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"No, it is not a breach of my oath because it is beyond my control; I use the policies that are in place." Ethical challenges faced by healthcare workers in the provision of healthcare to cross-border migrants in Botswana

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Abstract

Background With a growing global population of migrants, understanding the complex dynamics between healthcare providers and policy restrictions is crucial for ensuring equitable access to healthcare. The main objective of this qualitative study was to explore the ethical challenges faced by health care providers in the provision of health care to migrants.

Methods We conducted in –depth interviews with 11 healthcare providers, which were analysed using thematic analyse. Atlas ti software was used to analysis the data.

Results Healthcare workers reported facing ethical challenges as a result of not being able to provide medical care to migrant patients because healthcare policies deny them access to healthcare. These policies make it difficult for healthcare professionals to fulfil their duties in accordance with their oath. Failure to provide healthcare to migrant patients can cause moral distress for healthcare workers and affect their well-being. Reporting migrant patients to the police was mentioned as another ethical challenge, which is a breach of confidentiality. Several healthcare providers have developed strategies to address the limitations of migrants' access to healthcare, including encouraging migrants to access healthcare from their home country and using private healthcare facilities.

Conclusions Health policies influence the way health care providers carry out their tasks, which can either positively or negatively impact access for vulnerable migrant groups. To address the challenges faced by healthcare providers in implementing their professional ethics, inclusive policies should be introduced, and human rights and ethics training should be provided, as well as ongoing dialogue to ensure that healthcare providers fulfil their professional obligations toward all migrant patients.

Keywords Healthcare workers, Medical ethics, Policies, Access, Health care, Migrants, Botswana

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Background

Medical ethics are founded on a set of values that professionals can refer to in the case of any confusion or conflict. Medical ethics entail the principles of autonomy, justice, beneficence, and nonmaleficence [1–3]. The Hippocratic Oath requires that the patient's health be paramount, and that the oath taker not allow secondary aspects such as physical appearance, faith or social status to interfere with the duty to provide the highest standard of care [2, 3]. Similarly, nurses adhere to ethical guidelines such as the Florence Nightingale Pledge or the International Council of Nurses (ICN) Code of Ethics, which emphasize compassion, nondiscrimination, and patient-centered care. These guiding principles ensure that nurses provide equitable and ethical treatment to all patients, including migrants, regardless of their background. Healthcare providers' duty to their patients requires basic health care as a fundamental right of all humans [4]. At the very least, maintaining health and being able to continue working are essential parts of life [4]. It is a fundamental good because it determines whether or not we, as humans can pursue life, relieve pain, minimize suffering, and create the necessary basis for life [4].

In addition, healthcare providers are required to maintain patient confidentiality. Healthcare providers are responsible for ensuring that, while carrying out their professional duties, they comply with applicable healthcare policies and guidelines [5]. In other words, healthcare providers should comply with professional regulators and patients and provide best practices based on the autonomous exercise of professional judgement [5]. Although healthcare professionals play an important role in ensuring that migrants have access to healthcare, they face ethical challenges [5]. Studies [5, 6] have reported that healthcare providers oscillate between consciously juggling accountability expectations and more automatically applying tacit practice knowledge that is implicit, experiential and often not formally articulated, but deeply embedded in their professional practice. This includes intuitive decision-making and adaptive skills developed through years of practical experience in specific healthcare contexts. The authors also went on to say that healthcare providers' efforts to find a balance between satisfying their obligations and acknowledging the often-unavoidable reality of contextual constraints that produce inconsistent patterns. A study by Low et al. [7] stated that healthcare providers face ethical dilemmas in terms of conflicts that arise when prioritizing different ethical principles in the care of this complex patient population, including the principles of respect for autonomy, nonmaleficence, beneficence, and justice. Another study by Sanggaran et al. [8] reported that doctors working within the immigration detention system may experience conflicting loyalties to their patients, employers and departments of immigration and border protection. Furthermore, doctors who work in detention centres may feel ethical responsibilities to voice their concerns, but this may conflict with their obligations to their employer [8].

In the African context, there is a lack of empirical information on migrant health care and the ethical responsibilities or professional duties of health workers [9]. While attention has increased in recent years to the ethical issues facing migrants accessing health services, most of the related attention has focused on the migrant perspective [9]. Less attention has been given to the ethical challenges faced by health workers in developing countries when providing health care to migrants. Healthcare workers in southern African countries encounter a myriad of ethical challenges when providing healthcare to migrants. The complexities of migration health policy, practice, and research confront health workers with a minefield of ethical dilemmas [10]. These dilemmas include challenges such as balancing limited healthcare resources between migrants and local populations, addressing language and cultural barriers in providing equitable care, navigating legal constraints on treating undocumented migrants, and ensuring confidentiality when collaborating with immigration authorities.These challenges are further compounded by the difficulties in providing proper care and treatment for HIV-infected migrants, as existing healthcare systems in both South Africa and Lesotho experience obstacles in delivering adequate care [11]. Migrants in this region often lack access to adequate sexual and reproductive healthcare (SRH), which exacerbates their vulnerability to poor health outcomes [12]. Furthermore, the ethical standpoint in African countries is also influenced by poor leadership and organizational ethics, contributing to challenges in healthcare delivery systems [13].

African countries have taken several measures to accommodate migrants, though the approaches have varied across the continent. In Tunisia, the government has worked to improve access to services for refugees and asylum-seekers, including providing legal assistance, education, and addressing vulnerabilities like gender-based violence [14]. They have also established a refugee task force and referral mechanism to better support new arrivals. The Gambia, Benin, and Seychelles provide visa-free access for all African citizens [15]. In 2023, Rwanda joined this group of countries offering visa-free access to all Africans [16]. The African Union has developed a Migration Policy Framework and Plan of Action to guide member states in managing migration in a humane way

that respects migrants' rights [17]. This includes promoting freedom of movement, combating human trafficking, and integrating migration into development policies. Some countries, like South Africa, have introduced policies like the National Health Insurance (NHI) system to provide universal healthcare access, which benefits both citizens and migrants [18]. Under the NHI, all children, including those of asylum seekers or undocumented migrants, are entitled to basic healthcare services, while asylum seekers and undocumented migrants are entitled to emergency medical services and services for notifiable public health conditions [18]. However, xenophobia and discrimination against migrants remain challenges in many African countries that need to be addressed [19–21]. Overall, while African countries have made some progress in areas like visa openness and developing migration governance frameworks, significant challenges remain in fully implementing these policies and ensuring the rights and wellbeing of migrants across the continent.

Moreover, ethical dilemmas regarding the treatment of migrants and refugees are closely related to systemic and cultural concerns, posing challenges to the core of professional work [22]. The pressure from migration in southern Africa has led to increased challenges in meeting the medical demands of both citizens and migrants, contributing to medical xenophobia and aggravating existing healthcare challenges [23]. Undocumented migrants, in particular, present a significant ethical dilemma for healthcare workers due to limitations in accessing healthcare services [24]. Additionally, research has shown that migrant women may participate in research to access quality healthcare, highlighting the vulnerabilities and resourcefulness of migrant populations [25]. Cross-cultural encounters between patients with a migration background and healthcare professionals also present difficulties and challenges, emphasizing the need to explore the ethical aspects involved in providing culturally competent care [26]. Furthermore, ethical challenges arise in the context of providing tuberculosis treatment and care to non-refugee migrants in high-income countries, particularly those who do not face immediate danger or violence [27]. The COVID-19 pandemic has further highlighted the ethical challenge of providing equitable healthcare access for all, regardless of citizenship and social status, within the framework of resource-limited healthcare systems [28]. In the context of Botswana, little research has been conducted on what individual healthcare workers themselves consider to be ethical behaviour when facing dilemmas and concerns in their daily work with migrants. A study by Sabone et al., [29] only examined everyday ethical challenges of collaboration between nurses and physicians. The study found that health care professionals reported that their ethical challenges arose from resource shortages, differing professional attitudes, and a stressful work environment. This paper explores the ethical challenges confronted by healthcare workers in Botswana as they navigate the intersection of healthcare policies and the provision of medical care to migrant patients. In this study, we define migrants as individuals who have crossed an international border from their place of residence, irrespective of their legal status, the voluntary or involuntary nature of their movement, and the reasons behind it [30]. Moral distress occurs when healthcare professionals recognize the ethically appropriate action to take but feel powerless to execute it due to institutional constraints, lack of resources, or external pressures [31]. This feeling of powerlessness can lead to frustration, guilt, and a sense of compromised integrity [31]. For instance, a nurse might experience moral distress when they know that a patient requires a particular treatment, but hospital policies or resource limitations prevent them from providing it. Ethical dilemmas, on the other hand, arise when healthcare professionals face situations where two or more ethical principles are in conflict, making it unclear which course of action is morally right. In such cases, there is no straightforward solution, and choosing one ethical principle may compromise another [1].

Botswana health care system

Botswana's health delivery philosophy prioritizes providing quality and affordable health services through a decentralized model, with primary health care as its foundation [32]. Funded by government taxation, the Ministry of Health oversees policy formulation, regulations, and service guidelines [33]. Botswana's healthcare system is governed by several key policies aimed at ensuring the provision of equitable and comprehensive healthcare services to all residents, including migrants. The National Health Policy and the Integrated Health Service Plan are the primary documents outlining the country's health strategies and objectives [34]. The National Health Policy of Botswana emphasizes universal health coverage and equitable access to healthcare services. The public sector dominates, with over 80% of services accessed through public health facilities, offering free services at referral hospitals and primary clinics. Private hospitals serve those with private medical aid [35]. Healthcare services are organized into different levels based on service complexity, with 27 health districts ranging from mobile stops and health posts to primary hospitals, district hospitals, and three referral hospitals [35]. A teaching hospital at the University of Botswana provides specialized services, though it is still in development stage.

An estimated 84% of Botswana's population lives within a five-kilometer radius of a health facility [32]. However,

equitable distribution of public healthcare facilities is still a challenge. In rural areas, about 77% of the population lives within a five-kilometer radius of a facility, compared to 96% in urban areas [32]. Public clinics charge a registration fee of five Pula for citizens and 80 Pula for non-citizens, offering services such as laboratory tests, TB screening, HIV/AIDS care, antenatal care, immunizations, and family planning [36]. Free HIV testing and antiretroviral treatments are limited to citizens, excluding international migrants [37]. The main countries of origin for migrants in Botswana are neighbouring HIV-epidemic countries like Zimbabwe, South Africa, and Zambia [38, 39]. In 2020, Botswana's non-citizen population totalled 110,268, with 43% being female and 57% male. The largest nationalities among them were Zimbabwean (58.31%), South African (5.20%), Indian (5.12%), Chinese (4.33%), and Zambian (4%) [40, 41]. In 2022, Botswana registered 723 refugees and 89 asylum seekers, mainly from Somalia (44.95%), the Democratic Republic of the Congo (36.09%), Burundi (8.16%), Uganda (2.62%), and Rwanda (2.48%) [41]. The flow of asylum seekers, migrant workers, and trafficked persons makes Botswana a key transit and destination country, particularly for low-skilled individuals. Botswana is not a signatory to the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) (2000), and thus is not obligated to promote and protect the rights of refugees and asylum seekers within its borders. Consequently, refugees in Botswana face numerous challenges due to policies that deny them access to socio-economic rights [42]. Given that Botswana is a signatory to the 1951 United Nations Convention, the 1967 Protocol on the Status of Refugees, and the 1969 Organization of African Unity Convention, it has a duty to protect refugees and asylum seekers. Additionally, WHO Resolution WHA 61.17 calls on member states, including Botswana, to recognize the health of migrants as a human right through policy and legal frameworks, improved migrant-sensitive health systems, monitoring of migrant health, and strengthened networks and partnerships [43]. However, it remains unclear how Botswana has acted on this resolution, which mandates that health services be accessible regardless of immigration status, and that barriers to such access be prioritized by policymakers and stakeholders [43]. The IOM (44) highlights two areas of discrimination against international migrants in Botswana: limited knowledge of available legal provisions among migrants, and the lack of clear guidelines on service provision to migrants. This leads to confusion among both migrants and service providers regarding the rights and responsibilities of migrants, particularly at the district level. Consequently, healthcare workers in government facilities often face dilemmas in assisting undocumented migrants due to outstanding unpaid hospital bills [44].

Theoretical framework

As articulated by Beauchamp and Childress in 2013 [2], bioethical principlism has furnished a theoretical construct that enables the systematic arrangement and dissemination of the findings of the present investigation. Bioethical principlism helps healthcare workers address ethical challenges by providing a framework and set of principles to guide their decision-making. The four major principles of bioethics—autonomy, beneficence, nonmaleficence, and justice—are central to this framework [45–47]. These principles help healthcare workers consider the rightness or wrongness of actions in healthcare, research, and biotechnology [48]. Principlism allows for the consideration of issues that affect not only the individual patient but also the entire society [49]. It emphasizes the importance of respecting patient autonomy and involving patients in their own treatment decisions. By drawing from moral theory, principlism provides a structured approach to resolving ethical dilemmas and promoting ethical awareness and professionalism among healthcare professionals.

For the purpose of this study, the concept of respect for autonomy pertains to the responsibility of a healthcare provider to facilitate an individual's ability to make deliberate, voluntary, and thoughtful decisions regarding their own well-being [45–47]. This includes ensuring that patients who possess decision-making capacity actively participate in the process of obtaining informed consent, while patients lacking such capacity have a designated representative to partake in decision-making on their behalf. Although distinct, the principles of non-maleficence and beneficence are intricately interrelated. Non-maleficence denotes an obligation to abstain from engaging in actions that may cause harm to a patient, whereas beneficence signifies an obligation to engage in actions that are likely to promote the welfare of a patient [45–47]. The principle of justice, on the other hand, encompasses the fundamental entitlement of patients to be treated equitably, with "equity" being determined by considerations of a patient's societal status and inherent biological circumstances [45–47]. From this perspective, justice serves as a call to ensure fair treatment of patients when allocating limited medical resources, including access to healthcare services. The use of Beauchamp and Childress' bioethical principlism (2013) as the theoretical framework for this study provides a robust structure for analyzing the ethical challenges faced by healthcare providers in Botswana when treating migrant populations. The principles of bioethical principlism were instrumental in formulating the research questions. Each principle

helped to shape questions that probed the specific ethical challenges healthcare providers encounter. Additionally, during the data collection process, in-depth interviews with healthcare providers were designed to capture information relevant to each of the four principles. This ensured a comprehensive understanding of the ethical dilemmas from multiple perspectives. Furthermore, the data analysis process involved categorizing responses according to the four principles. This allowed for a systematic examination of the ethical issues and facilitated the identification of patterns and common themes related to autonomy, beneficence, non-maleficence and justice. Bioethical principlism has been widely used in various studies [7, 50] to address ethical challenges.

Methods

This qualitative study delves into the ethical challenges faced by healthcare workers in the context of exclusive health policies affecting migrants. In this qualitative study, we conducted individual, semi-structured interviews with healthcare providers who treat migrant patients in various settings to explore their experiences with ethical challenges in delivering healthcare to migrants. We used exploratory qualitative design, which enables researchers to explore the context and environment in which participants operate, leading to a deeper understanding of the subject matter [51], especially useful in areas where there is limited existing knowledge [52, 53]. This design is particularly useful when the research topic is new, not well understood, or lacks prior research, allowing for the exploration of complex issues in-depth [54]. It helps researchers gather rich, detailed data to build a foundation for future research [53].This design is used to investigate phenomena, generate insights, and understand the meanings individuals or groups ascribe to social or human problems [54].

The study was conducted in Gaborone and Francistown, two major cities in Botswana. Gaborone, the capital city, is located in the southeast near the South African border and serves as the country's economic center, housing numerous government offices, financial institutions, and businesses. Gaborone has over 15 public clinics providing primary care, maternal and child health services, and treatment for common illnesses and injuries. Five clinics (three with maternity services and two without) were selected for the study. Francistown, the second-largest city, is in the northeast and is well-connected by road and rail to Gaborone and neighboring countries. Francistown has around 10 public clinics offering similar essential healthcare services. Four clinics (two with maternity services and two without) were included in the study. These cities were chosen due to their higher population densities, which increase the demand for healthcare services and amplify ethical challenges, making them ideal for studying these issues. Urban areas typically have a more diverse population in terms of socio-economic status, ethnicity, and health conditions. Many cross-border migrants reside in cities for job opportunities and access to social services. Cities also have varied healthcare policies and administrative practices compared to rural areas. Studying these variations helps tailor ethical guidelines to different urban contexts. Focusing on cities allows the study to capture a wide range of ethical challenges faced by healthcare providers in complex urban healthcare environments.The fieldwork was undertaken by the first author between May and July 2019.

Sampling method and participants

A purposive sampling method was used for the recruitment process, during which the researcher identified suitable participants from the clinics. The nurse in charge of the clinic was asked for permission to conduct the study in the health facility. The lead researcher contacted the potential respondents in person and by telephone and explained the objectives and the inclusion and exclusion criteria. Interviews were conducted with 11 health care workers (7 nurses, 2 doctors and 2 midwives; each one interview session per participant lasted for approximately 70–80 min. The sample size for this study was determined based on the principle of data saturation, a common guideline in qualitative research. Data saturation occurs when additional data collection no longer yields new information or themes. In this study, we reached data saturation by the 11th interview, as no new themes emerged and existing themes were sufficiently explored. This aligns with the rule of thumb suggesting that a sample size of 10–15 participants is often adequate for qualitative studies with a focused scope. Hence, 11 participants were deemed sufficient to provide a comprehensive understanding of the ethical challenges faced by healthcare workers in the provision of healthcare to cross-border migrants in Botswana. Healthcare providers who had worked at the clinic for at least 2 years and had provided medical care to migrants were eligible to participate. Healthcare providers who had worked for one year or less were excluded because it was assumed that they did not have much experience dealing with migrants.

Data collection and analysis

One-on-one in-depth interviews were conducted with health healthcare providers in English and lasted for approximately 70–80 min. An interview schedule as a guide for the detailed interviews. Face-to-face interviews were conducted with healthcare providers. The guide was designed to capture demographic characteristics of healthcare providers, information about

healthcare entitlement for migrants, experiences of healthcare providers in dealing with migrants seeking health care services, access to healthcare for migrants in Botswana and use of health policies when providing healthcare services. The guide was designed by the lead researcher and co-researchers provided inputs in finalising the guide. The guide was piloted in 2 clinics, with data collected by interviewing four healthcare providers in the selected clinics in Gaborone. A pilot study was carried out to help the researcher to get a sense of the interview questions in order to develop them further if necessary. This also helped the lead researcher with his approach in asking the interview questions to help build confidence and to allow him to align the questions more closely with the topic under investigate.

The data were analyzed using Atlas ti version 9, following a bioethical principlism framework to organize ethical themes. All interviews were transcribed verbatim, with sentences used as units of analysis. The lead researcher and co-researchers independently reviewed and coded each transcript, comparing raw data and coded meanings to reach consensus on codes and interpretations. Thematic content analysis was employed to explore ethical challenges faced by healthcare providers in interdisciplinary practice [55, 56], enabling the identification of themes and patterns within the data [57]. The research team collaboratively identified themes and sub-themes, organizing them into a codebook. To ensure trustworthiness, standard qualitative research guidelines were followed [58, 59], including thorough review and coding of transcripts. An initial list of codes was developed based on the research question, with additional codes emerging from the data. These codes were refined into more abstract categories, leading to the creation of broader themes that illustrated key ethical challenges faced by health providers in the provision healthcare services to cross border migrants. Manual coding and analysis were used to maintain close interaction with the data, mitigating the limitations of software analysis such as distancing from the data and potential decontextualization of codes [60].

Ethical considerations

Ethical approval was obtained from the Institutional Review Board at the University of Botswana and the Ministry of Health, and written informed consent was obtained from the participants**.** Accordingly, all names are pseudonyms for reasons of confidentiality and anonymity.

Table 1 Demographic characteristics of the participants

Participant ID	Sex	Age range Number years Worked		Educational level
Nurse in charge,clinic 1	Female	40–49	12	Diploma
Nurse,clinic 3	Female	25–35	4	Degree
Nurse, clinic 1	Female	25–35	4	Degree
Nurse, clinic 2	Female	35–45	7	Diploma
Nurse, clinic 3	Female	35–45	8	Diploma
Doctor, clinic 4	Male	30–35	8	Degree
Midwife, clinic 5	Female	40–49	10	Diploma
Doctor, clinic 6	Male	35–45	8	Degree
Nurse, clinic 4	Male	25–35	3	Diploma
Nurse, clinic 6	Female	35–45	6	Diploma
Midwife, clinic 7	Female	40–49	11	Diploma

Results

Eleven health care providers participated in the study. Detailed information on the socio-demographic characteristics of the participants can be found in Table 1. As shown in the table, most of the participants are 35 to 45 years old females, the majority had diploma, and had worked for four to eight years.

Coding frame and quotation book

In this section, we describe the ethical challenges that health care workers encounter when providing health care to migrants. Three themes emerged from the participant interviews: 1) Justice, 2) Non-maleficence /Beneficence, 3) Confidentiality (Autonomy), non-maleficence and justice see to Table 2.

Theme 1: Justice

The principle of justice addresses fairness and the equitable distribution of health resources. Exclusionary policies violate this principle by denying fair access to healthcare for migrants. Participants reported that policies and guidelines exclude migrants from accessing some health services at government clinics and hospitals. These guidelines stipulate that migrants are entitled to health care but must pay to receive these services. However, migrants are not entitled to access ARVs. Therefore, healthcare workers are developing strategies to address these policy gaps. One respondent said,

> *"HIV testing is free, and migrants must pay for treatment. Me, as a nurse, I have played my role according to policy by providing the test. I end up that I have not given him/her the ARVs but have solicited some other means which include suggest-*

Table 2 Overview of themes and findings

Themes	Principle of Bioethical Principlism	Explanation
Policies /guidelines that exclude migrants from accessing healthcare Professional ethics of Health Workers Visa Health Policies	Justice	This principle addresses fairness and the equitable distribution of healthcare resources. Exclusionary policies violate this principle by denying fair access to healthcare for migrants
Moral distress related to policies	Beneficence/Non-maleficence	Moral distress occurs when healthcare providers feel they cannot act in the best interest of their patients (beneficence) or feel forced to act in ways that cause harm (non-maleficence)
Reporting Migrant patients to the Police (Ethical dilemmas in balancing legal obligations and patients rights)	Confidentiality (Autonomy),Non-maleficence and Justice	Healthcare workers face ethical conflicts between respecting patient confidentiality (autonomy) and following legal mandates. Reporting migrants may cause harm (non-maleficence) and contribute to systemic inequities (justice)

ing they use private clinics or hospital, because we cannot offer them from the government. This is another way you can find the ARVs; neither is it possible at least start in the home country or other clinics where they can get them at subsidized prices but they do agree. I have solicited some other means that migrants can be assisted in stand of him/her because I cannot render service, which means he/she can stay without getting help, whereas he/she can find some money and go somewhere" (BMN,2).

Another respondent provided justification for breaching a professional oath.

"No, it is not a breach of my oath because it is beyond my control; I use the policies that are in place. They should be given all the services, but they should pay for them (BFN, 11).

The above quote illustrates how health care providers are limited by policies ensuring that they provide all the necessary care to migrants. Health care workers may be loyal to professional, personal, and political commitments, but they are bound by ethical codes that impose additional obligations on them (e.g., the Hippocratic Oath taken by the doctors and Nightingale Pledge for nurses). Because policies do not include migrant access to certain health care services, health care workers must go an extra mile to offer other options that migrants could use to ensure that they receive proper care. Health care workers emphasize social relations and empathy as part of their professional identity. For instance, respondents know where they can obtain medicine using a local pharmacy. They also encourage migrants to return to their home country to obtain medicine. It is also clear that migrants are treated as 'others' who do not deserve access to health care services. Healthcare workers also stressed that it is their job to ensure that all services are provided to patients. However, the policies restricted them from carrying out their duties diligently, and it was often difficult for them not to provide ARVs to migrants, as this was a violation of their oath.

Respondents also described how the policies restricted them from carrying out their duties in accordance with their professional ethics.

One of the participants commented that.

The migrants not having access to HIV/AIDS services is a difficulty to me as a breach of my nurse's oath a lot, because I will be attending the patient who is very sick and I will want that patient to start treatment in order to recover but then the barrier becomes financial means that the patient doesn't have money to start treatment, so to me I feel I haven't completed care to the patient and is also difficult for us to help them, so sometimes we end up suggesting them to go back home and start treatment but then we are not sure if the person is going to start treatment when he gets home, so there is no continuity of care (BFN, 7).

This quote illustrates how health care providers face challenges, and the feeling of not providing health care to migrants means that they have carried out their duties. They also stressed that it is a beach of their oath because they are expected to attend to a patient and provide the necessary care. Health care providers also understand that refusing to provide health care services to migrants goes against the moral foundations of their profession and are constantly forced to go against their will. This is against the principle of a benevolent normative statement of a moral obligation to act for the benefit of others, helping them to further their important and legitimate interests, often by preventing or removing possible harm. Policies that prohibit migrants from accessing certain

health care services from public health act against the principle of benevolence.

Theme 2: Non-maleficence and Beneficence

Non-maleficence is the principle of "do no harm'. When healthcare providers are forced by policies to take actions that they believe may harm patients, or when they are prevented from taking actions they believe would benefit patients, they experience moral distress. This distress arises from conflict between their professional and ethical commitment to avoid harming patients and constraints imposed by institutional policies. Respondents noted:

> *"As a healthcare practitioner, we are supposed to be able to help someone in any way they may need you, but because of the ARV policy, there is a limitation to how much we may help someone; this is difficult for me as a breach of my oath (BFN, 4).*

Respondents also went on to say that helping migrants is difficult and that this can affect them emotionally, that *ARVs are not provided for migrants "if the person dies, the picture remains in my mind" (BMN, 1).*

> *"People are not given ARVs, and patients die in our hands" (BFN, 8).*

This quote illustrates how health care workers need to shut down some of their emotions to make their practice bearable. Several voiced their feeling of becoming 'inhumane'… They also went on to say that lack of access to ARVs for migrants can contribute to stress, which can also lead to stress-related disease, which raises the issue of their health. The following quote illustrates how health care workers accept situations in which they are not able to provide care and that situation is beyond their control:

> *Failing to provide a specific form of health care, i.e., ARVs, is painful for us as healthcare workers, but we refer to the guidelines. A lack of ARs for migrants can contribute to stress for health care workers and cause disease, but we are trying to do so. We live with all these issues, and we are accustomed to that –re amogela seemo (we accept the situation), o nna moko o thata (to be tough). It is beyond our control; you can end up sick or have stress-related issues (BFN, 10).*

Additionally, moral distress can also be related to the principle of beneficence, which is the ethical obligation to act in the best interest of the patient. When policies prevent healthcare providers from acting beneficently-i.e., providing the best possible care this can also lead to moral distress.

Theme 3: Confidentiality, Non-maleficence and justice

Reporting migrants to the police conflicts with the ethical principles of confidentiality, non-maleficence and justice. Confidentiality involves protection information and privacy. Reporting migrants to the police breaches this principle, as it involves disclosing information without the patient's consent. Healthcare providers are ethically bound to keep patient information confidential unless there is a clear and justifiable reason to break that confidentiality such as an immediate threat to others. Respondents mentioned that they had heard that nurses report migrant patients who do not have papers to the police. The respondents expressed concerns that reporting of migrant patients to the police is a breach of confidentiality. Some midwives reported that pregnant migrant women who did not have papers were reported to the police:

> *I have heard migrants being reported for not having papers, especially at the maternity ward; the midwives report them. I think reporting the migrants to the police is a breach of confidentiality; we see many patients, whether they are migrants or not or some of their police cases, but we are not supposed to report. Once we take the patient and report, then we have already breached everything because, obviously, you will want to give certain information to the police. Even if we have not given the police those confidential issues, the patient will only think that they can hold us accountable, so I think it is unprofessional unless it is her case where the client came and assaulted the nurses. In addition, those issues I will understand that we have to involve the police; otherwise, if healthcare cases then, it is not necessary to call the police because of breaching confidentiality. (BFN, 3).*

Another participant also stated,

> *I have heard that nurses do report migrants to the police; our role as nurses is to alleviate suffering and treat patients and keep records available if the police are looking for a migrant, and we give them additional details where necessary. You can only report in cases where the migrant patient is violent. Reporting migrants to the police is unethical. Reporting migrants to the police has an impact on how migrants access health care services (BFN, 5).*

Health care workers understand that refusing to provide life-sustaining care goes against the moral foundations of their profession and are constantly forced to confront the realities underlying these dry statistics. Respondents also realized that some undocumented migrants would be scared about visiting health care

facilities for fear that they would be reported to the police. They also mentioned that it is difficult for service providers to report undocumented migrants to the police as service providers. As shown by one of the respondents:

> *My duty as a nurse is to treat patients, but you would find some people phoning the police to report patients who do not have documents. I have realized that some patients would be scared about visiting the clinic if we reported them to the police. That one is difficult for me (BFN, 9).*

Additionally, reporting can also related to the principle of non-maleficence, which is the ethical "do no harm". So, reporting migrants to the police can cause significant harm to the individuals involved, such as detention, deportation, or other legal consequences. This principle dictates that healthcare providers should avoid actions that would knowingly cause harm to their patients. Reporting migrants can perpetuate systemic inequalities and discrimination, violating the principle of justice, which seeks to ensure that all patients, regardless of their legal status, receive fair and equitable treatment.

Moreover, these findings show that health care providers' independence is seriously compromised because it is controlled by state authorities using health policies and guidelines. There is an intangible presence of state authorities, through health policies and the politicization of migration issues, by health care providers who report migrants to the police. Thus, instead of providing care, interactions resemble investigative interrogations. Respondents also explained what the oath says regarding the provision of health care, whereas the policy documents exclude migrants from receiving all free health care services. Health care providers also explained that there is nothing they can do in terms of ensuring that migrants are provided with health care services and that they always ask them to pay and bring the necessary documents.

Discussion

In this qualitative study, we sought to explore the ethical challenges encountered by healthcare workers in the provision of healthcare to migrants. Our findings reveal compelling insights into the multifaceted nature of these challenges and their implications for both healthcare providers and the migrant populations they serve. Our study highlights the significant impact of health policies contributing to the exclusion of migrants from healthcare services. The bureaucratic hurdles and eligibility criteria embedded in these policies create barriers that compromise the fundamental right to healthcare for this vulnerable population. The ethical dilemma arises as healthcare workers grapple with the tension between their commitment to providing care and the restrictive policies that hinder access. Our findings resonate with the broader discourse on the impact of restrictive health policies on migrant populations [61, 62]. The bureaucratic hurdles embedded in these policies contribute to the exclusion of migrants from essential healthcare services, echoing the concerns raised by Priebe et al. [63] and Castañeda et al. [64]. As our study reveals, healthcare workers grapple with the ethical tension created by policies that compromise their commitment to providing equitable care to all individuals. Our study builds upon the work of Holmes [65] by highlighting the nuanced experiences of healthcare workers who navigate the ethical complexities of exclusion in their daily practice. One notable strategy employed by healthcare workers is the encouragement of migrants to seek healthcare services from their home country. This approach may be an adaptation to restrictive health policies by redirecting individuals to their home country's healthcare system. This strategy reflects the ingenuity of healthcare workers in finding alternative solutions to address the limitations posed by exclusive policies. This strategy aligns with findings of Biswas et al. [66], who emphasize the importance of recognizing and leveraging migrants' transnational healthcare practices. Although not a universal solution, encouraging migrants to access healthcare in their home country acknowledges the existence of alternative healthcare systems and may be seen as a pragmatic approach given existing policy constraints. While the literature provides a foundation for understanding the impact of health policies on migrant healthcare, our study offers a unique qualitative lens, emphasizing the personal and ethical dimensions of these challenges.

The conflicts between professional ethics and institutional policies identified in our study align with the observations made by Kalengayi et al. [67] and Vanthuyne et al. [68]. The ethical dilemmas faced by healthcare workers underscore the challenges posed by institutional constraints in balancing the principles of beneficence and justice inherent in professional ethics. Our study echoes the call for a closer examination of professional guidelines in healthcare, as advocated by Tarlier [69] and Leineweber et al. [70]. Strengthening these guidelines to explicitly address conflicts between professional ethics and policies can provide healthcare workers with a more robust ethical framework for navigating complex situations. The ethical dilemmas surrounding the reporting of migrants to the police, as identified in our study, resonate with the concerns raised by Hargreaves et al. [71] and Sahraoui [72]. The conflicting obligations faced by healthcare workers highlight the tension between the duty to

provide care and the legal obligations that may require reporting specific situations. Our findings align with the observations of Sandelowski et al. [73] and Hacker et al. [74] regarding the potential impact of reporting on the trust relationship between healthcare providers and migrant populations. The erosion of trust, as identified in our study, underscores the broader implications for effective healthcare provision to migrants. Our study aligns with the observations of Mladovsky et al. [75] and Amroussia [76] in highlighting the pervasive influence of power dynamics in shaping the interaction between healthcare workers, migrants, and policies. Power imbalances contribute to the exacerbation of ethical challenges, particularly for marginalized migrant populations.

Conclusion

Our qualitative exploration of the ethical challenges in providing healthcare to migrants offers valuable insights into the intricate interplay between healthcare policies, professional ethics, and the lived experiences of both healthcare providers and migrant populations. As we conclude, this study highlights several key themes, highlighting the urgency of systemic changes in policy, education, and advocacy. The ethical challenges identified in our study, ranging from exclusion by health policies to conflicts between professional ethics and institutional policies and from the reporting of migrants to the police, collectively underscore the complexities inherent in migrant healthcare. The narratives shared by healthcare workers reveal the emotional and ethical dilemmas they encounter daily, emphasizing the need for a more nuanced and inclusive approach to healthcare provision.

Our study contributes to the literature by providing a qualitative lens through which to address the ethical challenges faced by healthcare workers. While previous research has illuminated the impact of policies on migrant healthcare, our findings offer a deeper understanding of the personal and ethical dimensions of these challenges. By incorporating the voices of healthcare providers, our study enriches the discourse on the lived experiences of those at the frontline of migrant healthcare delivery. The ethical challenges identified in our study call for urgent policy reforms to create a more inclusive and ethically sound healthcare system. Revisiting and restructuring health policies to prioritize equity and inclusivity is paramount. Additionally, the conflicts between professional ethics and institutional policies underscore the need for ongoing education and training programs that equip healthcare workers with the ethical tools necessary to navigate complex situations within the constraints of existing policies. The reporting of migrants to the police emerges as a particularly sensitive and ethically charged issue requiring a delicate balance between legal obligations and the duty to provide care. Our findings emphasize the necessity for collaborative efforts between healthcare institutions and legal authorities to establish guidelines that uphold patient confidentiality while ensuring public safety.

Abbreviations

ARV Antiretroviral
SRH Sexual Reproductive Health

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

G.B conceptualized the idea, and discussed it with T.G and D.S.R. GB did data collection and analysis for the study. G.B shared the results with T.G and D.S.R for their input. GB did the writing of the first draft of the manuscript and T.G and D.S.R provided input. G.B edited the final manuscript and shared it with TG and D.S.R for editing. All the authors reviewed the final manuscript.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethical approval and consent to participate

Ethical approval was granted by the University of Botswana (Institutional Research Board) and the Ministry of Health Ethics Committee (HDPME 13/18/1). Participants were informed about the study purpose and the benefits and risks of participating in the study. All respondents received an interview guide and a declaration of consent. Written informed consent was obtained before the interview. Informed consent to participate in the study was obtained from all participants. All methods were performed in accordance with relevant guidelines and regulations at the University of Botswana.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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