

# Holding the line: lived experiences of mental health, moral injury, and organizational support among public-health professionals in the Rohingya Camp, Bangladesh — a phenomenological study

Md. Ruhul Amin 

## Author Affiliation:

Department of Public Administration,  
Comilla University, Cumilla,  
Bangladesh

## Correspondence:

[rubel@cou.ac.bd](mailto:rubel@cou.ac.bd)

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## ABSTRACT

**Introduction:** Public-health professionals in the Rohingya camps work amid chronic scarcity and ethical tension. This study examined their lived experiences of mental health, moral injury, and organizational support to identify practical, context-fit improvements.

**Method:** Qualitative hermeneutic phenomenology with fifteen semi-structured interviews across cadres. Data were audio-recorded, transcribed/translated, and analysed using a reflexive thematic analysis informed by a hybrid deductive–inductive approach, drawing on Job Demands–Resources, Conservation of Resources, moral-injury, and Perceived Organizational Support lenses. Trustworthiness was supported by analyst triangulation, an audit trail, and COREQ (Consolidated Criteria for Reporting Qualitative Research) guidance.

**Results:** Nine themes clustered into four domains: (1) demand–resource imbalance with spillover beyond shifts (sleep disruption, rumination) and in-flow micro-regulation; (2) moral injury under scarcity and constrained agency (stock-outs, early discharges, bureaucratic delays, indicator dominance); (3) organizational support as felt (reflective supervision, buddy rotations/micro-check-ins, protected micro-breaks, confidential on-roster counselling); and (4) policy–context fit (offline-first data entry, stable templates, locally empowered approvals).

**Conclusions:** Low-friction, context-fit methods can break loss spirals, reduce moral-injury assessments, and maintain safe, compassionate care, making staff well-being a design challenge.

**Keywords:** demands–resources, job, moral injury, phenomenology, public-health professionals, Rohingya.

## Introduction

Prolonged humanitarian crises in Cox's Bazar expose health workers to extreme stress, ethical challenges, and resource scarcity.<sup>[1,2]</sup> Studies show humanitarian and

health workers face high burnout and secondary trauma due to continuous exposure to intense suffering, often mirroring distress experienced by displaced populations.<sup>[3]</sup> Recent studies show persistent anxiety and depression among workers, highlighting the need for systemic, context-sensitive interventions beyond individual resilience training.<sup>[4]</sup> Within mental health discourse, moral injury denotes psychological harm from witnessing or engaging in actions that violate one's moral values. Moral injury describes ethical distress from dilemmas or betrayal, extending beyond burnout to explain suffering not rooted solely in exhaustion.<sup>[5]</sup>

Supportive workplaces reduce ethical harm through supervision, peer support, and accessible counselling, strengthening staff resilience and long-term sustainability.<sup>[6]</sup> In under-resourced camp settings, well-being policies rarely translate into protected time, adequate support, or safe reporting, exposing gaps between policy and practice.<sup>[7]</sup>

In the Rohingya response, demand surges, infrastructure disruptions, and complex referrals often weaken the implementation of well-intended policy frameworks.<sup>[8]</sup> Conceptual clarity matters because organizational support includes diverse elements whose effects vary across roles, tasks, and work contexts. This study used phenomenology, the JD-R (Job Demands–Resources), and moral-injury frameworks to explore how public health professionals interpret their daily routines, ethical tensions, and personal experiences of burden and coping.<sup>[9]</sup> JD-R explains how high emotional and cognitive demands, combined with limited resources and support, drive either strain or engagement. Moral-injury frameworks link value conflicts and perceived transgressions to lasting psychological harm, guiding organizations to ethically support affected individuals.<sup>[10]</sup> Together, these lenses allow the study to connect subjective experience with modifiable features of work design and organizational climate.

This study also examined how public health professionals in Rohingya camps experience and manage work-related strain, ethical tensions, and organizational support. The JD-R model links high demands—caseloads, trauma, time pressure—to engagement or strain.<sup>[11]</sup> COR (Conservation of Resources) showed resource loss fuels further depletion, while small, consistent gains help mitigate these effects. POS (Perceived Organizational Support) connects individual experiences with organizational climate, shaping whether employees perceive policies as meaningful, supportive, and accessible during high-demand periods.

This phenomenological study explored Rohingya camp

health workers' mental health challenges, moral injury, and perceptions of organizational support, providing evidence to inform staff well-being policies and to improve humanitarian organizational practices.

### Method

In this study, a qualitative, hermeneutic phenomenological design was used to elicit and interpret the lived meanings of public health professionals. Ethical approval was obtained (Approval Code: ERC-2026-0413-06), which guaranteed voluntary participation, informed consent, confidentiality, and anonymity. The participants had the freedom to drop out at any time. The researchers respected the accepted ethical principles of conducting research on human subjects.

Reporting was done according to COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines where necessary. Purposeful, maximum-variation sampling was employed to reflect heterogeneity across roles [e.g., public-health nursing, EPI (Expanded Programme on Immunization-focused on vaccinating children), surveillance, M&E (Monitoring and Evaluation), MHPSS (Mental Health and Psychosocial Support)/health promotion] and across organization types (government, INGO/NGO/UN). Purposeful sampling prioritizes theoretical relevance and rich data over representativeness; information power guides sample size, with fewer interviews needed for credible, detailed insights.<sup>[12]</sup> Conducted fifteen one-to-one interviews, meeting adequacy criteria, aligning with evidence that thematic patterns often stabilize within the first dozen interviews. Inclusion required  $\geq 6$  months in the Rohingya response, consent capacity, and diverse roles, sexes, and organizations; data were analysed using reflexive, hermeneutic thematic analysis. Used a mixed deductive–inductive approach to conduct the study. Two analysts double-coded 20–25% of transcripts, resolving discrepancies collaboratively. The remaining transcripts were single-coded and peer-reviewed for complex sections. Trustworthiness was ensured through triangulation, audit trails, reflexivity, COREQ-aligned reporting, and detailed contextual descriptions to support transferability.<sup>[13]</sup>

### Results

#### Participant characteristics

Fifteen public-health professionals participated, spanning public-health nursing, EPI, surveillance, M&E, and MHPSS/health-promotion roles across government,

**Table 1. Demographic characteristics of the respondents**

<b>Id</b>	<b>Age</b>	<b>Sex</b>	<b>Cadre/Role</b>	<b>Org Type</b>	<b>Duty Station (Code)</b>	<b>Time in current role</b>	<b>Typical schedule</b>
1	29	Female	PHN (Public Health Nurse)	Govt	Camp 1E Health Post	2.5 yrs	6 days/week; rotating day/evening
2	34	Male	EPI Focal Point	Govt	Camp 3 Clinic	4 yrs	5.5 days/week; campaign OT
3	31	Female	Surveillance Officer	INGO	Camp 5 Primary Health Care	3 yrs	6 days/week; on-call outbreaks
4	27	Female	MHPSS	NGO	Camp 7 Community Centre	1.5 yrs	5 days/week
5	36	Male	M&E Officer (Health)	UN	Camp 9 PHC	5 yrs	5 days/week; field visits 2x/week
6	30	Female	PHN (Nurse)	INGO	Camp 10 PHC	2 yrs	6 days/week; rostered weekends
7	33	Male	Surveillance Officer	Govt	Camp 12 Health Post	3.5 yrs	6 days/week; night alerts possible
8	28	Female	MHPSS	UN	Camp 14 Women-F Centre	2 yrs	5.5 days/week; outreach shifts
9	35	Male	EPI Focal Point	NGO	Camp 16 EPI Centre	4.5 yrs	6 days/week; campaign nights
10	32	Female	M&E Officer (Health)	INGO	Camp 18 Field Office	3 yrs	5 days/week; monitoring missions
11	29	Male	Surveillance Officer	UN	Camp 20 Health Post	2 yrs	6 days/week
12	26	Female	PHN (Nurse)	NGO	Camp 22 PHC	1.2 yrs	6 days/week; alternating weekends
13	38	Male	EPI Focal Point	Govt	Camp 24 EPI Hub	6 yrs	5.5 days/week; campaign surge
14	30	Female	MHPSS	INGO	Camp 27 Community Hub	2.8 yrs	5 days/week; evening youth sessions
15	37	Male	M&E Officer (Health)	Govt	<i>Bhasan Char</i> Health Sector	4 yrs	5 days/week; monthly island rotations

**Table 2. Thematic analysis**

Participant ID	Theme	Code	Excerpt (abridged)
P07	Chronic vigilance & emotional carryover	Sleep disturbance & hypervigilance	"I wake at 3 a.m. thinking about the patient I sent home..."
P12		Cognitive carryover	"Even at home the ward is in my head—voices, forms, queues."
P03	Momentary regulation in high-tempo care	Micro-resets between cases	"Three slow breaths and a sip of water—one minute to reset."
P10		Peer micro-check-ins	"A two-minute 'you, okay?' from my buddy helps..."
P05	Operational pressures & sense-making	Queue-induced triage tension	"When the waiting area swells...I start fast-tracking..."
P09		Documentation pressure	"Midday the registers win—I'm split between form and patient."
P01	Ethical friction at the interface	Resource-constrained refusals	"Today we cannot provide this' sits heavy—did I fight hard enough?"
P06		Early discharge for capacity	"Discharging early to free a bed felt like betrayal."
P11	Systemic bottlenecks & bureaucratic drag	Protocol vs urgency	"We needed an alert but waited for authorizations."
P02		Procurement/approval delays	"Stuck between patients and purchase approvals."
P13	Metrication & narrative loss	Data-human story dissonance	"The dashboard wants numbers; my shift is stories."
P04		Supportive supervision	"How are you coping?' and rotation... I actually sleep."
P08	Scaffolded support & containment	Protected micro-breaks	"A break is real when someone covers me... 20 minutes."
P14		Unclear escalation ladder	"Without a clear referral ladder, every refusal becomes a fight..."
P15	Policy-context fit & implementation fidelity	Policy-context misfit	"Power cuts make uploads fail... re-enter late at night—exhausting."

INGO/NGO, and UN facilities in the Rohingya camps (Cox's Bazar, Bangladesh) – Table 1.

### Thematic Analysis

Nine interlocking themes described how workers experience (1) mental health in daily camp work, (2) job demands and moral injury, and (3) organizational enablers/barriers (Table 2).

### Chronic vigilance and emotional carryover

Participants reported lingering hyperarousal beyond shifts, marked by disrupted sleep, intrusive recollections of ethical dilemmas, somatic tension, and intensified distress following surge periods or complex clinical decisions.

*“Sleep is never deep after a heavy clinic. I wake at 3 a.m. thinking about the patient I sent home—did I miss something?”* (P07)

*“Even at home the ward is in my head—voices, forms, the queue moving too fast. I slow my breathing, but scenes keep replaying.”* (P12)

These accounts reflect a demand–resource imbalance (JD-R) with inadequate recovery opportunities, producing work–home spillover. The pattern aligns with resource–loss spirals (COR)—loss of sleep/time/psychological safety begets further loss. Comparable elevations in distress among humanitarian/health workers are reported in Bangladesh and allied settings.<sup>[14]</sup>

### Momentary regulation in high-tempo care

Staff narrated on-shift micro-regulation—brief breathing routines, one-minute pauses between patient clusters, micro-breaks with water/stretching—and boundary rituals (shower/journaling) to contain spillover. Peer micro-check-ins (“you, okay?”) and task-swaps (“I’ll finish the register if you handle the referral”) were repeatedly described as small, usable buffers.

*“Before the next cluster I do three slow breaths, sip water—one minute to reset my head.”* (P03)

*“A two-minute ‘you, okay?’ from my buddy helps more than a long meeting. It tells me I’m not alone.”* (P10)

These micro-resources help interrupt loss spirals (COR) and partially rebalance the JD-R equation in real time. Their salience as felt supports dovetails with evidence that perceived organizational support (POS) via supervisor care, peer architecture, and protected recovery moments—attenuates strain and improves role sustainability.<sup>[15]</sup> In the Rohingya response, peer-based coping is consistent

with regional reports of socially embedded support in constrained health systems.

### Operational pressures shaping sense-making

Care delivery faced patient surges, documentation demands, and system failures, causing rapid triage, physical strain, and divided attention.

*“When the waiting area swells, I start fast-tracking, but my body is tense—like I’m missing something while keeping the line moving.”* (P05)

*“Midday the registers win. I’m split between the form and the patient—both feel urgent.”* (P09)

Dual clinical-reporting demands amplify cognitive load, worsening perceived quality and post-shift carryover—again a JD-R configuration of high demands with thin resources.<sup>[16]</sup> When reporting templates change mid-surge or systems lack offline resilience, workers experience “policy as friction,” a mechanism linked to moral-distress appraisals in crisis care. Frontline accounts from Bangladesh similarly show how operational constraints interact with ethics and workload to shape mental-health outcomes.<sup>[17]</sup>

### Policy context fit & implementation fidelity

Participants contrasted policies “on paper” with whether they are workable under outages, surges, and staffing constraints.

*“The policy sounds good, but with power cuts the uploads fail, and we re-enter late at night—exhausting.”* (P15)

*“Changing the form mid-campaign created chaos. Keep it stable and offline-first; then policy helps, not hurts.”* (P08)

Poor implementation fit amplifies cognitive load (JD-R), drains scarce resources (COR), and fuels ethical strain when compliance competes with care. Guidance that ignores field constraints risks epistemic and practical misalignment in humanitarian settings. Participatory, co-designed adjustments stable templates, offline-first entry, scheduled micro-breaks with cover—are supported by implementation literature in mental-health systems redesign.<sup>[18]</sup>

### Discussion

This phenomenological study illuminates how public-health professionals in the Rohingya camps experience a persistent demand–resource imbalance that carries beyond the working shift (Themes 1–3), a pattern of moral injury

under scarcity and constraints (Themes 4–6), and a gap between policies on paper and supports as felt (Themes 7–9). Workers experienced disrupted sleep and rumination from ethical challenges, relying on peer support and in-the-moment coping, while systemic pressures worsened distress; structured support, micro-breaks, buddy systems, clear escalation, and confidential counselling proved protective, addressing daily mental-health experiences and organizational interventions. They also align with the study's integrated theoretical lens (phenomenology, JD-R, COR, moral injury, and POS).

Firstly, the work–home spillover and “always-on” vigilance map onto JD-R predictions that chronic emotional/cognitive demands with thin recovery resources generate strain and reduced engagement. Participants' descriptions of broken sleep, somatic tension, and intrusive replay also exemplify COR “loss spirals,” in which depletion of time, sleep, and psychological safety makes subsequent strain more likely. Comparable elevations in humanitarian/health worker distress have been reported in Bangladesh and allied crisis contexts, supporting external validity.<sup>[19]</sup>

Secondly, the data differentiate moral injury from burnout, showing guilt, shame, and self-doubt stem from morally injurious events, such as care denial or procedural delays, aligning with research linking value-violation distress to constrained agency. Findings show operational issues—surge changes, online-only systems, unclear escalation—amplify moral residue among refugee-camp public health workers.

Thirdly, policy-context mismatch hinders implementation; effective execution demands participatory design, offline workflows, stable templates, and empowered local decision-making. Findings indicate that seemingly minor design decisions may produce disproportionate influence on perceived quality, moral stress, and recovery.

### Conclusion

This study shows Rohingya camp health workers face chronic demand–resource imbalance and moral injury, but practical buffers—reflective supervision, buddy rotations, micro-breaks, clear referrals, and confidential counselling—help mitigate stress and support well-being. Implementation fidelity—stable templates, offline-first entry, and local approvals—is crucial to ensuring effective, low-cost support, reducing moral injury, and maintaining safe, humane care. Future research should test these adjustments through implementation evaluations and mixed-methods designs across cadres and settings.

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