Institutionalizing Anti-Migrant Discourse in Public Healthcare: An Analysis of Medical Xenophobia against Zimbabwean Migrant Women in Johannesburg

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Abstract

The provision of healthcare services to African migrants within the South African public healthcare system has been characterized as marred by medical xenophobia. While the literature on xenophobia in the country draws connections between xenophobic violence and how the migrant is characterized through demeaning metaphors in the media and the political space, medical xenophobia literature somewhat remains with the burden of categorically connecting specific practices that constitute medical xenophobia with the broader anti-migrant discourse. Drawing on the narratives of Zimbabwean migrant women seeking antenatal care services within the public healthcare system in Johannesburg, this paper analyzes the utterances and practices of some healthcare providers to draw connections with the anti-migrant narratives obtaining in the media, the political space, and certain anti-migrant formations (bearers of discourse). Like studies before it, this paper observes medical xenophobia and relying on Foucault's disciplinary power as a conceptual tool, it argues that the utterances by some public healthcare professionals are indeed unabridged rearticulations of the normalized anti-migrant discourse in various sites bearing anti-migrant discourse. While acknowledging that some bureaucrats' practices are tangential to the anti-migrant discourse, which decouples their individual actions from the discursive norm, the paper maintains that the standardized anti-migrant discourse for the large part provides frames of reference for some healthcare providers on how to perceive and treat the migrant patient, as their utterances are a restage of this discourse, usually with little to no annotations.

Keywords: medical xenophobia, discourse, Zimbabwean, South Africa, migrants, public healthcare

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INTRODUCTION

The provision of healthcare services to African migrants within the South African public healthcare sector is characterized as marred by "medical xenophobia," which Crush and Tawodzera (2014) define as the discrimination of the migrant "others" based on their non-national presence. The challenges that migrants face when seeking care are documented by many. These include verbal and physical abuse, language barriers, and in some cases the demand for documentation and user fees (Lefko-Everett, 2008; Vearey and Nunez, 2010; Hunter-Adams and Rother, 2017; Makandwa and Vearey, 2017). Some characterize these as medical xenophobia (Crush and Tawodzera, 2014; Zihindula et al., 2017; Chekero and Ross, 2018; Munyaneza and Mhlongo, 2019).

The characterization of these challenges as medical xenophobia has not gone unchallenged. Crush and Tawodzera (2014) caution against a broad application of the term, citing how locals also face challenges within the public healthcare system, a fact that has been observed by many (Jewkes et al., 1998; Vearey, 2012, 2014; Oosthuizen et al., 2017; Maphumulo and Bhengu, 2019). Vanyoro (2019) also critiques the idea of medical xenophobia or the indiscriminate exclusion of migrants, documenting how public healthcare providers, as street-level bureaucrats, draw upon other philosophies like "therapeutic citizenship" and "bureaucratic incorporation" to ensure that migrants get access to medical help.

Another key consideration in the interrogation of the idea of medical xenophobia is the health system itself that is characterized by significant systemic challenges. Thus, while medical xenophobia indeed exists, as some challenges that migrants face are very specific to them and stem from their nationality, some studies argue that the context of service provision should be considered. The South African public health sector faces significant challenges that include brain drain, heavy workloads, understaffing, and the burden of communicable diseases like HIV and AIDS, which incapacitates the system to satisfactorily meet the needs of all health help-seekers (Jewkes et al., 1998; de Jager, 2009; Kruger and Schoombee, 2010; Maphumulo and Bhengu, 2019; Malakoane et al., 2020). However, while the considerations of these factors should be key in understanding the complex terrain of health help-seeking in the public healthcare sector, they should not be the premise for bundling the experiences of migrants with those of citizens. Anti-migrant attitudes mediate the experiences of migrants when they seek healthcare.

The studies that highlight medical xenophobia observe that healthcare providers harbor anti-migrant sentiments, which are manifested in how they deal with migrant patients (Crush and Tawodzera, 2014; Zihindula et al., 2017; Munyaneza and Mhlongo, 2019). However, while the literature argues – mostly in a cursory fashion – that these anti-migrant sentiments are reflective of the broader sentiments that permeate sections of the society, it is mostly preoccupied with the excavation of specific practices that constitute medical xenophobia (the "what" aspect of the issue). While we have literature that discuss general xenophobia in

the republic (Crush, 2001, 2008; Crush and Pendleton, 2004; Landau et al., 2005; Neocosmos, 2006; Misago, 2016) and literature that draws connections between this xenophobia and how migrants are characterized in the media and other spaces (Danso and McDonald, 2001; Mawadza and Crush, 2010; Mawadza, 2012; Banda and Mawadza, 2015; Tarisayi and Manik, 2020), migration and health literature, especially on medical xenophobia, remains saddled with the burden of clearly drawing links between the discursive framing of the migrant (in the media and other spaces) and this medical xenophobia.

This paper feeds into medical xenophobia literature, edifying it by attempting to draw clear links between the xenophobic practices in the public healthcare space and the discursive framing of migrants, especially in various forms of the media and the political space. By focusing on specific utterances and practices of some nurses and frontline staff, the paper argues that just as the portrayal of migrants by the media and some politicians largely informs xenophobic practices in sections of the wider society (Danso and McDonald, 2001; Mawadza and Crush, 2010; Banda and Mawadza, 2015; Tarisayi and Manik, 2020), the same discursive framing of the migrant provides a template for certain nurses and frontline staff on how to perceive and interact with migrant patients. The paper argues that discourse informs practice, and certain practices in the public healthcare bureaucracy are indeed almost a mirror image of the discourse obtaining in the media and the political spaces, as this discourse is rearticulated with little to no annotations.

MIGRATION AND HEALTH IN SOUTH AFRICA

South Africa is a popular destination for migrants in the region, dating from the migrant labor regime under apartheid (Crush, 1992; Crush et al., 1995) to the present day where migration is now more a result of people seeking better livelihoods and fleeing conflict and environmental hazards (Landau and Wa Kabwe Segatti, 2009; Crush et al., 2017; Stats SA, 2022). The number of foreign-born populations in the country has increased over the years. The 2022 census recorded 2,4 million migrants, which is a considerable increase from 800,000 in 1996 (Stats SA, 2022). Most of the migrants are young adults between the ages of 20 and 44 years, which partly explains why the establishing of families in the country is becoming a norm (Polzer, 2008; Crush and Tevera, 2010).

As migrants establish themselves in the country, the need for healthcare services arises. It must, however, be noted that healthcare is not the primary reason why migrants are in the country. While a handful of migrants are indeed in the country for medical reasons (Pophiwa, 2009; Crush et al., 2012; Vearey et al., 2018), for many, the need for healthcare only arises once they are in the country. South Africa has a two-tier health system – the private health system that offers world-class services to those who afford, and the state-funded public health system relied upon by large sections of the population (Crush and Tawodzera, 2014). The citizens must therefore share services with migrants within the public system, most of whom

do not afford the private sector. This system that these populations rely on grapples with many systemic challenges that incapacitates it to satisfactorily meet the needs of its own citizens (Coovadia et al., 2009; de Jager, 2009; Crush and Tawodzera, 2014; Maphumulo and Bhengu, 2019; Malakoane et al., 2020). The system is therefore met with an additional task of providing services to an increasing migrant population, which is coupled with often unclear and confusing policies regarding migrants' access to healthcare services in the sector.

On the surface, the country's policy on migrants' access to health services is progressive. The National Health Act of 2003 guarantees access to basic health services for all, and it guarantees free access for all pregnant and lactating women, and for children under the age of six (RSA, 2004). Section 27 (g) of the 1998 Refugees Act also guarantees refugees the same access to treatment as citizens. However, sub-national policies are vague on these provisions. In Gauteng province, where this study was conducted, the Hospitals Ordinance 14 of 1958 does not mention free services for all pregnant and lactating women and children under six (Section27, 2022). The 2020 Gauteng Department of Health's Circular 27, Policy Implementation Guidelines on Patient Administration and Revenue Management (Gauteng DOH, 2020), sections of which were deemed illegal by the Johannesburg High Court after litigation (Khumalo, 2023), classified all non-citizens as full-paying patients, and it has been argued how these gray areas in policy usually lead to the disenfranchisement of migrant patients, as some medical staff manipulate this schism in policy to deny migrant patients services (Section27, 2022). This partly explains why some boldly characterize the practices of some nurses and frontline staff as medical xenophobia (Crush and Tawodzera, 2014; Zihindula et al., 2017; Munyaneza and Mhlongo, 2019). This paper, while acknowledging the systemic challenges within the public healthcare system and the attendant confusing policy, supports the medical xenophobia explanation. However, to fully understand the premise of medical xenophobia, it is critical to locate it within the broader xenophobia literature.

METAPHORICAL FRAMING OF MIGRANTS AND XENOPHOBIA IN SOUTH AFRICA

Intolerance against African immigrants is as old as the democratic dispensation itself. The failure by the democratic government in alleviating poverty and delivering on electoral promises has left many citizens disgruntled (Tshitereke, 1999; Crush, 2008; Adjai and Lazaridis, 2013). This disgruntlement is often directed at African migrants with whom they share space and limited resources in the once "forbidden cities" (Landau et al., 2005). Migrants are perceived as hindering the full enjoyment of the fruits of democracy, and consequently, there have been periodic and sustained violent attacks against migrants in the republic (Crush, 2001, 2008; Crush and Pendleton, 2004; Neocosmos, 2006; Adjai and Lazaridis, 2013; Misago, 2016).

The media has been seriously implicated in the negative characterization of migrants through demeaning metaphors that are drawn upon by certain sections of the population in their attacks of migrants (Mawadza and Crush, 2010; Polzer and Takabvirwa, 2010; Mawadza, 2012; Adjai and Lazaridis, 2013; Banda and Mawadza, 2015; Tarisayi and Manik, 2021). For example, aquatic metaphors like "waves," "tides," "flowing," "pouring," which exaggerate the numbers of migrants in the country are frequently used (Mawadza and Crush, 2010). These cast migrants as invaders and a burden on the country. Indeed, migrants have been blamed for "stealing" jobs, abusing the system by living at the expense of taxpayers, and for overwhelming and swamping the healthcare and other systems (Tshitereke, 1999; Banda and Mawadza, 2015). The global literature has observed how this framing of migrants through this crisis lens constructs individual perceptions of the social order (Sides and Citrin, 2007; Moore et al., 2012; Gallagher, 2014; Blinder and Jeannet, 2018). In South Africa, tabloid and other forms of media, which have also been accused of overly focusing on undocumented migrants, refugees, and asylum seekers, while ignoring skilled migrants (Tarisayi and Manik, 2021), have been implicated in being responsible for how the general news consumers perceive and respond to immigration and migrants (Wasserman, 2010; Kariithi, 2017).

As argued by Moore et. al (2012), these narratives have a political thrust, as political parties with anti-migrant agenda pursue them. The recent election cycles in South Africa have been marked with various political parties drawing on the anti-migrant discourse for political expediency (Mashego and Malefane, 2017; Bornman, 2018, 2019b, 2019a, 2024; Madia, 2018; Mailovich, 2018; Davis, 2019; Fogel, 2019; Machinya, 2022). For example, in 2018, the then Minister of Health, Dr Aaron Motsoaledi was on record for accusing migrants of flooding South Africa and overburdening the public health system (Heleta, 2018; Moodley, 2018). In 2017, the then Minister of Police, Fikile Mbalula, was also on record for blaming ex-Zimbabwean soldiers residing in the country for violent crimes (Maromo, 2017). Across the opposition political aisle, in 2017, Herman Mashaba, former mayor of Johannesburg and now leader of the Action SA party, was recorded blaming illegal immigrants for holding the country to ransom and for causing unemployment (Chaskalson, 2017). At the time of writing, he was canvasing people to "investigate" spaza shops run by migrants, which he blames for acting as fronts for criminal activities (Kgobotlo, 2024). Gayton Mackenzie, the leader of the Patriotic Alliance party, has also become popular on the political scene with his anti-migrant rhetoric. For example, at the launch of his 2024 national elections' manifesto in Orlando Stadium in Soweto, he was quoted accusing "illegal" foreigners as devils sent to sell drugs to South Africans, and he went on to blame migrants for unemployment in the country (Moichela, 2023; HRW, 2024). If elected, he threatened, he was going to go to Rahima Moosa Hospital to switch off the oxygen supply for foreigners (Mlambo, 2023). While the efficacy of these narratives on substantive electoral gains is yet to be established, politicians still cling to the anti-migrant discourse.

Besides the political space, certain formations in society also harness and reinforce these anti-migrant narratives. Of note is the Put South Africans First (PSAF) movement, which is a social media formation that became popular around 2019 by mobilizing the citizens around hashtags like "All foreigners must leave," "We want our country back," and "Clean South Africa" (Dratwa, 2023), and these messages found articulation on the ground through Operation Dudula, a militant group that queries the membership and presence of foreign nationals in the country (Nhemachena et al., 2022). The media and politicians are thus very central in framing the narratives around immigration, and these draw from and influence the other.

These narratives, Neocosmos (2006) argues, are coopted into various government departments. For example, the Department of Home Affairs has been accused of being xenophobic in its dealing with asylum-permit applications for refugees and other visas (Adjai and Lazaridis, 2013; Johnson, 2015; Khan and Lee, 2018; Carciotto, 2021). Similarly, the South African Police Services (SAPS) is also known for abusing and preying on especially undocumented migrants from whom they occasionally demand bribes (Harris, 2001; Valji, 2004; Nduru, 2005; Vahed and Desai, 2008; Polzer and Takabvirwa, 2010; Adjai and Lazaridis, 2013).

Those who allude to medical xenophobia base their arguments on the institutionalization of anti-migrant narratives in the public health system. The literature on medical xenophobia (Crush and Tawodzera, 2014; Zihindula et al., 2017; Munyaneza and Mhlongo, 2019), including those who sparingly allude to this term (Alfaro-Velcamp, 2017; Hunter-Adams and Rother, 2017; Makandwa and Vearey, 2017; White et al., 2020), argue that the institutionalization of the anti-migrant discourse is in the public healthcare space. However, it still remains to be categorically ascertained how the practices of healthcare providers (nurses and frontline staff) are specifically indicative and reflective of the discursive norm on migrants. This article, while far from being a comprehensive discussion on this topic, feeds into the above literature, arguing that medical xenophobia indeed exists. Moreover, the utterances and practices of some healthcare providers seem to prove that the anti-migrant discourse that populate the media and the political and other platforms is co-opted by some public healthcare bureaucrats in its raw form, and it provides a mental roadmap for perceiving and dealing with migrants.

CONCEPTUAL FRAMEWORK: DISCIPLINARY POWER

This paper uses the concept *disciplinary power*, particularly nibbling on the notions of the *discursive norm* or *normalization* (Foucault, 1977, 1978, 1982), to articulate how the dominant forms of "knowledge" about migration from various forms of the media and the political space assumes the authority of truth. It also shows how this "knowledge" is materially enacted and embodied in the practices of some public healthcare professionals toward migrant patients. In a profound shift in the understanding of how power operates in modern societies, Michel Foucault (1977, 1982) coined the term *disciplinary power* to represent more subtle and pervasive

mechanisms of control (opposed to spectacular forms found in sovereign power). These control mechanisms are embedded in everyday life, shaping individuals and populations through a complex web of institutions, norms, and practices. Shifting focus from the body as the primary site of power, Foucault argues that *disciplinary power* targets the mind, behavior, and identity of individuals. More specifically, it is concerned with the regulation of daily life, the management of time, space, activity, and the creation of a self-regulating subject who internalizes the superior norm and discourse that permeate the society (Haugaard, 1997; Lilja and Vinthagen, 2014).

Foucault provides the mechanisms for such form of power, one of them being *normalization* (standardization/universalization), which is a process by which standards of behavior are established, against which individuals are measured, judged, and corrected. This is facilitated by systems of knowledge (institutions) that claim to know the individual, or any communication and representation (verbal or otherwise) that enables activity or limits it (Johnston, 1991; Nadesan, 2008; Lilja and Vinthagen, 2014). According to Foucault (1977, 1978, 1982), individuals are manufactured and reconstituted (subjectification) through these systems of knowledge that provide fields of comparisons and frames of reference for individuals on how to perceive and respond to the political and social order. Thus, to Foucault, "analyzing power must then embrace an analysis of how subjects are gradually, progressively, really and materially constituted through a multiplicity of organizations, forces, energies, material desires, thoughts etc." (Kelly, 1994: 35). This paper harnesses these thoughts, arguing that the anti-migrant discourse in platforms like the media, the political space, and other societal formations constitutes systems of knowledge that shape how some healthcare providers perceive and interact with the migrant patient.

Of course, Foucault has been criticized for this focus on the microphysics of power. Some, coming from a Marxist perspective, critique Foucault's analytics of power for negating economic and material dimensions of life (Fraser, 1981; Wacquant, 1989). Others, coming from a humanist position of a free and rational subject, criticize Foucault's conceptualization of power for limiting the possibility of agency, democratic participation, resistance and social transformation, and the moral dimensions of everyday life (Fraser, 1981; Honneth and Roberts, 1986; Shapiro, 1986; Butler, 1989; Hartsock, 1989; Diamond et al., 1990). Indeed, a laser focus on microphysics of power does not envision that people, while being subjects of discourse, exercise agency, and they may draw from other philosophies that either inadvertently or overtly stage resistance against dominant narratives. As this paper observes, and as has been observed elsewhere (Vanyoro, 2019), some healthcare providers exercise agency and discretion in their encounter with migrant patients, which certainly decouple their practices from the dominant anti-migrant discourse.

Thus, while acknowledging the above shortfalls of *disciplinary power*, the paper nevertheless maintains that the concept is useful in the understanding of how individual behavior is not autonomous of dominant and prevailing forms of knowledge. Using this concept, the paper draws attention to how the practices and

utterances of some healthcare providers are reflective and indicative of the anti-migrant discourse that has been standardized and normalized in the media, the political space, and certain societal formations. This discourse, the paper posits, shapes the perceptions and practices of certain healthcare providers, as their utterances are largely a rearticulation of this discourse in its exact form.

METHODS

This paper is part of the author's PhD project, which broadly focuses on how Zimbabwean migrant women navigate maternal health inequities in South Africa, therefore the narratives are from 13 Zimbabwean migrant women (see Table 1) who have been in the country from as early as 2008. The paper focuses on the utterances and practices that the participants attribute to nurses and frontline staff in their interactions in healthcare facilities. Furthermore, the paper attempts to draw parallels with the anti-migrant discourse that populates certain platforms outside the healthcare facilities, especially in the conventional media, political discourse, and narratives from other anti-migrant platforms in the community and on social media platforms.

Table 1: Study population

Participant	Years in South Africa	Stated Age	Residence
Nyasha	8	35	Ebony Park
Samantha	12	Undisclosed	Ivory Park
Faith	7	30	Rabie Ridge
Mai Brenda	9	32	Ivory Park
Seda	11	37	Ivory Park
Mberi	12	40	Rabie Ridge
Jessica	16	38	Ebony Park
Chipo	11	39	Ivory Park
Octavia	15	42	Ebony Park
VaMasibanda	6	29	Ivory Park
Mai Precious	5	Undisclosed	Ivory Park
Mary	7	Undisclosed	Rabie Ridge
Gwaumbu	6	26	Ivory Park

Source: Author's own work

The author conducted the study in Ivory Park, Ebony Park, and Rabie Ridge, suburbs located in Midrand, which is situated in the north of Johannesburg and encompasses suburbs around the N1 highway north of the Jukskei River. I should therefore make

it clear that the analysis in the paper largely applies to this context, though through extrapolation, the findings may be useful in understanding other contexts as the narratives of the participants here corroborate those in studies outside this context.

The suburbs in this study, which are adjacent to each other, fall under the Johannesburg Metropolitan Municipality and are all adjacent to the township of Tembisa, which is under the Ekurhuleni Municipality. Therefore, participants in this study use various healthcare facilities in both municipalities, especially Tembisa Hospital, which is the only referral hospital closer to where the participants live. Also, while some participants may reside in Ivory Park, it is usually convenient for them to use facilities in Tembisa, as some of these facilities are much closer to them than the ones situated in Ivory Park. Within these suburbs, Black Africans constitute almost 99% of the population (Stats SA, 2022). While data on the number of migrants within the space is unavailable in census reports, the author, through regular prior visits to a relative in Ivory Park, observed that the suburbs host a significant number of African migrants, especially Zimbabweans, which made the place a convenient site for the author's PhD project.

The focus on Zimbabwean nationals was justified by the fact that Zimbabwe contributes a large portion of migrants in the country as a result of the deteriorating political and economic situation in that country (Polzer, 2008; Crush and Tevera, 2010; Chiumbu and Musemwa, 2015). The recent South African 2022 census report records Zimbabweans in the country as a little over 1 million, which is 45% of the migrant population (Stats SA, 2022: 31). However, owing to border porosity and inadequate record keeping by the government, these official statistics may not be an accurate reflection of the actual numbers of immigrants in the country (Chekero and Ross, 2018; Chekero and Morreira, 2020).

The study used purposive and snowballing sampling to recruit participants, and the author benefited from existing networks in Ivory Park to recruit more participants. Interviews ranged between 30 and 75 minutes; all participants consented to the recording of the interviews and pseudonyms were used throughout the study. The researcher obtained ethics (non-medical) approval from the University of the Witwatersrand. Obtaining data from women was not an easy task, especially considering that the researcher is a man. For women, especially the married or those living with intimate partners, the author provided a leeway for the partners to be joint participants in the interviews. The interviews, which were semi-structured, were conducted in Shona, the native language of most of the participants and the author. The interview audios were transcribed into English and the author repeatedly listened to and read them to generate themes; this was done using thematic content analysis. Three main themes were discovered: physical and verbal abuse, the demand for user fees, and the demand for passports. The author observed that the utterances accompanying these practices were in most cases a mirror image of anti-migrant articulations in the media, the political space, and certain anti-migrant formations gaining considerable popularity in the community.

RESULTS AND DISCUSSION

Verbal and physical abuse: Rearticulation of the numbers and burden nomenclature

The characterization of migrants as a burden and coming in numbers into the country to swamp the public healthcare system permeates the media and the political space (Mawadza and Crush, 2010; Banda and Mawadza, 2015; Matlala, 2018; Moodley, 2018; Tarisayi and Manik, 2020). In this study, these same characterizations were rearticulated, with no annotations, by some nurses whose verbal and physical abuse of migrant patients was accompanied by these characterizations. For example, Samantha, who delivered her baby in 2022 at Esangweni Clinic in Tembisa, narrated how she was verbally abused by attending nurses who were complaining about how foreign nationals come into the republic to burden them with work. According to her, some of the nurses were shouting at her, saying how they wished for Operation Dudula to come and take all the foreigners away:

> That day, I was assisted by a male midwife. Another woman came … to assist the man. The man was okay, he was never rough with me, but the woman was rough. I had stitches done on me, and she did it without giving me an injection. She did it live. She said for me not to make any movement, and if I did and smear her with my blood, things were not going to be good for me. The man had the injection to administer, but the woman objected to it. … She actually said that foreigners come all the way here to burden them with work. She asked why I did not go back to Zimbabwe to deliver instead of burdening them with work. … They were casually saying, "Call you father, Mugabe, from the grave to help you," because I was pushing before eight centimeters (cervix dilation). I was feeling that I should push, but they were objecting. I pushed anyway and the child came out, yet they were saying I shouldn't. … They will be saying that foreigners are coming to burden them with work. The day I went for three days (postnatal follow-up visit) to the clinic with this child, … they were saying they wish for Dudula to come and take us all because we were coming to burden them ... They will be saying, "Go back to your country, don't you have hospitals there?" (Samantha, interview, Ivory Park, 6 April 2024).

The casual references to Operation Dudula, an anti-migrant group known for crude and violent attacks against African migrants (Masweneng, 2022; Nhemachena et al., 2022) directly locates some of the nurses' utterances in the discourse of anti-migrant formations that popularize anti-migrant discourse. Participants in this study continued to narrate their ill-treatment in public healthcare facilities, with the healthcare professionals constantly blaming them for inundating the system. Nyasha, who also delivered her baby at Esangweni Clinic in 2017, narrated how the nurses were shouting at her, citing how Zimbabweans are bothering them and how the

people with the name "Nyasha" were many and becoming a problem, implying that Zimbabweans are many and crippling the system:

> I gave birth there, but it was not easy there. They were always shouting at us saying, "Your doctors are doing nothing in Zimbabwe, while you are busy bothering us here in South Africa. I have just helped another patient by the name Nyasha. You Nyashas are troublesome. The Nyashas are becoming a problem here" (Nyasha, interview, Ebony Park, 24 February 2024).

Similarly, Faith explained how she was ill-treated at Tembisa Hospital in 2021. She cited verbal abuse from nurses, whom she claimed were blaming Zimbabweans for being too many and for coming into the country for their maternal health needs:

> I was ill-treated at Tembisa Hospital. They don't like foreigners, especially those from Zimbabwe. They will be shouting at us saying, "You Zimbabweans are coming in numbers to deliver here … you are delivering here in numbers," and many other things they were saying (Faith, interview, Rabie Ridge, 16 March 2024).

Mai Brenda, who delivered through cesarean-section (C-section) at Tembisa Hospital in 2022, also cited ill-treatment from nurses. She narrated how the nurses were uncouth and shouting, blaming migrants for coming to South Africa to deliver and to trouble them:

> I delivered the same day through C-Section. So, after I was operated on, when it comes to them giving you your baby, they throw it at you … they will be shouting at you saying, "Foreigners, you are troublesome. Your habit is to come and deliver here instead of your country. Did you not hear that you should go back home?" (Mai Brenda, interview, Ivory Park, 24 February 2024).

While migration for health help-seeking is indeed a present phenomenon in South Africa (Crush et al., 2012; Crush and Chikanda, 2015), it should not be overstated. I argue that the exaggeration of this phenomenon is directly connected to how migrants are generally characterized with regards to healthcare seeking in various spaces (Banda and Mawadza, 2015; Heleta, 2018; Matlala, 2018; Moodley, 2018). The utterance against Mai Brenda, "Did you not hear that you should go back home?" is arguably a clear indication that the specific nurse benefits from the narratives of Operation Dudula and other political figures who are on record calling for the mass deportation of foreign nationals (Mashego and Malefane, 2017; Nhemachena et al., 2022). According to Foucault, knowledge systems discipline individuals to think and act in specific ways (Foucault, 1977; Kelly, 1994; Lilja and Vinthagen, 2014). In our case, it is quite evident that the anti-migrant discourse as a system of knowledge

in the media, the political space and other societal formations disciplines, train certain individuals, and provide frames of reference for behavior, as this discourse is rearticulated in almost similar ways.

Demand of user fees: Policy implementation with undertones of popular anti-migrant discourse

As stated earlier, the policy regarding the payment of user fees is very confusing. While the National Health Act (NHA) No. 61 of 2003 precludes all pregnant and lactating women from paying user fees, the Gauteng Department of Health Circular 27 of 2020 categorized all non-citizens as full-paying patients. This has "enabled hospitals to interpret its provisions to deny pregnant women and children access to free services if they are asylum seekers [and] undocumented persons" (Section27, 2022: 8). While it is quite a simplistic view that demanding user fees is indicative of medical xenophobia, sometimes the utterances accompanying the process of demand justify this judgment. As this study observed, the statements by some frontline staff closely dovetailed with some narratives to the effect that migrants should pay for services (White et al., 2020; White and Rispel, 2021). Seda, a participant in this study, narrated how in 2020 when she used Thuthukani Clinic and Tembisa Hospital for antenatal care, she had to pay. Additionally, the frontline staff said that migrants are too many and should therefore pay – a narrative that has close links with the discourse elsewhere that migrants are abusing the system and "stealing" the birth rights of citizens (Crush and Tawodzera, 2014; Banda and Mawadza, 2015; White and Rispel, 2021):

> When I was pregnant with the first one in 2016, it was good, but for the second one (2020) it was different. There were problems now. The difference was that on every checkup they required us to pay money (R395 – approximately 22 USD). So, if you go to Tembisa for checkup, they would require money from you as a foreigner. If you don't have money, they do not tend to you … they record that you have a debt. So, it was now different. In 2016 I did not pay any money, but back in 2020 I paid lots of money, from registering until I delivered. You will not get a card without paying money. So, the difference was huge. It was very tough. … I paid R700 (approximately 38 USD) for the card. Without paying that money, you wouldn't get any help … They were saying we foreigners are too many and we are a burden, so we should pay" (Seda, interview, Ivory Park, 6 April 2024).

Considering the livelihood strategies of most participants in this study (scrap collection, house help, and small market stalls), these amounts of money are relatively significant. While the demand for payment was implementation of policy, statements related to the volumes of migrants and the burden they impose on the system highlight

how some members of staff draw on prevailing anti-migrant discourse, and the schism in policy may sometimes serve as a platform for the articulation of such discourse.

Mberi, another participant in this study, also narrated how payment is indeed required. She narrated how the frontline workers accompany the demand for payment with the narrative that if migrants do not want to pay, they should trek back home for services, which is a discourse largely situated in utterances by politicians. For example, the then (2022) Limpopo Health Member of the Executive Council, Dr. Phophi Ramathuba was recorded ranting to a Zimbabwean patient that the province did not have a budget for migrants (Monama, 2022). This rhetoric has been very popular with politicians in the past years, and it is creeping to the public healthcare sector where these narratives are repeated. Mberi narrated:

> With the current situation, … if I get ill, they will not tend to me if I don't have money to open a file … It's either I produce money, and even if I do, they will give a prescription for me to get medication elsewhere … I was told that migrants should get services back home, and if I want services here, I should pay (Mberi, interview, Rabie Ridge, 24 March 2024).

This was the case with many participants in this study. Jessica and Chipo also claimed that it is now impossible to get attended to without payment, and that frontline staff tell migrant patients that its either they pay or go back home for services – utterances that are reflective of the dominant discourse:

> Nowadays, it requires money. To register you need money. On delivery you cannot be discharged until you pay. Those days it was good. It's only becoming a problem these days … These days, people are complaining a lot. They are told that nothing is for free and if they can't stand it, they should get a bus back home. Money. Money is now required more (Jessica, interview, Ebony Park, 16 March 2024).

> It is now getting very tough these days. During the time I first gave birth (2014), it was not as tough as it is now. It is now getting very tough. The person who was registering me clearly told me that there are no free services for those who don't pay tax ...There is huge change now as compared from the beginning. When we gave birth, there was no money required. The only money that was required was for the card and the stamp. Now the monies that are required are a lot. The money can be as high as R621 (Chipo, interview, Ivory Park, 25 February 2024).

The reference to paying tax draws from the prevailing narratives, mainly by politicians who argue that migrant patients are overwhelming the system, which has no budget for foreign nationals (Banda and Mawadza, 2015; Heleta, 2018; BusinessLive, 2019;

Monama, 2022). Thus, this discourse accompanies the implementation of policies that are, of course, already confusing. Yet, as confusing as the policies are, these utterances seem to prove that implementation of policy is accompanied by broader discourse regarding the number of migrants in the country and the supposed burden they impose on the system. Other participants, while not specifically noting any phrases from the healthcare staff that mirror the universalized norms on the characterization of migrants, nevertheless narrated an over-emphasis on the demand for payments:

> On this one (second child delivered in 2021), I paid around R600. They gave me the card, but I had to pay to get a stamp so the baby would go to clinic. The stamp needed, I think, R652 or R632. Locals don't pay. I also delivered through operation (C-section), and when I went for the removal of the stitches, I paid money. It was around R300. It doesn't exceed R400, it's almost like at a private hospital … at Tembisa, they treat you bad even after paying, because you are a foreigner (Faith, interview, Rabie Ridge,16 March 2024).

> …at Tembisa, on the second child in 2019, I paid. It was foreigners only … I remember when I was getting in labor, I paid R150. When I was due to be discharged, they said the money was not enough. I remember I paid R300. If you haven't paid, they will not give you the baby's card, the one you use to go to scale (postnatal checkups) with … [the reason was being] a foreigner. They will say you have no papers … you have no proper documentation. But even if you had a passport, they made you pay (Mai Octavia, interview, Ebony Park, 23 March 2024).

When Mai Octavia and Chipo delivered in 2019, the Gauteng Circular 27 of 2020 that categorized migrants as full-paying patients was not yet in effect. It potentially highlights the fact that frontline staff can draw upon the normalized discourse about immigrants and implement it as policy, even in advance of its inclusion in official directives. Therefore, while we should definitely consider the confusing policy terrain that healthcare staff work under (White et al., 2020; White and Rispel, 2021), we should also consider that the disjuncture in policy is tantamount to manipulation (Section27, 2022). Moreover, it can serve as a platform for the rearticulation of popular anti-migrant discourse. To some degree, then, anti-migrant discourse creeps into the public health system as it is reflected in some frontline staff's utterances. Resultantly, the public health bureaucracy becomes somewhat of an echo chamber of this harmful discourse. As Foucault argues, discourse is critical in agenda setting (Foucault, 1977, 1982), and as seen above, some politicians' utterances seem to have become the "superior norm" that sets the tone for the policy implementation environment in the public health system.

Demand for passports: A blatant form of exclusion or clerical requirement?

Of the documentation required for the registration of patients, especially in Gauteng province, the Gauteng Department of Health specifically requires proof of identification, which can be a passport, identity document, refugee permit, among other identifying documents, including proof of residential address (Gauteng DOH, 2020). While these requirements should be for the purposes of registration and the classification of patients, when migrants are seeking care, they encounter challenges from frontline staff that overemphasize the need for passports (White and Rispel, 2021). This potentially indicates that other agendas may be at play, because above a wide array of documents needed for registering patients, utility bills and proof of residence can also serve the same purpose and some migrants indeed use these (Crush and Tawodzera, 2014). In Messina, Limpopo province, it has already been documented how frontline staff can simply use the information that the migrants verbally provide (Vanyoro, 2019). However, in this study, some participants narrated how the overemphasis on passports has led to them being outrightly sent away from facilities. For example, Mberi, like many other participants in the study, noted that it can be difficult to get services if one is not in possession of the "proper papers" – a synonym for an up-to-date passport:

> During that time (in the past), nothing like that was happening. Even when opening a file for treatment or checkups, they didn't want anything. You would just go for registration using your proof of residence only … (These days), if you have no papers, they will not tend to you. You may be sent back … If I don't have proper papers, they will not treat me … So, the situation now is different from the beginning (Mberi, interview, Rabie Ridge, 24 March 2024).

Mberi's narrative is proof that it is indeed possible for a migrant patient to get services without a passport, as was the case during the period she calls "that time," which is around 2012 when she delivered her first baby. Backing this fact, some participants stated how they were tended to without passports, proving that denial of services based on passports may be more rooted in other intentions, other than the simple registration of patients. In 2012 and 2021, Faith stated how she used her Zimbabwean drivers' license for registration:

> I registered using a Zim driving license (Faith, interview, Rabie Ridge,16 March 2024).

Similarly, VaMasibanda managed to register at Rabie Ridge Clinic in 2019 without any documentation, with the staff only relying on what she verbally provided:

> The nurses treated me very well because the first time I went there, they only asked my residential address and name. They asked me if I had a passport, and

> I said I didn't have. They didn't say anything (VaMasibanda, interview, Ivory Park, 24 March, 2024).

Mai Precious was also able to register in 2023 without any form of documentation, and she only verbally provided the information that was needed:

> I have no papers that I use. I do not even have a passport … They served me without it. I was just giving them the details they needed (Mai Precious, interview, Ivory Park, 20 April 2024).

This is proof that while passports make the registration and classification of patients easy, discretion and improvisation by staff can ensure no one is denied services on account of not producing a passport. To prove that the requirement of passports is not cast in stone and is dependent on attending staff, Mary recounted how she was sent away at Tembisa Hospital in 2019 for failing to produce a passport, and was, however, served the following day at the same facility by a different person under similar circumstances:

> They wanted an ID (identity document) or passport, and I didn't have any, so I went back home. I went there the following day and encountered a different person, and I registered without a passport (Mary, interview, Rabie Ridge, 25 February 2024).

Gwaumbu also faced a situation mirroring Mary's. She narrated how she was sent away from Thuthukani Clinic in 2021 because she did not have "papers," only to be served at Halfway House Clinic:

> I went to Thuthukani, and they chased me away because I did not have papers, but at Midrand (Halfway House Clinic) they served me like that (Gwaumbu, interview, Ivory Park, 20 April 2024).

From the above, it is clear that the demand for passports is not a standardized practice, and it is dependent on the attending staff, perhaps their mood for the day, and probably a candid expression of medical xenophobia. While the above narratives are insufficient to categorically inform the conclusion that the emphasis on passports is a manifestation of medical xenophobia, they tend to gravitate toward that direction, especially when read in concert with observations elsewhere that an emphasis on passports is a mechanism for denying migrants services based on their nationality (Crush and Tawodzera, 2014; Chekero and Ross, 2018; White et al., 2020). A critical lesson from the above narratives, which we also get from Vanyoro (2019), is that healthcare providers are always innovative in finding means, sometimes against the grain, to ensure that all patients, including migrants, receive services. This gives

credence to Foucault's critiques who aver that his conceptualization of disciplinary power limits the possibility of agency (Honneth and Roberts, 1986; Shapiro, 1986; Butler, 1989; Hartsock, 1989; Diamond et al., 1990). In a context where the wisdom of providing services to migrants is questioned in various platforms, some healthcare providers draw on other forms of reasoning that go against the common narrative. Therefore, in acknowledging medical xenophobia and how it is largely indicative of the prevailing discourse, the limits of discourse in orienting practice must be appreciated.

CONCLUSION

This paper attempted to ascertain how practices termed "medical xenophobia" draw from the broader anti-migrant discourse by drawing parallels between public healthcare providers' practices with the anti-migrant discourse outside the public healthcare system. The migrant women in this study claimed that they encountered physical and verbal abuse, an emphasis on passports, and the demand for user fees – challenges that have been documented by many (Lefko-Everett, 2008; Vearey and Nunez, 2010; Hunter-Adams and Rother, 2017; Makandwa and Vearey, 2017; Chekero and Ross, 2018). Importantly, through a focus on some statements that the participants attributed to healthcare providers that accompany these practices, it is evident that some of these utterances are reflective and indicative of the anti-migrant discourse that permeate the media, the political, and other platforms. This, the paper argued, is proof that these platforms serve as systems of "knowledge" that provide some templates for some bureaucrats in the public healthcare sector on how to make sense of and interact with migrants. This dovetails with Foucault's argument that discourse in institutions of knowledge (bearers of discourse) discipline individuals by training them how to react to and perceive the subjects of this "knowledge" or discourse (Foucault, 1977, 1982; Kelly, 1994; Haugaard, 1997).

However, the paper also found that while anti-migrant discourse certainly provides frames of reference for some bureaucrats, agency and discretion mediate the practices of some nurses and frontline staff. This makes the public healthcare bureaucracy not an entire echo chamber for what obtains in the media and the political and other spaces. Thus, as Foucault's critiques argue, *disciplinary power* is not always overbearing, as agency and the moral dimensions of life can resist the superior norm (Fraser, 1981; Honneth and Roberts, 1986; Shapiro, 1986; Butler, 1989). As seen in this study, especially regarding the demand for passports, certain individual practices are tangential to the standardized narratives. Be that as it may, most of the evidence in this paper points to medical xenophobia, and the discourse about migrants through various demeaning metaphorical representation in the media, in politicians' utterances, and in anti-migrant groupings find their way into the public healthcare bureaucracy, as certain practices and statements of some bureaucrats are verbatim articulations of the prevailing anti-migrant narrative in those spaces. The paper therefore concludes that the practices that constitute medical xenophobia within the public healthcare system are rearticulations and restaging of the anti-migrant discourse that has been

popularized by the media, politicians, and certain anti-migrant groupings in the community. Just as this discourse provides a blueprint for sections of the society in the "othering" of the migrant, sometimes through violent confrontations, the same discourse usually presents itself as a frame of reference regulating the behavior of certain bureaucrats in the public healthcare system.

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