

**The experience of humanitarian nursing
in developing countries**

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requirements for the degree of Master of Health Science

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma at a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.”

Signed:

Shane Lal

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Abstract

Humanitarian aid work by health care professionals in developing countries has increased in recent years as healthcare professionals become more aware of global inequalities in health. Disaster relief, basic health promotion including immunisation, surgical, medical and military interventions are the major areas in which health professionals engage in the alleviation of suffering and efforts to improve health outcomes.

While much has been documented in literature on the perceptions of healthcare professionals, little has been published internationally on the nature of nurses' experiences of humanitarian work in surgical contexts. This study has explored nurses' experiences of humanitarian work in developing countries. A qualitative descriptive research methodology was selected. Purposive sampling was used to recruit four nurses who had volunteered for humanitarian work from New Zealand. Data comprised taped in-depth conversational interviews and analysis was undertaken using van Manen (1997) methodological steps. Findings revealed that nurses' experience of providing humanitarian aid comprises: feeling anxious, worried and being misunderstood, practising differently and adjusting to life back home. The continued adjusting and readjusting required by such work realises the nurses' potential both personally and professionally.

The findings of this study highlight the need to better prepare nurses who volunteer for humanitarian work in developing countries. Recommendations have therefore been made for recruiting organisations, education, practice and further research. Nurses who have an interest in such work may also benefit from these findings because they offer first-hand experiences that illuminate the nature of humanitarian work in developing countries.

Key to Transcriptions

In presenting the research findings, the following conventions have been adopted within this dissertation:

- Italics:* Identifies the interview data provided by the nurse participants
- Names: with permission of the nurse participants, their individual stories are identified with pseudonyms
- ... Denotes material deleted from the text
- [] indicates insertion of additional material by the researcher, to assist clarity
- () are used in author/ date quotations

The Key Terms used

Humanitarian aid/assistance: Aid to a stricken population that complies with the basic humanitarian principles of humanity, and neutrality (World Health Organisation, 2010)

Developing nation: Countries with lower income average, a relatively undeveloped infrastructure and less industrialization than developed nation (Crigger & Holcomb, 2007)

Donor nation: An act of giving from a country to another as a moral imperative to do good (Thieren, 2007)

Host nation: The country who is the recipient of the services provided by the donor nations (Thieren, 2007)

Chapter One: Study Overview

Introduction

Humanitarian work means volunteering personal and professional skills and time to assist populations in resource-poor countries. Most often this is done out of goodwill by individuals, organisations and/or nations. This dissertation report is the result of a small qualitative study that addresses the question: what is the nursing experience of humanitarian work in developing countries? I have used the terms humanitarian work/humanitarian aid work throughout this study because nurses associate these terms with being away from their usual work context, in a different environment/country and in a voluntary capacity. The terms humanitarian aid work or voluntary work are used interchangeably throughout the literature from Canada, the United Kingdom, the United States, New Zealand and Australia. This chapter focuses on the purpose of the study, the background and context, researcher pre-understandings and establishing the significance of the topic for nursing.

Purpose of the Study

This project was undertaken to more fully understand New Zealand nurses' experiences of humanitarian work in developing countries. Humanitarian nursing work is multifaceted, complex and variable in nature depending on the context. This study seeks to gain understanding of the nature of nurses' work experience to contribute to a greater understanding of humanitarian work. A qualitative methodology informed by the work of van Manen (1997) was used to analyse, interpret and present the study findings.

Background

In the 14th and 15th centuries, missionaries from Western nations travelled to less developed lands with the intention of introducing religion, bringing 'civilization' and

improving the living conditions of ‘natives’ thereby bringing them in line with European standards (Nordlund, 2009). In the current century, wealthy countries, donor groups and religious organizations continue to send volunteer groups to improve standards and resolve conflict in war zones, alleviate the economic burden and reduce health disparities for less developed communities (Dickenson-Hazard, 2004; Heck, Bazemore, & Diller, 2007; Nordlund, 2009; Pezzella, 2006). Humanitarian work includes the multifaceted range of activities undertaken by many civilians, military organisations and health professionals. Most of these individuals or groups adhere strongly to the WHO-UNICEF Alma-Ata principles to attain health outcomes that are acceptable by the impoverished communities (Frossard & Bojarska, 2007; Thieren, 2007).

Most of the humanitarian aid prior to the end of the Cold War focussed on saving lives and alleviating suffering in countries affected by natural disasters (Dufour, De Geoffroy, Maury, & Grunewald, 2004). While this continues to be so, other factors recognised to contribute to inequalities in health are the effects of economic, social and environmental changes that impact on healthcare of developing nations (Pezzella, 2006). The World Health Organisation (WHO), the United Nations (UN), the World Bank (WB), government organisations (GO), non-government organisations (NGO), charitable bodies such as the International Committee of the Red Cross (ICRC) and faith-based organisations are agencies whose contributions and health initiatives have made a positive difference to millions of people (Belger & DeForge, 2007; Bunyavanich & Walkup, 2001; Dufour, et al., 2004; Frossard & Bojarska, 2007; Jayasinghe, 2009; Pezzella, 2006; Ruger, 2005).

Increasing awareness of humanitarian crises in countries such as Rwanda in 1994, has led the developed world to evaluate the delivery of humanitarian aid, standards of care, ethical issues and the rights of recipient populations (Bunyavanich & Walkup, 2001;

Dufour, et al., 2004; Heck, et al., 2007; Jayasinghe, 2009; Thieren, 2007). Other areas of concern relating to humanitarian work and its delivery include its effectiveness, sustainability of services and the imposition of Western values on developing nations (Thieren, 2007). There are now principles and codes of conduct for humanitarian workers involved in the developing world (International Federation of Red Cross and Red Crescent Societies, 1995; Sommers-Flanagan, 2007; Thieren, 2007). The principles and codes of conduct guidelines developed by WHO that honour the principles of impartiality, neutrality and independence are incorporated by many voluntary organisations (Thieren, 2007). Studies have shown that health professionals also strongly adhere to their own professional guidelines when working in challenging circumstances (Crigger & Holcomb, 2007; Hunt, 2008, 2010; Tschudin & Schmitz, 2003).

Global health initiatives have become an important topic of focus in international public health discussions (Bunyavanich & Walkup, 2001). This is raising public awareness about workers whose skills, motivation and professional knowledge have become integral to the delivery of humanitarian services in developing countries. Specialised and other health professionals leading various teams have helped to save many lives and contributed to improved health outcomes for many others. Good intentions and moral obligation to assist people in need are cited as the main reasons for participating in the provision of such care (Pezzella, 2006; Sommers-Flanagan, 2007; Tschudin & Schmitz, 2003). Historically, the highly commendable humanitarian aid provided by nurses in war and poverty stricken areas has been associated with the work of Florence Nightingale and Mother Teresa (Tschudin & Schmitz, 2003). However such work has also been critiqued and labelled “down stream” (Tschudin & Schmitz, 2003, p. 358), drawing attention to the basic and technically absent nature of the care delivered. Increasingly common in current humanitarian work, health care is delivered using

advanced technical equipment and the specialised skills of healthcare professionals. Yet this approach is also criticised for creating an environment of dependence in impoverished communities (Parfitt, 1999).

Nurses feature significantly amongst the health professionals engaging in humanitarian work (Crigger, Brannigan, & Baird, 2006; Tschudin & Schmitz, 2003). The participation by New Zealand nurses in humanitarian and international aid has been documented since the 1920s (Caughley, 2001). New Zealand nurses have participated globally with other nurses via international organisations such as WHO, the UN, the ICRC and other government and non-government agencies (Caughley, 2001; New Zealand Red Cross, 2009). Reports indicate that they experience a range of challenges not previously encountered in their home countries (Thorne, 1997; Tschudin & Schmitz, 2003). They are challenged to broaden and transform their traditional views of nursing in order to deliver safe and competent care in other contexts (Crigger, et al., 2006; Leininger, 1978/2002; Leininger & McFarland, 2002; Tschudin & Davis, 2008; Tschudin & Schmitz, 2003). Yet they also inevitably bring their previous understandings and expectations to the countries needing assistance. Thus, as a nurse and researcher who has participated in humanitarian work, I need to articulate the pre-understandings that relate to this study.

Researcher pre-understandings and assumptions.

Pre-understandings derive from a tradition or context with which the researcher is familiar (Nystrom & Dahlberg, 2001; van Manen, 1997). My experience as an intensive care nurse in a cardiac humanitarian team working in the Fijian Islands has provided me with certain understandings about what it is like to work in a developing country. Fiji is the country where I was born and raised but due to political instability, my family was among the thousands that left the country. I came to New Zealand in 1988 and have worked in general surgical and acute cardiac intensive care since 1992.

My work with the cardiac team in Fiji has occurred regularly over the last 5 years and as recently as 2010, when I embarked on this research study. In order to become more aware of the pre-understandings and assumptions relating to my own experience, I was interviewed by my supervisor prior to commencing data collection. The following pre-understandings were identified from the process of sustained reflection.

I have:

- Empathy and a strong desire to care for people who have fewer opportunities for health care and access to resources.
- Willingness to contribute my specialist clinical knowledge in nursing.
- A sense of wanting to belong to the country and people that I left over two decades ago.
- A wish to make a positive difference to my people and the country of my birth.
- A keenness to share information in ways that does not diminish or disempower health professionals in the host country.
- A strong affiliation with the health care humanitarian team.

The following statement is an excerpt from my own interview:

We arrive with exhilarated feelings; to work with good intentions. Sometimes it's feelings of achievement, completion of the work we had done, for those were the goals set. But it's also the look in their faces, hanging on the promises that we made, not by saying but by doing. We hoped that we changed some lives. But we know that others will have to wait. We hope, we hope and they wait until we arrive again with the same promise. We don't always leave with the same elated feelings, thinking, promising; we must come again, for there is so much more to be done. (Shane, 2009)

Context of the Study

Nurses' work in developing countries can be on short or long term assignments.

Organisations such as the Mèdecins San Frontières (MSF), Oxfam, Mercy Ships and government organisations such as military and navy facilitate short-term (two to three weeks), medium-term (four to six months) and long term (a year or more) visits (Nordlund, 2009). Red Cross missions from New Zealand can vary in length but are more usually six to eighteen months (New Zealand Red Cross, 2010).

According to Caughley (2001), 189 nursing assignments were recorded in New Zealand between 1989 and 2001. However I have been unable to obtain specific data since then from either the Nursing Council of New Zealand or NZRC. New Zealand nurses work with varied humanitarian organisations such as mentioned above can volunteer as often as they wish or can afford. Most nurses work voluntarily and thus do not receive payment. Some have their travel and accommodation expenses met, while others pay for these expenses as well. In this study, all nurses volunteered, three had their travel and accommodation expenses met and one did not.

Significance of the Study

This study gives voice to nurses by describing the lived experience of a phenomenon that is little understood. Individuals, professional groups and organisations who may benefit from this study's findings include registered nurses who aspire to provide humanitarian aid and organisations involved in recruiting and hiring such nurses.

Structure of Dissertation

This dissertation is presented in five chapters. Chapter One provides an introduction to the study topic, including the purpose of the study, background, pre-understandings and assumptions, context, significance and the structure of the dissertation. Chapter two reviews the literature relating to the nature of humanitarian work with a focus on

nursing. Chapter three outlines the research methodology, ethical considerations methods of data collection, analysis and criteria for establishing rigour. Chapter four presents the thematic findings interpreted from the stories of four nurses who have undertaken humanitarian work. Finally, chapter five discusses findings and makes recommendations for nursing practice, education and further research.

Conclusion

New Zealand nurses have a significant role in the humanitarian work delivered to developing countries, war zones and in response to natural disasters. The nature of such work varies in complexity and diversity with nurses taking on positions that range from providing direct care to more challenging managerial roles. The work is complicated by unstable economic, social and political circumstances. This small study will present a description of New Zealand nurses' experiences of providing humanitarian work in developing countries.

Chapter Two: Literature Review

Introduction

This chapter reviews the literature relating to humanitarian work carried out by health professionals in developing countries, with a focus on the work of nurses. The literature comprises research from both national and international sources along with some published autobiographical and biographical accounts by healthcare professionals. A brief introduction to what humanitarian work in the developing countries constitutes has been presented in Chapter One. The definitions relating to humanitarian work have been presented in The Key Terms used (see p.viii).

Humanitarian Work

Humanitarian action is a complex and dynamic process that involves multifaceted activities (Gardemann, 2002; Pupavac, 2004; Thieren, 2007). It delivers a programme of activities designed to protect civilians affected by natural disasters and war. It provides needs for survival, health services and support in political, physical, sexual, psychological and economic crises (Thieren, 2007). Such work requires a democratic and multiprofessional approach using skills beyond technical and scientific knowledge in areas of expertise to achieve positive outcomes (Gardemann, 2002).

Health delivery is a vital component of humanitarian work. Most health professionals uphold philosophies similar to the Hippocratic oath (Thieren, 2007) and thus have a professional obligation to resolve inequalities in health care (Gallagher, 2009; International Council of Nurses, 2006; Numminen, van der Arend, & Leino-Kilpi, 2009). Nurses and health professionals are among those who have global awareness of health disparities and willingly respond to the needs of the people in crisis situations (Tschudin & Davis, 2008; Tschudin & Schmitz, 2003). Nurses engaged in humanitarian work believe that they can have a practical impact and utilize their skills

to their full potential (Tschudin & Schmitz, 2003). This often means becoming involved in new situations and in roles that they may not have experienced before (Tschudin & Schmitz, 2003).

The literature examined for this study includes published research studies as well as articles that presented professional opinions on humanitarian issues and accounts of personal experience. Review of this literature is presented thematically under subsequent headings: the nature of humanitarian work, ethical issues, reasons for volunteering and power issues. The findings of many studies overlapped as the following discussions will demonstrate.

The Nature of Humanitarian Work

Whilst humanitarian work in foreign lands appears exciting and heroic to many health care professionals and aid workers, the complex nature of delivering such aid has been articulated by numerous authors (MacRae, 2008; Markus & Zwi, 2002; Parfitt, 1999; Pezzella, 2006; Pupavac, 2004; Walsh, 2004; Zinsli & Symthe, 2009). Missions led by health care professionals operate within strict time limits, resource constraints, with awareness of local knowledge, and in partnership with the local providers (MacRae, 2008; Markus & Zwi, 2002). Thus, it is recognised that humanitarian health care providers not only contribute skill and knowledge but appreciate and uphold local knowledge, culture and deliver work effectively within this local context (Murray, 1999; Parfitt, 1999).

Nurses from developed Western nations have contributed significantly to humanitarian missions (Alsop-Sheilds, 2000; Eucken, 2008; Gately, 2005; Parfitt, 1999) and New Zealand nurses' humanitarian work in developing countries has been documented by (Caughley, 2001; Fleck, 2008; Zinsli & Symthe, 2009). Some nurses are affiliated with organisations such as the Red Cross, whose principles and protocols are guided by

international humanitarian laws (New Zealand Red Cross, 2009). Nurses in the New Zealand military have also worked in disaster situations and war stricken areas (Crawford & Harper, 2001; Waxman, Guest, & Atkinson, 2006). Through global awareness and charitable efforts, their knowledge has added significantly to inter-professional medical and military teams whose work also extends to looking after civilians whose needs range from basic to complex war related procedures (Agazio, 2010; Cooke, 2005; Crawford & Harper, 2001; McBain, 2006; Waxman, et al., 2006; Zinsli & Symthe, 2009).

There has been some exploration of the experience of humanitarian work. A phenomenological study reported by Zinsli & Smythe (2009) revealed concerns about danger and personal security and the differences in culture and practices of local people. The stories of seven nurses, who worked in disaster and emergency nursing, highlighted themes of difference and similarity. Differences experienced were cultural, linguistic and related poverty and the resilience of people recovering from disease and ill health with minimal technology. Similarities were evident in the emotions and losses expressed despite differences in cultural values language and possessions. The nurses involvement in overcoming these differences was described in terms of walking the journey with these people. The findings also suggested that nurses' ability to cope with the variety of challenging situations was probably what drew them to volunteer again.

Army nurses' experiences are similar to those experienced by many non-military humanitarian missions (Agazio, 2010; Bjerneld, Lindmark, McSpadden, & Garrett, 2006; Crawford & Harper, 2001; Hunt, 2008, 2010; Zinsli & Symthe, 2009). Agazio (2010) reported that army nurses practising in military humanitarian missions other than war zone situations required specialised skills and personal adaptation under austere conditions. Nurses needed additional physical and mental preparation to nurse civilian populations who had sustained serious injuries along with other diseases of developing

countries such as cerebral malaria. They also needed preparation in relation to ethical, moral and cultural conflicts experienced (Bjernereld, Lindmark, Diskett, & Garrett, 2004; Hunt, 2008, 2010; Parfitt, 1999).

Surveys and interviews of one hundred and ninety eight (49%) naval and military officers that examined preparedness and retention for humanitarian work by (Drifmeyer & Llewellyn, 2004a) have reported similar findings to that of Agazio (2010). A further study that investigated what constituted effective humanitarian assistance (Drifmeyer & Llewellyn, 2004b) reported that in addition to training and education, appropriate tools, techniques and evaluating criteria were essential to achieving more effective outcomes in humanitarian work. Drifmeyer and Llewellyn (2004b) claim that monitoring the outcome of humanitarian work is rarely done as evidenced by gaps in literature findings.

Both studies (Agazio, 2010; Drifmeyer & Llewellyn, 2004b) also suggest that skill with a level of autonomy in practice is essential to function effectively in the challenging setting of military humanitarian work. The relatively low response rate in these studies limits the generalisability of these findings although other studies that focussed on non-military nursing have reported similar findings (Bjernereld, et al., 2004; Bjernereld, et al., 2006; Hunt, 2008, 2010). Cultural, moral and intellectually challenging situations were commonly experienced and most nurses believed that they were ill-prepared for their work (Crigger & Holcomb, 2007; Hunt, 2008, 2010; Parfitt, 1999; Thorne, 1997).

Ethical Issues /Principles and Codes

Attempts to alleviate human suffering, especially in crisis situations and during humanitarian interventions are fraught with ethical concerns (Markus & Zwi, 2002; Sommers-Flanagan, 2007). Hunt (2008) used a phenomenological approach to gain a deeper understanding of the ethical issues and moral reasoning employed by Canadian health care professionals involved in humanitarian aid work in developing countries.

Participants struggled to respect local customs and beliefs when these clashed with their own values. Other dilemmas related to barriers to providing care to the locals and differing understanding of health, illness and death. There were challenges to their identity and they experienced the paradoxical effects of trust and distrust from the local community.

Further qualitative research by Hunt (2010) explored the moral experiences of Canadian health care professionals in humanitarian crisis situations. The aim of this study was to investigate how to best address the ethics of health care practice in a context that was significantly different to the professionals' practice in their home countries. Hunt's participants included nine doctors, five nurses and a midwife along with three human resources and field coordinators involved in the recruiting and training of health care professionals. The findings demonstrated that humanitarian work is a morally complex activity that requires preparedness, support, and examination of the motivation for embarking on such work (Hunt, 2010). Power imbalances and the impact of organisational culture on everyday moral experiences were also reported.

These studies were based on the experiences of Canadian health care professionals' diverse roles. It is clear that ethical and moral dilemmas often overlap in practice and further exploration of such issues will provide greater awareness of humanitarian work (Bell & Carens, 2004; Crigger & Holcomb, 2007). Furthermore, the outcomes of interventions relating to humanitarian work are qualitatively different from one another and thus are difficult to measure and compare (Robertson, Bedell, Lavery, & Upshur, 2002). The cultural diversity of humanitarian workers from different backgrounds add to the varied and complex nature of ethical issues and their subsequent resolution (Hunt, 2008). Research that provides a multiplicity of views will enhance existing evidence of what constitutes and best supports humanitarian aid work.

Reasons for Volunteering

Motivation to engage in voluntary aid work has been discussed by many authors (Light, 2007; MacRae, 2008; Maner & Gailliot, 2007; Nordlund, 2009). Researchers who have examined nurses' motivations and willingness to work in humanitarian contexts include (Bjerneld, et al., 2006) and (Crigger & Holcomb, 2007). Autobiographical accounts of nurses and other health care professionals engaging in humanitarian work also discusses motivating factors (Belger & DeForge, 2007; Cobey, 2002; Cooke, 2005; Cullen, 2010; Hamer, 2010; Maner & Gailliot, 2007; McBain, 2006; Mckenzie, 2006; Walsh, 2004). These accounts highlight many challenges including ethical and moral dilemmas, personal risks, local norms and practice challenges, language barriers and working with minimal resources. Although often referred to, these subjective accounts of experiences are less valued in the hierarchy of evidence due to lack of critique and/or adherence to research protocols (Thorne, 1997).

A qualitative study that used semi-structured face-to-face interviews to explore the perceptions of humanitarian work with twenty returning Swedish health care professionals highlighted preparedness, professional competence and previous experience of humanitarian work as key factors to achieving better outcomes (Bjerneld, et al., 2004). The participants discuss the complex nature of humanitarian work and reported stressors such as security concerns, the unexpected nature of the work and heavy workloads. Positive perceptions and feelings about other participants were factors perceived as contributing to success (Bjerneld, et al., 2004). However, although nurses expressed personal and professional satisfaction, high levels of stress were reported particularly in relation to armed conflicts, crimes, rapes and living conditions (Bjerneld, et al., 2004). The authors therefore recommended tighter screening and interviewing processes for the selection of health care personnel and appropriate preparation or training prior to humanitarian aid work deployment (Bjerneld, et al., 2004).

A later study by the same researchers Bjerneld, et al. (2006) investigated Scandinavian health professionals' motivations, concerns and expectations in relation to humanitarian work. These participants had had no previous humanitarian work experience. The findings revealed that health professionals expected that the nature of humanitarian work would be different and challenging and that making a difference to others would provide them with a sense of achievement. Nurses also reported concerns about their professional competency for humanitarian work, financial security and negative reactions from their families. Despite this, a strong desire to contribute for reasons of personal development and satisfaction was evident (Bjerneld, et al., 2006). The authors used of Maslow's hierarchy of needs as a theoretical construct to identify motivational needs and thus these findings present a strongly Western perspective.

Findings from European researchers may mirror those from other countries but may not be fully generalisable to Asian populations or to countries with significant Pasifika populations. Researching humanitarian aid within different cultural groups will therefore extend current knowledge.

Power Issues

Ideally, the delivery of all humanitarian work should be bound by standards and protocols that respect the health infrastructure and culture of the recipient nation (Dufour, et al., 2004; Pezzella, 2006). However research by Markus and Zwi (2002) has clearly demonstrated the dominance of foreign team values on the prevailing institutional arrangements and structures of local services. Using a mixed method case study, the authors explored the experience of humanitarian intervention by International Council of Red Cross (ICRC) in an Afghanistan hospital during the 1990s, which was also during a period of political conflict. The authors reported that resource limitations, cultural and linguistic gaps between health professionals and the local population added

to the complex nature of humanitarian work (Markus & Zwi, 2002). A more population based approach to health care was recommended as beneficial to the locals.

The following excerpt from a Ghazni surgeon in this study caught my attention:

They supported us more than we needed - they trained us not like Afghans, but like Europeans. A glove was not used for two patients, but was disposable; everything was disposable - we got that kind of training, now we have to go back to our ways, use things with caution. They trained us like rich people. We are not rich. (Markus & Zwi, 2002, p. 122)

This story communicates a powerful message to health professionals. It demonstrates the importance of understanding resource limitations and preparing health professionals for resource depleted countries more appropriately. Working with awareness of local resources and in collaboration with local teams has been identified as empowering and promoting independence in local communities (Heck, et al., 2007; Parfitt, 1999; Walsh, 2004).

Case studies add depth of understanding in relation to the issue of investigation, however the focus on one organisation (ICRC) and/or one setting has limitations in terms of generalisability to other contexts (Polit & Beck, 2006).

Of particular relevance to the question of nursing patients from another culture was a study undertaken by Parfitt (1999). In an ethnographic study of twelve nurses from continents excluding Europe and South America, Parfitt explored the influence of cultural values of nurses on aid work in primary health care in developing countries. Her findings revealed that 'power' is utilised by nurses in practice both to empower and/or to increase dependence on the services provided by donor nations thus overriding the humanistic values of beneficence, which initially attract nurses to humanitarian work (Parfitt, 1999). These findings facilitate understanding of the effect of Western

nurses' behaviour on the local communities. The core dimensions of 'work', 'power' and 'humanism' can promote health development and encourage augmentation of existing health care system to support the sustainability and independence of local practices (Parfitt, 1999). Given that nurses' experiences are subjectively and contextually different, extending research to achieve multiple perspectives of nurses' experiences working cross-culturally will contribute further understanding.

Failure to understand cultural subtleties in promotion of health activities by Westerners is another challenge faced by many humanitarian workers and is consistent with study findings in (Bell & Carens, 2004; Dufour, et al., 2004). In line with Parfitt's (1999) findings, Bell and Carens (2004) reported that Western humanitarian workers and organisations may not be familiar with unexpected complications in developing countries or know how to deal with subtle behavioural nuances of people with different cultural and political systems (Bell & Carens, 2004).

Researchers who have explored cross cultural nursing experiences more generally assert that recognising the power differentials inherent in health service delivery is essential for effective clinical practice (Spence, 2001). Cultural theorist Madeline Leininger whose seminal work, - an ethnographic study of lived experiences with the Gadsup culture in the eastern highlands of Papua New Guinea - argued that "very serious ethical and moral issues can arise if health care professionals make assumptions and decisions based on Western child and adult rearing practices that do not fit non-Western or underdeveloped people" (Leininger, 1978/2002, p. 217). Furthermore, insufficient understanding of local ways, language and skill can have serious implications for successful communication with local people or at government level (MacRae, 2008).

Conclusion

This chapter has drawn from a range of pertinent literature to contextualise and justify this study. Although the focus of this literature search was based on nurses' experience, the studies reviewed had either a nursing or combined health care professional focus. The review of research has demonstrated an emphasis on concepts such as power, ethics, values, motivation and healthcare professionals' perception of humanitarian aid work. The findings have provided insight into the overlapping issues of ethical and moral dilemmas, cultural difference and power differentials. The experiences of health professionals including nurses have been examined in the context of primary care, hospitals, emergency settings and post war conflict zones.

This study focuses on the experience of humanitarian nursing in developing countries by participants volunteering from New Zealand. In contrast to another study on New Zealand nurses by (Zinsli & Symthe, 2009) which was reported in the context of an emergency setting, this study will explore experiences of nurses in military, general and pediatric intensive care settings. The following chapter will present the methodological and ethical principals that underpin this study and outline the methods used.

Chapter Three: Methodology and Methods

Introduction

This chapter describes the methodology and research methods used in this study. It provides an overview of qualitative research and the rationale for selecting an interpretive approach. Ethical considerations, methods of data collection, analysis and issues pertaining to rigour will also be discussed. A qualitative descriptive study informed by the interpretive work of van Manen (1997) researching lived experience, has been selected. In this study, the stories of nurses whose humanitarian work has been based in the developing world are interpreted against similar personal/professional experiences of the author/ researcher.

Interpretive Research

Interpretive research belongs within the qualitative research paradigm that recognises the culturally derived and historically situated nature of world (Crotty, 1998; Shank, 2006). More specifically, research informed by van Manen's (1997) hermeneutic phenomenological approach seeks to understand structures inherent in the lived human world (van Manen, 1997). Meaning is based not on the discovery of new forms of knowledge but upon shared understanding of phenomena that can provide direction in a complex and subtle world (Shank, 2006; Willis, 2007). The phenomenon of interest - nurses' experience of providing humanitarian aid - is explored in this study by describing and identifying the essential nature and characteristics of the phenomenon. I have sought, as van Manen asserts, to be attentive to life as lived, the "infinite variety of human experiences and the explication of these experiences" (1997, p. 7).

van Manen (1997) argues that "human science research efforts are really explorations into the structures of the human life world, the lived worlds as experienced in everyday situations and relations" (van Manen, 1997, p. 101). He describes the fundamental

existentials: spatiality (lived space), corporeality (lived body), temporality (lived time) and relationality (lived other). These are interrelated structures which assist in illuminating the ways in which all humans experience the world (van Manen, 1997).

Bollnow (1961) refers to 'lived space' as the time spent everyday in the world that is not subconsciously reflected upon. 'Lived space' includes the influence of context, place and time on human experience. "Lived other" describes the relationships we maintain with others in the interpersonal space that we share (van Manen, 1997, p. 104). The notion of "lived time" focuses subjectively on how a person experiences the events of the moment, the past, anticipated future and his/her reflections on these. This includes related sentiments such as happiness, sadness or anxiety attached to that time. "Lived body" is described as the presence of one as he meets another. The demeanour of a person is subject to his relationship with the other. This is seen, for example in how one reveals oneself when he/she meets a close friend as opposed to meeting a stranger (van Manen, 1997, p. 103).

Qualitative approaches depend significantly on the relationship between the researcher and the participants (Toombs, 2001). It is the sharing of subjective experiences between the participants and the researcher that assists understanding of the essential of meanings in an experience (Munhall, 1994). Furthermore, since researcher presuppositions influence all research, it is important to remain openly critical throughout the process of inquiry (Nystrom & Dahlberg, 2001). This is especially true in interpretive studies where the researcher must articulate his/her own prejudices in relation to the research question and interpretations (Nystrom & Dahlberg, 2001; van Manen, 1997).

The following methodological steps, described by van Manen (1997) were used to guide the research process:

Turning to the nature of lived experience

According to van Manen (1997), the starting point of phenomenological inquiry is identifying what deeply interests the researcher. My interest in investigating the lived experience of nurses' humanitarian work in developing countries derives from personal experience of humanitarian work in developing countries during the last five years. I felt honoured knowing that I was helping others in greater need and I returned from each mission with a level of personal satisfaction that was hard to describe. Yet the experience also exposed me to challenges that prompted me to question my practice decisions.

A criticism of phenomenological inquiry is that the researcher may know too much about the phenomena to be investigated (van Manen, 1997). It is important for researchers to make their biases, assumptions or presuppositions explicit so that awareness of this influence is heightened (van Manen, 1997). The pre-understandings that I held prior to commencing this study were made explicit in an interview with my supervisor and through ongoing critical reflection on what I was reading and hearing during the research process. (see Researcher pre-understandings and assumptions. Chapter One).

Investigating the experience as we live it rather than as we conceptualize it

According to van Manen (1997, p. 62), the purpose of phenomenological research is to "borrow" other people's experience and their reflections on their experiences in order to come to a better understanding of the phenomenon under investigation. My intention when interviewing the participants was to gain a detailed understanding of the feelings and concerns underpinning their experience. I used open inquiry questions, inviting participants to share stories of their experiences, for example: "Can you describe a recent humanitarian work experience?" I would then ask them to elaborate on that

situation and to talk about their feelings, relationships and actions. I wanted to gain a detailed understanding of what the experience was like (van Manen, 1997) .

Hermeneutic Phenomenological Reflection

Reflecting phenomenologically requires sustained contemplation. The process includes listening to stories, identifying relevant experiences and meanings, thinking, questioning, reading, writing and rewriting. I had to decide which parts of the interview texts were essential to the description of the experience as lived. van Manen (1997, p. 77) asserts that grasping the phenomenological structure of lived experience involves “a process of reflecting appropriately, of clarifying, and of making explicit the structure of the lived experience” in its vividness. He further elaborates that meaning is multi-dimensional and multi-layered. This involves isolating structures of meaning or themes and removing the extraneous aspect of stories (van Manen, 1997). It was a slow and tedious process. I repeatedly went back and forth between thinking writing, reflecting, and retrieving the most relevant data. My supervisor’s patience and her passion for phenomenology assisted these interpretive processes.

The Art of Writing and Re-writing

As previously mentioned, the overlapping nature of the interpretive process required that I move between the parts and the whole text to construct successive or multiple layers of meaning (van Manen, 1997). The writing process was challenging and as a new researcher, I needed supervision and guidance to work out how to articulate both parts and the whole of the phenomenon. This process included reading the interpretations I had written, thinking about the most appropriate words, selecting the best excerpts and re-reading, before writing the parts and the whole text again and again.

Maintaining a Strong and Orientated Relationship

To understand nurses' experience of humanitarian work it was essential that I did not stray to other details in the interview texts. It was easy to be distracted by stories about atrocities and war. I had to stay focused on the significance of these and what they meant in terms of the phenomena I was exploring. My aim was to understand the experience of providing humanitarian aid in its entirety rather than as I had experienced it personally. I needed to communicate depth and breadth of meaning in the description.

Considering Parts and Whole

"Human science study is a systematic study of human experience" (van Manen, 1997). However to avoid frustration from overwhelming data, the researcher must constantly measure the overall design of the study/text against significance and the parts that make up its totality. I carefully explored layers of meanings to achieve crafted pieces of writing. The explication of the pre-understandings, the back and forth processes of listening, reading, thinking, writing and re-writing and the ongoing fusion of the parts and whole, lead to the development of tentative themes and sub-themes, which in turn, were used as a guide for creating the final description. The themes eventually formulated emerged from previous themes in a way that identified and communicate the meaning of the phenomenon as a whole.

Ethical Considerations

Ethics approval for conducting this research study was sought from the Auckland University of Technology Ethics Committee (AUTEC) in March, 2010. After some minor amendments as requested by AUTEC, ethics approval was granted on the 26 March 2010 (see Appendix A).

Preservation of participants' rights and dignity and a guarantee to do no harm to anyone involved in the research process was maintained through the following procedures:

Participant Selection

Selection of participants was purposive. One of the “guiding principles of phenomenological sampling is to select participants who have experienced the phenomenon under study and must be able to articulate what it is like to have lived that experience” (Polit & Beck, 2006, p. 274). Thus, nurses who were willing to talk about their experiences providing humanitarian work aid were invited to participate. To avoid coercion, the potential participants were identified through professional networks and intermediaries. A participant information sheet (see Appendix B) was given to potential participants through intermediaries and the individual then made contact with the researcher if they wished to participate. Recruitment occurred in order of response and thus reduced selection biases. However due to the small scale of the dissertation, only four participants were selected. The participants comprised of two male and two female nurses. The participants’ age ranged from late twenties to mid-forties. Their experience of humanitarian work in developing country totaled eighteen years. Within the group, one nurse had completed nine years of humanitarian work while another had done a single trip of three weeks. The other two had experienced three to four years of humanitarian work. Three of the nurses’ clinical experience lay in pediatric cardiac intensive care and general critical care nursing and one worked with the military to provide humanitarian aid.

Informed Consent

The consent process emphasised the voluntary nature of participation, the ability to stop the interview and to withdraw from the process at any time prior to the completion of data analysis. This included being able to have raw data deleted and destroyed without being disadvantaged in any way (see Appendix B). The participant information sheet outlined the above issues and these were fully discussed, along with any further questions, prior to the signing of the consent form (see Appendix C) and

commencement of the interview. Transcriber consent was also obtained (see Appendix D) following selection of a recommended transcriber from Auckland University of Technology.

Protection from Exploitation

Involvement in research should not place a participant in a relationship that could disadvantage or exploit the study participant (Polit & Beck, 2006). Participants were assured that their involvement was voluntary and that ethical approval had been gained for the study. Mechanisms for maintaining participants' anonymity and confidentiality of data were clarified before the interview and participants were offered up to 3 sessions of counseling by the AUT Health and Counseling Centre, should they experience mental/emotional discomfort attributable to their participation in the study. However no one required these services.

Confidentiality and Anonymity

The participants' privacy and identity were protected by the use of pseudonyms on the research transcripts and all subsequent analyses. In face to face interviews, anonymity cannot be maintained; therefore the participants were assured of security of their data and the confidentiality assurances of the transcriber and supervisor with access to the raw data. All electronic material was password protected and hard copies were stored in a locked cupboard. Following completion of the study, all of the original data will be stored securely at AUT to be destroyed after a period of six years.

Data Collection

Data was collected via digital voice recorder, semi-structured, in-depth face-to-face conversational interviews with individual participants. A venue and time for each interview that was convenient for both the participant and the researcher was mutually decided. Venues were free of interruptions and noises that could interfere with the

quality of recorded conversation. The interviews were conducted utilizing a digital voice recorder. As nurses were being asked to recall experiences that could stir uncomfortable or distressing memories, there was some potential risk in terms of emotional harm. The probing nature of the questions could surface concerns that the study participants had previously repressed. Thus, it was essential that participants knew that they could decline to answer any such questions and they could access counselling if necessary.

The Interview Process

On arrival at the interview venue and after the initial greeting, a hot drink was provided for the participant. The recording equipment was set up within appropriate proximity to comfortable seating for both researcher and the participant. Explanation of the conversational nature of interview was provided and consciousness of the digital recorder was soon lost as the interview progressed.

The interview commenced with an unstructured, open ended question: “How did you become involved in humanitarian work”? Participants were then invited to share stories from their practice, for example, “Can you describe a recent humanitarian work experience as in much detail as possible?” These were followed by prompts such as: “Can you tell me how you were feeling?” and “What were your hopes and fears?” In asking these questions, I was probing for insights into nurses’ experiences of humanitarian work in developing countries. Other follow-up questions were based on data that the participants were providing and its relevance to the research question. The use of nod, “mm” or a pause to allow time for thinking and encourage the participants to provide rich description (Kvale & Brinkmann, 2009).

Following the interviews, the data was transcribed and was made anonymous, ready for interpretive analysis.

Data Analysis

I used the selective approach outlined by van Manen (1997, p. 93) to analyse the interview data. This meant going back and forth reading and re-reading the four interview texts. I was looking for sentences, statements and phrases that described aspects of the experience of working in developing countries.

Following the development of tentative themes from all of the transcripts together, a dialogue with my supervisor assisted the development of second level analysis. I worked again through the interpretations and data excerpts, clustering and reclustered common ideas and possible themes. I became very familiar with the participants' stories and was gradually able to identify the essential aspects of the phenomenon as a whole.

Some examples of tentative themes were: feeling anxious and being misunderstood, building relationships and practising differently, seeing and witnessing desperate needs, having power, adjusting to changing and challenging roles and adjusting to life back home. These were refined to become the following final themes: feeling anxious, worrying and being misunderstood, building relationships and practising differently, and readjusting to life back home.

Maintaining Rigour (Trustworthiness)

Maintaining rigour in interpretative phenomenological research is an important but a contentious issue (Koch & Harrington, 1998; Polit & Beck, 2006) that has direct implications for the legitimacy of nursing science (de Witt & Ploeg, 2006, p. 215). The findings of such studies are not neutral and value free (Morse, Barrett, Mayan, Olson, & Spiers, 2002) because they offer increased understanding of the aim of multiple interpretations of meaning of human experience (van Manen, 1997). It is also agreed that qualitative research is an umbrella term that covers a variety of research traditions

(Koch & Harrington, 1998). Morse et al.(2002) argue that while there is surmountable debate on strategies and methods, literature has focused on “how to do” qualitative research in optimizing outcomes or findings (Morse, et al., 2002). However it is also problematic to use prescribed criteria for evaluating the plausibility of the research processes and outcomes (Koch & Harrington, 1998). van Manen (1997, p. 162) asserts instead that “a certain openness is required in human science research that allows for choosing and exploring techniques, procedures and sources that are not always foreseeable at the onset of the research project”.

Based on a critical appraisal of issues of rigour in interpretive phenomenology, the following criteria, as proposed by Koch (1994, 1996), Koch and Harrington (1998) and van Manen (1997), were adopted for this study: auditability, reflexivity and self-awareness.

Auditability

According to (Polit & Beck, 2006), auditability refers to the degree to which an outsider can follow a researcher’s methods, decisions and analysis. Therefore, a “good qualitative researcher moves back and forth between design and implementation to ensure congruence among question formulation, literature, recruitment, data collection strategies and analysis” (Morse, et al., 2002, p. 10). Processes such as these allow the reader to audit the events, actions and influences of the researcher to establish the soundness of a study (Koch, 1994, 1996).

Auditability in this study was demonstrated through the provision of rationale of decisions relating to procedures and techniques, such as purposive sampling and the selection of participants who could tell stories about the phenomenon of enquiry.

Making pre-understanding explicit (see Chapter One) assists to surface assumptions about research phenomena (van Manen, 1997). In all research, either qualitative or

conventional, researchers have to deal with pre-understandings in order to “remain open throughout the research enquiry” (Nystrom & Dahlberg, 2001, p. 339) for it influences all stages of the research process from data collection, analysis of findings to conclusion (Nystrom & Dahlberg, 2001). Examples of processes such as those outlined were clearly documented to illustrate congruence with the method, in a logical order.

Reflexivity

van Manen (1997, p. 11) describes phenomenology to be “self critical and intersubjective in the sense that it continuously examines its own goals and shortcomings of its approach and achievements”. The human science researcher is constantly involved in questioning all that he/she hears, reads, writes and thinks about in relation to the phenomena of enquiry (van Manen, 1997). Furthermore, as Koch and Harrington (1998) describe, the outcome of reflexivity promotes an equitable ongoing context where many voices of the participants may be heard. There is reflexive engagement between researcher, participants, literature and readers of the textual analysis.

In order to maintain reflexivity in this study, prolonged engagement with the four transcribed texts allowed me to extract the essential meanings from each participant’s stories. The questions “what is the meaning of this” and “what else could it mean” were asked repeatedly throughout the analysis processes, thus using self critique and reflection to arrive at the final thematic presentation of the findings. The bringing together of many nursing voices required sustained patience and, once again, my supervisor’s insight and expertise guided me to a critical understanding of the research process and the study findings.

Self-Awareness

Research projects are driven by the background and understanding that researchers bring to the research project (Koch & Harrington, 1998). Therefore, a researcher needs to enquire (reflect, speak and write) in a manner that is oriented in a pedagogic sense (van Manen, 1997, p. 138). van Manen (1997) asserts that phenomenological research carries a moral force and its ultimate aim is to become fully aware of who we are. In this study, 'who we are' is nurses with experience of humanitarian work.

As stated previously, one of the reasons behind this research was my experience in a surgical cardiac team that provided humanitarian aid in the Fijian Islands. I therefore entered this research with pre-understandings of what such work entails. The pre-understandings outlined in Chapter One were a constant point of reference for my thinking and writing throughout the project. When reviewing literature, for example, I became aware of the experiences I held in common with some of the researchers. Parfitt's (1999) work on the influence of Western values of the non Western communities resonated with my experience in Fiji. But I needed to be aware that this may or may not be part of other's experiences.

The methodology, review of literature and listening to the participants helped me to more fully understand the nature of humanitarian work. In doing the analysis, I had to remain open to hearing stories and developing understandings that were both similar to and different from my own. Common to the phenomenon was the noticeable difference in cultural norms and values between the nurses' countries of origin and humanitarian aid settings. Less common was the experience of ethnic conflict and the impact of violence on the experience of providing humanitarian aid.

Sustained engagement in this research project has provided me with personal and professional growth that I could not have foreseen before I began this research.

Summary

This chapter has introduced the methodology underpinning this study. A qualitative descriptive approach guided by van Manen (1997) was used to undertake the research process. I have outlined the methods and the ethical principles used and explained and justified appropriate criteria for judging this study.

The following chapter will present description and analysis of the research findings.

Chapter Four: Findings

Nurses perhaps more than any other group of professionals experience the paradoxes, the dilemma and the challenges at the jagged interface between science and service. We occupy a precarious position at the juncture where science and technology intersect with human suffering and human hope in most sustained and intimate way. (Styles, as cited in Nolan & Hazelton, 1995, p. 11).

This chapter will present the research findings. It describes nurses' experience of undertaking humanitarian work in developing countries. Close examination of the nurses' accounts revealed the following sequential themes: feeling anxious, worrying and being misunderstood, practising differently and adjusting to life back at home. These themes and their sub-themes describe the essential aspects of the experience of providing humanitarian aid. Interpretation will be supported by excerpts from the nurses' interview data. Pervasive throughout is the overarching theme of adjusting and readjusting.

Theme 1: Feeling Anxious/Worrying and being Misunderstood

Humanitarian work in developing countries often means travelling to exotic places and cultures with other nurses and medical staff. It is accompanied by intertwined feelings of anxiety, trying to fit into the team, being misunderstood, working to gain trust and worrying about safety. While some nurses have very little idea of what to expect on their arrival, others have some awareness of what it will be like due to a previous similar experience of humanitarian work.

Finding one's place

Undertaking humanitarian work begins with feeling anxious and worrying about what the work will entail, who one will be working with and how he or she will fit into the

team. Nurses know the nature of their work will not be the same as in their home country and they worry about what they will see and how will they cope.

Fitting in with the humanitarian aid team is another source of anxiety, especially for nurses who are on their first mission. The team consists of people from different countries, each with their own culture, language and differing areas of expertise. There is no time to practice working together prior to arrival. Yet, finding one's place within the team provides incentive and drive for work performance. The participants talked about adjusting to their positions and roles.

Kate describes her first meeting with the team as their work began:

“You ask them what they do and what their background is. There are many cultures and some who’ve had a lot of experience The American nurse didn’t have that much experience. You basically bounce ideas around to get a feel for how they work. The team works surprisingly well with each other and I think that’s partly because everybody is in the same situation. Everybody is new, nobody knows anyone. I was the only one from New Zealand. It’s interesting. You basically have to place your trust [in them] quite quickly.” (Kate, p. 4)

Kate wants to fit in with the team. She immediately asks others about their level of experience and this helps to develop the understanding and trust essential for working together. Having different nationalities does not seem to matter when the focus is on getting the work completed.

Nurses who have previously worked in humanitarian missions know that having a common purpose binds the team:

“The first couple of trips, when it was a mixed team, it worked really well considering you had a bunch of thirty strangers who had never worked together before. I think it worked really well because everyone was there for a common goal. I think as long as everyone keeps it in

mind what they're there for, it worked well. When people's individual egos get in the way, then it breaks down and things don't work so well."
(Nancy, p. 7)

Nancy had previously experienced personalities who had disrupted teamwork. In her experience, focussing on the reasons for coming together ensures success.

Nurses with prior experience in developing countries find themselves guiding and supporting their new colleagues:

"I guess when you normally enter another country, you have a certain amount of time to adapt to it and you can start as a junior member of the team. Then, you are the senior and you are expected to do the job. They organised a welcome committee but [ultimately] you are relied on to do the job well. We actually had three team members who had been to Pakistan several times and one of them had a special support role. For example, she organised our roster and got us settled – without that it would have been much harder." (Kate. p. 2)

Kate suddenly finds herself in senior role. She is grateful for the assistance of nurses with previous humanitarian experience in the country. Practice is different and diverse in nature. The nurses allocate roles and positions to support the local healthcare professionals' needs in caring for patients.

Nancy similarly speaks of supporting and educating local practices:

"I think [the] Pacific will always be reliant on people coming here or teams going there but it is important that we work along-side the local staff and support and educate. It's important to acknowledge the skills that they do have. And not just going in and taking over and presuming that we know better than them. That's not what it's about." (Nancy.p.14)

Nancy acknowledges the host nation's need for ongoing support but respects their existing knowledge. She wants the local nurses to see that the skills she brings

complement the knowledge that they already have. She understands the importance of involving and supporting the local nurses rather than taking over.

Working with the locals also means becoming a reluctant leader:

“It feels a bit funny to walk into somebody else’s unit and then immediately give advice. It doesn’t come completely naturally, unless the environment is welcoming. It can be much harder being senior nurses; teaching and supervising the local team to care for the children after cardiac surgery. One has to know and respect the other culture before stepping in, and not knowing how much English they would be speaking made it harder. This was part of the problem. It was either lack of equipment, or lack knowledge. I took on a patient load but essentially, I tried to stay back and act as a mentor rather than taking over. The local nurses became colleagues very quickly but in the end, they turn to you for support which is quite intimidating.” (Kate.p.2)

Kate knows that she must lead but finds this adjustment difficult. She believes that it is morally wrong to start giving advice without knowing what is important to the local team and the language barrier makes this more difficult. Reluctant to take over, she tries to support from behind while maintaining a respectful relationship. Kate believes that providing guidance has long-term benefits. It improves and adds to existing knowledge enabling the local nurses to work with the visiting teams.

Working on longer humanitarian projects brings other challenges. In addition to adjusting to working together as a team, the nurses must live in close proximity with each other:

“We lived so closely, almost out of each other’s pockets for nine months. Sometimes there was friction, but you just couldn’t just go home to a whisky. It’s a long [way] away from home. It became harder to maintain that enthusiasm as the time went on. You lost that initial excitement of helping people; it was just like counting down the days. But we had to

still go on for we knew that it was a finite sort of situation and it will come to an end. I think whoever selected us looked at the team dynamics of who could get on with whom. For, they were a very close and supportive bunch of people.” (Paul. p. 6)

Paul finds it hard working away from home for such a lengthy period of time. There is no personal space and little time for relaxation. His enthusiasm wanes and he finds himself counting days. It helps knowing that the mission will come to an end.

However he is not alone and the support of the other team members provides him with the incentive to continue work.

Being misunderstood

Inherent in humanitarian nursing are the extra challenges of coping with distrust and local suspicions. A nurse describes arriving in a country in which she had previously worked, yet having her interests and intentions questioned. She senses discrimination:

“When I arrived I got separated out, interrogated and searched. I felt nothing but hostility from immigration. They didn’t want people coming in to help those whom they perceived to be unworthy. I didn’t understand how anyone could think that people are inferior because of their race or religion, sexuality, or whatever. I struggle with that.” (Nancy.p.9)

Nancy is entering Palestine via Israel. She is with a team providing cardiac surgery to children with congenital defects but providing services in countries where tensions and hostilities exist challenges her professional values and codes of conduct. The codes of ethics that underpin her practice mean that she cannot take sides. She wants to provide care to anyone who needs it.

Another nurse’s experience was more dramatic. The team was to begin work correcting congenital defects and doing eye, orthopaedic and gynaecological surgery. However on arrival, the local authorities try to undermine the team’s intention to do surgery in their country. Mike recalls feeling amazed and frustrated by the circulation of a local rumour:

“There was rumour circulating that the ship was only there to steal organs from people – we were being accused of organ theft! People were told not to have operations at the ship because they would have their organs taken and sold overseas, which was utter rubbish! You try to do a good thing and there are always people who hate good things being done.” (Mike. p.10)

Mike cannot imagine being accused of organ theft. Being part of the Mercy Missions means sacrificing monetarily as well as volunteering one’s time and expertise to assist those in need. He is astounded and disappointed by the tensions and misunderstandings associated with his humanitarian efforts.

Gaining trust

Nursing in developing countries also means experiencing distrust from local health care professionals. Learning how to work together takes time and regular visits help build relationships:

“I guess the [local] staff are a bit harder and more cynical until they get to know you and realise that you are coming backwards and forwards. You know, as in what are your reasons for being there.... is [or is] this just a trip away for you? Do you actually really care about us as people? Or ‘who the hell are you to try to tell me what to do? So there’s that initial scepticism that you will just come in and then go again.”
(Nancy, p.7)

Nancy senses hesitation and suspicion on the part of the local health care professionals. They want to see genuine commitment to them and their patients and worry that the new team may not have their best interests at heart. They need to be reassured that the team will involve and include them in the care of their patients. Nancy recognises and respects this concern and thus experiences increasing acceptance as she returns on successive occasions.

Kate's experience is more immediately positive. She is surprised at the almost instant acceptance by the local people and cannot imagine that she would be as trusting.

However there are patients that need more reassurance when receiving care:

It's quite amazing really. I don't think that I would have trusted someone, not knowing what they were saying but definitely. The appreciation was really evident. The teenagers were quite trusting although the 17 year olds were a little more guarded and we would usually use the local nurse. If we were trying to explain something, we'd ask the local nurse to help us out." (Kate, p. 5)

Nurses whose work takes them to areas ravaged by war, have patiently earned the trust of the local people. This means waiting for the locals to voluntarily seek help from the team:

The scary thing was, when we first got there (for the first few days), there were very few people there. We wondered whether they were hiding and watching. We saw young males, we saw reporters, the SAS [Special Air Service] were out there doing their thing and there were lots of dogs. That was it. Apart from the lady who was screaming, there were no [other] ladies, no children. It didn't take long because we were patrolling, we were out there. It took a little while to gain their trust but when they figured out that we were there to help, they were queuing up outside the compound. We had a compound about 1km long, with one entry and people would be queuing up outside because they knew that we could help them. We started off with a small group and then people started coming in from nowhere...." (Paul, p.3)

Paul remembers the initial withdrawal and guarded behaviour of the local people. They needed to know if the team was trustworthy before they sought help. Paul senses being watched until they knew he would help them.

Worrying about safety

Providing humanitarian aid can also expose nurses to life threatening situations. In addition to keeping patients safe, they worry at times about themselves:

There was the threat that we could be killed by militia. It is an eerie feeling, it gives you goose bumps. You had to have someone with you at all times and carry your weapon, even as a nurse. I had a rifle attached to my first aid kit, just in case. You had to be vigilant; you know if they [the militia] were there, that the things aren't that safe. (Paul, p.2)

Paul has witnessed the remains of some horrific torture and mutilation. Extra vigilant, he ensures he is always accompanied. He carries a weapon and is on guard at all times.

Mike remembers being in a similar situation:

There were some rumours in town that it wasn't safe and the ship always encouraged us to go around in twos. There was one time I felt a bit scared. I went out with some friends one night. There were young guys running around the town and it would have been quite dangerous to be out alone. There were some really dark alleys where you weren't safe. (Mike, p. 10)

Mike's taken-for-granted right to socialize outside work in his own country is significantly curtailed in the aid environment. He is apprehensive about leaving the security of his ship. There is disorder and unrest in the local town and being alone is dangerous.

Theme 2: Practising Differently

Humanitarian teams bring modern technology and skills to developing countries, and have to adapt to the resources available in host countries. This theme describes the ways in which nurses adjust their practice in the less affluent context of developing countries.

Nursing is different in nature from how they have been educated or trained. Paul describes the challenges of suddenly having to step up:

“I’d spent most of my time in the army working with the infantry at a fairly basic nursing level. In early 1999, I got posted to the field hospital and this surgical project coming up that was a big deal and I thought ‘bloody hell, I’ve had no post-op experience, where am I going to fit into this thing’?” (Paul.p.7)

Paul’s previous work within the infantry had prepared him to care for military personnel. He suddenly finds himself in a situation beyond his normal level of practice knowledge.

Yet, providing humanitarian aid in developing countries also means arriving with technology and skills that the locals do not have, recognising and appreciating local ways and returning to more basic levels of practice is fundamental to the experience:

“It would be very easy to go in and take over and say that we are a first world country, we have all this technology, we have all this stuff, and therefore we must be right. We’re not – we’re very often not. They can teach us things as well. They can teach us basic stuff. We rely so much on technology that we get really bad at just getting back to basics, looking at the patient, looking at things in the environment and utilising what we’ve got at a basic level. We get so reliant on having what we want because of money and the fact is that they can achieve as good patient outcomes and survival rates as we can – what’s that about? It’s about basic care, not all the fancy things...” (Nancy. p.4)

Nancy learns that having the latest technology does not make the aid team superior. She values working with their resources and recognises that use of technology does not necessarily result in better outcomes. The experience of providing humanitarian aid is helping her to hone basic assessment and observation skills.

There are many other ways in which the nature of humanitarian aid practice differs from one’s home country:

“There’s no focus on things that we [would] do routinely [at home]. There’s no one-to-one nursing in the ICU. It’s normally one to two or one to three and it is very task orientated. On the first trip, we tried until we were blue in the face to emphasise how important it was to do mouth care... it wasn’t going to happen no matter how many times we said – it just wasn’t a priority. Getting the child through the surgery and getting them home safely is much more important [to them]” (Nancy.p.2)

Nancy works differently according to local team expectations. She learns that additional care deemed important at home is not a priority in the context of humanitarian work. Surviving surgery and getting home is what matters to the people in this context.

Nurses experience significant difference in practice values when caring for hospitalised children in developing countries. A nurse tries to understand and adjust to local beliefs:

“In their environment families don’t get to visit. There’s a red line drawn across the door to the ICU[Intensive Care Unit]. It’s not accepted practice that family can come in and visit and spend time with the children. We expect our parents to be there just about all the time and to be helping out and to want to be there. We couldn’t change their policies and say: ‘you must do family- centred care.’ Even things around death...we had a child die and we’re used to getting the families in and putting the child in mum’s arms and allowing parents to spend time with the child after they’ve died. For them, no they don’t want to see the child, they don’t want to see the body and they don’t want any involvement. That takes a bit of getting your head around – yes, it’s different to us but it doesn’t make them wrong and it doesn’t make us right. It’s just different” (Nancy.p.3)

Nancy struggles to reconcile her own values and change her practice to align it with local expectations. She believes visiting is beneficial for both the children and the parents. She tries to understand and respect the local way of thinking by recognising that the two systems are different.

Language barriers and cultural difference add to the difficulty in understanding the local ways of life:

“The kids in Gaza – many of them had never seen a foreign or white face in their lives but they weren’t scared of you. They interacted with you and language was a barrier but we got through it. They taught us words and we taught them words...you get to know their families. Their families are big and we’d see them in the ward afterwards” (Nancy.p.6)

Both nurses work hard with the local people to build effective relationships. They build rapport by getting to know their families and learning words together. Non-verbal communication techniques assist in ascertaining some meanings:

“You end up trying to use sign language and trying to point and do everything that you can because it’s part of how I nurse. I tell the parents, I talk with the child. We did try to learn a couple of words so we could say ‘hi’ and ‘how are you.’ Just to get the interaction going. On the other hand, it didn’t take much – if you had some bubbles, they were giggling! You didn’t need as many words, in some ways, as you do over here.” (Kate p.5)

Kate’s account suggests that interacting with children is similar the world over, yet the relationships Mike experiences are different from those he is used to in New Zealand:

“It is different from cultural perspective, thinking of things that are relevant to them. On a practical note, you don’t interact with them as much as you would usually, because of the language barrier, although Mercy Ships do a really good job of organising local interpreters if we wanted to explain things to the patients. There was still not much of an interpersonal relationship with the patients. Whilst in New Zealand we have different cultures such as Indians, Maori, and the Pacific Island people and yet we all have the same piece of land in common. In Liberia, I was on their turf, their space and some of their cultural stuff was quite different.” (Mike. p.6)

For Mike, it was being in another land that made the relationship quite different. There is a sense that he knows he will never know their world and thus accepts that relationships will be different from those he establishes with patients in New Zealand.

Working within local resources

The fact that there is less support from medical staff and different and often unreliable equipment also forces the nurses to practice differently:

“The blood gas machine had broken; we couldn’t get magnesium at all. The ventilation wasn’t great. This child was off-colour, the blood pressure was dropping and there was nobody to turn to. The intensivist was in theatre with the bleeding child. I knew the ventilator but wasn’t familiar with the setting so I changed the setting to the type of setting I was familiar with. I was more in control and I managed to stabilise the child. This was risky considering the child was already unstable and I couldn’t take blood gases. It often didn’t go as anticipated. There were a lot of complications with the kids.” (Kate p. 3)

Kate is faced with a difficult clinical decision relating to a very unstable child. She knows that she cannot get medical support immediately and takes a risk that she would not normally take. She is forced to rely on her clinical judgement more independently than would be required in her home country.

Kate must also accept and learn to work with less than ideal equipment and medication.

“They had the basic things. There were some needles, some syringes but you had to save on everything you can. Some times you had drugs and sometimes you didn’t. You didn’t have them in the forms you wanted. For example, you might only have one solution, one type of tablet and then you’d have to crush them, and then mix it in 20 ml syringe and take the portion you needed and leave the rest for the next day. The labs also weren’t able to take every thing for testing. There are no things such as gastric feeds there so you do have to get them feeding [babies] as quickly

as possible and accept that they will be as pale and puffed out after the feed but that's how things work.” (Kate.p.6)

Kate knows that she cannot not rely on having the same equipment, level of laboratory screening and/or the range of drugs she is used to at home. She takes extra care with preparation and usage to minimise waste. She must also accept that improvement will be slower for patients.

Mike experiences more demanding nurse to patient ratios, alongside the greater challenge of communication:

“I also found that I had a lot of tasks to do. I’m used to looking after 1 or 2 patients in intensive care – whereas over there, you’d be looking after 3 or 4 or 5 patients so you find yourself running from one thing to the next and getting used to ...different languages.... it wasn’t the same as what I was used to in New Zealand.” (Mike p.6)

Like Kate, Mike is unable to provide the level of care he is used to back home. He finds himself rushing to get work completed. Language difficulties delay his work even further.

Tension vis-à-vis professional values and codes of conduct

Although most nurses providing humanitarian aid are very experienced, the nature of work continues to challenge them:

“You’re working outside your normal limits. You don’t have a doctor available 24 hours a day. You make the decisions knowing that it’s not your normal environment and you are not bound by the same legalities.” (Nancy. p.9)

Nancy has acquired considerable experience through working beyond the scopes of practice as determined by the Nursing Council of New Zealand (Nursing Council of

New Zealand, 2007). She knows that when on a mission she is not bound by her usual legislative and professional requirements.

Coping in difficult clinical situations means that the nurses must make decisions that they would normally make in collaboration with medical staff in their home countries:

“It takes some getting used to. We [an American nurse and I] had a really sick kid and we went through all the different scenarios: pathophysiology, why he is actually sick? Is it medical? Is it surgical? And what can we do next...until we came up with a plan that we were both happy with. We needed to work out between ourselves what our threshold was before we had to ring for backup. Nine times out of ten, the plan was exactly what we thought it would be... but it is quite different to make that call when it’s your arse on the line.” (Nancy.p.9)

Nancy thinks through her options carefully before calling on the medical support. She is working in a paediatric intensive care unit where patients’ conditions can change rapidly due to many possible causes. Despite Nancy’s previous experience and expertise, she is challenged to make decisions without medical support and is aware of the risks of taking such responsibilities.

Their experiences cause them to start questioning their own professional standards and care provision delivery in the developing country:

“I had no reason not to help these guys – everything had been taken away from them, they were displaced people and the country was falling apart. You’re just a little part of that help but it felt really good, it helped improve the health of some people and some to survive. We looked after a supposed militia. You had to be very careful because we found that it was a good time for people to start pointing fingers at each other and we didn’t know what was going on (with the language barrier and stuff). People were being attacked and the attacker would say ‘he’s militia’ but

you don't know. It could be a squabble between family members; you just don't know." (Paul.p.4)

Paul nurses civilian patients who are in desperate need of medical help. But some patients are members of a militia group. He resists being distracted when delivering care and focuses on the small difference he can make by helping those people affected by war.

Cultural and linguistic barriers also impact on quality of care. The ability to explain things clearly to parents when things go wrong with children is frustrating:

"A dad was really angry because his son had many complications. He had been operated on before we arrived and he just got worse and worse. He had another surgery and [the father] was clearly unable to express his grief and frustration. You could see that he was trying to get our attention. I really felt the frustration at not being able to do any thing and the language barrier was quite difficult." (Kate.p.5)

Kate knows this father needs information and support but she feels trapped by the inability to communicate adequately. Providing information [informed consent] to patients and families is an essential part of nursing care practice back home (Nursing Council of New Zealand, 2007).

Thus, nursing in developing countries means constantly adjusting one's practice according to each situation and then being similarly challenged again upon one's return home.

Theme 3: Adjusting to Life Back Home

Theme three focuses on revealing nurses' experience of coming home to the abundance of everything that has restricted their practice in developing countries. There are feelings of frustration settling back into previous work roles, different values and a culture that is much more focussed on the individual. Moreover, the rewarding nature

of humanitarian work has provided them with a new found respect for other cultures, less reliance on technology and new insights into the meaning of team support.

Adjusting to work back at home is not easy and takes time. Nurses reminisce their experience in developing countries as they try to adjust to work in New Zealand:

“It makes you want to bang heads together here. It makes you want to take some of the people here who take what we have for granted and be able to show them something like that. You want to say: ‘for all your whingeing and complaining about what’s wrong with the system, the unit and the people. We’ve got it so easy and so good.’ People just take it for granted. We’ve got no problems compared with what they put up with and get on with [in the developing countries]. I found it a bit frustrating at first but on the other hand, when problems and things come up, they don’t stress me. It’s just nothing! If this is the biggest problem we’ve got then [we have] get over it! In some ways, it’s an anti-climax coming home.” (Nancy.p.11)

Nancy is frustrated by nurses who do not appreciate working in a well resourced health system. She wishes others could experience what she has so that they develop a better understanding of the lives of nurses’ in developing countries. She is comparing the two different worlds and recognizes that the problems faced by nurses in Western nations are significantly less than those in developing countries. Furthermore, she now finds her previous work less challenging and is able to solve problems with greater ease.

Mike similarly experiences needing time to adjust:

“...the longer you’re away; the more you get soaked in the local experience and the local environment and the issues of that environment. It did take time to adjust to being back here, but there were some challenges... it does remain with me that we’re so well off and they are so poorly off. It certainly reminds me of what we’ve got although you can lose some of the important impact that it has on you. You can forget what

it's like to be much better off; just as I got absorbed in the way it was over there... [Here] you can use another piece of gauze or another pair of gloves or throw something away because it fell on the floor. You know there are plenty more in the cupboard" (Mike. p. 8)

Mike is continually reminded of the disparities between developed and under developed nations. He is also aware that, in time, the memories of his humanitarian work will lose their significance and he will again become oblivious to abundance of resources in New Zealand.

Yet, pervading the nurses' consciousness are strong positive memories of their work in developing countries. Nursing in a context of desperate need is a fulfilling and satisfying experience.

Feeling rewarded

While nursing in developing countries brings many unanticipated and morally challenging situations, it is also a rewarding experience:

"It was amazing to see a child come in (who was blue) and to have a repair done that is a complete cure. Just the look on the family's face, the mothers' faces – they've got their child back that they knew was going to die without it. Just the excitement and the thankfulness on their faces – there was a language barrier but you knew what everyone was thinking and feeling just by the look on their faces. They were just so thankful for what you were able to do for them." (Nancy.p.6)

Nancy sees the effect of the surgery on her patients and the difference it makes to the lives of the whole family. She loves seeing the gratitude and relief on the mothers' faces after surgery that has saved their children.

Mike also sees the difference the surgery makes to the patients' lives. The types of surgery he has been involved with and the associated social implications are profoundly different from those he has experienced in New Zealand:

“Women with obstetric fistulas are ostracized by their communities and families, it’s pretty cruel. After their surgery, they’d have dress ceremonies, a passing out parade for patients and they leave the ship with big smiles on their faces, they are given a new lease on life. Providing this sort of health care is enriching and satisfying. I was making a positive difference because they had a new lease on life. They were very happy and thankful. You could just tell that they were thankful.” (Mike.p.2).

There is also reward in returning on subsequent missions. Nancy experiences overwhelming gratitude from people whom she regularly visits in her humanitarian work:

“They are so welcoming and friendly...so open despite being beaten back time and time again. They will welcome you with open arms every single time that you visit. It really stands out. Just an incredible group of people and that’s what makes it. That’s why I’m passionate about going back there and trying to make a difference– they have nothing. They had no money but when you arrived at their house, they would run down the road and come back with a bottle of Fanta that might have cost them six months wages just to be hospitable to you and to show friendship. It was just amazing, the friendship that they showed and the welcome and happiness they had to see us, it was amazing, just amazing.” (Nancy.p.4)

Nancy loves the openness and friendliness of the local people. She is overwhelmed by their generosity when they have so little.

Providing humanitarian aid allows nurses to experience a totally different way of life:

“You get huge opportunity to do things... You can go to visit the prison, you can visit orphanages or you can help out with feeding programmes, you to see the patient’s whole journey.” (Mike.p.10)

Mike has visited homes of some of his patients. He witnessed their disabilities and the improvement following surgery. Seeing people achieve better quality of life after the surgery is hugely rewarding.

Reflecting on the experience of humanitarian work and the glaring disparities in health outcomes and resources, nurses wish their New Zealand colleagues could have similar opportunities for learning. Time gradually erases the vivid nature of their experience as settle into life back home. But in the back of their minds they also look forward to further opportunities for such work. Providing humanitarian aid helps nurses to realise their potential in ways that practice in New Zealand does not.

Realising potential

It is clear that engaging in humanitarian nurse work helps to advance nurses personally and professionally. It awakens and develops an understanding of political and economic differences. It also provides numerous opportunities for problem solving:

“[The] huge range of experiences makes you a bit more tolerant of other people and other cultures. It makes me appreciate [resources]. I’m more tolerant person and more aware that there’s more than one way of solving an issue or a problem. When you’ve got limited resources, you learn to be ingenious, a bit more lateral thinking. I certainly enjoyed the experience. It’s something I would recommend to anyone – it has been really valuable to me personally and professionally.” (Paul.p.9)

As Paul reflects on his experiences of humanitarian work, he is aware of the development in his understanding of cultural differences and the ways in which he is more a critical thinker and more creative when working with minimal resources. He values the opportunities that humanitarian work has provided in terms of his development.

Nancy also recommends such work to others:

“I think it’s a shame that we don’t take the time to understand each other better and understand other cultures. I think humans are too judgmental of each other and it’s a shame that more people don’t take the time to give of themselves and give of their time and knowledge to do these things. I think everybody can benefit from it – personally and professionally. It’s one small thing but it does make a difference in the world.” (Nancy.p. 14)

Humanitarian work has significantly increased Nancy’s understanding of other cultures. This is something that matters to Nancy and she hopes that others would benefit similarly. There is a sense that she is thinking more broadly than nursing.

Kate arrives home, valuing strong and effective team efforts. She also recognises the positive impact on her own skill as a nurse:

“It was a really good opportunity to test your limits. I didn’t really know how it was going to be and I tried to take it as it came, but what you come back with is the feeling that you can solve tricky problems and that you can work together without a shared language. It doesn’t always take the latest technology or the best equipment – it takes a team effort (Kate. p. 9)... It gave me an intensive to explore humanitarian work further and I would like to do it again some time in future.” (Kate, p.8)

Humanitarian work has provided positive experience of team working and has enabled Kate to see and appreciate that the latest technology is not always necessary. Through working with others, in the absence of common language, she has learnt new ways of problem solving. The experience of providing humanitarian aid is one that she wishes to continue.

Pervasive Theme: Adjusting and Readjusting:

Inherent in the previous three themes is a recurring notion of adjusting and readjusting. Nurses on missions to developing countries cannot anticipate and prepare for all the challenges that they will face. They find themselves having to adapt their previous

practices, learn new ones, make do with the resources available and work with others with different values and expectations. Returning to their more technically advanced environment is also hard having experienced the health disparities and service gaps common in less developed countries. Although they readjust with time, the commitment to improve outcomes for that in need compels many to return and thus the tensions associated with the adjustment continues.

Working in developing countries means adjusting to vastly different priorities. Mike gets caught up in a father's desperate act of poverty:

"I remember when a man came up to me and asked me if I would buy his daughter because he needed some money. You think about how wrong it is that someone should be thinking as desperately as that. They need money so much that they're prepared to sell their child. It's not right. The need was just huge! I was emotionally overwhelmed by it; I didn't say that I cried but I would go back to the ship and read a book or jump on the internet and sent an email. To me, it's a bit of a cop-out [to switch off]. The need was so great, not just the number but the type. On the ship you're at work so you just concentrate on that. You're doing your job and that occupies your attention. When you are on the land, you are looking around thinking 'oh man, look at that, look at that, look at that.'" (Mike, p.3)

Mike cannot imagine giving his child away for money and yet he understands the father is looking for survival for his daughter and himself. The enormity of the request overwhelms him. He almost cannot adjust and yet he must. Keeping busy and finding distractions help but not sufficiently.

Having to adjust to providing less than ideal ongoing treatment is also hard. Nancy has to adjust to not being able to help all patients who require surgery:

“You see a lot of children who come through with their families who have to be turned away and that’s really hard. They see you as having this God-like status because you’re coming and you can cure their child. You can’t always do it – there’s a lot of surgery that you just can’t do. You can’t do complex surgery that will take three [stage] repairs over time because they family can’t afford medication. They might never get back there [home] again. The cost, the time and the resources to do a three stage repair is not possible there. It’s really hard when you come from a society where you can throw money around into everything.”(Nancy.p.6)

Nancy sees a huge need to correct complex cardiac defects, but her team is unable to offer the best treatment because of potential complications, insufficient time and inadequate resources. She has to adjust her best practice expectations and cope with turning parents away.

In an overall sense, there are initial adjustments associated with finding one’s place in the team. Then, inherent in ‘practising differently’ are the adjustments and readjustments associated with being confronted by different values and priorities and coping with different clinical situations. The adjustments continue as and when the nurses return home to their previous employment.

Summary

The experience of providing nursing humanitarian aid in developing countries is one of recognising the need to change one’s practice to align with the priorities, values and resources within the local community. This often means accepting a focus on survival, for example, rather than providing two hourly mouth cares. It also means feeling anxious and scared about extending one’s practice beyond the level previously practiced at home. Significantly, it is an experience of feeling rewarded in ways not previously imagined. The nurse’s practice is less constrained than in his/her own country and this

release of potential is what draws them to return. The experience, in an overall sense, is one of constant adjustment.

Chapter 5: Discussions and Recommendations

Introduction

The previous chapter described the experience of nursing humanitarian work in developing countries. Discussion of the key research findings will now be presented in relation to previous research studies. This chapter will also make recommendations for practice, education and further research.

Release of Potential

This study has shown that the experience of practising nursing in developing countries is inherently different from practice in the developed world. The findings of this study reveal that nurses must work through different moral, ethical, cultural, language barriers and resource constraints when providing humanitarian aid. Yet they also show that the experience is enriching and provides professional and personal growth. The findings support other studies in showing that providing humanitarian aid is multidimensional and relational in nature yet also contextually different (Agazio, 2010; Bjerneld, et al., 2004; Bjerneld, et al., 2006; Drifmeyer & Llewellyn, 2004a; Hunt, 2008, 2010; MacRae, 2008; Parfitt, 1999). Cultural, political and economic factors differ from country to country and this affects nurses' experiences. Humanitarian work in a hospital context is different from working in a military environment but there are many shared experiences. This study's findings show that, although humanitarian practice may differ in terms of specialization and nursing decisions are made on a situational basis, the nurses invariably relied on professional and ethical codes of practice as they adjusted to providing humanitarian aid.

Working within resource limitations also challenges nurses to expand and extend their roles and responsibilities. This includes expansion of clinical decision making, their ability to teach and coach others and their capacity for leadership and management.

Despite the anxiety related to practising beyond their usual legislative parameters, the nurses often found within themselves a potential not previously realised.

First-hand experience of life in developing countries, the poverty, gaps in the health services and the desperate plight of many individuals is a sobering experience. Yet this is countered by the reward experienced through providing hope and contributing to improvement in the daily lives of less fortunate people. Nurses take pride in the fact that they are playing a part in the reduction of global ill health. Global awareness and nurses' involvement in humanitarian issues has been discussed in literature (Crigger, et al., 2006; Tschudin & Davis, 2008; Tschudin & Schmitz, 2003). Despite the anxiety, worry and potential for being misunderstood, the nurses in this study grew personally and professionally, through participation in the provision of humanitarian aid.

Bringing van Manen's existentials to the findings

The study findings reveal that the relationship with others in humanitarian work is fundamental to all aspects of practice and the ongoing adjustment by nurses. van Manen uses the term "relationality" or lived other to describe the lived relation human beings maintain with each other in the interpersonal space that we share (van Manen, 1997, p. 104). The findings of this study reveal a strong sense of collaboration inherent in the experience of humanitarian work. Practice was based on the sensitivity to others' needs and nurses showed an openness and willingness to work together, learn from each other and adapt to local ways.

The relational nature of humanitarian work has been addressed to some extent at both political and organisational level in the literature. The relationship is usually represented as two dimensional. The success of the mission is dependent firstly on establishing relationships with the host nation, and secondly with donor team members (Pezzella, 2006; Pupavac, 2004). Previous research has emphasised the motivation and

interest of workers (Bjerneld, et al., 2006; Hunt, 2010; Pupavac, 2004) and donor interest is recognized as essential in establishing trustful relationships. The findings of this study also reveal the possibility of experiencing a negative reception on arrival. Part of the initial experience of 'lived other' for the participants in this study was the experience of feeling unnerved by security procedures.

Anxiety related to role uncertainty, security concerns and establishing relationships with local and donor teams has been reported in previous research (Bjerneld, et al., 2004; Pupavac, 2004). This was evident in the present study when the nurses' intentions were challenged because they were foreigners. The literature speaks of the improper donor conduct and exploitation by some volunteer groups and organisations in the name of humanitarian service (Pezzella, 2006) but the findings of this study suggest that, although affected by initial tensions when entering the host countries, the nurses adjusted their planned humanitarian aid work according to the needs of the local community.

A significant finding of this study was the rewarding nature of interpersonal and collaborative relationships. Most nurses providing humanitarian aid are experienced clinicians with strong professional attitudes. Humanitarian work allows them to take on roles not taken previously. Teaching and adapting Western concepts to local situations requires patience, different approaches and working hard to become accepted. The nurses in this study established supportive and respectful relationships with colleagues and locals. There is no sense that the care that they provided was inappropriate or lacked appreciation of local cultures.

Coming to understand different cultural expectations relating to the care of patients in developing countries helped the nurses to adapt to local ways of management.

Although humanitarian nurse workers valued practices such as parental involvement in

the care of hospitalised children, they showed understanding of local local perspectives relating to this aspect of care. Parfitt (1999) claimed that the ethnocentric approach of Western medicine on developing nations' healthcare practice can be either enabling or disabling in the formation of long-term relationships. The findings of my study revealed nurses' respect and capacity to understand and align practices with local expectations, demonstrating an enabling rather than disabling approach. This would suggest that New Zealand nurses' experience of the 'lived other' when providing humanitarian aid embodies the notion of culturally sensitive practice and efforts to achieve culturally safety (Nursing Council of New Zealand, 2007).

The findings of the present study were similar to those of Bjerneld, et al., (2004) in that providing humanitarian aid was more complex and challenging than anticipated by the nurses prior to commencement. However the nurses in the current study experienced the cross-cultural aspect of practice more positively, perhaps because they were better prepared through their understanding of cultural safety. The present study's findings also show that humanitarian work humbled and broadened the nurses' thinking in many ways. They learnt to reduce their reliance on technology and become more innovative and adaptable in their practice.

The overwhelming and rewarding nature of humanitarian work experience is congruent with the findings of other researchers. Bjerneld et al. (2006) found that motivational and altruistic values were the primary reasons for pursuing humanitarian work but that many humanitarian workers became involved without knowing what the work entailed. This was also evident in the findings of this study as nurses adjusted and readjusted, supported by more experienced team colleagues.

Providing humanitarian aid is also accompanied by concerns for personal safety and not knowing the extent of potential danger or threat. Political instability and violence in

areas of humanitarian need heighten awareness of existing threats. van Manen (1997, p. 102) states that, “the space that we find ourselves affects the way we feel. Walking alone in a foreign and busy city may render a sense of lostness, strangeness, vulnerability and possibly excitement or stimulation”. The notion of ‘lived space’ or ‘spatiality’ helps us to understand the vulnerabilities experienced when providing aid in developing countries (van Manen, 1997, p. 102). Nurses in this study experienced differing levels of threat and had to guard against potential harm as they continued their work. These findings are congruent with those of (Agazio, 2010) who claims that personal adaptation to austere conditions, together with speciality skills, are fundamental to safe practice in challenging environments.

Undertaking humanitarian work means experiencing a new and challenging environment and increased interdependence. Thus, the existential of ‘lived space’ overlaps with ‘lived other’ to reveal the complex nature of the phenomenon. The relational nature of the work increases nurses’ resilience and this, coupled with compassion and support for each other, assists in overcoming the constraints of humanitarian work.

When practising within the resource constraints of developing countries, nurses are constantly reminded of differences between their current situation and the home environment in which they usually work. Practice was not heavily influenced by the presence of high-tech equipment and standards of care were constrained according to the resources available locally. Although such variations were often a source of concern for the humanitarian nurse workers, they quite quickly overcame feelings of ‘lostness’ and vulnerability through the interpersonal relationships they developed and shared.

The findings in this study revealed how nurses came to understand that the codes and practice guidelines of Western nations were not always relevant when practising in

underdeveloped countries. Thus, there was a difference in the legislative contexts or 'space' between developing and home countries. The findings of this research do, however support Hunt's (2008) claim that complex ethical dilemmas arising from incompatibilities in practice and cultural differences affect clinicians emotionally and morally. The findings of the present study provide additional insight into donor colleague support and the development of trust between donor and host teams.

The influence of humanitarian work on nurses' personal and professional values was noticeable on return to their home countries and work environments. The findings revealed feelings of frustration with co-workers during their readjustment to well-resourced work places. Exposure to global inequalities in health and resources had affected them at a personal and professional level. Awareness of global health care issues is increasingly becoming an area of focus for nurses wanting to participate with other health care professionals in international healthcare and decision making (Crigger, et al., 2006; Crigger & Holcomb, 2007; Thorne, 1997; Tschudin & Davis, 2008). The findings revealed that, although time reduced the severity and impact of humanitarian aid experiences, it also allowed nurses to reflect on what it means to contribute to such work.

In this chapter the study findings have been discussed in relation to the significant literature reviewed in chapter two. Two of van Manen's existentials: 'lived other' and 'lived space' have assisted further illumination of the complex nature of humanitarian nurses' work in developing countries. The study findings concur with those reported in other research studies. However this study has extended experiential understanding and surfaced some differences seemingly inherent in the practice of New Zealand nurses.

Limitations of the Study

This research was carried out for a dissertation as part of a Master of Health Science degree and thus, the project was conducted within a twelve month timeframe with a small number ($n = 4$) of New Zealand nurses. This limits generalisability to other contexts.

A further limitation of this study is that the contexts of the experience differed at the national level and also at the level of specialty. The participants in this study were drawing on experiences from Pakistan, East Timor, Liberia, Palestine and Samoa. Speciality variations included paediatric, general intensive care and military nursing. Furthermore, the timeframes were a mixture of long and short-term missions and this may have affected the extent to which the nurses were impacted by the phenomenon of providing humanitarian aid.

Yet this research has revealed experiences in common. Some of the findings are congruent with other reported research (Agazio, 2010; Bjerneld, et al., 2004; Bjerneld, et al., 2006). They also extend and support the non-researched literature (Clayden, 2007; Cooke, 2005; Cullen, 2010; Hamer, 2010; McBain, 2006).

Recommendations

Implications for recruiting organizations.

Nursing in developing countries as humanitarian workers requires clinical expertise in addition to other attributes. It calls for a worker who is flexible, adaptable, innovative and resilient. Recruiting organisations seek to employ highly skilled healthcare professionals with unquestionably good intentions. As demonstrated in this study and the reviewed literature, nursing in a culturally and geographically different context that is resource-depleted is significantly different from working in one's home country, and these factors increase the complexity of humanitarian work.

Government and non-government organizations, charitable bodies such as the New Zealand Red Cross and faith based organizations such as World Vision who are involved in recruiting nurses have a responsibility to better educate/prepare these professionals prior to their deployment. Preparatory training for nurses embarking on humanitarian work should aim to address the contextual issues/cultural issues pertinent to nursing in specific humanitarian settings.

The findings of this study also support calls for mentorship in the humanitarian workplace. This means that, where possible, experienced nurses should be available to support new and less experienced colleagues.

Recommendations for nursing education and practice.

Current nursing education includes cultural sensitivity and safety relating to cultural difference at national and local levels in New Zealand but global issues are not part of the curriculum in undergraduate nurse education in many countries. The emphasis on cultural safety in New Zealand nursing education has benefited nurses to some degree. However this would appear to be insufficient in terms of preparing nurses for humanitarian work. Education that combines global health with clinical practice in developing countries could be offered in university and/or technical institutes collaboratively with recruiting agencies. Short courses could be developed for registered nurses wanting to volunteer for humanitarian work. Courses that focus on global health could be offered at postgraduate level by universities. Such opportunities would attract nurses who are proactive and/or involved at political/ legislative level and those nurses who wish to take their work internationally. Furthermore, nurses intending to undertake humanitarian work as an extension to their usual professional role have an obligation and professional responsibility to prepare themselves to practice safely in another context. The internet is increasingly becoming an accessible and affordable medium for acquiring and sharing knowledge and experience. The use of this forum

alongside more formal opportunities for education will assist nurses and other health professionals to better prepare themselves for humanitarian work.

Recommendations for further research.

It is clear that nurses who embark on humanitarian work in developing countries require broad, general and specific understanding of what the work entails in different settings. Qualitative research such as this can provide rich descriptions of subjective experiences adding to the growing body of understanding relating to specific phenomena of interest. Larger studies and the use of mixed method approaches will contribute to further understanding. For example research that specifically compares donor nations' nurses' experience with those of the host nation would gain a deeper understanding of both world views. This may assist in clarifying assumptions made by humanitarian workers as to the most appropriate practice for the nations in which humanitarian service is provided.

Conclusion

This study was inspired by personal involvement in humanitarian work with a cardiac team from New Zealand to the Pacific island country of Fiji where I grew up. Providing humanitarian aid in a setting that was familiar in terms of the culture, language, educational and health systems was an advantage for me. However this is not always the case for others.

This small study has described nurses' experiences of undertaking humanitarian work in developing countries. Using qualitative descriptive methodology, it has illuminated some of the contextual differences relating to humanitarian work but most importantly, it has illuminated commonalities of meaning among nurses.

The phenomenon of providing humanitarian aid is constituted by feeling anxious, worried and being misunderstood, practising differently and adjusting to life back home.

The continual adjusting and readjusting realises the nurses' potential to develop both personally and professionally.

Appendices

Appendix A: Ethics Approval (AUTECH)



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTECH)

To: Deb Spence
 From: **Madeline Banda** Executive Secretary, AUTECH
 Date: 26 March 2010
 Subject: Ethics Application Number 10/30 The experience of humanitarian work by nurses in developing countries.

Dear Deb

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH) at their meeting on 8 March 2010 and that I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTECH's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTECH's meeting on 12 April 2010.

Your ethics application is approved for a period of three years until 25 March 2013.

I advise that as part of the ethics approval process, you are required to submit the following to AUTECH:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 25 March 2013;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics>. This report is to be submitted either when the approval expires on 25 March 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTECH and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
 Executive Secretary
 Auckland University of Technology Ethics Committee

Cc: Shane Lata Lal shanevishwa@hotmail.com

From the desk of ...
 Madeline Banda
 Executive Secretary
 AUTECH

Private Bag 92006, Auckland 1142
 New Zealand
 E-mail: ethics@aut.ac.nz

Tel: 64 9 921 9999
 ext 8044
 Fax: 64 9 921 9925
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Appendix B: Consent Form

Consent Form



Project title: The experience of humanitarian work by nurses in developing countries.

Project Supervisor: Deb Spence

Researcher: Shane Lal

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated / /10
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on / / 10 AUTEK Reference number *type the AUTEK reference number*

Note: The Participant should retain a copy of this form.

Appendix C: Participant Information

25 February 2011

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Participant Information Sheet



Date Information Sheet Produced:

15/02/10

Project Title

The experience of humanitarian work by nurses in developing countries.

An Invitation

My name is Shane Lal. I am a registered nurse with a back ground in general and cardiac intensive care nursing. I would like to invite you to participate in research study that will describe humanitarian work experiences of New Zealand nurses' in the developing countries. Your participation will be voluntary and you may withdraw from participation at any time without any adverse consequences.

What is the purpose of this research?

A significant number of health professionals that provide assistance to around the world countries affected by natural disasters and developing countries that lack of resources in the health sector. The purpose of this research is to explore and understand the humanitarian work experiences of nurses working in such countries.

It is expected that this study will also provide greater understanding of the nature of nurses' experiences and could assist to prepare potential humanitarian workers in future.

How was I chosen for this invitation?

You have been identified through professional networks with knowledge of your continuing humanitarian work. You have been provided with preliminary information about the study and if you are interested in participating, the researcher's contact details will be given to you.

This version was last edited on 3 December 2007

An information sheet and a consent form for voluntary participation will then be sent out to you. Selection will be made in order of response that is by return of the 'agreeing to participate' form.

What will happen in this research?

I (researcher) will interview about your humanitarian work experience. This will take the form of conversational interviews that will be taped. Interviewing will occur in a place that private and mutually convenient.

These taped interviews will be transcribed by a transcriber who has signed a confidentiality agreement prior to commencing this work. Following analysis of each of the participants' stories, a dissertation report and journal article will be published and available via AUT library.

What are the discomforts and risks?

In this research project, you will be asked to recall your lived experience of humanitarian service in developing countries. The study is of potential risk to you in terms of emotional harm. Recalling the experience of providing aid in developing countries may stir memories that are uncomfortable or distressing.

How will these discomforts and risks be alleviated?

If you experience distress or discomfort during the interview, I will discontinue the interview at your request. You will be offered up to 3 sessions counselling by the AUT Health and Counselling Centre and/ or be able to withdraw from the study. All relevant information including tapes and transcripts, or parts thereof, will be destroyed if you choose not to participate.

What are the benefits?

Being a part of this study will provide you with the opportunity for facilitated self reflection. You will also be contributing to work that will provide greater understanding of the health professional humanitarian experience in developing countries and could assist to prepare potential humanitarian workers.

What compensation is available for injury or negligence?

Counselling will be provided by the AUT Health and Counselling Centre should you require this during or following the interview.

The presence of a support person during the interview, will also be accommodated

How will my privacy be protected?

Your privacy will be protected through data protection which will be secured by the process of substituting identification (ID) numbers to your data records and transcripts. Consent forms and all demographic data will be stored separately in a locked cabinet. Characteristics such as name, sex, or cultural identity that could connect you to your data will not be disclosed.

What are the costs of participating in this research?

The primary cost to you is time. Each interview is anticipated to be an hour and half long.

To minimise transport costs, the interview will take place at a venue suitable to you. A taxi chit or voucher will be provided if required. There will be risk of loss of time.

What opportunity do I have to consider this invitation?

You will be provided with a participation information sheet and agreeing to participate form. Your willingness to participate is to be acknowledged by the return of the 'agreeing to participate' form. Three to four participants will be selected in order of response.

How do I agree to participate in this research?

On receipt of 'agreeing to participate' form, I will contact you and arrange a time to meet with you for signing of the consent form prior to the interview.

Will I receive feedback on the results of this research?

Yes. The place of the dissertation report and potential journal publication will be disclosed to you on completion of the research.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

25 February 2011

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Deb Spence

Email: deb.spence@aut.ac.nz

Work Phone: 9219392

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Shane Lal

Auckland University of Technology

Akoranga Campus

School of Health Care practice

Email: shane.lal@aut.ac.nz

Work phone:

Project Supervisor Contact Details:

Deb Spence

Email: deb.spence@aut.ac.nz

Work Phone: 9219392

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*,
AUTEK Reference number *type the reference number*.

Appendix D: Transcriber Confidentiality Agreement

Confidentiality Agreement



For someone transcribing data, e.g. audio-tapes of interviews.

Project title: The Experience of humanitarian work by nurses in the developing countries

Project Supervisor: Deb Spence

Researcher: Shane Lal

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):

.....

Date:

Project Supervisor's Contact Details (if appropriate):

.....

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ATEC Reference number *type the ATEC reference number*

References

- Agazio, J. (2010). Army nursing practice challenges in humanitarian and wartime missions. *International Journal Nursing Practice*, 16, 166-175.
doi:10.1111/j.1440.172X.2010.01826.x
- Alsop-Sheilds, L. (2000). Perioperative care of children in a transcultural context. *Association of Operating Room Nurses Journal*, 71(5), 1004- 1013.
- Belger, J. R., & DeForge, B. R. (2007). Faith-based social services: The challenges of providing assistance. *Journal of Religion & Spirituality in Social Work*, 26(4), 1-19. doi:10.1300/j377v26n04_01
- Bell, D. A., & Carens, J. H. (2004). The Ethical dilemma of international human rights and humanitarian NGOs: Reflections on a dialogue between practitioners and theorists. *Human Rights Quarterly*, 26(2), 300-329.
- Bjerneld, M., Lindmark, G., Diskett, P., & Garrett, M. J. (2004). Perceptions of work in humanitarian assistance: Interviews with returning Swedish health professionals. *Disaster Management and Response*, 2(4), 101-108.
doi:10.1016/j.dmr.08.009
- Bjerneld, M., Lindmark, G., McSpadden, L. N., & Garrett, M. J. (2006). Motivations, concerns, and expectations of Scandinavian health professions volunteering for humanitarian assignments. *Disaster Management and Response*, 4(2), 49- 58.
doi:10.1016/j.dmr.2006.01.002
- Bollnow, O. F. (1961). Lived-space. *Philosophy Today*, 5, 31-39.

- Bunyavanich, S., & Walkup, R. B. (2001). US public health leaders shift toward a new paradigm of global health. *American Journal of Public Health*, 91(10), 1556-1558.
- Caughley, J. (2001). *Humanitarian, international nursing and the New Zealand and recipients of the Florence Nightingale medal, 1920-1999* (Masters Thesis). Victoria University, Wellington. Retrieved from <http://researcharchive.vuw.ac.nz/handle/10063/81?show=full>
- Clayden, J. (2007). Volunteering in Mozambique. *Kai Tiaki: Nursing New Zealand*, 12(11), 15.
- Cobey, J. C. (2002). Physicians and surgeons volunteering in developing countries: A personal perspective. *Clinical Orthopaedics and Related Research*, 396, 65-72.
- Cooke, R. (2005). Three New Zealand nurses become a small part of healing in Banda Ache. *Kai Tiaki: Nursing New Zealand*, 11(6), 26-27.
- Crawford, J., & Harper, G. (2001). *Operations East Timor: The New Zealand defence force in East Timor 1999-2001*. Auckland: Reed Publishing Ltd.
- Crigger, N. J., Brannigan, M., & Baird, M. (2006). Compassionate nursing professionals as good citizens of the world. *Advances in Nursing Science*, 29(2), 15-26.
- Crigger, N. J., & Holcomb, L. (2007). Practical strategies for providing culturally sensitive, ethical care in developing nations. *Journal of Transcultural Nursing*, 18(1), 69-76. doi:10.1177/1043659606294198
- Crotty, M. (1998). *The foundation of social research: Meaning and perspective in the research process*. Australia: Allen & Unwin.

- Cullen, H. (2010). Recovery nursing in Nepal: A fulfilling journey. *Kai Tiaki: Nursing New Zealand*, 16(11), 22-23.
- de Witt, L., & Ploeg. (2006). Critical appraisal of rigour in interpretative phenomenological nursing. *Journal of Advanced Nursing*, 55(2), 215-229.
doi:10.1111/j.1365-2648.2006.03898.x
- Dickenson-Hazard, N. (2004). Goba! health Issues and challenges. *Journal of Nursing Scholarship*, 36(1), 6-10.
- Drifmeyer, J., & Llewellyn, C. (2004a). Humanitarian service and recruitment and retention of uniformed services medical personnel. *Military Medicine*, 169(5), 358-359.
- Drifmeyer, J., & Llewellyn, C. (2004b). Towards more effective humanitarian assistance. *Military Medicine*, 169(3), 161-168.
- Dufour, C., De Geoffroy, V., Maury, H., & Grunewald, F. (2004). Rights, standards and quality in a complex humanitarian space: Is Sphere the Right tool? *Disasters*, 28(2), 124-141.
- Eucken, E. (2008). A backpack and a mission: The journey of a missionary nurse. *Creative Nursing*, 14(4), 140-151. doi:10.1891/10784535.14.4.149
- Fleck, K. (2008). *Finding the shadows in the mirror of experience: an ontological study of the global worker* (Masters Thesis). Auckland University of Technology, Auckland.
- Frossard, J., & Bojarska, A. (2007). Employment opportunities with international agencies, mission organisations and government hospitals. *Anaesthesia*, 62(1), 78-83.

- Gallagher, A. (2009). International Council of Nurses 24th quadrennial conference: Nursing ethics. *Nursing Ethics*, 16(6), 287-289. doi:10.1177/0969733009343977
- Gardemann, J. (2002). Primary health care in complex humanitarian emergencies: Rwanda and Kosovo experiences and their implications for public health training. *Croatian Medical Journal*, 43(2), 148-155.
- Gately, R. (2005). Sudan: A Humanitarian response to a silent genocide: An American nurse's perspective. *Journal of Emergency Nursing*, 31(3), 325-332. doi:10.1016/j.jen.2005.01.008
- Hamer, H. (2010). Teaching in Viet Nam a two-way learning process. *Kai Tiaki: Nursing New Zealand*, 16(11), 28-29.
- Heck, J. E., Bazemore, A., & Diller, P. (2007). The shoulder to shoulder model: Channeling medical volunteerism toward sustainable health change. *Family medicine*, 39(9), 644-650.
- 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.
- Hunt, M. R. (2010). Moral experience of Canadian healthcare professionals in humanitarian work. *Prehospital and Disaster Medicine*, 24(6), 518-524.
- International Council of Nurses. (2006). *ICN code of ethics for nurses*. Geneva, Switzerland: International Council of Nurses. Retrieved from http://www.icn.ch/images/stories/documents/about/icncode_english.pdf
- International Federation of Red Cross and Red Crescent Societies, &. (1995). *Code of conduct for the international Red Cross Movement and NGOs in disaster relief*

- Jayasinghe, S. (2009). Contracts to devolve health services in fragile states and developing countries: Do ethics matter? *Journal of Medical Ethics*, 35, 552-557. doi:10.1136/jme.2007.022863
- Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, 5(19), 976-986. doi:DOI: 10.1111/j.1365-2648.1994.tb01177.x
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing*, 24(1), 174-184. doi:DOI: 10.1046/j.1365-2648.1996.17224.x
- Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity *Journal of Advanced Nursing*, 28(4), 882-890. doi:DOI: 10.1046/j.1365-2648.1998.00725.x
- Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2nd ed.). Los Angeles: Sage Publications.
- Leininger, M. (2002). Life-cycle culturally based care and health patterns of the Gapsup of New Guinea: A non-western culture. In *Transcultural nursing: Concept, theories, research and practice* (3rd ed., pp. 217-237). New York, NY: McGraw-Hill medical Publishing Division. (Original work published 1978)
- Leininger, M., & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed.). New York, NY: McGraw-Hill Companies.

- Light, D. W. (2007). On motives and moral foundations for our work, our lives, our society. *Smith College Studies in Social Work* 77(4), 89-111.
doi:10.1300/J497v77n04_06
- MacRae, G. (2008). Could the system work better? Scale and local knowledge in Humanitarian relief. *Developement in Practice*, 18(2), 190-200.
doi:10.1080/09614520801898970
- Maner, J. K., & Gailliot, M. T. (2007). Altruism and egoism: Prosocial motivations for helping depend on relationship context. *European Journal of Social Psychology*, 37, 347-358. doi:10.1002/ejsp.364
- Markus, 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.
- McBain. (2006). Making a difference in the developing world. *Kai Tiaki: Nursing New Zealand*, 12(11), 16-17.
- Mckenzie, C. (2006). To help is human. *Nursing Standard*, 20(20), 70-71.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal Qualitative methods*, 1(2), 1-19.
- Munhall, P. L. (1994). *Revisioning phenomenology: Nursing and health science research*. New York: National League for Nursing Press.
- Murray, J. S. (1999). Pediatric nursing health care delivery plan for humanitarian missions in developing countries [Review of literature and personal experience]. *Pediatric Nursing*, 25(4), 387-397.

New Zealand Red Cross. (2009). *New Zealand Red Cross News: 150 years of humanitarian action*. Retrieved 3rd December, 2010, from http://www.redcross.org.nz/cms_show_download.php?id=121

New Zealand Red Cross. (2010). *Becoming an aid worker*. Retrieved 1st October, 2010, from http://www.redcross.org.nz/cms_display.php?st=1&sn=11&pg=4867

Nolan, A., & Hazelton, L. (1995). *The practicing nurse*. Sydney: W. B. Saunders/Bailliere Tindall.

Nordlund, J. J. (2009). Volunteering for humanitarian projects. *Clinics in Dermatology*, 27, 395-400. doi:10.1016/j.jclindermatol.2009.02.013

Numminen, O., van der Arend, A., & Leino-Kilpi, H. (2009). Nurses' code of ethics in practice and education: a review of the literature. *Scandinavian Journal of Caring Sciences*, 23, 380-394. doi:10.1111/j.1471-6712.2008.00608.x

Nursing Council of New Zealand. (2007). *Competencies for registered nurses*. Wellington, New Zealand: Nursing Council of New Zealand. Retrieved from <http://www.nursingcouncil.org.nz/download/73/rn-comp.pdf>

Nystrom, M., & Dahlberg, K. (2001). Pre-understanding and openness - a relationship without hope? *Scandinavian Journal of Caring Sciences*, 15, 339-346.

Parfitt, B. (1999). Working across cultures: A model for practice in developing countries. *International Journal of Nursing Studies*, 36, 371-378.

Pezzella, A. T. (2006). Volunteerism and humanitarian efforts in surgery. *Current Problems in Surgery*, 43(12), 848-929. doi:10.1067/j.cpsurg.2006.09.002

- Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal, and utilisation* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Pupavac, V. (2004). Psychosocial interventions and demoralizations of humanitarianism. *Journal of Biosocial Sciences*, 36. doi:10.1017/S0021932004006613
- Robertson, D. W., Bedell, R., Lavery, J. V., & Upshur, R. (2002). What kind of evidence do we need to justify humanitarian medical aid? *The Lancet*, 360, 330-333.
- Ruger, J. (2005). The changing role of the World Bank in global Health *American Journal of Public Health*, 95(1), 60-70.
- Shank, G. D. (2006). *Qualitative research: A personal skills approach* (2nd ed.). New Jersey: Pearson Merrill Prentice Hall.
- Sommers-Flanagan. (2007). Ethical considerations in crisis and humanitarian interventions. *Ethics & Behaviour*, 17(2), 187-202.
- Spence, D. G. (2001). Prejudice, paradox, and possibility: Nursing people from other cultures than one's own. *Journal of Transcultural Nursing*, 12(2), 100-106.
- Thieren, M. (2007). Health and foreign policy in question: The case of humanitarian action. *Bulletin of the World Health Organisation*, 85(3), 218-224.
- Thorne, S. (1997). Global consciousness in Nursing: An ethnographic study of nurses with international perspective [Research]. *Journal of Nursing Education*, 36(9), 437-442-.

- Toombs, S. K. (2001). Introduction: Phenomenology and medicine In *Handbook of phenomenology and medicine*. (pp. 1-26.). Dordrecht: Kluwer Academic Publishers.
- Tschudin, V., & Davis, A. J. (2008). *The globalisation of nursing*. Oxford: UK: Radcliff publishing.
- Tschudin, V., & Schmitz, C. (2003). The impact of conflict and war on international nursing and ethics. *Nursing Ethics*, 10(4), 355-367.
doi:10.1191/0969733003ne61oa
- van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). Canada: The Althouse Press.
- Walsh, D. S. (2004). A framework for short-term humanitarian health care projects. *International Nursing Review*, 51, 23-26.
- Waxman, B. P., Guest, G. D., & Atkinson, R. N. (2006). Disaster preparedness and humanitarian aid- The medical response to the Indian Ocean disaster: Recommendations and RACS actions. *Australia and New Zealand Journal of Surgery* 76, 1-3. doi:10.1111/j.1445-2197.2006.03662.x
- Willis, J. W. (2007). *Foundations of qualitative research: Interpretive and critical approaches*. London: Sage Publications.
- World Health Organisation. (2010). *World health definitions*. Retrieved 3rd December, 2010, from <http://www.who.int/hac/about/definitions/en/index.html>
- Zinsli, G., & Symthe, E. A. (2009). International humanitarian nursing work: Facing difference and embracing sameness. *Journal of Transcultural Nursing*, 20(2), 234-2411. doi:10.1177/1043659608330351

