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Ethical imperatives in migration health: Justice and care in forced migration contexts

AKM Ahsan Ullah PhD, FASS

FASS, Universiti Brunei Darussalam, Bandar Seri Begawan, Brunei Darussalam

Correspondence
AKM Ahsan Ullah, PhD, FASS, Universiti Brunei Darussalam, Bandar Seri Begawan, Brunei Darussalam.
Email: akmahsanullah@gmail.com

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Abstract

This article examines the ethical imperatives of migration health, focusing on displaced populations such as the Rohingya and Syrian refugees. Forced migration, driven by conflict, persecution, and climate disasters, presents profound ethical challenges to global healthcare systems. Utilizing deontological ethics, utilitarianism, and human rights-based approaches, the research addresses key principles like justice, equity, autonomy, and non-maleficence in healthcare provision for refugees. Empirical insights reveal significant barriers to healthcare access for displaced populations, including systemic discrimination, resource scarcity, and cultural constraints. Ethical dilemmas are particularly evident in resource allocation, prioritization of acute over chronic conditions, and neglect of mental health services. Through case studies from Rohingya camps in Bangladesh and Syrian refugee settings in Turkey and Jordan, the study highlights inequities in healthcare delivery, exacerbated by cultural and logistical challenges. The article emphasizes on culturally sensitive training, participatory healthcare design, and equitable resource distribution as critical pathways to ethical healthcare. Policy recommendations include prioritizing mental health, harmonizing national policies with international human rights law, and fostering global accountability frameworks.

KEYWORDS
forced migration, human rights, justice, migration health ethics, refugee healthcare

1 | INTRODUCTION

Forced migration has emerged as one of the greatest challenges of the 21st century, fuelled by the confluence of armed conflict, political persecution, environmental disasters and the growing threat of climate change.[1,2] As millions of people are displaced across borders, their health needs become an urgent priority. This has posed profound ethical dilemmas for health systems and policy makers alike. Migration health ethics refers to the application of ethical principles to health interventions for displaced people, emphasising fairness, justice, human rights and the protection of vulnerable groups.[3] This ethical framework addresses the dual challenge of resource scarcity and the particular vulnerabilities of forced migrants, such as legal barriers to healthcare, discrimination and psychosocial stressors.[4,5,6]

[1]Betts, A. (2013). Survival migration: Failed governance and the crisis of displacement. Cornell University Press.
[2]McAdam, J. (2012). Climate change, forced migration, and international law. Oxford University Press.
[3]Klingler, C., Odukoya, D., & Kuehlmeyer, K. (2018). Migration, health, and ethics. Bioethics. 32(6), 330–333.
[4]Gibney, M. (2015). The Ethics and Politics of Asylum: Liberal Democracy and the Response to Refugees. Cambridge University Press.
[5]Barış, M., Sert, G., & Önder, O. (2025). Ethical challenges in accessing and providing healthcare for Syrian refugees in Türkiye. Bioethics. 39(1), 49-57.
[6]Ullah, AKM. (2024). Ethical Framework and Inclusivity: Research Mechanics of Difficult-to-Reach Migrants in civil military context. Journal of International Humanitarian Action. 9(2), 1-14.

This article analyses the intersection of migration, health and ethics in the context of forced migration, particularly Rohingya and Syrian refugees. By engaging with empirical evidence and dominant theoretical frameworks, this provides an understanding of the complex ethical dilemmas that arise in the provision of healthcare to displaced people. It also explores possible ways of addressing these ethical challenges within the broader framework of global migration policy in order to enrich the ongoing scholarly discourse on justice, equity and human rights in migration health policy.

Forced migration, defined as the involuntary displacement of people due to factors such as conflict, persecution or environmental disasters, is an urgent global challenge.[7,8] According to the United Nations High Commissioner for Refugees (UNHCR), the number of forcibly displaced people (refugees, asylum seekers and internally displaced persons) worldwide exceeded 100 million in 2022.[9] These people often suffer from severe disruption to their lives, psychological trauma and, above all, limited access to essential health services.[10,11] Healthcare in the context of forced migration is usually provided by international organisations, national governments and non-governmental organisations (NGOs).[12,13] However, the lack of infrastructure, weak coordination mechanisms and limited resources exacerbate the existing health challenges. The ethical dilemmas arising from these healthcare challenges are extensive and invoke the key principles of equity, equality, autonomy, non-malfeasance and beneficence.[14] Healthcare for displaced people is not only a medical and logistical concern, but also a moral imperative.

The ethical discourse on migrant health states that the international community, healthcare providers and host countries have a moral obligation to provide forced migrants with equitable and adequate healthcare. This responsibility is firmly rooted in the principles of distributive justice, the right to health as enshrined in international human rights law, and the ethical imperative to protect vulnerable populations who may not have the opportunity or resources to advocate for their own health needs.[15,16]

Much of the existing literature focuses on the logistical aspects of health care in the context of forced migration, often overlooking the complex ethical dimensions involved. This study fills these gaps and takes an in-depth look at the ethical aspects of health care for forced migrants, making an important and much-needed contribution to the field.

2 | OBJECTIVES AND METHODS

This article aims to evaluate the ethical principles and theoretical framework that should apply to health interventions in the context of forced migration. The article also presents evidence of health outcomes in the case of Rohingya and Syrian refugees and analyses how refugee regimes can best incorporate ethical considerations into their health policies. The research not only justifies health interventions based on sound ethical theory, but also links these principles to policy decisions to ensure that health care for forced migrants is provided in a way that is both just and fair.

The central research question underlying this study is: How can healthcare systems be structured to uphold the dignity and rights of forced migrants while ensuring equity and justice in healthcare access and delivery? The study contributes to the growing discourse on migrant health ethics and situates its analysis within contemporary debates on global health policy, human rights and international politics.[17,18] Methodologically, the research is based on a qualitative analysis with a critical review of policy frameworks, case studies and reports from international organisations such as the World Health Organisation (WHO) and the United Nations High Commissioner for Refugees (UNHCR). The study applies ethical theories — such as deontological ethics, utilitarianism and human rights-based approaches — to migrant health to provide an angle through which to examine the moral imperatives of health care. For example, utilitarian approaches are explored in resource allocation dilemmas balancing acute and chronic health needs in refugee settings. Cases such as the challenges of healthcare provision in the Rohingya camps in Bangladesh and the Syrian refugee population in Jordan are compared to illustrate how ethical frameworks work under different resource constraints. Insights from bioethics, public health and international law are brought together to address the intersection of health needs, equity and justice.

2.1 | Sampling strategy

I conducted a series of in-depth interviews and observations in 2023 to explore lived experiences of accessing health services and the services provided to the refugees. This study employs a purposive sampling strategy to capture the diverse experiences of refugees in accessing healthcare. Given the focus on ethical dilemmas in migration health, participants were selected based on their direct engagement with healthcare services, either as recipients or providers.

[7]United Nations High Commissioner for Refugees (UNHCR). (2022). Global trends: Forced displacement in 2022.
[8]Ullah, AKM.A. (2014). Refugee Politics in the Middle East and North Africa: Human Rights, Safety and Identity. London: Palgrave McMillan.
[9]UNHCR, op. cit. note 7.
[10]Carballo, M., & Nerukar, A. (2001). Migration, refugees, and health risks. Emerging Infectious Diseases, 7(3), 556-560.
[11]Asif, Z., & Kienzler, H. (2022). Structural barriers to refugee, asylum seeker, and undocumented migrant healthcare access: Perceptions of Doctors of the World caseworkers in the UK. *SSM - Mental Health*. 2, 100088.
[12]International Organization for Migration (IOM). (2019). World Migration Report 2020.
[13]Ullah, AKM.A. (2018). The intersections of migration and governance in Bangladesh. South Asia Journal. 26:(Special Issue):45-55.
[14]Klingler, et al., op. cit. note 3.
[15]Van de Pas, R., Hill, P.S., Hammonds, R., Ooms, G., Forman, L., Waris, A., Brolan. C.E., McKee, M., & Sridhar, D. (2017). Global health governance in the sustainable development goals: Is it grounded in the right to health? Global Challenges. 1(1), 47-60.
[16]Zimmerman, C., Kiss, L., & Hossain, M. (2011). Migration and health: A framework for 21st century policy-making. PLoS Medicine. 8(5), e1001034.
[17]Faden, R. R., & Powers, M. (2006). Social justice: The moral foundations of public health and health policy. Oxford University Press.
[18]Benatar, S.R., Daar, A.S., & Singer, P. A. (2003). Global health ethics: The rationale for mutual caring. PLOS Medicine. 1(3), e41.

The study included two groups: (1) Rohingya refugees in Cox's Bazar, Bangladesh, and (2) Syrian refugees in Suruç, Turkey. These cases were chosen for their illustrative value in highlighting ethical challenges in resource-constrained healthcare settings.

For the Rohingya sample, 10 refugees who had accessed healthcare services in Cox's Bazar in the last three years were selected. Additionally, 4 healthcare workers providing services in refugee camps were included to understand the systemic challenges of healthcare provision. The Syrian refugee sample comprised 11 individuals living in the Suruç tent camp in Turkey, 4 healthcare providers, and 4 staff from non-governmental organizations (NGOs) involved in refugee health interventions. The selection of these participants was based on their ability to provide detailed insights into healthcare access, barriers, and ethical dilemmas in refugee contexts. The sample size was determined based on data saturation, where additional interviews did not yield new themes. While the sample may not be fully representative of all refugee health experiences, it captures a wide range of perspectives, allowing for an ethical analysis. These interviews were complemented by detailed on-site observations to gain a better understanding of their living conditions. The data informed my analysis and allowed me to link the empirical findings to the relevant theoretical frameworks to support my thesis.

Both groups have endured extreme forms of displacement due to ethnic persecution and armed conflict. The Rohingya, a stateless minority from Myanmar, have faced systematic violence and denial of citizenship, leading to one of the world's largest refugee crises. Similarly, Syrian refugees have been displaced due to prolonged civil war, with many experiencing severe trauma, destruction of healthcare infrastructure, and loss of livelihood. The severity of their displacement experiences makes them critical cases for examining ethical dilemmas in healthcare. Both refugee groups are among the most well-documented populations in forced migration studies, allowing for triangulation of findings with existing reports from the United Nations High Commissioner for Refugees (UNHCR), the World Health Organization (WHO), and non-governmental organizations. The availability of secondary data strengthened the empirical foundation of the study and allowed for a more comprehensive analysis of healthcare ethics in refugee settings. The Rohingya and Syrian cases exemplify broader ethical challenges in migration health, including resource scarcity, discrimination, prioritization of healthcare needs, and the clash between cultural values and medical ethics. Their experiences provide a lens through which ethical principles such as justice, equity, and human rights can be examined in forced migration contexts.

2.2 | Interview protocols

The study employed semi-structured interviews to allow flexibility while maintaining focus on key research themes. Interview guides were designed based on the ethical principles of justice, autonomy, beneficence, and non-maleficence. For refugees, interview questions explored their experiences with healthcare access, perceived barriers, and ethical concerns such as discrimination, resource prioritization, and cultural considerations. For healthcare providers and NGO staff, questions addressed the ethical dilemmas they encountered, including issues of triage, systemic discrimination, and constraints in service delivery. All interviews were conducted in 2023. Interviews with Rohingya refugees were conducted in Rohingya and Bengali with the assistance of trained interpreters, while interviews with Syrian refugees were conducted in Arabic. Healthcare workers and NGO staff were interviewed in English or the respective local languages. Interviews were recorded with participants' consent and transcribed verbatim. Anonymity was ensured by assigning pseudonyms to all participants.

2.3 | Data analysis

Data were analyzed using thematic analysis, following Braun and Clarke's six-step framework: (1) familiarization with data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. The initial coding focused on ethical dilemmas in healthcare provision, such as prioritization of acute over chronic conditions, cultural sensitivities, and systemic inequities. The themes were then mapped onto ethical theories, including deontological ethics, utilitarianism, and human rights-based approaches, to frame the findings within broader ethical debates.

3 | CONCEPTUALIZING HEALTH ETHICS

The ethics of medical care is an important area that addresses the moral obligations that underlie the medical care, especially for the forced migrants. Based on justice, equality and human rights, it aims to ensure equal access to healthcare for refugees, asylum seekers and internally displaced persons. These populations often face socio-economic, political and legal barriers that compromise their well-being and challenge global commitments to human rights and moral responsibility.[19,20] The Syrian refugee crisis is an example. Host countries such as Turkey, Jordan and Lebanon have limited resources, forcing healthcare providers to prioritise acute illnesses over chronic conditions.[21] While this utilitarian approach is pragmatic, it raises ethical dilemmas in terms of equity. Chronic diseases such as diabetes and hypertension often go untreated, disproportionately affecting the most vulnerable, including the elderly and disabled.

The prevailing four-principle framework (autonomy, beneficence, non-maleficence and justice) often neglects the cultural and

[19]Beauchamp, T. L., & Childress, J. F. (2019). Principles of biomedical ethics (8th ed.). Oxford University Press.
[20]Gostin, L. O., & Archer, R. (2007). The duty of states to assist other states in addressing serious health threats: A legal perspective. Global Governance: A Review of Multilateralism and International Organizations. 13(3), 275–292.
[21]Doocy, S., Lyles, E., Delbiso, T. D., & Robinson, C. (2016). Health service access and utilization among Syrian refugees in Jordan. International Journal for Equity in Health. 15(1), 108.

situational complexities of forced migration.[22] For example, autonomy requires individual choice, which can conflict with family-centred norms in refugee communities. Alternative concepts, such as relational autonomy and the ethics of care, emphasise context-specific considerations and inclusivity.[23,24] While cultural norms, such as favouring female providers, are cited as barriers, financial, legal and logistical barriers are often found to be even more significant.[25] Ethical frameworks for health care in migration must prioritise equity and equality and address discrimination and systemic barriers in order to uphold the dignity and universal right to health care.[26,27]

3.1 | Migration health ethics and theoretical issues

The health ethics of migration involves addressing the unique health needs of forced migrants through the application of fundamental ethical principles such as justice, equality, and human rights. These principles guide ethical decision-making and policy formulation, drawing on diverse theoretical frameworks, including deontological ethics, which emphasize duty and moral obligations; utilitarianism, focused on maximizing well-being; and human rights-based approaches, which prioritize the inherent dignity and rights of all individuals.

Deontological ethics, which has its roots in the philosophy of Immanuel Kant, emphasises duty and moral principles over outcomes.[28] In the area of migrant health care, this framework prioritises the inherent right to health care, regardless of resource constraints, while focusing on dignity and equality to protect migrants from systemic discrimination. However, its rigidity can hinder practical implementation in resource-limited settings such as refugee camps, where prioritisation is often unavoidable.

In contrast, utilitarianism, as formulated by John Stuart Mill, aims to maximise the overall good, which makes it pragmatic for health crises.[29] For example, vaccination campaigns in overcrowded camps can prevent the outbreak of disease, which benefits the majority of people. However, utilitarianism often marginalises vulnerable groups, such as people with chronic diseases, by putting aside their long-term needs in favour of immediate benefits.

The human rights-based approach, enshrined in international treaties such as the ICESCR,[30] provides a legal and moral basis for non-discrimination and equitable healthcare. By embedding ethical obligations in enforceable human rights norms, it ensures accountability and emphasises healthcare as a fundamental human right. However, political and resource constraints often limit its practical application, particularly in low- and middle-income countries hosting refugees.

Social justice theory, influenced by thinkers such as John Rawls and Amartya Sen, emphasises an equitable distribution of resources in healthcare, prioritising disadvantaged groups such as women, children and people with disabilities.[31] By addressing structural inequalities, it complements deontological and human rights-based approaches and strikes a balance between immediate humanitarian needs and long-term resource allocation. One promising development is the integration of these frameworks. For example, hybrid models combine the pragmatic prioritisation of utilitarianism with deontology's focus on dignity and rights. In Syrian refugee camps, emergency trauma care could follow utilitarian principles, while equitable access to treatment for chronic diseases corresponds to a rights-based perspective. Such integrative approaches enable ethical, context-sensitive health strategies that address both immediate and systemic challenges in the context of forced migration.

The theoretical frameworks can be operationalized in forced migration healthcare by structuring ethical decision-making around both immediate needs and long-term equity. Deontological ethics can guide policies ensuring that all refugees, regardless of status or available resources, have access to essential healthcare based on their intrinsic rights. Utilitarian principles can be applied in triage systems within refugee camps, prioritizing medical interventions that maximize overall well-being, such as vaccination campaigns or emergency care. However, this must be balanced with a human rights-based approach, which mandates healthcare as a fundamental entitlement, ensuring marginalized groups—such as women, children, and those with chronic illnesses—receive adequate attention. In practice, this operationalization could involve developing equitable triage frameworks, culturally sensitive training for healthcare providers, and policy alignment with international human rights laws to hold host governments and NGOs accountable for ethical healthcare delivery in displacement contexts.

4 | CRITICAL REVIEW OF LITERATURE

The literature on Syrian refugees points to significant health challenges, such as the strain on the healthcare systems of the host country, the prioritisation of acute illnesses over chronic diseases and the limited provision of mental health services. Reports from camps in Jordan, Lebanon and Turkey show how healthcare providers prioritise acute life-threatening conditions over chronic conditions such as diabetes and hypertension due to limited resources.[32] The selected studies emphasise ethical concerns such as justice and equity through

[22]Gillon, R. (2003). Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals." *Journal of Medical Ethics*. 29(5), 307–312.
[23]Held, V. (2006). *The Ethics of Care: Personal, Political, and Global*. Oxford University Press.
[24]Mackenzie, C. (2014). Relational autonomy and healthcare. In: A. Veltman, & M. Piper (Eds.), *Autonomy, Oppression, and Gender* (pp. 129–151). Oxford University Press.
[25]Parmar, P.K., Agrawal, P., Greenough, P.G., Goyal, R., & Kayden, S. (2019). Health access and utilization survey among Rohingya refugees in Cox's Bazar, Bangladesh. *Conflict and Health*. 13(1), 1–13.
[26]Gostin & Archer, op. cit. note 20.
[27]United Nations. (1966). International Covenant on Economic, Social and Cultural Rights. Retrieved March 26, 2025, from https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights
[28]Misselbrook, D. (2013). Duty, Kant, and deontology. *British Journal of General Practice*. 63(609), 211.
[29]de Lazari-Radek, K., & Singer, P. (2017). *Utilitarianism: A Very Short Introduction*. Oxford: Oxford University Press.
[30]United Nations, op. cit. note 27.
[31]Ekmekci, P. E., & Arda, B. (2015). Enhancing John Rawls's Theory of Justice to Cover Health and Social Determinants of Health. Acta Bioethica. 21(2), 227-236.
[32]Doocy, et al., op. cit. note 21.

utilitarian and human rights-based frameworks that ground theoretical analysis in the lived experiences of refugees.

Research increasingly calls for an ethical framework that recognises inequalities and vulnerabilities in healthcare provision for migrants. Studies focus on the intersection of justice, human rights and health ethics in migration and examine the obligations of states, international organisations and healthcare providers to ensure equitable access to healthcare for forced migrants. Despite progress, there are still critical gaps. Much of the research focuses on high-income countries and neglects low- and middle-income countries (LMICs), where most displaced people live. Moreover, the rights-based approach often overlooks broader socio-political factors that influence migrant health, and the role of non-state actors, such as humanitarian organisations, remains under-researched.

Ng et al.[33] analyze ethical dilemmas in migrant healthcare, focusing on access, equity, and policy implications. While their work emphasizes equity and human rights, it falls short in addressing how these principles are practically implemented within fragmented healthcare systems. Similarly, Carballo and Nerukar's[34] seminal study on vulnerability of migrants to infectious diseases in overcrowded camps lacks a thorough exploration of the ethical dimensions surrounding healthcare interventions. Abubakar et al.[35] advocate a rights-based approach to health and emphasise the moral and legal imperatives to protect migrants. However, their broad analysis leaves gaps in the specific ethical theories applicable to migrant health. Benatar criticise the neoliberal policies that affect access to healthcare, but fail to examine the application of ethical frameworks in the context of forced migration.

De Luca and Tondini[36] address ethical challenges in the provision of healthcare to refugees in the Mediterranean and highlight the tensions between utilitarian and deontological ethics. Kluge et al.[37] examine the healthcare inequalities that have worsened during the COVID-19 pandemic, but do not fully address the ethical frameworks required to design interventions. Building on their observations, this paper proposes structured approaches for ethical decision-making in healthcare in forced migration. Hynie[38] examines the mental health needs of refugees, focusing on post-migration stressors but neglecting the ethical obligation of healthcare providers to prioritise mental health. Pavlish, Noor and Brandt[39] highlight the cultural barriers to accessing healthcare for Somali immigrant women, but limit their analysis to a single population group.

Silove et al.[40] and WHO[41] emphasise the integration of mental health services but do not address the ethical principles guiding these interventions. Freedman[42] and Kirmayer et al.[43] address issues such as gender-based violence and culturally competent care, but do not adequately address justice and equity. Médecins Sans Frontières[44] discusses the dilemmas of health care in conflict zones and emphasises the need to contextualise these challenges within ethical theory. Wickramage and Mosca[45] propose the Health-in-All-Policies (HiAP) approach, which incorporates health into migration policy. However, Taylor et al.,[46] who examine the health outcomes of Iraqi refugees, lack a focus on ethical prioritisation frameworks.

In contexts of forced migration, justice, as articulated by Rawls and Sen, demands equitable distribution of resources, particularly for those systematically disadvantaged. The human rights-based approach, rooted in the International Covenant on Economic, Social and Cultural Rights (ICESCR), asserts the right to health as a fundamental entitlement, obligating states and international organizations to ensure non-discriminatory, accessible, and adequate healthcare services.[47] This perspective aligns with Beauchamp and Childress' principle of justice, which mandates fair distribution of healthcare irrespective of legal status. However, justice in migration health is often undermined by geopolitical and economic constraints, shifting the corresponding duty onto humanitarian organizations and host states, despite their limited capacities.[48] Ethical tensions arise when resource allocation follows utilitarian logic, prioritizing emergency care over chronic conditions, thereby neglecting long-term refugee health needs.[49] Integrating justice into principlism necessitates a delicate balance between immediate humanitarian responses and the development of sustainable healthcare frameworks that uphold dignity and equity. A justice-oriented approach to principlism transcends the conventional focus on autonomy, shifting the ethical lens toward addressing structural inequalities that impede healthcare access for migrants and refugees.

To meaningfully advance the literature, the paper integrated a detailed normative analysis of ethical principles tailored to the migration context. For example, the application of Beauchamp and

[33]Ng, S. H., Kaur, S., Cheah, P. Y., Ong, Z. L., Lim, J., & Voo, T. C. (2024). Migration health ethics in Southeast Asia: A scoping review. Wellcome Open Research. 4:8:391.
[34]Carballo & Nerukar, op. cit. note 10.
[35]Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., et al. (2018). The UCL-Lancet Commission on Migration and Health: The health of a world on the move. Lancet. 392(10164), 2606-2654.
[36]De Luca, G., & Tondini, M. (2014). Healthcare in the Mediterranean refugee crisis: Ethical challenges. European Journal of Public Health, 24(5), 707-712.
[37]Kluge, H. H. P., Jakab, Z., Bartovic, J., D'Anna, V., & Severoni, S. (2020). Refugee and migrant health in the COVID-19 response. Lancet. 395(10232), 1237-1239.
[38]Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. Canadian Journal of Psychiatry. 63(5), 297-303.
[39]Pavlish, C. L., Noor, S., & Brandt, J. (2010). Somali immigrant women and the American health care system: Discordant beliefs, divergent expectations, and silent worries. Social Science & Medicine. 71(2), 353-361.
[40]Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. World Psychiatry. 16(2), 130-139.
[41]World Health Organization (WHO). (2019). Promoting the health of refugees and migrants: Draft global action plan, 2019-2023.
[42]Freedman, J. (2016). Sexual and gender-based violence against refugee women: A hidden aspect of the refugee "crisis". Reproductive Health Matters. 24(47), 18-26.
[43]Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Canadian Collaboration for Immigrant and Refugee Health (CCIRH). Common mental health problems in immigrants and refugees: General approach in primary care. CMAJ.183(12), E959-E967.
[44]Médecins Sans Frontières. (2017). Health care under fire: The impact of violence on health care systems in conflict zones.
[45]Wickramage, K., & Mosca, D. (2014). Can Migration Health Assessments Become a Mechanism for Global Public Health Good? *International Journal of Environmental Research and Public Health. 11*(10), 9954-9963.
[46]Taylor, E. M., Yanni, E. A., Pezzi, C., Guterbock, M., Rothney, E., Harton, E., Montour, J., Elias, C., & Burke, H. (2014). Physical and mental health status of Iraqi refugees resettled in the United States. Journal of Immigrant and Minority Health. 16(6), 1130-1137.
[47]Van de Pas, et al., op. cit. note 15.
[48]Gostin & Archer, op. cit. note 20.
[49]Doocy, et al., op. cit. note 21.

Childress' principles of biomedical ethics — justice, beneficence, non-maleficence and autonomy — provided a basis for analysing case studies in LMICs that have treated Rohingya and Syrian refugees. Examples from Bangladesh, where health systems have adapted innovative triage systems for Rohingya refugees, or Lebanon's health strategies for Syrian migrants illustrate the application of these principles and offer actionable insights.

5 | EVIDENCE

A critical evaluation of ethical principles and frameworks requires an in-depth assessment of their theoretical foundations, their practical applicability and their consistency with the realities of migrant health. Such an assessment involves objectively analysing the strengths and weaknesses of frameworks such as deontological ethics, utilitarianism, human rights-based approaches and social justice theories to determine their reliability and relevance in addressing ethical dilemmas in forced migration. In the case of the Rohingya crisis, for example, healthcare providers face the dilemma of limited resources, overcrowding and unequal access to care. In Bangladesh, the influx of over one million Rohingya refugees since 2017 has overwhelmed the healthcare infrastructure, particularly in the Cox's Bazar district. Their statelessness exacerbates their vulnerability as they have no legal rights and protection, including access to basic health services.[50] The ethical dilemmas in this context arise from the tension between the right to health and the limited resources available in a low-income host country. Humanitarian organisations, including the World Health Organisation (WHO) and Médecins Sans Frontières (MSF), have played a crucial role in providing emergency medical care, but long-term care, particularly for chronic diseases and mental health, remains inadequate.[51]

A recurring ethical dilemma for healthcare providers in refugee camps is the equitable distribution of scarce resources. One healthcare worker expressed the seriousness of the situation: "One of the most difficult dilemmas we face is deciding who gets access to limited medical resources. For example, when there is a shortage of medicines or medical equipment, we have to prioritise certain patients, but it often feels like we have to decide who should survive or live without adequate care. The need is overwhelming and we can not help everyone. This raises the question of how we balance the principle of justice — who deserves priority? The elderly? Pregnant women? Or children? These are painful decisions." This statement illustrates how equity in healthcare is often constrained by external factors that force providers to make morally difficult decisions that directly impact the survival and well-being of vulnerable populations.

From the perspective of the refugees themselves, their experiences of healthcare are characterised by feelings of injustice and neglect. A Syrian refugee in Turkey said: "We are grateful for the doctors, but sometimes we feel that we are treated differently because we are refugees. Some people are too sick, but they wait for days to get help. There is not enough medicine and some of us have to choose between feeding our children or getting treatment. We do not have the same access as others outside the camp. I have the feeling that we are forgotten." This feeling emphasises the ethical principle of care, or rather the perceived absence of care, as refugees struggle to reconcile their urgent need for medical care with the constraints of resource scarcity and systemic neglect.

Field staff are also aware of ethical issues at the system level and share the concerns of healthcare providers and refugees alike. As one field worker noted, "From a policy and systemic perspective, the most pressing ethical issue is inequitable access to healthcare. Many healthcare providers are forced to make decisions based on what is available rather than what is needed. This leads to inequalities where some refugees receive treatment while others are denied care, often based on arbitrary factors such as proximity to a clinic or the urgency of their condition. The ethical principle of equal treatment is often violated in this context. In addition, many refugees suffer from mental health problems that are often overlooked, as mental health services are scarce and physical health is often prioritised in crisis situations." This highlights the profound ethical challenges associated with healthcare systems that fail to address the full spectrum of refugees' needs, particularly mental health, which is often neglected in favour of more immediate physical problems.

The focus on mental health is a critical but narrow lens through which to analyse the health challenges of forced migrants. Mental health is undeniably vital as refugees often experience profound psychological trauma, anxiety and depression due to displacement, conflict and loss. Addressing mental health is essential to upholding ethical principles such as autonomy, beneficence and justice. For example, untreated mental illness can interfere with refugees' ability to make informed decisions about their lives and healthcare, which violates the principle of autonomy. Similarly, the principle of beneficence requires that healthcare providers actively improve the well-being of patients, which is not possible without treating mental health. From a justice perspective, equitable access to mental health services is crucial, as these needs are often undervalued in humanitarian contexts despite their prevalence.[52]

However, focusing solely on mental health risks marginalising other critical health conditions, such as non-communicable diseases (NCDs) and HIV/AIDS, which are also chronic in nature and essential to address. These conditions are critical to ethical compliance for several reasons. First, the principle of non-maleficence — "do no harm" — requires that health systems prevent the deterioration of the health status of people with chronic diseases. Neglecting NCDs or HIV/AIDS in refugees could lead to serious complications or premature death, thus violating this principle. Secondly, the principle of equity requires that health systems allocate resources fairly and

[50]United Nations High Commissioner for Refugees (UNHCR). (2021). Public health strategy for refugees and asylum seekers.

[51]Ullah, AKM.A. (2016). Globalization and the health of Indigenous peoples: From colonization to self-rule. New York: Routledge.

[52]Silove, et al., op. cit. note 40.

ensure that people with chronic diseases are not penalised simply because their condition is less visible or immediate compared to acute emergencies. For example, untreated diabetes can lead to life-threatening complications such as kidney failure, and untreated HIV/AIDS undermines both individual and public health through the continued transmission of the disease.[53]

Treatment of these chronic conditions is critical to promoting comprehensive health outcomes and social integration, in addition to mental health. Refugees with untreated chronic conditions often face barriers to work, education and social engagement, perpetuating the cycle of poverty and marginalisation. In Syrian refugee camps, for example, people with NCDs often report feeling excluded from community activities due to their physical limitations, which also exacerbates mental health issues.[54] Therefore, while the focus on mental health is important, extending the analysis to other chronic conditions would provide a more holistic approach to ethical health care for migrants and better align with the principles of equity and comprehensive care.

NGO staff working in the field face additional ethical dilemmas, particularly in balancing respect for cultural practises with the need to provide care. An NGO worker in Cox's Bazar said: "A big challenge for us is dealing with cultural and religious sensitivities in healthcare. For example, women in the Rohingya community avoid seeking medical help because there are no female healthcare providers. Even if we want to respect their cultural values, it becomes an ethical problem when these sensitivities prevent access to basic healthcare. It is a constant struggle between cultural respect and the duty to provide necessary medical care. We are also concerned about the long-term effects on mental health, but are unable to provide adequate mental health care due to limited financial resources. This raises the ethical question of whether we are neglecting these needs." This challenge reflects the ethical tension between respecting cultural norms and ensuring equitable care, particularly for vulnerable groups such as women and people with mental health problems.

These voices — from healthcare providers, refugees, fieldworkers and NGO workers — illustrate the complex ethical imperatives at play in the context of forced migration. Justice, equity and care are compromised by resource scarcity, systemic inefficiencies and cultural barriers. This emphasises the urgent need for an ethical framework that can guide healthcare provision in this challenging environment.

From a deontological perspective, inequalities in healthcare access and quality, particularly when they affect vulnerable populations such as women in Rohingya refugee camps, represent a fundamental violation of the ethical principle of justice. Justice requires that all people, regardless of their gender, social status or migration background, are treated with equal dignity and respect.[55,56]

Similarly, the Syrian refugee crisis has posed significant ethical challenges to healthcare systems in Turkey, Jordan and Lebanon, the countries hosting millions of displaced Syrians.[57] These host countries have faced overwhelming demand for healthcare services, often resulting in emergency care being prioritised over routine care.[58] In Lebanon, for example, refugees make up almost a third of the population, putting a strain on an already fragile healthcare system.[59]

The scarcity of resources in the Syrian refugee camps in Jordan often forces healthcare providers to prioritise immediate life-threatening conditions, such as trauma caused by the conflict, over the long-term treatment of chronic conditions such as diabetes or hypertension.[60] This prioritisation raises ethical concerns about fairness. Vulnerable individuals with chronic conditions run the risk of being overlooked despite their significant need for medical care. Utilitarianism supports this decision as a way to maximise the overall good, but also points to the moral trade-offs that occur in such scenarios.

Mental health is another area where empirical evidence points to serious ethical concerns. In many refugee camps, including those of the Syrian and Rohingya populations, mental health services are either inadequate or non-existent, despite the fact that these populations often suffer from trauma, anxiety and post-traumatic stress disorder (PTSD).[61] From a human rights-based perspective, this neglect of mental health care violates the fundamental right to the highest attainable standard of health enshrined in the International Covenant on Economic, Social and Cultural Rights.[62] The lack of consideration of mental health emphasises structural inequalities and calls into question the ethical obligation of healthcare providers to do no harm (non-maleficence) and to provide comprehensive care, including mental and psychological well-being. The principle of non-maleficence is difficult to uphold when chronic care is neglected, which can lead to long-term harm for people with persistent health conditions. In addition, autonomy is often compromised as refugees have limited access to healthcare services due to socio-economic and legal barriers.

A Rohingya mother in Cox's Bazar recounted her difficulties accessing maternal healthcare. "When I was pregnant, I feared for the life of my baby. There were no female doctors at the clinic, and my husband didn't want me to see a male doctor. I waited for hours, but in the end, I had to leave without treatment. My neighbor gave birth at home with the help of other women, but her baby didn't survive. We don't have a choice—either we risk complications or we don't seek care at all." This shows gender-based barriers in healthcare, reflecting ethical challenges related to autonomy and justice.

A healthcare worker in a Jordanian refugee camp expressed concerns over the ethical dilemmas of prioritization. "Every day, we

[53]Doocy, et al., op. cit. note 21.
[54]Abu Hamad, B., Jones, N., Samuels, F., & Gercama, I. (2020). Mental health and psychosocial support for Syrian refugees in Jordan and Lebanon: Between difference and exclusion. Health Policy and Planning. 35(2), 215–227.
[55]Beauchamp & Childress, op. cit, note 19.
[56]Misselbrook, op. cit. note 27.
[57]Ullah, AKM.A. (2016). Refugee mobility: Causes and perspective in the Middle East. Orient 1. 1: 61-69.
[58]Doocy, et al., op. cit. note 21.
[59]Abu Hamad, et al., op. cit. 54.
[60]Ullah, AKM.A. (2015). Abuse and Violence against migrant domestic workers: A case from Hong Kong. *International Journal of Area Studies*. 10(2), 207-224.
[61]Silove, et al., op. cit. note 40.
[62]UN, op. cit. note 30.

have to choose. Do we treat the child with pneumonia who needs immediate care, or do we allocate resources to a diabetic patient who requires lifelong medication? The system forces us to focus on urgent cases, but the long-term neglect of chronic diseases is devastating. These patients are essentially left to deteriorate because we don't have the capacity to care for them properly." This illustrates the utilitarian trade-offs in resource allocation and the ethical tensions between immediate life-saving interventions and the long-term well-being of refugees. A Syrian refugee in Turkey shared their experience of seeking mental health support. "People say I should be grateful to be alive, but they don't understand what's inside my head. I can't sleep, I have nightmares, and I don't feel like myself anymore. I tried to talk to a doctor, but they told me physical health comes first, and there are no mental health professionals here. We are alive, yes, but we are not really living." This demostrates the systemic neglect of mental health services for refugees and the ethical failures in ensuring holistic care. It reinforces the need for a rights-based approach that includes mental health as a fundamental component of healthcare.

An undocumented refugee in Lebanon described their fear of seeking medical attention. "I have a heart condition, but I avoid going to the hospital. If they ask for my documents, what do I say? I heard stories of people being reported to the authorities when they tried to get medical help. So I just pray nothing happens to me. What else can I do?" This underscores the ethical conflict between healthcare as a fundamental human right and the exclusionary policies that prevent undocumented migrants from accessing services.

5.1 | Health outcomes

The health outcomes of the Rohingya and Syrian populations reflect significant inequalities due to systemic challenges in accessing healthcare. For the Rohingya population, severe overcrowding in refugee camps in Bangladesh has resulted in limited access to healthcare, with barriers to reproductive and maternal health being particularly pronounced. Cultural and systemic barriers, such as the lack of female healthcare providers and legal restrictions on their mobility, exacerbate these problems. Chronic conditions such as diabetes and hypertension are often neglected, while mental health conditions such as trauma due to systemic violence and displacement due to resource scarcity go untreated.

Syrian refugees face similar challenges. Host countries such as Lebanon, Turkey and Jordan are struggling under the burden of limited health resources. Emergency care is often prioritised, leaving chronic diseases untreated. For example, diabetes and hypertension patients often report difficulties in accessing continuous care. Mental health issues such as PTSD and anxiety are prevalent, yet mental health services are either minimal or non-existent. These gaps highlight the systemic inequities in health care for displaced populations and highlight the lack of long-term health planning. These health consequences emphasise the critical ethical dilemmas in the context of forced migration and highlight the relevance of ethical principles such as justice, equality and non-maleficence. Equity in the form of equal access to healthcare is violated when resources are disproportionately distributed or when cultural and systemic barriers prevent vulnerable groups such as women or people with chronic conditions from receiving adequate care. The lack of female healthcare providers in the Rohingya camps, for example, shows that gender equality, a key principle of distributive justice, has not been taken into account.

Utilitarian ethics is often applied in such situations to maximise overall utility, which justifies prioritising emergency care over chronic conditions. However, this approach raises ethical concerns about neglecting the long-term health of vulnerable groups. For example, prioritising acute injuries over chronic illnesses for Syrian refugees may save more lives in the short term, but exacerbates health inequalities. A human rights-based approach provides an alternative framework by emphasising the right to health for all people, including access to mental health services — a right that is often ignored in refugee settings.Incorporating this framework ensures that ethical imperatives guide healthcare interventions and balance immediate needs with long-term equity.

6 | CONCLUSION

This study illuminates the ethical imperatives in migration health by integrating theoretical frameworks with empirical insights from Rohingya and Syrian refugee contexts. The findings highlight profound ethical dilemmas in healthcare provision, particularly around justice, equity, autonomy, and non-maleficence. For instance, chronic underfunding and the prioritization of acute care over long-term health needs illustrate the tensions between utilitarian pragmatism and rights-based ethics. Similarly, cultural barriers and systemic inequities underscore the importance of adapting healthcare systems to meet the specific needs of vulnerable populations without compromising their dignity.

The theoretical engagement in this article bridges the gaps in the existing literature by offering a nuanced application of deontological ethics, utilitarianism, and human rights-based approaches to forced migration contexts. While deontological ethics emphasizes the moral duty to uphold universal healthcare rights, utilitarianism offers a practical lens for resource allocation. A hybrid approach, integrating these frameworks, emerges as a promising model for addressing ethical challenges in refugee healthcare. The application of social justice theories underscores the need for equitable distribution of healthcare resources, particularly in low- and middle-income countries hosting large refugee populations.

This research makes contributions to the scholarship on migration health ethics by foregrounding the voices of refugees and healthcare providers and contextualizing theoretical insights with empirical evidence. It advances the discourse by identifying cultural sensitivity and structural reform as critical pathways to ethical healthcare delivery. The novelty lies in its exploration of ethical frameworks tailored to forced migration and its actionable recommendations for policy and practice. For example, mental health services should be prioritized alongside physical healthcare through scalable interventions such as group therapy and telemedicine. A global

accountability framework, supported by entities like the WHO and UNHCR, can ensure equitable distribution of resources and enhance the resilience of healthcare systems in host countries. Tailored training programs can empower healthcare workers to respect cultural norms while ensuring access to care, particularly for marginalized groups such as women in conservative communities. Involving refugee communities in the design and implementation of healthcare programs can enhance autonomy and ensure that services are aligned with their specific needs and values. Transparent triage systems, underpinned by principles of justice and equity, should prioritize the most vulnerable populations, such as children, the elderly, and those with chronic illnesses.

By situating these recommendations within the broader context of ethical theory and global migration policy, this article provides a framework for addressing the ethical dilemmas in migration health. It calls for a paradigm shift that balances humanitarian needs with long-term systemic equity to ensure the dignity and rights of displaced populations are upheld.

CONFLICT OF INTEREST STATEMENT

None to declare.

ORCID

AKM Ahsan Ullah https://orcid.org/0000-0003-1441-141X

AUTHOR BIOGRAPHY

AKM Ahsan Ullah is Associate Professor of Geography, Environment and Development at the University of Brunei Darussalam (UBD). He has an extensive research portfolio and has worked with prestigious institutions such as the City University of Hong Kong, IPH at the University of Ottawa, McMaster University, Saint Mary's University, Dalhousie University in Canada, the American University in Cairo (AUC), Osnabruck University, Germany, and the Asian Institute of Technology (AIT), Thailand. His research areas include migration and mobilities, international relations, intercultural encounters and development, with a geographic focus on the Asia-Pacific, Africa, and Middle East, and theoretical focus on globalization and neoliberalism, development and human rights, transnationalism, gender, intersectionality and the everyday life.

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