. (2001). Prejudice, paradox, and possibility: Nursing people from cultures other than one's own. *Journal of Transcultural Nursing, 12*(2), 100–106.

Spence, D. (2003). Nursing people from cultures other than one's own: A perspective from New Zealand. *Contemporary Nurse, 15*(3), 222–231.

Sphere Association. (2018). *Sphere handbook: Humanitarian charter and minimum standards in humanitarian response*. Practical Action Publishing. https://handbook.spherestandards.org/en/sphere/#ch001

Spradley, J. P. (1979). *The ethnographic interview*. Rinehart and Winston.

Stephenson, C. (1991). The concept of hope revisited for nursing. *Journal of Advanced Nursing, 16*(12), 1456–1461. https://doi.org/10.1111/j.1365-2648.1991.tb01593.x

Stevermer, A. C. (2012). International disaster humanitarian assistance for nurses. In M. P. Couig (Ed.), *Annual review of nursing research* (Vol. 30, pp. 209–224). Springer Publishing Company.

Stievano, A., & Tschudin, V. (2019). The ICN code of ethics for nurses: A time for revision. *International Nursing Review, 66*(2), 154–156. https://doi.org/10.1111/inr.12525

Storesund, A., & McMurray, A. (2009). Quality of practice in an intensive care unit (ICU): A mini-ethnographic case study. *Intensive and Critical Care Nursing, 25*(3), 120–127. https://doi.org/10.1016/j.iccn.2009.02.001

Strachota, E., Normandin, P., O'Brien, N., Clary, M., & Krukow, B. (2003). Reasons registered nurses leave or change employment status. *Journal of Nursing Administration, 33*(2), 111–117. https://doi.org/10.1097/00005110-200302000-00008

Strasser, R., Kam, S. M., & Regalado, S. M. (2016). Rural health care access and policy in developing countries. *Annual Review of Public Health, 37*(5), 395–412. https://doi.org/10.1146/annurev-publhealth-032315-021507

Stukas, A. A., Hoye, R., Nicholson, M., Brown, K. M., & Aisbett, L. (2014). Motivations to volunteer and their associations with volunteers' well-

being. *Nonprofit and Voluntary Sector Quarterly, 45*(1), 112–132. https://doi.org/10.1177/0899764014561122

Suominen, T., Kovasin, M., & Ketola, O. (1997). Nursing culture: Some viewpoints. *Journal of Advanced Nursing, 25*, 186–190.

Sussman, N. M. (2000). The dynamic nature of cultural identity throughout cultural transitions: Why home is not so sweet. *Personality and Social Psychology Review, 4*(4), 355–373.

Sykes, K. J. (2014). Short-term medical service trips: A systematic review of the evidence. *American Journal of Public Health, 104*(7), e38–48. https://doi.org/10.2105/AJPH.2014.301983

Talamo, A., Mellini, B., & Barbieri, B. (2017). La documentazione "Il ruolo dei "Locally Designed artifacts" nel lavoro infermieristico: uno studio etnografico in reparto [The role of locally-designed organizational artifacts in supporting nurses' work: An ethnographic study on the wards]. *Professioni Infermieristiche, 70*(2), 115–125. https://doi.org/10.7429/pi.2017.702115

Tassell, N., & Flett, R. (2011). Motivation in humanitarian health workers: A self-determination theory perspective. *Development in Practice, 21*(7), 959–973. https://doi.org/10.1080/09614524.2011.590889

Tavares de Souza, M., Dias da Silva, M., & de Carvalho, R. (2010). Integrative review: What is it? How to do it? *Einstein (São Paulo) [online], 8*(1), 102–106.

The Lancet. (2020). Humanitarian crises in a global pandemic [Editorial]. *Lancet, 396*(10249), 447. https://doi.org/10.1016/S0140-6736(20)31749-9

The World Bank. (2021). *Understanding poverty*. The World Bank. https://www.worldbank.org/en/understanding-poverty

Theofanidis, D., & Fountouki, A. (2008). Nursing theory: A discussion on an ambiguous concept. *International Journal of Caring Sciences, 1*(1), 15–20.

Thorne, S. (1997). Global consciousness in nursing: An ethnographic study of nurses with an international perspective. *Journal of Nursing Education, 36*(9), 437–442.

Thorne, S. (2000). Data analysis in qualitative research. *Evidence-Based Nursing, 3*, 68–70.

Timboe, H. L., & Holt, G. R. (2006). Project HOPE volunteers and the Navy Hospital Ship Mercy. *Military Medicine, 171*(10 Suppl 1), 34–36. https://doi.org/10.7205/milmed.171.1s.34

Tjoflat, I., Karlsen, B., & Saetre Hansen, B. (2016). Working with local nurses to promote hospital-nursing care during humanitarian assignments overseas: Experiences from the perspectives of nurses. *Journal of Clinical Nursing, 25*(11–12), 1654-1662. https://doi.org/10.1111/jocn.13182

Torraco, R. J. (2016). Writing integrative literature reviews: Guidelines and examples. *Human Resource Development Review, 4*(3), 356–367. https://doi.org/10.1177/1534484305278283

Trelles, M., Dominguez, L., & Stewart, B. T. (2015). Surgery in low-income countries during crisis: Experience at Médecins Sans Frontières facilities in 20 countries between 2008 and 2014. *Tropical Medicine & International Health, 20*(8), 968–971. https://doi.org/10.1111/tmi.12523

Troeger, C., Blacker, B. F., Khalil, I. A., Rao, P. C., Cao, S., Zimsen, S. R., Albertson, S. B., Stanaway, J. D., Deshpande, A., & Abebe, Z. (2018). Estimates of the global, regional, and national morbidity, mortality, and aetiologies of diarrhoea in 195 countries: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet Infectious Diseases, 18*(11), 1211–1228.

Truter, I. (2007). African traditional healers: Cultural and religious beliefs intertwined in a holistic way. *South African Pharmaceutical Journal, 74*(8), 56–60.

Tschudin, V., & Davis, A. J. (Eds.). (2008). *The globilisation of nursing*. Radcliff Publishing.

Tutton, E., Seers, K., & Langstaff, D. (2009). An exploration of hope as a concept for nursing. *Journal of Orthopaedic Nursing, 13*(3), 119–127. https://doi.org/10.1016/j.joon.2009.07.006

United Nations. (n.d.). *Sustainable development goals agenda*. United Nations. https://www.un.org/sustainabledevelopment/development-agenda/

United Nations. (2015). *Deliver humanitarian aid*. United Nations. http://www.un.org/en/sections/what-we-do/deliver-humanitarian-aid/index.html

United Nations. (2020). *The Sustainable Development Goals Report 2020*. United Nations. https://unstats.un.org/sdgs/report/2020/The-Sustainable-Development-Goals-Report-2020.pdf

United Nations Development Programme. (2019). *Overview: Human Development Report 2019*. UNDP. http://hdr.undp.org/sites/default/files/hdr_2019_overview_-_english.pdf

United Nations Development Programme. (2020). *Human development reports: Data*. UNDP. http://hdr.undp.org/en/content/latest-human-development-index-ranking

University of Technology Sydney. (n.d.). Research Ethics and Integrity Policy. https://gsu.uts.edu.au/policies/research-ethics-integrity-policy.html

Upvall, M., & Leffers, J. (Eds.). (2014). *Global health nursing: Building and sustaining partnerships*. Springer.

Upvall, M., Leffers, J., & Mitchell, E. M. (2014). Introduction and perspectives on global health. In M. Upvall & J. Leffers (Eds.), *Global health nursing* (p. 6). Springer.

van der Geest, S., & Finkler, K. (2004). Hospital ethnography: Introduction. *Social Science & Medicine, 59*(10), 1995–2001. https://doi.org/10.1016/j.socscimed.2004.03.004

VanRooyen, M. J., Hansch, S., Curtis, D., & Burnham, G. (2001). Emerging issues and future needs in humanitarian assistance. *Prehospital Disaster Medicine, 16*(4), 216–222. https://doi.org/10.1017/s1049023x00043338

Wall, S. S. (2015). Focused ethnography: A methodological adaptation for social research in emerging contexts. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 16*(1).

Wallace, D. (1996). Experiential learning and critical thinking in nursing. *Nursing Standard, 10*(31), 43–47. https://doi.org/10.7748/ns.10.31.43.s49

Walsh, D. S. (2004). A framework for short-term humanitarian health care projects [Article]. *International Nursing Review 51*(1), 23–26. https://doi.org/10.1111/j.1466-7657.2003.00203.x.

Watson, M. J. (1988). New dimensions of human caring theory. *Nursing Science Quarterly, 1*(4), 175–181. 1 https://doi.org/0.1177/089431848800100411

Watson, J. (1979). *Nursing: The Philosophy and Science of Caring*. Little, Brown and Company.

Watson, J. (1999). *Nursing: Human science and human care: A theory of nursing*. Jones and Bartlett.

Watson, J. (2013). Nursing: The philosophy and science of caring (rev. ed.). In M. C. Smith, M. C. Turkel, & Z. R. Wolf (Eds.) *Caring in nursing classics: An essential resource*, 243–264. Springer Publishing Company.

Watson, J., & Turkel, M. (2010). Measuring the caritas processes: Caring factor survey. *International Journal for Human Caring, 14*(3), 15–20.

Wegner, R. A., Boal, A., Walters, L., Thomas, T., Wells, E., Griswold, J., & Oravec, D. G. (2010). Bringing comfort to Haiti. *Plastic Surgical Nursing, 30*(3), 133–149; quiz 150–131. https://doi.org/10.1097/PSN.0b013e3181ee16ce

Weiner, E. (2011). Research issues for nursing and midwifery contributions in emergencies. *Prehospital Disaster Medicine, 26*(2), 109–113. https://doi.org/10.1017/S1049023X11000124

Wenger, E., McDermott, R., & Snyder, W. M. (2002). *Cultivating communities of practice*. Harvard Business School Press.

Wenger, E., & Traynor, B. (2015). *Introduction to communities of practice: A brief overview of the concept and its uses*. https://wenger-trayner.com/introduction-to-communities-of-practice/

Werker, E., & Ahmed, F. Z. (2008). What do nongovernmental organizations do? *Journal of Economic Perspectives, 22*(2), 73–92.

White, K. (2002). Nursing as vocation. *Nursing Ethics, 9*(3), 279–290.

White, M. C., & Close, K. (2016). Lasting impact: Insights from a surgical mission-based mentoring training programme in the Republic of Congo. *British Medical Journal (BMJ) Global Health, 1*(3), e000102. https://doi.org/10.1136/bmjgh-2016-000102

White, M. C., Linz, P. E., & McColl, I. (2020). The need for safe, affordable, timely surgical care in low-income countries. *International Journal of Surgery: Global Health, 3*(1), e11. https://doi.org/10.1097/gh9.0000000000000011

White, M. C., Peterschmidt, J., Callahan, J., Fitzgerald, J. E., & Close, K. L. (2017). Interval follow up of a 4-day pilot program to implement the WHO surgical safety checklist at a Congolese hospital. *Globalization and Health, 13*(1), 42.

Whitehead, J., & Wheeler, H. (2008). Patients' experiences of privacy and dignity. Part 1: A literature review. *British Journal of Nursing, 17*(6), 381–385. https://doi.org/10.12968/bjon.2008.17.6.28904

Whitehead, T. L. (2005). Basic classical ethnographic research methods. *Cultural Ecology of Health Change, 1*, 1–29. https://tony-whitehead.squarespace.com/s/Classical-Basic-Ethnographic-Methods-58ez.pdf.

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies, 47*(6), 761–769. https://doi.org/10.1016/j.ijnurstu.2009.12.012

Withers, M., Browner, C. H., & Aghaloo, T. (2013). Promoting volunteerism in global health: Lessons from a medical mission in northern Mexico. *Journal of Community Health, 38*(2), 374–384. https://doi.org/10.1007/s10900-012-9627-z

Wolcott, H. F. (1999). *Ethnography: A way of seeing.* AltaMira Press.

World Health Organization. (2013). *Health literacy: The solid facts* (9289000155). WHO Regional Office for Europe. https://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf

World Health Organization. (2015). *Tracking universal health coverage: First global monitoring report*. World Health Organization. http://www.who.int/healthinfo/universal_health_coverage/report/2015/en

World Health Organization. (2017, December 13). *Newsroom: World Bank and WHO: Half the world lacks access to essential health services, 100 million still pushed into extreme poverty because of health expenses*. World Health Organization. https://www.who.int/news-room/detail/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses

World Health Organization. (2018a). *Delivering quality health services: A global imperative for universal health coverage* (924151390X). World Health Organization. https://apps.who.int/iris/handle/10665/272465

World Health Organization. (2018b). *Primary health care and health emergencies*. World Health Organization. https://apps.who.int/iris/handle/10665/326451

World Health Organization. (2020a). *Basic documents* (49 ed.). World Health Organization. https://apps.who.int/gb/bd/

World Health Organization. (2020b). *Global health observatory: SDG target 3.c—health workforce*. World Health Organization. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-(per-10-000-population)

World Health Organization. (2020c). *Health workforce: Overview*. World Health Organization. https://www.who.int/health-topics/health-workforce#tab=tab_1

World Health Organization. (2020d). *Maternal mortality: Fact sheet*. World Health Organization. https://www.afro.who.int/health-topics/maternal-health

World Health Organization. (2020e). *Nursing and midwifery*. World Health Organization. https://www.who.int/health-topics/nursing#tab=tab_1

World Health Organization. (2020f, June 1). *News release: COVID-19 significantly impacts health services for noncommunicable diseases*. World Health Organization. https://www.who.int/news-room/detail/01-06-2020-covid-19-significantly-impacts-health-services-for-noncommunicable-diseases

World Health Organization and the United Nations Children's Fund (UNICEF). (2020). *Operational framework for primary health care: Transforming vision into action* (9789240017832). World Health Organization. https://www.who.int/publications/i/item/9789240017832

World Telehealth Initiative. (2020). *Our dentistry program is facilitating healthier smiles in Guinea*. World Telehealth Initiative. https://www.worldtelehealthinitiative.org/blog/guinea-program-update

Yan, Y. E., Turale, S., Stone, T., & Petrini, M. (2015). Disaster nursing skills, knowledge and attitudes required in earthquake relief: Implications for nursing education. *International Nursing Review, 62*(3), 351–359. https://doi.org/10.1111/inr.12175

Youth With A Mission (YWAM) Medical Ships. (n.d.). *The ship*. YWAM. https://ywamships.org/medical-ship/the-ship/

Youth With A Mission (YWAM) Ships. (n.d.). *About YWAM ships*. YWAM. https://www.ywamshipskona.org/

Zinsli, G., & Smythe, E. A. (2009). International humanitarian nursing work: Facing difference and embracing sameness. *Journal of Transcultural Nursing, 20*(2), 234–241. https://doi.org/10.1177/1043659608330351

APPENDICES

Appendix A. UTS HREC Approval

HREC Approval Granted - ETH16-0426

Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>
Mon 6/6/2016 11:02 AM

To: Doug Elliott <Doug.Elliott@uts.edu.au>; Sonja Dawson <Sonja.Dawson@student.uts.edu.au>; Research Ethics <research.ethics@uts.edu.au>

Dear Applicant

Thank you for your response to the Committee's comments for your project titled, "An ethnographic study of nursing on board Mercy Ships.". Your response satisfactorily addresses the concerns and questions raised by the Committee who agreed that the application now meets the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007). I am pleased to inform you that ethics approval is now granted.

Your approval number is UTS HREC REF NO. ETH16-0426.

Approval will be for a period of five (5) years from the date of this correspondence subject to the provision of annual reports.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:
* if accessing within the UTS network: https://rm.uts.edu.au
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on " RM6 – Research Master Enterprise " after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
E: Research.Ethics@uts.edu.au

Appendix B. Mercy Ships Institutional Review Board Approval

2 Jun 2016

Mrs Sonja Dawson, RN
Avondale College
Faculty of Arts, Nursing and Theology
185 Fox Valley Rd, Wahroonga, 2076
Australia

Subject: Research proposal entitled "*An ethnographic study of nursing on board Mercy Ships*"

Dear Mrs Dawson,

Your study proposal entitled "An ethnographic study of nursing on board Mercy Ships" has been submitted to the Chairman of the Mercy Ships IRB. After careful review the Mercy Ships IRB has elected to defer judgement to the The University of Technology Sydney ethics panel which has already reviewed and given provisional approval to the study. You are hereby granted consent to conduct the study aboard the Africa Mercy provided that it is conducted as outlined in the study proposal and that you keep the Mercy Ships IRB informed of any changes to the study or study status as approved by the UTS ethics panel.

Permission is granted to proceed with the study. Please submit a copy of any abstracts or manuscripts that may result from this research for our records.

Sincerely,

Peter E. Linz, MD
International Chief Medical Officer

www.mercyships.org • Bringing Hope and Healing...
P.O. Box 2020, 15862 Highway 110 N., Garden Valley, TX 75771-2020 • Tel: 1-903-939-7000 • Fax: 1-903-882-0336

Appendix C. Mercy Ships Information Sheet

INFORMATION SHEET

An Ethnographic Study of Nursing on a Mercy Ship (UTS HREC ETH16_0426)

WHO IS DOING THE RESEARCH?

My name is Sonja Dawson. I am an RN who has previously worked with Mercy Ships for a number of years, and I am currently doing 6 months of service on board the MV Africa Mercy. Concurrently, I am a PhD student at The University of Technology Sydney. My university supervisors are Professor Doug Elliott, Professor Debra Jackson and my field supervisor is Dr Michelle White (Mercy Ships).

WHAT IS THIS RESEARCH ABOUT?

I want to find out about how nurses view and understand their voluntary experiences of working with Mercy Ships. I'm interested in exploring the culture of nursing practice on board the Africa Mercy, including beliefs, perceptions and motivations of volunteer nurses. This may also include identification of any specific skills developed whilst working in this ship-based setting, and factors that favourably contribute to or hinder nursing practice on board. My hope is that results from this study will increase the professional awareness about Mercy Ships amongst the nursing discipline in Australia and internationally. Findings from the study are also expected to make an original and substantial contribution about the volunteer involvement of nurses in humanitarian projects, which to date is only anecdotal in the published literature. It is therefore anticipated that study findings will provide a firm foundation to develop further nursing-related activities and strategic planning for Mercy Ships during their service expansion. Findings may also inform nursing educators and managers in the organisation when orienting staff transitioning into nursing roles on the ship(s) and provide a greater understanding of nurses' behaviour within this unique practice context.

IF I SAY YES, WHAT WILL IT INVOLVE?

You are invited to participate in the research project which will take place from July – December 2016. This involvement will mean one or all of the following:

- letting me observe you as we work together when we are engaged in nursing practice over the course of your volunteer service on board the Africa Mercy. I will collect observations in the form of field notes,
- being part of a focus group of approximately 1 hour that will be audio-recorded and transcribed, and
- participating in a 30-60 minute semi-structured interview that will be audio-recorded and transcribed.

In summary, your contribution to the project will require approximately 2 hours over and above your normal scheduled working time.

ARE THERE ANY RISKS/INCONVENIENCE?

I am required to notify you of possible risks and inconveniences should you agree to take part in the research. There are very few risks because the research has been carefully designed. It is possible that you might experience some feelings of self-consciousness knowing you are being watched. However, being in the study should not pose any additional risk than if you were working on board and satisfying the criteria for accountability in a professional nursing capacity within the health care team. The small risk associated with participating in the interview and focus groups is that you may become aware of emotional thoughts and feelings sharing your experiences, and the possible inconvenience for the time required to contribute to the interview and focus group. Lastly, I need to inform you that it is my ethical responsibility to disclose any information to the nursing leadership on board if there was a breach in your nursing practice

where patient or colleague safety was put at risk. Again, this is no different to the requirement of any RN accountable to the International Nurses Code of Practice. If this was to occur, you would be informed by me before any further action was taken. To meet any of these concerns, counselling is provided by the Chaplain Department on board. You are able to use this service whether you are in the study or not.

CONFIDENTIALITY AND DISCLOSURE INFORMATION

Data collected from you during the research will remain within the confidence of the researcher/s. Confidentiality of individual participants will be assured. Reports will not identify individual volunteers and pseudonyms will be allocated to data. Data will be kept secure in password protected files on the Principal Researcher's computer and stored for five years after completion of the study, when it will be destroyed. In any publication, information will be provided in such a way that participants cannot be identified.

CAN I ACCESS RESULTS?

Yes, you can ask for a summary of the findings on completion of the study by emailing me.

WHY HAVE I BEEN ASKED?

You are a valued team member that is able to give me the information I am seeking because you fit the selection criteria of being an RN working on board the MV Africa Mercy between July and December 2016.

DO I HAVE TO SAY YES?

You don't have to say yes. Your participation in this study is entirely voluntary. There is no payment to nursing staff for participation. Please note that you are free to choose not to take part in this research and you may withdraw at any time without providing a reason. Withdrawing will not disadvantage you in any way during your time on board or in any future engagement with Mercy Ships.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have any inquiries or concerns about the process or should you ever feel disadvantaged in being part of this research, please feel free to discuss these with anyone from the study team as listed below.

1. Sonja Dawson (RN, PhD Candidate) Lecturer in Nursing, Avondale College of Higher Education; volunteer nurse with Mercy Ships from June 2016 - Jan 2017 sonja.dawson@mercyships.org +1 954 538 4422 (International)
2. Professor Doug Elliott (RN, PhD) Professor of Nursing, Faculty of Health, UTS doug.elliott@uts.edu.au + 61 2 9514 4832 (Australia)
3. Professor Debra Jackson (PhD FACN) Director, Oxford Institute of Nursing & Allied Health Research djackson@brookes.ac.uk +44 (0)1865 482736 (United Kingdom)
4. Dr Michelle White (MB ChB, DCH, FRCA) Deputy Chief Medical Officer & Medical Capacity Building Director, Africa Mercy michelle.white@mercyships.org +1 954 538 6110 (International)

If you would prefer to talk to someone who is not connected with the research, you may contact the Research Ethics Officer via Research.Ethics@uts.edu.au, and quote approval number UTS HREC ETH16-0426.

Appendix D. Consent Form

CONSENT FORM

I _____ *(participant's name)* agree to participate in the research project*: An Ethnographic Study of Nursing on a Mercy Ship (UTS HREC ETH16_0426)* being conducted by Sonja Dawson; (contactable at sonja.dawson@mercyships.org and +1 954 538 4422) as part of her Doctor of Philosophy degree at the University of Technology Sydney.

I understand that the purpose of this study is to find out about how nurses view and understand their voluntary experiences of working with Mercy Ships, which involves exploration of the culture of nursing practice on board the MV Africa Mercy, including beliefs, perceptions and motivations of volunteer nurses. This may also include identification of any specific skills developed whilst working in this ship-based setting, and factors that favourably contribute to or hinder nursing practice on board.

I understand that I have been asked to participate in this research because I am a valued team member that fits the selection criteria of being an RN working on board the MV Africa Mercy between July and December 2016. I also understand that my participation in this research will involve observation of my nursing practice whilst working as an RN, being part of a focus group of approximately 1 hour that will be audio-recorded and transcribed, and participating in a 30-60 minute semi-structured interview that will also be audio-recorded and transcribed.

I am aware that I can contact Sonja Dawson or either of her University supervisor(s) Professor Doug Elliott, or Professor Debra Jackson, or her field supervisor Dr Michelle White (Mercy Ships) if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Sonja Dawson has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant)

_____ ____/____/____
Signature (researcher)

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number which is UTS HREC ETH16_0426. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix E. Demographic Data

An ethnographic study of nursing on a Mercy Ship

CLINICAL AREA: _____

1. Age:_____
2. Are you: (please tick as necessary) □ Male □ Female
3. Which country are you from? _____
4. What is your professional background?

   □ Nurse (Registered /Enrolled)

   □ Nurse Midwife

   □ Educator

   □ Clinical Nurse Specialist

   □ Nurse Practitioner

   □ Other (please describe) _____
5. Have you volunteered with Mercy Ships before? Yes □ No □
6. If you answered yes, how many times have you volunteered with Mercy Ships? AFM_____ Other Mercy Ships (circle)

   Island Mercy / Good Samaritan / Caribbean Mercy / Anastasis
7. How many years of experience have you had in health care?

   □ < 1 Year □ 1 - 2 Years □ 2 - 5 Years

   □ 5 - 10 Years □ > 10 < 15 Years □ > 15 Years

Appendix F. Interview Guide

Semi-structured Interview Questions (guide)

1. Can you tell me what 'nursing' is here?
2. Is there anything particular you can identify about clinical nursing in this context?
3. Do you function as a nurse differently here than you do at home?
4. What skills are you using?
5. How might these skills differ from your scope of practice off the ship (at home)?

   Why?
6. What are the joys you have experienced here as a nurse?
7. What are the challenges here working as a nurse?
8. What motivated you to come (first timers)?
9. What motivated you to return (alumni)?
10. Any final comments about anything related to nursing we didn't cover?

Appendix G. A Snapshot of a Morning Shift in D Ward

The following text is an excerpt of field notes taken Aug 18, 2016.

Mariama, 17 years old, has suffered from fibrous dysplasia on her face for the past 5 years and is basically starving to death. She is fragile, underweight, anaemic, and withdrawn. She has a tumour the size of a rockmelon in her mouth, that is impeding her airway and oesophagus. She arrived at the ship, accompanied by her father, wearing a scarf around her head, with an offensive, pungent odour coming from her mouth. She can no longer eat food properly; for the past few months has been pushing rice grains up the side of her mouth, but in the last week, has only been able to take small sips of soup and water through a straw to survive. Her eyes look down, she looks incredibly sad, frightened, and devoid of hope.

Today is the day. Mariama will be operated on to have her tumour removed. Night duty nurses say both her and her father have been awake since 4 am. Her father was Muslim and had been praying on his knees next to her bed. He sleeps on a mattress on the floor next to Mariama's hospital bed. Mariama had had her pre-operative shower earlier and is now sitting on the edge of the bed, dressed in a white hospital gown, that hangs limp. She is visibly anaemic, noticeable on her palms and under her eyes. She has a sign above her bed reminding nurses and translators she cannot eat or drink. But she has an intravenous drip in situ, slowly infusing glucose and electrolytes needed for rehydration. Seven crew members are on standby with her blood type, anticipating being called to the medical laboratory to donate a unit of their precious whole blood to her while she is in theatre, throughout the day. She has already been given two units preoperatively as her haemoglobin was 4.3.

The nurse speaks with Mariama via two translators. The nurse, from Germany, speaks English to the first translator, who relays the message in French to a second translator, who speaks to Mariama's father in Ewe (dialect). Despite the ward being in a morning flurry, she remains quiet and composed. The nurse asks if she needs to use her bladder, as soon, she will be accompanied around to the operating theatre. She says yes. The nurse unhooks her IV fluid from the pole, and walks her across the room to the toilet, rearranges a magnet and hangs the IV bag on it, placed on the toilet cubicle's steel wall. What would we do without magnets!

Change of shift occurs at 7am, and nurses from the night shift and day shift gather in a circle at the desk. The charge nurse beckons the translators over for the start of the shift. Patients know the routine. Mariama quietly moves back to her bed, and the nurse in charge begins by welcoming each crew member to the ward and tells them how grateful she is for each person there. Today is 'Thankful Thursday', and she encourages anyone who wishes to speak out and say what they are grateful for. Five nurses in the circle speak out. The Charge nurse then invites each present to bow their heads and pray for the patients having surgery that day, for those recovering from surgery in the previous days, and for those patients they anticipate will be discharged. Various nurses and translators pray for God to guide the surgeon's hands during Mariama's long surgery and for peace to reign in the operating theatre, for the equipment to function well. Another nurse prays for the MCB team, travelling up country today, for the Galley staff, and for the speedy arrival of an anticipated part to repair the broken coffee machine. After a minute of silence, a nurse leads out with a melody and encourages those that know the words to sing along. "Ascribe greatness to the Lord our God…. His work is perfect, and all His ways are just ..." The moment is holy, quiet, patients and caregivers watch on from their beds. It feels like

peace descended in that moment, and for that moment, nothing else mattered. The genuine and authentic desire of all there for God to guide each one in their tasks that day was noticeable.

Nursing handover starts with each nurse from night duty handing over at the bedside to the individual nurses assigned to each patient. I look over to Mariama's bed. A lonely tear trickles down her face. The nurse caring for her notices too and asks the translator if she is in pain or if she is frightened. The translator answers the nurse without asking the patient. The nurse, getting slightly annoyed, says to the translator "no, please ask her – I want to know from her". The translator obliges, though says she cannot speak for herself due to the tumour, and her father knows her best. The father, listening in, answers and says Mariama is crying because she is happy that today she will finally have the tumour removed and says she will be able to have a new face. He thanks the nurse for her kindness, and the nurse asks the translator to ask Mariama if she can give her a hug. Mariama nods her head, but there is no movement of her mouth or sound – the tumour has taken away that privilege for her to speak. The nurse embraces Mariama. Her father says no one had been close to Mariama for some time, not even her siblings, because of the smell coming from her mouth and they were scared. He said they had tried to get rid of the smell but nothing they used could mask it.

The nurse reminds the translator to tell her that it will not be long until she goes around to the operating theatre, and that when she wakes up, she will be back in her bed. The nurse reminds Mariama about the 'Wong Baker' Pain Scale - holding up the laminated card from the notes. "We don't want you to have pain, so please tell us how you feel when we ask by pointing to the face that shows how you are, ok?" The nurse points to another patient on the other side of the room with a bandage around her face. She says… "you will wake up with that on your face, like her, and probably a mask on your face giving you some oxygen for the first little while. Do you remember, what we talked about last night, you will have a tube in your nose and that will help us give you food and pain medicine until you can swallow again. It's nothing to fear – everyone has it". The patient opposite, overhearing the conversation, and who was from a neighbouring English-speaking country, speaks to Mariama in a local dialect … "These people are good, you will be ok – look at me, I am doing well. Just trust God". The mother of a 3-year-old child who had a salivary gland cyst removed in the next bed nods in agreement. The ward is their new community for this moment in time.

As I observe, I get the sense of how important the testimony of others is in that moment. For Mariama and her father, it is absolute relief that they have an answer to their long suffering, and they can see someone else that has walked through and survived that process.

The nurse caring for Mariama checks her IV line and completes some paperwork in her chart, then moves on to getting medication for her next patient