Ethical Challenges Encountered by Humanitarian Aid Workers in Temporary Displacement Camps in the Context of Covid-19

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Humanitarian aid workers face several ethical challenges. They work in resource-limited settings, navigate power imbalances and face obstacles responding to populations affected by crisis. The Covid-19 pandemic added additional layers of challenge in places such as camps for refugees and internally displaced persons. However, the impact of the pandemic in these settings was varied, and in many cases, less than anticipated, raising questions about calibration of Covid-19 prevention and response to local realities. We conducted an exploratory qualitative descriptive study to better understand humanitarian aid workers' experiences in temporary displacement camps in the context of the Covid-19 pandemic. We interviewed 10 humanitarian aid workers with pandemic experience working in the Middle East, Africa, Asia and Europe, among others. Participants described ethical challenges, including implementing proportionate Covid-19 prevention strategies while mitigating harms of this response; navigating an environment with misinformation; responding to expectations of external authorities; fulfilling aid worker obligations amidst a global pandemic; questioning power imbalances within the humanitarian aid organizational hierarchy. Further understanding these ethical challenges may help orient training and policy to support responses to the needs of displaced populations in future public health emergencies, as well as better support humanitarian aid workers in these situations.

Introduction

Early in the pandemic, Covid-19 was predicted to have devastating impacts on refugees and Internally Displaced Peoples (IDPs), especially those living in temporary displacement camp settings (ACAPS 2020; International Rescue Committee, 2020; Truelove *et al.*, 2020). An influential report predicted that, without the implementation of public health measures, 98 percent of the population living in the Bangladesh Kutupalong Expansion site, the world's largest refugee camp, would be infected within the first year of the pandemic (Truelove *et al.*, 2020). This estimate, and others like it, were perhaps unsurprising as refugees and IDPs have high rates of comorbidities (van Berlaer *et al.*, 2017; Kleinert *et al.*, 2019; Akter *et al.*, 2021; Al-Rousan *et al.*, 2022), frequently live in substandard, crowded living conditions (UNHCR 2018), and have limited access to clean water, sanitation facilities (UNHCR 2020; Akter *et al.*, 2021; Alawa *et al.*, 2021; UNHCR 2021) and healthcare (Akter *et al.*, 2021; Alawa *et al.*, 2021). It was anticipated that their Covid-19 risk would be amplified due to these conditions, which reduce the ability to follow public health

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measures, such as social distancing or hand hygiene, or to isolate and obtain timely healthcare when sick.

Humanitarian assistance is 'designed to save lives, alleviate suffering, and restore and promote dignity in the wake of disasters and during large-scale emergencies' (Pringle and Hunt, 2015, p. 1). Humanitarian aid organizations play crucial roles in IDP and refugee camp settings. In many camps, they are responsible for providing healthcare, carrying out immunization programmes, and implementing water, sanitation and hygiene interventions, amongst other services. They are often involved in the implementation of infectious disease responses—whether in response to outbreaks of measles in a refugee camp, to the spread of cholera within a community or region, or to broader epidemic or pandemic conditions. The circumstances within which these organizations operate—such as widespread resource shortages or seeking to act as neutral and impartial parties in regions of conflict—can lead to difficult ethical questions for humanitarian aid organizations, as well as ethically challenging situations for aid workers. Organizational-level ethics issues that have been discussed in the literature include resource allocation (Hurst *et al.*, 2009), difficulties maintaining independence amidst donor interests, especially when these donors are governments (Slim, 2015; Broussard *et al.*, 2019) and determining when to provide aid and when to withhold it for concern that it may lead to more harm than benefit (Slim, 2015). Ethical challenges have also been identified at the level of individual humanitarian workers, including difficulties working within organizational constraints (Schwartz *et al.*, 2010; Durocher *et al.*, 2016), implementing resource allocation and triage (Hunt, 2008; Sinding *et al.*, 2010; Sheather *et al.*, 2022; Singh *et al.*, 2022), working in communities with cultural norms or expectations that differ from those of the aid organizations or aid workers (Bell and Carens, 2004; Bjerneld *et al.*, 2004; Hunt, 2008; Sheather *et al.*, 2022) and navigating power imbalances between (and among) aid workers and populations being assisted (Hunt, 2009; Rességuier, 2018). Through a critical systematic literature review, Côté and Drolet (2023) highlight the breadth of subjective ethical experiences of humanitarian workers in relation to felt pressure, uncertainty, dilemma, blindness, silence, myopia, distress and obligation and emphasize the complex ethical terrain of this domain of practice. Gustavsson *et al.* (2022) have further explored this through understanding the factors that could lead to moral distress, understood as the 'negative stress reaction that in turn could lead to secondary psychological consequences' (p. 2) due to moral residue of 'ruminating and lingering feelings regarding moral challenges during a longer time period' (p. 16).

Since the end of the pandemic, commentaries and reports have been published describing how Covid-19 played out in humanitarian settings, including displacement camps, and some of the challenges that surfaced. For example, reports from the World Health Organization's (WHO) Global Health Cluster (GHC) document difficulties implementing pandemic responses against a backdrop of pre-existing resource and personal protective equipment (PPE) shortages (GHC 2020; GHC 2023b), reaching vulnerable populations due to movement and visa restrictions (GHC 2020; GHC 2023b; GHC 2023c) and negotiating with national governments (GHC 2020; GHC 2023a; GHC 2023c). Maintaining essential health and other services was also challenging due to underfunding of humanitarian aid (GHC 2023b; GHC 2024).

As the pandemic subsided, humanitarian response plans shifted orientation from a pandemic-outbreak focus to the integration of Covid-19 management into the general disease response (GHC 2024). Nevertheless, there is value in reflecting on, and seeking to further understand what occurred during the different phases of the Covid-19 pandemic in humanitarian settings and exploring ethical challenges that have arisen, so that the needs of populations such as IDPs and refugees can be better assisted in future pandemics.

Methods

We conducted an exploratory qualitative description (QD) study to better understand '**what are ethical challenges encountered by humanitarian aid workers in temporary displacement camps in the context of Covid-19?**' QD is 'an empirical method of investigation aiming to describe the informant's perception and experience of the world and its phenomena' (Neergaard *et al.*, 2009, p. 2). QD was chosen for this study given its aims were to further understand events and perspectives, and generate a 'rich, straight description' of ethical challenges encountered by humanitarian aid workers (Neergaard *et al.*, 2009, p. 2).

We drew on sources including Schofield *et al.* (2021) and Jia *et al.* (2021) to develop the following operational definition of ethical challenges for the purposes of our inquiry:

> Ethical challenges arise when interests and/or values that people deem to be important are at odds or in conflict with each other, or appear to be impeded or threatened in some way. These situations may or may not require a decision to be made, and include, but are not limited to, situations that present as ethical dilemmas, constraints, tensions, uncertainty or distress.

Sampling and Recruitment

We employed maximum variation purposeful sampling, with a goal of recruiting people who had worked with a humanitarian organization in temporary displacement camp settings during the Covid-19 pandemic. We aimed to recruit diverse participants in terms of experience with different aid organizations, professional backgrounds and geographic locations of work (Patton, 1990).

Recruitment proceeded through three strategies: we emailed professional contacts (three participants recruited) and humanitarian aid organizations and research networks to inquire if they would be willing to share information about the study or whether they knew of individuals who might be eligible and interested to participate (one participant recruited). Remaining participants were recruited through snowball sampling, whereby we invited participants to suggest others who might be interested and eligible to take part (six participants recruited).

Participants

A total of 10 humanitarian aid workers participated: six nurses, two finance/project coordinators and two physicians. Seven participants self-identified as women, two as men and one who did not explicitly identify with a gender. They discussed their humanitarian aid experiences in geographic locations including Southern Asia (discussed by three participants), Western Asia (three), Middle East (three), Northeast Africa (three), Horn of Africa (one), East Africa (one), Central Africa (one) and Europe (one). Participants included nine international humanitarian workers and one national humanitarian worker who collectively were affiliated with three national or international humanitarian organizations during the pandemic (though several participants had previously worked for other organizations prior to the pandemic). The international humanitarian workers were originally from Europe or North America, and one was from Africa. The participants' experiences of working in temporary displacement camps during the pandemic ranged from January 2020 through to December 2022, with four participants being interviewed while they were working in the camp, and the others interviewed after returning to their home setting.

Interviews

We developed an initial interview guide drawing on the literature of humanitarian and infectious diseases ethics, including frameworks related to ethics and aid work (Hunt *et al.*, 2014) and public health ethics (Upshur, 2002). RM conducted a pilot interview with a humanitarian aid worker, resulting in further refinement of the guide. As data collection proceeded, we adapted the interview guide in an iterative manner as new insights emerged. Interviews ranged from 40 to 80 minutes in duration and written consent was obtained prior to each interview. All interviews were conducted by RM virtually on Microsoft Teams between August and December, 2022. Interviews were audio-recorded, and when possible, video-recorded. They were transcribed smooth verbatim (Mayring, 2014) and transcripts were reviewed for accuracy.

Data Analysis

Data analysis was initiated concurrently with ongoing interviews so that insights could be integrated into the ongoing data collection, such as adaptation of the interview guide. Analysis was guided by the inductive approach of conventional content analysis (Hsieh and Shannon, 2005), which is well-suited to exploratory inquiries (Elo and Kyngäs, 2008) and frequently used in qualitative descriptive studies (Neergaard *et al.*, 2009). RM developed codes to label segments of text (Elo and Kyngäs, 2008) in response to questions such as 'what is this segment about?' and 'how is it like, and not like, other segments?' (Green and Thorogood, 2018, p. 259). It was common for a segment of text to be labelled with multiple codes. Codes were defined in a separate codebook, which was refined as each transcript was coded. The coding structure was discussed with MH during regular analysis meetings.

Once the coding of all transcripts was complete, RM grouped like codes into 'generic categories' (Elo and Kyngäs, 2008) and created mind maps to link related categories. We continued to group categories into higher levels of abstraction until we created themes related to ethical challenges. Feedback and discussion with

Table 1. Summary of themes of ethical challenge

Theme	Description
Proportionality and alignment of Covid-19 measures	The pandemic response is not matching the needs of local contexts, and in some cases, creating harms
Navigating an environment of misinformation and mistrust	Community mistrust is creating challenges for both humanitarian aid workers and community members following public health measures
Responding to expectations of external authorities (a) Alignment of international guidance with local realities (b) Alignment between host country government expectations and humanitarian organizations' commitments	Challenges related to responding to the needs of the local context (food, water, varying Covid-19 impacts) while trying to follow what at times felt like discordant guidelines. Also describes difficulties abiding by humanitarian and organizational commitments while working in the confines of another country.
Fulfilling aid worker obligations in the context of a global pandemic	Difficulties being a humanitarian aid worker in the context of a global pandemic—resource shortages and travel restrictions creating particular challenges
Questioning organizational practices around national and international staff	Power imbalances between national and international staff, and opportunities the pandemic provided to challenge these existing dynamics

colleagues who have qualitative research experience (including current and former humanitarian workers, as well as scholars and students with training in fields including bioethics, rehabilitation sciences, family medicine and social sciences) was also important in each part of the data analysis process.

Ethical Considerations

Informed consent was provided by each participant prior to their interview. This study was reviewed and approved by the McGill Faculty of Medicine and Health Sciences' Institutional Review Board (study no. A07-B70-22B).

Reflexivity

We engaged in reflective practices throughout the course of the project. RM is Canadian-born, and at the time of conducting this research was a master's student in bioethics, with an undergraduate degree in life sciences, and new to qualitative research. MH is an experienced qualitative and humanitarian health ethics researcher, and previously practiced as a physiotherapist in international development and post-conflict reconstruction settings. While efforts were purposefully made to strengthen reflexivity through reflexive writing (field notes and voice memos) (Olmos-Vega *et al.*, 2023), and feedback from colleagues of varying professional backgrounds (Olmos-Vega *et al.*, 2023), it must be acknowledged that this research was carried out remotely by people based at a university in a high-income country, far from the realities faced by aid workers and people living in displacement camps.

Results

Using inductive techniques, we developed five themes related to the experiences of ethical challenges reported by the participants during their work in displacement camps over varying periods of the pandemic (Table 1). Selected verbatim quotations are included to illustrate aspects of the analysis.

Participants described a range of challenges associated with pandemic responses in camp settings. They reported that camp conditions led to the expectation that Covid-19 was going to significantly impact people living in the displacement camps where they worked. Almost all participants, however, described being surprised when the predicted situation did not unfold. They generally reported limited impacts of Covid-19 in terms of direct caseloads and hospitalizations in their camp settings. While some participants attributed the

low caseloads to the populations in their camp settings being younger or having limited access to Covid-19 testing, participants also underlined that there were few patients requiring hospital care for Covid-19. These contextual features and the ways that the situation unfolded over time shaped the participants' perceptions of the ethical challenges involved.

Proportionality and Alignment of Covid-19 Measures

Participants reported a 'huge preparedness' (P5) for Covid-19 prevention and response that was rolled out in the early weeks and months of the pandemic and calibrated based on the results of several modelling studies predicting dire consequences of Covid-19 outbreaks in the camps. Participants accepted the rationale for this initial response given the knowledge that was available at the time and the predictions for devastating impacts of Covid-19 in camp settings. However, as time passed and Covid-19 appeared to have much less impact in camp settings compared to what had been predicted and compared to what was unfolding in other locales and regions globally, the stringency of public health measures that were still being deployed created tensions for some participants. They questioned whether it was unethical to continue to push so strongly a Covid-19 preparedness agenda that did not match the ongoing Covid-19 reality in these camps, especially given the appreciable consequences of these measures for populations struggling to address their everyday needs. A participant who worked in two camp settings during the pandemic framed this concern in relation to whether the approach taken to Covid-19 in the camps was a problematic imposition of external priorities that did not adequately account for local realities:

> They have so many, so many layers that are like basic needs that are not covered. Covid is like, on top of it, is like I don't care, you know. And when you see that people—you go do messages, OK, social distancing, washing your hands, you know, in a country where there's no water or… It's a bit like, OK, maybe […] it's very much like a Westerner perspective, no? (P3)

As the pandemic progressed and there continued to be limited case counts in camp settings, the justification for these measures was seen as increasingly shaky due to the burdens and harms that resulted. Four participants stated that quarantine and isolation requirements for staff resulted in staffing shortages that exacerbated difficulties for healthcare access for camp residents. Strategies to manage risks of nosocomial transmission of Covid-19 were also described as creating healthcare difficulties. For example, patients who were classified as suspect cases were separated into areas and units that were often short-staffed and under-resourced. Only upon receiving a negative Covid-19 test could these patients be moved to other treatment areas. One participant, a physician working in a camp in South Asia, found this situation particularly challenging and described children with Covid-19 symptoms 'suffering' (P7) in the suspect ward until they received a negative Covid-19 test.

Nearly all participants also described how the massive investment of resources, staff and funding into the Covid-19 response had impacts on general healthcare provision and other critical programs in the camps. Such challenges are well described by one participant:

> …the, the, the biggest problem [of Covid-19] I would say was that we, we saw these floodings we saw how it was affecting food security… ummm…We, we saw how it was affecting access to healthcare. But there was no funding. We saw like an outbreak of malaria. We saw an increase in, in, in, in malnutrition. You know all of these things so—So I would say the ethical dilemmas I encountered most to Covid was actually, an exacerbation of […] Of, of, of the normal, umm, problems that there [was] no longer funding for. (P5)

While participants understood the need for a rapid response to Covid-19 and its potential consequences in camp settings during the initial phase of the pandemic and given all the uncertainties involved, they reported increasing discomfort associated with maintaining these measures despite there being limited spread of Covid-19, and while other needs were not adequately attended to for camp residents. This struggle appeared to be most salient in relation to the consequences on other domains of healthcare provision.

Navigating an Environment of Misinformation and Mistrust

Nearly all participants reported that fear, stigma, misinformation and mistrust created interlinking challenges. Several participants described difficulties balancing

infection control objectives with the social stigma for community members complying with these measures.

Misinformation and misconceptions about Covid-19 also contributed to fear and mistrust of healthcare personnel. One nurse who worked in a camp in Central Africa described 'tremendous difficulties' (P9) working in a community where misinformation was rife, despite their organization providing services in that community for many years. They described how community trust 'turned on a dime,' (P9) with healthcare workers receiving threats and being concerned about violence:

> I can remember like we, we would have a really hard time like working in the community that—like we had been accepted by [them] that entire time because, you know, they would throw rocks at us, they would cross the street, they would shout 'corona' at us […] And so it made the work really, really hard on top of it. (P9)

Despite their desire to help, the level of mistrust led to acute safety concerns for this participant and their team, and they were eventually transferred to another location.

Some participants also mentioned that the low numbers of Covid-19 cases in the camps contributed to hesitation to take up public health measures: 'And then when you see that the people do not really comply with the measures and in any case, there's no cases, no?' (P3) This participant worked in a setting where Covid-19 had had limited impact, even describing how 'nobody really cares about Covid here.' (P3) This perception, along with what the participant described as existing mistrust of government and healthcare institutions, made it difficult to convince the camp population to comply with preventive measures like social distancing.

Responding to Expectations of External Authorities

All participants reported challenges navigating external influences and interests. Participants described these challenges in relation to two domains: international public health guidance from entities such as the WHO, and pressures and expectations exerted by national governments.

International guidance that was misaligned with local realities

Half of participants reported challenges and tensions when guidance from external authorities was seen as not accounting adequately for the contextual features of the setting where they worked. This perception was most frequently expressed by participants working during the early phases of the pandemic. Some reported feeling that international guidance was well-suited to countries in the global north, but not for the resource-constrained settings of temporary displacement camps:

> But just I think the struggle was a little bit like with Covid—like WHO had all these guidelines and Ministry of Health, like, based in a capital, had all these guidelines, but there was no way that we could conform with them. […] None of those resources were available from a medical standpoint, but also from like a…from a…from a like household setting standpoint, like you couldn't isolate, you couldn't tell people to do this, this or this. So it was just kind of this like a bit of an ethical dilemma of, like, we know these are the guidelines, but we can't actually follow them. (P6)

Nearly all participants expressed that culture and community values were important considerations for the public health response. They described difficulties following policies that did not adequately account for cultural practices such as sharing food, specifically during Ramadan. One participant in Western Asia described challenges in that there was limited guidance that recognized the cultural importance of such traditions, questioning 'how do we do Ramadan safely?' (P1) It was challenging to 'find a balance between public health and umm yeah, culture and community.' (P1)

Some participants also described challenges when they lacked confidence in the recommendations themselves, especially early in the pandemic, due to a perception of disorganization and uncertainty about what measures would be effective. More challenging yet were situations for several participants when they questioned the scientific basis of specific public health messages. A participant who worked in Central Africa during the first few months of 2020 described their team's response when there was a directive by the WHO to discourage the use of mask-wearing within communities. They reported that there was 'frustration within the teams cause like [certain WHO based directives] did not make sense to us at all.' (P9) This participant's experience illustrates the difficulty for aid workers when their own professional judgment conflicted with international guidelines that they were required to follow. These and other similar public health messages

threatened the sense of trust with communities and created discomfort within aid workers to promote public health directives they saw as ineffective or problematic.

Misalignment between host country government expectations and humanitarian organizations' commitments

Several participants also reported challenges due to pressure from government officials and concerns about compromising humanitarian commitments. For example, one participant in Western Asia discussed challenges related to government influence in the operations of a Covid-19 facility. The participant, while acknowledging the importance of collaboration with the host government, described how it was 'morally distressing' (P1) to follow care protocols that were dictated by another authority whose standards did not align with those of their own organization. The participant struggled with whether their organization should compromise and provide suboptimal care to the displaced population, or refuse to, but not be able to provide care at all. Ultimately, the organization ended up withdrawing their services from the facility due to these concerns.

Several participants also experienced distress or discomfort when observing discrimination towards displaced populations by government authorities. For example, interviewees described more stringent public health measures being applied to refugees compared to the host community. The implementation of additional movement restrictions on displaced populations compounded pre-existing challenges, including healthcare access. A nurse described how the lockdown of a temporary displacement camp in Southern Asia resulted in the residents having reduced access to health services located outside of the camp:

> But during these lockdowns, it was like military guard. [The displaced population] could not leave, um, except for medical emergencies. Umm, but so there would be a…You know, like a government of [South Asian country] military person standing at the gate, who was, had the authority to decide what was considered a medical emergency or not, which we really struggled with. (P2)

This quotation reflects the challenges encountered by participants working in an environment with political interests, norms and healthcare expectations they viewed as being at odds with the standard or expectations of their aid organization or their professional commitments.

Fulfilling Aid Worker Obligations in the Context of a Global Pandemic

Pandemic travel bans and restrictions introduced new challenges for providing aid. Several participants stated that national and international travel restrictions forced them to remain in very challenging settings for longer periods without respite. The imposition of travel bans resulted in several participants being unable to leave these locations, a situation which they described as distressing. Many participants also expressed discomfort that evacuation might not be possible even if they became sick or the security situation deteriorated. Covid-19 appeared to create a novel circumstance in that it was the first time these international aid workers did not have the ability to leave:

> always the organization has said, like if you hit your limit, all you need to say…like no questions asked… is that you need to go. And so we've always kind of held onto that. Like if I hit my limit…I can go. And then it was like, well, you can't. (P1)

Some participants also discussed how travel restrictions created logistical barriers for care delivery. Movement and border restrictions led to global supply disruptions, as well as resource and staffing shortages in the camps. This was particularly salient in countries that relied heavily on international aid as an integral part of their healthcare system. One participant even described how early in the pandemic, the inability to get pain medication into a Central African country resulted in clinicians 'performing healthcare on patients without sedatives or pain [relief] and things like that, but it's kind of like, like what is the option? Like if we, if we don't do these surgeries like this person will die. But they're gonna be mostly awake for this.' (P9)

Overall, travel bans and restrictions enacted during the pandemic were a source of challenge, leading to supply and personnel shortages and causing distress as it limited the participants' ability to provide needed services, making it difficult for them to fulfil their humanitarian obligations.

Questioning Organizational Practices Around National and International Staff

Participants described navigating their roles within aid organization hierarchies and how the pandemic impacted these experiences. Nearly all participants described power imbalances between national and

international staff, and discussed how this power imbalance impacted their relationships and interactions (the exception was the national staff member participant, who worked for a national, not international, non-governmental organization, and therefore did not have the experience of working directly with international staff). Examples include an international participant who reflected on how their perspective was given more weight in team decisions and their viewpoint was rarely questioned by national staff members. Another participant described discomfort with the pressure that was exerted by international staff for national staff members to be vaccinated, 'instead of like, having conversations with them.' (P8)

The pandemic had significant impacts on organizational structures and human resource planning within some humanitarian organizations. Four participants described how movement restrictions for international staff led to other staff members taking on roles for which they had limited experience. However, this reconfiguration was described by three participants as also challenging power dynamics within these organizations in ways that they welcomed, as it allowed national staff to take on management and leadership positions that were previously held by international staff. As described by one participant in Western Asia, this reconfiguration altered their organization's practices in ways that have endured:

> there's been a big push in the whole organization since Covid that we realized we can nationalize a lot of positions that hadn't been that way before. […] Covid's kind of accelerated this… kind of reframing of that kind of, these traditional power dynamics. (P1)

One participant described, however, that national staff in their project were not provided adequate support to successfully assume these new roles. As such, this participant felt there was a missed opportunity because national staff 'didn't necessarily receive the tools or guidance of the… support' required 'to really reach that step.' (P4)

Some participants also reported discomfort or distress related to differing level of access to healthcare between international and national staff. One international participant in Southern Asia expressed that they felt 'very uncomfortable' (P2) knowing they may get the opportunity to be evacuated through medivac (in the latter phase of the pandemic), but national staff, and patients in the community, would be very unlikely to be. A few other participants, however, stated that these evacuation protocols were unavoidable, and even appeared to accept this dynamic as an inherent component of humanitarian aid. One participant, a physician, stated that while it 'sounds super harsh' and even 'difficult to accept,' having people evacuated from locations where they were solely deployed to provide aid is 'a logical approach.' (P4)

These experiences and perspectives reflect the varied ways that participants identified the pandemic context as influencing asymmetries of power between national and international staff of the organizations with which they worked.

Discussion

The participants in this study described a range of situations that gave rise to ethical uncertainty, tension or dilemmas during their involvement as aid workers during the Covid-19 pandemic. Several of these challenges, namely, working in environments with widespread misinformation and mistrust, struggling to uphold humanitarian commitments while working within rules of local or national authorities, as well as power differentials between international and national staff have been well documented in the humanitarian ethics literature (Schwartz *et al.*, 2010; Slim, 2015; Gotowiec and Cantor-Graae, 2017; Nichol and Antierens, 2021; Singh *et al.*, 2022). Several of the other findings are more specific, or arose in distinctive ways, during the Covid-19 pandemic.

A major source of ethical concern addressed by participants is whether and how pandemic responses should be adapted to local contexts where refugee and displaced person camps were situated, especially when the priorities identified in international guidelines did not align with the most pressing needs experienced by people in these settings. Rapid and widespread preparedness efforts were initiated in humanitarian settings in the early phases of the Covid-19 pandemic. These actions were clearly justified based on credible modelling studies that predicted severe consequences for camp settings (ACAPS 2020; International Rescue Committee, 2020; Truelove *et al.*, 2020). However, when Covid-19 did not materialize as expected in camp settings, our participants reported that, from the perspective of communities that had difficulty to secure clean water and adequate shelter, Covid-19 preventive measures seemed to be a distant and externally imposed priority. This dynamic presents important

ethical challenges. One facet of this situation in the settings where the participants were located was that many of the people responsible for implementing public health measures were themselves international aid workers from Western nations, reinforcing the perception of externally imposed rules that did not adequately align with local realities. Moreover, the emergent nature of the pandemic made it especially difficult to assess the effectiveness of preventive interventions that were implemented. As the pandemic progressed, the importance of tailoring public health measures to local contexts and to match community realities became clearer, yet such actions appear to have not been taken in many humanitarian settings, with humanitarian aid workers continuing to implement international guidelines without clear benefit to local communities.

Humanitarian workers' perceptions of an insufficiently adapted public health response were also documented by Jones *et al.* (2023). Similar to the perspectives reported by participants in our study, British international aid workers felt that the Covid-19 response in humanitarian settings was more aligned with the Covid-19 situation facing the UK, a high-income country, rather than with the local contexts where they were working (Jones *et al.*, 2023). Based on their findings, these authors argue for the importance of adapting Covid-19 policies to better reflect realities in different settings and adjust public health responses in consequence. Similar calls for more country-specific pandemic responses have been made based on experiences in a range of humanitarian settings (IASC 2020a; GHC 2023a; GHC 2023b). In the Central African Republic, for example, humanitarian practitioners reported discomfort with the prioritization of the pandemic response over addressing basic needs, especially considering the relatively young population, resulting in a lower overall vulnerability to the impacts of Covid-19 (GHC 2023b).

A full review of pandemic guidelines is beyond the scope of this paper. However, when reviewing several of the guidelines that were released early in the pandemic, it is notable that most do discuss the importance of tailoring response plans to local settings. In March 2020, the guidance document 'Scaling-Up Covid-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Including Camps and Camp-Like Settings,' was released by the Interagency Standing Committee (IASC) with a section stating: 'Specific COVID-19 outbreak readiness and response plan needs to be developed for each collective site, in alignment with national and local plans, and be based on the prevailing risks, capacities and gaps present at the site level' (IASC 2020b, p. 4). In May 2020, the IASC released another document that identified the need to 'develop a Covid-19 emergency plan specific to the setting, based on the identified risks and capacities' (IASC 2020a, p. 7) and that the emergency plan 'should balance the potential benefits of strict outbreak control measures with the socio-economic and protection consequences' (IASC 2020a, p. 7). This guidance included scenario-based recommendations based on viral transmission across four epidemiological conditions: 'no reported cases,' 'sporadic,' clusters of cases', and 'community transmission.' The flexibility in this document is helpful, but it seems that the categories of 'no reported cases,' 'sporadic,' and 'clusters of cases' are all oriented to funnelling resources into preparing for the community transmission scenario. In essence, these scenarios are structured as graduated steps in preparation for community transmission. One of the few sections that is focused on other needs is entitled 'sustain essential health and social services.' Here, there is helpful guidance in the 'no reported cases' scenario, which prioritizes non-Covid-19 essential services to ensure 'continuity of services when transmission increases, and services start being compromised.' (IASC 2020a, p. 20). However, there was limited guidance regarding *how* to adapt Covid-19 responses to national priorities and local situations, nor how to assess if services are being compromised. The issue of tailoring responses to local contexts is especially challenging in camp settings where case reporting may be limited, and where IDP and refugee camp populations may be stigmatized or left out of national assessments or priorities. Failing to adapt these global responses to local contexts also risks replicating colonial patterns in humanitarian work, which remains an ongoing ethical concern for the field (Slim, 2015).

Power imbalances and differing treatment access among national and international staff in humanitarian aid organizations were another ethical challenge for our participants. While a more fulsome perspective from national staff is clearly missing from this study, the participants discussed the pandemic as both a context where power imbalances were amplified in some instances, such as for the possibility of being medically evacuated if one became sick, but also as presenting opportunities to address some asymmetries of power within aid organizations. Power differentials among international and national staff have been discussed by a range of commentators and are an active area of reflection and debate in the humanitarian sector

(Fassin, 2007; Redfield, 2012; James, 2020). Alongside their professional expertise, national staff contribute important insights that can help enhance understanding and engagement around cultural and community norms between the local population and international staff, and better understand security situations based on their knowledge, networks and personal contacts (James, 2020). Nevertheless, leadership roles are often assigned to international staff. The pandemic presented a novel situation with global travel restrictions disrupting these power dynamics within aid organizations. As in this study, Jones *et al.* (2023) reported that during the pandemic national staff took on roles that had previously been held by international staff as a result of entrance restrictions enacted by several nations during the pandemic. These shifts of responsibility from international to national staff during Covid-19 were welcomed by our participants as steps towards recalibrating power dynamics within aid organizational hierarchies. Covid-19 appears to be the first time that border restrictions were so widespread as to result in wider disruptions of power relations across the aid sector. Given that our sample is largely made up of international aid workers, it would be beneficial to explore national staff members' experiences and perceptions of these changes, and how this situation has continued to evolve over time, including whether this redistribution of responsibilities has been maintained.

An overarching consideration that cut across several of the ethical challenges encountered by study participants was a sense of dissonance between what they were expected to do (for example, by national governments or international pandemic guidelines) and what aid workers themselves felt they ought to do (for example, based on humanitarian commitments or their understanding of local community contexts). While this dissonance is not unique to Covid-19, it played out in distinctive ways due to pandemic-related factors such as travel restrictions and supply chain shortages. Participants described feelings of frustration, distress or uncertainty, especially when they could not act in accordance with their own values or beliefs in how to best manage a situation. Moral distress is defined by Kälvemark et al as 'traditional negative stress symptoms…that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake' (Kälvemark *et al.*, 2004, p. 1082–1083). Studies have found that moral distress is related to feelings of frustration (Wilkinson, 1987; Wiegand and Funk, 2012; Wolf *et al.*, 2016; Gotowiec and Cantor-Graae, 2017), suffering (Harrowing and Mill, 2010), guilt (Wolf *et al.*, 2016), powerlessness (Wolf *et al.*, 2016; Gotowiec and Cantor-Graae, 2017) and depression (Wolf *et al.*, 2016) in both healthcare and humanitarian aid workers. Moral distress can also result in poor job retention for healthcare workers (Corley *et al.*, 2001; Austin *et al.*, 2017; Schaefer *et al.*, 2019), which has implications for long-term patient care and potential future staffing shortages. Direct negative impacts on patient care have also been reported (Wilkinson, 1987; Gotowiec and Cantor-Graae, 2017), including as a result of aid workers experiencing psychological impacts from facing ethical challenges (Gotowiec and Cantor-Graae, 2017). A greater awareness of moral distress and its precipitating ethical challenges in a pandemic situation may help humanitarian aid workers be better prepared to face them or ask for help when needed (Gustavsson *et al.*, 2020).

Limitations

This study has several limitations. First, the timing at which participants were interviewed may lead to recall bias, especially in the context of the quickly evolving pandemic. Several participants reflected on experiences that they had had two years previously. Given the rapidly changing circumstances, viewing these challenges 'through the lens' of later experience may have influenced how participants narrated or reassessed experiences from earlier in the pandemic. Second, the composition of the sample of interviewees is also a limitation, and the purposive sampling goals were only partially realized. While participants had diverse professional backgrounds and worked in camp settings in eight regions, nine participants were international staff, and only one was a national staff member. As a result, the perspectives captured in this study are primarily those of international aid workers whose views of the ethical issues involved in a global pandemic are influenced by this background and positionality, and who have limited knowledge of sociocultural contexts within different regions. Organizational representation is also limited. Among the participants in this study, only three organizations were represented, with eight out of ten participants having worked with the same organization. These sampling limitations resulted in part due to constraints for conducting this empirical study as part of RM's Master's thesis and challenges in recruitment, especially with reaching national staff members of humanitarian organizations.

Conclusion

This research illuminates the complex ethical terrain of humanitarian practice in the context of the Covid-19 pandemic. The findings offer several insights that could be taken into consideration in preparing for future infectious disease outbreaks in temporary displacement camps, including highlighting the importance of tailoring public health responses and guidelines to local socio-cultural contexts, resource constraints of displacement camp settings and the prioritization of preventive public health measures relative to other pressing needs. Shifting epidemiological circumstances should be monitored over time and the public health response adjusted accordingly. The study also highlights the challenge of navigating misinformation and mistrust in communities, and how communication around the rationale for and burdens of an infectious disease response has implications for trust, legitimacy and acceptance in communities. The study also sheds further light on challenges aid workers face when navigating external factors such as international guidelines, national policies and regulations and pandemic-related global travel and resource constraints. Furthermore, the pandemic entrenched some forms of power differentials between national and international aid workers, while also providing opportunities to redress other asymmetries of power between national and international staff. Identifying these ethical challenges presents ways to enhance preparedness for future pandemics in order to better support aid workers and populations that they assist.

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Conflict of Interest

The authors declare that they have no competing interests.

R.M. was affiliated with the Division of Experimental Medicine, McGill University, Montreal, QC H4A 3J1 while completing the study.

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Author Contributions

R.M. and M.H. are responsible for the planning and design of the project. R.M. drafted the interview guide with feedback and revisions from M.H. R.M. interviewed the participants of the study. R.M. analyzed interview data with feedback and guidance from M.H. The article was drafted by R.M. with feedback and revisions by M.H.

Ethical Statement

Written informed consent was provided by each participant prior to their interview. This study was reviewed and approved by the McGill Faculty of Medicine and Health Sciences' Institutional Review Board (Internal Study Number: A07-B70-22B).

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References

ACAPS. (2020). *COVID-19 Rohingya Response*, available from: acaps.org.

Akter, S., Dhar, T. K., Rahman, A. I. A. and Uddin, M. K. (2021). Investigating the Resilience of Refugee Camps to COVID-19: A Case of Rohingya Settlements in Bangladesh. *Journal of Migration and Health*, **4**, 1–16.

Al-Rousan, T., AlHeresh, R., Saadi, A., El-Sabrout, H., Young, M., Benmarhnia, T., Han, B. H. and Alshawabkeh, L. (2022). Epidemiology of Cardiovascular Disease and Its Risk Factors Among Refugees and Asylum Seekers: Systematic Review and Meta-Analysis. *International Journal of Cardiology: Cardiovascular Risk and Prevention*, **12**, 200126.

Alawa, J., Al-Ali, S., Walz, L., Wiles, E., Harle, N., Awale, M. A., Mohamed, D. and Khoshnood, K. (2021). Knowledge and Perceptions of COVID-19, Prevalence of Pre-Existing Conditions and Access to Essential Resources in Somali IDP Camps: A Cross-Sectional Study. *BMJ Open*, **11**,e044411.

Austin, C. L., Saylor, R. and Finley, P. J. (2017). Moral Distress in Physicians and Nurses: Impact on Professional Quality of Life and Turnover. *Psychological Trauma: Theory, Research, Practice and Policy*, **9**, 399–406.

Bell, D. A. and Carens, J. H. (2004). The Ethical Dilemmas of International Human Rights and Humanitarian NGOs: Reflections on a Dialogue Between Practitioners and Theorists. *Human Rights Quarterly*, **26**, 300–329.

Bjerneld, M., Lindmark, G., Diskett, P. and Garrett, M. J. (2004). Perceptions of Work in Humanitarian Assistance: Interviews with Returning Swedish Health Professionals. *Disaster Management & Response: DMR: An Official Publication of the Emergency Nurses Association*, **2**, 101–108.

Broussard, G., Rubenstein, L. S., Robinson, C., Maziak, W., Gilbert, S. Z. and DeCamp, M. (2019). Challenges to Ethical Obligations and Humanitarian Principles in Conflict Settings: A Systematic Review. *Journal of International Humanitarian Action*, **4**, 1–13.

Corley, M. C., Elswick, R. K., Gorman, M. and Clor, T. (2001). Development and Evaluation of a Moral Distress Scale. *Journal of Advanced Nursing*, **33**, 250–256.

Côté, L. P. and Drolet, M. J. (2023). Ethical Issues Arising in Humanitarian Work and Possible Responses to Them: Results from a Critical Literature Review. *Canadian Journal of Bioethics = Revue Canadienne De Bioethique*, **6**, 16–32.

Durocher, E., Chung, R., Rochon, C. and Hunt, M. (2016). Understanding and Addressing Vulnerability Following the 2010 Haiti Earthquake: Applying a Feminist Lens to Examine Perspectives of Haitian and Expatriate Health Care Providers and Decision-Makers. *Journal of Human Rights Practice*, **8**, 219–238.

Elo, S. and Kyngäs, H. (2008). The Qualitative Content Analysis Process. *Journal of Advanced Nursing*, **62**, 107–115.

Fassin, D. (2007). Humanitarianism as a Politics of Life. *Public Culture*, **19**, 499–520.

Global Health Cluster. (2020). GHC Study Findings: Country-Based Key Informant Interviews.

Global Health Cluster. (2023a). Study to Examine COVID-19 Vaccination in Humanitarian Settings.

Global Health Cluster. (2023b). Study to Examine Multisectoral Collaboration for COVID-19 Response in Humanitarian Settings.

Global Health Cluster. (2023c). Study to Examine the Coordination of COVID-19 Response in Humanitarian Settings.

Global Health Cluster. (2024). Impact Analysis of Covid-19 on Humanitarian Health Response.

Gotowiec, S. and Cantor-Graae, E. (2017). The Burden of Choice: A Qualitative Study of Healthcare Professionals' Reactions to Ethical Challenges in Humanitarian Crises. *Journal of International Humanitarian Action*, **2**, 1–10.

Green, J. and Thorogood, N. (2018). *Qualitative Methods for Health Research*. Thousand Oaks, United States: Sage: Sage Publications Inc.

Gustavsson, M. E., Arnberg, F. K., Juth, N. and von Schreeb, J. (2020). Moral Distress Among Disaster Responders: What Is It? *Prehospital and Disaster Medicine*, **35**, 212–219.

Gustavsson, M. E., Juth, N., Arnberg, F. K. and Von Schreeb, J. (2022). Dealing with Difficult Choices: A Qualitative Study of Experiences and Consequences of Moral Challenges Among Disaster Healthcare Responders. *Conflict and Health*, **16**, 24.

Harrowing, J. N. and Mill, J. (2010). Moral Distress among Ugandan Nurses Providing HIV Care: A Critical Ethnography. *International Journal of Nursing Studies*, **47**, 723–731.

Hsieh, H.-F. and Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, **15**, 1277–1288.

Hunt, M. R. (2008). Ethics Beyond Borders: How Health Professionals Experience Ethics in Humanitarian Assistance and Development Work. *Developing World Bioethics*, **8**, 59–69.

Hunt, M. R. (2009). Moral Experience of Canadian Healthcare Professionals in Humanitarian Work. *Prehospital and Disaster Medicine*, **24**, 518–524.

Hunt, M. R., Schwartz, L., Sinding, C. and Elit, L. (2014). The Ethics of Engaged Presence: A Framework for Health Professionals in Humanitarian Assistance and Development Work. *Developing World Bioethics*, **14**, 47–55.

Hurst, S., Mezger, N. and Mauron, A. (2009). Allocating Resources in Humanitarian Medicine. *Public Health Ethics*, **2**, 89–99.

Interagency Standing Committee. (2020a). Interim Guidance. Public Health and Social Measures for Covid-19 Preparedness and Response in Low Capacity and Humanitarian Settings.

Interagency Standing Committee. (2020b). Interim Guidance. Scaling up Covid-19 outbreak readiness

and response operations in humanitarian situations. Interim Guidance and Camp-Like Settings.

International Rescue Committee. (2020). *New IRC analysis reveals risk that coronavirus transmission rates in Moria, Al Hol and Cox's Bazar refugee camps could outpace those seen on the Diamond Princess cruise ship, [online],* available from: https://www.rescue.org/press-release/new-irc-analysis-reveals-risk-coronavirus-transmission-rates-moria-al-hol-and-coxs [accessed 31 March 2023].

James, M. (2020). 'Who Can Sing the Song of MSF?': The Politics of 'Proximity' and Performing Humanitarianism in Eastern DRC. *Journal of Humanitarian Affairs*, **2**, 31–39.

Jia, Y., Chen, O., Xiao, Z., Xiao, J., Bian, J. and Jia, H. (2021). Nurses' Ethical Challenges Caring for People with COVID-19: A Qualitative Study. *Nursing Ethics*, **28**, 33–45.

Jones, N., Few, R., Lake, I. and Wooster, K. (2023). Sustaining Disaster aid in the Onset of the COVID-19 Pandemic. *Journal of Emergency Management*, **21**, 85–96.

Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P. and Arnetz, B. (2004). Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System. *Social Science & Medicine (1982)*, **58**, 1075–1084.

Kleinert, E., Müller, F., Furaijat, G., Hillermann, N., Jablonka, A., Happle, C. and Simmenroth, A. (2019). Does Refugee Status Matter? Medical Needs of Newly Arrived Asylum Seekers and Resettlement Refugees—A Retrospective Observational Study of Diagnoses in a Primary Care Setting. *Conflict and Health*, **13**, 39.

Mayring, P. (2014). *Qualitative Content Analysis—Theoretical Foundation, Basic Procedures and Software Solution*. Klagenfurt, Austria: Social Science Open Access Repository.

Neergaard, M. A., Olesen, F., Andersen, R. S. and Sondergaard, J. (2009). Qualitative Description—The Poor Cousin of Health Research? *BMC Medical Research Methodology*, **9**, 52.

Nichol, A. A. and Antierens, A. (2021). Ethics of Emerging Infectious Disease Outbreak Responses: Using Ebola Virus Disease as a Case Study of Limited Resource Allocation. *PLoS One*, **16**, e0246320.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L. and Kahlke, R. (2023). A Practical Guide to Reflexivity in Qualitative Research: AMEE Guide No. 149. *Medical Teacher*, **45**, 241–251.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods*. Thousand Oaks, United States: Sage: Sage Publications, Inc.

Pringle, J. and Hunt, M. (2015). Humanitarian Action. In H. Ten Have (ed), *Encyclopedia of Global Bioethics*. Cham, Switzerland: Cham: Springer, pp. 1–10.

Redfield, P. (2012). THE UNBEARABLE LIGHTNESS OF EX-PATS: Double Binds of Humanitarian Mobility. *Cultural Anthropology*, **27**, 358–382.

Rességuier, A. (2018). The Moral Sense of Humanitarian Actors: An Empirical Exploration. *Disasters*, **42**, 62–80.

Schaefer, R., Zoboli, E. L. and Vieira, M. M. (2019). Psychometric Evaluation of the Moral Distress Risk Scale: A Methodological Study. *Nursing Ethics*, **26**, 434–442.

Schofield, G., Dittborn, M., Selman, L. E. and Huxtable, R. (2021). Defining Ethical Challenge (s) in Healthcare Research: A Rapid Review. *BMC Medical Ethics*, **22**, 135.

Schwartz, L., Sinding, C., Hunt, M., Elit, L., Redwood-Campbell, L., Adelson, N., Luther, L., Ranford, J. and DeLaat, S. (2010). Ethics in Humanitarian aid Work: Learning from the Narratives of Humanitarian Health Workers. *AJOB Primary Research*, **1**, 45–54.

Sheather, J., Apunyo, R., DuBois, M., Khondaker, R., Noman, A., Sadique, S. and McGowan, C. R. (2022). Ethical Guidance or Epistemological Injustice? the Quality and Usefulness of Ethical Guidance for Humanitarian Workers and Agencies. *BMJ Global Health*, **7**,e007707.

Sinding, C., Schwartz, L., Hunt, M., Redwood-Campbell, L., Elit, L. and Ranford, J. (2010). 'Playing God Because You Have to': Health Professionals' Narratives of Rationing Care in Humanitarian and Development Work. *Public Health Ethics*, **3**, 147–156.

Singh, N. S., Redman, B., Broussard, G., DeCamp, M., Rayes, D., Ho, L. S., Robinson, W. C., Sankari, A., Maziak, W. and Rubenstein, L. (2022). 'We Will Never Give Up': A Qualitative Study of Ethical Challenges Syrian Health Workers Face in Situations of Extreme Violence. *Disasters*, **46**, 301–328.

Slim, H. (2015). *Humanitarian Ethics: A Guide to the Morality of Aid in War and Disaster*. New York, NY: Oxford University Press.

Truelove, S., Abrahim, O., Altare, C., Lauer, S. A., Grantz, K. H., Azman, A. S. and Spiegel, P. (2020). The Potential Impact of COVID-19 in Refugee

Camps in Bangladesh and Beyond: A Modeling Study. *PLoS Medicine*, **17**,e1003144.

UNHCR. (2018). Rohingya Refugee Emergency at a Glance, [online], available from: https://unhcr.maps.arcgis.com/apps/Cascade/index.html?appid=5fdca0f47f1a46498002f39894fcd26f [accessed 31 March 2023].

UNHCR. (2020). Bidibidi refugee settlement (Uganda), [online], available from: https://www.unrefugees.org/refugee-facts/camps/ [accessed 31 March 2023].

UNHCR. (2021). Inside the world's five largest refugee camps, [online], available from: https://www.unrefugees.org/news/inside-the-world-s-five-largest-refugee-camps/ [accessed 31 March 2023].

Upshur, R. (2002). Principles for the Justification of Public Health Intervention. *Canadian Journal of Public Health*, **93**, 101–103.

van Berlaer, G., Elsafti, A. M., Al Safadi, M., Souhil Saeed, S., Buyl, R., Debacker, M., Redwan, A. and Hubloue, I. (2017). Diagnoses, Infections and Injuries in Northern Syrian Children During the Civil war: A Cross-Sectional Study. *PLoS One*, **12**,e0182770.

Wiegand, D. L. and Funk, M. (2012). Consequences of Clinical Situations That Cause Critical Care Nurses to Experience Moral Distress. *Nursing Ethics*, **19**, 479–487.

Wilkinson, J. M. (1987). Moral Distress in Nursing Practice: Experience and Effect. *Nursing Forum*, **23**, 16–29.

Wolf, L. A., Perhats, C., Delao, A. M., Moon, M. D., Clark, P. R. and Zavotsky, K. E. (2016). "It's a Burden You Carry": Describing Moral Distress in Emergency Nursing. *Journal of Emergency Nursing*, **42**, 37–46.