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Understanding the motivation of nurses volunteering for non-disaster humanitarian service

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ABSTRACT

Background: Nurses who volunteer in a nondisaster humanitarian surgical mission receive little attention in the research literature.

Purpose: The purpose of this study was to explore how nurses involved in short-term nondisaster humanitarian care perceived and managed their experiences of working in a volunteer nursing capacity in a low- to middle-income country.

Method: An immersive ethnographic method was used. Participants comprised 150 international registered nurses from 12 countries. Data collection incorporated 49 semistructured interviews and reflections on 1,500 hours of participant observation. Data were analysed using a thematic, inductive approach, following the consolidated criteria for reporting qualitative research guidelines.

Results: The results of this qualitative enquiry revealed essential aspects of the nursing culture within a specific humanitarian nursing context—that is, promoting social justice and addressing health disparity through the delivery of compassionate surgical care. This paper presents data describing nurses' motivations for participating as volunteers in humanitarian work.

Discussion: Nurses are more likely to offer increased effort and enthusiasm when there is congruency between their beliefs, their professional identity, and their ability to enact on these. Understanding humanitarian nurses' motivations gives guidance to leaders involved in managing, attracting, and retaining suitable nursing staff and orienting, debriefing, and supporting re-entry after withdrawing from short-term medical assignments that share a common imperative to care for the underserved.

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1. Summary of relevance

Problem/issue: The current nursing workforce in low- to middle-income countries is unable to provide sustainable management of health care needs

What is already known: Expatriate nurses are significantly involved in volunteer humanitarian work. Their involvement in 'disaster and conflict response' is reported in the literature, but the evidence for involvement in nondisaster contexts is sparse

What this paper adds: The current evidence base is extended by this in-depth exploration of volunteer nurses' motivations within not-for-profit organisations offering humanitarian curative surgical

care. Nurses' motivations were found to reflect a deep connection with their identity, their purpose, and their desire to improve the quality of life of the underserved

2. Introduction

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2019) predicted that in 2020, 168 million people, globally, would require humanitarian aid. This humanitarian aid is usually reactive and delivered in the context of natural disasters, wars, or health epidemics (McGowan et al., 2020). Nevertheless, long after a crisis requiring humanitarian assistance has been resolved, ongoing needs in vulnerable communities with inadequate infrastructure and systems remain. Humanitarian aid, therefore, encompasses both disaster and nondisaster responses (United Nations Office for the Coordination of Humanitarian Affairs (OCHA),

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2019). The care given by nurses within organisations offering specialist help within an international nondisaster response has not been typically connected with the term 'humanitarian', and this represents a considerable gap in the literature.

Currently, there is a global shortage of health professionals, with many more needed to achieve the United Nations Development Programme's universal health coverage goal (United Nations, 2019). The global burden of disease needing to be addressed by surgery is 30%; globally, five billion people do not have access to safe, affordable surgery or anaesthesia (Shrime, Bickler, Alkire, & Mock, 2015b). This need is most urgent in low- to middle-income countries (LMICs). Globally, in a humanitarian context, health professionals, including nurses, are volunteering their services to enable an expanded provision of health care in LMICs.

The term "humanitarian health response" broadly describes the promotion of another's welfare, related to their health needs, including surgery (Shrime, Bickler, Alkire, & Mock, 2015b). Current surgical deficits in LMICs have therefore resulted in a range of humanitarian government and nongovernment, secular or faith-based agencies working together to support countries unable to meet their people's health needs (Shrime et al., 2015a; Ng-Kamstra et al., 2016).

Teams are deployed by both governmental and nongovernmental organisations using ships to provide global health care, each with different models of funding and care. Ships are self-sufficient mobile platforms that can reach regions where clean water, electricity, and medical services are limited or non-existent (Shrime, Sleemi & Ravilla, 2015a). The U.S. Navy hospital ships USNS Comfort and USNS Mercy are 1000-berth floating hospitals, working in partnership with NGOs such as Project HOPE to give humanitarian assistance and disaster response for global health diplomacy purposes (Larter, 2020; Licina, 2013). Other charitable organisations operating ships to deliver health care include Youth with a Mission (YWAM) ship equipped ministries that use ocean-going vessels, yachts, and riverboats in Colombia, the Amazon, Micronesia, and Panama (YWAM Ships, n.d.). Medical Ships Australia serves Papua New Guinea, offering eye surgeries, dental care, primary health care, and community health education (YWAM Medical Ships, n.d.), and Mercy Ships International currently serves the continent of Africa with the largest civilian hospital ship, called The Africa Mercy (Mercy Ships, 2015). Some charitable ship platforms are staffed by professional crew that volunteer their service for varying lengths of time without remuneration. Health services, including surgical procedures are then able to be offered to the marginalised free of charge.

Within the global nursing workforce, a subgroup of volunteers joins short-term medical teams offering elective curative surgical procedures. These teams typically select patients for whom, once surgery has been completed, their debilitating conditions are rectified. This includes, for example, people who are seeking cataract surgery, maxillo-facial and vesicovaginal fistula repair, and other similar procedures.

International volunteering in health care projects is receiving scholarly attention due to increased participation, although noticeably, volunteer nurses as health professionals are not. "Voluntourism," a term applied to travellers who combine holidaying and aid-giving, has been subject to increasing critical reflection (Morgan, 2007). Service-learning has been described as a form of experiential learning while working, and has been drawn into the debate, encompassing the argument that participants likely receive more than they give, questioning their altruistic motivations (Sykes, 2014). Service learning projects are thought to possibly do more harm than good with inadequate, if any, accountability, increased costs, and possible long-term detriment to the recipients once their project concludes (Lough, Tiessen, & Lasker, 2018; Suchdev et al., 2007). Distinct from the voluntourism model

that often refers to combining a holiday with experiential learning (McCall & Iltis, 2014), this article's use of the term "volunteer" refers to qualified and experienced health professionals, including registered nurses, rather than health students on learning placements.

While nursing within a disaster response situation has been reported (Sloand, Ho, & Kub, 2013), the authors identified research relating to nurses' involvement in acute care practice in a nondisaster humanitarian context was sparse (Dawson, Elliott, & Jackson, 2017). A comprehensive investigation of volunteer nurses' contributions to humanitarian work is valuable to ensure they adequately prepare for and are supported when in these roles. Identification of factors that might enable nurses' participation can strengthen and increase their effectiveness through their volunteer service.

3. Aim

The aim of the study was to explore volunteer registered nurses' motivations for and perceptions of participating in remote, international humanitarian work, through the lens of a charitable, nongovernmental hospital ship. Factors that enhanced their choice to volunteer in this context were explored.

4. Methods

4.1. Methodology

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

4.2. Setting

The lead author lived and worked as a registered nurse located on a ship docked in a remote LMIC setting of a port city on the African continent for six months to explore the volunteer nurses' experiences and identify their motivations for entering this area of work. At the time of the study, there were several different organisations using ships to provide global health care. The ship at the centre of this study was administered by a charitable, nongovernmental organisation (NGO) that facilitated acute and complex surgical procedures. The ship remained in port for approximately 10 months by invitation from the host countries' governments. The NGO's stated aims are to offer selected lifesaving and life-changing procedures to address the burden of unmet surgical needs, share professional knowledge, and build confidence amongst health professionals by providing medical capacity-building courses and contributing to strengthening the local health infrastructure. A further aim is to assist in mentoring and networking with local health professionals in the improvement of patient outcomes within their

local systems. The organisation's capacity-building programs focus on professional development for local medical, nursing, and support staff and are conducted most often onsite in local hospitals. There is appropriate follow-up, and sustainability is achieved with ongoing relationships within host countries.

4.3. Sample

Nurses formed approximately one quarter of the ship's entire crew. Nurses were required to have the equivalent of a Bachelor of Nursing degree and two years' relevant postgraduate surgical experience. Qualifications specific to nursing roles outside the ward areas were commensurate with the position filled: operating theatre or recovery room experience, education, palliative care (counselling and communication), or advanced wound care skills. All crew volunteer their services without financial remuneration. Crew pay a monthly fee for room and board and fund their return airfares from their home country to the ship's location, personal expenses, and travel insurance. Participants are expected to fundraise or self-fund their trip(s), a model that has been sustained for over 40 years by this NGO. The sample in ethnographic research typically involves the whole group under investigation at the time. Throughout the 6 months of data collection, approximately 150 volunteer nurses rotated through the hospital and were observed in their respective roles. Each nurse joining the team was informed of the study in a general orientation session on their arrival, and an "opt-out" consent process was offered. A further invitation for an individual interview was extended. No participants opted out. Throughout the study period, 49 nurses gave written consent to be interviewed.

Data were collected by the first author during fieldwork as an active participant-observer in the natural setting between July 2016 and January 2017. Full immersion in the environment while living on board and participating in a nursing role enabled a detailed description of data through participation in all domains within the study's context. Participant observation involved documenting field notes, memos, and reflections on selected processes and considerations related to the nursing care; approximately five months of 10 hours per day amounted to 1500 hours. Field notes were written into a journal after the observation concluded. In this study, the first author balanced the insider-outsider roles sufficiently to be accepted by the group as a co-worker while maintaining an outsider's objectivity. This balance was achieved due to the first author's previous decade-long voluntary nursing service with the same NGO on another hospital ship in a remote location, with a decade-long hiatus before returning to conduct this study. Co-authors had not had any prior connection with the NGO and were not onsite but processed data with the first author.

All face-to-face semistructured interviews were held onsite, by the first author, in a private space removed from the hospital ward to provide confidentiality. Each interview lasted from 30 to 60 min and contained open-ended questions such as 'What led you to volunteer here?' The first author transcribed audio interviews verbatim. No repeat interviews were carried out. Data comprising transcripts, written field notes, and reflections were uploaded into a qualitative data management software program (NVivo; QSR International, v12, 2018) for storage, classification, and management.

Thematic analysis was conducted by the first author, beginning with immersion in the raw data then coded by an inductive process, and arranged manually into categories and subcategories (Braun & Clark, 2006). After comparing codes with co-authors, codes were reduced, and findings were organised into themes and subthemes. This was a subjective process in which data were mapped and remapped in discussions between all authors until consensus on overarching themes and related subthemes was reached.

To assure the credibility of interview transcripts, participants reviewed and validated them. Participants represented all nursing subdepartments on the vessel, including patient selection and admissions, operating and recovery rooms, postoperative wards, treatment room, palliative care, and medical capacity-building teams involved in mentoring nurses. Email communication was used if interviewees had left the field before the research period had concluded, and potential ambiguity within transcripts was checked with the participants. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist informed the study's method (Tong, Craig, & Sainsbury, 2007).

Adherence to ethical principles in research was an essential part of ensuring integrity and merit in the quality and rigour of this study (Flick, 2014). Before the study commencement, the research was approved by a university human research ethics committee and the NGO's International Review Board. Audio interviews were transcribed and edited using coding numbers to preserve confidentiality. Data storage was consistent with the responsibilities outlined in the Australian National Statement on Ethical Conduct in Human Research (National Health & Medical Research Council, 2007).

5. FINDINGS

5.1. Participant characteristics

The convenience sample comprised volunteer registered nurses from 12 countries. The average age of participants was 35 (range: 22 to 66 years), with a time of service with the NGO ranging from 3 weeks to more than 15 years of consistent volunteer service. Interviewees included those volunteering for the first time ($n = 16$), those with previous experience on a short-term placement and returned for a second field service ($n = 12$), and those who had been on board for more than 1 year ($n = 5$), for 2 years or more ($n = 14$), or up to 15 years ($n = 2$). Over half the sample had volunteered with the NGO previously and had therefore been to more than one field location in an LMIC ($n = 33$). There was a balanced mix of younger, single participants, with few social ties or financial commitments, and others who were either on the ship with their spouse and children (attending school onboard) or had adult children back in their home countries. Participants who were interviewees have been deidentified and given a number (#); for example, 'There is such a spirit of teamwork here' (#10) indicates the quotation was by Interviewee #10.

Participants felt a strong desire to share their experiences, gain further cross-cultural understanding, and gain career experience by caring for patients with the increased severity of conditions they had not necessarily cared for in their home countries. Overlying these considerations was an altruistic belief system of wanting to be involved in something tangibly worthwhile and a wish to invest their time, money, and skill to make a difference to people in less equitable situations than people in their home countries. Findings revealed the complexities and emotions around the decision by nurse volunteers to enter into humanitarian work. As one participant described, "The thing that motivates me is because I know this is where my heart is. That is the only way I can describe it" (#16). Participants expressed a strong motivation that arose from the alignment of their values with the NGO's organisational aims, their altruistic ideals, and their courage and willingness to extend their skill to others in need.

The theme "Nurses' motivations" is elucidated by three subthemes: (i) Conviction: "I just knew I was meant to be here," (ii) Confidence: "I know that I can help make a difference," and (iii) Courage: "Out of my comfort zone." Participants' motivations for humanitarian work were found to reflect a deep connection with their values, representing their identity, their purpose and meaning

through service, and their desire to contribute to making a difference to others' quality of life. Using the study's ethnographic approach, a correlation between what participants perceived to be true for themselves and how they responded in their voluntary roles was established.

5.1.1. Conviction: "I just knew i was meant to be here"

Participants were explicit and diligent in researching the humanitarian organisation before committing to volunteer work. Spending time researching online and speaking with or learning about previous participants who knew of the organisation was typical. Numerous participants were aware of the potential to volunteer at a much earlier stage than they were either ready for or had the professional experience required to apply. The participants' views aligned with the organisation's goals, and the work the NGO conducted resonated with them. One nurse stated, "As a nurse. . . I just felt drawn into being a part of it; I just knew that is what I wanted to do" (#14).

Admiration for the way the organisation was conducted prompted volunteers to align with and to implement their values practically within an environment that accommodated their ideals. As one participant stated, "Just the whole ethos, everything about it . . . I respect the organisation and therefore, I want to be part of it" (#02).

Others found that this avenue facilitated a means to enact and develop their perceived identity within a belief system and worldview that they resonated with—for example, "I have a big dream of working more in-depth in global health and addressing infant mortality issues . . . that is really, really important to me and part of my future" (#30).

Of note, participants expressed a desire to be involved in resolving great need and were dedicated to the cause of helping others. One said, "Working at home [country], I didn't feel important. If I quit my job, someone else would be there to take my place. But here, well, it's not the case" (#11). The desire to contribute to making a change to individuals' situations was strong, aligning with the altruistic nature of many nurses. One stated, "I just feel a draw. I really think I'm called here, like I'm really doing something good here" (#14). Participants felt they were in the right place and their identity was a good fit with the organisation, motivated by working within a team of people with the same vision and values that were beneficial to the patients and themselves. This was not referring to social uniformity but rather to share a common purpose for wellbeing amongst individuals and communities. One participant indicated, "No-one is getting paid big bucks to be here. Everyone here is on the same level and here for the same reason" (#33).

Nurses stated their conviction to "give back" came from a sense of having been educated and with access to resources required for them to work effectively in their home countries. They felt they had the opportunity to assist in producing positive outcomes—for example, "I feel a sense of responsibility for not taking [education] for granted, and for sharing that with others who don't have those opportunities" (#06).

5.1.2. Confidence: "I know that i can help make a difference"

Participants had the self-confidence that they were in the right place at the right time, felt equipped professionally, and had the appropriate emotional and financial support of others. They considered support offered from family, friends, their wider community, or nursing colleagues instrumental in helping them decide to volunteer. Some had previously participated in short-term humanitarian projects through school or university, or in nursing positions that had contributed to building confidence and inspiration. One participant stated, "I was encouraged by both a professor at nursing school and by a family friend to pursue this work. I feel like

the preparation I had as a burn's ICU [Intensive Care Unit] nurse was helpful. It's amazing how much has transferred over" (#31).

The ship hospital provided clean water, a constant electricity source, and access to reliable resources such as monitoring equipment; these were not guaranteed in a local LMIC setting. Knowledge the resources were likely to be dependable motivated volunteers with confidence their involvement could successfully make a difference. One participant shared, "Working in this [ship] context offering high-quality care and taking the skills I learned as a nurse at home to benefit another country, but still having the resources and access to things that I needed" (#11).

An expectation that surgery delivered on board the ship would positively transform the quality of a patient's life fuelled nurses' sense of purpose and intrinsic reward. One participant suggested that her involvement on the volunteer mission was more satisfying than work in her home country: "Here you have people who have had no other choice. We can offer them what they can't have. I just feel like I am doing so much more good here" (#14).

Another of the participants stated the incentive to begin and then continue her volunteer nursing role arose from witnessing patients' transformations, which she described as "addictive" (#48). Furthermore, their service encompassed more than aiding the patients' physical healing; it included an emotional context by allowing the nurse to instil hope to patients who had previously been depleted of all hope. That hope extended beyond post surgery outcomes and often changed the nurse's perception of their patient's trajectory. That is, hope became tangible; patients felt acceptance by the nurses and others, which nurses believed empowered patients to participate in their community again. One participant contemplated, "It is the patients that keep me coming back. Seeing the changes in them . . . seeing the difference in their demeanour when they leave the ship. I feel that's what really makes being here worth it" (#23).

Participants had robust advocacy for those who presented as vulnerable. They held the firm resolve that the underserved patient deprived of a reasonable quality of life deserved more than they had previously been given the opportunity for. Further, participants had a desire to restore dignity to individuals and were motivated by their perception they could be effective change agents in that process through their actions: "I love that people get access to surgery that they literally couldn't otherwise access . . . This is what love and hope look like, and I can be a part of delivering that" (#20a).

Participants were altruistically motivated to action: "There are so many different things that prevent people from getting health care that is a right. That's what drives me to want to bridge that gap of injustice and unfairness" (#27). The desire to bridge that gap not only required confidence but leads to the next subtheme: stepping out in courage to act.

5.1.3. Courage: "Being out of my comfort zone"

Many participants felt the opportunity to work in this humanitarian context appealed to their desire for a situation very different from what they had been involved with previously. That required courage and putting themselves in a position of vulnerability as they went from a known to an unknown environment. Volunteer nursing was a credible cause, and in doing so, participants connected the application of current knowledge to new learning experiences and expanding their flexibility. As one participant noted, 'I wanted to go out of my comfort zone . . . go to a place, to people who need help, where no others are coming to help them' (#46).

Some nurses were motivated by stepping beyond their prior experience. A nurse in the patient selection team stated, "You've got to concentrate on the people that you can help. It's hard; there is far more that we have to say no to, but to cope, you have to just concentrate on the ones you can help" (#02). Moreover, an-

other said, "I just really did not know what to expect. This has taken me totally off guard. It's way different . . . and way harder than I thought. But still, I like that it requires me to be adaptable, flexible" (#42). Participants had a sense of accomplishment that they were facilitating an opportunity to contribute to the welfare of others while working in a like-minded team that pushed their boundaries and afforded both personal and professional growth.

6. Discussion

The key findings from this ethnographic study show nurses' connection with their professional identity in having incentive and commitment to step outside their usual professional and personal boundaries, choosing to sacrifice (e.g., comfort, salary) to fulfil a felt need. Adding to this connection, nurses placed importance on addressing social justice, which was balanced by their expectation of personal reward through perceived career experience (Riley & Beal, 2010). Furthermore, participants were motivated by the ideology of caring for underserved people by extending their geographical and professional boundaries in austere circumstances.

Nurses sensed empowerment, which was nurtured by being a part of a team of health professionals working together for one purpose: to see an improvement in the patients' quality of lives. Motivations of nurses have been documented (Toode, Routasalo, & Suominen, 2011), as well as those of health care workers involved in short-term humanitarian projects (Laleman et al., 2007). Identified literature relating to nurses' motivations for humanitarian work is limited and predominantly describes nurses responding to a disaster situation (Hargreaves & Golding, 2017). However, findings within a disaster response setting aligned with this study's findings. That is, intrinsic motivation arises from the personal beliefs and values of individuals even when not associated with a discernible reward such as financial gain Bassous (2015).

Professional commitment links personal belief and professional identification (Chang et al., 2015). Nurses are more likely to offer increased effort when there is congruency between their ideals, including altruism and their professional identity (McNeese-Smith & Crook, 2003). Our participants' motivation to carry the cost and possible sacrifice were also assisted by the support of professional colleagues and significant others, which made their decision to volunteer more attractive (Vinje & Mittelmark, 2008). Contingent rewards were a factor that inspired nurses to return: patients' gratitude and the recognition of those in the nurses' professional and social circles in their home countries (Ziedelis, 2018).

There is credible evidence that those who help others sustain a benefit themselves (Schwartz, 2007). Participants were motivated by extending themselves to help others, which enhanced their wellbeing. A nurse with typically altruistic motives sacrifices something of themselves to benefit others and may hope that doing so will deliver a reciprocal benefit (such as career advancement or personal satisfaction). While nurses in other studies have described financial reward (wages and leave entitlements) and flexibility in working hours as motivating factors (Bjorneld, Lindmark, McSpadden, & Garrett, 2006), these factors were not explicitly a factor for this study's participants as they volunteered on a nonremunerated basis.

Volunteerism is known to provide positive health benefits for individuals in the form of enhanced mental health, including feeling needed and being involved in something bigger than themselves (Stukas, Hoyer, Nicholson, Brown, & Aisbett, 2016). Our participants said that they believed the benefits of seeing changed lives, and the experiences they gained far outweighed the cost to themselves.

Confidence in believing that they were contributing to making a tangible, positive difference to patients' quality of lives was a motivating factor for the participants. Being grateful for the opportu-

nity of education and experience led to a sense of responsibility to share that with the underserved. Further, the opportunity to network with and invest in the local health personnel was a strong incentive in offering their services to others. Again, not inherently different to a nurse working in their home country, yet the often dramatic and visible difference in improved quality of lives brought much satisfaction. For nurses, vocation encompasses more than the concept of a 'role'; there is a personal engagement with the values and ideals of a chosen profession (Raatikainen, 1997). Because there is identification and ownership of these values, a nurse is drawn into a 'moral pull' (White, 2002). What motivated the nurses in this study to volunteer? It was the genuine feeling that they felt they were in the right place, along with their internal belief system, which demonstrated alignment with one's values to carry out a mandate (Carter, 2014).

The study participants' willingness to step into an unfamiliar environment to rise to the challenge of experiencing emotionally taxing choices of patient selection and the need for an increased measure of resilience and bravery demonstrates the concept of courage. Nurses enacting their convictions despite difficulties (Cleary & Horsfall, 2014), with the courage to go beyond their comfort zone, were apparent characteristics (Crigger & Godfrey, 2011; Gallagher, 2011). Importantly, nurses who step into broadened emotionally challenging positions and outside their usual professional comfort zone are likely to develop leadership skills that are transferable to their practice on returning to paid work in their home countries (Clancy, 2003). 'Comfort zone' does not necessarily allude to physical comfort, even though nurses need to adjust in adapting to a hospital environment on a ship. The concept of courage and being out of one's comfort zone in this study represents going from the known to the unknown. It encompasses professional discomfort and moral distress, arising from being faced with the great need with increased numbers of patients and the severity of their conditions not previously witnessed in their experiences in working in a western country. It includes processing emotions raised by injustice and suffering and being confronted with boundaries and limitations within trying to meet the overwhelming need.

Regardless of age or situation, a firm conviction for participating in making a difference to individuals' situations was evident. Conviction is a concept described as a strong belief in something. However, for these participants, it was a driving force that included their values and commitment to action. Alignment with the organisation's mission and values was an additional strong motivating factor. Volunteers who feel 'called' into their vocation are more likely to be energised, productive, creative, persistent and willing to go beyond the reasonable expectation of hours and role to see an improved outcome and success of intended goals.

6.1. Strengths and limitations of the study

The unique aspect of this qualitative research study is its context of the humanitarian work of volunteer nurses in a nondisaster setting. The diverse participants shared an imperative to care for those unable to access curative surgery other than accepting this NGO's services. While the setting of a hospital ship is uncommon for most of the nursing profession, it may resonate with nurses involved in "fly in, fly out" immersive settings in other complex humanitarian health projects run by NGOs, especially those with a curative surgical focus.

Methodologically, immersive ethnography as an active participant-observer enabled a deep and close account of perspectives. Further insight into the benefits of this methodological approach is reported elsewhere [authors withheld for blind peer review]. This study's findings illuminated a particular sample of nurses volunteering for a mobile team that has a consistently

high turnover yet attracts enough volunteers to sustain the NGO's work, and often the same nurses return multiple times for repeat placements. Their identified motivations of conviction, confidence, and courage have been contrasted and compared to the limited evidence base, which to date has predominantly focused on nurses working within a disaster response context.

Findings were derived from those study participants who were interviewed; those not interviewed may hold different views. Participants were from high-income countries only. Although many were widely travelled, none came from the perspective of having grown up in an LMIC. This presents a potential bias as nurses from an LMIC could have different perspectives.

6.2. Implications for practice, policy, and education

Understanding the motivation of nurses volunteering for humanitarian service may prepare future volunteers and provide a baseline for comparison with other international experiences in LMICs. Social justice, orientation, belief, and personal philosophy are considered likely to influence those participants who either return to their usual nursing work in their home countries or who seek future involvement in humanitarian work. Volunteer nurses see themselves as gaining psychosocial benefits through their service, including possible increased employability (by gaining an expanded global experience) and emotional satisfaction, but adversely, they may have difficulty on return when social integration and support is less available or as they judge their position at home accomplishing less than extraordinary change in their patients.

Further research into patients' perspectives would add to the understanding of how motivation and incentive influence nurses' attitudes, behaviour, and skill. The perspective of health professionals being mentored would also give insight into the impact of this motivated volunteer nursing workforce. Further research may focus on identifying learning and support needs of nurses who desire to engage in nondisaster humanitarian work. Additionally, research may better prepare relevant organisations to develop their selection processes, orientation, and ongoing professional development programs. A broader study of humanitarian workers from a variety of organisations and geographical locations would provide greater insight and validation into the motivations and incentives leading nurses to volunteer.

7. Conclusions

The successful improvement in the quality of life for individuals receiving curative surgery requires a multidisciplinary team, whether in a disaster or nondisaster humanitarian response. Nursing care is vitally important to the preoperative, perioperative, and postoperative care of the patient. Understanding the similarities and variations in the motivation of nurses involved in volunteer nondisaster international humanitarian work can inform nursing leaders in their recruitment and support efforts. It offers focused insight that may both assist and inform nurses contemplating future volunteer service and allow others who have worked elsewhere to compare their experiences with this study's participants. Recruitment for future volunteer work within this and other NGOs may be targeted with a greater understanding of factors providing incentive and motivation for the initial and repeated deployment of nurses in short-term health-focused humanitarian projects.

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Ethical statement

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Conflict of interest

The authors declare that they have no competing interests.

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