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“I just kept quiet”: Exploring Equity in a Service-Learning Programme

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Social justice underpins the sustainable development goal of health for all. In developing countries, social injustices are particularly severe and widespread, demanding critical and immediate attention. This article describes a qualitative, descriptive study that investigated pharmacy students’ responses to incidents of social injustice following their service-learning experiences in public-sector primary healthcare facilities in Cape Town, South Africa. Data were gathered from written reflection reports and then thematically analyzed using the pedagogy of discomfort as an interpretive framework. Themes were categorised according to students’ habitual responses to incidents of social injustice, how they interpreted their responses, and how they could promote social justice in the workplace as future healthcare professionals. Findings demonstrated students’ inability to take action and revealed that silence was the most common response to incidents of discrimination. These results highlight the ways in which the structural constraints of the societal status quo can perpetuate inequity. Study limitations include bias from students self-reports and their narrow understanding of structural barriers in the work-place. Intergenerational dialogue and advocacy is crucial across South African higher education to understand widespread social injustices. Embedding a critical approach to service-learning in the African context needs exploration.

Keywords: critical service-learning, pharmacy education, social justice, student voice, pedagogy of discomfort

The third sustainable development goal (STG) of the United Nations centers on universal health coverage, or the provision of accessible and affordable quality healthcare to all citizens globally (United Nations General Assembly, 2015). However, global disparities in health and human rights persist, and in Africa such inequalities are grave when compared with those present in industrialised countries (Benatar, 1998). Although healthcare for all South Africans was enshrined in a rights-based constitution (Constitution of the Republic of South Africa, Act 108, 1996), 20 years later, healthcare equality has still not been realised for the majority of the population. Despite a relatively peaceful transition from apartheid to a constitutional democracy, the country was rated, in 2009, as the most unequal society in the world—attaining a Gini coefficient of 0.7 (Mayosi & Benatar, 2014)—exhibiting widespread socioeconomic disparities impacting health. The Gini coefficient is a measure of a nation’s inequality status which is gauged between 0 and 1; with 1 indicating total inequality and 0 indicating equality. Most notable is the differentiation between the private and public health systems in South Africa; with the public health system serving about 80% of the population and using about 40% of all (and any) health care expenditure in South Africa, and the private health system serving about 20% of the population. This inequality can be further differentiated by the number of healthcare workers serving the majority of the population, with only 29% of pharmacists, for example, servicing the public health sector (South African Pharmacy Council, 2011).

Bowen (2014) defined social justice as society’s movement toward greater equality, economic fairness, acceptance of cultural diversity, and participatory democracy. The goals of social justice include

empowering marginalised communities and changing unjust institutional arrangements—outcomes that reflect the ultimate goal of social change, which implies beneficial advances in society (Bowen, 2014).

Issues of social justice are routinely included in the teaching of professionalism and ethics in medical education (Ginsberg et al., 2003); however, such instruction is often limited to theoretical, intra- and inter-personal concepts (Hafferty & Franks, 1994), which do not necessarily address the structural causes of social injustices (Metzl & Hansen, 2014). Some researchers have even suggested that social influences that affect health have been largely ignored in the field of bioethics (Dharamsi, 2006). Yet, health education reform calls for a new paradigm of mutual reciprocity between academic training institutions and the health system to address the healthcare needs of local underserved communities (Frenk et al., 2010). One of the values that underpins this type of partnership is equity within and among academic institutions, the health system, and the population being served (Boelen, Dharamsi, & Gibbs, 2012). Service-learning offers practitioners an opportunity to engage in social justice education to readjust power relationships in an effort to create more equitable institutional structures in the larger society (Bowen, 2014).

Academic institutions have been criticized, however, for implementing service-learning merely as a pedagogy for students to "apply and master traditional disciplinary knowledge … through active and engaged learning in the community" instead of as "a way to examine complex issues related to service and social justice, equity and diversity, identity and belonging, the public and the private" (Pollack, 2014:11). Mitchell (2008) labelled these approaches *traditional service-learning* and *critical service-learning*, respectively, and differentiated them according to their ability to either perpetuate or change the status quo. She posited that critical service-learning strives "to dismantle structures of injustice" by focusing on classroom and community experiences directed at social change, the redistribution of power, and the development of authentic relationships (Mitchell, 2008). Regarding social change, students are encouraged to identify the root causes of social, economic, and political inequalities that have shaped their lives and that of others. By reflecting on these structural causes, students can better understand real-world concerns as they challenge the status quo. Mitchell asserted that service-learning participants must become critically conscious of and expose the power dynamics and hierarchical barriers that are systemically entrenched in society. By confronting assumptions, stereotypes, and inequality, and recognising power "difference" within service experiences, the binary of "us" (the helpers) and "them" (the people that need help) can be dismantled. Mitchell (2008) advocated that authentic relationships based on "connection" recognise and work with difference. This connection challenges the self-other binary and emphasizes reciprocity and interdependence, whereby common goals and shared understanding create mutuality, respect, and trust, leading ultimately to social change. The development of authentic relationships requires dialogic engagement, which includes verbal exchange and "being together" to reconfigure power in ways that establish relationships based on equality (Mitchell 2008).

Much of the existing service-learning literature has emanated from the context of developed countries, mostly from the West, where the scale of socioeconomic inequality is not as dire as that in South Africa. This study examined the transferability of service-learning ideals and values produced in a relatively well-resourced, largely Western context to a resource-constrained context, and attempted to redefine the service-learning identity according to African ideals and values. Our research was guided by the following question: How does the implementation of a service-learning programme in a resource-constrained, non-Western context affect its ability to produce critical outputs? This question called for a re-examination of the power dynamics in the University of Western Cape, School of Pharmacy's service-learning programme, asking us to consider the "authenticity" of our partnerships, and to determine if there could exist is a measure of equality in a service-learning programme situated in an inherently unequal society where power differentials permeate the status quo?

In our study we use the pedagogy of discomfort in our service-learning programme because it focuses specifically on issues of difference, calling for an awareness and critical self-examination by educators and students of how their acceptance or non-acceptance of apparent social injustices is shaped by the dominant culture that maintains the status quo (Boler, 1999). The teaching of social justice is linked to the use of emotion, as evident from a study which examined the "blue-eyed, brown-eyed" teaching tool

among 10 –and 11-year old children in an integrated school in Northern Ireland (Zembylas & McGlynn, 2012). While emotions have been linked to power relationships, the connection between emotion and injustice—and how injustice reproduces emotions—remains to be examined in a pharmacy practice context.

The purpose of this study was to investigate fourth-year pharmacy students' learning during their service-learning in public sector primary healthcare facilities in Cape Town, South Africa. This article focuses on students' interpretations of incidents illustrative of social injustice encountered in the pharmacy. We first contextualize the service-learning environment and then introduce aspects of the pedagogy of discomfort. We then explain the methods and data collection process employed during the study. Results are presented by introducing the broad categories of incidents the students identified, followed by descriptions of their habitual responses to the incidents, their reflections, and anticipated future actions. Finally, we discuss how students' habitual responses, interpretations, and future actions speak to issues of equity in service-learning relationships and how this might affect future implications for the service-learning programme.

Contextualizing Our Pedagogy of Discomfort

The South African societal status quo is firmly rooted in a history of racial discrimination and social inequalities that are still pervasive 20 years after the beginning of democratic rule. Additionally, South Africa's fragmented health system is operating under strained conditions (Mayosi & Benatar, 2014). Infectious diseases, such as human immunodeficiency virus (HIV) and tuberculosis (TB), continue to peak (Nglazi et al., 2012), having devastating effects on poverty-stricken communities. Adding to the over-burdened health system are increases in non-communicable diseases and an aging population; healthcare disparities between public and private, and urban and rural sectors; severe understaffing in medical, nursing, and the pharmacy sectors; and infrastructural barriers, underfunding, and mismanagement (Mayosi & Benatar, 2014). With advances toward a decentralised, district-based primary health system aimed at offering a comprehensive health service package have come poor stewardship and weak accountability, leading to growing patient dissatisfaction. Nurses and community health workers remain South Africa's frontline workforce, with pharmacy staff serving primarily as medicine suppliers. Yet, patients prioritize access to medicines as an indicator of quality health service (Honda & McIntyre, 2012) since it is a basic health right.

The pedagogy of discomfort focuses specifically on issues of inequality as it calls for educators and students to critically examine how the dominant culture shapes the status quo and perpetuates social injustice (Boler, 1999). We used affective stimuli such as fear, guilt, anger, inhibition, frustration and disappointment, presented mainly as feelings of discomfort as a starting point for student reflection and learning.

Boler's (1999) pedagogy of discomfort is underpinned by the emotional dimensions of cognitive and moral perceptions, which can be used to question learned behaviours and assumptions enforced by the status quo or dominant culture. She examines how historical events shape the dominant culture in society, thereby influencing what and how people see and interpret social injustices. With repeated exposure to injustices, people feel powerless, become "numb" to efforts to take action against injustice, and, as a survival response, establish emotional barriers between themselves and others. This "survival numbness" is manifested as silence (or an inability to speak out), leading to either guilt or self-hatred, isolating people from each other and, by extension, their interconnectedness. This response stands in contrast to Mitchell's (2008) argument on behalf of critical service-learning, which stresses connectedness as a prerequisite for developing authentic relationships that accommodate dialogue.

Boler (1999) attests that self-imposed isolation is triggered by identity politics, power relations, and fear. Identity politics includes matters of diversity (i.e., race, language, gender, age, culture, and socioeconomic status) in which individuals draw distinctions between themselves and others, creating a binary mentality, or survival strategy, of "us" and "them" that helps to perpetuate the dominant culture or status quo. Boler's experiences with students revealed the ways in which teaching institutions are biased

by mainstream ideas that overshadow efforts to engage with "undesirable" (i.e., "bad, evil or wrong") emotions. Consequently, power relations become entrenched within institutions, thereby perpetuating the silences and proliferating discourses that deny affective learning. By contrast, in ideal service-learning experiences, hierarchical barriers among in-house facilitators, the community, and students are blurred.

In its ability to bridge or "connect" (Mitchell, 2008) divisions, empathy represents the core of a service experience. Fear of the powerful or being caught on the "wrong" side of the binary is likely to silence discourses, which impairs one's ability to empathize with others. This "passive empathy" occurs from within self-imposed barriers, where the focus is on the self and where the perspective of "what has happened to you might happen to me" perpetuates fear and silence, thus reinforcing numbness and isolation as a survival strategy. This isolation creates an illusion of being situated at a safe distance, immersing oneself in one's comfort zone, retaining an objective position of power as an observer, denying any connection with the other, and endorsing a passive spectator role. As Mitchell (2008) pointed out, this prevents or severely complicates the establishment of authentic relationships.

As has been demonstrated in previous research, the reflective process reveals the spectating or witnessing roles that pharmacy students assume during service experiences (Bheekie & Van Huyssteen, 2015). Spectating involves easy identification with the dominant culture, reinforces the binary mentality, and signifies learned and chosen modes of visual omission that lead to the imposition of distance between oneself and the other, or "emotional selectivity." As a result, the observer remains anonymous, denying the presence of injustice. Witnessing, by contrast, is a dynamic process that requires one to transcend self-imposed barriers by exploring both sides of the binary and embracing contradictions. In this way, judgement is suspended, and by "bearing witness" to ambiguities, contradictions, and internal struggles associated with social injustices, one can articulate structural causes and possible alternatives by dismantling these barriers, thereby achieving "action empathy." Boler's (1999) pedagogy of discomfort calls not only for inquiry, but also for action catalysed by learning to bear witness.

Methodology

This study was qualitative exploratory and descriptive in design. An action research approach was used to collect data from students following their service experiences. Findings from the analysed data were then used to adapt and focus the relevance of the service-learning programme of the School of Pharmacy at the University of the Western Cape (UWC) (Van Huyssteen & Bheekie, 2015).

Action research can be defined as a form of inquiry that seeks to inform and influence practice (O'Reilly & Kitimba, 2015). In this study, primary data were gathered from fourth-year pharmacy student reflection reports written between March and May 2015. Data were analysed using a thematic analysis approach (Braun & Clarke, 2006). The service-learning cycle of events started with (1) an on-campus orientation, which introduced students to service and community partnerships, learning objectives, assessments, and facility requirements, (2) the service experience at the assigned facility, (3) guided group reflection, and (4) a reflection report.

Setting

The University of the Western Cape is categorised as a historically Black university and is renowned for its active participation in South Africa's transition to democracy, priding itself on nurturing cultural diversity aimed at building an equitable and dynamic nation. During apartheid, the country's resources were allocated according to racial lines, where the White minority inherited the majority of the resources, leading to insurmountable socioeconomic disparities between race groups. Historically Black universities were also under-resourced in comparison to those of their White counterparts.

Originally, UWC was reserved primarily for the large "coloured" student population of the Western Cape province, a categorization still reflected in census data as of 2011 (see Table 1). The term *coloured* referred to one who was born from the co-habitation of a Black and White couple, and regarded as

“mixed” race. Presently, UWC’s student population reflects the country’s demographics (see Table 1), with a Black majority interspersed with local and international ethnic minority groups. Student activism remains robust as demand for access to higher education for disadvantaged students is recognised (e.g., the #feesmustfall2015 movement), and UWC’s ethos of community empowerment has been foremost on the national transformation agenda.

Table 1. South African Population by Race Group as Reported in the Mid-Year Population Estimates for South Africa (Statistics South Africa, 2016) and 2011 Census Data for the Western Cape Province

	Mid-year Population Estimates South Africa (2016)	Census Data for the Western Cape Province (2011)
African	80.7%	32.85%
Coloured	8.8%	47.78%
Indian/ Asian	2.5%	1.04%
White	8.1%	15.72%
Other	--	1.16%

Description of Health Facilities, Staff Roles, and Services

District-based primary level healthcare facilities, commonly called community healthcare centres, serve surrounding communities whose residents often cannot afford health insurance. By their nature, these facilities are characteristically overcrowded and understaffed. The facility manager is typically a registered nurse with extensive clinical experience and oversees routine operational procedures. Healthcare team role players, namely nursing, medical, pharmacy, allied, and support staff as well as community health workers, report directly to the facility manager. Usually, in-house pharmacy staff consists of a pharmacist(s) and pharmacist’s assistants, with intern pharmacists and community-service pharmacists appointed annually on a contractual basis. Intern pharmacists are graduates (who have completed four years of undergraduate study) undertaking practical training for one year at a health facility or community pharmacy in preparation for a national pre-registration examination conducted by the South African Pharmacy Council. The pharmacy is usually the last stop for patients requiring repeat and newly prescribed medication. Waiting time at facilities generally lasts between one to five hours (perhaps longer), leading to disgruntled patients. Dispensing is usually conducted through a burglar-proof window, on a “first-come, first-served” basis.

The School of Pharmacy at UWC and the provincial department of health (Western Cape) signed a memorandum of agreement in April 2015 for service-learning to be undertaken at pre-approved healthcare facilities. In-house pharmacist facilitators attend annual training workshops to familiarise themselves with roles and responsibilities, assessment methods, and effective sharing of facilitator experiences—all in preparation for final- (fourth-) year students undertaking service-learning at their respective facilities.

Study Sample

In accordance with the service-learning requirement for fulfillment of the PHA 403 course in 2015, fourth-year students worked a minimum of 54 hours over a two-week period—one week in March and

one week in May—under the supervision of an in-house pharmacist facilitator employed at the health facility. The primary skill that facilitators assessed onsite was student competence in dispensing medication to patients, which included assessing the prescription, selecting and labeling the medication, and counseling the patient. Group reflection occurred twice during this period, once after each week of the service experience. During group reflection, students were provided with thematic readers to help them as they examined issues of social injustice relative to their service experiences. The readers required students to engage with issues related to democratic values and social cohesion following the widespread xenophobic attacks that occurred in South Africa during this time.

The class consisted of 132 final-year pharmacy students. Students granted the researchers permission to analyze 34 reflective reports—17 reports from the March reflections and 17 from the May reflections. One participant submitted two reports, one in March and another in May. The demographic details of 33 participants are noted in Table 2.

Table 2. Comparison of Demographics of the PHA 403 Class (n = 132) and Study Participants (n = 33)

		Participants (n = 33)		**Entire class (n = 132)**	
		Number	**Percentage (%)**	**Number**	**Percentage (%)**
Gender	Female	24	72.3	84	63.6
	Male	9	27.3	48	36.4
Race	African	12	36.4	66	50.0
	Coloured	15	45.5	35	26.5
	Indian/Asian	3	9.1	19	14.4
	White	3	9.1	12	9.1
Age (in years)			Average 26.3±5.3 Median: 24 Range: 22-42		Average: 25.00±4.8 Median: 24 Range: 20-46
	20-24	20	72.7	95	72.0
	25-29	7	60.6	23	17.4
	30-34	3	21.1	6	4.6
	35-39	1	9.0	2	1.5
	40-44	2	6.0	5	3.8
	45-49	0	0.0	1	0.8

Ethical Considerations

Students were informed about the study during the on-campus orientation, and an information sheet outlining the research procedure was posted on the university's electronic learning management platform. After group reflection, students were asked to complete the consent form if they chose to participate in the study. Although all students had to complete a reflection report, only reports from students who gave informed consent to participate were used in the data collection and analysis. Ethical approval for the study was obtained from the University of the Western Cape Senate Ethics Committee.

Data Collection and Analysis

The study participants' individual reflection reports contained information underpinned by a critical incident that made each student feel uncomfortable in general (March) or as a result of an observed discrimination (May). Following the incidents, the students were asked to record their habitual or initial responses to these experiences of discrimination. Thereafter, they were asked to reflect on their habitual responses and how they felt about their reactions. Students offered insights into the ways in which they perceived their roles as future health professionals, and they were asked to describe their plan of action to address a similar incident should it arise

Written reports were qualitatively analysed using different coding approaches. One of the researchers initiated broad coding by dividing each report into two parts: (1) description of the incident and (2) perceived learning as interpreted by the student. Two experts in qualitative methodology (who not affiliated with pharmacy) free coded the transcripts. Two service-learning faculty and the two independent experts discussed codes, and emergent themes were identified. This article focuses specifically on student responses to the critical incidents.

Results

The results section introduces broad categories of incidents which students identified, followed by descriptions of their habitual responses to the incidents, reflections, and future actions. Three primary role players in the incidents were healthcare workers, patients, and students. Three types of discrimination were reported: (1) discrimination toward the student by other healthcare workers or patients, (2) discrimination witnessed by the student between healthcare workers or between healthcare workers and patients, and (3) discrimination perpetrated by the student. The students' reports of discrimination highlighted several key areas of social injustice occurring in pharmacies, based on age, race, language, and socioeconomic status. The primary themes that emerged from the reflection reports are summarised in Table 3.

Table 3. Primary Themes Identified from 34 Student Reflection Reports

Theme	Descriptive quote
Student's habitual response to incident of discrimination or social injustice:	
• Inaction: Emotional/physical	"*At that moment I just froze because the tone of her voice came out as if I did not belong there.*" (ID 22)
• Action: Confrontation	*"I asked the pharmacist why she failed to provide the necessary information to the patient."* (ID 71)
Student's reflections on habitual response:	
• Dissatisfied	"*I still feel guilty for not standing my ground to not have allowed the other staff members to influence my actions, simply to fit into the routine of the pharmacy."* (ID 31)
• Satisfied	"*I feel that I had made the right decision to remain calm and try to help the other customers to the best of my ability ... if I had forced to assist the patient I would be removing his rights to be treated with equality."* (ID 40)
• Unresolved: Could not become objective	"*I realised that my fear had turned to anger ... I went home that evening feeling battered and bruised emotionally."* (ID 38)

Anticipated role as future healthcare professional to address similar incidents in the future:	
• Taking responsibility	*"Our goal as health providers [is] to improve the life of the patient. Not to harm or hurt the patient ... whatsoever."* (ID 35)
• Ethics and professionalism	*"I would try my best to not get any personal feelings involved ... we are not there for ourselves, but to provide a service to the community."* (ID 28)
• Education of colleagues and patients	*"I feel we are equipped with skills to change negative perceptions and achieve equality in the working environment"* (ID 42).

Habitual Responses to Incidents of Social Injustice

Student reports first entailed identifying critical incidents, though these are not the focus of this article. Rather, we documented their initial responses when faced with incidents of social injustice. The primary themes related these responses included inaction (emotional or physical) and action (confrontation).

Inaction (emotional/physical)

When faced with instances of discrimination, the vast majority of students responded with inaction. In the context of this research, inaction refers to the avoidance of confrontation. In approximately half of these cases, inaction was the result of a deliberate choice wherein the student deemed silence the most appropriate response to the discriminatory incident. In the other half of these cases, inaction was not a conscious decision but rather the natural consequence of fear or of becoming emotionally overwhelmed by a situation, causing the student to either freeze (i.e., an inability to act or react due to, for example, shock or disbelief) or physically withdraw from the situation.

Students for whom inaction was a conscious and deliberate decision all reacted in response to discrimination from a patient. Specifically, most of these students were discriminated against by patients due to their young age, while one student was discriminated against on the basis of his race. In all of these cases, the patients either refused service from the pharmacy students due to perceived inexperience or accepted the service but chided the students for addressing matters which the patients felt youth should never address with their elders (e.g., directions for proper use of a suppository). The following are excerpts from student reports illustrating their responses to these discriminatory incidents:

- *At that moment I just froze because the tone of her voice came out as if I did not belong there. My habitual response immediately was to just keep calm ... in that moment I thought of the patient as well, putting myself in their shoes.*" (ID 22)
- "*I respected the geriatric patient's decision to be helped by the pharmacist and just went on to assist another patient instead and tried to proceed without feelings of prejudice or negativity."* (ID 40)

In those cases in which inaction was the natural consequence of fear or emotional distress, students had been discriminated against by pharmacists (on the basis of age, race, and sexual orientation) or by doctors (as a result of professional prejudice or an attitude of superiority); pharmacists had discriminated against patients (on the basis of perceived socioeconomic status); or, in one case, a student had discriminated against a patient on the basis of his sexual orientation (i.e., the student assumed that the patient's HIV-positive status was the result of his homosexuality). Many of the students who were discriminated against by pharmacists or doctors responded with inaction out of fear of disrupting the status quo within the pharmacy. For example, when a pharmacist admitted that he was racist and referred

to students from the University of the Western Cape as incompetent in comparison with students from other universities, one student described reacting in the following way: “I withdrew myself from raising any concerns due to fear of having a hard time with the rest of my service learning in pharmacy week” (ID 57).

In other situations, students were so shocked and disgusted by the behaviour of the pharmacists or doctors that they were rendered speechless or had to withdraw from the situation to compose themselves. For example, the following excerpt captures a student’s reaction to a doctor who had mistaken the student for a patient and had then asked the student when he or she had last been tested because the student looked like he or she had tuberculosis; the second is the student’s response to malicious comments from the pharmacist regarding the student’s sexual orientation:

- “I got angry and disgusted. I look at him straight in the eye with anger and frustration combined with lack of words for him.” (ID 35)
- “[It was] heart-breaking ... luckily I was going for lunch so I could deal with my emotions.” (ID 21)

Action (confrontation)

Some students, when faced with discrimination, responded with confrontation. It is important to note that confrontation in the context of this study refers to any instance in which discrimination was addressed directly with the perpetrator, either aggressively or calmly. As mentioned previously, only a small percentage of students chose to respond with confrontation. Some did so because they themselves were discriminated against; one student confronted a discriminator on a patient’s behalf.

The students who stood up for themselves did so mainly because they felt their education was being hindered as a consequence of discrimination. Students were sometimes given the impression that they had no right to say anything or correct anyone older or more experienced than themselves. For example, one student questioned a pharmacist’s assistant about why he or she was handling highly scheduled medication (morphine) when the assistant was not legally qualified to do so. Another student witnessed a pharmacist asking a doctor if the students could observe some of his consultation, but the doctor responded that he was not a “babysitter.” The following are excerpts from the student reports regarding these incidents:

- “I apologized for any misunderstandings and calmly explained what we had learnt in class and why it was important to abide by that.” (ID 28)
- “I proceeded to explain to the doctor that it is important for us to be exposed to the processes outside the pharmacy.” (ID 44)

Another student confronted a pharmacist when the pharmacist questioned his reasons for having a beard and then told him that only terrorists wear beards. The student wrote: “I felt I needed to change his misperceptions he had adopted and broaden his knowledge on the matter” (ID 42).

Another student confronted a pharmacist who had discriminated against a patient. This student witnessed the pharmacist failing to offer to a patient comprehensive medicine usage instructions, compelling the student to confront the pharmacist regarding the discriminatory behaviour: “I asked the pharmacist why she failed to provide the necessary information to the patient” (ID 71).

Reflections

As part of the course process, students were required to engage in a self-reflective process wherein they considered the discriminatory incident that had occurred, their response to it, and how they felt afterwards. Some students were able to articulate whether or not they were satisfied with their responses,

while others found themselves unable to properly engage in the reflective process for reasons discussed in the following sections.

Satisfaction with habitual response

Students who responded with inaction often did so in response to being discriminated against by either a patient or a pharmacist. Although the reactions to patient and pharmacist discrimination were similar, the underlying reasons driving these responses were very different. In the case of patients discriminating against students, students reported that their inaction was related, in all of the cases, to empathy the students felt toward the patients. Although shocked and sometimes hurt by the discrimination, students empathized with the patients' situations (e.g., the patients were ill and exhausted from waiting in long queues) thereby justifying the patients' discriminatory behaviour. The following student reflections exemplify these empathic responses:

- "I realized I had handled the situation well by politely stepping back and allowing the pharmacist to serve the patient. I thought of the patient ... waiting so long for medicine and then being helped by someone who looks young and inexperienced." (ID 22)
- "I feel that I had made the right decision to remain calm and try to help the other customers to the best of my ability ... if I had forced to assist the patient I would be removing his rights to be treated with equality." (ID 40)

All students who had been discriminated against by patients and had chosen to remain silent reported feeling satisfied with their habitual response.

The student who confronted the pharmacist who had discriminated against a patient reported being satisfied with his or her habitual response, and the majority of students (with one exception) who confronted pharmacists regarding discrimination toward them as students were satisfied with their responses. The one student who did not report satisfaction with his response (student who was discriminated against on the basis of growing a beard for his religion) was still very emotional during the time of reflection and, as such, was not able to engage in the reflective process with any kind of perspective or temporary objectivity.

Dissatisfaction with habitual response

The majority of students who were discriminated against by either pharmacists or doctors and had chosen to remain silent reported feeling dissatisfied with their response. The main reason for this dissatisfaction was that students felt that, as future healthcare professionals, they had a responsibility to strive for social justice; they felt therefore that in remaining silent they had missed a valuable opportunity to bring about positive change in the workplace. For example, after not confronting a pharmacist regarding racist comments, one student wrote: "I do feel the way I approached the situation should have been dealt with better and [I could] use such an opportunity to rather bring about change in the workplace" (ID 57).

Those students who had witnessed pharmacists discriminating against patients and had remained silent revealed a sense of dissatisfaction in their self-reflections. For example, when a pharmacist instructed one student to ignore a patient who had approached the pharmacy window to ask a question because it was not his turn, the student did not close the window but also did not stop another pharmacist from doing so and did not address the matter: "I still feel guilty for not standing my ground to not have allowed the other staff members to influence my actions, simply to fit into the routine of the pharmacy" (ID 31).

Unresolved

The remainder of students who had been discriminated against by pharmacists or doctors were unable to engage in the reflective process, as they were still too emotionally overwhelmed by the incidents. These

students claimed that they had been discriminated against on the basis of their sexual orientation, religion, and/or age. The following reflection excerpts illustrate students' responses to this discrimination:

- "I realised that my fear had turned to anger ... I went home that evening feeling battered and bruised emotionally." (ID 38)
- "It was shocking to me how someone [i.e., the pharmacist] who knew nothing about the concept had so much to say about it and found it amusing to mock my beliefs" (ID 42).

These and similar reflections suggest that students feel responsible for bringing about positive change in the workplace and therefore feel satisfied when they confront pharmacists or doctors about inappropriate behaviour and dissatisfied when they do not. In this study, students also felt that, while it was their responsibility to improve the behaviour of all pharmacy staff, this could not be extended toward patients. In fact, they believed that it was their duty as healthcare professionals to serve; thus, when patients did not behave appropriately, students felt it was important to keep in mind the patients' situations and empathize with them by remaining professional, non-confrontational, and silent.

Role as a future healthcare professional

Students' experiences with social justice reflected their future obligation, as healthcare professionals, to take responsibility, be ethical/professional, and to educate.

Taking responsibility. Students highlighted that the importance of being a healthcare professional centered on taking responsibility by putting patients first and showing respect for colleagues and other healthcare professionals, such as doctors. Students expressed great concern over the lack of compassion and respect for human dignity they observed in the interaction between patients and healthcare professionals. They observed that patients who were served in poorly managed community clinics received substandard care and that emergency cases were disregarded completely. The following excerpts from students illustrate their goal to counter these observations:

- "Our goal as health providers [is] to improve the life of the patient. Not to harm or hurt the patient ... whatsoever." (ID 35)
- "There is one common goal which is ... the well-being of the patient. As healthcare professions we are all integrated and require the expertise of one another in order to help the patient in the best way possible." (ID 46)

Ethics and professionalism. Not surprisingly, as a result of their SLiP week experiences, the students determined that discrimination has no place in the healthcare profession. They therefore discussed the need to remain objective and fair at all times, conducting themselves professionally and not allowing personal prejudices to dictate their behaviour in the workplace:

- "I would try my best to not get any personal feelings involved ... we are not there for ourselves, but to provide a service to the community." (ID 28)
- "...there is no place for discrimination in service to others." (ID 38)

One of the most frequently mentioned strategies was to improve respect among colleagues. Suggestions for achieving this goal included encouraging open communication through the provision of space for employees to share their views and respecting the views of others. The theme of equality also arose consistently throughout the reports, and students viewed the promotion of social justice and equality as part of their role as health professionals:

- "...make a conducive working environment where we are able to rectify each other without feeling ... undermined or devalued." (ID 71)
- "If staff members are educated and trained to embrace the beauty of diversity, then they can also educate the patients." (ID 21)

Education. Students articulated the importance of their responsibility to share their professional knowledge and engage in continuous learning. It is necessary for healthcare professionals to be constantly aware of the patients they serve and their changing needs, as well as their relationships with colleagues. Students suggested various ways in which they could promote learning, including workshops for staff members, education around issues of diversity, and learning new languages:

- "I feel we are equipped with skills to change negative perceptions and achieve equality in the working environment." (ID 42)
- "Being an educator ... to other staff members and to the public/patients." (ID 21)

Students also recognized that, apart from educating themselves and their colleagues, it is also important to educate patients regarding their rights and to understand pharmaceutical procedures and latest therapeutic approaches. In order to accomplish this, students suggested the use of posters in pharmacies, effective communication with patients throughout the dispensing process, and ensuring that patients leave with an adequate understanding of their medication and its use:

- *"I endeavour to ... promote understanding of the Patients' Rights Charter [Health Professions Council, 2003]."* (ID 71)
- *"An effort should be made to mitigate against the perceptions of the patients which are influenced by a lack of understanding of the processes involved in issuing medication."* (ID 43)

Discussion

Habitual Responses

As revealed in their self-reflections, students witnessed many incidents of discrimination in the community clinics and responded to these incidents in varying ways. Even though they believed that these acts were wrong, many of them chose not to report the incidents. Most of the students withdrew from these situations as a means of avoiding confrontation; they felt that they could not overtly express their emotional responses out of a fear of being ridiculed by pharmacy personnel or being perceived as "unprofessional." A majority of the students offered respect (for ones elders) as a justification for their inaction, while others felt that they needed to avoid contact with those who elicited feelings of anger and frustration in fear that they would react aggressively. As these responses suggest, "speaking up" is perceived as confrontational, the binary of silence/respect versus speaking up/confrontation/disrespect is ostensibly entrenched in students habitual responses.

The "respectful silence" that most students resorted to implied a condoning of the dominant culture at the workplace. After reflecting on their personal frames of reference (tradition, social, or cultural norm), students identified respectful silence as a seemingly inherent, automatic choice, which might have been adopted as a "survival" strategy since students were desensitized to institutional social injustices, thereby supporting the status quo. Arguably, this silence binary has a direct influence on students' perception of dialogue and their (in)ability to engage constructively in disagreements that arise from it. More broadly, this seems to be an aspect missing in democratic South Africa and in many contemporary South African leaders who maintain that the persistence of societal divisions is due in large part to the abrupt end of a healing dialogue started by the government's Truth and Reconciliation Commission (Rampele, 2012). Today, this dialogue has been replaced by denial characterized by silence. "South African society thus

oscillates between instances of passive citizenry and public outrage (e.g., violent service-delivery protests) and the government's crisis management strategy of talking followed by inaction and lack of social change" (Bheekie & van Huyssteen, 2015), leaving the citizens voiceless and powerless.

Based on the study's findings, one major factor that contributed to this "respectful silence" was discrimination based on age and inexperience, highlighting an intergenerational divide between the students, facilitators, and patients. In extrapolating from students' service experiences to South Africa's turbulent history, tensions brought about by silenced youth voices sparked a powerful force among educational institutions to propel the transformative agenda, as evidence most notably on two separate occasions. First, the 1976 school learner protests in Soweto was pivotal in South Africa's transformation, highlighting the protesters' refusal to accept the White-dominated institutionalization of the Afrikaans language as a teaching medium in Black schools, a strategy that aimed to deepen social, cultural, and ethnic divisions. Almost 40 years later, and 20 years into democratic South Africa, history repeated itself as the post-apartheid "born free" generation of students outwardly expressed their discontent with the slow pace of transformation promised in the 1996 constitution. Rising tuition fees and outsourcing of cleaning staff became the mantra that catapulted higher education institutions across the country into disarray, as violent student protests nationwide led to extensive infrastructural damage and a halting of academic programmes, thus reiterating the country's socioeconomic plight. Inevitably, educational institutions serve as the platform for social justice reform; yet, how are these institutions preparing graduates to engage across difference (such as age) if culture seems to be the primary culprit hindering meaningful exchanges?

Reflections

Upon reflection, some students expressed satisfaction with their habitual responses to the acts of discrimination witnessed in the community clinics: Whether they chose to withdraw or to speak out, these students felt they did what was best in the given situation. Overall, however, the majority of students felt that their passivity and lack of confrontation was an inappropriate response to witnessing acts of discrimination. It is important to note the difference in students' perceptions when they did not confront patients as compared to when they did not confront colleagues. In general, students did not regret not confronting patients. They often justified the patients' discriminatory actions by reminding themselves of the injustices the patients faced. In these cases, then, remaining silent emerged as an action based on a conscious decision as opposed to inaction based on fear or discomfort. However, this raises the question, If a person is justified in an act of discrimination (e.g., patients discriminating against students) because he or she was the victim of discrimination (by an unjust health system), the cycle of discrimination continues. This is exactly what Boler (1999) means when she referred to the ways in which the dominant culture teaches a person to omit certain acts and thus serve the dominant culture. Similarly, the "authentic relationship" that Mitchell (2008) proposed is threatened because trust and equality are absent.

However, students regretted not confronting colleagues who were guilty of discrimination. In these cases, the students viewed silence as inaction or the inability to act. Therefore, in such cases, silence was induced by fear or discomfort and was not a conscious decision. This fear related mainly to not wanting to upset those in authority and thereby ruin their SLiP week by challenging the status quo. Students experienced significant discomfort when they observed what many of them referred to as the dehumanisation of patients by the pharmacists. The students agreed that patients should be treated as individual human beings, not as numbers. Their discomfort suggests that this practice enables certain behaviours that would ordinarily be inconceivable to become permissible (e.g., *slamming doors in patients' faces, yelling at or ignoring patients who approach the counter with a query*). However, the discomfort and anger the students felt upon witnessing these behaviours did not lead them to action. Some students associated such actions with impossible levels of work stress, burnout manifesting as emotional exhaustion and depersonalisation (a defensive coping response to emotional exhaustion) (Rothman & Malan, 2011). Another reason seems to be related, at least in part, to the unspoken rule behind the

pharmacy window: If you conform, you have support. In this case, the students become bound by a professionally induced silence of solidarity wherein they do not approve of the behaviour of their colleagues but are too afraid to do anything about it.

Considering existing hierarchical barriers and the temporary (one week) presence of students in the facilities, it is inevitable that students assume a subordinate/submissive role during their service-learning experiences, which is deemed “acceptable,” reinforcing the dominant culture within the workplace. Any attempt on the part of students to challenge the status quo would be deemed disrespectful, thereby overriding the student’s attempt to engage with difference. Notwithstanding the service-learning concept that the triad partnership is based on reciprocity, students are destined to either feel powerless or lack the confidence and skill to engage in issues of social injustice, thereby minimizing any opportunity to initiate mutual dialogue with partners. Since the UWC School of Pharmacy has an established partnership with the pharmacy services, students might be discouraged to voice their discomfort with staff since that may be perceived as jeopardising or having negative repercussions on the partnership. Another reason for students not having a voice is that most of them will seek employment (internship and/or community service positions) in public-sector health facilities. Any attempt to raise issues of difference could be perceived as disadvantageous in their search for a potential placement. This power differential leads to silencing of student voices and reduces their dignity and self-worth as humans. The power differential within the pharmacy work environment, as highlighted in student reflections, is deeply entrenched; therefore, higher education efforts to engage in diversity and social injustice must be is imminent.

Future

In examining students’ discussions of their roles as future healthcare professionals, it became clear that they do consider it their responsibility to promote equality in the workplace and to contribute to the education of their colleagues about matters such as diversity. Though students might be silent, this silence is a result of fear, not indifference or the perception that promoting transformation and ensuring social justice is not a part of their future professional roles. However, the study findings uncover a concerning reality of UWC School of Pharmacy’s service-learning programme: It questions our claim to reciprocity, exhibited supposedly through the blurring of hierarchical barriers among students, service providers, and the community. Reflection on campus creates the space for a transparent forum whereby students and educators can examine issues of cultural diversity and tolerance in the context of a changing societal landscape. However a space for mutual reflection which is inclusive students, faculty, facilitators and the community could further demonstrate the importance of transparency.

If the microcosm of student experiences in health facilities are reflective of larger society (i.e., the macrocosm), then pharmacy training institutions must revisit their larger role in—and responsibility to—society. While the pharmacy profession places great emphasis on being recognised as a custodian of medicine, it lacks, collectively, the trained ability to discern how a host of structural constraints impact illness and health, otherwise known as *structural competency* (Metzl & Hanson, 2014). Reid (2014) further contested that a mismatch exists between the competencies that graduates have developed and the institutional and structural constraints they face when serving a population with widespread social ills. Structural competency is an attempt to develop and broaden skills that advocate for public health, social justice, and health equity—a curriculum focusing on social, cultural, and historical context in tandem with an active recognition of societal problems and a search for appropriate solutions (Metzl & Hansen, 2014). Pollack (2014) argued that “critical civic literacy blurs the separation between an individual’s professional life and an individual’s personal life, and as a result, the core content examines the intersection between the technical or theoretical area of specialization and the reality of social inequity that exists in our communities” (2014: 15).

Limitations

The self-reports by students may have limited this study; also, much of the work-based learning was self-directed, so we might have appealed inadvertently to students who were more motivated, and as such our

results might have been biased. In addition, the students spent limited time at the facility (1 week), precluding efforts to either foster authentic relationships with service staff or obtain an understanding of structural issues within the health service that perpetuated injustice. The results therefore lack depth regarding institutional imbalances impacting health and education. These results should also be interpreted with caution because data collection focused on discomfort; by design, it did not capture those instances of dedicated pharmacists and other healthcare professionals who worked hard to respect their patients, nor did it focus on those patients who were kind and understanding about the limitations of the health system and who showed their gratitude and support for the staff and students working to serve their needs.

Conclusion

This study aimed to examine the implementation of service-learning ideals in a resource constrained, non-Western context, and to better understand how such ideals would affect the programme's ability to produce critical outputs. Our findings highlight the inherent social and structural constraints that perpetuate incidents of discrimination in South Africa. Such constraints, emanating from the existential societal status quo, creates barriers for role players attempting to reach the service-learning ideal. In particular, the influence of age and its interpretation in the cultural context, seems to be a stumbling block to creating authentic relationships between role players in the service-learning environment. It points to the urgent need for the initiation of inter-generational dialogue within and across institutions and in society to foster authentic relationships able to explore the historical, social, cultural, and political contexts that have imposed barriers. Advocacy and critical citizenship is needed to transform South African society. The authors maintain that a critical approach to service-learning, one that is sensitive to and explicitly locates itself within African values and ideals, will be pivotal in this venture.

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References

Benatar, S. R. (1998). Global disparities in health and human rights: a critical commentary. *American Journal of Public Health, 88*, 295-300.

Bheekie, A., & van Huyssteen, M. (2015). Be mindful of your discomfort: An approach to contextualized learning. *International Journal of Research on Service-Learning and Community Engagement*, *3*(1).

Boelen, C., Dharamsi, S., & Gibbs, T. (2012). The social accountability of medical schools. *Education for Health, 25*, 180-194.

Boler, M. (Ed.). (1999). *Feeling power: Emotions and education.* New York: Routledge.
Bowen, G.A. (2014). Promoting social change through service-learning in the curriculum. *Journal of Effective Teaching*, *14*(1), 51-62.
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.
Constitution of the Republic of South Africa, Act 108. (1996). Government Gazette No. 17678, Pretoria, South Africa: Government Printers.
Dharamsi, S. (2006). Building moral communities? First, do no harm. *Journal of Dental Education*, *70*(11), 1235-1240.
Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., & Zuryak, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet*, *376*, 1923-1958.
Ginsberg, S., Regehr, G., & Lingard, L. (2003). To be and not to be: The paradox of the emerging professional stance. *Medical Education*, *37*, 350-357.
Hafferty, F. W., & Franks, R. (1994). The hidden curriculum: Ethics teaching and the structure of medical education. *Academic Medicine*, *69*(11), 861-871.
Health Professions Council of South Africa. (2003). National patients rights' charter. Pretoria, South Africa: Author. Retrieved from http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_3_patients_rights_charter.pdf
Honda, A., & McIntyre, D. (2012). *Health Economics Unit policy brief: Community preferences for improving public health services in South Africa.*. Retrieved from http://uct-heu.s3.amazonaws.com/wp-content/uploads/2012/03/HEU-Policy-Brief-public-preferences-for-health-care3_1.pdf
Mayosi, B.M., & Benatar, S.R. (2014). Health and health care in South Africa – 20 years after Mandela. *New England Journal of Medicine 371*(14), 1344-1353
Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science and Medicine*, *103*, 126-133. doi:10.1016/j.socscimed.2013.06.032
Mitchell, T. D. (2008). Traditional vs. critical service-learning: Engaging the literature to differentiate two models. *Michigan Journal of Community Service Learning*, *14*(2), 50-65.
Nglazi, M. D., Kaplan, R., Wood, R., Beker, L-G., & Lawn, S.D. (2012). Antiretroviral treatment uptake in patients with HIV-associated TB attending co-located TB and ART services. *South African Medical Journal, 102*(12), 936-939.
O'Reilly, M., & Kitimba, N. (2015). *Advanced qualitative research: A guide to using theory*. Los Angeles: Sage.
Pollack, S. (2014). "… and [social] justice for all [undergraduate degree programs]": Institutionalizing critical civic literacy in the undergraduate curriculum. In A. Finley & B. Checkoway (Eds.), *Civic learning and teaching* (pp. 9-18). Washington, DC: Bringing Theory to Practice.
Ramphele M. (Ed.). (2012). *Conversations with my sons and daughters*. South Africa: Penguin Books.
Reid, L. (2014). Moral distress and moral disorientation in the context of social accountability. *Journal of Graduate Medical Education, 6*(3), 583-584. doi:10.4300/JGME-14-00345.1
Rothman, S., & Malan, M. (2011). Work-related well-being of South Africa hospital pharmacists. *SA Journal of Industrial Psychology, 37*(1), 1-11. doi:10.4102/sajip.v37i1.895
South African Pharmacy Council. (2011). Pharmacy human resources in South Africa. Pretoria, South Africa: South African Pharmacy Council.
Statistics South Africa. (2016). Mid-year population estimates 2016. Pretoria, South Africa: Stats SA.
United Nations General Assembly. (2015). *Transforming our world: The 2030 agenda for sustainable development. Resolution adopted by the general assembly on 25 September 2015* (A/RES/70/1). Retrieved from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

Van Huyssteen, M., & Bheekie, A. (2015). Embedding relevance in pharmacy training: A case study from South Africa. *Pharmacy Education*, *15*(1), 270-274.
Western Cape Government, Department of Health and the University of the Western Cape, School of Pharmacy. (2015). Memorandum of agreement: Implementation of service learning programme (pharmacy) at health facilities (pp. 1-18). Bellville, Cape Town. University of the Western Cape.
Zembylas, M., & McGlynn, C. (2012). Discomforting pedagogies: Emotional tensions, ethical dilemmas and transformative possibilities. *British Educational Research Journal, 38*(1), 41-59.