Ethical challenges encountered by humanitarian aid workers in temporary displacement camps in the context of Covid-19

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List of abbreviations

ETC: Ebola Treatment Centre

EVD: Ebola Virus Disease

IDP: Internally Displaced Person

NGO: Non-Governmental Organization

PPE: Personal Protective Equipment

UNHCR: United Nations High Commissioner for Refugees

WHO: World Health Organization

Abstract

Humanitarian aid workers encounter a range of ethical challenges. They commonly work in resource limited settings, must navigate power imbalances, and face obstacles to respond to the needs of populations affected by crisis. The Covid-19 pandemic added additional layers of challenge in settings such as camps for refugees and internally displaced persons (IDPs). Crowded and austere living conditions and limited access to healthcare make refugees and IDPs vulnerable to contracting Covid-19 and experiencing negative outcomes. Surprisingly, however, impacts have been varied, and in many cases, less than anticipated, raising questions in some settings about calibration of Covid-19 prevention and response to local realities. I conducted an exploratory qualitative descriptive study to better understand humanitarian aid workers' experiences in temporary displacement camps in the context of Covid-19. I interviewed one national aid worker and nine international aid workers with experience working in displacement camps in the Middle East, Central Africa, the Horn of Africa, Eastern Africa, Northeastern Africa, Western Asia, Southern Asia, and Europe. I analyzed data using an inductive approach and constant comparative techniques. Participants experienced ethical challenges including: implementing a proportionate Covid-19 response while mitigating harms of this response; seeking to abide by Covid-19 protocols while managing consequences of public health measures on other realms of care; navigating an environment with misinformation; operating on a background of unclear global guidance, host country expectations, pandemic related travel restrictions, and resource constraints; questioning power imbalances within the humanitarian aid organizational hierarchy. Participants also discussed their own sense of preparedness to deal with these challenges, and recommended ways to feel better prepared for future pandemics and crises, including ethics advisory roles, better cooperation between local and global actors, and more

fulsome pre-departure training. A greater understanding of ethical challenges may help inform future humanitarian ethics guidance or training, and provide insights to support aid workers and humanitarian organizations respond to the needs of refugees and IDPs during future public health emergencies.

Résume

Les travailleurs humanitaires sont confrontés à toute une série de défis éthiques. Ils travaillent généralement dans des contextes où les ressources sont limitées, doivent gérer les déséquilibres de pouvoir et faire face à des obstacles pour répondre aux besoins des populations touchées par une crise. La pandémie de Covid-19 a ajouté des difficultés supplémentaires, comme dans les camps de réfugiés et de personnes déplacées à l'intérieur de leur propre pays. La proximité, les conditions de vie austères et l'accès limité aux soins de santé rendent les réfugiés et les personnes déplacées vulnérables à la contamination par le Covid-19 et à ses conséquences négatives. Il est toutefois surprenant de constater que les effets ont été variés et, dans de nombreux cas, moins prononcés que prévu, ce qui soulève des questions dans certains contextes quant à l'adaptation de la prévention et de la réponse à la Covid-19 aux réalités locales. J'ai mené une étude qualitative descriptive exploratoire pour mieux comprendre les expériences des travailleurs humanitaires dans les camps de déplacés temporaires dans le contexte de la Covid-19. J'ai interviewé un travailleur humanitaire national et neuf travailleurs humanitaires internationaux ayant travaillé dans des camps de déplacés au Moyen-Orient, en Afrique centrale, dans la Corne de l'Afrique, en Afrique de l'Est, en Asie occidentale, en Asie du Sud et en Europe. J'ai analysé les données en utilisant une approche inductive et des techniques de comparaison constante. Les participants ont été exposés à des défis éthiques, notamment : la mise en œuvre d'une réponse proportionnée au Covid-19 tout en atténuant les effets négatifs de cette réponse ; la volonté de respecter les protocoles du Covid-19 tout en gérant les conséquences des mesures de santé publique sur d'autres domaines de soins ; la navigation dans un environnement caractérisé par la désinformation ; le fait d'opérer dans un contexte de directives mondiales peu claires, les attentes des pays hôtes, les restrictions de voyage liées à la pandémie et les contraintes de ressources ; la

remise en question des déséquilibres de pouvoir au sein de la hiérarchie de l'organisation de l'aide humanitaire. Les participants ont également discuté de leur propre sentiment de préparation au sujet de ces défis et ont recommandé des moyens de se sentir mieux préparés pour les pandémies et les crises futures, y compris des rôles de conseil en matière d'éthique, une meilleure coopération entre les acteurs locaux et mondiaux, et une formation plus complète avant le départ. Une meilleure compréhension des défis éthiques peut contribuer à éclairer les futures directives ou formations en matière d'éthique humanitaire, et fournir des idées pour aider les travailleurs humanitaires et les organisations humanitaires à répondre aux besoins des réfugiés et des personnes déplacées lors de futures urgences de santé publique.

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This thesis is dedicated to my Uncle David, who passed away this year. You were deeply loved and will be greatly missed.

Contributions

I, Robyn Mellett, am the primary author of all chapters in this thesis. Dr. Ryoa Chung and Dr. Matthew Hunt played an important role in the development of the thesis topic of inquiry. I designed the qualitative descriptive study, created the consent forms, recruitment emails, and study posting. Dr. Matthew Hunt provided feedback and revisions on all components. I was the primary developer of the interview guide, and received edits and feedback from Dr. Matthew Hunt and Mr. Mathieu Simard. I conducted all interviews, wrote field notes, transcribed the interviews, and wrote synopses. I also carried out data analysis, with help and feedback from Dr. Matthew Hunt. Ms. Charlotte Ouimet provided the French translation of the abstract. All chapters are written by me, with feedback and edits from Dr. Matthew Hunt.

1.0 Introduction

1.1 Scenario

Consider the following:

You are a Canadian nurse who works as an international humanitarian aid worker in crisis situations, often in regions of conflict or disaster where populations and health systems face significant resource constraints.

You sign up for a mission to help people who have been displaced within a country in Central Africa, a region facing conflict and violence. You are deployed to an internally displaced persons' camp. The date is October, 2019.

Fast forward a few months, you begin to hear reports of a respiratory virus surfacing in China with the potential to cause outbreaks. There is not much known about the virus, but there are many reported fatalities. The virus begins to take hold in Europe and the Americas, where there are reports of exponential spread, hospitalization, and overwhelmed healthcare systems. Ventilators and personal protective equipment (PPE) are in short supply in many settings. You are worried. The country where you are located does not even have ventilators. Moreover, the population you are serving does not have access to clean water and lives in spaces that are too small to socially distance. The World Health Organization (WHO) announces that the virus, SARS-CoV2, which causes a disease called Covid-19, has reached the proportion of a global pandemic.

One morning, you hear on the radio that the country will shut its borders that night to inbound and outbound flights. You are one of ten international workers deployed by your organization to this locale. The environment is ripe with uncertainty and people are stressed and

anxious. The other international aid workers scramble to catch one of the last-minute flights out. You decide to stay and help the national aid workers tend to the needs of the displaced population. You wait for Covid-19.

And you wait. You listen to WHO guidance and follow what has been done in Europe and North America. You tell people to socially distance, wash hands, isolate, yet not to wear masks. Your organization and your team prepare for the arrival of the virus in the camp because you know it could lead to havoc where you are.

Covid-19 arrives. There are cases, but the disastrous scenario for which you prepared does not materialize. Instead, in response to the restrictive public health measures that have been taken, the camp community starts to lose trust, and access to and quality of other services that have been provided to the population begins to be compromised. Blockages in the supply chain lead to medication shortages. As the situation unfurls, you also begin to question the roll-out of the Covid-19 response.

Time passes and rumours and misinformation spread. You become fearful as you hear reports of physical violence against healthcare workers in your region. You just attended to a patient with a severe gunshot wound, but were unable to provide pain medication due to the supply chain disruption. You are exhausted. You feel that you have reached your limit, but the borders remain closed. You feel that there is no way out.

The above scenario reflects circumstances described by humanitarian aid workers whom I interviewed as part of my thesis research. While fictional, the narrative reflects real issues and challenges faced by these aid workers. It also introduces some of the themes and concepts that

will be explored over the course of this thesis which examines **ethical challenges encountered by humanitarian aid workers in temporary displacement camps in the context of Covid-19.**

In the following section, I will contextualize this thesis with information related to population displacement and the evolution of the Covid-19 pandemic.

1.2 Global population displacement

Over the past few years, record numbers of people have sought refuge in new locations, and even in new countries. At the end of 2021, there were 89.3 million forcibly displaced persons worldwide (UNHCR, 2022). Refugees account for 27.1 million of this total and are "people who have fled war, violence, conflict, or persecution and have crossed an international border to find safety in another country" (UNHCR, n.d.). Internally Displaced Persons (IDPs) account for 53.2 million of this total and are defined as:

> Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border (United Nations, 2004, p. 1).

The remaining 9 million displaced persons are made up of asylum seekers and Venezuelans displaced abroad (UNHCR, 2022). The number of forcibly displaced people has doubled since 2012, primarily because of increasing levels of armed conflict (UNHCR, 2022).

Host countries accommodate individuals forced to leave their country of origin. However, 83% of refugees are hosted by countries that are classified by the World Bank to be "low to middle income," including 27% who are hosted by countries classified as "Least

Developed" (The World Bank, 2021f; UNHCR, 2022). This situation raises concerns of further burdening already resource constrained settings (UNHCR, 2022). Türkiye, for instance, classified as an upper middle income country (The World Bank, 2021d), hosts the highest number of refugees, at 3.8 million (UNHCR, 2022). Figure 1 shows the distribution of refugees globally in major hosting countries, most of which are classified as either upper, middle, or low income (The World Bank, 2021a, 2021b, 2021e; UNHCR, 2022). As of 2021, the largest populations of IDPs reside in Syria, Columbia, Democratic Republic of the Congo, Yemen, Ethiopia, and Afghanistan (UNHCR, 2022).

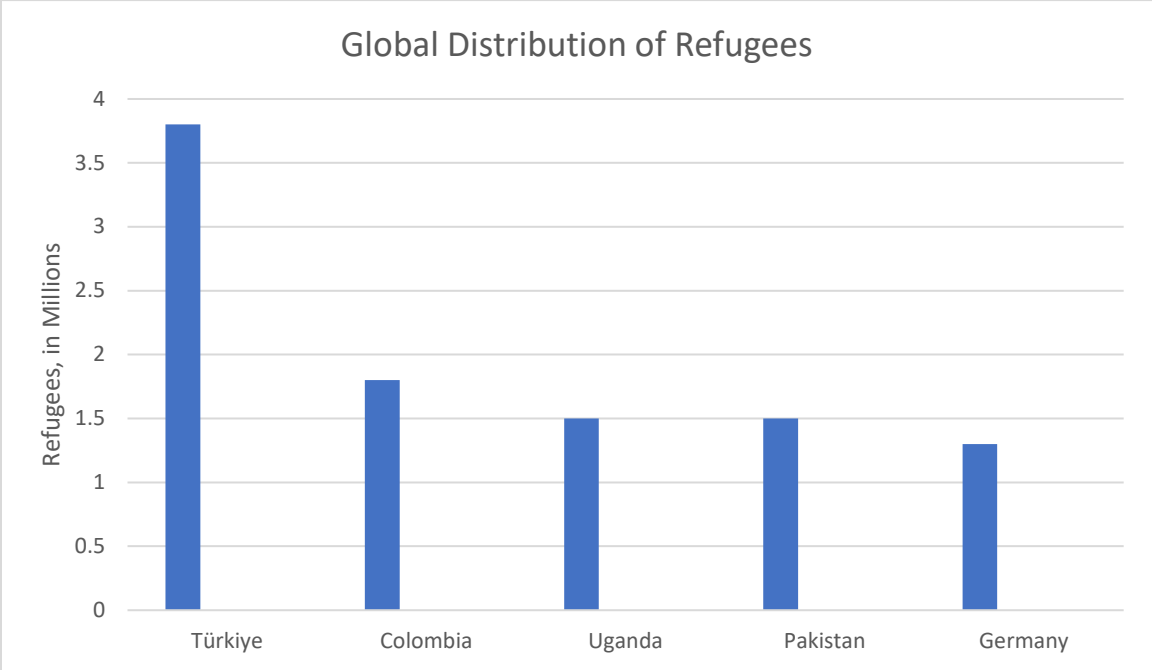

Figure 1: *Global distribution of refugees in refugee hosting countries, in millions at the end of 2021*. Adapted from the UNHCR Global Trends Report 2021 (UNHCR, 2022)

1.3 Covid-19, refugees, and IDPs

Covid-19 was first detected in Wuhan, China in late 2019. However, the precise origins of the Covid-19 pandemic remain unclear. One theory suggests that Covid-19 was passed from

animal to human in the Huanan Seafood Wholesale Market, as live animals susceptible to hosting coronaviruses—raccoon dogs, red foxes, and hox badgers—were sold during the time of the outbreak (Worobey et al., 2022). The presence of the genetic sequence of SARS-CoV2 (the virus leading to Covid-19) near vendors selling these animals supports this theory (Liu et al., 2023; Worobey et al., 2022). However, the competing lab leak theory, supported by the US Energy Department (Strobel, 2023), suggests that Covid-19 originated from the Wuhan Virology Institute, which conducts research on coronaviruses. A lack of a conclusive animal host lends support to the lab leak theory (Strobel, 2023). Regardless of origin, the impact of Covid-19 has been profound. Between its inception and April 2023, globally, there have been 762,201,169 reported Covid-19 cases and 6,893,190 deaths (World Health Organization, 2023).

Early in the pandemic, several reports predicted that refugees and IDPs, especially those living in temporary displacement camp settings, were going to experience high transmission rates of Covid-19 and subsequent disastrous outcomes (ACAPS, 2020; International Rescue Committee, 2020; Truelove et al., 2020). Researchers from Johns Hopkins University published a particularly influential report predicting that refugees living in the Bangladesh Kutupalong Expansion site, the world's largest refugee camp, would experience dire consequences from Covid-19. The modelling study indicated that there would be as many as 589,800 cases in the first 12 months of the pandemic (Truelove et al., 2020), with hospital capacity exceeding the existing 340 hospital beds in as little as 55 days (Truelove et al., 2020). The report also anticipated that without the implementation of an effective program of preventive public health measures within the first year of the pandemic, as many as 98% of the population residing in the Kutupalong expansion site would be infected (Truelove et al., 2020). Such predictions were perhaps unsurprising as refugees and IDPs have high rates of comorbidities (Akter et al., 2021;

Al-Rousan et al., 2022; Kleinert et al., 2019; van Berlaer et al., 2017), many live in substandard, crowded living conditions (UNHCR, 2018), and have limited access to water and sanitation facilities (Akter et al., 2021; Alawa et al., 2021; UNHCR, 2020a, 2021e), and to healthcare (Akter et al., 2021; Alawa et al., 2021). Such conditions render these populations less able to follow public health measures such as social distancing or hand hygiene, or seek healthcare, thereby further compounding Covid-19 risk.

Despite warnings of imminent disaster awaiting temporary displacement camps, as of December 15 2021, 116,893 positive Covid-19 cases were reported among the 82.4 million forcibly displaced people globally (UNHCR, 2021d). In other words, only 0.014% of the world's displaced population had reported testing positive. However, making these estimates is challenging given varying testing rates and case reporting. Comparatively, as of December 20, 2021, there were 5,926,597 reported global Covid-19 cases (World Health Organization, 2021) among the global population of 7.89 billion (The World Bank, 2021c), or 0.075% of the global population.

Among displaced populations, caseloads have varied between camps, geographic location, and timing of the appearance of variants. There were no positive cases among refugees living in camps in Cox's Bazar, Bangladesh until May 2020 (UNHCR, 2020e), and the camps continued to document low caseloads throughout October 2020 (UNHCR, 2020f). Interestingly, despite testing capacity increasing in these camps in September 2020, the positivity rate was lower than that of the host community (UNHCR, 2020g). Similarly, Jordan's two main refugee camps only began reporting positive cases around September 2020 (UNHCR, 2020b). The East and Horn of Africa and Great Lakes reported relatively fewer cases of Covid-19 compared to other regions in Africa (UNHCR, 2020d). Despite the existence of 100 refugee camps in this

region, by August 11, 2020 there had been no large scale outbreak declared in these settings (UNHCR, 2020d). In contrast, Iraq saw increasing Covid-19 cases over the same time period, and as of June 22 2020, there were as many as 1,100 new cases per day (UNHCR, 2020c).

Caseloads similarly varied in 2021, despite the arrival and roll out of Covid-19 vaccinations in some camp settings. The August 2021 United Nations High Commissioner for Refugees (UNHCR) report details a rise in Covid-19 cases, in part due to the Delta variant, with some countries in the Middle East and North Africa such as Iraq and Libya experiencing record high daily case counts (UNHCR, 2021a). Vaccinations started to arrive, with as many as 24,000 refugees living in camps in Jordan receiving doses (UNHCR, 2021a). In October 2021, while globally there was an overall decline of infection rates, many countries hosting large numbers of displaced peoples had less access and capacity to provide vaccinations to their citizens, along with displaced peoples (UNHCR, 2021b). In the Middle East and Northern Africa region, there were access difficulties attributed to vaccine certificates and other delays (UNHCR, 2021b). Similarly, only three out of 21 countries in West and Central Africa were able to provide two doses of vaccinations, though to just 10% of their population during this time (UNHCR, 2021b).

There was a decline in Covid-19 cases in November 2021 amongst refugees and asylum seekers globally (UNHCR, 2021c). Southern Africa reported very low caseloads among displaced "persons of concern," and as of November 22, 2021, only 1023 cases of Covid-19 had been reported in this population (UNHCR, 2021c, p. 3). During the same time period, 50% of refugees living in camps in Jordan received at least one vaccine, and 500,000 foreign nationals, including refugees and undocumented Afghans, were vaccinated (UNHCR, 2021c). Among other positive developments, the government of Tanzania permitted vaccine distribution in refugee camps (UNHCR, 2021c).

However, in December 2021, the downward trend in cases showed signs of reversing in some regions with the arrival of the Omicron variant (UNHCR, 2021d). There were several developments regarding vaccine status of refugees and other displaced peoples during this time: many refugees living in the Mbera refugee camp in Mauritania were vaccinated, and 53% of refugees living in camp settings in Jordan were vaccinated (UNHCR, 2021d). In the East and Horn of Africa and the Great Lakes region, 101,155 refugees received at least one dose of the Covid-19 vaccine (UNHCR, 2021d). As illustrated by this summary of developments from 2020 to 2021, informed by available data from UNHCR reports, caseloads and vaccination status among refugees and other displaced peoples have varied over time, and across regions.

1.4 Humanitarian aid, infectious disease responses and ethics

Humanitarian aid organizations carry out 'humanitarian action.' As defined by Hugo Slim (2015), "humanitarian action is a compassionate response to extreme and particular forms of suffering arising from organized human violence and natural disaster" (Slim, 2015, p. 1). For the purposes of this thesis, humanitarian aid organizations will include national and international non-governmental organizations (NGOs). These organizations play a critical role in responding to the needs of people living in precarious situations in situations of crisis, such as individuals living in temporary displacement camps. In many locations, these organizations are instrumental in providing refugee and IDP populations with access to healthcare, food, education, clean water, and other basic living needs. The difficult circumstances under which these organizations operate—such as those related to widespread resource constraints, 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. Some reported challenges for humanitarian aid workers include difficulties working within

organizational constraints (Schwartz et al., 2010), implementing resource allocation and triage (Hunt, 2008; Sinding et al., 2010), working in communities with cultural norms or expectations that differ with those of the aid organizations or aid workers (Bell & Carens, 2004; Bjerneld et al., 2004; Hunt, 2008), and navigating power imbalances between (and among) aid workers and populations being assisted (Hunt, 2009).

Amongst other activities, humanitarian aid organizations 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. There are a range of ethical considerations associated with the implementation of a public health response, such as those related to quarantine, surveillance, testing, patient confidentiality, and the proportionality of coercive actions. Some of these considerations arose during the 2014-2016 West Africa Ebola Virus Disease (EVD) epidemic which saw many international humanitarian aid organizations establish Ebola Treatment Centres (ETCs) in Liberia, Guinea or Sierra Leone. Some ethical challenges that have surfaced in this context include balancing the need to implement restrictive public health measures with the harms of these measures (Maduka & Odia, 2015); questions related to fairness of the possibility for international aid workers, but not national aid workers, to be evacuated for treatment in other countries if they contracted EVD (Royo-Bordonada & García López, 2016); along with questions as to who receives access to experimental therapies (Nichol & Antierens, 2021). The onset of the Covid-19 global pandemic has raised similar public health ethics considerations, this time from a global perspective, and has introduced additional questions. In the context of the pandemic, challenges related to public surveillance, ethics of quarantine, duty to treat (McConnell, 2020), allocation of scarce resources (Fariba & Saeedeh Saeedi, 2020), and

addressing misinformation have resurfaced. However, most of the emerging bioethics analysis during the pandemic has focused on how these challenges have played out in the context of the Global North, with less attention given to the public health response in low- and middle-income nations, or in the context of temporary displacement camps.

1.5 Rationale of the study

Humanitarian aid workers, or those working on behalf of humanitarian aid organizations to provide assistance to populations in crisis situations such as war and disaster, have played an important role in both the Covid-19 response, as well as maintaining essential services throughout the pandemic. Researchers have documented ethical challenges encountered by aid workers in humanitarian crisis settings, including epidemics such as the 2014-2016 West Africa EVD epidemic. However, there is limited research that has been published examining ethical questions and challenges encountered by humanitarian aid workers generally during infectious disease outbreaks and *specifically* in temporary displacement camp settings. As this context shares similarities with the 2014-2016 West Africa EVD epidemic—both involve highly infectious diseases in the context of low resourced settings—it is likely that the ethical challenges that arise within temporary displacement camps during Covid-19 will be similar to those that were experienced during the West Africa 2014-2016 EVD epidemic. However, differences such as the case rate fatality, mode and ease of transmission, global scope and impact, and vaccine distribution introduce a distinctive array of ethical considerations that have not yet been thoroughly explored.

Through my thesis research, I aim to answer the following research question: **what are ethical challenges encountered by humanitarian aid workers in temporary displacement**

camps in the context of Covid-19? Exploring this research gap is beneficial for two main reasons:

First, this study aims to help increase our understanding of what has occurred in temporary displacement camps during the Covid-19 pandemic, and especially the ethical challenges experienced by humanitarian aid workers. Making this knowledge available may help humanitarian organizations reflect on what could be done for future pandemics to respond more equitably and effectively to the needs of refugees and IDPs living in temporary displacement camps, both in terms of pandemic response, but also the continuation of other routine services.

Second, several leading experts and humanitarian aid workers have asserted that there is insufficient ethical guidance for humanitarian aid workers (Civaner et al., 2017; Hunt et al., 2012; McGowan et al., 2020; Sheather et al., 2022; Singh et al., 2022). Some have also identified a disconnect between the seemingly abstract ethical guidance that is produced and the actual problems encountered by aid workers in the field (Sheather et al., 2022; Singh et al., 2022). The findings of this study could help policy makers better understand some of the ethical challenges that are faced by humanitarian aid workers in the specific context of temporary displacement camps during the pandemic. These findings, combined with other research, knowledge and experiences, could help inform the development of future ethics guidance in infectious disease settings that is better tailored to the actual ethical and everyday challenges faced by aid workers.

1.6 Positionality and motivation for thesis project

I am a bioethics Masters student who became interested in qualitative research after acting as a research assistant on a qualitative research project examining Canadian health and social service professionals' perspectives on services and resources provided for refugees with

disabilities upon their arrival in Canada. Under the guidance of Dr. Matthew Hunt, a leading scholar in humanitarian health ethics, I developed an interest in humanitarian health ethics and how this could intersect with challenges faced by displaced populations. As the project was created during the time of a pandemic, examining ethical challenges related to COVID-19 seemed timely. The focus for my thesis was refined through discussion with my supervisor, Dr. Matthew Hunt, and Dr. Ryoa Chung (a leading philosopher with interests in global health) who was a member of my thesis committee.

1.7 Layout of thesis

In this chapter, I have provided an overview of the global displacement situation. I also charted changes in Covid-19 caseload data and vaccination status in displaced populations over the course of the early pandemic. This chapter also introduced some topics that will be explored in greater depth in Chapter 2 related to humanitarian, public health, and infectious disease ethics. I concluded by explaining the origins of my thesis topic.

Chapter 2 provides an overview of literature on several topics that inform the research presented in this thesis. I go into greater depth in discussing research surrounding ethical challenges of humanitarian aid work. I then examine public health and infectious disease ethics and illustrate these concepts with examples of ethical challenges arising during the 2014-2016 West Africa EVD epidemic and Covid-19 pandemic.

In Chapter 3, I present the methods for the qualitative description study that I have conducted. I outline the methodology, sampling, and recruitment of humanitarian aid workers to participate in interviews as part of this study. I then detail how I analyzed interview data.

Chapter 4 presents the results from the interviews with humanitarian aid workers, synthesized into six themes. Five themes describe ethical challenges that participants encountered while working in displacement camp settings: challenges of proportionality and alignment of Covid-19 measures, navigating an environment of misinformation and mistrust, responding to expectations of external authorities, fulfilling aid worker obligations in the context of a global pandemic, and questioning organizational practices around national and international staff. The sixth theme is about preparing for ethics in humanitarian work.

In Chapter 5, I discuss the results of the study. First, I compare the study findings to other empirical studies that have uncovered challenges experienced by humanitarian aid workers. I also investigate some concerns raised by findings related to moral distress and the hierarchy of aid organizations. I provide several recommendations to help aid workers be better prepared to respond to some of these challenges from an organizational perspective. I conclude by outlining study limitations.

Chapter 6 provides a short conclusion encompassing the entirety of the thesis.

2.0 Literature review

The following sections provide an overview of two key areas of academic and gray literature that inform this thesis. Section 1 examines ethical challenges arising in humanitarian aid work, with a particular focus on ethical challenges in the day-to-day activities of aid workers. Section 2 introduces the fields of public health ethics and infectious disease ethics, and discusses how these considerations and challenges play out in real life infectious disease scenarios through examining the 2014-2016 West Africa EVD epidemic and the Covid-19 global pandemic.

2.1 Humanitarian aid, humanitarian principles, and ethical challenges

Humanitarian aid organizations and their staff play important roles in assisting populations affected by war, epidemics, and natural disasters. Their activities include programs to provide food, healthcare, shelter, education, and social services. However, working in austere, shifting, and precarious contexts can create situations of uncertainty that neither organizations, nor their staff, know how to navigate. Normative guidance and codes of conduct offer reference points to orient aid workers and humanitarian aid organizations to handle these situations.

In 1965, the International Red Cross and Red Crescent Movement, an influential humanitarian aid network consisting of several entities, developed seven principles to guide its organizations, volunteers, and their staff through the ethical and operational dimensions of their activities (International Federation of Red Cross and Red Crescent Societies, 2023; Slim, 2015). Four of these principles—humanity, impartiality, neutrality, and independence—are derived from the four Geneva Conventions and their Additional Protocols of 1942, and are enshrined in International Humanitarian Law (Médecins Sans Frontières, n.d.). These four principles are commonly used as the grounding for many other organizational codes (Slim, 2015).

Following the inception of the seven principles, the International Federation of Red Cross and Red Crescent Societies and the International Committee of the Red Cross, along with other aid organizations, continued to develop ethics guidance and in 1992 published the more in depth Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief (International Federation of Red Cross and Red Crescent Societies, 1992; Slim, 2015). This Code outlines 10 tenets for aid organizations to guide their behavior and conduct in humanitarian endeavors (International Federation of Red Cross and Red Crescent Societies, 1992). In 1997, humanitarian organizations and experts came together to establish the Sphere minimum standards (Sphere Standards, 1997). These standards address key areas of humanitarian aid such as food security and nutrition, water and sanitation, shelter and settlement, and health (Sphere Standards, 1997). The standards are grounded in the Humanitarian Charter, a normative statement which adopts a rights-based approach to humanitarian aid, outlining the rights of populations impacted by disasters (Sphere Standards, 1997).

At times, the difficult situations inherent in humanitarian aid work may threaten, and even defy the ability of aid workers to abide by humanitarian principles, codes of conduct, and other obligations of humanitarian aid work (Broussard et al., 2019). Misalignment between what 'should' be done, and what 'can' be done results in ethical challenge. For the purpose of this thesis, I drew on concepts from Jia et al. (2021) and Schofield et al. (2021) to create the following definition for ethical challenge:

> Ethical challenges arise in situations 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 moral dilemmas, uncertainty or distress.

The scope of the concept of ethical challenge will be kept broad within this thesis—and in the empirical research study described in the following chapters—to include a wide range of experiences, including moral dilemmas, uncertainty, and distress. Jameton (1984) describes a moral dilemma to be when an individual has multiple ethically reasonable courses of action they could pursue, but each option entails conflicts amongst moral principles. In a dilemma, choosing any of the available options would result in the sacrifice of particular morals or values (Jameton, 1984; Kälvemark et al., 2004). Moral uncertainty results from an individual being unsure whether or not they are experiencing a moral dilemma, whether and what values may be at play, and what course of action to take (Jameton, 1984; Kälvemark et al., 2004). It may also involve uncertainty about whether the situation actually constitutes an ethical issue. Finally, moral distress has been defined 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. 1077)

Some characteristics of ethical challenges experienced by aid workers have been associated with the onset of moral distress. I will further elaborate on this topic in Chapter 5. Ethical challenges in the context of humanitarian aid may be differentiated between those occurring at an organizational or an individual level (though they are often intertwined).

2.1.1 Ethical challenges for humanitarian aid organizations

Humanitarian aid organizations may confront ethical questions related to the humanitarian enterprise itself, as well as while providing aid to populations. Slim (2015) outlines several recurrent problems encountered in humanitarian aid. First, aid may be manipulated (Leader, 1998) or coopted by external parties, agendas, and interests, thereby jeopardizing the

ability of aid organizations to abide by humanitarian principles (Slim, 2015). For instance, donor interests, especially when these donors are governments, may dictate the actions of the aid organization, consequently threatening independence (Broussard et al., 2019; Slim, 2015). Second, ethical questions may arise when the provision of aid itself can lead to harms (Slim, 2015). For example, providing aid to a community can incentivize armed forces to perform raids thereby putting civilians at greater risk of harm (Slim, 2015). Third, Slim (2015) outlines "risks of association" (p. 189). In other words, there can be repercussions when humanitarian aid organizations interact, or cooperate with, groups such as armed forces or governments. These interactions may unintentionally lend legitimacy to some of these groups, or, conversely, delegitimize the aid organization and undermine trust (Slim, 2015). This outcome is a particular concern when armed forces are required to protect the safety of aid workers (Slim, 2015). Other documented challenges for aid organizations include working with public authorities or governments who are antagonistic or distrustful toward the aid organization (Civaner et al., 2017), and allocating limited organizational resources—such as deciding in which locale to open a humanitarian project—in the face of several pressing needs that cannot all be met (Clarinval & Biller-Andorno, 2014).

2.1.2 Ethical challenges for humanitarian health workers

Several studies have documented ethical challenges directly experienced by humanitarian health workers in their everyday activities (Civaner et al., 2017; Hunt, 2008, 2009; Schwartz et al., 2010). Most of these studies have focused specifically on ethical issues encountered by international humanitarian workers—typically from countries in the global north—who respond to crises in other countries—though several studies have included national humanitarian workers (Civaner et al., 2017; Durocher et al., 2016; Sheather et al., 2022).

2.1.2.1 Navigating considerations related to culture and community

International aid health workers are deployed to new locations, often providing aid in new cultural contexts. National staff may also be working in communities and cultural contexts that are less familiar. Working in an unfamiliar environment can bring to light several ethical challenges for aid workers (Bjerneld et al., 2004; Civaner et al., 2017; Hunt, 2008; Sheather et al., 2022).

Adhering to personal values can be a challenge for aid workers when the local community, and/or staff have different perceptions and expectations on topics such as medical treatment, health and illness, death and dying, and the role that traditional medicine should play in care (Hunt, 2008). For example, surgeons deployed to Mogadishu with a humanitarian organization experienced ethical tensions when patients injured in combat declined amputations needed for their survival, preferring to die with a whole body than live with a missing limb (Bell & Carens, 2004). Such "clashing beliefs" between international healthcare workers and local patients created distress as the beliefs of the patients conflicted with values that the surgeons held as moral imperatives (Bell & Carens, 2004, p. 304). Schwartz et al. (2010) similarly found international aid workers to struggle when community norms differed from the values and practices of aid workers. One aid worker described a woman needing an urgent Caesarean Section, but local cultural norms required consent from both the mother and her husband (Schwartz et al., 2010). However, the husband was unwilling to provide consent, leaving the aid worker in an uncomfortable position (Schwartz et al., 2010). While they reported distress in not performing the procedure, the aid worker described how ignoring the cultural context and doing the surgery could have jeopardized the ability of the organization to provide care in the

community going forward (Schwartz et al., 2010). As illustrated by these examples, caring for patients in new cultural contexts can at times create difficult situations.

Humanitarian action involves parties receiving and providing aid; thus, there is an inherent power imbalance between the helper and those being helped (Civaner et al., 2017; Slim, 2015). This imbalance may be exacerbated when paired with legacies of colonialism tied to aid work (Hunt et al., 2014), and can introduce ethical tensions. Noticeable power inequities between aid workers and beneficiaries can leave aid workers feeling frustrated, and even with a perception that they are doing more harm than good (Gustavsson et al., 2022). Indeed, aid workers and organizations have the power to make long lasting changes to healthcare systems, which may be damaging to the community if aid workers lack the appropriate knowledge of the local context (Hunt, 2009). Similarly, power differentials can also result in patronization and degradation of beneficiaries if aid is not carried out in a sensitive manner that demonstrates respect and promotes their dignity (Civaner et al., 2017; Rességuier, 2018). Such a scenario was reported by an aid worker witnessing food distribution in Turkey who described aid distribution as humiliating when food was simply “thrown out from the trucks to the people” (Civaner et al., 2017, p. 7). Power imbalances may also threaten patient autonomy. Some local Turkish aid workers have stated that the chaotic situation resulting from disasters makes obtaining consent from patients challenging (Civaner et al., 2017). As such, some aid workers have reported themselves to be in the best position to make health related decisions on behalf of their patients (Civaner et al., 2017). While this may be permissible in certain emergent cases, such an approach and mindset can serve to further entrench inequities by dismissing the capacity of beneficiaries. In light of these considerations, there have been calls not only to acknowledge (Hunt, 2009), but also address steep power differentials (Rességuier, 2018).

2.1.2.2 Resource allocation in conditions of scarcity

Humanitarian crises often occur in locales where resources are already limited, and the needs outweigh available resources. When disasters occur, resource constraints such as medical supply limitations and staff shortages are exacerbated in the face of border restrictions, natural disasters, and conflict. These constraints can lead to ethical conflicts, and consequent frustration when aid workers are unable to provide aid for all people in clear need of assistance (Hunt, 2008). There are also reports of distress being felt by healthcare workers when resource allocation decisions that are made at higher levels in the organization are not accepted by the community (Sheather et al., 2022). Resource shortages may force aid workers to make difficult choices in terms of which patients to treat in the short term, and the extent that scarce resources should be reserved for future patients and those with chronic conditions (Schwartz et al., 2010; Sinding et al., 2010).

Aid workers may also face the difficult reality of providing substandard care to beneficiaries as a result of resource shortages (Hunt, 2009). For example, resource shortages such as lack of staff and beds available to humanitarian organizations in Syria required them to provide a reduced standard of care (Singh et al., 2022). Staff shortages can also lead to clinicians being in the uncomfortable position where they must choose whether or not to provide care that is at the limit of or outside their scope of practice and training (Hunt et al., 2013; Singh et al., 2022).

2.1.2.3 Institutional policies and interests

Institutional policies, interests, and guidance in aid organizations may constrain the aid workers' scope to make decisions when faced with an ethical dilemma. This situation can create feelings of powerlessness, discomfort, and moral distress when humanitarian aid workers feel

that they know the morally correct course of action to take, but are unable to act. In some situations, organizational policies may contribute to ethically difficult decisions (Schwartz et al., 2010). One example was reported by an international participant in a study by Schwartz et al. (2010). The participant was a health professional who cared for a patient with diabetes as part of an emergency response. The policies of the aid organization dictated that they should not initiate treatment for this patient due to the long-term resource requirements of this chronic condition which extended beyond the duration of the project. Despite being contrary to the organizational directive, the participant experienced tension as they believed that their duty to respond to the health needs of this patient outweighed long term resource considerations.

Organizational donor interests may also play a role in dictating care in humanitarian settings, sometimes neglecting real needs on the ground. Durocher et al. (2016) documented organizational interests to prioritize the care for people with HIV during the 2010 Haiti earthquake. While Haitian and international aid workers recognized the need to care for this group, there was a perception that this care was driven by donor interests as opposed to the needs of those most impacted by the earthquake (Durocher et al., 2016) .

There are also reports of vertical programs creating ethically challenging situations. In these cases, programs focus on a single medical condition, such as tuberculosis, and restrict aid workers to treating only patients with the identified condition (Schwartz et al., 2010). Such programs create ethical challenges when aid workers are forced to turn away patients seeking care for ailments that are outside the program (Schwartz et al., 2010).

A lack of institutional guidance and support may also lead to distress for humanitarian aid workers. Some frontline healthcare workers in Syria described experiencing ethical challenges because of unclear and limited ethical guidance and policy (Singh et al., 2022). Some stated there

was a lack organizational support and guidance on the field. While this situation promoted a degree of independence for some aid workers and enhanced their ability to use local knowledge, some also felt overwhelmed by the responsibility of decision making without guidance, in that they "couldn't be responsible for the lives of all" (Singh et al., 2022, p. 315). Similarly, Gotowiec and Cantor-Graae (2017) described aid workers in their study as having received limited support and guidance on the field from in the head offices of their organization. This silence forced aid workers to make decisions on the field with insufficient support, resulting in feelings of isolation and even abandonment (Gotowiec & Cantor-Graae, 2017).

There are a range of other ethical challenges encountered by individual aid workers that fall outside the three domains I have highlighted here. For instance, there are reports of humanitarian aid workers experiencing difficulties balancing staff safety with providing necessary care for patients (Singh et al., 2022). Other topics include the allocation and application of experimental therapies (Tambo, 2014), ethical implementation of research and data sharing (Schopper et al., 2009), protecting patient confidentiality (Civaner et al., 2017), and the proportional implementation of public health measures (Nichol & Antierens, 2021) in humanitarian settings.

As described above, aid workers reported experiencing distress when facing ethically challenging situations. In line with Kälvemark et al. (2004)'s definition, these "traditional negative stress symptoms" (p. 1077) resulting from difficult ethical situations constitute experiences of moral distress. Having to make decisions where individuals are unable to fully uphold their own moral values and ethical commitments can have consequences for the individual, and in the case of aid workers, the populations that they serve, as well as their colleagues and partners. These consequences will be further described in Chapter 5.

2.2 Public health ethics: an introduction

Seatbelt laws, tobacco control, alcohol prohibitions, and cholesterol regulations are just some examples of public health interventions implemented by governments and other authorities with the goal of protecting population health. There are many definitions of public health; however, as noted by Dawson and Verweij (2007), these definitions generally encompass two concepts. First, public health involves the health of groups of people, and second, that interventions, (which are often carried out by governments), require "collective action," on behalf of large groups of people (Dawson & Verweij, 2007, p. 21).

Public health ethics is a field of bioethics examining ethical considerations in the implementation, justification and prioritization of public health interventions such as public health promotion, resource allocation, screening programs, contact tracing, mandatory vaccination programs, and quarantine, among others. Discussions of public health ethics began in the 1970s and 1980s, covering topics including ethics of public health promotion campaigns (Faden & Faden, 1978; Kass, 2004), resource allocation (Kass, 2004), and in particular, ethical issues arising during the HIV/AIDS epidemic (Kass, 2004; Lee, 2012). Topics that received considerable attention during the HIV epidemic include the duty of physicians to notify third parties (Kass, 2004), ethics of screening programs in the absence of effective treatments (Kass, 2004), and considerations of how HIV testing policies could contribute to stigmatization (Lerner & Bayer, 2008).

2.2.1 Infectious disease and public health ethics

Ethical considerations arising in an infectious disease outbreak is a subcategory under public health ethics. Infectious disease outbreaks, until the arrival of SARS and Covid-19, had been relatively underexplored in the field of bioethics. While the HIV/AIDs epidemic was a

critical part of the development of the field of public health ethics, there has been less attention to ethical considerations associated with other infectious diseases, such as tuberculosis, cholera, or the measles. This neglect is thought to be in part the result of bioethics focussing primarily on advances of expensive biotechnology, the perception that infectious disease is easily solved through biomedical approaches, and that infectious disease mostly impact people in low income countries (what Selgelid describes as neglecting "problems of 'strangers' on the fringe of society and foreigners in faraway places." (Selgelid, 2005, p. 285) The relative neglect of infectious disease ethics calls into question issues of global justice, as populations most burdened by infectious disease often reside in the Global South, in settings facing resource constraints and limited ability to cope with the consequences of outbreaks (Selgelid, 2005).

Ethical challenges arising in infectious disease scenarios are important to critically examine, as morbidity and mortality of infectious disease is significant (Selgelid, 2005; Smith et al., 2004), and the tension between individual freedoms and the public good arises in multiple domains of an infectious disease outbreak response (Selgelid, 2005). Indeed, the widespread impacts of Covid-19, both in terms of the virus itself, and the public health response, underscore the need to examine these issues.

During infectious disease outbreaks, public health officials may need to consider the ethical dimensions of several interventions—including whether and to what extent stringent prevention measures should be implemented in a population, the extent of coercion justified in public health promotional campaigns (Kenny et al., 2006), and whether to implement mandatory vaccination (Selgelid, 2013), surveillance (Selgelid, 2013), and quarantine or isolation (Selgelid, 2013). They may also question the extent that citizens have a responsibility not to infect the greater population and how this responsibility impacts the moral justification of imposing more

stringent public health measures (Selgelid, 2013). Furthermore, public health officials may have to make decisions related to allocation of experimental therapies (Selgelid, 2013), and establish policies for the triage of scarce resources. Lastly, in an infectious disease outbreak, questions may arise related to the extent healthcare workers have a duty to treat infected patients despite risks to their own safety (Kenny et al., 2006; Selgelid, 2013).

2.2.2 Public health ethics frameworks

Several scholars have devised ethical frameworks (Childress & Bernheim, 2008; Childress et al., 2002; Kass, 2001; Thompson et al., 2006; Upshur, 2002) to assist in decisions of implementing public health measures, including those that may restrict liberty. I will highlight two influential and widely cited ethical frameworks for public health that are relevant for this thesis and the empirical project that will be explained in Chapter 3.

Upshur's framework for the Principles for the Justification of Public Health Interventions identifies four principles that can be used to appraise public health actions. First, the harm principle states that infringement on personal liberties is only justified to minimize or prevent harm to others. Second, the intervention must use the least restrictive or coercive means to achieve these goals. Third, the intervention must harness the reciprocity principle in that institutions burdening the public to follow certain measures must mitigate potential and real harms of these measures as well as make it as easy as possible to implement these measures. Finally, the public health intervention must follow the transparency principle: all stakeholders involved in a public health intervention should be involved in the decision making process, and this process should be free from manipulation or coercion (Upshur, 2002).

Thompson and colleagues, which included Upshur, later published a pandemic ethical framework, following the SARS outbreak. Informed by public health ethics literature and

challenges specifically related to SARS, the ethical framework consists of two components: (1) ethical processes, using an adapted version of the Accountability for Reasonableness Framework to implement ethically sound decisions, and (2) ethical values to guide these decisions. They identify 10 ethical values including, but not limited to, duty to care, equity, privacy, and proportionality (Thompson et al., 2006).

I have provided a brief history and overview of public health and infectious disease ethics and some of the common issues arising in each. I have described two examples of ethics frameworks that can be used for decision making on a population level. With the goal of illustrating the application of public health and infectious disease ethics, and moving more closer to the focus of my thesis research, I will now discuss some ethical issues arising during the 2014-2016 West Africa EVD epidemic and the Covid-19 global pandemic.

2.2.3 Ethical challenges arising during the West Africa Ebola outbreak 2014-2016

Prior to the epidemic of 2014-2016, EVD had appeared in isolated outbreak settings for over 20 years, resulting in thousands of cases (Keïta et al., 2018). The 2014-2016 West Africa EVD epidemic was the deadliest to date, with 28,600 cases and a corresponding 11,325 deaths (Centre for Disease Control and Prevention, 2019). The scale of the epidemic raised international alarm, and several humanitarian NGOs, government agencies and militaries established ETCs to help with isolation and control responses. For instance, Médecins Sans Frontières was heavily involved in the construction and operation of several ETCs in Liberia, in addition to those provided by the Liberian government, and World Food Programme, and the WHO, to name few (Cooper et al., 2016; Nyenswah et al., 2016). The public health response to this event raised several ethical challenges.

The community and cultural context were important considerations in the EVD public health response. For example, certain burial practices are a potential source of EVD transmission, as some communities wash the corpses and drink or wash their hands with this water (Omonzejele, 2014). Moreover, 'traditional autopsies' open the corpse, which may lead to viral transmission (Omonzejele, 2014). However, discouraging these kinds of cultural practices can have harms; both in terms of consequences of not carrying out these important cultural traditions for the community (Wilhelmy et al., 2021), and also perpetuating existing community mistrust towards healthcare workers and international organizations. Mistrust in communities can decrease community adherence in following public health measures (Blair et al., 2017), and may even lead to security concerns for public health responders (Wilhelmy et al., 2022).

There were also ethical tensions and challenges related to the use of ETCs. ETCs were critical in the infectious disease response for treating EVD patients and helping reduce EVD transmission through separating suspected cases (Washington et al., 2015). It was estimated that in Liberia between September 23 and October 31, 2014, 9,100 infections were prevented by having patients receive treatment in either an ETC or Community Care Centre (Washington et al., 2015). Nevertheless, there were drawbacks associated with using these centres. Misinformation, stigma, and risk of hospital-based transmission of EVD led to difficult ethical situations within ETCs. Some people associated ETCs with loved ones going to receive treatment at these centres and never returning (Nuriddin et al., 2018). There were also reports of misperceptions that the disinfectant chlorine was being used to kill patients (Carter et al., 2017; Nuriddin et al., 2018; Yamanis et al., 2016). EVD survivors discharged from these facilities also faced challenges such as social isolation (James et al., 2020; Kelly et al., 2019), verbal abuse (James et al., 2020), and income loss (Kelly et al., 2019).

As EVD is characterized by fever, GI symptoms, and headache (Bah et al., 2015) — symptoms shared by other prevalent diseases in West Africa such as Dengue fever (Zhang et al., 2014) and malaria (Simo et al., 2019; World Health Organization, 2014, 2022)—there were concerns that individuals presenting with these common symptoms may be mistakenly admitted to ETCs, and be exposed to EVD. Some patients with EVD symptoms spent up to 72 hours waiting for a PCR test in the "suspected" cases ward in an ETC, with other potentially positive EVD patients (Fitzpatrick et al., 2014). It was found that in a Médecins Sans Frontières-run EVD management centre in Sierra Leone, 61% of 157 admissions to the ETC were allocated to the suspect ward, of which only 46% of patients tested positive (Vogt et al., 2015). Therefore, as many as 54% of patients in the suspect ward may have been exposed to EVD (Vogt et al., 2015).

Another ethical tension arising during the EVD outbreak was related to patient confidentiality. While transparency by public health officials is important in a public health response, there is also a need to protect the confidentiality of patients testing positive (Wilhelmy et al., 2022). This protection is important to avoid breaches in confidentiality similar to the one that occurred in Nigeria, where an EVD patient's name and hospital where they were treated was given to the media (Maduka & Odia, 2015). Situations like these can discourage people from following public health measures if there are concerns that reporting symptoms or positive case status will be disclosed (Maduka & Odia, 2015).

Access to experimental therapies was another ethical concern during the EVD epidemic. Despite there being no approved EVD therapies or vaccines available during this epidemic, there were ethical questions related to whether to provide experimental untested therapies such as ZMapp to infected EVD patients (Tambo, 2014). Providing an untested treatment could harm current patients and prevent the controlled testing of these therapies for future patients (Donovan,

2014). Further, it can be hard to determine whether an infected patient would be able to adequately assess risks and benefits of experimental treatments. Someone confronted with a life threatening illness may not be able to provide appropriate informed consent (Nichol & Antierens, 2021; Salerno et al., 2016; Tambo, 2014), especially when the alternative treatment option is receiving none (Salerno et al., 2016).

The allocation of experimental treatment among staff has also been an infectious disease ethical concern highlighted during EVD. Many argue that healthcare workers should have prioritized access to experimental treatments because of the extra safety risks that they incur to care for potentially infected patients (Nichol & Antierens, 2021). Two American medical missionaries and a Spanish priest who were providing care on the frontlines of the EVD response and became infected with EVD, received access to the Zmapp experimental therapy (Donovan, 2014). However, local staff, many of whom undertaking the same burdens, were not afforded the same privileges (Donovan, 2014). This situation highlights global injustice in healthcare access and raises questions about the extent that healthcare workers deployed to international locations to provide assistance should be entitled to certain healthcare benefits.

Despite the importance of preventing the spread of EVD, prioritizing the EVD response also had consequences for other health services. For instance, in Liberia, Guinea, and Sierra Leone, there was an estimated additional 10,623 deaths due to healthcare access delays for diseases like HIV, malaria, and tuberculosis (Parpia et al., 2016). This situation created challenges for balancing the EVD response with consequences to healthcare services of other prevalent diseases.

2.2.4 Ethical challenges arising during Covid-19

The Covid-19 pandemic raises similar but also distinct ethical challenges compared to the EVD epidemic. Disruptions to global supply chains, high influxes of cases, constrained health systems, and staffing shortages, have led to global resource shortages. Healthcare workers have had to make difficult choices in triaging Covid-19 patients, allocating experimental and compassionate therapies, and prioritizing mechanical ventilator access (Fariba & Saeedeh Saeedi, 2020; World Health Organization, 2016). On a population level, decisions have been made to divert resources away from other treatments to fight the pandemic (Riera et al., 2021), which has had broad impacts on other domains. For instance, Riera et al. (2021), identified disruptions to cancer care worldwide during the pandemic, with survey studies reporting 77.5% of patients to have disruptions to their treatment. The most frequently reported delay or interruption was related to decreased access to healthcare providers (Riera et al., 2021). Similarly, disruptions to global supply chains, redirections of resources, cancellations of services due to lockdowns and social distancing, as well as decreased access to healthcare providers, all served as barriers to the hypertension crisis in low-income countries during the pandemic (Skeete et al., 2020). Resource shortages have also created difficult scenarios for the treatment and triage of acute Covid-19 patients along with the management and allocation of care for other chronic diseases.

The duty to treat, specifically the extent to which healthcare workers have an obligation to provide care for infectious patients, is another area of ethical consideration in the context of the global pandemic. Several arguments support healthcare workers having significant obligations to treat patients who are infectious despite there being a personal risk of infection. First, healthcare workers may inherently accept increased risk of infection in becoming a

healthcare worker (Malm et al., 2008). Second, healthcare professionals have a duty to treat as they have received special training and thus are beholders of special abilities (Clark, 2005; Malm et al., 2008). Third, healthcare workers may have a greater duty to care based on the principle of reciprocity (Malm et al., 2008). If society and the public have invested resources into the training of healthcare workers, through the form of subsidies and taxes, then there is the expectation that they provide care in crisis situations (Malm et al., 2008). Fourth, healthcare workers may receive priority access to life saving medications by virtue of their profession (Malm et al., 2008). These reasons strengthen healthcare workers duty to provide care during a pandemic.

Nonetheless, the strength of a healthcare worker's duty to treat in infectious disease crises depends on several factors. The seriousness of the infectious disease has implications for healthcare workers' duties to not only their own family, but future patients (Huber & Wynia, 2004; McConnell, 2020). They have a responsibility to avoid becoming infected in order to fulfill these obligations (Huber & Wynia, 2004). Duty to treat also depends on the effectiveness of the treatment being administered by the care provider, and whether the action that exposes the healthcare worker to risk will likely result in improvement for the patient (Selgelid, 2009). Furthermore, the strength of the duty to treat depends on society's ability and choices to protect healthcare workers through caring for them if they do get sick, and supplying them with PPE (Schuklenk, 2020). As such, the fatality rate of Covid-19, the availability of vaccinations and treatment, along with access to PPE, all introduce considerations in healthcare workers' treatment obligations.

To help 'flatten the curve,' reduce Covid-19 related morbidity and mortality, and help prevent hospitals and other healthcare institutions from becoming overwhelmed, governments implemented a range of public health measures and restrictions. These restrictions include

nation-wide lockdowns, mandatory mask wearing, stay at home orders, and quarantine and isolation requirements, amongst others. The degree of stringency of public health measures has varied between country and over the course of the pandemic. For instance, despite an initial outbreak early in the pandemic, stringent lockdown measures and strong public compliance led to Australia becoming relatively Covid-19-free during early 2021 (Stobart & Duckett, 2022). Similarly, China implemented rapid contact tracing, strict quarantine and isolation measures, and regional and national lockdowns leading to successful containment of the virus early in the pandemic (Chen et al., 2021). In contrast, Sweden showed a liberal approach to public health measures early in the pandemic giving the public the choice to enact measures (Ludvigsson, 2023). However, high mortality rates during early 2020 led public health officials to reconsider and implement stricter measures during the second and third wave (Ludvigsson, 2023). The United Kingdom was criticized for an uncoordinated Covid-19 response and subsequent high caseloads, with public health measures being delayed in their implementation, and rushed in their relaxation (British Medical Association, 2022).

While public health measures are critical in prevention of caseloads, especially in the context of a global pandemic marked with uncertainty, such interventions have come at a cost to other domains of life. For instance, there has been a global increase in domestic violence during the pandemic (Kourti et al., 2021; Sidpra et al., 2021). Stay at home and lockdown orders force victims of violence to spend more time with the perpetrators, with less of an ability to seek help from outside resources (Piquero et al., 2020). This reality is especially true for children, adolescents, and women (Williams & Pontalti, 2020; World Vision, 2020). Pandemic restrictions such as lockdowns and school closures have also impacted children's ability to go to school resulting in disruption to their educational and social development (Suguru Mizunoya, 2021),

with one meta-analysis of studies conducted in 15 countries to estimate that children have lost around 35% of a year's worth of learning during the pandemic (Betthäuser et al., 2023). Learning disruptions have been attributed to school closures and lockdowns, and adapted learning 'post' pandemic (Betthäuser et al., 2023). Pandemic restrictions have also been difficult for businesses and the economy, with lockdowns and travel restrictions creating significant challenges.

As demonstrated, Covid-19 has raised numerous ethical tensions and challenges such as those related to resource shortages, duty to treat, and balancing the consequences of public health measures with the severity of the disease. Other examples of ethical challenges arising during Covid-19 include the order of vaccination rollout and issues of equity in vaccine access, and considerations related to patient confidentiality and contact tracing.

2.3 Conclusion

Ethical challenges in humanitarian aid and the management of infectious diseases, including the 2014-2016 West Africa EVD epidemic and the Covid-19 global pandemic, have been described in the literature. However, there has been limited investigation of ethical challenges arising in humanitarian settings, such as temporary displacement camps, during the pandemic. In the next chapter, I will describe the objectives and methods of the research study that I conducted to examine this topic.

3.0 Methods

3.1 Methodological approach

I conducted an exploratory qualitative descriptive research study based on semi-structured in-depth interviews of humanitarian aid workers. As stated by Sandelowski (2000), qualitative description is "directed toward discovering the *who*, *what*, and *where* of events or experiences, or their basic nature and shape" (p. 338). This orientation fits well with the study's primary research question: **what are ethical challenges encountered by humanitarian aid workers working in temporary displacement camps in the context of Covid-19?** This primary research question was accompanied by the following secondary research questions:

1. What is the experience of humanitarian aid workers in implementing public health measures in temporary displacement camps during a pandemic?
2. How do pandemic related constraints (resource allocation, travel restrictions) create challenges for humanitarian aid workers in providing care to refugees and IDPs?
3. How could ethical challenges encountered in the context of Covid-19 and temporary displacement camps be minimized or avoided, and humanitarian workers better supported to respond to them?

I drew on articulations of the concept of 'ethical challenge' from Schofield et al. (2021) and Jia et al. (2021) to develop the following operational definition of ethical challenge for my study:

> Ethical challenges arise in situations 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 moral dilemmas, uncertainty or distress.

I selected qualitative description as the methodology to guide my research as it is well suited for exploratory inquiry attempting to better understand and begin to make sense of a healthcare related phenomenon in a particular context (Neergaard et al., 2009). Qualitative description enables access to first person accounts in responding to particular knowledge gaps, especially exploratory inquiry on topics for which there has been limited prior research. I carried out semi-structured interviews with open-ended questions to generate a "rich, straight description" of ethical challenges encountered by humanitarian aid workers in temporary displacement camp settings in the context of Covid-19 (Neergaard et al., 2009, p. 2).

3.2 Sampling and recruitment

I used purposeful sampling to identify individuals with experiences relevant to the primary research question (Patton, 1990). More specifically, I employed maximum variation sampling, with a goal to uncover themes or categories of ethical challenge that cut across a diverse range of participants (Patton, 1990). My sampling aim was to recruit national and international staff from a range of aid organizations, professional backgrounds, and geographic location of work.

Recruitment proceeded through three strategies. First, I emailed professional contacts of Dr. Matthew Hunt who may have had experience relevant to the study, or who knew of people with relevant experience with whom they could share the recruitment information (3 participants recruited). Second, I emailed 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 (1 participant recruited). Third, I used snowball sampling whereby study participants recruited through the two previous methods were invited to share information about the study with contacts in their networks, or to share with me

contact information of other potential participants (6 participants recruited). This method is especially appropriate for recruiting individuals within highly networked organizations, such as humanitarian aid organizations (Green & Thorogood, 2018).

3.3 Participants

A total of 10 participants were ultimately recruited for this study: six nurses, two finance/project coordinators, and two physicians. There were eight participants who self-identified as women, two who self-identified as men, and one who did not explicitly identify with a gender. They spoke to experiences in several geographic locations during the Covid-19 pandemic: three in Southern Asia, three in Western Asia, three in Northeast Africa, one in the Horn of Africa, one in East Africa, one in Central Africa, three in the Middle East, and one in Europe. Participants included nine international humanitarian workers and one national humanitarian worker who collectively were affiliated with a total of three organizations during the pandemic (though several participants had also worked for other organizations prior to the Covid-19 pandemic). When examining the overall sample, their 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 in the field, and the others interviewed after their return.

3.4 Data generation

I developed an initial interview guide informed by concepts from two ethics frameworks: Ethics of Engaged Presence (Hunt et al., 2014), which is focused on international humanitarian health work, and the Framework for the Justification of a Public Health Intervention (Upshur, 2002). I also integrated insights based upon my review of literature on humanitarian ethics, infectious disease ethics, as well as on the Covid-19 pandemic. Dr. Matthew Hunt provided

feedback on the interview guide, and I made further revisions. I conducted a pilot interview with a humanitarian aid worker in June 2022, resulting in further refinement of the guide. The duration of interviews ranged from 40 to 80 minutes. All interviews were conducted virtually on Microsoft Teams and took place from August 22, 2022, to December 10, 2022.

As interviews were carried out, I adapted the interview guide in an iterative manner as new insights emerged. The final interview guide is attached in Appendix 1. All interviews were audio recorded, and when possible, videorecorded (in some instances, connectivity issues prevented videorecording). I took short notes during the interviews. Following each interview, I completed these field notes with main takeaways, reflections, and other pertinent details (unusual occurrences, nature of interview), to record information and insights. These more subtle details and initial takeaways helped me better understand participant narratives. Then, I used the Microsoft Teams transcription feature to create an initial transcript of the interview. I listened to each interview and edited the initial transcript accordingly to ensure the accuracy of the transcription. Video recordings enabled me to annotate the transcript with non-verbal elements such as gestures, pauses or laughter. Each interview was transcribed smooth verbatim—some filler words like 'umm' were removed for a smooth reading, but some were intentionally left to preserve the overall impression of each participant's way of speaking (Mayring, 2014).

3.5 Data analysis

Data analysis was initiated concurrently with ongoing interviews so that insights could be integrated in the ongoing data collection, such as adaptation of the interview guide. After each interview was transcribed, I used transcripts and field notes to write short synopses (up to three pages) for each interview. These synopses summarized 1) participant background and sphere of work, 2) key ideas discussed in the interview, and 3) initial analytic insights, hunches and

reflections. The next steps of data analysis were guided by the inductive approach of conventional content analysis (Hsieh & Shannon, 2005) as this approach is well suited to studies where there is not a lot known about the topic of inquiry (Elo & Kyngäs, 2008). It is frequently used in qualitative descriptive studies (Neergaard et al., 2009). I began with open coding, where I went through each transcript, labeling segments of text (Elo & Kyngäs, 2008) in response to questions such as "what is this segment about?" and "how is it like, and not like, other segments?" (Green & Thorogood, 2018, p. 259). It was common for a segment of text to be labelled with multiple different codes. These codes were defined in a separate codebook. The codebook included a list of terms used to label segments of the text, along with a definition and anchoring quotation that functioned as an example from a transcript (Assarroudi et al., 2018). The codebook was refined as each transcript was coded, with most alterations occurring during the analysis of the first few transcripts. If codes only appeared in one interview, they were generally not carried to the next iteration of the codebook. The codebook went through several iterations, with the final version consisting of 86 codes.

Once the coding of all interviews was complete, I grouped like codes into "generic categories" (Elo & Kyngäs, 2008, p. 111). I then created mind maps to link similar generic categories together, and with feedback from Dr. Matthew Hunt, I continued to group categories into higher levels of abstraction until I was able to create themes related to ethical challenges. I also presented provisional findings to colleagues for feedback and used writing as a tool to expand and elucidate these themes. My analysis led to the generation of five themes of ethical challenge and one theme encompassing participants' views on preparing for ethics in humanitarian aid work. These themes will be presented Chapter 4.

3.6 Ethical considerations

This study was carried out to align with the principles of the Canadian Tri-Council Policy Statement: Respect for Persons, Concern for Welfare, and Justice (Government of Canada, 2022). Bearing this in mind, there were several ethical considerations that needed to be addressed. First, to ensure that the consent process was carried out in an informed and clear manner, prior to interview commencement, I went over the consent form (Appendix 2) with participants, and paused at regular intervals to allow the opportunity for questions. Furthermore, I sought separate consent for the interview to be audio recorded (and videorecorded in some cases). Recordings were viewable only by me, and the particular participant being interviewed. Access was allowed for both parties as Microsoft Teams did not permit the recording to be viewed by only one of the members involved in the video or audio call.

Second, due to the challenging circumstances of humanitarian aid work, I considered that it may be distressing and/or retraumatizing for participants to talk about certain experiences. To help mitigate this risk, I assured the participant that they would be free to stop the interview at any time, that they could decline to answer any of the questions during the interview and still proceed, and could withdraw from the study at any point prior to data analysis. I also encouraged participants to contact their local mental healthcare provider or distress hotline if they experienced distress before, during, or after the interview.

Several steps were taken to protect patient confidentiality. Upon interview transcription, transcripts were stripped of personal identifiers and relabeled as “participant 1, 2, 3…” and a document that matched names to participants was stored on a password protected Microsoft OneDrive file. Organizational affiliations were also removed. However, the occupation of aid

workers (doctor, nurse) and the general geographic location where they were working during the pandemic remained tied to transcripts and subsequent analysis.

3.7 Reflexivity

Practicing reflexivity is important in embracing the subjectivity inherent in qualitative research, and how a researcher's own experiences and perceptions can impact research methodology and interpretation of results (Olmos-Vega et al., 2023). I am a Canadian born master's student with an undergraduate degree in life sciences, and am new to qualitative research. I am not a humanitarian aid worker, and my knowledge of humanitarian settings is derived from reading academic articles, news sources, and conversations with aid workers with prior field experience. As such, I am less familiar with the social and institutional contexts of humanitarian work. Furthermore, my inexperience in qualitative research is likely also to influence the extent of data richness that has come out of this project.

Contextual reflexivity (Walsh, 2003) was especially important in this project which interrogates perspectives of the Covid-19 pandemic. Participants reflected on experiences occurring more than two years earlier and at a time of great uncertainty surrounding Covid-19. Thus, my interview questions, aiming to uncover perspectives of events that occurred years prior, were unavoidably influenced by what is now known about the pandemic and the virus. In the presence of current wide spread vaccination, it is easy to now forget just how prevalent the pandemic was in our lives a few years ago. Reflexive writing of memos, field notes, and conversations with other researchers and my supervisor Dr. Matthew Hunt, helped to uncover some of these perceptions and consider how they could influence the interpretation of findings (Olmos-Vega et al., 2023).

I also engaged in methodological reflexivity through being transparent about the methods, and carefully reflecting upon the rationale for certain decisions like sample size, or the purpose of using qualitative description methodology (Olmos-Vega et al., 2023; Walsh, 2003). These decisions were informed by a graduate level qualitative research course, reading academic articles, and seeking guidance from those with more qualitative research experience, such as my supervisor, Dr. Matthew Hunt.

Seeking guidance and feedback from others was an important strategy I used in strengthening reflexivity of this project (Olmos-Vega et al., 2023). I incorporated feedback from my supervisory committee during the initial stages of the project, and sought feedback on the interview guide for participants, and analysis of data. The individuals most involved in providing feedback had diverse professional backgrounds including physiotherapy, occupational therapy, social sciences, and qualitative research, and some were current or previous humanitarian aid health workers. My supervisor, Dr. Matthew Hunt, who was most involved in feedback for this project, is a leader in humanitarian health ethics research, and previously practiced as a physiotherapist in international development and post-conflict reconstruction settings. While his and other perspectives were integral in providing other viewpoints in this project, it must be acknowledged that this feedback, and my own work, come from people situated in a university in a high-income country, far from the realities faced by aid workers in displacement camps.

3.8 Summary

This study aimed to answer the primary research question, “what are ethical challenges encountered by humanitarian aid workers working in temporary displacement camps in the context of Covid-19?” I approached this question through conducting a qualitative descriptive

study and interviewing 10 humanitarian aid workers. The following chapter will detail the results of this qualitative descriptive study.

4.0 Results

Using inductive techniques, I developed 6 themes related to the experiences of ethical challenges reported by the study participants working in displacement camps over varying periods of the pandemic: challenges of proportionality and alignment of Covid-19 measures, navigating an environment of misinformation and mistrust, responding to expectations of external authorities, fulfilling aid worker obligations in the context of a global pandemic, and questioning organizational practices around national and international staff. The last theme, preparing for ethics in humanitarian work, broadly discusses participant perceptions of ethics and ethics preparation in humanitarian aid work. Selected verbatim quotations are included to illustrate aspects of the analysis.

4.1 Challenges of proportionality and alignment of Covid-19 measures

Participants described difficulties balancing public health priorities in the context of Covid-19 and temporary displacement camps. In particular, they experienced tensions between promoting measures to prevent and control the virus, with mitigating burdens and harms associated with the response. Many participants felt that the Covid-19 response was "disproportionate" (P3) to the medical need created by the virus in the settings where they worked. Furthermore, several participants expressed that the impact of Covid-19 in the local context seemed insignificant compared to the existing challenges already facing this population and that prioritizing the Covid-19 response had detrimental effects on access to general healthcare and for other humanitarian services.

Crowded camp settings force displaced populations to reside in tight living quarters, often with limited access to clean water. Participants described how these conditions, combined with high rates of comorbidities such as HIV in certain camp populations, led to the expectation

early in the pandemic that Covid-19 was going to significantly impact populations living in displacement camps. One participant described how aid workers expected that Covid-19 was "gonna spread like wildfire," (P9) referring to the fact that crowded living spaces in camp settings meant "people were just living right on top of each other." (P9) These conditions limited the ability of displaced populations to socially distance, further contributing to concern for Covid-19 outbreaks.

Participants reported that the Covid-19 prevention and response that was rolled out in camp settings was calibrated based on the results of modelling studies that predicted dire consequences of Covid-19 outbreaks in the camps. As stated by one participant, there was "huge preparedness" (P5) that was launched for Covid-19 at the outset of the pandemic in anticipation of expected widespread morbidity and mortality.

Almost all participants 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 the camp settings where they worked. As stated succinctly by one participant in Central Africa, "we totally got it wrong." (P9) Some participants attributed the low caseloads to the population in camp settings being younger. On the other hand, they also noted that these were settings with limited ability to test for Covid-19. Nevertheless, there was still an unexpectedly low number of patients requiring hospital care, with a doctor in Southeast Asia describing being surprised when "the number of [Covid-19] patients that we were…that we were admitting [to the hospital] was very low." (P7)

The low level of Covid-19 cases in the face of stringent public health measures created tensions for some participants who perceived it as unethical to have continued to push so

strongly a Covid-19 preparedness agenda that did not match the ongoing Covid-19 reality in these camps:

> "And there's a, a huge preparedness and we're all we're all very, very ready. […] I remember it being quite frustrating that, that they kept pushing for Covid when we didn't see it as an issue, and it was…it was hindering other activities because money should go to Covid, you know, it's Covid, Covid, Covid and. And that was not our problem. It was not what we were seeing…" (P5)

Given these circumstances, participants described reservations about promoting a Covid-19 response and encouraging the uptake of public health measures as the displaced population faced other hardships like living in conflict affected settings, living in crowded spaces without access to clean water, and exposure to other infectious diseases like cholera and malaria:

> "…to be completely honest with, within, the list of infectious diseases or communicable diseases that were kind of flagged as, OK, these are going to be on the rise in this setting, Covid was just like, part of the list." (P6)

A participant who worked in Northeastern Africa and Western Asia questioned whether the approach taken to Covid-19 in the camps was an 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)

The burdens and harms related to ongoing Covid-19 measures as the pandemic progressed created further challenges for participants who felt that they were difficult to justify. Four participants stated how quarantine and isolation requirements for staff resulted in staffing shortages, exacerbating difficulties for the provision of adequate healthcare provision for camp residents. While some of these participants outlined how this shortage was the result of staff members testing positive for Covid-19, others described how these protocols were often applied to staff who had a Covid-19 contact, had a Covid-19 symptom, or had mandatory isolation requirements for travel. A participant reported that:

> "we're very committed to following guidelines as it came to staff…like testing and isolation and all that kind of stuff, but also knowing the huge impacts that was having on our ability to program, when, when one quarter of the team might have been in isolation or whatever…" (P6)

Participants also noted that managing risks of nosocomial transmission of Covid-19 resulted in suboptimal care. Patients who were classified as suspect cases were separated to 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:

> "And so there was just a lot of concern that like… in trying to protect or prevent Covid spread, we were like, especially in the case of children, which were not as affected by Covid, it was really sort of…there was some concern that was affecting quality of care and even like loss of life because, you know, if a child needed resuscitation and that room like they didn't always have the same number of staff…" (P2)

Another 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 stated that the massive investment of resources, staff, and funding into the Covid-19 response had impacts on general healthcare provision and other programs in the camps. Participants described delays of several routine services such as those related to malaria prevention or domestic violence. One participant highlighted concerns that the Covid-19 response resulted in reductions to vaccination rates. 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 are no longer funding for." (P5)

Ultimately, participants described discomfort in continuing to implement stringent public health measures despite there being limited spread of Covid-19 in these settings, and while other needs were not adequately attended to. This struggle appeared to be the most salient in relation to the consequences on other domains of healthcare provision.

4.2 Navigating an environment of misinformation and mistrust

Nearly all participants reported that fear, stigma, misinformation, and mistrust created interlinking challenges. Participants described several rumours that circulated in camp settings:

that Covid-19 only killed black people, Covid-19 vaccines caused Covid-19, healthcare workers were infecting the population with Covid-19, or Covid-19 infected only non-believers or infidels. Some participants explained how the increase in information and communication technologies, and social media in recent years resulted in novel considerations related to misinformation spread during Covid-19.

Several participants also described difficulties balancing infection control objectives with the social consequences of some of these measures. Consistent with organizational policies and governmental guidelines for Covid-19 prevention, aid workers encouraged people residing in the camps to follow preventative public health measures like social distancing and isolating when necessary. However, mistrust and, at times, misinformation, generated stigma in communities for people complying with these measures. A doctor described the challenges around communicating the rationales for the steps that were being taken: “at the same time we needed to…Yeah, really try as much as possible to also explain to people why we're [promoting and carrying out public health measures] and to…Prevent, like, let's say, stigmatizing and taboos [for] patients because also this was happening very easily.” (P4) According to this participant, being transparent about public health measures and their effectiveness helped demystify these measures and reduce the likelihood of people being stigmatized.

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 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, mistrust led to safety concerns for this participant and their team, and they were eventually transferred to another location.

Some participants also mentioned that the limited impact of Covid-19 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 in government and healthcare institutions, made it difficult to convince the camp population to comply with preventive measures like social distancing. In line with the accounts of several other participants, this interviewee described how mistrust and misinformation also led to Covid-19 vaccine hesitancy.

In preparing for future pandemics, two participants expressed that it will be important to develop strategies to address misinformation. One participant described the importance of medical professionals having enough reliable information to share with communities about an infectious disease, before misinformation can take hold and propagate. The other participant stated that despite social media being used to disseminate misinformation, there is a need to harness social media's far-reaching capabilities and use it instead as a tool to combat misinformation.

4.3 Responding to expectations of external authorities

All participants reported challenges navigating external influences and interests, especially when these expectations were not aligned with the reality of the field. Participants described these challenges in relation to two domains: international public health guidance and expectations, and pressures exerted by national governments.

4.3.1 International guidance that was misaligned with local realities

Participants described three types of challenges in relation to international guidance from entities such as the WHO. As described earlier, many aspects of the public health guidance were perceived as not being contextually adapted to displacement camps. Second, guidance was perceived as lacking cultural sensitivity. Third, some participants reported feeling discomfort with the responsibility to disseminate public health messages endorsed by global public health authorities to communities if they were unsure of the rationale for the measure, or questioned it.

Half of participants reported challenges and tensions when guidance from external authorities was not contextually adapted to 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. […] So there is that like that that bit of an ethical dilemma of like, yeah, we know it's there. We know that you want us to be doing this, this and this…and you want us to be telling our patients to be doing—like to isolate, to do, to test on this day, to test on that day. But just the reality of like, 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)

This participant also mentioned concern of how misaligned guidance could deepen community mistrust. There appeared to be a "balance of wanting to encourage [public health measures], but also know that it wasn't possible..." (P6) The participant expressed concern that it would not only be a waste of time to encourage these communities to carry out measures that were not possible given the context, but could also "erode their sense of trust." (P6)

Nearly all participants expressed that culture and community values were important considerations for the public health response. Participants described difficulties following policies that did not adequately account for cultural practices such as sharing food. As described by one participant in the Middle East and Northeast Africa, referring to incorporating culture into public health guidelines, "it's an, it's an ethical dilemma of how you…where you draw the line and how you how you mitigate it and how you…Potentially also incorporate it." (P5)

Difficulties navigating social distancing and hand hygiene were highlighted specifically during Ramadan. One international participant explained how public health measures at times created tensions between national and international staff, as they felt as though international staff were put in the position of policing national staff on following public health measures during this holiday. Another participant in Western Asia similarly described challenges during Ramadan in that there was limited guidance that recognized the cultural importance of such traditions, questioning "how do we do Ramadan safely?" (P1) The participant stated that it was difficult to

promote public health measures while knowing the importance of these traditions, especially when day to day life can be difficult:

> "this is their one time that they can kind of like forget that there's a war, and get together with their families and their communities and so…That was, yeah, it was really difficult during that time […] to try and…Respect and 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. For example, one participant struggled with being responsible for carrying out Covid-19 protocols and guidelines without an explanation of why the measures were needed:

> "I'd like to understand like what the thought processes of why we need to wear all this PPE, you know like…You know, like even like shoe covers for when we're walking around outside. And it was like, I don't know if this makes sense, sort of thing…" (P8)

More challenging yet were situations when participants questioned the scientific basis of specific public health messages. A participant, who worked in Central Africa during the first few months of 2020 when there was a directive to discourage the use of mask wearing, reported:

> "Like behind doors, everybody is like, this is insane. Like, like we're medics. We know that this isn't right. But we did—I mean—but again, like if the WHO was like coming out with like—these are the guidelines like, who are you to be the one to say like, well, we're not gonna do that, right? Yeah, but no—there—there was a lot of grumbling. And a lot of frustration within the teams cause like it did not make sense to us at all." (P9)

This participant struggled to follow the expectations and guidance of external governing bodies as this messaging did not align with their own knowledge as a healthcare professional.

4.3.2 Misalignment between host country government expectations and humanitarian organizations' commitments

Several participants reported challenges due to governmental pressures and concerns about the compromise of humanitarian commitments. For example, a nurse who worked in a temporary displacement camp in South Asia described difficulties opening a Covid-19 hospital. Due to a heavy investment of funds, the government put significant pressure on the organization to open the facility, despite there being few severe Covid-19 cases. The opening was described as rushed, with the timeline being dictated by the government and the care standards not matching those of the organization. The participant even described a national staff member who died of Covid-19 after being transferred to the under-prepared Covid-19 facility. As questioned by the participant, "Why did we open up something that wasn't actually gonna provide the care…?" (P8) The participant struggled with the fact that while "Probably…she might have died anyway […] but who knows if she'd gotten, gotten to like an ICU five hours earlier where she should have gone in the first place." (P8)

Another participant in Western Asia also discussed challenges related to government influence in the operations of a Covid-19 facility. The participant described how it was *"*morally distressing" (P1) providing care dictated by another authority whose standards did not align with those of their own organization. The interviewee explained that it was hard to *"*accept working under these conditions which we know are not right*"* (P1) by providing what they felt was suboptimal care in "giving these medications which aren't proven or accepted by WHO" (P1) but which the government insisted upon. However, the participant also felt that it was important to

"collaborate" (P1) with the host government. They questioned whether it "would be better to bear witness and to try and improve along the way the healthcare being provided." (P1) The participant struggled with whether their organization should compromise and provide suboptimal care to the displaced population, or to not provide care at all. Ultimately, the organization ended up withdrawing their services from the facility due to these concerns.

Similar themes came up in other interviews. One participant described that the government ordered their aid organization to collect names and addresses of displaced peoples coming for Covid-19 testing. However, people were reluctant to provide this information because "they were worried about being taken away from their family" (P8) and isolating if they tested positive. Despite not complying with the government's request, the participant stated that it was challenging not knowing "the ramifications of refusing to follow the government's request." (P8) This situation created a particularly concerning dynamic with the possibility of the population being reluctant to seek testing or care, or the government rescinding the permission for the aid organization's activities in that area if they were seen as not complying with the government's rules.

Another participant described their discomfort when political interests dictated access to care. They described how individuals with certain political affiliations were preferentially vaccinated, leading to vaccine shortages for others with greater medical vulnerabilities to Covid-19. The participant described how at times they "were able to put [their] foot down and very diplomatically" (P9) continue with their vaccine rollout. However, the participant also stated that sometimes compromise was necessary: "Other times [government officials] would just kind of look at us and be like if you guys want to keep doing what you're doing then…you're going to vaccinate [the people of my choosing] and that's all there is to it." (P9)

Participants also experienced distress or discomfort when observing how the displaced population was treated by government authorities. Some interviewees described differences in the level of stringency of the public health measures applied to the displaced population compared to the host community, with measures perceived to be stricter for the displaced population. The implementation of additional movement restrictions on displaced populations also compounded pre-existing challenges including healthcare access. A nurse described how the lockdown of a temporary displacement camp in Southern Asia resulted in limited 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 that may be at odds with the standard or expectations of the aid organization.

4.4 Fulfilling aid worker obligations in the context of a global pandemic

Many participants described how pandemic travel bans and restrictions introduced new challenges for providing aid. Three participants were already deployed to camp locations prior to the onset of the pandemic. The imposition of travel bans resulted in several participants being unable to leave these locations, which was described as distressing. Many participants expressed discomfort at the fact that if they became sick, or if they were providing aid in a conflict-affected country and the security situation deteriorated, they would not be able to be evacuated. Covid-19

appeared to create a novel circumstance in that it was the first time these 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)

Several participants also stated how national and international travel restrictions forced them to remain in what are often very challenging settings for longer periods without rest or respite. A participant who was working in a country in Central Africa described how:

> "if you're working 12-14 hour days every day like you need a break…but because the travel restrictions were so bad nobody was allowed to leave anywhere. So we were told just to take our vacations in our rooms. But like I mean where I was in the [Central African country] like we had no Wi-Fi…like there was no TV like...So they were like if you need a break you can just stay in your room. And I was like, ohh fantastic. This is so restful. So yeah, so everybody, everybody is getting burnt out at like a very accelerated rate." (P9)

Some participants also discussed how travel restrictions created logistical barriers for care delivery. This was particularly salient in countries that relied heavily on international aid as an integral part of their healthcare system. Visa and entry requirements, along with quarantine and isolation requirements, led to staffing shortages and impacted care.

Participants also reported that movement and border restrictions led to global supply disruptions and resource shortages in the camps. One participant working in Western Asia described how a nationwide lockdown prevented shipments of PPE from entering the country.

Mobile clinics that functioned to serve the population in temporary displacement camps were halted because the limited supply of PPE was prioritized for secondary healthcare facilities. Thus, “it became a do-no-harm aspect and we weren't able to be sending teams if we didn't have the proper [PPE] …we had to kind of prioritize the most lifesaving activities, which were the hospital…” (P1)

Some participants reported how medication shortages compromised care provision. Alarmingly, one participant 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 [relievers] 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 exacerbated or created new challenges for humanitarian aid workers. Movement restrictions also created difficulties for staffing and care logistics, as well as supply chain disruptions leading to shortages of equipment and supplies.

4.5 Questioning organizational practices around national and international staff

Participants described their experience navigating their role within the aid organization hierarchy, and how and whether the pandemic impacted this experience. Nearly all participants were aware of power imbalances between national and international staff. The national staff member worked for a national, not international, NGO, and therefore did not have the experience of working with international staff. Conversely, many of the international staff participants acknowledged how this power imbalance impacted their relationships and interactions. One international participant reflected on how they were rarely challenged by national staff when

making decisions. Another participant described how the power imbalance was reflected in the influence that was exerted for national staff to be vaccinated:

> "…because international staff are more in management [positions], it was kind of like more of putting pressure on your national staff to get vaccinated even instead of like, having conversations with them, it was more like, you just need to do what I say, sort of thing." (P8)

Four participants described how movement restrictions for international staff led to the reconfiguration of the organizational structures. In some cases, this resulted in staff members taking on roles for which they had limited experience. However, this reconfiguration was described by three participants to also challenge existing power dynamics within these organizations in ways that they welcomed: it allowed national staff to fulfill more managerial and responsible positions that were traditionally held by international staff. As described by one participant in Western Asia, this reconfiguration altered the way that their organization approached filling these kinds of roles:

> "there's been a 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 roles. As such, there was a sense of missed opportunity in challenging traditional power dynamics:

> "I also found it difficult that actually […] a very many people ended up in positions that…that they maybe had the potential for, but they didn't necessarily receive the tools or the guidance or the…yeah, support that they would need in order to really reach that step." (P4)

Some participants also reported experiencing discomfort or distress upon observing a differing level of access to healthcare between international staff, national staff, and patients. One international participant in Southern Asia raised how they felt "very uncomfortable" (P2) knowing they may get the opportunity to be evacuated through medivac (in the latter parts of the pandemic), and that they "would have just been taken out of there," (P2) but national staff, and patients in the community, would be unlikely to receive such a privilege. A few other participants, however, stated that these evacuation protocols were unavoidable, and even appeared to accept this as an inherent component of humanitarian aid. One participant, a doctor, stated that while it "sounds super harsh," (P4) and even "difficult to accept," (P4) having people evacuated from locations where they were solely deployed to provide aid was "a logical approach." (P4)

Differences were also discussed in relation to the types of Covid-19 vaccines received by national and international staff, with international staff receiving more premium vaccines, without a clear rationale as to why. A participant described this dynamic as an "us and them conversation" (P8):

> " [international staff] were able to get you know the Pfizer or the Moderna vaccine and then [national staff] got like, one from China […] that always just kind of like sat a little bit uncomfortable with me because it was like […] if this vaccine was not good enough for, for me, then why are we giving it to…to other people? " (P8)

Overall, the pandemic seemed to have pushed participants to examine some of to the power dynamics associated with models of international humanitarian aid and the way that these organizations are structured. In some respects, the pandemic presented opportunities to rebalance asymmetries of power, while in other ways these dynamics were amplified.

4.6 Preparing for ethics in humanitarian work

When asked about their perspectives on ethics, and ethics guidance and training in humanitarian aid, nearly all participants stated that they were either not very well informed about ethics guidance, or that they received minimal ethics guidance or training from their organization. Four participants stated that their ethics training and background was primarily knowledge of humanitarian and medical ethics principles. However, several reported that they were unsure how to apply them in particular contexts: “Because we have our guiding general principles, but then it’s like when you start getting the new pieces of, of each situation, it gets a little bit fuzzy, right?” (P8) Interestingly, however, these contextual nuances seemed to be unimportant for one nurse in Central Africa, who felt that humanitarian situations were for the most part alike: “copy [and] paste.” (P9) This participant believed that there was usually a protocol that could be applied for every humanitarian situation encountered.

While several participants said they relied primarily on previous humanitarian experience to manage ethical decision making, two participants stated that they received substantial pre-departure training in ethics from their organization. Two other participants stated that they did not feel the need, nor have the time, to seek out formal ethics guidance for advice in the field: “Umm I must admit we were, we work very, very, very long hours and I have to prioritize my time and I'm not gonna prioritize it on something that I don't see as a medical need.” (P5, referring to searching for ethics guidance) In contrast, bringing several colleagues and/or local

partners together during difficult decisions was proposed as useful to discuss priorities and possible courses of action as this helps “share the responsibility and the burden.” (P1)

Participants were asked broadly about their sense of preparedness to face challenges, whether ethical or otherwise, during the pandemic. Answers were mixed. Only three participants stated that they felt unprepared to respond to these situations. Other participants felt that given that this was the first global pandemic in their lifetimes, they did not really know how else they or their organization could have better prepared for the challenges that would arise. Some participants stated that while they may not have been prepared for the pandemic, previous experience in chaotic and emergent environments prepared them for the feeling of being unprepared, and helped them build the confidence and resiliency needed to make it through.

Participants also provided suggestions on how organizations could better prepare and support aid workers. Two participants explained how it could be helpful to consult with an ethics board or advisor in ethically challenging situations. Other participants suggested that having increased pre-departure training for some of these challenges would be helpful, both in terms of increasing personal resiliency and providing psychological support. Other suggestions were focussed on general pandemic preparedness, including having countries have a stock of medical equipment, increased cooperation between actors, and engaging in careful analysis of what occurred during the Covid-19 pandemic in humanitarian settings to identify lessons that could be applied in future pandemics.

5.0 Discussion

This chapter consists of three parts. I first situate and discuss the results of this study in the context of other research on ethical challenges in humanitarian aid provision, raising some concerns related to moral distress and hierarchies of aid organizations along with way. I then make several recommendations for humanitarian aid organizations, and conclude by discussing the study limitations.

5.1 Ethical challenges in humanitarian work

Participants raised concerns regarding the proportionality of the Covid-19 response, a key issue arising in public health ethics. The benefits of a public health intervention need to outweigh the trade-offs and drawbacks, for the intervention to be justified (Childress & Bernheim, 2008; Kass, 2001). Participants felt that the public health response in camps did not always meet this standard, and some reported that it resulted in more harm than good. They expressed that the burdens of the Covid-19 response, including, suboptimal care for 'suspect' Covid-19 patients and delays or disruptions to other humanitarian services, were not outweighed by the benefits of infection control when Covid-19 did not materialize as expected in temporary displacement camps. Such a finding aligns with Fiona Terry's paradox of humanitarian action: "it can contradict its fundamental purpose by prolonging the suffering it intends to alleviate" (Terry, 2002, p. 2). Other empirical studies exploring the experiences of aid workers have also documented the humanitarian response being perceived as unhelpful, and even harmful for a community. These perceptions were borne out of observing resources not being directed to areas of high need (Civaner et al., 2017; Hunt, 2009), sometimes due to a lack of appropriate needs assessment (Civaner et al., 2017). Aid workers in another study also reported feeling that the

humanitarian response was doing more harm than good by providing false hope to beneficiaries (Gustavsson et al., 2022).

A second ethical challenge experienced by the participants arose due to working in environments with prevalent misinformation about Covid-19 and mistrust towards healthcare workers. Several participants reported feeling frustrated when responding to the lack of community acceptance of public health measures, with some describing significant propagation of misinformation about the virus. Rumors—such as healthcare workers infecting communities with Covid-19, that Covid-19 was to eradicate black people, that Covid-19 only infected infidels or non-believers—circulated widely. As reported by a participant in this study, misinformation and mistrust resulted in security concerns for their team, preventing them from providing needed assistance to the people living in the camp. Other participants described how misinformation and mistrust created stigma for population members implementing certain public health measures. Thus, misinformation required aid workers to balance infection control with how these very same measures could lead to negative social and health consequences for the community. Misinformation in humanitarian or disaster settings is not uncommon, and has been documented elsewhere, including during the 2014-2016 West Africa EVD epidemic (Kpanake et al., 2016; Nuriddin et al., 2018; Singh et al., 2022). Jones et al.'s (2023) study examining disaster aid during Covid-19 similarly found that Covid-19 related rumors—such as healthcare workers infecting communities with the virus, or that seniors carried the virus—were prevalent in humanitarian settings (Jones et al., 2023).

Participants in this study also described challenges demonstrating respect for cultural traditions and values within the public health response. Ramadan was particularly difficult to navigate, given that the social nature of this holiday was at odds with public health prevention

measures. Cultural differences in norms and values have been identified as a source of challenge for aid workers elsewhere (Bjerneld et al., 2004; Hunt, 2008, 2009; Schwartz et al., 2010). In particular, Schwartz et al. (2010) documented cultural differences between local communities and international aid workers as contributing to challenges navigating consent procedures, patient confidentiality, and the order of triage (Schwartz et al., 2010). These prior studies identified the cultural differences themselves to be the crux of ethical challenge for aid workers. In contrast, participants in my study seemed to suggest that the ethical challenge was the result of not having public health *guidance* that adequately accounted for these cultural nuances. As such, participants reported feeling unsupported in navigating the cultural landscape of the public health response in the camps. When examining this guidance considering The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, aid workers were prevented from upholding tenet five, which states, "We shall respect culture and custom" (International Federation of Red Cross and Red Crescent Societies, 1992, p. 4). Poorly contextualized guidance left aid workers finding it difficult to balance the public health response with cultural considerations in the community.

In a similar vein, participants described international public health guidance as poorly contextualized for their setting, and struggled to promote public health measures that were often impossible to implement due to space and resource constraints. These feelings were exacerbated by knowing of the other extensive challenges that displaced populations face daily to meet their basic needs. The perception of a maladapted public health response was also documented by Jones et al. (2023). Similar to my study, British international aid workers felt that the Covid-19 response in humanitarian settings was tailored to the Covid-19 situation facing the United Kingdom, a high income country, rather than to the relevant local contexts (Jones et al., 2023).

They expressed the importance of realizing that Covid-19 will impact countries and localities differently and adjusting the public health response in consequence.

Carrying out their roles as aid workers in the context of a pandemic amidst global resource constraints and supply chain disruptions was difficult for participants. Staffing and PPE shortages resulted in logistical challenges and had consequences for patients losing access to services that had to be halted due to these shortages. The findings highlight a stark ethical challenge during Covid-19: those in camp settings experienced striking impacts of global resource shortages that amplified long standing resource constraints. Previous studies have documented challenges related to border restrictions and resource constraints in humanitarian settings (Hunt, 2008, 2009; Schwartz et al., 2010; Singh et al., 2022). At times, resource shortages have forced aid workers to provide a lower standard of care, which has been described as challenging (Hunt, 2008, 2009; Singh et al., 2022). However, unlike my study where participants described far reaching resource constraints, previous studies present these resource shortages as more restricted to the particular humanitarian setting, rather than a manifestation of a larger global phenomenon.

Power imbalances and differing treatment access among national and international staff in humanitarian aid organizations was another area of ethical concern for respondents. International staff may be volunteers, receive a stipend, or be paid employees of aid organizations, and are deployed to other countries. Comparatively, national staff are people hired within a country where a humanitarian crisis has occurred to provide assistance to affected populations. They may be hired from amongst the local population or come from other regions of the country. Power differentials and unequal treatment of international and national staff are

concerns that have been discussed elsewhere and are an increasing area of debate in the humanitarian sector (Fassin, 2007; James, 2020; Redfield, 2012).

Several international participants expressed discomfort about their ability to access medivac services, something that was largely unavailable to national staff if they became ill. This ability for international, and not national, staff to access certain healthcare opportunities is not new (Fassin, 2007). For example, differing access to healthcare among aid workers was highlighted during the 2014-2016 West Africa EVD epidemic. Two American missionaries and one Spanish priest were evacuated from West Africa and repatriated to the United States and Spain, respectively, to receive the experimental treatment ZMapp (Donovan, 2014). There was much controversy as to why African healthcare workers, who similarly risked their lives to provide care, were not also offered this unapproved but potentially lifesaving treatment (Donovan, 2014).

Considerations of power and influence may also be more subtle, including in relation to whose knowledge is valued and who contributes to decision-making processes. For example, in an ethnographic study of the aid organization Médecins Sans Frontières, Redfield (2012) observed a pattern of international staff participating more actively and voicing their views in meetings compared to national staff, who remained mostly silent. In a study of humanitarian workers from Canada, Hunt (2008) reported that participants described feeling uncomfortable when they perceived that local staff were placing too much trust in them. Schwartz et al. (2010) documented something similar, in that some international participants experienced unease when their expertise was perceived by beneficiaries as greater than that of local staff. One participant in my own study documented observing national staff deferring to international staff without

challenge. These findings support the need to examine hierarchies between national and international staff more broadly.

My study did highlight a related and potentially positive outcome of measures implemented to contain Covid-19: pandemic related travel restrictions seemed to disrupt existing power dynamics within aid organizations. National staff play critical roles in mediating cultural and community norms between the local community and international staff. They may help translate dialects, and even assess security situations in the local contexts based on their knowledge, networks, and personal contacts (James, 2020). Nevertheless, leadership roles are often assumed by international staff, despite often being less attuned to the local context in part due to their temporary deployment. During the pandemic, however, access to several countries was restricted, and national staff assumed more responsible and powerful roles traditionally held by international staff. Jones et al. (2023) identified a similar pattern of national staff taking on roles that had been held by international staff as a result of entrance restrictions enacted by several nations during the pandemic (Jones et al., 2023). Covid-19 appears to be the first time that border restrictions were so widespread as to result in wider disruptions of power relations within aid organizations. These shifts of responsibility from international to national staff during Covid-19 were welcomed by my participants as steps towards levelling power dynamics within aid organizational hierarchies. Nevertheless, reports of these shifts in roles and responsibilities from my study are largely drawn from the perspectives of international aid workers. It would be beneficial to explore national staff members' experiences and perceptions of these roles shifts, and how this situation evolved over time.

5.2 Moral distress

As described above, this qualitative descriptive study identifies a range of ethically challenging circumstances encountered by aid workers. Participants described feelings of frustration, distress or uncertainty associated with them, especially when they could not "preserve all interests and values at stake" (Kälvemark et al., 2004, p. 1077). These responses can be viewed from the perspective of moral distress, which is defined as, "traditional negative stress symptoms" "…that occur due to situations that involve ethical dimensions and where the healthcare provider feels she/he is not able to preserve all interests and values at stake" (Kälvemark et al., 2004, p. 1077).

Cultural differences between staff and patients (Agazio & Goodman, 2017), and challenging workplace conditions (Schaefer et al., 2019) have been associated with moral distress. These were also sources of moral distress for my participants who described feeling conflicted over promoting a Covid-19 response that was not sensitive to the cultural nuances within a community. As such, they experienced tension between the importance of Covid-19 prevention, and wanting to respect local cultural values and traditions. Further, several international participants reported negative psychological impacts as a result of border restrictions implemented during a global pandemic; they felt trapped and anxious working in countries confronted with difficult situations, for unknown time periods without respite.

Working within institutional rules and systemic expectations also can contribute to moral distress, particularly when it comes to both acting against, or in accordance with, guidelines that aid workers feel are not sensitive to the needs of the healthcare setting (Nilsson et al., 2011), or serve as an obstacle for patient care (Kälvemark et al., 2004). Participants in my study generally shared that most of their discomfort stemmed from following, rather than opposing external

guidelines. The discomfort in following outbreak guidance stemmed from a perception that this guidance was primarily tailored to the Covid-19 realities and priorities of wealthy nations, rather than the situation facing people living in temporary displacement camps. Some participants were also uncomfortable promoting public health measures that they knew could not be carried out in the setting of their displacement camp.

Ethically challenging situations can induce or exacerbate the experience of moral distress, of which the consequences can be significant, both for healthcare workers, and patients. Studies have found that moral distress is related to feelings of frustration (Gotowiec & Cantor-Graae, 2017; Wiegand & Funk, 2012; Wilkinson, 1987; Wolf et al., 2016), suffering (Harrowing & Mill, 2010), guilt (Wolf et al., 2016), powerlessness (Gotowiec & Cantor-Graae, 2017; Wolf et al., 2016), and depression (Wolf et al., 2016) in both healthcare workers and humanitarian aid workers. Furthermore, physical symptoms such as gastrointestinal disturbances, sleep problems (Hines et al., 2021), fatigue, and appetite changes following experiences of moral distress have been reported (Wolf et al., 2016). Moral distress can also result in poor job retention for healthcare workers (Austin et al., 2017; Corley et al., 2001; Schaefer et al., 2019) which has implications for long term patient care and potential future staffing shortages. Direct negative impacts to patient care have also been reported (Gotowiec & Cantor-Graae, 2017; Wilkinson, 1987), potentially as a result of aid workers experiencing psychological impacts from facing ethical challenge (Gotowiec & Cantor-Graae, 2017). Addressing ethical challenges in humanitarian aid requires careful attention to the sources that contribute to moral distress, and supporting people who experience it.

5.3 Recommendations

Participants from my study provided suggestions for how humanitarian workers could be better prepared to deal with ethical challenges during future pandemics. Ethical guidance and training of humanitarian aid workers to respond to challenging situations has been described by various commentators as lacking, contradictory, and at times, insufficiently relevant (Gotowiec & Cantor-Graae, 2017; McGowan et al., 2020; Sheather et al., 2022; Singh et al., 2022). Much of the ethical guidance and training for aid workers is grounded in humanitarian principles, and some aid workers have described that much of this guidance has little relevance for the real world problems they encounter as humanitarian aid workers (McGowan et al., 2020; Sheather et al., 2022; Singh et al., 2022). Findings in my study echo some of these perceptions. Some stated that their knowledge of ethics was limited to the four fundamental humanitarian principles. Most described how they had little awareness of existing ethics guidance, or that they had received minimal ethics training from their organization.

Drawing on the study findings, I have created a list of recommendations that may be considered by humanitarian aid organizations in preparing for future pandemics. These recommendations may help inform culturally sensitive, informed outbreak responses, and also support aid workers navigate ethical challenges during infectious disease scenarios, which is especially important given the consequences surrounding moral distress.

1. **Outbreak response guidance in humanitarian action needs to be able to be contextually adapted**. Despite the global reach of a pandemic, the application of guidelines must be tailored to what is realistic and practical to be carried out in a particular setting. There will inevitably be uncertainty in the early phases of a pandemic, and responsiveness is needed for adjusting course as new information emerges. Guidance

should also seek to account for local values, culture, and health perceptions of communities. Having increased flexibility in tailoring guidance to context means that more professional discretion and judgement may be required of aid workers in the field (Singh et al., 2022). While flexibility can be an advantage in supporting the agency and independence of local communities and of field workers, too much ad hoc decision making should be avoided to prevent aid workers from feeling overburdened with responsibility (Singh et al., 2022).

Nevertheless, there are also dangers of using individual judgment for the basis of decisions that could have long lasting impacts for a community, especially if aid workers are insufficiently knowledgeable of local contexts. Incorporating perspectives, and involving local staff, national aid workers, and community leaders is critical to appropriately adapting guidance and implementing outbreak responses. Having locally based approaches also helps fulfill tenet seven of The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief: "We shall attempt to build disaster response on local capacities" (International Federation of Red Cross and Red Crescent Societies, 1992, p. 4).

2. **Misinformation must be addressed**. Misinformation and subsequent community mistrust can lead to difficulties carrying out the public health response and ethical challenges for aid workers. As observed in this study and elsewhere (Wilhelmy et al., 2022), mistrust can at times lead to safety concerns for aid and healthcare workers, creating a difficult situation where aid workers are unable to fulfill their aid obligations. In other words, misinformation may prevent aid workers from upholding the "humanitarian imperative" (International Federation of Red Cross and Red Crescent

Societies, 1992, p. 3). As such, addressing misinformation is critical. As suggested by participants, and consistent with initiatives being developed within the aid sector (Humanitarian Policy Group, 2022), humanitarian aid organizations can use tools such as social media to communicate with community members and disseminate reliable information about the virus.

3. **More fulsome pre-departure ethics training.** Most participants in the study reported that they had minimal knowledge of ethical guidance or had no formal ethics training. Some participants also reported that their ethics knowledge and training within their humanitarian aid organization was limited to the fundamental humanitarian principles (neutrality, independence, humanity, impartiality), but did not know how these principles could be applied in specific contexts. The findings of this study support the use of case based learning and discussion in pre-departure training. Case based learning and discussion, along with informal and formal debriefings with colleagues can be effective in preparing for and processing ethical challenges (Fraser et al., 2015; McGowan et al., 2020; Simm, 2021).

Simm (2021) suggests that group based value reflection methodology may be a suitable way to help train aid workers to make decisions in ethically charged situations and to cope with lingering feelings of moral distress. The approach begins with a case, presents a group of aid workers with several options, follows with a group discussion of everyone's selections, and concludes with analysis of how these options interact with certain ethical principles (Simm, 2021). Such an approach is grounded in discussion with other colleagues, which has been shown to be an effective method of alleviating some of the moral burden when making ethically challenging decisions (Hunt et al., 2012).

4. **Explore perspectives of national staff.** Participants in my study described how border restrictions resulted in national staff assuming more managerial and responsible roles in the humanitarian aid organization. Aid organizations should examine the perspectives of national staff on these role shifts, and whether and how these shifts impacted their involvement with their communities during the pandemic. Having a more fulsome understanding of the effects of nationalising these positions may be important for humanitarian aid organizations in considering the extent of international aid worker deployment and more localized approaches to aid provision.

5.4 Limitations

This study has several limitations. First, the timing in 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 2-3 years ago. Viewing these challenges 'through the lens' of later experience may influence how participants narrate or reassess experiences they had earlier in the pandemic. For example, the reported perception that Covid-19 responses felt disproportionate may be enhanced when viewing these measures through the 'post Covid-19' era of vaccination and when Covid-19 now seems to be a secondary priority on the global stage. At the onset of Covid-19, there was considerable uncertainty in how the virus was going to play out in camp settings and given the scientific modelling and predictions, the promotion of public health measures and adaptations to programming may have been the rational approach at the time. It may be that looking back, participants find it easier to critique the response knowing how Covid-19 ultimately impacted these settings and populations.

The sample of interviewees is also a limitation. Initially, I carried out this study with purposeful sampling and the goal of maximum variation of participants. My aim was to explore

ethical challenges that arose across a diverse sample of participants. However, this objective was only partially achieved. 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 such, the perspectives of international staff are heavily represented in this study. 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. However, many participants had previous experience with several other aid organizations over the course of their careers. These sampling limitations resulted in part due to constraints for conducting this empirical study for my MSc thesis and challenges in recruitment, especially with reaching national staff members of humanitarian organizations. Furthermore, I began observing fewer new ideas arising after interview eight. Given this insight, along with the time constraints of my MSc thesis, I stopped recruiting after the tenth interview.

Several participants described harms of using global outbreak guidance with a “one size fits all” approach. Keeping this in mind, and aligned with the epistemological framing of this qualitative descriptive study, findings should not be generalized to other locales but rather offer a point of departure for considering how ethical challenges arise in particular contexts, and from different points of view. In agreement with Jones (2023), it is clear that infectious disease realities impact locales differently, and this is important to consider when examining findings. A key takeaway from this study is the importance of developing infectious disease responses that fit local realities.

6.0 Conclusion

Continuation of the scenario introduced in Chapter 1:

After spending 7 months in the IDP camp in Central Africa, you have now returned to Canada. The date is May, 2020. You have had many sleepless nights these past few weeks. The challenges you dealt with during your mission reverberate and occupy your mind. However, the nature of these difficulties still surprise you—you were never forced to choose one patient over another to provide Covid-19 treatment, and you yourself were never that fearful of catching Covid-19.

Instead, other scenes occupy your thoughts. You can hear the wheezing cough of the child who came to the hospital for bronchitis treatment, but who had to be isolated to another ward with fewer nurses and less equipment until they tested negative for Covid-19. You remember the government pressuring your team to open a new Covid-19 hospital, despite you knowing it was not ready. You watched a fellow staff member die from Covid-19 in this very hospital. You can't help but wonder if things would have been different if they had been taken elsewhere.

While you are supportive of humanitarian assistance, certain aspects about this mission particularly disturbed you. You witnessed displaced people in the camp being confined by the government 'in the name of public health,' but did not see this measure applied to the host community. You reflect on, and even judge yourself when you scolded a group of national staff breaking public health protocols when breaking their fast during Ramadan. You felt useless when you told people in the camp to socially distance and wash hands knowing that practically it was impossible.

Nevertheless, this mission also inspired hope for humanitarian aid and your ability to make a difference. Border closures led to many of your national colleagues filling new roles at which they excelled. You also felt proud helping a patient with Covid-19 be with their family while they died—something that was not possible in other wealthier nations at this time.

You continue to reflect. What is needed for the future? How can we better respond to other infectious disease crises? How can we support aid workers and the populations they serve?

Chapter 1 began with a narrative of an aid worker deployed to Central Africa to tend to the needs of IDPs in a camp setting. They did not—and could not—know the sorts of questions and challenges that the Covid-19 pandemic would generate. In the first narrative, the aid worker was concerned about the potential for Covid-19 to infiltrate camp settings based on what was known about Covid-19 at the time. However, the challenges they ultimately faced in camp settings, as described in the first and final narrative, were quite different to the chaos initially predicted—an experience that corresponds with those of the humanitarian workers whom I interviewed as part of this thesis research.

My intent in undertaking this thesis research was to help address a gap in the literature around humanitarian ethics by seeking to answer the question "what are ethical challenges encountered by humanitarian aid workers in temporary displacement camps in the context of Covid-19?" While several studies have examined the first hand ethical experiences of humanitarian health aid workers in a variety of settings (Civaner et al., 2017; Gotowiec & Cantor-Graae, 2017; Hunt, 2008, 2009; Schwartz et al., 2010; Singh et al., 2022), these experiences have not yet been thoroughly explored in the context of a pandemic. Given that several Covid-19 risk factors are prevalent in displacement camp settings; namely, crowded living spaces, high rates of comorbidities and limited healthcare access, learning more about how

Covid-19 played out in camps and about the challenges that arose has merit in preparing for, and responding to, future infectious disease crises.

I conducted a qualitative descriptive study, interviewed 10 humanitarian aid workers, and generated five themes of ethical challenge experienced by participants. These ethical challenges included considerations of proportionality and alignment of Covid-19 measures, navigating an environment of misinformation and mistrust, responding to expectations of external authorities, fulfilling aid workers obligations in the context of a global pandemic, and questioning organizational practices around national and international staff. The sixth theme encompassed participant perspectives and views on preparing for ethics in humanitarian work.

The findings generated by the study have several takeaways for future infectious disease outbreaks. They highlight the importance of having a public health response that is sensitive to the situation of a local community, their ability to implement public health measures, and how this relates to other corresponding needs. Infectious diseases should be monitored over time and the public response adjusted accordingly. Otherwise, the burdens of an infectious disease response may outweigh potential benefits of disease prevention.

This study also demonstrates a need for infectious disease outbreak response guidance that is sensitive to local cultural contexts and values that communities deem important. Participants highlighted the need for international guidance that helps to navigate the balance between public health prevention measures and respect for cultural traditions. How this fine balance is achieved has important implications for trust, legitimacy, and acceptance in communities.

In addition to introducing new challenges to humanitarian aid work in camp settings, Covid-19 also highlighted issues that have identified in other humanitarian contexts. Border restrictions, which have been an issue in other humanitarian conflict settings, became more salient and widespread during Covid-19, contributing, along with supply chain disruptions, to an exacerbation of pre-existing resource shortages. Border closures also led to many international staff being prevented from entering countries requiring aid, resulting in staff shortages, alterations, and disruptions to care. Humanitarian healthcare workers have reported similar concerns in other settings, including dilemmas that ensue when seeking to provide adequate care to affected populations.

Power differentials between national and international staff were also highlighted during Covid-19, both in positive and negative ways. Some participants described how Covid-19 intensified these power imbalances through international staff receiving preferential access to certain vaccines and medivac services. However, others stated that Covid-19 related border restrictions disrupted some power relations within their organization's hierarchy: they reported that many national staff members assumed positions with more authority that had previously been held by international staff.

It is my hope that the findings generated through this exploratory qualitative descriptive study will contribute to a better understanding of ethical challenges that arose for humanitarian workers in temporary displacement camp settings during the pandemic. Along with insights garnered from other research and sources of expertise, a more informed understanding of ethical challenges that arise in a pandemic may help humanitarian aid workers respond more appropriately to potential needs of displaced populations in future infectious disease epidemic or pandemic scenarios.

Additionally, the experiences of ethical challenges reported by participants include elements of moral distress. This situation is concerning for the wellbeing of humanitarian aid workers. Moreover, a limited ability to cope with these challenges has implications for the populations aid workers seek to assist due to impacts on the provision of healthcare and other services. The findings in this study thus highlight the need for further research related to how moral distress may be prevented, alleviated, or managed. One way this could be done is through more comprehensive formal ethics guidance and support in humanitarian aid organizations (Gustavsson et al., 2020), given that several participants in my study described ethics guidance they received to be limited. In sum, I hope that the findings from this thesis can be used both to benefit aid workers in their ethical preparation for missions, and also the populations that they intend to help by highlighting considerations related to the need to tailor pandemic responses to the particular realities of temporary displacement camp settings.

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Appendix 1

Interview Guide

Pre interview briefing:

Thank you for coming to participate in this qualitative study.

The aim of this project is to **examine ethical challenges encountered by humanitarian aid workers in temporary displacement camp settings in the context of COVID-19**. As such, this interview aims to examine some of your experiences and challenges encountered working in temporary displacement camp settings in the context of COVID-19, specifically from January 2020 onwards.

Your name, organizational affiliation, and name of camp of which you worked will be removed from interview data during analysis and publication. However, your professional role in the camp and general geographic location of the camp where you worked may be connected to certain excerpts in transcripts during analysis and publication. More details on confidentiality are outlined in the consent form. (Now go through consent form with the participant. Ask if they have any questions or clarifications about the consent form or about the audio or video recording aspects).

Your interview will be audiorecorded (and videorecorded if virtual). The purpose of recording the interview is to help ensure the accuracy of data transcription that occurs after the interview. Accurate transcripts are important to data analysis and certifying that we have correctly interpreted what you tell us. However, recording is not mandatory to participate in these interviews and if you do not consent to be recorded, we will instead take detailed notes of the interview.

You will be asked a series of questions based on an interview guide developed by the researcher. The interview may deviate from this interview guide depending on the answers given. The interview can be paused, or stopped at any time, and you can withdraw participation in the study at any time with no explanation or penalty. However, please be aware that once data analysis and publication is initiated, we will not be able to remove your interview data from analysis. You may also decline to answer any of the questions, and can still proceed with the remainder of the interview. There is one designated break built into the interview guide, but you may take as many breaks as desired throughout the interview. Do you have any questions or clarifications prior to beginning the interview?

Main questions and prompts

Introductory Questions (Background)-Ask in this order

1. Can you tell me about your professional role working as a humanitarian aid worker during COVID-19?
2. Can you tell me about your typical work day working in [insert refugee camp name]? Please describe in detail.

Broad open ended questions-Ask next

3. What was the impact of COVID-19 on [refugee and IDP camp]?
    a. Was this impact similar, or different, to what was expected?

   b. How did this change over the course of the pandemic?
   c. How did COVID-19 impact your professional role as []?
4. Can you tell me about whether your typical workday changed during COVID-19?
5. **What kinds of ethical challenges have you encountered working at camp x during COVID-19?** (Can provide the following definition is the participant feels confused: by ethical challenges I mean challenging situations where difficult decisions must be made but you may have felt that no choice was "correct," you felt unsure as to which option was the best choice, you felt uneasy or uncomfortable about a course of action that you may have to take in a given situation, or you knew which option was the correct choice but could not choose this option due to various constraints).
   a. Which one(s) do you think has been the most significant?
   b. Which issue have you encountered most frequently?
   c. Are these similar or different to the types of ethical challenges that you may have observed in humanitarian settings prior to COVID-19? How?
   d. Is there a particular experience or challenge that you would like to share that keeps you up at night?
6. **What was your experience assisting refugees and IDPs during COVID-19?**
   a. How did you feel about working with individuals who had probable or confirmed cases of COVID-19?
   b. Can you tell me a bit about whether this impacted your personal life or family?
   c. Is there any particular experience or situation that you feel conflicted about that you feel is important to share?

Depending on their answers to above questions, the next set of questions may be asked in varying orders to achieve a logical flow. *Break possibility here*

Bank of additional/probing questions

Public Health measure implementation

In the camp where you worked, can you tell me a bit about your role in implementing or encouraging others, either other staff, people living in the camp, or patients, to follow public health protocols during COVID-19?

- **If the participant was directly involved in the implementation of public health measures--What was your experience implementing COVID-19 public health protocols?**
  - What was your experience like encouraging others to follow COVID-19 rules? Did you ever feel uncomfortable or uneasy encouraging others to follow public health measures? Please describe in detail.
  - Can you tell me about whether you encountered any difficulties when enforcing public health measures?
    - Personally? Procedurally?
  - How did you perceive public health protocols to differ, if at all, between those mandated by your organization compared to those instituted by the host country and health system?
- **If not in the role of public health measure implementation:**

- Within your job as a [insert name of job here], in what way were you involved in encouraging others to follow public health measures?
- What was your impression regarding how public health measures were implemented? Could this have been improved?

ALL:

- **What are some of your thoughts regarding appropriateness of public health measures compared to the impact of COVID-19 in the camp where you worked? In other words, what are your thoughts in terms of how COVID-19 was handled in the camp? Could this have been improved?**
  - **If yes, how?**
  - **If not, what worked well?**
- (If applicable): What was your experience administering and/or allocating vaccines during your time at camp (x). Were there any ethical challenges related to vaccine distribution?
- How was the host community involved in public health measure implementation?
- How were local health care providers involved in the implementation of public health measures?
- **Can you tell me a bit about your experience working with local/international staff in the context of COVID-19? What was your experience like in encouraging other staff to follow public health measures?**
- What are your thoughts on local and international staff encouraging others to follow public health rules?

<u>Policy/Resource/governmental constraints</u>

- **COVID-19 introduced a wide range of travel restrictions and limitations on movement worldwide. How did this impact your ability to provide care in these camps?**
- Can you tell me about your experience of the interaction of the local healthcare system and the care provided by your organization?
- **Can you tell me a bit about how your experience working with available resources during your time at the [camp] during COVID-19?**
  - What was your experience of dealing with resource allocation prior to the COVID-19 pandemic in [camp]?
  - **How did this change during COVID-19, if at all?**
  - (if applicable): What did you notice, if anything, in regard to continuation of other services for refugees and/or IDPs during COVID-19?
- **Ask if applicable: What were your perceptions of the ability of international staff to make a meaningful contribution to aid work on the ground?**

<u>Ethical Preparation and Guidance</u>

- **How did you feel in terms of being prepared to face some of the ethical challenges that you described?**
  - How did your organization train you to respond to ethical or difficult decisions?
  - **How did your prior experience/training prepare you for these situations?**

- **What are your thoughts on some of the existing ethical guidance or policy for humanitarian aid?**
  - How did you feel in situations where you felt that you lacked professional guidance?
- Do you have any suggestions on how you may have felt better prepared to face some of these difficult situations?

Aid worker and interaction with patients

- **In previous humanitarian aid ethical literature, there is mention of power dynamics that can exist between those who are assisting and those who are being assisted. How do you view the power dynamics between you (humanitarian aid workers) and those you are assisting in the context of humanitarian aid work?**
  - How did this change, if at all, during the COVID-19 pandemic?
- **How do you view the power dynamics between international and local staff?**
  - How did this change, if at all, during the COVID-19 pandemic?

Additional questions:

1. Is there anything else you would like to mention that has not been already said?
2. Are there any other ethical challenges that our discussion has prompted that you would like to share?
3. Do you have any suggestions (from a personal, or organizational level) that may help or minimize some of the challenges you had mentioned for future pandemics or epidemics?

Debriefing

This concludes the question answer portion of the interview. Thank you very much for your time and contribution to humanitarian aid ethics. We appreciate your perspective on the important topic of ethical challenges in pandemic and camp settings, and we have learned a lot from today. We are still recruiting participants for this study, and if you know of anyone within your organization or similar organizations that may be interested in being interviewed for this project, we would really appreciate any potential contacts you could provide.

Ultimately, if you reconsider your participation in the study and would like to withdraw, please feel free to contact us. There is no penalty if you decide to withdraw from the study.

Thank you again for your time and your willingness to share your experiences with us.

Appendix 2

Information and Consent Form

Title of Study:

Ethical challenges encountered by humanitarian aid workers working in temporary displacement camp settings in the context of COVID-19

Who is leading this project?

Robyn Mellett, MSc candidate in the Department of Experimental Medicine, McGill University
Email: robyn.mellett@mail.mcgill.ca
Tel: (403)-988-5734

Supervised by Matthew Hunt, PT, PhD, School of Physical and Occupational Therapy, McGill University
Email: matthew.hunt@mcgill.ca
Tel: (514) 389-4400 ext. 00289

What is the context of this study?

The COVID-19 pandemic has affected people around the world, but certain populations are more susceptible to its negative impacts. Individuals living in temporary displacement camp settings, namely refugees and Internally Displaced Peoples (IDPs), are at particular risk of both contracting COVID-19 and suffering severe outcomes. This is due to factors such as overcrowded living conditions, limited access to clean water, insufficient sanitation services, as well as the presence of other health problems within these populations. Humanitarian aid organizations have been important in the COVID-19 response in temporary displacement camp settings, both in reducing viral transmission, treatment of positive cases, and instituting public health measures. While several ethical challenges have been identified in humanitarian aid assistance in emergency settings, such as navigating power imbalances, distributing scarce resources, and working within institutional confines, how ethical challenges may arise and play out is less understood in the context of a pandemic and camp settings.

What is the purpose of this study?

The purpose of this research project is to better understand the ethical and day-to-day challenges encountered by humanitarian aid workers working during COVID-19 in temporary displacement camp settings hosting refugees and internally displaced peoples (IDPs). We aim to understand the range and nature of these challenges and consider whether and how the pandemic context brings to light new ethical considerations compared to other humanitarian settings. Such knowledge could contribute to future efforts to create training programs for humanitarian workers to refine ethics guidance in the sector, and to inform policy and practices of humanitarian organizations.

Through this study, we are seeking to answer the research question, **what are ethical challenges encountered by humanitarian aid workers working in temporary displacement camps in the context of COVID-19?** To do this, we are recruiting international and national humanitarian aid workers for interviews.

Who can participate?

We are looking for 10-12 international or national humanitarian aid workers who have worked in temporary displacement camps for at least 2 months during the period of January 2020 onwards. Interviews will be conducted in English and take place online or in person. To be eligible for this study, all the following criteria must be met:

1. Have experience working in a temporary displacement camp as a humanitarian aid field worker from January 2020 onwards for at least 2 months;
2. Be 18 years or older;
3. Be able to participate in an interview in English; and
4. Provide written informed consent (including for videorecording).

What will happen if I participate in this study?

If you agree to participate in this study, you will be asked to participate in an interview during which we will ask you questions about your experience working in temporary displacement camps both prior to COVID-19 (where applicable), and in the context of COVID-19. The interview will be approximately one hour, and we will audio record (and videorecord if interview is virtual) the interview. If you do not provide consent to be recorded, we will instead take detailed notes during the interview. The interview can be paused, stopped, and/or your participation withdrawn at any point during the interview. Additionally, you may ask questions at any point during, before, or after the interview.

The interview can either take place in person at McGill University in Montreal, over the telephone, or virtually using the secure video conferencing software Webex or Microsoft Teams. Please note that if you choose for these interviews to take place in person, you will not be compensated for any travel costs incurred.

Are there any risks or benefits to participating in this research?

There are minimal anticipated risks in participating in our interview. However, one potential risk is that speaking about your experience working in humanitarian settings in challenging contexts may be distressing. In the event that you experience distress during or after the interview, we suggest that you seek support from your local mental health care provider, or call a distress hotline. We also emphasize that the interview can be paused at any time throughout and that you may withdraw from the study at any time without explanation or penalty.

Another risk of participating in this study is potential identification upon publication of the study. Your professional role in a camp, and general geographic area of the camp where your worked may be tied to certain excerpts from your interview during analysis and publication.

However, risk of identification is minimized through removing personal identifiers during data analysis and publication such your name, humanitarian organization affiliation, and name of camp that you worked.

You will not be paid for your participation, and you will not receive any personal benefit from being in this study. However, your participation may help us better understand ethical challenges involved in humanitarian aid work in camp settings and in the context of a pandemic. This may help develop future ethics training or ethics guidance that is aligned with experiences of humanitarian aid workers, and hence support them to be better able to assist individuals such as refugees and IDPs.

What will you do with my answers?

We will analyze responses given by all participants to help better identify and understand ethical challenges encountered by international humanitarian aid workers working in temporary displacement camp settings in the context of COVID-19. The results will be published in the form of a master's thesis and scholarly article. This may be presented at a conference or other meeting.

Can I refuse to participate and/or withdraw from the study?

Participation in this study is entirely voluntary. You may decline to answer certain interview questions and/or withdraw from the study at any point without any explanation or penalty. However, please be aware that once data analysis and publication is initiated, we are not able to remove your interview data from analysis. Regardless, we will still make great efforts to ensure that your privacy and confidentiality are protected.

Privacy and confidentiality

There are several ways that efforts will be made to protect your personal data. For virtual interviews, Webex or Microsoft Teams videoconferencing software will be used as it has been approved by McGill IT services and complies with Canadian and Quebec privacy laws. Your name, humanitarian organization affiliation, and name of camp where you worked will not be attached to your interview data. However, excerpts from the interview may be linked to your professional role in a camp, or the general geographic location of the camp where you worked. These details may be important in contextualizing ethical challenges encountered in camp settings.

Who can I talk to if I have questions during the study?

If you have any questions, you can contact us at the following address:

Robyn Mellett
MSc Candidate with a specialization in Biomedical Ethics, Department of Experimental Medicine

Phone: (403)-988-5734
Email: robyn.mellett@mail.mcgill.ca

Matthew Hunt
Professor, School of Physical and Occupational Therapy, McGill University
Phone: 514-398-4400, ext. 00289
Email: matthew.hunt1@mcgill.ca

Institutional Review Board: If you have any questions about your rights as a research participant, please call the McGill University Faculty of Medicine's Institutional Review Board at 514.398.3124

How can I agree to participate in this study?

By signing this consent form and submitting it to us. We will provide you with a copy of the form that you can keep for future reference.

CONSENT Statement

Participant's Statement
The study has been explained to me and my questions have been answered to my satisfaction. I agree to participate in this study. I do not waive any of my rights by signing this consent:

_____

Name of Participant Signature Date

I provide consent for the interview to be audiorecorded (and videorecorded if conducted virtually):

_____

Name of Participant Signature Date

Researcher Statement

I have discussed this study in detail with the participant and have answered their questions to the best of my ability.

Name of Researcher Signature Date

Appendix 3

McGill | Faculty of Medicine and Health Sciences | Faculté de médecine et des sciences de la santé

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July 6, 2022

Dr. Matthew Hunt
Physical and Occupational Therapy
3654 Sir William Osler
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eRAP/Info-Ed File Number: **22-07-009** **IRB Internal Study Number: A07-B70-22B**

Study Title: *Ethical challenges of the humanitarian aid response to COVID-19 in temporary displacement camps*

McGill Principal Investigator: Matthew Hunt

Student Investigator: Robyn Mellett

Dear Dr. Hunt,

Thank you for submitting the above-referenced study for an ethics review, on behalf of your Master's student, Robyn Mellett.

As this study involves no more than minimal risk, and in accordance with Articles 2.9 and 6.12 of the 2nd Edition of the Canadian Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans (TCPS 2 2018) and U.S. Title 45 CFR 46, Section 110 (b), paragraph (1), we are pleased to inform you that an expedited/delegated review was conducted and ethics approval for the study is provided 06-Jul-2022, valid until **05-Jul-2023**. The study proposal will be presented for corroborative approval at the next meeting of the Committee.

The following documents were reviewed and approved:

- Research protocol (Version 1, dated June 16, 2022);
- Study instruments (Version 1, dated June 16, 2022);
- Consent form (Version 1, dated June 16, 2022)

The Faculty of Medicine and Health Sciences Institutional Review Board (IRB) is a registered University Research Ethics Board working under the published guidelines of the Tri-Council Policy Statement 2, in compliance with the Cadre de référence en recherche avec des participants humains (MSSS, 2020), and the Food and Drugs Act (17 June 2001); and acts in accordance with the U.S. Code of Federal Regulations that govern research on human subjects (**FWA 00004545**). The IRB working procedures are consistent with internationally accepted principles of good clinical practice.

The Principal Investigator is required to immediately notify the Institutional Review Board Office, via

amendment or progress report, of:

- Any significant changes to the research project and the reason for that change, including an indication of ethical implications (if any);
- Serious Adverse Effects experienced by participants and the action taken to address those effects;
- Any other unforeseen events or unanticipated developments that merit notification;
- The inability of the Principal Investigator to continue in her/his role, or any other change in research personnel involved in the project;
- A delay of more than 12 months in the commencement of the research project, and;
- Termination or closure of the research project.

The Principal Investigator is required to submit an annual progress report (continuing review application) on the anniversary of the date of the initial approval (or see the date of expiration).

The Faculty of Medicine and Health Sciences IRB may conduct an audit of the research project at any time.

If the research project involves multiple study sites, the Principal Investigator is required to report all IRB approvals and approved study documents to the appropriate Research Ethics Office (REO) or delegated authority for the participating study sites. Appropriate authorization from each study site must be obtained before the study recruitment and/or testing can begin at that site. Research funds linked to this research project may be withheld and/or the study data may be revoked if the Principal Investigator fails to comply with this requirement. A copy of the study site authorization should be submitted the IRB Office.

It is the Principal Investigator's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

The McGill IRB wishes you and your colleagues every success in your research.

Sincerely,

Roberta M. Palmour

Roberta Palmour, PhD
Chair
Institutional Review Board

cc: Sylvain Baillet, PhD, Associate Dean, Research
Robyn Mellett
A07-B70-22B (22-07-009)