"There is a human being there": A Critical Pedagogic Approach to Shift Perceptions of Patient Worthiness in South Africa

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I, Sara Ilyse Jacobson, hereby declare that this thesis represents my work in concept and execution, except where otherwise indicated.

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Abstract

Socially marginalised individuals in South Africa may be deemed unworthy of scarce resources to promote health and treat illness. Perceptions of patients' relative worthiness impact health-seeking behaviour and outcomes: those deemed unworthy may receive inferior care or be denied health services altogether. Current in-service learning strategies to address unequal treatment in the Primary Health Care facility have not resolved the problem. There is a gap in the literature regarding why perceptions of patient worthiness persist among clinicians in the Global South and among nurses in particular. This study utilised a critical participatory action research methodology whereby a group of nurses and cross-border migrants - a socially marginalised population in South Africa - engaged in dialogue and critical reflection over one year. Findings indicate that perceptions of worthiness are informed by sociocultural and historical factors that promote the practice of shifting blame for systemic failures onto individuals. Worthiness determinations on the part of clinicians, support staff, and patients from the general population justify dehumanising actions that harm socially marginalised patients, maintain social and institutional hierarchies, and preserve the unequal status quo. Shifting perceptions of socially marginalised people from stereotypical characters to dynamic individuals is humanising and, therefore, vital to dissuade the practice of triaging patients based on perceived worthiness. Critical reflection on problematic assumptions, motivations, and beliefs through dialogue provides an alternative to traditional in-service training; it holds promise as a strategy to deter worthiness determinations and counter the motive to justify unequal systems. Facilitators of effective dialogue-based strategies foster a learning environment where participants feel free to listen and speak without judgment. Providing opportunities for learners to consider the perspectives of others through narrative or theatrical activities is also essential if perceptions of worthiness are to shift.

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1. Context

Introduction

I volunteered as a health educator with a local non-profit organisation during my senior year of college. My role was to facilitate community workshops on the prevention and treatment of HIV. I loved it. I felt I was making a difference, perhaps for the first time. After graduation, I moved on to another volunteer assignment with a health education focus, this time in a rural Honduran village. As part of our pre-service training, health volunteers visited a hospital to observe a delivery. We entered a dark room to find a young woman labouring on a table, nude and uncovered, while a nurse shouted at her. To my dismay, I learned that while our group had been permitted to observe the birth, her family members had not. To this day, I am appalled by what I witnessed.

Years later, I became a registered nurse. I learned how to do the job during shifts in an Emergency Department in the American South. Working in a well-resourced, fully staffed hospital, I was often reminded of the woefully inadequate health system in Honduras. Later, while in Zambia, I shadowed a physician in the paediatric unit of a teaching hospital where one nurse was responsible for one hundred and fifty patients, placed three in a cot for lack of space. Upon my arrival in South Africa soon thereafter, I was struck by stories about understaffed Primary Health Care (PHC) facilities, medication stockouts, and lengthy patient queues. I also began to hear about mistreatment directed towards socially marginalised people. At the time, my job was to design, develop, and implement in-service training for health workers in the public health care system on behalf of the National Department of Health (NDoH). Though training was proposed as the solution to many of the problems clinicians and patients faced, it seemed inadequate. I strove to develop engaging and interactive learning sessions, yet I believed in-service training alone would be insufficient to bring about meaningful change in the health system.

My perspective regarding the effect of training on health outcomes has evolved due to contrasts I have observed across contexts where injustices are tolerated to varying degrees. This shift has led me to consider many questions: How can a 1:150 nurse-to-patient ratio in a Zambian paediatric ward be acceptable? Why are health centre personnel who berate and shame patients permitted to keep their jobs? Where is the outrage? Moreover, how can anyone, let alone government officials and donors, believe that a single workshop on stigma will solve the enormously complex challenges facing the South African health workforce? Deliberation on these questions ultimately led me to pursue this research topic.

Literature Review

Robust health systems are characterised by a high-performing health workforce, reliable service delivery, sound health information, procurement and finance systems, and effective leadership and governance (World Health Organization, 2010; WHO, 2007). Well-functioning systems provide timely, respectful, and appropriate care and are trusted by the communities they serve (Ghebreyesus, 2018). Health outcomes in many low- and middle-income countries (LMICs) fall far below global standards due to weak and inadequate health systems (WHO, 2007), which often lack human and material resources to provide quality care (Kruk et al., 2018). High-quality health service delivery is only possible with a competent, skilled health workforce. Nurses are essential for the health system to function in resource-constrained settings, as they are the first point of contact between patients and health facilities.

The realisation of the goal of Health for All put forth in the Declaration of Alma-Ata (International Conference on Primary Health Care, 1978) has been hampered by the persistence of health inequities within and between countries (Kruk et al., 2018; Frenk et al., 2010). To attain Health for All, nations must strengthen health systems (WHO, 2007) and promote health equity, the absence of disparities in service quality (Braveman et al., 2017; Hixon et al., 2013). Health care is equitable if it is available, affordable, and of high quality; consequences of poor quality care include unequal access to services and patient dissatisfaction (Kruk et al., 2018). Health service delivery in many LMICs is insufficient, as evidenced by misdiagnoses, treatment delays, non-adherence to evidence-based treatment, and negative patient experience of care (Kruk et al., 2018). Poor quality health services result in low utilisation, community mistrust, and adverse health outcomes, even when access increases (Ghebreyesus, 2018).

An initial narrative literature search was conducted between February 2019 and January 2021 via the University of Cape Town online library, Google Scholar and PubMed. Given the interdisciplinary nature of the topic under consideration, it was necessary to conduct a broad review drawing upon literature from the fields of health sciences education, global health and development, psychology, and nursing. In consultation with supervisors, the initial search was conducted using the following search terms: “health equity”, “health worker attitudes”, “health workforce”, “hidden curriculum”, “informal learning”, “in-service learning”, “othering”, “stereotypes”, “stigma”, “training”, “worthy” and “worthiness.” Variations in terms were used to enhance search results. The reference lists of included journal articles were also reviewed to identify additional studies.

Unequal Treatment

Negative patient experiences discourage engagement in care, delay treatment, and inhibit access to preventive services (Duby et al., 2018). Actual or anticipated discrimination on the part of health workers increases patients' risk of both infectious and non-communicable diseases, including depression and stroke (Hunt et al., 2017; Major & O'Brien, 2005). Trust may only be established if patients believe clinicians will not cause them harm (Gilson et al., 2005); therefore, the patient-clinician relationship is central to quality health service delivery (Frenk et al., 2010).

Clinicians determine which patients deserve their time and attention (Ramsey et al., 2024; Digby et al., 2018). Perceptions of patient unworthiness impede access to quality care (Hunt et al., 2017). Worthiness determinations are influenced by social, political, cultural, and educational factors, including messages conveyed through formal and informal learning channels (Higashi et al., 2013; Willen, 2012; Mizrahi, 1984). Patients may be deemed low priority because they represent undesirable (Fassin, 2008; Jeffery, 1979) or stigmatised groups (Scorgie et al., 2013; Parker, 2012); are believed to pose a physical risk to the clinician (Phelan et al., 2008); require more time to care for than other patients (Digby et al., 2018), or because of a belief that they do not deserve to be treated (Duby et al., 2016; Jeffery, 1979). A body of research describes medical students' and physicians' perceptions of patient worthiness; factors influencing nurse perceptions remain largely unexplored in the literature. Moreover, most learning strategies to shift perceptions of patient worthiness rely upon methods that are neither supported by the literature nor informed by nurses' perspectives.

Socially marginalised individuals – from refugees to sex workers to the unhoused – may be deemed unworthy of scarce human and financial resources to promote health and treat illness. Patients from the general population are often privileged over the socially marginalised, who may be mistreated, neglected, or denied care altogether (Hunt et al., 2017; Wanyenze et al., 2017; Burgess, 2016; Mtetwa et al., 2013). Access to quality health care for the socially marginalised is more challenging than for the general population (Hunt et al., 2017). Many socially marginalised people experience stigma; they have or are perceived to have an attribute that marks them as different, which leads them to be devalued by others (Major & O'Brien, 2005). Stigma arises from labelling and stereotyping and may lead to social rejection (Phelan et al., 2008). Discrimination is a form of enacted stigma (Parker, 2012).

The mistreatment of socially marginalised people seeking health care is widely described in the literature. Patient mistreatment can take many forms, including denial of services (Wanyenze et al., 2017), public humiliation (Mtetwa et al., 2013), confidentiality breaches (Luvuno et al., 2019), and inappropriate referral (Scorgie et al., 2013). To reduce health

inequity, attention must be paid to marginalised individuals and groups that experience social exclusion and discrimination (Braverman et al., 2017), resulting in poorer health outcomes than the general population (Kruk et al., 2018).

Most of the literature examines unequal treatment from the perspective of either the patient or the clinician; few studies present data collected from both patients and health workers. One notable exception is qualitative research by Jewkes et al. (1998), who explored nurse-patient relationships in an obstetric ward within two hospitals in South Africa. Findings indicate that nurses considered themselves superior to patients, demanded compliance by employing techniques such as scolding and blame, and used distancing strategies, including neglect. The authors recommend addressing remuneration and staffing issues, reinforcing professional ethics, sanctions for misbehaviour, and workshops to change nurses' attitudes (Jewkes et al., 1998). The degree to which these strategies may be relevant and applicable in present-day Primary Health Care (PHC) facilities remains unclear.

A standard recommendation in the Southern African Development Community (SADC) literature on patient mistreatment is for clinicians to undergo 'sensitisation' training (Luvuno et al., 2019; Wanyenze et al., 2017; Sheibe et al., 2016; Delany-Moretlwe et al., 2015; Vearey, 2014; Mtetwa et al, 2013), which assumes the underlying cause of the problem is a lack of knowledge or skills. Although knowledge and skill gaps may inform worthiness determinations, political, organisational, and operational factors also influence whether some patients are privileged over others. Duby et al. (2018), authors of a study regarding barriers to health care access among key populations - those at increased risk of HIV acquisition and onward transmission - in South Africa, endorse sensitisation training combined with competency training, yet conclude the approach may only succeed with clinicians who do not hold prejudicial attitudes. This recommendation begs the question: How might attitudes and behaviour shift among clinicians who harbour prejudices?

Learning strategies to promote clinician attitude and behaviour change described in the literature derive primarily from the Global North (Kyndt et al., 2016; Bjørk et al., 2013; Bluestone et al., 2013; Burks & Kobus, 2012; Nilson et al., 2012; Lee, 2010; Shapiro, 2008; Perkins et al., 2007; Ellis & Nolan, 2004). Emphasis is placed on barriers and facilitators to adopting new clinical guidelines and biomedical practices within well-resourced health systems (Grimshaw et al., 2002; Fox & Bennett, 1998), which may differ from the challenges and enablers encountered by clinicians in resource-limited settings. Studies that explore clinician attitudes and behaviours are described within the socio-political contexts of countries such as the United States (Smith et al., 2018), which differ from the contexts of LMICs. For example, research from the Global North emphasises implicit biases that clinicians maintain at an

unconscious level (Byrne & Tanesini, 2015; Burgess et al., 2007), which may be less relevant in LMICs, where biases tend to be more explicit (Kennedy & Prock, 2018; Parker, 2012).

Whereas most published studies explore the attitudes and behaviour of medical students and practising physicians (Mulder et al., 2019; Higashi et al., 2013; Taylor, 2013; Mayer, 2010; Mennin, 2010; Bennett, 2004; Mizrahi, 1985), few consider factors that inform nurse attitudes and behaviour, including tacit learning processes that occur outside of the classroom (Bjørk et al., 2013). Studies derived from the Global North do not illuminate the contextual, historical, and cultural factors that influence nurses' perceptions of patients in LMICs such as South Africa. Likewise, though the experiences of socially marginalised people who face stigma and discrimination while seeking health services have been widely documented, perceptions that underpin clinician attitudes and behaviour towards them remain largely unexamined. There is a gap in the literature regarding why such perceptions persist among clinicians in the Global South and among nurses in particular.

Worthiness

To be worthy is to be good enough. Perceptions of worthiness, the degree to which others deserve attention or respect (Oxford English Dictionary, n.d.), influence whether people are willing to help those in need (Haynes & Olsen, 2006). The criteria by which people are deemed worthy or deserving of assistance have shifted over time based on decision-makers' priorities (Wright, 1988; Rosner, 1982). The perceived worthiness of various cohorts has been examined, including the unhoused (Wright, 1978), emergency department patients (Jeffery, 1979), survivors of natural disasters (Haynes & Olsen, 2006), and people with dementia in rehabilitation centres (Digby et al., 2018).

Lerner and Miller (1978) hypothesise that people believe in a just world, which leads them to assume that others usually get what they deserve; in short, 'bad' people - or people who engage in 'bad' behaviour - deserve to suffer. Sher (1983) summarises this sentiment as follows: "The virtuous deserve reward, the wicked punishment, the hard-working to prosper, and the improvident and lazy to do without" (p.9). If misfortune falls upon those who do not deserve it, for instance, if a law-abiding civilian is attacked, we may have to accept the possibility that we, too, may suffer (Lerner & Miller, 1978). When faced with evidence that the world is not just, Lerner and Miller (1978) maintain that we adopt strategies to preserve our sense of justice and order. People may respond to others' misfortunes by offering assistance. Alternatively, they may decide that a victim is bad, reckless, or unworthy and, therefore, undeserving of help (Haynes & Olson, 2006). Those identifying with a victim's situation ('It could have been me') are likely to offer support rather than derogation (Lerner & Miller, 1978).

Assessment of the relative deservingness of others is conditional and often based on assumed or actual characteristics (Willen, 2012). For instance, during humanitarian crises, people are less willing to aid those perceived as lacking humanness (Andrighetto et al., 2014). Dehumanisation occurs when others are tacitly viewed as animals without unique human characteristics, such as civility and higher cognition, or as objects lacking emotionality and warmth (Haslam, 2006). Whereas animalistic dehumanisation is associated with emotions such as revulsion and disgust, mechanistic dehumanisation is characterised by indifference (Haslam, 2006).

Perceptions of Patient Worthiness

Judgements inform clinician behaviour (Higashi et al., 2013). "For better and worse, clinicians are human, so moral and social judgments from the broader community can penetrate into the world of healthcare relationships" (Hill, 2010, p.10). Health workers routinely determine who deserves treatment and who does not, which impacts the quality of care received (Higashi, 2013). A determination of unworthiness may cause treatment delays that result in poor health outcomes (Willen, 2012). For example, sex workers are less likely to seek health services at facilities where they anticipate verbal abuse (Konstant et al., 2015), which may deter them from obtaining crucial preventive and curative services.

Patients deemed undeserving of care are often blamed for their medical conditions, especially if they are perceived to have self-induced illnesses as a result of deviant or immoral behaviour (Hill, 2010; Wear et al., 2006; Jeffery, 1979). Such patients include those whose conditions are thought to be brought upon themselves by engaging in risky behaviours, such as drinking, overeating, or promiscuity. An alcoholic patient who presents with oesophageal varices may be blamed for his or her condition. Likewise, a person who injects drugs (PWID) and presents with an abscess may be considered less worthy of treatment than a person with a similar diagnosis who does not inject.

Patients considered less worthy are often labelled 'difficult' or 'bad' and may be the subject of derisive humour (Wear et al., 2006) or lecturing. Health workers may also demonstrate nonverbal signs of rejection, including negative body language and reduced eye contact (Byrne & Tanesini, 2015; Mizrahi, 1984). Fassin (2008) maintains that differentiating between 'good' and 'bad' patients enables clinicians to tolerate their learned emotional indifference towards those deemed undesirable.

Socially marginalised patients such as cross-border migrants, sex workers, and transgender people may elicit feelings of hostility or disgust among clinicians (Hill, 2010; Wear et al., 2006; Mizrahi, 1985). Those who experience othering are at risk of being publicly humiliated or

denied care, as illustrated by incidents documented by Luvuno et al. (2019) when transgender people in KwaZulu-Natal Province, South Africa, were denigrated by health facility staff who gawked at them. Likewise, clinicians may ask sex workers inappropriate and unnecessary questions and encourage them to leave the sex industry (Wanyenze et al., 2017; Scorgie et al., 2013). As Shapiro (2008) asserts, “Once the patient becomes the other, empathy is no longer necessary” (p.5).

For some health workers, attaining facility targets may be more important than fostering a therapeutic relationship between patient and caregiver (Freshwater & Stickley, 2004). Patients may be deemed less worthy of care, not because their behaviour is considered morally wrong, but because they are perceived as a poor investment of the clinician’s time (Higashi et al., 2013). In such cases, the care of specific individuals may be privileged over others as a result of cultural and organisational processes; those who require additional attention, for example, due to agitation or an increased risk of falls, may be deemed less deserving of care than ‘easy’ patients who require less of the clinician’s time (Digby et al., 2018).

The stratification of patients by perceived worthiness does not align with the way clinicians are taught to behave during formal pre-service and in-service (post-basic) training; however, the practice may be conveyed implicitly. Higashi (2013) argues that learning how to work efficiently by differentiating patients based on perceived worthiness “is part of the clinical training process” (p.20). Likewise, Jeffery (1979) found that expected features of undesirable or ‘rubbish’ patients informed the treatment (or lack thereof) provided in Casualty Departments in the United Kingdom. Clinicians did not need direct contact with patients to deem them undesirable; rather, assessments were made based on experiences shared by colleagues (Jeffery, 1979), highlighting how informal interaction and organisational culture influence worthiness determinations.

Nurse attitudes and behaviours often reflect the prevailing cultural norms of the communities where they live and work and are, therefore, not easily changed (Kruger & Schoombee, 2010). As Wood and Jewkes (2006) assert, “The gap between nurses' personal politics (reflecting wider social norms) and public health imperatives is an important challenge for health services, as it jeopardises the delivery of high quality, effective services” (p.116). It is unlikely that health workers intend to treat patients poorly; therefore, it is crucial to ascertain why some clinician-patient interactions remain negative (Fonn & Xaba, 2001). It is also important to consider that not all marginalised patient encounters are negative (Duby et al., 2018). Findings by Digby et al. (2018) suggest that nurses who adopt an ethic of caring and seek connection with patients deemed unworthy by other clinicians can maintain a therapeutic relationship.

South African Context

The Truth and Reconciliation Commission, a restorative justice body established after the fall of apartheid, conducted an Institutional Hearing on the Health Sector in June 1997. The hearing highlighted the role of governmental and educational institutions in perpetuating the differential treatment of South Africans before and during the apartheid era through race-based fund allocation and segregation of health care facilities, among other practices (Truth and Reconciliation Commission, 1998, 4). The Commission found:

> The health sector, through apathy, acceptance of the status quo and acts of omission allowed the creation of an environment in which the health of millions of South Africans were neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights (Truth and Reconciliation Commission, 1998, 5:250).

Although the Commission did not uncover evidence of gross human rights violations committed by nurses, it found that the profession lacked accountability for ethical codes, including the nurse's pledge (Truth and Reconciliation Commission, 1998, 4), as evidenced by the failure of the South African Nursing Council to challenge racial segregation in health service delivery. In *Divided Sisterhood: Race, Class, and Gender in the South African Nursing Profession*, Marks (1994) characterises pre-service nurse training under apartheid as depoliticised because emphasis was placed on individuals rather than the social determinants of health. She contends that this approach led many African nurses to adopt the same blame-the-victim mentality towards disempowered patients espoused by their white mentors (Marks, 1994).

Nurses are essential to the South African PHC system, especially in rural areas where physicians are scarce (OXFAM South Africa, 2020; Mayosi & Benatar, 2014). As indicated in the *2030 Human Resources for Health Strategy*, there is a shortage of PHC health personnel, and one out of every two health care workers in the public sector is a nurse (NDoH, 2020). Nurses often see more than the maximum of 35 patients per day stipulated in the *Implementation Guideline of Health Workforce Normative Guides and Standards for Fixed Primary Health Care Facilities* (Republic of South Africa, 2 October 2015).

The National Department of Health defines the scope of practice of various health cadres. Specific regulations for nurses and midwives are codified in the Nursing Act of 2005. The scope of practice for professional nurses is more expansive than that of staff and auxiliary nurses. Power dynamics within the health sector dictate that nurses are subordinate to doctors and in control of patients (Coovadia et al., 2009; Marks, 1994). They also reinforce a strict hierarchy

among different cadres of nurses (Marks, 1994) and between nurses and patients (Jewkes et al, 1998).

The Constitution of the Republic of South Africa (1996) guarantees that everyone has the right to access health care services. Most people in the country rely on the publicly funded health system (Walker & Freemantle, 2023). The primary demand of health care service users is respectful and fair treatment (Gilson et al., 2005). Upon graduation, nurses pledge that they "will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient" (South African Nursing Council, n.d.). In addition, the Patients' Rights Charter adopted by the NDoH sets forth rules of professional conduct, including "a positive disposition that demonstrates courtesy, human dignity, patience, empathy and tolerance" (Health Professions Council of South Africa, 2008, p.6). The Charter also permits patients to complain about health services, have the complaint investigated, and receive a complete response (NDoH, 1999).

Despite the guarantee of the right to health enshrined in the constitution, inequities persist (Mayosi & Benatar, 2014; Coovadia et al., 2009). Racial disparities in quality of care and other socioeconomic factors that affect health outcomes predate apartheid (Coovadia et al., 2009; Marks, 1994). Mayosi and Benatar (2014) maintain that the expectation that such disparities would dissipate in post-apartheid South Africa failed to consider the social determinants of health as well as policy implementation challenges. This expectation also disregarded organisational and operational issues faced by an overstretched, underresourced, and fractured health system (OXFAM South Africa, 2020; Rispel et al., 2018; Chopra et al., 2009).

PHC facilities in South Africa are characterised by understaffing and poor operational management (Rispel et al., 2018; Coovadia et al., 2009). In many clinics, clearing the queue is of primary concern to staff, who may work beyond their scope and have insufficient capacity to provide comprehensive care (Chopra et al., 2009). Tactics to increase efficiency and clear the queue, such as the distancing techniques of objectification, omission, intimidation, and avoidance identified by Mizrahi (1985; 1984), persist within the public health system (Fassin, 2008; Jewkes et al, 1998). According to Therborn (2009), distancing is a stealthy and subtle source of health inequality.

Ethical lapses remain common in the health system. For instance, cross-border migrants may be denied treatment based on their immigration status despite having a legal right to access primary health care services (Zihindula et al., 2017; Crush & Tawodzera, 2014). Many patients, especially those from marginalised and stigmatised groups, expect mistreatment when they visit the clinic (Duby et al., 2018; Kennedy & Prock, 2018; Nyblade et al., 2009). Blaming

patients for their medical conditions remains a persistent problem (Kruger & Schoombee, 2010; Dlamini et al., 2007). Clinicians in South Africa may justify their behaviour by claiming they know better than their patients (Fassin, 2008). Although well aware of ethical tenets guiding their work, including the Patients' Rights Charter and the nurse's pledge of service, health workers "develop arguments to justify what they would otherwise admit as unjustifiable" by citing high workload and poor patient attitudes (Fassin, 2008, p.267).

The legacy of apartheid persists in South Africa, the most unequal country in the world (Sulla et al., 2022). Thirty years since the fall of white-minority rule, race remains the primary driver of inequality, followed by disparities in educational access (Sulla et al., 2022). Inequity, including differential access to quality health services, has far-reaching consequences for most people in the country. Why, then, is it tolerated?

Perceptions of Patient Worthiness in the South African Health System

Contrary to the prevailing notion of nursing as a caring profession, nurses in South Africa have historically been perceived as rude, cruel, and even abusive, especially within sexual and reproductive health services (Chopra et al., 2009; Coovadia et al., 2009; Wood & Jewkes, 2006; Jewkes et al., 1998). Clinicians in the public system have traditionally considered patients ignorant and inferior (Jewkes et al., 1998; Marks, 1994). At the same time, nurses, particularly African nurses, have long been blamed for health system failures (Marks, 1994). Fassin (2008) contends that clinician behaviour may only be understood in a historical context, including how the nursing profession conferred status upon African women during the apartheid era (Marks, 1994).

Socially Marginalised Patients

"Educational and health institutions, when left unchallenged, have acted as conduits for reproducing broader social problems, including those associated with power, hierarchy and social class" (Martimianakis and Hafferty, 2016, p.279). Despite stated ideals of equitable care, health service delivery remains suboptimal, especially for socially marginalised people who may be deemed unworthy of attention and respect. Unequal treatment leads to adverse health outcomes: members of highly marginalised groups, such as transgender people, may avoid seeking health services for preventable conditions or engage in risky procedures such as the injection of illicit hormones (Luvuno et al., 2019). The ways in which perceptions of the relative worthiness of one socially marginalised group – cross-border migrants – manifest within the PHC facility are described in the section below.

Barriers to Quality Health Care: Cross-Border Migrants

South African industries such as mining have long relied on internal and cross-border migrants to provide inexpensive labour, which has subsequently informed social development and the distribution of disease within the country (Coovadia et al., 2009). Cross-border migrants include people seeking work and those forcibly displaced from their country of origin due to violent conflict or persecution (Alfaro-Velcamp, 2017). The latter group comprises refugees and asylum-seekers, individuals whose request for refugee status has yet to be determined (United Nations High Commissioner for Refugees, 2018), and undocumented migrants. Most refugees live in countries that neighbour their country of origin (UNHCR, 2018). According to the International Organization for Migration (2024), South Africa has nearly three million cross-border migrants, the highest figure on the continent.

Morrice (2012) contends that "the powerful discourses surrounding asylum seekers and refugees impose negative social definitions and associations that are assimilated and learned informally from the media, from encounters with others, and their expectations and assumptions" (p.266). Cross-border migrants in South Africa have long been blamed for the loss of economic opportunities and increased crime, especially in disadvantaged areas (IOM, 2024; Vanyoro, 2019), and are presumed to carry a high burden of infectious diseases, such as tuberculosis (Vearey, 2014). As a result, they have been subjected to attacks, notably in 2008 and 2018, resulting in further displacement, injury, and loss of life (IOM, 2019). Since there are no refugee camps in South Africa, refugees and asylum-seekers generally seek health care services from public facilities (Coovadia et al., 2009).

The COVID-19 pandemic placed additional stress on an already overburdened health system (Mukumbang et al., 2020). Epidemics have historically been characterised by assignations of blame that play on existing tensions: "Stigmatization follows closely on the heels of every pathogen" (Jones, 2020, p.3). In times of crisis, public perceptions about who is worthy of social protection inform critical decisions (Gade, 2010). Those from 'barbaric' foreign countries or cultures are at risk of being deemed undeserving from a policy perspective and, therefore, denied the protections afforded to others (Fox, 2001). Front line health workers may also be called upon to make decisions regarding whom to treat (Sztajnkrycer et al., 2006) and how to allocate scarce medical resources, both for patients diagnosed with infectious diseases and those who require care for other urgent conditions (Emmanuel et al., 2020). Although "Infectious diseases have little respect for, and are poorly contained by, political borders and governmental mechanisms designed to enforce them" (Willen, 2012, p.813), cross-border migrants who contract illnesses are often considered undeserving of protection (Willen, 2012) and health care (Vearey, 2014).

Xenophobia, dislike or prejudice against people from other countries (Oxford English Dictionary, n.d.), manifests as ethnic slurs, inappropriate comments or physical violence (Zihindula et al., 2017). Institutional xenophobia informs policies and practices that may lead to exclusion and discrimination against cross-border migrants within government structures, including health care facilities (Ruiters et al., 2020; Vanyoro, 2019), resulting in underutilisation of services (Zihindula et al., 2017). Because institutional xenophobia often manifests in insidious ways, it may be considered less problematic than the violence that accompanies more overt manifestations (Ruiters et al., 2020). Crush and Tawodzera (2014) contend that migrants seeking health care services in South Africa are triaged not based on health status but rather on their race, language, and country of origin. Health xenophobia may emanate from both clinicians and support staff, including administrators and security guards (Walker & Freemantle, 2023).

Clinicians may consider cross-border migrants problematic because of communication challenges, lack of documentation, or the belief that migrants abuse the system (Vanyoro, 2019; Zihindula et al., 2017; Crush & Tawodzera, 2014). Lack of clarity regarding non-nationals' legal right to access health services exacerbates marginalisation and places clinicians in the position of making determinations of worthiness based on presumed legal status (Mukumbang et al., 2020; Alfaro-Velcamp, 2017). In light of organisational and operational challenges facing the South African health system, it is difficult to attribute mistreatment to health xenophobia alone (Vanyoro, 2019; Crush & Tawodzera, 2014): "Simply because a migrant from another country receives poor or abusive treatment at a South African health facility, we cannot automatically assume that it is because they are foreign or that this is evidence of xenophobia" (Crush & Tawodzera, 2014, p.660). Long queues and brief consultations may emanate from organisational policies that result in low staffing levels rather than prejudice or discrimination. There is a need to explore the nuances of the relationship between PHC facility nurses and cross-border migrants to determine the underlying causes of mistreatment and potential learning strategies to address them.

Patient Worthiness in the PHC Facility: Sex Workers

Most sex workers - people who sell consensual sex (Oliveira & Vearey, 2017) - in South Africa are internal or cross-border migrants (Scheibe et al., 2016). Sex work is criminalised and stigmatised in most countries around the world (Harcourt & Donovan, 2005), including South Africa (Sexual Offences Act, 1957). Laws designed to curb sex work rarely achieve desired outcomes (Harcourt & Donovan, 2005) and may legitimise abuse and mistreatment of sex workers by clinicians and the police (Scorgie et al., 2013).

People who engage in sex work are exposed to a range of occupational health and safety risks that affect their physical and psychosocial well-being (Scheibe et al., 2016; Delany-Moretlwe et al., 2015): pregnancy is frequently unintended; termination of pregnancy is common and contraceptive use, including emergency contraception, is low (Willis et al., 2016; Delany-Moretlwe et al., 2015). Sex workers are vulnerable to acts of violence, including rape and assault (Wanyenze et al., 2017; Konstant et al., 2015; Deering et al., 2014; Scorgie et al., 2013). Those who experience violence may be reluctant to seek help for fear of being arrested (Duby et al., 2018; Wanyenze et al., 2017). Sex workers may also be unwilling to self-identify to health workers for fear of being mistreated or denied access to services (Scheibe et al., 2016; Delany-Moretlwe et al., 2015).

Sex workers are at exceptionally high risk of being deemed unworthy of care, given their compounded vulnerabilities (for instance, they may also be cross-border migrants or unhoused), their need for routine sexual and reproductive health services, and the illegality of their work (Duby et al., 2018; Scorgie et al., 2013). Sex workers are often blamed for bringing illness or infection upon themselves as a result of their behaviour (Hunt et al., 2017). Mistreatment by personnel within PHC facilities in South Africa and the region is well-documented (Wanyenze et al., 2017; Hunt et al., 2017; Scheibe et al., 2016; Metewa et al., 2013; Scorgie et al., 2013). Negative healthcare experiences discourage sex workers from seeking care, resulting in missed opportunities to access preventive services (Scheibe et al., 2016; Delany-Moretlwe et al., 2015). Stigma or fear of stigma often leads to delayed care and treatment nonadherence (Mtetwa et al., 2013; Nyblade et al., 2009). Duby et al. (2018) maintain that even when key population members such as sex workers "manage to access health services, those provided in the public sector health system in South Africa are often inappropriate, inadequate or insensitive to their particular needs" (p.2).

Worthiness Determinations as Learned Behaviour

Clinicians' assumptions and beliefs may manifest as stereotypes and prejudices (FitzGerald & Hurst, 2017) that influence their decisions (Burgess et al., 2007). People learn to triage others by perceived worthiness through both formal and tacit learning processes. Since the problem, as defined by the NDoH, non-governmental organisation (NGO) implementing partners, and educators, is a lack of awareness, it is assumed that sensitisation or 'awareness-raising' workshops are the solution (Byrne & Tanesini, 2015). However, sensitisation training does not mitigate the effects of stereotypes on clinician behaviour; on the contrary, attempts to minimise explicit negative attitudes may have the paradoxical effect of activating implicit stereotypes (Byrne & Tanesini, 2015). Despite evidence indicating its ineffectiveness (Simelane et al., 2018; Bluestone et al., 2013), the NDoH and donors endorse the sensitisation approach to in-service capacity development.

Formal Learning

Knowledge, skills, and attitudes comprise the three learning domains (Taylor & Hamdy, 2013). Though new knowledge and skills may be observed and measured during formal learning activities, attitudes are intangible and difficult to change through traditional methods (Lee, 2011). Even if an educational intervention results in attitudinal shifts, behaviour change does not necessarily follow (Perkins et al., 2007). Educational activities that succeed in changing clinicians' attitudes and intentions may not translate into desired action if the behaviour in question is strongly habitual and unyielding to conscious cognitive deliberation (Nilsen et al., 2012). Though improved clinical performance is the desired outcome of in-service learning activities, behaviour change does not automatically lead to a change in patient outcomes (Fox & Bennett, 1998).

In-service training (sometimes called Continuing Professional Development or CPD) refers to formal learning activities designed to attain instructional objectives (Feldacker et al., 2017; Lee, 2011). Learning outcomes are influenced by factors including the participant selection process, the nature of the learning experience, and the degree to which the practice environment is open to change (Ellis & Nolan, 2004). The impact of in-service learning on clinical practice often remains unmeasured (Lee, 2011). *The Lancet Global Health Commission on High-Quality Health Systems in the SDG Era* maintains that interventions designed to change clinician behaviour at the individual or facility level have only modest effects and are unlikely to improve the overall performance of the health system (Kruk et al., 2018).

In-service training is often put forth as the solution to unequal patient treatment. In South Africa, as in other LMICs, training generally employs a didactic approach, even though passive instruction has little effect on learning or clinical outcomes (Simelane et al., 2018; Bluestone et al., 2013). Training generally takes the form of what Freire (2005/1970) characterises as the banking concept of education, a traditional pedagogic approach whereby students receive 'deposits' from an all-knowing teacher. In this environment, students are considered passive receptacles of clinical knowledge, generally provided via lecture in a classroom setting. The assumption is that problematic attitudes and behaviour will vanish once clinicians undergo training on the constitution and the Patients' Rights Charter (never mind that it is posted on the clinic walls) and memorise the definition of stigma. This approach fails to consider that stating information is not synonymous with learning (Kyndt et al., 2016) and that awareness training alone cannot mitigate the effects of stereotypes and negative attitudes (Byrne & Tanesini, 2015). Moreover, the traditional approach rarely accounts for sociocultural context, an essential component of learning. As Dirkx (1998) asserts, "To think about adult learning as potentially transformative is to ground the content and processes of learning concretely within

the lives of those with whom we work in an educative capacity, as well as within the sociocultural context in which those lives are embedded" (p.10).

The Human Resources Directorate of the NDoH oversees formal in-service learning for health professionals in the public sector. Nurses who work in PHC facilities are often required to attend trainings, sensitisations and orientations regarding policies, guidelines and clinical content updates (Simelane et al., 2018). Although knowledge acquisition in the absence of communication and decision-making skills is insufficient to develop a competent health workforce (Frenk et al., 2010; Chen et al., 2010), significant human and financial resources are put into didactic training. Once-off workshops remain the go-to solution despite a lack of evidence of their effectiveness (Simelane et al., 2018; Bluestone et al., 2013).

In-service learning activities are coordinated at the provincial level by Regional Training Centres (or People Development Centre, as it is known in the Western Cape) located within the nine provinces in collaboration with NGO implementing partners. In-service training content is often fragmented, disease-specific, and donor-driven (Feldacker et al., 2017). As a result of poor coordination and inappropriate participant selection, clinicians may remain absent from health facilities for long periods to attend training, some of which may be neither relevant nor applicable to their work.

While employed by an NGO supporting the NDoH, I was asked to update a training manual to sensitise clinicians to the needs of highly marginalised key populations. The manual included didactic modules on topics such as stigma and discrimination. Uncomfortable with the prospect of updating such a resource, I proposed an alternative: a multimodal toolkit centring the lived experiences of key population members seeking health services. The final toolkit included video clips from interviews conducted with people willing to share their stories, including Nelson, a former PWID who had also experienced homelessness. Nelson shared that he was often denied care and blamed for the medical conditions that brought him to the health facility. He also articulated his perception that some staff have preconceived notions about the motives of socially marginalised patients: *"You see them, and you've made your mind up on who the person is: they're a thief, they're here to steal something, they're here to hustle me; so, before they've even asked for help, you've already made a judgement call"* (Nelson*, Key Populations Sensitization and Competency Development Toolkit*, 2018). One comment, in particular, remained at the forefront of my thoughts as I considered the concept of patient worthiness and potential learning strategies to address it. In reference to socially marginalised patients, Nelson said,

> This individual belongs to someone. This is someone's brother, someone's father, someone's sister, someone's mother: this is someone. This person belongs somewhere. And how would we feel if it was your kid walking in, and being sworn at and thrown out to the system that's taken an oath to help you? (*Key Populations Sensitisation and Competency Development Toolkit*, 2018).

Tacit Learning

In-service learning does not take place in a vacuum. Each PHC facility has a unique organisational culture shaped by norms, beliefs, and behaviours that affect the learning process (Fox & Bennett, 1998). Context, motivation, health systems challenges, and social influences impact whether learning and behaviour change occur (Martimianakis & Hafferty, 2016; Taylor & Hamdy, 2013). It is, therefore, incorrect to assume that training participation will result in improved outcomes. As Rowe et al. (2005) assert, "Correct knowledge often does not predict correct performance" (p.1027). For instance, clinicians may be motivated to apply new knowledge and skills gained through in-service training but then find they are thwarted by a restrictive organisational culture upon returning to the workplace (Lee, 2011). Efforts to change attitudes and behaviour through formal training may also be derailed by conflicting messages conveyed via tacit learning channels. Such counter-messages may lead to suboptimal patient care, as well as cynicism and burnout among health professionals (Mulder et al., 2019). Strategies to overcome these barriers remain largely unexplored in the literature.

Numerous studies describe in-service training interventions intended to change clinician behaviour (Simelane et al., 2018; Grimshaw et al., 2002; Fonn & Xaba, 2001); however, few acknowledge that most learning occurs outside the classroom (Eraut, 2004). Tacit learning takes place during regular, day-to-day interactions both within and outside the workplace (Mulder et al., 2019; Bjørk et al., 2013; Hafferty & Castellani, 2009; Bennett et al., 2004; Eraut, 2004). In contrast to formal learning, tacit learning occurs on an ad hoc basis and does not rely upon a curriculum. Tacit learning takes place in settings and situations in which learning may not be the primary aim but is required to solve a problem (Manuti et al., 2015), as when a clinician turns to colleagues or decision support tools to make a diagnosis when a patient presents with an unfamiliar constellation of symptoms. Tacit learning may be either facilitated or constrained by work organisation and social and interpersonal dynamics (Eraut, 2004), as in the case of solo practitioners in rural facilities who are precluded from on-the-job learning opportunities with colleagues.

Workplace norms and practices are influenced by non-formal learning processes, including tacit learning, the hidden curriculum, and the null curriculum, that which is learned when something is omitted from the formal curriculum and not taught (Hafferty & Castellani, 2009; Flinders et al., 1986). In health sciences education, the hidden curriculum refers to unwritten or unstated rules, values, norms, and attitudes clinicians infer from educators, supervisors, processes, and group dynamics (Mulder et al., 2019; Bennett et al., 2004). The hidden curriculum may reinforce formal learning objectives and best practices; alternatively, it may convey messages that contradict the content of the formal curriculum (Bennett et al., 2004). The hidden curriculum manifests in different ways across contexts and should not be viewed as uniform or constant (Lawrence et al., 2018). Interventions to address the perceived adverse effects of the hidden curriculum have focused on developing humanistic traits such as empathy at the micro level through curriculum - rather than organisational - reform (Martimianakis et al., 2015).

Stratifying patients by perceived worthiness is learned behaviour, though not necessarily acquired in a classroom. Although clinicians are taught to treat all patients equally during formal training, counter-narratives may be transmitted by educators, supervisors, and peers. As Liao (2014) asserts, “The difference between what we say we do and what we actually do as doctors and teachers can be stark” (p.169). Educators’ behaviour reflects their personal beliefs and prevailing professional, institutional, and societal values (Phillips & Clarke, 2012). Mizrahi’s (1984) observations of interactions between medical interns, residents, and patients illustrate how conflicting messages may be conveyed through non-verbal communication: “Sometimes house officers would snap their fingers impatiently. At other times they fell asleep, yawned, and otherwise communicated boredom and restlessness” (p.161).

Learning Strategies to Promote Nurse Attitude and Behaviour Change

There is a gap in the literature regarding nurse perceptions of patient worthiness, especially in LMICs such as South Africa. Most published research is descriptive and presented from the perspective of the socially marginalised patient. Prior studies examining the moral evaluation of marginalised patients have been conducted using interpretive and ethnographic methods such as observation (Vanyoro, 2019; Digby et al., 2018; Higashi et al., 2013; Willen, 2012; Mizrahi, 1985; Mizrahi, 1984), interviews (Duby et al., 2018; Zihindula et al., 2017; Jeffery, 1979) and focus group discussions (Luvuno et al., 2019; Hunt et al., 2016; Mtetwa et al., 2013; Scorgie et al., 2013). Strategies described in the literature to shift clinician attitudes and behaviour focus on medical students and physicians; few studies explore the perspective of nurses. Moreover, the described learning activities are often designed by researchers and influenced by donor priorities; nurses are seldom engaged in a joint effort to find acceptable solutions to shift attitudes and behaviour and improve the quality of care for socially marginalised patients.

Attempts to change problematic clinician attitudes and behaviour in South Africa through sensitisation workshops have been largely unsuccessful. This failure may be due, in part, to contradictory messages transmitted to learners through implicit and explicit means. Though content regarding patients' rights is embedded within the formal curriculum, some educators and supervisors demonstrate stigmatising and prejudicial behaviour towards 'unworthy' patients, as do high-ranking government officials. This includes the Limpopo Member of the Executive Council (MEC) for Health, whose rant at the bedside of a hospitalised foreign national in 2022 was widely circulated on social media.

Perkins et al. (2007) maintain that educators must understand learners' attitudes, subjective norms and perceived behavioural control if behaviour change interventions are to succeed. It is also crucial to understand the context and health systems in which clinicians work, which is why interventions emanating from the Global North and put forth by Western donors may be of limited value in South Africa. Johnson and May (2015) argue that learning interventions based on action (for example, audit and feedback) are more likely to change clinician behaviour than activities designed to change attitudes through persuasion. Strategies to shift clinicians' attitudes and behaviour should also consider that learning occurs in both formal and informal settings and that what is learned may counter prosocial training content that calls upon health workers to treat all patients with dignity and respect.

Research Gap

There is a disconnect between the egalitarian principle of Health for All espoused in the classroom and clinicians' attitudes and behaviour. Socially marginalised people, including cross-border migrants, are likely to be deemed unworthy of care in the PHC facility. Worthiness determinations impact health-seeking behaviour: those deemed unworthy may receive inferior care or be denied services altogether (Burgess, 2016), which deters future engagement with the health system. Current learning strategies to remedy unequal treatment have not resolved the problem. If unaddressed, vulnerable patients will not obtain essential primary health care services, which increases the risk of complications related to poor management of acute and chronic conditions, thus placing further strain on an overstretched health system.

It is imperative to examine the dynamics between clinicians and socially marginalised patients in South Africa that impede the provision of equitable health care. This research project seeks to address a gap in the literature regarding learning strategies that minimise the triaging of socially marginalised patients based on perceived worthiness. The study utilises a novel approach to identify factors that shape nurse perceptions of worthiness and learning methods that may help address unequal treatment in resource-constrained settings in the

Global South. This study seeks to answer the following research questions: 1) How do PHC facility nurses perceive and understand patient worthiness?; 2) Which formal and informal learning processes inform PHC facility nurse attitudes, values, and perspectives regarding patient worthiness?; 3) How may learners, supervisors, and educators address or deflect counter-narratives regarding patient worthiness?

2. Theoretical Framework

Introduction

The reflections that Nelson, whose story was incorporated into the Key Populations Toolkit, shared about his experience seeking health services continue to resonate with me and inform how I have decided to explore this research topic. This study aims to identify learning strategies to minimise the triaging of socially marginalised patients based on perceived worthiness. To achieve this aim, it is imperative to consider how and why perceptions of worthiness arise and how learning influences assumptions that lead people to determine that some are more deserving than others. I have selected three theoretical perspectives to shed light on this complex topic: system justification theory, transformative learning theory, and engaged pedagogy. I have concluded that identifying learning strategies to address unequal treatment requires a combined approach that draws upon social psychology, from which system justification theory emerged, and critical pedagogy, in which transformative learning theory and engaged pedagogy are grounded. This chapter describes these interrelated theories in further detail, including how they elucidate the research topic under consideration and how they complement one another.

Though widely documented, there is little outcry about the inequity inherent in the South African health system, including unequal patient treatment. System justification theory provides a way to scrutinise the assumptions and beliefs that lead people to rationalise and accept the societal status quo (Jost & Banaji, 1994). It helps explain why unequal systems are tolerated, even by those they most stand to harm (van der Toorn et al., 2015). System justification theory also helps explain why formal didactic training remains the go-to intervention to address patient mistreatment despite a lack of evidence of effectiveness. Transformative learning theory and engaged pedagogy complement system justification theory by drawing upon critical pedagogical techniques that help unearth and challenge the problematic assumptions, beliefs, attitudes, and behaviours that maintain the status quo.

The goal of inquiry in critical theory is to explore power dynamics and then act in the pursuit of social justice (Apple, 2013; Apple, 2008; Guba & Lincoln, 1994). Critical pedagogy is distinct from traditional modes of instruction in that educators prioritise equity and fairness (Giroux, 2010). It is an active process through which theory is linked to practice, both in and out of the classroom (Apple, 2008; hooks, 1994); critical pedagogical techniques emphasise practical application rather than remaining in what Kincheloe (2007) describes as the “contemplative realm” (p.22). Freire’s (2005/1970) concept of conscientisation and the practice of engaged pedagogy described by hooks (2010;2003;1994), whereby learner experience and stories are recognised as a valid and necessary part of the learning process, exemplify critical pedagogy in action.

The central tenet of transformative learning theory is that problematic perspectives may be transformed through critical reflection on assumptions and beliefs, a process that occurs through dialogue (Mezirow, 2000;1997;1990). Engaged pedagogy, which emphasises power dynamics and the learner's voice, is the link that connects transformative learning and system justification theories. Engaged pedagogy considers historical context and social hierarchies, with emphasis on race, gender, and class (hooks, 2010;1994;1989). Engaged pedagogy also helps illuminate why traditional in-service learning methods to promote clinician attitude and behaviour change have failed, and which educational strategies may be more effective.

Dramatic techniques developed by Augusto Boal and described in his book *Theatre of the Oppressed* (2008/1974) illustrate how critical pedagogical practices promote learner engagement. Boal (2008/1974) contends that theatre is political. He conceives of theatre as action, a language through which oppressed people may express themselves, and a form of knowledge. According to Boal, theatre aims to encourage people to take action through active participation in dramatic activity rather than remaining passive spectators. Boal's dramatic methods, including forum theatre, invite learners to engage in collaborative storytelling that promotes conversation and debate. They enable learners to observe the outcomes of their actions, which provides opportunities for critical reflection and, ultimately, perspective transformation.

Alternate theoretical perspectives have been considered, including the critical realist philosophy of Sociologist Margaret Archer, who contends that structure and agency are distinct yet interdependent and must be decoupled (Koopmans & Schiller, 2022; Scambler, 2012). Archer maintains that reflexivity is the mediator that links structure and agency and categorises reflexives into types, including pro-social 'metareflexives' and passive 'fractured reflexives' (Collins et al., 2015; Scambler, 2012; Vandenberghe, 2005). Collins et al. (2015) argue that such categorisation suggests that "Some, apparently, have more (and better) reflexive and agentic propensities than others" (p.385). Though compelling, Archer's sociological approach does little to illuminate how and why determinations of worthiness are made within the public health system. The complex interplay between structure and agency is well-suited for exploration through the lens of social psychology, which interrogates how social factors influence the motivation and behaviour of individual actors, including clinicians and patients. System justification theory, which explains why people are motivated to support existing social arrangements, including those detrimental to them, clarifies the very issues this study seeks to examine.

Archer's contention that reflexivity occurs through internal conversations with oneself (Collins et al., 2015; Scambler, 2012; Vandenberghe, 2005) discounts the role of interpersonal communication in the critical reflection process. It also fails to consider cognitive and affective processes, such as attitudes and stereotypes, that arise outside of conscious awareness (Byrne & Tanesini, 2015; Burgess et al., 2007; Gladwell, 2006) and may not surface through conversations with oneself. In contrast, Mezirow's transformative learning theory and hooks' engaged pedagogy promote dialogue with others as a way to engage in critical reflection about problematic assumptions and beliefs that, left unchallenged, lead to the preservation of the status quo (**Figure 1**). System justification theory, transformative learning theory, and engaged pedagogy are discussed further in the sections below.

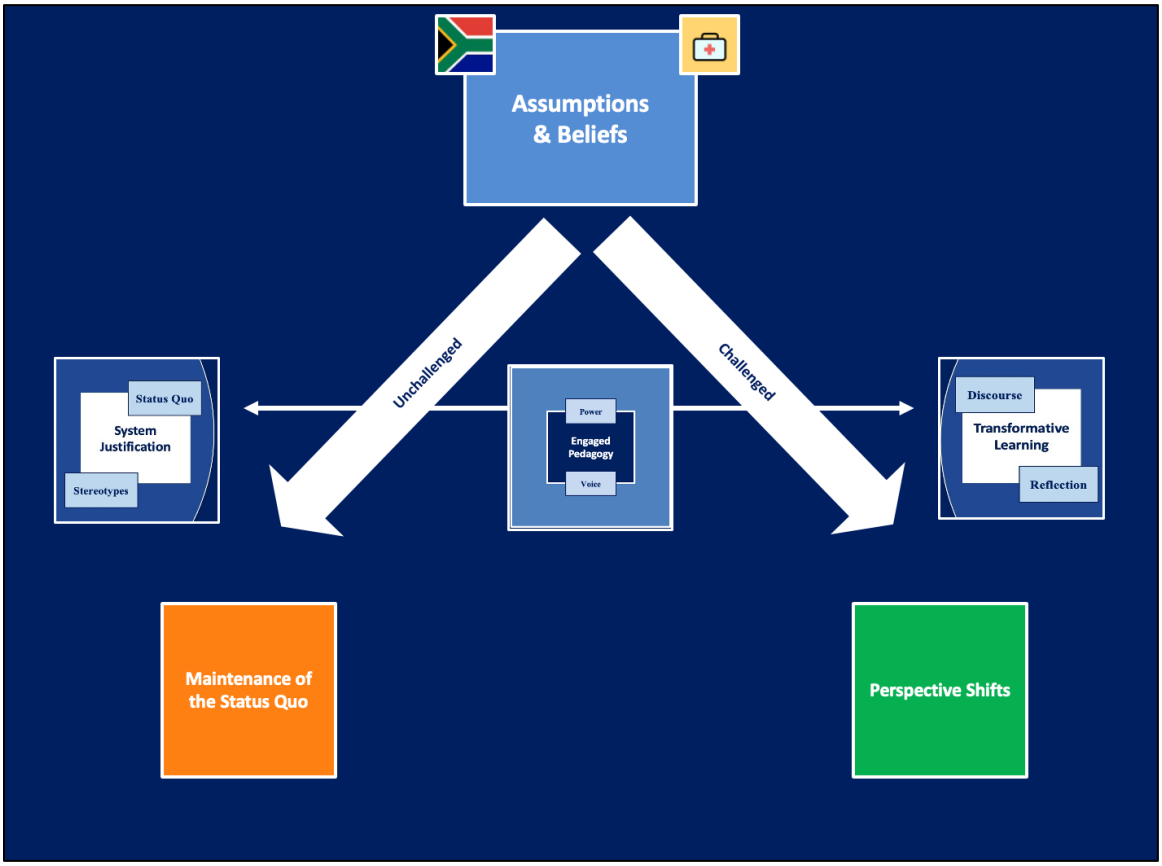

Figure 1: Relationship Between Three Theoretical Perspectives

Theoretical Perspectives

System Justification Theory

Social psychology is the study of the behaviour of individuals in social and cultural settings (Argyle, 2023). Social psychologists seek to understand how people perceive and relate to themselves and others by studying human behaviour in various contexts (Harvard University, n.d.). The unit of analysis in social psychology differs from that of sociology; whereas social psychologists study how social factors influence individual behaviour, sociologists examine large populations or groups. As this research project aims to shift individual perceptions of patient worthiness through the utilisation of novel learning strategies, it is fitting to draw upon social psychology.

Introduced by social psychologists Jost and Banaji in 1994, system justification theory maintains that people are often motivated to perceive existing social arrangements as fair and legitimate, even those perpetuating disparities (Jost & Hunyadi, 2003; Jost & Banaji, 1994). The theory applies to social situations at family, community, institutional, and country levels (Jost & Banaji, 1994). System justification theory emerged as a way to understand and explain the ideological processes that legitimise "historically situated, enduring systems of inequality and exploitation" (Jost et al., 2019, p.384) such as those found in South Africa, where mistreatment across social systems is both anticipated and rationalised. Jost and Banaji (1994) assert, "Once a set of events produces certain social arrangements, whether by historical accident or human intention, the resulting arrangements tend to be explained and justified simply because they exist…inequality between individuals or groups needs to be justified in order for it to be maintained" (p.11). Nowhere is this more true than in South Africa, the country with the highest inequality in the world (Sulla et al., 2022).

Proponents of system justification theory contend that "the human capacity for rationalisation lends considerable stability and support to the social system" (Jost & Hunyadi, 2003, p.123). System-justifying actions include defending existing policies and harsh evaluations of those who criticise the system (Kay & Friesen, 2011). People may defend certain aspects of the system but not others (Jost, 2017). For instance, an individual may defend economic inequality but challenge existing social arrangements pertaining to gender.

System justification often occurs outside of conscious awareness and persists even though it may be detrimental to the very people motivated to maintain the system (Jost & Banaji, 1994). The motive to justify existing social arrangements perpetuates the status quo and, by extension, the racial, gender, and economic inequalities pervasive in unequal systems (Jost, 2017). The tendency to rationalise existing systems helps explain why social change is so hard to achieve (Jost & Hunyadi, 2003).

Jost et al. (2019) assert that system justification theory "directly addresses the psychology of the social order and the ways that it imposes itself on the thoughts, feelings, and behaviours of individuals and groups" (p.384). In a given situation, people may be motivated to varying degrees to preserve their own interests and self-esteem, the interests of the groups to which they belong, or the interests of the social systems on which they rely (Jost & Banaji, 1994). Advantaged groups often benefit from maintaining the status quo and are, therefore, more likely to experience the positive effects of system justification than disadvantaged groups (Jost & Hunyadi, 2003). Whereas for advantaged group members, self, group, and system-related interests are often consistent (Jost & Hunyadi, 2003), disadvantaged group members' interests may conflict: the status quo meets the needs of the advantaged quite well. In contrast, accepting the status quo often places the disadvantaged at odds with the motive to preserve their self and/or group interests (Jost & Hunyadi, 2003).

"The use of stereotypes and other ideological devices to preserve the legitimacy of the existing social system" (Jost & Hunyadi, 2003, p.112) is a crucial area of focus, especially in the early literature on system justification theory. In their seminal article, Jost and Banaji (1994) contend, "[p]eople will ascribe to themselves and others traits which are consonant with their social position, whether positive or negative, rather than question the order or legitimacy of the system which produced such an arrangement or outcome" (p.11). This tendency helps explain why system justification often leads disadvantaged groups to justify their position in the social hierarchy (van der Toorn et al., 2015) and demonstrate outgroup favouritism (Jost, 2017).

The strength of the system justification motive depends on situational and dispositional elements (Jost, 2019). It is context-dependent and moderated by four factors (**Figure 2**): perceived threats to the system that may jeopardise its legitimacy, a belief that the system is inescapable, a belief that the system has been in place for a long time, and a sense of powerlessness or dependence (Jost, 2019; Kay & Friesen, 2011). People who feel dependent on social, economic, and political systems are often more likely to justify them than those who do not (Jost, 2019). Those who feel a lack of personal control may seek reassurance by defending their social systems (Kay & Friesen, 2011) and activate the system justification motive to reclaim a sense of control over their lives (van der Toorn et al., 2015). Likewise, individuals who

feel powerless are motivated to perceive authority figures, governments, and hierarchical social systems as legitimate (van der Toorn et al., 2015). Put simply, “powerlessness fosters system justification” (van der Toorn et al., 2015, p.93).

People tend to rationalise the systems on which they rely, especially if they believe the situation is unlikely to change (Kay et al., 2009). Jost & Hunyadi (2003) maintain that system justification serves a palliative function in that it helps individuals cope with seemingly inevitable social realities and feel better about their current circumstances; justification allows people to believe that the systems they depend on are stable, predictable, and fair (Jost & Hunyadi, 2003). The system justification motive has also been shown to decrease negative affect (Jost, 2019).

It is compelling that the strength of the system justification motive is moderated by specific beliefs and perceptions because it explains why people tend to justify systems from which they do not benefit. Critical examination of the assumptions that underpin these moderators may help shift perceptions that motivate individuals to defend the status quo. Educators who comprehend why students and teachers justify unequal systems may then apply critical learning techniques to decrease the motivation.

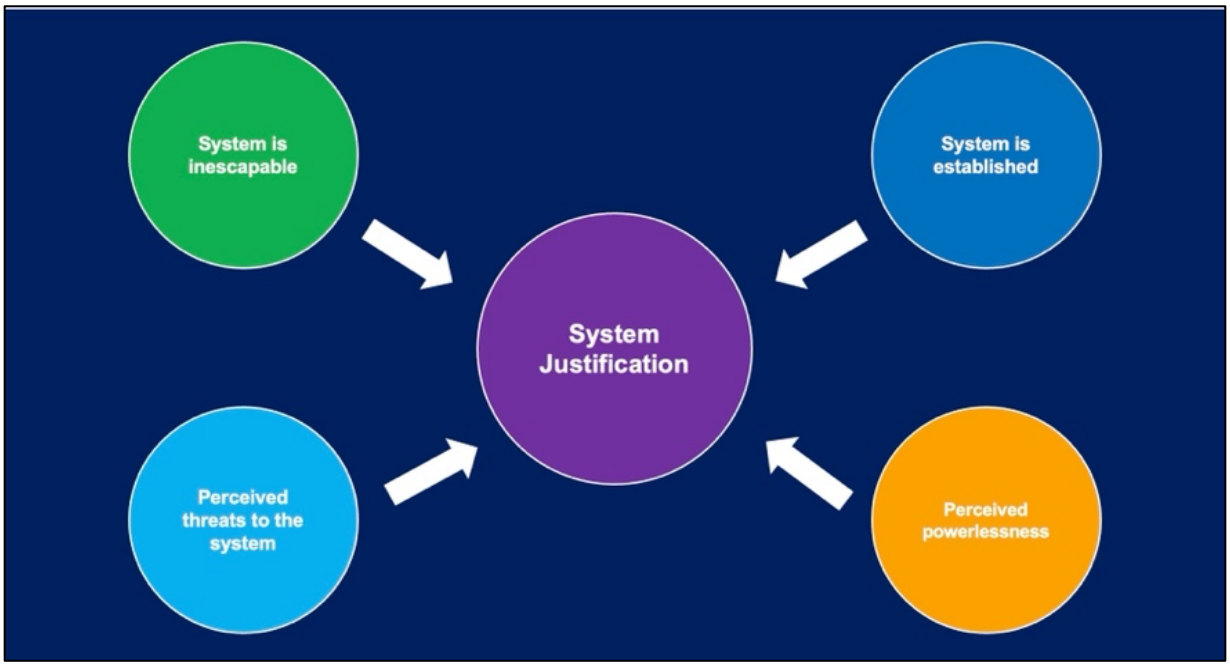

Figure 2: System Justification Moderators

Although it may seem counterintuitive for disadvantaged individuals and groups to justify the very social systems that may cause them harm, Jost et al. (2012) argue that system justification satisfies three psychological needs: the epistemic need to reduce uncertainty and maintain a predictable worldview; the existential need to manage threats; and the relational need for belonging. Kay et al. (2009) contend that system justification protects people from the unsettling belief that the system they depend on is illegitimate. Though perceiving the status quo as legitimate and fair addresses psychological needs, system justification also has consequences, especially for disadvantaged people. Rationalising the status quo may lead the disadvantaged to internalise the inequity they experience (Jost & Hunyadi, 2003). Moreover, attributing systemic failures to individuals rather than addressing the underlying factors that perpetuate mistreatment maintains existing social arrangements, as evidenced by apartheid-era apologists who highlighted individual 'bad actors' within health facilities rather than the system as a whole (Baldwin-Ragaven et al., 2000).

Justification of the status quo is an obstacle to social change (Jost, 2017). If a situation is considered acceptable and legitimate, there is no motivation to change one's attitudes or behaviour (Jost & Banaji, 1994). This helps explain why the traditional in-service sensitisation approach has failed to minimise the practice of triaging socially marginalised patients. In addition, critiques of the system are often met with resistance and backlash (Jost, 2019), a reality underscored by reports of job loss and violence faced by health workers who protested disparities in apartheid-era service delivery (Truth and Reconciliation Commission, 1998, 4). As Jost et al. (2012) assert, "Moral outrage, in other words, is often more easily directed at those who dare to challenge the system than at those who are responsible for its failings" (p.317).

As with any theory, system justification has its critics. The central critique is that while system justification does indeed occur, rationalising the status quo is not a unique phenomenon and is unworthy of its own theory (Owuamalam et al., 2019). While proponents maintain that the motive to justify the system is often distinct from the motive to justify oneself or one's social group, opponents argue that the motives are the same (Owuamalam et al., 2018) or that system justification is simply a random event that does not require further explanation (Brandt, 2013).

Opponents of system justification theory often base their arguments on the theory of social identity put forth by Tajfel and Turner (1986), which states that people organise themselves into social groups, attribute favourable group characteristics to themselves, and engage in in-group favouritism, resulting in stereotyping of outgroup members. Critics argue that social identity theory explains why disadvantaged group members justify existing social arrangements (Owuamalam et al., 2019). In a rebuttal, Jost et al. (2019) maintain that while social identity

theory focuses on group-level processes, it does not explain system-level processes, especially those perpetuating injustice and exploitation. This assertion echoes Jost and Hunyadi's (2003) earlier work, in which they contend that social identity theory does not account for the fact that people support unjust social systems, even when a different system would better serve their interests. Jost (2019) summarises his counterargument by citing the following example: "[I]t is naïve to assume that the only people who defend and justify the capitalist system, for instance, are those who benefit from the system or are otherwise motivated by self-interest" (p.21).

Critics of system justification theory also cite cognitive dissonance in their arguments. Cognitive dissonance is a negative psychological state arising from inconsistency between two or more attitudes, beliefs, or behaviours (APA Dictionary of Psychology, n.d.). For example, a clinician who endorses the principle of health equity may experience cognitive dissonance after mistreating a marginalised patient. Owuamalam et al. (2018) contend that in stable social systems, the potential for cognitive dissonance is low; therefore, the motivation to justify the system should also be low. In response, Jost (2019) argues, "I see no reason from a cognitive dissonance perspective why a highly stable social system – such as capitalism – would fail to inspire motives for justification, as long as citizens feel that they are choosing to participate in it – as opposed to being coerced (as in a totalitarian system)" (p.21). For cognitive dissonance to occur, one generally feels responsible for the consequences of the action undertaken (Jost & Hunyadi, 2003). In contrast, people may justify the status quo even when they are not directly responsible for perpetuating it (Jost & Hunyadi, 2003).

System justification theory identifies specific perceptions, assumptions, and beliefs that motivate people to legitimise and defend unequal systems such as the South African health system, in which some patients are deemed more worthy of care than others. It elucidates attitudes and behaviour that at first glance may seem counterintuitive, as when disadvantaged people rationalise the status quo, though it may cause them harm. System justification theory clarifies why opposition to the inequity of the current system has not been more vocal. Finally, it helps explain why the educational status quo is maintained through the implementation of learning 'solutions' that rely upon traditional didactic methods known to be ineffective. As this theory has emerged from the field of social psychology rather than education, I have decided to apply it in conjunction with two interrelated pedagogical perspectives: transformative learning theory and engaged pedagogy.

Transformative Learning Theory

Freire's concept of conscientisation, through which people develop a critical awareness of the forces that influence their lives, is considered a social-emancipatory version of transformative learning (Taylor, 2008; Dirkx, 1998), a theory of adult learning that describes how shifts in perspective occur (Mezirow, 1997). Transformative learning is "the process by which adults learn how to think critically for themselves rather than take assumptions supporting a point of view for granted" (Mezirow, 2009, p.103). Based on the notion that critical reflection emanates from dialogue and that shifts in perspective take time, transformative learning theory "demands that we be aware of how we come to our knowledge" (Mezirow, 2002, p.8). Transformative learning thus provides an alternative to the traditional banking approach to education.

Mezirow's transformative learning theory posits that adults develop frames of reference, meaning perspectives that define our worldview and influence our thoughts, belief systems and interpretation of events (Taylor, 2008; Mezirow, 2000; Mezirow, 1997; Mezirow, 1990). A frame of reference is the set of expectations, beliefs, values, and assumptions through which we understand our experiences (Cranton, 2002; Mezirow, 1997); it is expressed as a point of view (Taylor, 2008; Mezirow, 1997). Our perspectives "serve as a lens through which we come to perceive and understand ourselves and the world we inhabit" (Dirkx, 1998, p.4). Perspectives are acquired through life experience (Dirkx, 1998) and assimilated from culture, community, and family, often uncritically (Cranton & Roy, 2003; Mezirow, 1997).

According to transformative learning theory, perspectives are transformed through critical reflection on assumptions and beliefs that influence our thinking and the sense we make of our experiences (Taylor & Cranton, 2013; Taylor, 2008; Cranton, 2002; Mezirow, 2000; Dirkx, 1998; Mezirow, 1997; Mezirow, 1990). Critical reflection enables us to consider why we behave as we do and the outcomes of our behaviour (Mezirow, 1990). Developing the capacity for reflection takes time and practice (Taylor, 2008). Mezirow (2000) contends that critical reflection occurs through discourse, a type of dialogue that seeks common understanding and clarity about how we justify our beliefs. He argues that discourse is central to deriving meaning (Mezirow, 1997) and requires only that participants are willing to seek understanding and reach consensus (Mezirow, 2000). Mezirow's (2000) assertion that "the only alternatives to discourse for justifying a belief are to appeal to tradition, authority, or force" (p.10) aligns with system justification theory: those motivated to rationalise the status quo have little incentive to reflect upon or challenge their beliefs about the current system.

Transformative learning may only occur if learned content does not fit into an existing frame of reference (Mezirow, 1997). As Cranton and Roy (2003) contend, "What happens once we expect to happen again…When something different happens, we can be led to question our way of seeing the world" (pp.87-88). The perspective transformation process begins when a person experiences an event or encounters new knowledge that does not fit with an existing assumption or belief (Cranton, 2002), what Mezirow (1990) calls a "disorienting dilemma" (p.5). Though disorienting dilemmas often follow major disruptions in everyday life, such as the death of a loved one or divorce, they may also be elicited through conversation, reading, or immersion in an unfamiliar culture (Mezirow, 1990).

I experienced a disorienting dilemma early in my public health career. While working as a Health and Safety Trainer, I was invited to join a workshop facilitated by an avid motorcyclist. To the external eye, he looked every bit the part, down to his attire and long grey beard. In response to a question about his other interests, the facilitator stated that he makes lollipops, which contradicted my conception of bikers. I quickly realised I had pigeonholed him into my preconceived notion of how such a person behaves. Through reflection on this lighthearted example, I realised I would have to examine other assumptions and stereotypes I harboured about those with whom I interacted, a realisation evocative of Mezirow's (1997) assertion that "educators must help learners become aware and critical of their own and others' assumptions" (p.10) for transformative learning to take place.

Transformative learning theory has been critiqued for its emphasis on the rational, cognitive, and explicit. Taylor (2001) maintains that "transformative learning is a process that can operate on an implicit level, less dependent on the conscious act of reasoning and rationality" (p.221). Likewise, Dirkx (2001) contends that meaning-making is an extrarational process "rather than merely reflective and rational" (p.64). Taylor (2001) and Dirkx (2008; 2001) argue that Mezirow's focus on rationality minimises the role of feelings, emotions, and imagination in learning. Taylor and Cranton (2013) critique the absence of empathy in transformative learning theory, which, they contend, enables learners to develop a shared understanding and to identify with others' perspectives. In the same article, Taylor and Cranton (2013) highlight that another common critique of transformative learning theory – namely, that it fails to consider social context - is invalid and easily refuted by reading Mezirow's work.

Critics take issue with the assumption that transformative learning always results in positive outcomes (Taylor & Cranton, 2013; Morrice, 2012). Citing the example of asylum seekers and refugees in the United Kingdom, Morrice (2012) asserts, "There is a deeper underbelly of learning that is not captured by transformative learning" (p.267) and calls upon educational theorists to consider "the potential disbenefits and negative outcomes of learning on identity

and conceptions of self" (p.267). Newman (2012) questions the theory's legitimacy, arguing that examples of transformative learning cited in the literature, including Mezirow's writing, simply illustrate sound educational practice. Despite this criticism, I appreciate the emphasis on critical reflection, challenging assumptions, and dialogue to shift perspectives.

Building on Mezirow's (2000) contention that "The justification for much of what we know and believe, our values and our feelings, depends on the context - biographical, historical, cultural - in which they are embedded" (p.3), Taylor and Cranton (2013) maintain that transformative experiences may only be understood in the contexts in which they took place, and were later recalled. This research topic requires consideration of the complex history and sociocultural context of South Africa. Although Mezirow stresses the importance of context in general, transformative learning theory does not consider specific social constructs, nor does it explicitly interrogate power differentials. In contrast, engaged pedagogy foregrounds these elements, which enables learners to scrutinise problematic assumptions regarding race, class, and gender. It also addresses power dynamics in social and educational settings, a component I wish to explore through this research project. Engaged pedagogy builds upon transformative learning theory to incorporate key sociocultural elements not previously afforded due attention (Ellsworth, 1989). It is, therefore, essential to include it in the theoretical framework.

Engaged Pedagogy

Informed by sociocultural factors, including status, power, and race, worthiness appraisals are inherently political. Educator and theorist bell hooks (1994) maintains that "our ways of knowing are forged in history and relations of power…the education most of us had received and were giving was not and is never politically neutral" (p.39). Though often used synonymously, status and power are distinct. Whereas status relates to prestige and respect, power refers to control over resources and outcomes (van der Toorn et al., 2015; Fiske, 1993). For instance, although nurses within the health system may be afforded a relatively high status, signified by the epaulettes on their uniforms, many lack power because they do not control resources.

Building on Freire's work, hooks champions a democratic approach to education, which she terms engaged pedagogy. hooks considers the classroom a dynamic rather than static environment and acknowledges the contribution of each learner: "Engaged pedagogy assumes that every student has a valuable contribution to make to the learning process," which is "especially important for students who otherwise may not have felt that they were 'worthy,'

that they had anything of value to contribute" (hooks, 2010, p.21). For hooks (1994), the term 'engaged' serves as a reminder that the classroom is ever-changing and that learning should always be exciting. In recognition that most students are taught via traditional didactic methods through which the instructor's voice is elevated above all others, hooks (2003) asserts, "any radical pedagogy must insist that everyone's presence is acknowledged. That insistence cannot be simply stated. It has to be demonstrated through pedagogical practices" (p.17). hooks likens agency, the ability to take action or choose which actions to take (Cambridge Dictionary, n.d.), to "our capacity to be active participants in the pedagogical process" (hooks, 1994, p. 183).

In contrast to the conventional banking approach, whereby learners are instructed to commit content to memory, students in the democratic classroom learn to develop critical thinking skills (hooks, 2010;2003). hooks (2003) contends that engaged pedagogy enhances the capacity of learners to be aware, to reflect, and to "act in ways that further self-actualisation, rather than conformity to the status quo" (p.72). Engaged pedagogy addresses critiques raised by educators who maintain that critical pedagogy fails to adequately address race, gender, class, and classroom power dynamics and that "educational researchers who invoke concepts of critical pedagogy consistently strip discussions of classroom practices of historical context and political position" (Ellsworth, 1989, p.300). In short, engaged pedagogy promotes "education as the practice of freedom, rather than education that merely strives to reinforce domination" (hooks, 1994, p.4).

hooks (2010;2003;1994) identifies conversation as the defining feature of democratic education and asserts that listening intently "strengthens our capacity to learn together" (hooks, 1994, p.186). Whereas in traditional learning environments, the voices of some students are privileged over others because of their race, sex, or class (hooks, 1994), an essential component of engaged pedagogy is that each learner's voice must be acknowledged, valued, and heard (hooks, 2010). hooks (1989) describes speaking as "both a way to engage in active self-transformation and a rite of passage where one moves from being object to being subject" (p.12). "[M]oving from silence into speech" (hooks, 1989, p.9) is particularly meaningful for learners who occupy lower positions along a social hierarchy. In later work, hooks (2010) affirms this assertion, stating: "Genuine conversation is about the sharing of power and knowledge; it is fundamentally a cooperative enterprise" (p.45).

hooks (2010) attests that "engaged pedagogy makes us better learners because it asks us to embrace and explore the practice of knowing together" (p.22). She contends that building a learning community is essential "to create a climate of openness and intellectual rigour" (hooks, 1994, p.40), one that "allows for discomfort and discord" (Franklin, 2009, p.201). Per engaged pedagogy, community is cultivated by considering the learning environment as a

communal space, valuing each learner's voice, and acknowledging experience and stories as "relevant ways of knowing, as important, vital dimensions of any learning process" (hooks, 1994, p.89). In the engaged classroom, learners share personal stories "in ways that are significant, in ways that build and sustain communities across differences" (Generett, 2009, p.92). Fostering a learning community also has the potential to satisfy the relational need for belonging, a psychological need placated by system justification (Jost et al., 2012).

hooks' writing spans a range of related topics, including critical pedagogy, feminism, race, and class. In much of her work, theory is interwoven with personal narrative, a practice for which she has been praised and critiqued. Generett (2009) describes early encounters with engaged pedagogy in which "Her story made the theory come to life" (p.97). Likewise, Franklin (2009) asserts that hooks' approach provides "an account of pedagogy that is at once personal as well as situated in relation to a larger institutional history and a broader set of societal conditions" (p.210). In my reading of hooks, I find that incorporating personal experience makes the theory accessible and highlights potential ways it may be applied in other educational settings. The use of narrative also helps me decipher some of the more radical terminology hooks uses to describe her theoretical perspective.

hooks' work has been critiqued as self-indulgent and narcissistic (Franklin, 2009; Wallace, 2004), especially writing produced later in her career. Franklin (2009) argues that hooks fails to account for her position as a public figure during this period: "Whereas in her earlier work, relying on the categories of race, class, and gender to analyse her social location seems sufficient, they become less adequate as her privilege grows and as she and her work achieve an increasingly established place in the academy" (p.202). In addition, Jaramillo and McLaren (2009) contend that hooks' theory does not adequately address the objective nature of class, while at the same time describing her work as "a powerful expression of revolutionary critical pedagogy" (p.31).

I concur with critics who argue that hooks' writing is, at times, self-aggrandising, a feature particularly evident in work produced later in her career. I find it problematic that while hooks stresses that critical pedagogy must be put into practice, she provides few concrete suggestions on how to do so, save for a journal writing exercise (hooks, 1994). This type of guidance is essential for educators to foster dynamic learning environments, especially those in which students accustomed to passive lessons may be reluctant to engage. Moreover, although hooks' framing of conversation as the great equaliser may hold on American college campuses, it is unlikely to succeed to the same degree within hierarchical institutions in the Global South. Despite these limitations, I find value in hooks' narrative style, which integrates theory and personal experience, and her endorsement of storytelling as an educational tool. Sociocultural

factors that affect the learning environment and the centrality of the learner's voice are of particular relevance to this study, which is why engaged pedagogy has been incorporated into the theoretical framework.

Critical Pedagogy to Challenge the Status Quo

Traditional in-service learning in South Africa exemplifies Freire's banking concept of education (2005;1970), whereby students are passive recipients of knowledge 'deposited' by sagacious teachers, a hierarchical and authoritarian approach (hooks,1994) that privileges the instructor's voice. The didactic 'stigma is bad, don't stigmatise' method to address problematic clinician attitudes and behaviours does not work, so why do we keep doing it? Reliance on conventional sensitisation training in the absence of evidence that it improves outcomes is a type of educational system justification: doing things the way they have always been done, not because it is effective, but because that is how it has always been done. There must be a better way.

Writing of her experience implementing a theatre-based capacity development initiative in rural Kwa-Zulu Natal province on behalf of the government, Doësebs (1998) acknowledges the "ghost of apartheid" (p.179) and concludes, "people needed more time to share and reflect upon their own experiences, for true education and understanding to occur. I learned that events and past experiences were the best teaching aids, going far beyond a well-prepared document for training" (p.178). This realisation affirms Mezirow's (2000) assertion that critical reflection over time is essential to attain perspective shifts and hooks' (2010) promotion of experiences and stories as "a way of knowing" that "helps us to connect to a world beyond the self" (p.53). It also supports Petty et al.'s (1995) argument that attitude change arising from personal experience is more durable than that which emerges "as a result of passive information exposure" (p.110).

Mezirow's (2000) endorsement of critical reflection on assumptions to address inequality aligns with hooks' (2003;1994) promotion of education as the practice of freedom. Likewise, Jost and Banaji (1994) maintain that explicit focus on challenges that emanate from the unequal status quo may help mitigate the adverse effects of system justification. Whereas "education as we conventionally know it plays a crucial role as the location where students learn to embrace the values that go with the status quo" (hooks, 2003, p.166), engaged pedagogy encourages teachers and learners alike to share experiences, consider how context affects learning and behaviour, and acknowledge the hierarchies that preclude individuals from having a voice, both in and out of the classroom. Critical reflection through dialogue thus provides a way to challenge assumptions and beliefs that underpin the motive to justify the unequal status quo in South Africa.

3. Methodology

Introduction

This study utilised a novel approach to address a gap in knowledge regarding perceptions of patient worthiness, examine the factors that underlie such perceptions and explore learning strategies to minimise the practice of triaging socially marginalised patients. Findings may ultimately inform in-service learning for clinicians in South Africa and other countries in the Global South. Due to the large number of marginalised populations, selecting one group as an exemplar to explore perceptions of socially marginalised patients was necessary. I chose cross-border migrants because they are at high risk of being deemed unworthy of care as a result of compounded vulnerabilities (for instance, a refugee may also be a sex worker or unhoused) and opacity regarding their legal right to access public services. The sections below describe the research methodology as initially designed. Variations that ensued are discussed in further detail in the Findings chapter.

Research Design

While conceiving this study, I considered several design options. Given the intricacies of the topic, I determined that a positivist approach would not be appropriate. My first inclination was to utilise standard qualitative methods, namely key informant interviews and focus group discussions. Prior professional experience in public health exposed me to these methods, which aligned with my original conception of what qualitative research entails. Upon reflection, I concluded that a topic as complex as this would require time to explore, and I decided to take an alternate approach. Serving as the sole researcher would limit my ability to examine the concept of worthiness within the South African context in sufficient detail. I sought a creative and collaborative research design that would allow for in-depth investigation of the topic while embracing its social justice mandate.

This study ultimately employed a critical participatory action research (CPAR) methodology to further understanding of perceptions of worthiness within the local context. Action research seeks to elicit perspectives and develop approaches to address problems and improve practice (Beaulieu, 2013; McNiff, 2013). Participatory action research promotes the development of strategies to change the status quo in collaboration with engaged stakeholders (Beaulieu, 2013). It is characterised by shared ownership, orientation towards analysis of social problems, and transformative action towards solving those problems (Tracy, 2019). Critical participatory action research is a form of action research that allows groups to engage in analysis and self-reflection with the specific aim of addressing injustice and enacting social change (Kemmis et al., 2013).

I decided that CPAR would be appropriate for this research project, as it is an ongoing process of action and reflection (McNiff, 2013) in which each step informs the next phase (Beaulieu, 2013). CPAR "offers an opportunity to create forums in which people can join one another as co-participants in the struggle to remake the practices in which they interact" (Kemmis et al., 2013, p.20). The CPAR methodology would allow time and space to reflect on this complicated topic, resulting in more nuanced and meaningful data than may have been collected through traditional means. Given the questions under consideration, selecting a methodology that enabled participants to engage with one another over time rather than take part in a single key informant interview or focus group discussion made sense.

"The critical paradigm assumes subjective knowledge, but it takes this one step further to assume that participants are co-researchers. That is, they not only construct knowledge but they engage in the understanding of others' knowledge construction" (Taylor & Cranton, 2013, p.42). The collaborative CPAR learning process calls for meaningful participation over time from an intimate group of co-researchers invested in the topic. CPAR is a method through which stakeholders come together to address a social problem; it is not intended to result in generalisable and objective findings, nor does it require a large sample size. The more I learned about CPAR, the more I became convinced it was an appropriate way to explore perceptions of worthiness. Though a departure from the methods I was familiar with through my public health and nursing practice, I was excited to take a different approach in collaboration with others and see where it might lead.

Characteristics of Study Population

It was imperative to find participants who were willing and able to engage for a prolonged period. I believed the careful selection of participants interested in exploring this topic over time would minimise the risk of withdrawal, so I opted to apply purposive sampling. To gain a deeper understanding of the factors that inform nurse perceptions of worthiness and identify learning strategies to shift attitudes and behaviour towards socially marginalised patients, it was essential to recruit nurses. The original intention was to include six to ten professional and enrolled nurses working in public PHC facilities in the City of Cape Town and six to ten nurses working in public PHC facilities in the City of Tshwane, all within catchment areas known to include cross-border migrants and other socially marginalised populations. Nurses employed within other levels of the health system, such as hospitals, were excluded, as this study focuses on PHC facility nurse perceptions. Nurses who work in for-profit clinics were also excluded from this study, as they fall outside the mandate of the Human Resources Directorate of the NDoH.

In addition to nurses, I sought to recruit three to five representatives from non-governmental organisations (NGOs) that advocate for the rights of refugees and asylum-seekers in South Africa. Activists' participation was intended to provide an opportunity for clinicians to explore the concept of patient worthiness alongside representatives of a socially marginalised group and to consider joint solutions to address the inequality that ensues when some patients are privileged over others. Study participation would provide an opportunity for nurses and activists to share their perspectives, which might then influence future learning interventions to address patient mistreatment. I felt that the inclusion of people who have chosen to become activists would also minimise the potential for psychosocial harm, given the possibility of difficult conversations.

Recruitment and Enrolment

Though I anticipated challenges in the recruitment of PHC facility nurses due to administrative hurdles and scheduling, I expected recruitment of activists to be easier; surely, representatives from NGOs would be eager to share their perspectives on this topic, given its relevance to the people they serve. This was not the case, as will be described in the next chapter. I communicated with select NGOs to identify potential participants, including a medical humanitarian organisation and a local non-profit that supports refugees and migrants. Given their involvement in refugee and migrant health advocacy, I believed these organisations were uniquely placed to identify activists and nurses interested in the topic and willing to participate. At the time of recruitment, the humanitarian NGO was implementing an initiative with migrants in the City of Tshwane and expressed interest in collaboration, which is why the enrolment of Tshwane nurses was initially considered.

To encourage a range of perspectives, I sought participation from nurses who have reservations about cross-border migrants and other socially marginalised patients, recognising that such participants might be challenging to identify and retain. I also anticipated that willing and 'sensitised' nurses might harbour implicit biases. To recruit nurses working in PHC facilities, I was required to obtain approval from the City of Cape Town City Health Department. Upon completing the application process, I was granted permission to contact the Area North, South, and Central managers overseeing sixteen of the city's PHC facilities. After communicating with the three area managers, I was allowed to contact operational managers at each facility to inquire whether nurses might be interested in participating in this research project. Few of the operational managers responded to my initial inquiries. I followed up with additional emails, phone calls, and WhatsApp messages. A handful of operational managers eventually agreed to share information about the study with facility staff. Some then provided the names of nurses who expressed interest.

Data Collection Methods

In recognition that perspective shifts occur over time and that efforts to change attitudes and behaviour through once-off didactic workshops are not supported by the literature, this study was designed to include multiple interactions over one year. Since the study began during the second year of the COVID-19 pandemic, it was essential to utilise feasible, practical and safe data collection methods. I therefore proposed a hybrid approach incorporating both remote and physically distanced face-to-face interactions. Emphasis was placed on methods that promote critical reflection and exploration of potential disorienting dilemmas, including forum theatre, a technique I first encountered while supporting undocumented workers in high-risk jobs.

Instructional modalities that draw upon applied drama and, more recently, applied improvisation (Gao et al., 2018) provide learners with fun and engaging opportunities to experiment with different roles in a safe environment (Arveklev et al., 2015) and to consider others' perspectives. Theatre-based activities also enable learners to explore how status is embodied and power is negotiated in everyday interactions (Taylor & Taylor, 2017). Far from being prescriptive, forum theatre activities encourage participants to try out ideas, consider possible scenarios, and then enact them (Boal, 2008/1974). Forum theatre is not to be confused with role-play, as learners are invited to draw from their own experiences rather than step into a predefined scene (Middlewick et al., 2012).

Augusto Boal, who devised forum theatre, states, "It is not the place of the theatre to show the correct path, but only to offer the means by which all possible paths may be examined" (Boal, 2008/1974, p.119). Central to Boal's work is his contention that anyone may enjoy acting, regardless of artistic talent. Unlike dramatic activities that rely upon a script, forum theatre invites learners to make decisions and then consider the outcomes or consequences of their actions, an essential part of the critical reflective process (Mezirow, 1990). Forum theatre also provides opportunities for conversation and reflection during debrief sessions that follow the enactment of each scenario. In health sciences education, forum theatre techniques are used to dramatise clinical practice scenarios that end poorly for the service user (Middlewick et al., 2012).

Initial Session

To commence the project, activists and nurses were invited to join an initial session, during which our dialogue about perceptions of patient worthiness began. The session also included a forum theatre activity that followed the process outlined by Boal (2008/1974): 1) Participants were asked to tell a story about a problem encountered by a socially marginalised patient that was difficult to solve. 2) The actors (other participants) performed a brief scenario portraying

the problem and the unsatisfactory outcome. 3) Following the scenario, participants were asked whether they agreed with the enacted solution. 4) The same scenario was repeated, with other participants changing the dramatic action to devise a different solution. 5) Once all proposed solutions had been dramatised, participants discussed whether the solutions were acceptable to the group. I then led a debrief, during which I asked participants to make sense of what we had just seen and heard and to reflect upon the solutions that had been proposed.

Critical Reflection

At the end of the initial session, participants were invited to collaborate with me by engaging in critical reflection and further conversation about ways to shift nurse perceptions of patient worthiness. Since critical reflection requires a hiatus during which learners may reassess their perspectives (Mezirow, 1990), participants were invited to propose ways to reflect with fellow group members throughout the study period, for example, via a messaging application or video conferencing. In accordance with CPAR principles, participants determined the parameters of the next phase of the research process, which also promoted ownership and investment in the project.

Follow-Up Sessions

Follow-up sessions enabled participants to build rapport, consider each other's assumptions, perspectives and challenges, and maintain engagement over time. They also provided an opportunity for participants to interpret and reflect upon interim findings, which I shared orally, graphically, and in writing. As indicated in the research proposal, the initial plan was for the CPAR group to meet in person at the beginning of the year-long study period and then again at the end, with intermittent remote sessions in between (see **Figure 3** below for the proposed process).

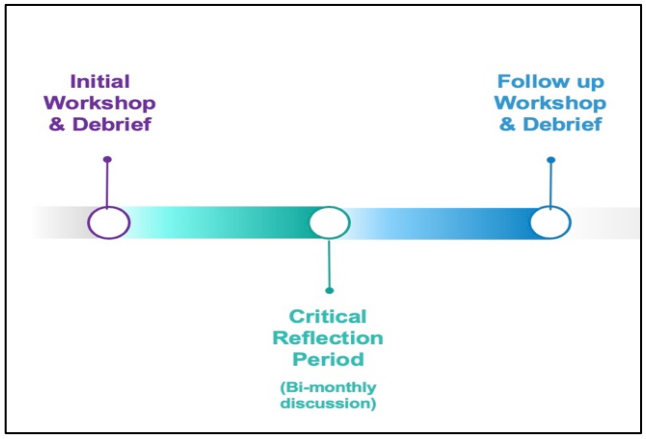

Figure 3: Proposed Process

Data Analysis

Data included transcripts from all CPAR group sessions, scenarios developed during forum theatre activities, and a transcript of all conversations conducted via WhatsApp, the selected online communication platform. Audio recording and transcription of all sessions, acknowledgement of the subjective role of the researchers, and participant feedback on findings helped validate data and enhance trustworthiness, credibility and transferability (Lincoln & Guba, 1985). Prolonged engagement with participants also helped promote study credibility (Lincoln & Guba, 1985). Given that critical self-reflection is recognised as a way to enhance the trustworthiness of qualitative research (Lincoln & Guba, 1985) and in recognition of my role as a CPAR group participant, I noted my critical reflections in writing throughout the process. I also held regular discussions with my supervisors, and what McNiff (2013) calls critical friends, to enhance study quality and trustworthiness and identify potential researcher bias.

Data were analysed using the constant comparative method of grounded theory, an inductive process of joint coding and analysis (Glaser & Strauss, 1967) to explore a novel phenomenon (Chun et al., 2019). Transcripts were analysed for content and themes using NVivo qualitative analysis software, with an emphasis on assumptions, motivations, and beliefs. Scripts developed during the forum theatre activities were shared with fellow participants to confirm their accuracy and provide an opportunity for feedback. Once I had conducted initial data analysis, I provided written and verbal summaries to participants and elicited their feedback via member checking to enhance data trustworthiness and dependability.

Positionality

Throughout the two and a half years I volunteered in Honduras, I designed, developed, and implemented health education sessions for teachers, students, lay midwives, nurses and community health workers. At the time, I believed I was doing something meaningful, at least at first. By the end of my service, my idealism had faded. I questioned whether my efforts to teach people how to improve their health made much difference amidst abject poverty. The village where I lived had no electricity, telephones, or paved roads. A community of subsistence farmers, families ate what they grew and little else. I departed Honduras wondering if the nutrition, hygiene, and reproductive anatomy sessions I facilitated had any impact, given my inability to address the root causes of health disparities. Today, more than two decades since I left the country, I continue to reflect on these questions.

I have had the opportunity to live and work in various contexts in the Global South, a privilege that has informed how I perceive my surroundings, conduct research, and interact with people whose backgrounds differ from mine. Cross-cultural experiences within the health

sector have enabled me to see firsthand how social determinants affect health outcomes and how standards of care considered untenable in the Global North are often accepted as the norm in other parts of the world. I have learned that perceptions of patient worthiness develop both within and beyond the PHC facility. Long-held beliefs regarding the socially marginalised influence clinicians' perceptions, attitudes and behaviour; they are not surmountable through the traditional, didactic 'don't stigmatise' approach employed by public health educators and donor-funded partners.

My experience in Honduras undoubtedly informed subsequent professional and educational pursuits, including the decision to become a public health specialist and then a nurse, and to undertake this research project. Though I enjoyed the practical component of my pre-service nurse education, I found the classroom disappointing, largely because instructors relied upon standard didactic methods. I was disheartened by course content that was insulting in its simplicity: my paediatric nursing course commenced with a slide depicting stuffed animals and a caption that read: "Families come in all shapes and sizes".

I have been involved in health workforce capacity strengthening activities for the past two decades, both in my native United States and in LMICs, including Honduras, India, Zambia, and the Pacific. Prior to enrolling in nursing school, I obtained a graduate certificate in instructional systems development, an experience that expanded my conception of what adult education could entail. It led me to realise that while training is often put forth as the solution to performance problems, it is rarely sufficient to address systemic challenges.

I relocated to South Africa in 2016 to design, develop, and implement in-service capacity strengthening initiatives for nurses and community health workers on behalf of the NDoH. It soon became apparent that despite numerous sensitisations regarding human rights and the impact of stigma on health outcomes, unequal treatment of socially marginalised patients persists. I have determined this is due in part to xenophobia within the public health system. For example, I once shared an eLearning module I developed to increase health workers' knowledge about HIV treatment with a senior NDoH staff member. The individual instructed me to remove an embedded video depicting a Malawian patient and replace it with a South African one before disseminating it to clinicians.

I spent three months volunteering with refugees and asylum-seekers on Lesvos, Greece, in the first quarter of the study period. During this time, I heard stories about the unequal treatment of socially marginalised people seeking health services. This allowed me to consider how perceptions of worthiness manifest outside Africa. It also provided insight into factors that cause people to flee their countries of origin to seek safety and a better life elsewhere. My

experience on Lesvos highlighted just how inhumanely people deemed unworthy may be treated, as when the Greek coast guard pushed boats full of newly arrived refugees and asylum-seekers back into the sea. During my time on Lesvos, I also witnessed moments of profound humanity and acts of solidarity with refugees and asylum-seekers, a reminder that determinations of worthiness are indeed mutable.

Stigmatisation, blame-shifting, and a hostile political climate exacerbate health inequities that socially marginalised people face in South Africa. I wish to identify novel learning strategies that stimulate perspective shifts rather than stand-alone training that does nothing to improve health outcomes. I acknowledge that my experience in health workforce education, nursing, curriculum development, and global health has influenced data collection and my interpretation of findings, as has my interest in playwriting. Considering the aim of this study and my concomitant position as CPAR group facilitator and member, my subjectivity as a researcher is a given and has been routinely interrogated through self-reflection and regular communication with my supervisors to flag assumptions and potential biases.

4. Findings

Introduction

In critical participatory action research, a dedicated group of people committed to addressing inequality undertake a collaborative reflective learning process. The formation, composition and dynamics of the CPAR group and the evolution of our conversations over time are, therefore, integral components of this research project. The selection of the CPAR methodology has resulted in two types of findings: themes that have emerged from the data and findings regarding the process itself. This chapter begins with an explanation of steps taken to recruit participants and an overview of CPAR group composition, followed by a description of the dialogical process and a detailed exploration of themes that surfaced.

Recruitment

Nurses

Nurse recruitment proved to be a more significant challenge than anticipated. One operational manager suggested that nurses did not express interest because her facility had been inundated with research requests. A manager from another clinic shared the contact details of five nurses who had indicated interest in the study; in the end, only one attended the initial session. This led me to believe that nurses were reluctant to dedicate time outside of regular working hours, as they would have had no reason to express interest had they been unconcerned about the topic. I ultimately obtained the names of eight potential nurse participants, extended an invitation to each one to attend the initial session and requested their preferred date, time, and location. Two days before the session, I sent a reminder and promptly received four apologies. A fifth apology was sent a few hours before we were scheduled to meet. Most nurses cited the date, time, or location as the reason for cancellation. At this point, I became concerned that no nurses would participate in the study, rendering the entire project moot.

It is possible that had I stuck with the original methodological approach, I would have been able to recruit more nurses. Participation in a single key informant interview or focus group discussion would have required less time and effort than engagement as a CPAR group member (the same may be said of stand-alone training compared to learning processes implemented over time). In the end, two nurses joined the session: a professional nurse working at a PHC facility in the Southern Suburbs and an enrolled nurse employed at another PHC facility in the Southern Suburbs. While the professional nurse remained active throughout the study period, the enrolled nurse stopped participating after the initial session despite multiple follow-up attempts. A professional nurse recruited by an activist participant joined the CPAR group during

our fourth session. Another professional nurse joined the group during our fifth session after being recruited by the nurse who had joined the session prior. Given the rocky start to nurse recruitment, I was thrilled to have two additional participants join the group and even more pleased that they had been identified by fellow members.

Activists

Activists were initially recruited from Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) in the Western Cape that support refugees and other socially marginalised people. The initial response from organisations with which I had an existing relationship, including one where I had volunteered, was lower than expected. This was surprising, given how closely this study aligns with their mission and values and because I had followed their research request processes. At the time, I thought, if representatives from this organisation did not wish to participate, what hope did I have of recruiting other activists? A promising lead at a non-profit humanitarian organisation also failed to come to fruition due in part to complications resulting from a robbery at their office. This was a disappointment, as it was preceded by a conversation during which staff had expressed interest in participating. Another non-profit organisation that promotes refugee health and rights agreed to send two representatives to the initial session, one of whom remained active throughout the study period. A contact from the Patient Partners initiative, conceived by my supervisor, led to the recruitment of three additional activists, all foreign nationals living in Cape Town.

The unanticipated challenge of recruiting activists made me wonder why they may have been reluctant to participate. I had assumed (perhaps incorrectly) that individuals affiliated with these organisations would be keen to share their perspectives and willing to take part in after-hours activities. It is possible that non-participation was the result of decisions taken at leadership and managerial levels and did not indicate a lack of interest. Recruitment challenges led me to appreciate the nurses and activists who ultimately agreed to participate, especially their willingness to commit to a lengthy and potentially uncomfortable process facilitated by a stranger.

Participant Profiles

Seven participants ultimately served as members of the CPAR group: three nurses and four activists, one of whom is also a nurse, although not currently practising in South Africa. My participation brought the total number to eight. Written informed consent was obtained from all participants before the commencement of the study, including consent for audio recording of all in-person and online sessions. A brief profile of each pseudonymous member may be found below:

- **Zimkhitha:** A professional nurse from South Africa undertaking a postgraduate public health diploma. At the beginning of the study period, Zimkhitha served at a PHC facility and then transitioned to a position as a subdistrict TB Coordinator. Zimkhitha is direct: She speaks her mind and shares her opinions freely. Zimkhitha joined the initial session and remained active throughout the study.

- **Zongwe**: An activist, asylum-seeker and member of a local community-based organisation that supports refugees and asylum seekers. Zongwe worked as a nurse in his home country of the Democratic Republic of Congo (DRC) and Zambia before relocating to South Africa. Thoughtful and articulate, Zongwe has an ability to view challenging situations from the perspective of others. Zongwe has been a member of the CPAR group since its inception.

- **Joseph**: A project manager and member of the leadership team of the organisation referenced above, Joseph is a DRC national who has resided in South Africa for many years. By his own account, Joseph is results-oriented and expresses a desire to enact change. Joseph joined the group alongside Zongwe and has remained active ever since.

- **Tamai**: An activist, graduate student, asylum-seeker, and journalist from Zimbabwe, Tamai is also an educationalist interested in critical pedagogy. Tamai often refers to fellow group members as comrades, sisters, and brothers. Tamai has been a member of the CPAR group since the initial session.

- **Fabrice:** A mild-mannered volunteer with an NGO promoting refugee health and rights. Fabrice is from the DRC and speaks with a French accent. He reiterates key words and phrases to stress information he believes to be important. Fabrice joined the initial session and has remained an active member.

- **Ndiliswa**: A professional nurse with over 35 years of experience in public and private health care across South Africa and the Middle East, Ndiliswa's cross-cultural experiences inform her perspective. Joseph invited Ndiliswa to join the group. She entered at the mid-point of the study period.

- **Lulama**: A soft-spoken yet proud professional nurse from South Africa, Lulama has worked with key populations, including sex workers and transgender people, at an NGO-run clinic in Cape Town and with inmates in correctional facilities. Ndiliswa informed Lulama about the group. Though her participation commenced later in the study period, Lulama remained an active and vocal group member.

Process

Group Sessions

We found the doors locked upon arriving at the venue where the initial session was to be held. As I walked around the building searching for someone to open the door, I worried that after finally overcoming recruitment challenges, those who had shown up would leave. To my surprise, participants, most of whom did not know one another, waited an hour in the car park while I secured a new venue, an occurrence that I continue to reflect upon. When we finally commenced the session, each participant took the opportunity to speak and share their experiences; they even stayed late to make up for the delayed start. The initial session included a forum theatre activity, during which participants created scenarios related to the topic and then enacted them (see **Appendix** for a summary of scenarios developed during the initial session and a follow-up session).

Despite concerns that the inauspicious start would reflect poorly on my coordination skills and deter people from joining subsequent sessions, nearly all of the participants who enrolled at the beginning remained engaged throughout the year-long study, thus demonstrating their commitment to the process. Some even invited other people to join. It was heartening to see how group motivation was sustained despite recruitment challenges and barriers to participation, including one evening session that coincided with both scheduled power cuts known as load shedding - leaving us in the dark for part of the session - and a taxi strike, which limited transport options to and from the venue. Although the original plan was to conduct two face-to-face sessions, one at the beginning of the process and another at the end, participants requested additional meetings. The group also decided to conduct remote sessions via a teleconferencing platform to share critical reflections and interim findings, and to establish a WhatsApp group to promote interaction between sessions. Ultimately, six CPAR group sessions were conducted at the following points in time: March 2022, June 2022 (remote), August 2022 (remote), September 2022, November 2022, and February 2023, as indicated in **Figure 4** below.

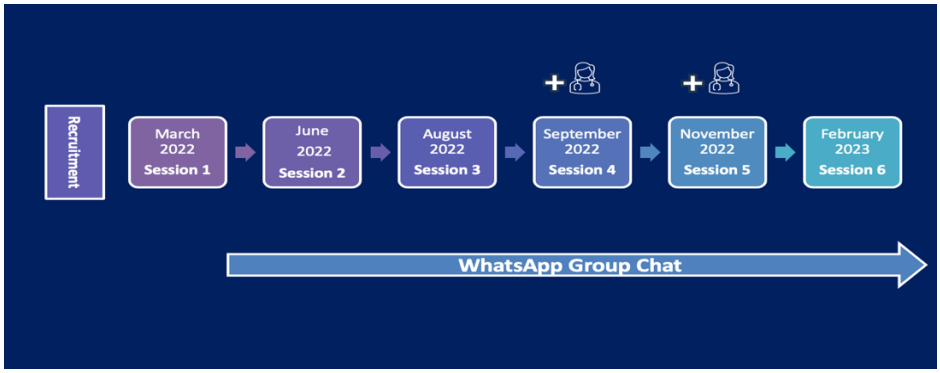

Figure 4: CPAR Group Process

Patient Worthiness WhatsApp Group

The WhatsApp group created immediately after our initial session remained active throughout the study. The platform served as a means for group members to maintain contact, discuss session logistics, share personal updates, and summarise key points after each conversation. It also enabled participants (myself included) to share resources and media relevant to the topic, including audio clips, videos, and news articles, as well as images of pro-refugee graffiti I encountered while volunteering in Greece. Some of these materials provided the impetus for conversation in later sessions.

In addition to serving as prompts, media shared via the WhatsApp group offered insight into content circulating on social media throughout the study period (regardless of its veracity or origin). Media also highlighted messages that contradict those imparted during government-endorsed sensitisations about respectful patient treatment and human rights. The WhatsApp group became particularly active around the midpoint of the study, which coincided with the widespread circulation of the video of the Limpopo MEC berating a Zimbabwean patient and recordings of a nationalist vigilante group diverting foreign patients away from PHC facilities (group members shared video clips of both incidents in the group chat).

During this time, a nurse expressed concern that our WhatsApp group chat and related conversations focused on only one socially marginalised population, though the topic at hand affected a range of others, which indicated that she felt comfortable sharing misgivings about the process with me. I emphasised that I did not intend to prioritise one socially marginalised population over others and reiterated the rationale for focusing on one specific group. Internally, I worried that this participant might withdraw from the study (she did not) and was relieved that it did not deter her from engaging in subsequent sessions. Though hesitant to raise the matter with the rest of the group, she contributed to future conversations during which we considered other socially marginalised people. At the time, I wondered whether her reluctance arose from a fear of upsetting other members or was perhaps reflective of a cultural norm favouring indirect communication. I also found it noteworthy that she chose not to share content about other marginalised populations in our WhatsApp group chat.

Overall, activists were more engaged on the platform than nurses. However, nurses responded to audiovisual content and questions posed by other group members (although some questions remained unanswered, perhaps due to concurrent participation in other group chats). Barriers to participation in the WhatsApp group chat included load shedding, which precluded some members from accessing the internet, and the theft of one participant's mobile phone during a mugging, both of which highlight challenges that must be considered when incorporating technology into learning activities in the South African context.

Themes

Given the emphasis on one socially marginalised population and the composition of the CPAR group, findings regarding cross-border migrants arose during most of our interactions, including forum theatre activities and WhatsApp communication**.** The persistence of hierarchies within and beyond the health facility emerged as a major theme, which was unsurprising considering the historical context and stratification characterising the South African health system. Formal and tacit learning that occurs at institutional and community levels also emerged as a common theme, as did channels through which counter-narratives are conveyed. As anticipated, barriers to providing quality primary health care services were another frequent topic of conversation, namely systemic challenges emanating from the rigid hierarchy within the PHC facility. The inherent humanity of patients and nurses who must navigate this complex sociocultural context also emerged as a major theme. Findings regarding hierarchies, learning, health system challenges, and humanness have been categorised into four interrelated themes: A) *We Become Tribalists*; B) *Learning from One Another*; C) *Everyone Gets Ill-Treated*; and D) *There is a Human Being There*. Findings are described in further detail in the sections that follow. In recognition of the centrality of the learner's voice in engaged pedagogy, the headings and subheadings below include verbatim quotes from participants.

A. "We Become Tribalists"

Hierarchies and the stratification of individuals based on perceived or actual social status in South Africa were featured prominently in our sessions. Participants identified criteria by which people are ranked, including country of origin, immigration status, race, class, and tribe. Conversations emphasised that social and systemic hierarchies are maintained and bolstered by stereotypes. For example, in our September session, an activist shared his observation that *"if you are a black, especially if you come from outside South Africa, you are stereotyped that you don't pay for health. Like, you don't pay for your care, like you are coming to get a free service".* Participants highlighted *"known stereotypes"* about socially marginalised people, for instance, that migrants do not work and *"immigrant[s] are drug dealers and kidnappers"* (Nurse, June 2022), a perception reiterated by the same participant later in the study:

> *You find someone's doing a very decent job, but they're like, 'don't get close. They're doing drugs'. So, there's also stigma, there's also stereotype and labelling because you're an immigrant* (Nurse, September 2022).

Perceptions of South African nurses as rude, dispassionate, and demotivated were also highlighted, especially in our final session, when a participant referred to the *"stereotype nurse"* [sic] on three separate occasions. Nurses also described instances when their peers disparaged

them for taking care of socially marginalised patients. During our November session, a nurse described her experience serving incarcerated people:

> *Now, he is a patient. He's not the offender you took from the cells, from the holding cells. He is under our care now. And that makes you as a clinician at times to be labelled, you know, with other names, that you are too much of a mother, you are too much of a sister and too much of a neighbour.*

The following sections describe findings regarding social and systemic hierarchies in further detail.

Social Hierarchies: "It's in the Roots"

The ways that hierarchies enforced under apartheid have impacted individuals and communities was a frequent topic of conversation, especially around the mid-point of the study (August-November 2022). The legacy of apartheid was particularly salient in our September session when a new nurse participant explained how apartheid policies and practices reinforced notions of hierarchy, superiority, and inferiority among and between racial and ethnic groups in South Africa:

> *[W]e were born in apartheid, we grow up in apartheid, raised in apartheid, trained in apartheid…Black patients were attended at the black communities, so xenophobia started within our country, okay? Because the whites they think they were superior than coloureds. The coloureds, they thought they were superior than blacks, and we blacks - we're Xhosas, we're Zulus, we're Xhosas. I'm a Xhosa, I thought I'm better than a Zulu…so it's in the roots. So, if it's in the roots, you're going to see it in the fruit. What is the fruit? The present generation.*

Of note, during the following session in November 2022, an activist stated that participating in the CPAR group helped him understand the South African perspective regarding perceived worthiness. Findings pertaining to stratification based on race, tribe, and country of origin are further described below.

Stratification: "A Route to Hate"

During a remote session in August 2022, a nurse raised after the fall of apartheid made a striking comment, which was echoed by other participants in later conversations:

> *As Africans, we were taught to hate each other…That is what is happening in South Africa. We're still fighting racial issues. We're still fighting inequality, and you need to be a certain type of person to be assisted*.

In the following session, the same nurse expanded on the sentiment, stating,

> *It has been a route to hate or a route to separate Africans from Africans… to the extent that we become tribalists…So now, when the immigrants came to South Africa, they came to a sort of a broken nation*.

Later, when the conversation turned to the mistreatment of cross-border migrants, the same participant explained:

> *[W]hen there's another one coming in, we already hating so much. So, we even hate more because now it's like, even from here, "I am better than Zulu, but I'm far more better than you"*.

In the same session, an activist shared his understanding of the perspective of South Africans who mistreat refugees and migrants:

> *We feel like we are not stable when a fellow African is close to me and looks like me. We are really suspicious; we don't feel comfortable. We are feeling challenged, and also, we therefore want to prove to that person that I'm far much better than you because apartheid has told us that we are not of value.*

The nurse who introduced the notion that South Africans are taught to hate revisited the topic in our November session, stating that some cross-border migrants are treated poorly because *"even with ourselves as South African, we don't really like each other that much…So now, when another black person comes from another region, it's a worse thing. It's like, 'I don't even like the Zulu. I'm a Xhosa. I don't like Sotho, so why must I like the Zimbabwean'"?* During our final session, an activist returned to the idea that South Africans were taught to hate each other and then reflected, *"there's an implication now where thirty years after the freedom, people were born outside the apartheid, they still behaving somehow very funny. And you ask yourself, this person is still twenty-five. How on earth was she behaving this way"?*

I was struck by descriptions of social stratification based on tribe shared during our sessions. I have interacted with South Africans from various backgrounds and tribes and know that many take pride in their heritage. Yet, the degree to which tribal identity influences perceptions of worthiness amongst Africans - and how it subsequently impacts cross-border migrants - came as a surprise. I found the social stratification on Lesvos, Greece, where the treatment of refugees and asylum-seekers is determined by their ethnicity and country of origin, to be equally striking. For instance, Ukrainian refugees bypassed the refugee camp entirely and were not subjected to the invasive security measures imposed on refugees of colour. On several

occasions, I entered the camp with an Afghan community volunteer who was stopped, searched, and asked to present identification, whereas I was not, a practice that perpetuates the stereotype that refugees are dangerous and untrustworthy. Likewise, I heard several health workers in the camp express sentiments indicating mistrust of refugees, such as, "She said this, but I do not believe her" in reference to the bathing, breastfeeding, and care of their children.

Interacting with socially marginalised people in a different context during a portion of the study period enabled me to consider patient worthiness from another perspective. In response to a request from CPAR group members who expressed interest in learning how refugees and asylum-seekers are treated outside of South Africa, I shared my observations and reflections. I highlighted similarities and differences between the situations in Lesvos and South Africa in our WhatsApp group chat and during two remote sessions that took place while I was overseas. Participants expressed particular interest in the images of graffiti that I shared; in response to an image of pro-refugee graffiti at the entrance of the infamous Moria refugee camp, an activist replied, "*Indeed, such a footstep to follow*". Engagement of the CPAR group during this time enabled us to reflect on the concept of worthiness from a distinct vantage point and to acknowledge that it is not unique to the South African context.

Health System Hierarchies: "We Misuse the Powers"

Our conversations affirmed that a strict and inflexible hierarchy pervades the public health system and that stratification persists within the PHC facility. Participants described a rigid arrangement in which doctors rank higher than nurses, operational managers (who are themselves nurses) rank higher than front-line nurses, clinicians and support staff rank higher than patients, and patients from the general population rank higher than those representing socially marginalised groups. In addition, health science educators occupy an elevated position relative to students. Nurse participants depicted operational managers as enforcers and disciplinarians, "*superiors*" to be feared. They emphasised the disconnect between clinicians who provide direct patient services and their supervisors, who may not know what is occurring "*on the ground*". As an activist explained during our November session:

> *There's some people that we cannot see, or the patient cannot see,*
> *who is giving instruction and pressure to these nurses.*

Exerting Authority: "Treat People Differently"

Anecdotes shared by participants affirm that some patients are considered more deserving of the clinician's time, attention, and respect than others. As a nurse explained during our initial session, *"It would seem as normal to treat people differently"*. In the same session, the activist who is also a nurse shared his perception that health workers in South Africa provide

preferential treatment to white patients because they know their rights and will shout and threaten to file a report if they do not receive proper care. In contrast, *"a black person, when he comes, maybe they assume that he doesn't know where to report, what to do. There is an attitude".* The same activist later shared his belief that white and coloured patients are served first because it is believed they can pay for services. During our initial session, he also described how he thinks race affects nurse performance:

> *It's a doctor, black, then the execution of nurses who are coloured or white is different. If it's a white doctor, then the execution of black nurses is different. So, I've seen that in different perspective. And I don't understand why a patient has to come to suffer in the middle of this whole thing.*

Activists described instances when they or their family members were mistreated and disrespected by personnel working in the public health system, especially during our initial session. Most highlighted times when staff shouted or used an aggressive tone. For example, an activist recalled his mother's stay in an inpatient ward as follows:

> *That doctor came in and she…find my mother still there. And then she screamed, "Is this woman still alive?" Some nurses were shocked to hear it from her, but nothing they could have done*.

The activist also stated that he had expected more compassionate care because the doctor was black. During the same conversation, another activist shared that sometimes clinic and hospital staff do not inform family members that their loved ones have died, "*so the dignity of the dead is not respected"*. This is perceived as a serious cultural breach, according to the activists, especially within immigrant communities. Later in the session, a nurse summarised patient care within the public health system as follows:

> *Even though most have been ill-treated, at least a few they're being treated right*.

Hierarchies also persist within the nurse-patient relationship, exemplified by instances when the nurse exerts authority to do what is 'best' for the patient rather than involving the individual in the decision-making process. During our final session, a nurse characterised this behaviour as a misuse of power and patient intimidation, which she then illustrated by sharing an example of a typical nurse-patient interaction:

> *Because I'm a nurse, so you can't tell me…This is what you are having. This is what I'm going to do. Do you want it, yes or no?*

Security guards are perceived as literal and figurative gatekeepers at the clinic. Both nurses and activists described instances in which security guards asked to see patient appointment cards or demanded that they present documents to enter the facility grounds. As a nurse explained during our September session,

> *The securities at the gate, they are triaging the patients.*

Later in the conversation, while discussing clinician behaviour, another nurse stated,

> *Yes, nurses are the front of the health system. But if you listen to almost everyone here, it start[s] at the security guard. He's the one who wants to look at the card. What he has to do with the card, by the way?*

The same nurse highlighted that clerical staff may also pose barriers to patient access; by the time the patient reaches the clinician, his or her experience has been affected by personnel encountered before the consultation.

Pecking Order: "Frustrated from Above"

Health system hierarchies were identified as an underlying cause of the anger that clinicians feel and express in the workplace. As a nurse explained during a conversation about supervisors in our September session,

> *Those people may make us angry. We can't confront them because they're superiors; we don't want to be disciplined. So, I will snap to the one that I'm seeing: the patient.*

An activist then summarised the situation, stating,

> *As they cannot express their anger to those on top, they just releasing to those who are down.*

As with anger, participants asserted that health workers take their frustrations with facility hierarchies out on patients. During our September session, an activist stated,

> *People are frustrated from above. They've got their issues from the system that is in place.*

He then shared his perception of a frustrated nurse:

> *I've got my problem, and you [are] a burden on top of what I have already. So, my plate is full. How can I help you?*

We revisited the topic during our final session, at which time another activist highlighted the link between hierarchies, nurse frustration, and patient mistreatment:

> *Ill-treatment of patients can come out of that, you see. Why? Because it's coming from above. It's not within. I wouldn't want to blame the nurse at this level. I would think that this thing is actually external, is coming from above, from policymakers.*

Turned Away: "You Might Not Be Assisted"

Communication was identified as a barrier to equitable care for patients not conversant in an official South African language. During our initial session, a nurse shared an anecdote about a fellow clinician who said of a cross-border migrant seeking care,

> *This one must wait here. I don't know what to say.*

Another nurse stated that communication with cross-border migrants was improving because patients now know to bring family members to the facility to assist with interpretation. In a later session in September, a third nurse expressed the opposite view, stating,

> *One patient won't be helped because of their language. "Come tomorrow with the interpreter." Where is that patient gonna get the interpreter? There's no interpreter.*

Several participants perceived that in the Western Cape, non-Afrikaans speakers receive inferior treatment and services. During our initial session, an activist recalled a time when a relative fell gravely ill, and family members spent six hours calling for an ambulance. Emergency assistance only arrived after the phone was passed to an Afrikaans-speaking child in the household. When another activist shared a challenge he encountered at a specific facility during a later conversation in August, a nurse replied,

> *Even if you can speak to a manager - I know people there are quite Afrikaans - you might not be assisted.*

Conversations throughout the study indicate that cross-border migrants have been turned away from health facilities due to a lack of "*papers*" despite their legal right to access PHC services in South Africa. This barrier was exacerbated during the extensive COVID-19 lockdown period when the Department of Home Affairs stopped processing visas and permits. The situation left many refugees and asylum-seekers in limbo, a scenario that participants enacted during our first forum theatre activity. Through my volunteer experience in Greece, I came to understand the degree to which the asylum-seeking process dictates daily life. Though this topic arose during our initial CPAR session, it did not fully resonate with me until I realised how challenging and time-consuming the process can be while on Lesvos.

Unwelcome: "Why Are You Here?"

Participants provided numerous examples illustrating that socially marginalised people are often unwelcome in the PHC facility and considered undeserving of primary health care services. For instance, in our September session, a nurse explained that some clinicians are averse to examining unhoused people because they are perceived as dirty and smelly. During the same session, the belief that some patients are less worthy of clinicians' time was highlighted by another nurse, who shared the following example of a typical interaction between a clinician and a cross-border migrant:

> *"Why are you here?"* she says. *"What are your nurses doing? We are treating you here".*

Assumptions and stereotypes about socially marginalised patients that bolster perceptions of unworthiness were shared throughout our conversations. In our initial session, a nurse attributed stereotypes about cross-border migrants - for instance, the assertion that *"' You're an immigrant, you're all the same. I don't care. You all from Zim,'"* - to clinicians' *"background beliefs,"* stating,

> *It's just beliefs, man, and just generally not happy that certain people they are coming to our country. "They're giving us more burden, giving us more work", and stuff like that.*

During our September session, another nurse cited generalisations that some of her fellow clinicians express towards cross-border migrants:

> *Your nurses in your countries, they're just doing nothing because all of you, you came here.*

In her own words, she then stated,

> *Now as if they are the burden to the health system. These people are sick. Nobody invite to be sick.*

These examples highlight the striking finding that clinicians' enmity and contempt are directed not only towards cross-border migrants but also towards foreign nurses who (presumably) benefit when their patients flee to South Africa. Participants also highlighted the distinction made between African and non-African clinicians. In the words of an activist who spoke about South Africa's reliance on Cuban doctors to deliver clinical services during times of crisis, including the onset of the COVID-19 pandemic,

> *South Africa, at some point, they have got a problem with neighbouring people. They prefer someone from Thailand or from China or from Cuba, rather than a Zimbabwean*.

Shifting Roles: "If We Become Patients"

In three of six CPAR group sessions, activists stressed that clinicians are also community members. They emphasised that, at times, nurses assume the role of patient and may experience a resulting change in status when they present at the health facility. In the words of the activist who is also a nurse:

> *If we become patients, how will we be treated? Would we be considered with the same values, or would we be also treated the same way we treat when we are clinicians?... Are we the people that we serve? Are we the people where we live? Because, at the clinic, you are a clinician, and you still have a community where you come from. So, you are people there. You are the people.* (November 2022)

Clinicians may be treated differently when their role shifts to that of a patient, demonstrating how deeply ingrained social and systemic hierarchies influence our assumptions, perceptions, and behaviour. This begs the question: Where, when, and how do such thoughts and beliefs develop, and what steps may be taken to minimise actions that result in unequal treatment? Conversations during which our group considered how clinicians, patients, and community members learn helped shed light on this question.

B. "Learning from One Another"

Participants considered hierarchies inherent in other institutions, specifically the education system in which clinicians and allied health workers are trained. During a conversation about pre-service nurse education in our September session, the activist who is an educationalist asserted,

> *We have to challenge our methodology of teaching, the pedagogy, and also the curriculum…We may suggest that there's need to decolonise the curriculum and also to liberate the way we teach, and they should not be confined to the old order or the colonial or apartheid system of doing things.*

He also maintained that the colonial education system is dehumanising, because *"it doesn't give people a proper picture of power. It disempowers people. It doesn't give people dignity".*

Learning arose as a topic in most sessions, during which we discussed the content and structure of pre-service and in-service nurse education, and how tacit (informal) learning takes place. My experience designing, developing, and implementing in-service training for health workers influenced our conversations. For example, I often expressed my opinion that one-time sensitisation training to address unequal patient treatment is ineffective. Our sessions affirmed that prevailing hierarchies and misperceptions about the root causes of health system challenges inform the learning process. Findings regarding formal and tacit learning are described in the section below, as are alternative learning strategies proposed by participants, including community education.

Formal Learning: "What and How Nurses Learn"

During our initial session, an activist argued that pre-service education should encourage students to consider social factors that affect marginalised patients:

> *It's good to teach a nurse how to give a medicine, but you should know also, if I receive a foreigner, why this guy is here in this country? What is his right? What I should do as a nurse for him to make him feel safe?*

Participants also highlighted gaps in health workers' technical knowledge and skills. For instance, in our final session, a nurse lamented that pre-service training has changed and asserted that some new graduate nurses are ill-prepared to enter the workforce, citing the example of labour and delivery:

It's not that they don't want to do the job; they can't do it. It's not that they're not willing because now she's there already, and she's appointed to be, because they see the bar. She got the green bar for midwifery, but she can't catch a baby.

Perceived challenges to the education system were sometimes met with defensiveness. In response to an activist who sought to learn what and how nurses learn during our September session, a nurse objected, stating,

Now we're gonna go as far as interrogate how nurses learn and everything, whereas we [are] dealing with individuals here, and let me tell you that nursing college or nursing school, in as far as formal education is concerned, has absolutely nothing to do with people's attitudes. They're not imposing.

Limitations of workshops as an educational method were highlighted by an activist who stated in our initial session,

We have had so many workshops, and these workshops have only maybe helped the individuals that went to the workshop, but it has not gone much to the community where people can use now the skills that were learned at the workshop.

He also noted that follow-up to determine what (if anything) changes post-workshop is often lacking. Six months later, in September, the same activist revisited the topic:

[W]orking through sensitisation, trying to explain to people this and that, sometimes it's not working cause it's becoming maybe the old system. Maybe we need another approach.

During the same session, the activist who encouraged clinicians to consider the needs of cross-border migrants in our initial conversation highlighted challenges associated with traditional in-service learning:

A workshop for one hour, two hours, a day…Maybe they will be tired listening and forget… And that person, tomorrow and after tomorrow, after a month, she will be facing the same situation. She will be meeting the same people where every night, when she's going back in her community, is still listening those speech who say, "Those people who are there, why do they come here in South Africa?" When they open the TV, they can see a minister talking badly about immigrant and foreigners…How the change might can come to them because what they say negatively is more than the information that they receive positively?

Despite the stated limitations of the *"old system,"* a third activist proposed workshops as a potential solution to address the unequal treatment of socially marginalised patients in nearly every session.

Tacit Learning: "Chatting in the Tea Room"

Participants stressed that much of what health workers learn occurs outside the classroom. As a nurse explained during an online session in June 2022, this type of learning *"happens informally, in terms of people teaching and learning from each other and just chatting in the tea room".* The same participant revisited the topic during our September session:

> *[T]he learning is mostly informal, where someone will share something in the tea room, and we find, actually, people share the same view and where they take the platform to actually discuss the matter.*

She then emphasised,

> *It's people experiencing their personal views that has got nothing to do with the profession and what it stands for.*

The nurse who joined our group in September described living and working outside of South Africa as a tacit learning experience, especially her interactions with people from different backgrounds:

> *I've worked with everybody. I tried to understand the cultures.*

This comment reminded me of the profound engagement I had observed a few months earlier between refugees and asylum-seekers from vastly different countries who participated in weekly health education sessions at a women's centre on Lesvos, one of the few places on the island where people from disparate cultures interacted.

During the same session, an activist shared a personal example highlighting how and when tacit learning may occur. He said of his wife,

> *She's a quiet lady. And it was difficult for me to discover when she's angry or not. And three years later, I discover something: when she's washing pot, and you can hear gah! Pah! It took me three years…So I was learning how to live with a wife in the house, only me and her.*

Tacit learning was referenced by another activist, who stated in our final session,

> *Informal learning in places like hospitals, clinics, actually can help our learners, our nurses, our future nurses or health professionals to do better, actually to have a hands-on approach with patients.*

Of note, CPAR group conversation was also identified as a type of informal learning. During our June session, an activist asserted,

> *These meetings are very important because we are learning from one another. When I hear what Zimkhitha is doing, I learn. And maybe it pushes me also to do more…that can give also another way of doing things than maybe dwelling on my way of doing*.

Alternate Approaches: "Where the Change Can Come"

During our final session, an activist suggested we teach community members about the clinician's role as well as ***"****the roles of the patient also at the clinic towards the institution itself as a clinic, as a structure, and the clinician. And the role that patient can play from the community"* and then stated, *"I think that's where the change can come from"*. The community education approach is not without its challenges. For example, during a conversation in November regarding socially marginalised people such as sex workers and members of the LGBTQ+ community, the same activist questioned what to teach children when *"this is a reality that is happening there, and he will be going at school where this [sic] realities are happening, but at home, we don't embrace it. So, it's not only to us as parents or community leader a challenge, but also to our kids a challenge. How do we cope with these realities?"*

Throughout the study, participants shared alternatives to the traditional banking approach to in-service learning. In our final session, the activist who encouraged us to move away from the "*old system*" a year prior suggested we consider ways to address patient mistreatment with *"positive engagement, not looking back to what the nurse was doing before, but now we are in the new era"*. During the same session, another activist recommended a problem-based approach *"whereby they involve learners in the community, in the hospitals where they will be working, so that there will be understanding of the issues that are taking place there than to create this distinction between the practical and the theory"*.

The alternate learning approaches proposed during our conversations were framed as a means to address persistent health system challenges. For example, in our September session, an activist suggested we target *"the most influential people of the system"* rather than focus

our efforts on front-line health workers alone. The same activist stressed the importance of educating patients about appropriate clinic behaviour, for instance,

> *It doesn't matter [if] you're very sick, you don't need to jump the queue*.

Acknowledging health system issues during conversations about learning affirms that education does not take place in a vacuum. It also verifies that in-service learning is context-dependent and unlikely to improve health outcomes if systemic issues remain unaddressed. Health system challenges identified by participants are described in further detail in the section below.

C. "Everyone Gets Ill-Treated"

Challenges within the hierarchical, under-resourced South African health system were a frequent topic of conversation. Concerns participants raised align with systemic issues identified in prior research, including understaffing, long queues, inadequate commodities, poor quality of care, and unequal treatment of socially marginalised patients. In our final session, an activist summarised the situation as follows:

> *We treat fundamental services like health…as commodities and not as rights*.

Conversations throughout the year-long study period suggest that poor treatment is often justified across systems - from Home Affairs to the health system to the traffic department - by employing an 'everybody does it' mentality. As a nurse noted on two separate occasions,

> *In South Africa, everyone at some point experiences ill treatment…I'm not justifying that. I'm just saying we are on the same when it comes to that. Everyone gets ill-treated* (August 2022) *…people are generally being treated badly in a public space, like in a public facility* (March 2022).

Patients encounter a range of service providers within the PHC system, including physicians, nurses, allied health professionals, and Community Health Workers (CHWs). Given the composition of the CPAR group and the nurse's role as the primary provider of health services within PHC facilities, our conversations focused on nurses. Clinicians' motivations, responsibilities, and workloads were discussed in detail, as were patients' perceptions of them. Findings regarding health system challenges are described in further detail below.

Nurse Motivation: "They Don't See Us as Caregivers"

Nurses' motivation to enrol in pre-service training and subsequently join the health workforce was discussed during the first and last CPAR group sessions. Participants identified stability, salary, and service as key motivators. In our final session, a nurse explained,

> *[W]e are there to serve the community. Yes, we know that [we are] about to get paid at the end of the day. That is a reward. But the main thing that's going to depend also, what was your goal when you wake up in the morning you go to work?*

During our initial session, an activist argued that underlying motives affect patient care:

> *There is a passion of so many nurses in this career, and some people they just venture into nursing for money, and it make it completely different when you in front of a patient.*

Lack of appreciation was highlighted as being particularly demotivating: *"You will never get the compliments"* from managers, stated a nurse during our September session. The same nurse emphasised the toll that front-line service delivery takes on health workers, and the mentality of nurse supervisors:

> *They see us as workers. They don't see us as caregivers because that is also a strain to the nurses as well…It costs us physically and emotionally, also. I mean, seeing all these sick people.*

Patient preferences also affect motivation. For instance, in our final session, the same nurse shared examples of stated preferences that impact the motivation of clinicians, including *"I can't be attended by this one. Where is the doctor?"* and *"I don't like that nurse. I won't be attended by this nurse".* Likewise, in our initial session, an activist stated that members of his community *"prefer to go to a white nurse, a white doctor, and perhaps a coloured doctor or a coloured nurse - or if they fail to find a foreign national nurse or foreign national doctor - than to go to a local black nurse".*

Perception of Nurses: "It's Like, We Treat People Bad"

Patient perceptions of clinicians featured heavily in our initial conversation. Findings align with the stereotypical depiction of nurses in South Africa as cruel and xenophobic. Some nurses rejected this perception as a generalisation that places all nurses under "*the same umbrella*" (Nurse, March 2022). Towards the end of the session, after several activists had shared personal stories that highlighted negative interactions with health workers, a nurse expressed

concern that clinicians were being portrayed poorly, stating, *"Now each and every one of us, it's like, we treat people bad"*. She then conveyed sadness about the way nurses were being depicted, at which point an activist replied,

> *The reaction that we brought forward could feel a little bit offending because we only showing the bad side of nurses because we're foreign nationals.* He continued, *The attitude of nurses sometimes. I know you're not all the same and a lot of goodnesses [sic]. Very few bad, that's for sure*.

During a later conversation, the same activist highlighted that doctors are often perceived as more respectable than nurses.

In South Africa, nurses are blamed for a range of systemic challenges, including those beyond their scope of practice. As a nurse explained in our initial session,

> *It will always be nurses' fault, right? It will always come back. "You see those nurses; they are laughing there".*

She then summarised the perceptions of patients:

> *Food ran out in a hospital. Whose fault is it? It's [a] nurse…Beds are few. Whose problem is it? It's a nurse…Nurses, we know they are most of the time defined as the backbone of the health system because they do most of the work. But not everything that fails within the health system is a nurse's problem.*

In a later session in September, the same nurse asserted, *"nurses always take the blame".*

Clinicians' attitudes towards patients arose as a frequent topic, especially in our initial session, during which an activist asserted that when *"a patient comes from certain location or certain background, there is already an attitude in receiving a patient."* In response, a nurse stated, *"I think whichever nurse or doctor's doing that, it's out of their own attitude, their own belief".* Another nurse then suggested that clinicians *"treat the ones that are in front of us with care, so that when they talk together, like 'you mean that one, she was so kind to me,' because more than anything, you don't want to sit in front of a client that doesn't appreciate; that doesn't like the fact that they are being seen by you".*

Later in the conversation, the same nurse assumed the role of a patient, stating, *"And look at that nurse. Attitude,"* and then proceeded to explain the sentiment in detail:

> *People are responding to nurses because of what they've been told. Some of them they've never really experienced the bad nurse, but because they know someone else in a bad encounter with a nurse, so now they're just going to paint nurses with the same thing.*

These findings suggest that while both nurses and activists maintain that stereotypes influence others' perceptions of them, their perceptions of one another are also informed by stereotypes.

Staffing: "The System Hasn't Changed"

The shortage of PHC facility nursing staff was highlighted as a major challenge. Participants attributed nursing shortages to various causes, including insufficient resourcing, staff turnover, absenteeism, vacations, and maternity leave. They noted that while catchment area populations have increased over time, the facility staffing mix often remains the same, resulting in clinics that are "*flooded*" with patients to the point that *"nurses, they can't cope"* (Nurse, February 2023). During our final session, an activist likened this situation to the one encountered at the Department of Home Affairs:

> *The moment those official[s] get there, they found out the yard is full of people, they said, "How on earth are we going to serve these people"*?

He proceeded to describe the situation in PHC facilities as follows:

> *So many nurse[s] have learned during the apartheid. Before the apartheid and after the apartheid. And yet, the system somehow is still the same. The system hasn't changed. Now they're saying…five nurses is supposed to serve here. And, after thirty years, the number has not; nothing has been done or changed.*

Participants added that while staffing levels at the facility remain the same, nurses' scope of practice has expanded due to the addition of services. As a nurse stated during our initial session*,*

> *I cannot do something that is outside what I'm supposed to do because we are governed by laws and by job description…We do what we can at amount of time given and the amount of opportunity given.*

Nurses and activists also drew attention to the expectation that nurses must remain in the clinic and attend to patients at the end of the day, while doctors are permitted to go home.

During our final session, activists identified foreign national clinicians as an untapped resource that could help *"offload this pressure in the clinic by utilising the resources that we have, instead of going to outsource outside"*. At the same time, they indicated that many cross-border migrants who served as nurses in their countries of origin cannot practice in South Africa. Registration with the South African Nursing Council is an onerous and expensive process (as I can attest). Foreign national clinicians may also face language barriers, though activists maintained that learning English is not an insurmountable challenge. On the contrary, both activists and nurses emphasised that knowledge of a second language is advantageous in clinical settings, especially facilities that serve cross-border migrants.

The Queue: "All of Them, It's Eight o'clock"

The absence of a proper clinic appointment (diary) system was identified as an ongoing challenge. As a nurse explained during our final session, patients are instructed to arrive at the PHC facility at the same time of day:

> *Their appointment is written eight o'clock. But the patient will be seen at one or two o'clock. The patient will show you that it's eight o'clock. All of them, it's eight o'clock.*

The result is an influx of patients in the morning, many of whom arrive in the early hours to avoid the queue yet are not seen by a clinician until the afternoon, if they are seen at all. Some patients are turned away after waiting the entire day in the queue, only to be told to return the following day and wait again.

The same nurse shared that during prior employment in a PHC facility, she established a close rapport with patients and took steps to reduce waiting times, emphasising that if a patient spends all day in the queue without being seen, it is impossible to furnish a sick note. She described being admonished by other nurses upon her departure for setting the standard of care too high and providing "*VIP treatment*" to patients. At another point in the conversation, an activist described how local anti-immigrant groups attribute long clinic queues to cross-border migrants:

> *They would actually think that it's because of that one who is from Congo or from Zimbabwe. Yet, it's because the Minister of Finance who has allocated few resources…to appoint nurses, or enough nurses which would adequately serve that centre* (February 2023).

The Folder: "Not Supposed to Be Here"

The notion of belonging - or lack thereof - emerged several times, especially during the first few sessions. The presence or absence of a patient's folder (or file), another frequent topic of conversation, helps determine whether that patient 'belongs' in a particular facility. According to participants, creating a new patient's folder is the responsibility of the administrative staff. The folder is then handed to the clinician, who documents the patient's medical history and chief complaint. As with the appointment card, the folder serves as proof that a patient is welcome, a sentiment illustrated by a participant who recalled an encounter between a nurse and a cross-border migrant in which the nurse asked,

> *Why don't you understand? We have already told you. In fact, do you have a folder here?* (Activist, September 2022).

The activist believed the nurse had effectively told the patient,

> *You are not supposed to be even here.*

The same activist also shared his belief that personal details noted in the folder, including asylum-seeker status and financial means, may affect clinicians' perceptions and treatment of the patient.

The first forum theatre **scene** enacted by participants during our initial session depicted a scenario in which a man seeks care for his wife, a cross-border migrant who is in labour yet has no papers. In this scenario, immediately following a request for assistance, a nurse enquires about the patient's papers and states that proper documentation is required to create a folder. In both versions of the enacted scene, the nurse is depicted as a gatekeeper. Yet, as the participant who assumed the nurse's role in the first scenario explained during our debrief,

> *A nurse has got nothing to do with your paper. Can I just clarify that? Wherever you are turned away because of a paper, a nurse has nothing to do with admin of your file. A nurse is not responsible for to create your file.*

The Unworthy Patient: "Taking Our Time"

Findings indicate a common perception that patients are responsible for health system challenges, particularly long queues and insufficient commodities. Blame takes many forms. At times, patients are held responsible for their medical conditions or those of their family members. Participants noted that some clinicians blame patients by chastising them for late presentation or not seeking assistance at the pharmacy before coming to the clinic. For

instance, in our initial session, an activist shared a story about relatives who brought a family member who had had a stroke to the hospital, only to be told,

> *You guys bring this man very late.*

Socially marginalised patients are often blamed for monopolising the clinician's time and attention. During our September session, a nurse highlighted that some clinicians who consult with sex workers presenting with sexually transmitted infections (STIs) perceive it to be a *"waste of time, even if we treat them because they're gonna come back".* Members of other socially marginalised groups are also identified as the source of health system challenges, a situation highlighted by another nurse who described perceptions of LGBTQ+ patients:

> *[A]s a clinician inside the consulting room, I still want to consult this person with dignity. But the queue is long outside…when this patient is coming out of the consultation room, she is being labelled, the stones are thrown, saying "You are taking our time"* (November 2022).

Patients from the general population may blame cross-border migrants for long queues and medication stockouts, as illustrated by an anecdote told from the perspective of a South African who encounters Shona-speaking patients in the PHC facility:

> *You guys, now we can't come on the clinic any time we want anymore. We come here, you already full [sic] the seats. There's no more space for Me to sit. Why don't you go back to your country? Now we come here, I gonna leave here four o'clock because of you* (Activist, November 2022).

During the same session, a nurse cited an example that depicts how some patients attribute staff and resource shortages to cross-border migrants, namely, complaints overheard in the passage while they are in the consultation room:

> *Where are their own nurses? Why are they taking our time? She is giving them medication. She is finishing all our treatment for this person.*

Participants enacted a similar scenario during the forum theatre activity that occurred later in the session. In this **scene,** patients in the queue complain about the long wait while a cross-border migrant is attended to in the consultation room. Whereas the nurse treats the patient respectfully, the patients in the queue disrespect both the marginalised patient and the clinician. In the second iteration of the scene, one patient in the queue complains loudly. A fellow patient attempts to diffuse the situation, stating,

> *"We are Africans. We must help one another,"* and "*How do you feel if you find yourself in a foreign land?"*

While designating roles before the enactment of the scene, the activist portraying this character expressed willingness to participate, provided he was not assigned the role of a transgender person. This comment illustrates that those who are themselves socially marginalised may harbour negative perceptions of people from other marginalised groups, though they face similar challenges when seeking care.

Nurse (Mis)behaviour: "We Can Be Very Rude to Patients"

The pressure under which clinicians work was identified as a cause of poor patient care. Emphasis on clearing the queue has implications for the quality of health services: the more patients to be seen, the less time is available to listen, explain treatment options, and provide respectful services. Participants also highlighted the correlation between clinician demeanour and patient health, and the importance of a warm welcome:

> [*T]he moment the nurse calls your name, you start feeling that you're getting healed. Because you know that [they] will give you medicine, they will check your blood and stuff like that. And when you will be finished with the nurse, at least you're halfway healed. But if you get there and the question that you start getting: "Where's your passport? Where are you from? What's your language? Its [sic] add up to your sickness* (Activist, February 2023).

During our September session, a nurse stated,

> *It's not just easy for us as well. But it doesn't justify that we must be rude to them as well because we can be very rude to patients*.

In our final session, the same nurse reiterated the point, stating,

> *I have to come on duty. I'm angry, I'm frustrated, there's something That didn't go well at home. Now I'm taking that to those people that are around me that has nothing to do.*

Later in the conversation, she asserted,

> *It's easy to take that anger to the person that is close to you if you don't have a solution.*

In the same session, another nurse stated,

> *You wanna know why are there attitudes and everything? I think, more than anything, it has an influence on personal experiences…It actually has nothing to do with the health system. It has nothing to do with the Department of Health. It's opinions and people's attitudes.*

At another point in the conversation, a nurse maintained,

> *Yes, we have attitudes, but I think we are very angry also, but to the government.*

In our final session, the same nurse asserted:

> *How to address all this that we are talking about? Because it's an attitude. It starts with us.*

Of note, whether in reference to clinicians or patients, the term 'attitudes' always had negative connotations in our conversations and was often conflated with behaviour.

In May 2022, an activist shared an audio clip in our WhatsApp group chat that appeared to capture a conversation between a clinician and a cross-border migrant in which the clinician enquired about the length of time the patient had been in South Africa, his employment status, and whether he was involved in crime. The clinician then told the patient that he must return to his country of origin. We discussed this clip and its implications during an online session the following month. Another activist shared that he had asked community members who heard the recording to consider that "*all these patients go to different clinics and they don't get such kind of interrogation, and why only this person was interrogated that way?"*. He encouraged fellow activists and community leaders to withhold judgment, try to *"be in the middle of the story,"* and *"dig deeper [rather] than just basing maybe our ideas on what suits us as immigrants."* He went on to say, *"Yes, if it happened it was an isolated case, which is not supposed to be generalised,"* which echoed a comment made by another activist during our initial session:

> *We'll have to look at hospital and clinic differently to analyse different hospitals, different settings. And not to just to say, all nurses, all hospitals, all clinics are xenophobic or anti-immigrant, or they have attitude towards immigrants.*

Unaccountable: "Easy to Get Unprofessional"

The nurse's pledge (or oath) was mentioned in most conversations held throughout the study, especially when the topic turned to unequal patient treatment. According to one nurse,

> *It starts from the pledge, right? You made sure from first year that you understand how to treat patients. But then those attitudes they arise from personal perspective. It doesn't collectively make all nurses like that. It doesn't make nursing about that* (September 2022).

During the same session, other participants expressed a more cynical view, as illustrated by a nurse who stated,

> *We know as a nurse, we took a pledge that we will treat everyone equally without discrimination. But we don't do that.*

In our final session, the same participant questioned whether a nurse would remember the pledge *"once you've got your uniform and you start your contract".* She stated that it is "*very easy to get unprofessional,*" yet asserted "*it has nothing to do with the government because you will find…there are policies that are there*" (February 2023).

Participants emphasised that clinicians are aware of their duty to behave ethically and to treat patients with respect. As a nurse stated in our August session,

> *People that are in the hospital, they are practitioners. They know what's right. And they know what's not right.*

The same nurse explained that clinicians provide care to cross-border migrants *"because it's their duty to do that,"* even though they would prefer not to *"because of what they were taught about foreign nationals".* During a later conversation in November, an activist asserted,

> *We need to break the barriers of hate so that people would understand that 'Okay, when I become a nurse already, I come here, I've got a duty to do'.*

In our initial session, the same activist characterised nurses who hold positions in both the public and private sector as *"two different people in one"* and implied that accountability mechanisms in the private sector result in improved quality of care, whereas in the public sector, *"No one will punish. They can't fire you. You are safe this side".*

Our conversations suggest that in many PHC facilities, rights afforded under the Patients' Rights Charter are not realised. Though complaint boxes may be present, participants questioned whether submitted complaints are ever read or reviewed. Group members noted that patients are reluctant to file complaints about mistreatment because they believe *"nothing will be done"* (Nurse, February 2023). Those who complain may be met with anger or defensiveness. For example, during our August session, an activist recalled meeting with an operational manager to discuss a situation he had observed in a PHC facility:

> *I just explained what happened there and how I felt about it. She stood and was beating the table to tell me that I cannot teach her how to do.*

Clinicians shared similar reservations about bringing complaints to the attention of management. According to one nurse, managers often listen to complaints and state their intention to provide feedback, but do not follow through. During our final session, a nurse described what happens when staff report problems to operational managers:

> *They do write down all our complaints. "We will come back to you. We will address this." …but we won't get no feedback.*

Consequences: "I'm Taking a Risk"

Activists reported that many cross-border migrants in South Africa do not seek health services due to fear and mistrust; some believe the risk of entering a health facility is so great that it puts their lives in danger. Reactions to the media shared by activists on our WhatsApp group chat around the mid-point of the study suggest that escalating anti-immigrant rhetoric elevates the risk of those seeking health services. In September 2022, an activist wrote,

> *It is really getting worse*.

Soon thereafter, another activist forwarded a message from an unknown source stating, "*We are not safe in clinics and hospitals anymore*".

Participants highlighted the consequences of mistreating socially marginalised patients, including cross-border migrants. In our September session, an activist described a hypothetical scenario in which a patient with a mental health condition seeks assistance, *"yet you discriminate, you don't wanna help him, you are rude, and the language is not okay…what is gonna happen?".* Nurses stressed the impact of treatment delays on patients and communities. For example, patients fearing deportation may not share accurate contact information, making follow-up by CHWs a challenge, or they may not return to the clinic to

initiate treatment should they test positive for an infectious disease such as tuberculosis. As a nurse explained during our initial session,

> *If I start to treat you differently because of your illness or anything you're travelling with…that'll also affect your adherence; you won't take treatment.*

Participants also described the risks associated with advocating for quality health services, specifically that those who speak up may ultimately be denied care. One activist described the challenges of discussing patient mistreatment as follows:

> *Most people don't want to hear about it because it's very bad, that we just take it. It's very bad. And we just limit ourselves to say, "This is not good. We cannot tolerate this," and we don't go beyond that* (June 2022).

In the following session, the same activist shared that he had written a complaint about his own health care experience, stating,

> *I'm taking a risk, but I want this story at least to be heard.*

The subdued activism that participants described is markedly different from the activism I observed on Lesvos, where public spaces are covered with pro-refugee graffiti that draws attention to human rights violations. I believe this is because the risks associated with expressions of solidarity with refugees and asylum-seekers are more attenuated in Greece, where host country nationals and citizens from other European Union countries engage in activism.

Patient (Mis)behaviour: "Were You Even Trained?"

Participants emphasised that problematic attitudes and behaviour are not the sole purview of clinicians. As an activist asserted during our initial conversation,

> *Some patients, they are so rude,* and later in the session, *he's sick; he bring all his rudeness or attitude to the nurse, and he's expecting you guys to act like everything, it's okay.*

At another point in the conversation, a second activist said,

> *I've seen a lot with nurses. I've seen also a lot with patients because it's both ways. We have got patients who come to the clinic with attitudes.*

A nurse concurred, stating that some patients *"know already what to get at the clinic. Like, they know medication to get. And the nurse did not prescribe this medicine. Then there is a fight. 'You don't know what you are doing here. Why are you even here? Were you even trained?'".*

During our November session, the same nurse asserted,

> *I think people are angry, citizens are angry…as a clinician, you are caught in between…You don't have to choose, but they force you to: "So which side are you?"*

Participants also stated that some patients modify their behaviour depending on which clinician attends to them, as indicated in the following example shared by an activist:

> *If it's that nurse, if that kind of a nurse, then I will behave*.

Considered in tandem with the accusations of blame noted earlier, these findings illustrate how nurses and patients jockey for power and status within the hierarchical public health system.

The enrolled nurse who participated in our initial session stressed that clinicians are not the only ones who consider some patients more deserving than others:

> *This worthiness, it happens even amongst the patients.*

She then provided the following example:

> *They come into the clinic; they stand in the queue. And the lady was pushed on the back by one of the clients. They said, "You don't belong here. Why are you not going to the ABC clinic? This is our XYZ clinic."*

This finding, reiterated in later sessions and the second forum theatre activity, led me to reconsider my assumptions regarding who mistreats socially marginalised people in the PHC facility. In turn, it led to the realisation that determinations of patient worthiness are made not only by clinicians and support staff but also by fellow patients, which has implications for learning interventions to address unequal treatment. This finding also illustrates how dehumanising practices help justify the belief that some are more worthy of respect than others.

D. "There is a Human Being There"

Throughout our sessions, participants described instances when they experienced or witnessed dehumanising treatment, either as clinicians or as patients. Despite prevailing stereotypes to the contrary, conversations affirmed that both nurses and patients, including those representing socially marginalised groups, are human beings and should be treated as such. Our March, August, and November sessions emphasised humanising cross-border migrants and other socially marginalised people. As an activist asserted during our initial conversation:

> *If someone flees his country to another country, he has a full right to receive assistance, whether he got a paper or not, because you need first to think about to save life, and other things will come just later. Cuz the life of the person is better than the paper that you are asking me. He can have a paper, but if he's not alive, that paper will mean absolutely nothing.*

Humanness: "He's a Patient"

Value judgments of socially marginalised patients emerged as a theme throughout our conversations. For instance, during our September session, a nurse asserted,

> *What has put that person to that situation? I mean, why is none of my business. This person now, whether is coming with HIV, is coming with the STI, my duty is to provide the health, give medication, educate where I need to be educating, not judging them.*

Likewise, during an online session in August, an activist stated that we should *"try to educate people or help people to understand that no matter how a patient comes to the clinic, first of all, the person is human before even being a foreigner or being a national or being whoever"*.

Towards the end of the study period, the same activist shared news of his child's birth in our WhatsApp group. He concluded a detailed description of the labour and delivery by stating,

> *I just want to motivate some of my colleagues that not all clinics or hospitals have the same attitudes towards people from different backgrounds. My wife couldn't speak English, but doctors and nurses, as well as cookers, had means to communicate*.

The message was notable because it described an overwhelmingly positive and dignified experience within the public health system, even though the patient did not speak an official South African language.

Affirmation of the inherent humanity of patients extended beyond cross-border migrants. For example, in our November session, a nurse who has worked in the prison system stated,

> *As a nurse, we are being taught not to be judgmental. The offender comes, whether that offender has killed your next-door neighbour, now he is here. The minute he comes in through that door, he is no longer an offender. The title changes. He's a patient. He or she is a patient.*

Soon thereafter, she asserted,

> *That person is still a human being. There is a human being there.*

The same nurse shared a similar sentiment while describing her first day of work at a clinic for sex workers and transgender people:

> *When I got there, I found people. I found human beings.*

These words resonate with me because they echo the perspective expressed by Nelson, whose story I incorporated into the Key Populations Toolkit. They also confirm that not all clinicians treat socially marginalised patients poorly; on the contrary, some recognise the inherent humanity of all people, regardless of their position along a particular social or systemic hierarchy.

It became apparent through our conversations that clinicians may also be subjected to dehumanising treatment, either by patients or fellow staff members. For instance, during our November session, a nurse recalled visiting an unfamiliar facility on official business and being instructed to use the public restroom. She concluded the anecdote by stating,

> *I don't have to wear a uniform to be treated with decency*.

In our final session, an activist suggested this challenge may be addressed by taking lessons *"out in the community to show to the community that clinicians are not only giving the service, but they're part of the community. They are also human being with feelings"*.

Evolution of CPAR Group Sessions

The findings described here emanate from conversations between a group of nurses and activists who became a learning community. Now that the findings have been presented, I will return to the process undertaken by the CPAR group. Although perceptions of worthiness within the public health system remained the focus throughout, the tenor of our conversations shifted over time. In our initial session, participants shared experiences of mistreatment they or their family members had endured. The following two sessions coincided with the height of anti-migrant activity and the Limpopo MEC's viral rant. Although group members continued to share personal experiences, the conversation shifted towards the current sociocultural context in South Africa and its historical underpinnings. We also began to explore how perceptions of worthiness are shaped through tacit learning processes. In the following session, we welcomed a new group member who drew our attention to the legacy of apartheid and the tribal divisions that remain in its wake. From then on, our conversations veered away from personal narrative towards a deeper exploration of the constructs, stereotypes, and assumptions that bolster social and institutional hierarchies.

The member we welcomed in the following session highlighted dignified interactions that reinforce the inherent humanity of both patients and clinicians, examples that were subsequently enacted during our second forum theatre activity. At this point, we began to focus more intently on potential ways to remedy the problems under consideration. By our final session, the conversation had progressed to critical reflection on macro issues, including health systems challenges, accountability, and health policy. At participants' request, we also began to consider potential recommendations and how they may be disseminated to key stakeholders. This conversation continued beyond the conclusion of our final session via our WhatsApp group chat and teleconferencing, and has resulted in the decision to share lessons learned in succinct, formatted written briefs and, where possible, in-person discussions.

The evolution of CPAR group sessions over time led our focus to shift from negative personal experiences to exploration of the assumptions, motives, and contextual factors that inform determinations of worthiness. It is noteworthy that our words also shifted from descriptions of situations in which "*we just take it"* or there was "*nothing they could have done*" to the proactive "*that's where the change can come from"* and "*it starts with us*". This shift demonstrates the power of prolonged dialogue to unearth and challenge the assumptions and beliefs that shape our perceptions of others (**Figure 5**). Moreover, it illustrates how critical reflection on historical and sociocultural factors helps learners understand why systems that preserve the unequal status quo are justified and maintained.

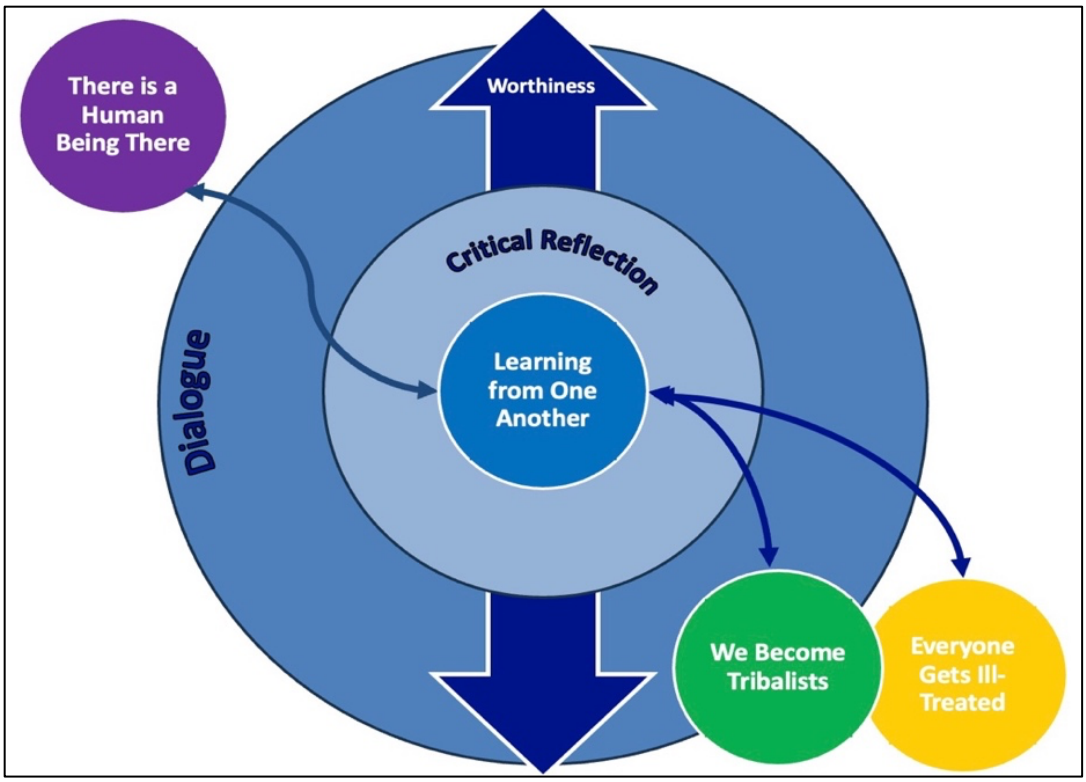

Figure 5: Learning shapes perceptions of others in both positive and negative ways. Critical reflection through dialogue challenges assumptions that lead to determinations of unworthiness.

5. Discussion

Introduction

This research project emanated from a desire to understand why some patients are considered more worthy of care than others and a belief that conventional in-service training to address unequal treatment is ineffective. It aimed to utilise a novel approach to explore nurse perceptions of patient worthiness in South Africa and identify learning strategies to curtail the practice of triaging socially marginalised patients in resource-constrained settings. This study sought to answer the following research questions: 1) How do PHC facility nurses perceive and understand patient worthiness?; 2) Which formal and informal learning processes inform PHC facility nurse attitudes, values, and perspectives regarding patient worthiness?; 3) How may learners, supervisors, and educators address or deflect counter-narratives regarding patient worthiness? The CPAR methodology, in which a small group of participants collaborate to address injustice and enact social change, made it possible to attain the aim of this research project. Throughout the year-long study, participants provided insight into the three research questions while exploring how clinic support staff and patients from the general population also shape perceptions of (un)worthiness. The CPAR process provides a template for a learning strategy that may prove more effective than the traditional sensitisation approach to dissuading unequal treatment of the socially marginalised.

The major themes that emerged from this study underscore how the sociocultural context in which we live, work, and learn shapes our perceptions of others, especially those for whom status and power remain elusive. In South Africa, the legacy of apartheid is evident in social and systemic hierarchies that preserve inequality and pit Africans against Africans. Findings affirm that stereotypes and stratification are mutually reinforcing and that hierarchies within and beyond the PHC facility impact both clinicians and patients. Many of the health system challenges described throughout the study arise from rigid hierarchies that preclude nurses and patients alike from receiving the care and attention they deserve.

The didactic training method to address patient mistreatment persists despite evidence that learning often occurs tacitly through informal conversations. Formal in-service learning activities, including stand-alone sensitisations and workshops, have failed to shift negative perceptions of socially marginalised people that result in determinations of (un)worthiness. This failure may be attributed in part to conflicting messages transmitted by government officials and influential community members through media channels and interpersonal communication. Study findings indicate that learning is context-dependent and that in-service training is unlikely to shift problematic attitudes and behaviour if systemic challenges remain unaddressed. Findings also suggest that affirming the inherent humanity of both patients and nurses is central to the provision of equitable care.

What implications do study findings have for the critical educator? In this chapter, I present an interpretation and analysis of findings as they relate to the theoretical framework. I describe a process I have termed the Worthiness Cascade, whereby stereotype content attributed to the socially marginalised engenders feelings of contempt, leading to determinations of unworthiness that help maintain hierarchies and preserve the status quo. Alternatives to traditional in-service training that may disrupt the Worthiness Cascade are also described, namely dialogue and critical reflection.

In recognition of the complexities embedded within the hierarchical, under-resourced PHC facility, this chapter highlights health system challenges noted throughout the study, most of which may not be remedied through educational interventions alone. Actions that promote humane care of patients and clinicians in light of said challenges are also described. The chapter concludes with suggestions for educators who wish to facilitate dialogical processes with learners in other settings and a final reflection on my positionality as a participant observer. Motives and assumptions that shape perspectives and influence the behaviours that give rise to unequal treatment are emphasised throughout.

Motivation

While rehearsing theatrical productions, actors frequently ask the director, "What's my motivation?". In other words, they want to know why the characters they portray do what they do. Often propelled by emotion, motivations are the driving force behind each character. They also differentiate characters from one another. Outside of rehearsal, people are less inclined to consider what motivates them to behave in a particular way and even less likely to consider the motives of others: it is easier to attribute a nurse's inattention to "*attitude*" or a patient's poor medication adherence to laziness than to contemplate the underlying reasons for their actions.

CPAR group dialogue was fuelled by a desire to comprehend why clinicians, support staff, and patients in South Africa behave as they do, as indicated by the activist who commented, "*People were born outside the apartheid, they still behaving somehow very funny. And you ask yourself, 'This person is still twenty-five. How on earth was she behaving this way?'"*. Joint exploration of our motives and the motives of others was itself motivating, especially since our conversations included both clinicians and socially marginalised people. Implications for the critical educator are clear: explicit focus on the motives that drive our actions – why we behave as we do and the assumptions that underpin our behaviour - is imperative to shift perceptions of worthiness. Moreover, educators who understand why learners and teachers are motivated to justify unequal systems may then apply critical pedagogical techniques to decrease the motivation.

Assumptions

The Truth and Reconciliation Commission (1998, 4) portrays the sociocultural system inhabited by those who benefited from apartheid as "a closed world, surrounded by fences, prohibitions and some terrible assumptions about their fellow countrymen and women" (p.1-2). At the heart of this research project lie assumptions that, if left unchallenged, bolster inequality and the status quo. The theoretical perspectives that frame this study explain why people justify unequal systems, and propose methods to shift the assumptions and beliefs that legitimise them. Pairing system justification theory with critical pedagogy is a novel way to explore and understand a complex systemic issue while identifying potential learning strategies to address it. System justification theory provides a social psychological lens through which to consider the assumptions, motivations, and beliefs that lead individuals to accept and rationalise the status quo rather than question it. The central tenet of transformative learning theory is to challenge our assumptions through critical reflection and discourse. Correspondingly, engaged pedagogy identifies dialogue as a key component of democratic education and stresses that each learner should be recognised and heard.

Bohm et al. (1991) maintain that our opinion of another person "may be profoundly affected by the way we think and feel about someone else who might share certain aspects of his behaviour or even of his appearance," which leads us to "assume that our attitude toward him arises directly from his actual conduct" (p.2). Likewise, Mezirow (2009) contends, "Our expectations powerfully affect how we construe experience; they tend to become self-fulfilling prophecies. We have a proclivity for categorical judgment" (p.95). Critical reflection on assumptions is a necessary yet insufficient step to curtail the tendency to make categorical judgments about others, especially those who are socially marginalised.

Although transformative learning theory acknowledges that context and culture play a role in the learning process, it does so in superficial terms and thus provides little direction to educators who wish to explore them with learners. In contrast, engaged pedagogy foregrounds sociocultural and historical context, power dynamics, and praxis, essential factors "if the terms critical education and especially 'critical pedagogy' are to have any substantive meaning and if they are to avoid becoming simply rhetorical" (Apple, 2013, p.8). In so doing, engaged pedagogy provides a way to question the assumptions and beliefs that shape our perspectives while considering the contexts in which they develop.

Stereotypes and other beliefs reinforced through formal and tacit learning channels inform worthiness perceptions, which, in turn, maintain hierarchies and promote the shifting of blame for systemic failures onto individuals. CPAR group members' affirmation of the inherent humanity of patients and clinicians despite the many health system challenges that surfaced

brings hope that such perceptions are not insurmountable. The following sections consider findings in light of the theoretical framework and the literature. Emphasis is placed on dialogue as a learning strategy and a potential means to shift perceptions of worthiness.

The Worthiness Cascade

CPAR group dialogue affirms that determinations of worthiness in South Africa are intricately linked to sociocultural, political, and historical context (Willen, 2012; Fassin, 2008). Negative stereotypes influence assumptions and beliefs about the degree to which others deserve attention and respect. In turn, determinations of worthiness help maintain hierarchies and the unequal status quo. The following sections examine components of the Worthiness Cascade (**Figure 6**) in further detail. At each step lies an opportunity to intervene and disrupt the process, thereby reducing the likelihood that specific individuals will be considered more or less deserving of care than others.

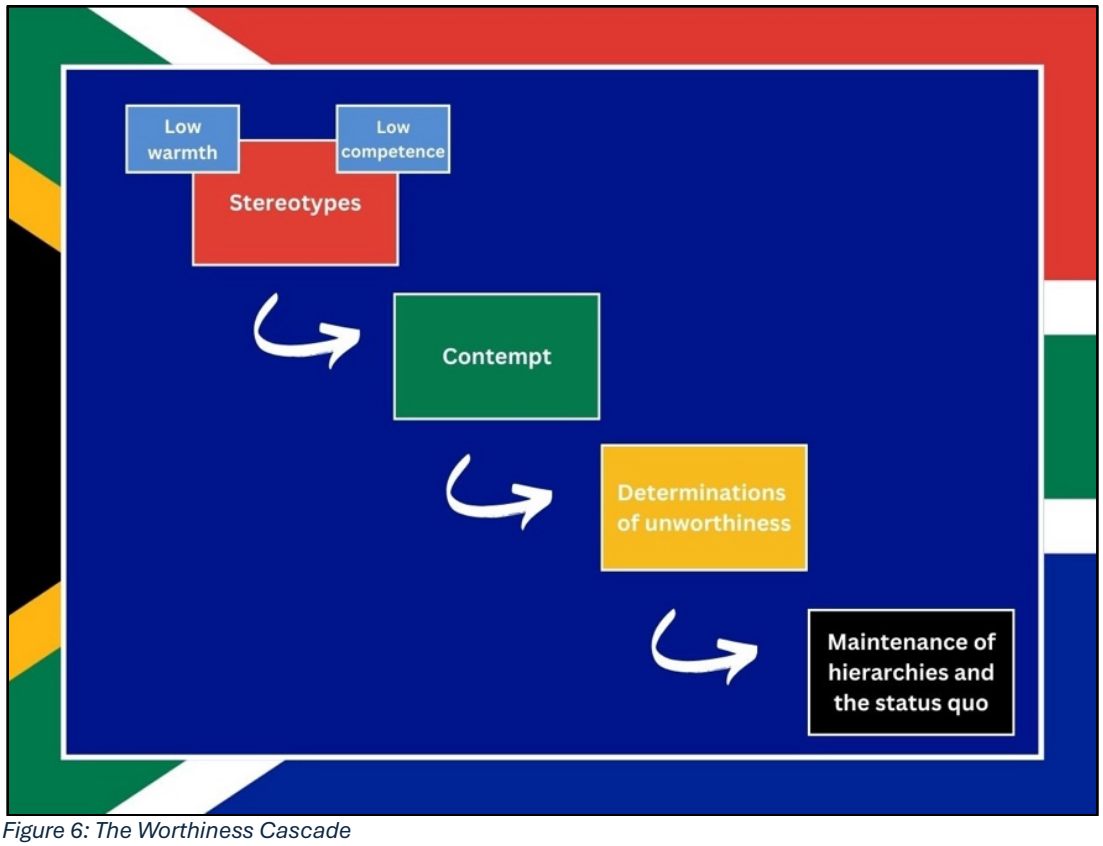

Figure 6: The Worthiness Cascade

Stereotypes

Stereotypes, beliefs about individuals based on group membership (Fiske, 1993), are a type of shorthand; they lead people to perceive others as one-dimensional stock characters rather than full-fledged human beings. Throughout our sessions, nurses and activists emphasised how stereotypes influence others' perceptions of them. Whereas nurses challenge stereotypes that cause patients to place them all under "*the same umbrella,*" their perceptions of socially marginalised patients are often informed by stereotypes (*"' You're an immigrant, you're all the same'")*. Likewise, cross-border migrants who bristle at stereotypes depicting them as dishonest and prone to violence often maintain stereotypes that shape their perceptions of clinicians.

People stereotype themselves and others in ways that rationalise the current system (Kay et al., 2009; Jost & Hunyadi, 2003; Jost & Banaji, 1994). For instance, stereotypes that portray immigrants as "*drug dealers and kidnappers*" who are "*all from Zim*" perpetuate the belief that cross-border migrants are untrustworthy, dangerous, and homogenous, which helps justify the unequal treatment to which they are subjected in the health facility. Negative perceptions persist even in the absence of direct interaction, as indicated by the participant who stated, "*People are responding to nurses because of what they've been told…Some of them they've never really experienced the bad nurse,"* and the activist who expressed concern about anti-migrant messages conveyed by government ministers. This finding aligns with Jeffery's (1979) research, suggesting that clinicians need not interact directly with 'rubbish' patients to develop negative perceptions of them. It also illustrates how tacit learning influences our assumptions and beliefs.

Stereotypes and power are "mutually reinforcing because stereotyping itself exerts control, maintaining and justifying the status quo" (Fiske, 1993, p.621). Stereotypes sustain existing power dynamics "by limiting the options of the stereotyped group" (Fiske, 1993, p.623) and depicting differences between powerful and powerless groups "in ways that make these differences seem legitimate and even natural" (Jost & Banaji, 1994, p.10). Whereas powerful groups are often stereotyped in a manner that explains their success, stereotypes about the powerless reinforce the assumption that they are to blame for their current situation (Jost & Banaji, 1994). Moreover, disadvantaged groups often harbour negative stereotypes about one another (Jost & Banaji, 1994), as illustrated by findings suggesting that patients from the general population tend to stereotype fellow socially marginalised patients. In short, stereotypes preserve social hierarchies and help justify inequality (Jost & Banaji, 1994), a reality reaffirmed by this research project.

Warmth and Competence

Fiske (2018; 2015) maintains that stereotype content may be categorised along two dimensions: warmth and competence. Individuals and groups characterised as warm are considered trustworthy, friendly, and honest. Those characterised as competent are perceived as capable, intelligent, efficient (Fiske, 2018), and cooperative (Cuddy et al., 2007). In contrast, those deemed low in warmth and competence are considered untrustworthy and incapable (Fiske, 2015). The warmth dimension is primary because it signals whether the intentions of others may help or cause harm (Fiske, 2018). Thus, competitors are stereotyped as lacking warmth (Cuddy et al., 2007). Once others' intentions have been established by assessing their perceived warmth, their competence to act upon these intentions is determined (Fiske, 2018). Put simply, people gauge others' perceived warmth and competence to ascertain whether they are friends (*"She was so kind to me"*) or foes ("*You are taking our time"*; "*She is finishing all our treatment")*.

Whereas some groups are characterised as high in warmth and competence across cultures and contexts (for instance, the middle class), others are rated low on both dimensions (Fiske, 2018). Socially marginalised people, including refugees, sex workers, and the unhoused, fall into the latter category (Fiske, 2018; 2015), as the findings of this study demonstrate. Some groups are consistently rated high in one dimension and low in the other. For example, the elderly are often characterised as both warm and incompetent (Fiske, 2015). In countries with high-income inequality, such as South Africa, many groups fall into ambivalent high-low categories, resulting in lay determinations of their relative deservingness (Fiske, 2018).

Study findings suggest that perceptions of warmth and competence influence behaviour. The acrimony that socially marginalised people often face when seeking health care illustrates how such perceptions affect those who rate low in both dimensions. Stereotypes depicting individuals deemed low in warmth and competence as "lazy, irresponsible, and unintelligent allow people to blame these groups for their own poverty and to deflect blame from the system" (Jost & Hunyadi, 2003, p.112), a situation highlighted by the activist who stated, "*if you are a black, especially if you come from outside South Africa, you are stereotyped that you don't pay for health"*.

Cuddy et al. (2007) have determined that each combination of warmth and competence predicts a distinct emotion: admiration (high warmth, high competence), pity (high warmth, low competence), envy (low warmth, high competence), and contempt (low warmth, low competence). Whereas warmth predicts active reactions, competence predicts passive reactions (Fiske, 2015). Reactions may be either positive or negative: perceptions of high warmth predict active helping behaviour, while perceptions of low warmth predict attacking

behaviour (Fiske, 2015), which aligns with the finding that socially marginalised people in South Africa are often treated with contempt, both within and beyond the health facility. Passive behaviour may take the form of social distancing, exclusion, or neglect of people stereotyped as low in competence (Cuddy et al., 2007). Passive behaviour also includes limiting access to health care ("*this one must wait")* and other vital services (Cuddy et al., 2007).

Findings suggest that perceptions of socially marginalised people in South Africa are shaped both by stereotypes and the cultural and historical context from which stigma emerges (Parker, 2012). Stereotype content described throughout our sessions aligns with research indicating that cross-border migrants are consistently rated low in dimensions of warmth and competence (Fiske, 2015). Perceived as competitors for scarce health resources (Vanyoro, 2019), they are considered to have low warmth and, therefore, malicious intent. Anecdotes that depict attacking and passive behaviour towards cross-border migrants by clinicians *("Why are you here? What are your nurses doing?")* and government officials ("*they can see a minister talking badly about immigrant and foreigners")* are therefore unsurprising.

According to Dirkx (2001), "We sometimes find ourselves feeling strongly about something or toward someone without really consciously knowing or understanding why or from where these feelings came" (p.65). Cuddy et al. (2007) argue that emotions predict behaviour more strongly than stereotypes, which has implications for learning strategies that aim to address unequal treatment: in-service training that 'sensitises' participants about stereotypes will not suffice. Moreover, the traditional didactic approach may exacerbate systemic issues by conveying the demotivating message that all clinicians in the PHC facility mistreat patients (*"each and every one of us, it's like we treat people bad")*.

The perception that nurses in South Africa lack warmth ("*This is what I'm going to do. Do you want it, yes or no?"*; "*those nurses; they are laughing there"*) and competence ("*You don't know what you are doing…Were you even trained?*") helps explain why they, too, are often subjected to attacking and passive behaviour by supervisors, colleagues, and patients. Respectful care increases patient perceptions of clinician competence (Gilson et al., 2005). An encounter with someone who does not exhibit behaviour consistent with preconceived notions of warmth and competence - for instance, a kind and capable nurse - may lead individuals to experience a disorienting dilemma, causing them to question their prior assumptions. Of note, nurses in the United States, where I trained and practised, are generally perceived as warm and competent, which affirms that sociocultural context informs stereotype content as well as associated assumptions and beliefs.

Stereotypes bolster the assumption that socially marginalised people are untrustworthy and incapable. Since they rate low in dimensions of warmth and competence, cross-border migrants seeking health care in South Africa are at risk of active and passive attacking behaviour: they may be mistreated, blamed for their medical conditions, or denied care altogether. As Roth (1972) contends, "the category into which the patient has been placed may have more effect on determining the decisions of medical personnel than does his immediate behaviour" (p.845). Dehumanising experiences deter further engagement with the health system, resulting in treatment delays and missed opportunities for preventive services. The findings of this study suggest that the tendency to categorise socially marginalised people by perceived warmth and competence may indeed be what distinguishes clinicians who mistreat patients from those who are respectful to all.

Stereotypes and Contempt

Perceptions of low warmth and competence predict contempt (Cuddy et al., 2007), the feeling that someone is unworthy of respect (Britannica Dictionary, 2022). Those considered unworthy of respect will likely be deemed unworthy of quality health services, which helps explain how determinations of worthiness arise and why some people are considered less deserving of care than others. Digby et al. (2018) maintain that "Patient worthiness is reflected in the language used and the value judgements made by others when discussing patients" (p.381). Throughout our sessions, CPAR group members described instances in which contempt towards socially marginalised people, such as the "*dirty"* and *"smelly*" unhoused and sex workers, for whom STI treatment is considered a *"waste of time",* was expressed. This finding echoes Jeffery's (1979) research, indicating that clinicians in the United Kingdom felt no moral obligation to treat patients whose medical conditions were believed to result from their own poor decisions.

Participants shared examples that illustrate health workers' contempt for both cross-border migrants and clinicians in their countries of origin (*"nurses in your countries, they're just doing nothing").* This intriguing finding highlights that nurses who "*always take the blame*" when things go wrong in the PHC facility may themselves blame other nurses for systemic failures. A similar display of contempt emerged during our second forum theatre activity when an activist portraying a disgruntled patient from the general population exclaimed, "*They have their own nurses who can give them care"*. These statements are compelling, given that in South Africa, **"**the failures of the health services and the intolerable strains in the hospitals have often been blamed by the public on the black nurses who are the most visible scapegoat for a multitude of ills" (Marks, 1994, p.196). Blame, a type of moral criticism, is often expressed as anger (Malle et al., 2018). Per system justification theory, this finding suggests it is often less risky to find fault with contemptible individuals than to question the legitimacy of the system.

Expressions of contempt are not limited to the socially marginalised, as evidenced by the nurse who commented, "*In South Africa, everyone at some point experiences ill treatment…people are generally being treated badly in a public space, like in a public facility*". This statement bolsters findings by Jewkes et al. (1998) regarding the tendency of South African clinicians to treat people with contempt arising from "an underpinning ideology of patient ignorance and inferiority" (p.1788). In effect, those considered ignorant and inferior are also likely to be deemed low in warmth and competence and then treated accordingly.

Though associated with distancing and disgust (Roseman, 2018), expressions of contempt are not intended to correct or transform the target person. Malle et al. (2018) maintain this is because those in power are not interested in changing others for whom they feel contempt, and people who lack power are unable to do so. If the findings of this study are any indication, contempt and its consequences persist in the present day, and its repercussions extend beyond patients to clinicians ("*I don't have to wear a uniform to be treated with decency*").

Hierarchies

Stereotypes imposed upon socially marginalised people in South Africa reinforce perceptions of low warmth and competence. As a result, they may be treated with contempt and considered unworthy of care by both clinicians and fellow patients. Roseman (2018) asserts, "Insofar as behaviors of contempt affect the target's social standing, they may contribute to formation and maintenance of social status hierarchies" (p.120). Worthiness determinations bolster hierarchies through "the unequal allocation of recognition and respect" (Therborn, 2009, p.3), which helps maintain inequality. This state of affairs is facilitated by "intimate connections between the nursing profession and the state, through both its institutions and its ideology, as well as their acceptance of its hierarchies and normative values" (Marks, 1994, p.12), which situates nurses in an uncomfortable position between patients and their employer ("*So which side are you?").*

The rigid hierarchy within the PHC facility precludes nurses from speaking freely to their supervisors for fear of being disciplined. hooks (1989) maintains that fear of speaking "often characterises the way those in a lower position within a hierarchy address those in a higher position of authority" (p.15). She argues that "It is impossible for education to take place within a context where a discipline-and-punish model frames social relations" because students and teachers cannot have mutual respect when "overt hierarchal power dynamics make domination of the weak by the strong acceptable" (hooks, 2010, p.112). As the findings of this study suggest, the same may be said of the PHC facility, where nurses may remain silent to avoid reprimand by their supervisors and then mistreat patients because *"they cannot express their anger to those on top".* Dlamini et al. (2007) contend that anger "allows the suspension of

normal human emotions associated with caring for sick persons, as well as the professional ethic of caring" (p.396-397). In contrast, fostering an environment where clinicians feel valued, recognised, and heard can minimise the tendency to take anger and frustration out on those who occupy lower positions in a stratified system.

Vanyoro (2019) asserts that many of the barriers cross-border migrants in South Africa encounter when seeking care stem from "facility-level hierarchies and individual discretion in the rationing of health care services" (p.8). Although hierarchies were not replicated within the CPAR group, they were a recurring topic of conversation. As described in the Findings chapter, participants emphasised how apartheid-era hierarchies are maintained in institutions (*"people there are quite Afrikaans - you might not be assisted")* and communities (*"I'm far much better than you because apartheid has told us that we are not of value")*. That such hierarchies are often justified by Africans, who occupied the lowest rung within apartheid-era social stratification, adds context and complexity to the question of how and why determinations of worthiness manifest in South Africa. It also affirms that the disadvantaged are often motivated to justify the very systems most detrimental to them (van der Toorn et al., 2015; Jost et al., 2012). Though some may view this reality as grim, I find it illuminating; critical educators who comprehend what compels people to justify unequal systems are well-placed to employ learning techniques to challenge beliefs that underlie the motivation.

The correlation between tribal identity and perceptions of worthiness was particularly salient when our conversation turned to cross-border migrants ("*I don't like Sotho, so why must I like the Zimbabwean?"*; *"I am better than Zulu, but I'm far more better than you")*. This striking finding exemplifies how social stratification promotes discord between disadvantaged groups that might otherwise benefit from unified efforts to challenge systemic inequality. It aligns with Spooner and John's (2020) assertion that "deeply held beliefs and half-truths instilled through apartheid mean that some people continue to be caught in their own history and to relive it" (p.281). It also underscores how apartheid-era divide-and-conquer strategies that pit Africans against Africans persist in the present day ("W*e are not stable when a fellow African is close to me and looks like me")*. In her early work, hooks (1989) draws attention to "the way we as black people directly exercise power over one another when we perpetuate white-supremacist beliefs" (p.113). As study findings suggest, such power may be wielded through stereotyping, stigmatisation, and other dehumanising actions.

Walker and Freemantle (2023) argue that failure to provide equitable health services has resulted in a system in which "all poor black people are denied their humanity and their rights in South Africa, and those slightly higher up aggressively and anxiously defend their own position by discriminating against those lower down" (p.58). Much like nurses, whose anger

towards their superiors is displaced onto patients, patients from the general population often take their frustrations with systemic failures out on the socially marginalised, who rank below them along social and institutional hierarchies.

Cross-border migrants and other marginalised patients are perceived as competitors for scarce health resources, including the clinician's time. Since competitors are considered to have low warmth, they are likely to be perceived as foes (Fiske, 2018; Cuddy et al., 2007). Instead of challenging the adequacy of the under-resourced health system, patients are pitted against patients, thus reinforcing existing hierarchies. As van der Toorn et al. (2015) assert, "People may justify the current (unequal) system by endorsing stratification as an appropriate method of social organisation and rationalising each individual's or group's position in the hierarchy, including their own" (p.96).

The Status Quo

hooks' (1989) perspective regarding the sociocultural context of the United States in the late 1980s resonates in present-day South Africa: "While we no longer live within the rigid structures of racial apartheid that characterised earlier moments in our history, we live within a culture of domination, surrounded by institutions - religious, educational, etc. – which reinforce the values, beliefs, and underlying assumptions of white supremacy" (p.63). That such a culture is legitimised by the people it is most likely to harm indicates a strong motivation to justify the system. The motive to maintain the status quo endures, even though South Africa remains inherently unequal and fragmented along lines of race and class.

System justification featured in the data collected throughout this study. Activists and nurses highlighted instances when clinicians, patients, and government officials rationalised the unequal health system. A CPAR group member also justified the education system in which clinicians are trained. Findings indicate that in the current sociocultural context, it is easier to justify the existing system than to challenge it, which aligns with hooks' (2010) contention that "most folk would rather stay with the status quo even if to change would be an improvement" (p.138).

Perceived Threats to The System

The motive to justify the status quo is activated by perceived threats to the system (Jost, 2019; Kay & Friesen, 2011). Study findings indicate that cross-border migrants are considered a threat to the health system. Nowhere is this more evident than in the inflammatory rhetoric employed by Operation Dudula, a vigilante group established in 2021 that blames systemic failures on African immigrants (Myeni, 2022) and advocates for their expulsion as a means to

remedy crime, unemployment and health service delivery challenges (Walker & Freemantle, 2023). Media shared in our WhatsApp group confirm that, rather than critique a government that allocates insufficient funds and personnel to the health system, vigilante groups perpetuate the misconception that cross-border migrants are to blame for long queues and medication stockouts. This finding was reinforced by the activist who stated, "*They would actually think that it's because of that one who is from Congo or from Zimbabwe. Yet, it's because the Minister of Finance who has allocated few resources"*.

The actions of Operation Dudula and like-minded groups bolster the anti-foreigner rhetoric espoused by high-ranking government officials (Chutel et al., 2023; Walker & Freemantle, 2023). As noted in our WhatsApp group chat, Operation Dudula members entered PHC facilities on numerous occasions during the study period, insisted that patients show their documents, and demanded that foreign nationals leave the premises. Clinic administrators and security guards often ignored these acts, though they violated patients' rights. Since Operation Dudula and other vigilante groups maintain the societal and health system status quo, their behaviour was met with tacit approval rather than outrage.

Throughout the study, participants described instances when patients from the general population made derisive comments indicative of their contempt for cross-border migrants (*"Why don't you go back to your country?")* and complained they were taking up valuable time and resources. A similar scenario was enacted during our second forum theatre activity. While portraying patients from the general population, two activists lamented, *"This immigrant is taking too much time,"* and insisted *"They must find their own doctors"*. Rather than question the legitimacy of a system that requires them to queue for hours, frustrated patients often blame socially marginalised people who, like them, are seeking health services.

Our dialogue validated that defensiveness often emerges when a system is threatened or challenged, as illustrated by the nurse who argued that unequal treatment should be attributed to individuals rather than the system itself ("*It actually has nothing to do with the health system"*). Critique of the education system was also met with defensiveness (*"Now we're gonna go as far as interrogate how nurses learn")*. Findings support Kay & Friesen's (2011) assertion that the "system-justification motive sheds light on why these system failures - or even well-intentioned criticisms - often lead to a retrenchment and defense of the system, rather than using the opportunity of failure to identify ways in which the system can be improved" (p.361). Of note, the same participants who asserted that "*the system has nothing to do with it*" explained that frustration with rigid organisational hierarchies leads clinicians to direct their anger towards patients rather than their superiors.

Decreasing the System Justification Motive

Findings suggest that blaming individual nurses and patients for systemic problems is often preferable to the alternative: acknowledging that the health system is unjust, a premise perhaps too destabilising to consider. The weaker the system justification motive, the lower the likelihood that a person will legitimise the status quo, a notion embodied by the activists who participated in this study. Therefore, decreasing the motive to rationalise the status quo is a prerequisite for social change. To shift perceptions of worthiness, it is paramount to identify and apply learning techniques that attenuate the system justification motive.

Jost et al.'s (2012) assertion that the system justification motive satisfies the psychological need to manage threats, reduce uncertainty, maintain a predictable worldview, and to belong has implications for learning activities that aim to address unequal treatment: if some of these needs are met through other means – by reducing perceived threats or belonging to a learning community, for example - the motive to justify the current system may decrease. Likewise, the strength of the system justification motive is context-dependent and moderated by the four factors described earlier (Jost, 2019). Moderating the strength of one or more of these factors (for example, perceived threats to the system and perceived powerlessness) provides another means to disrupt the Worthiness Cascade and decrease the motive to justify unequal systems (**Figure 7**). In practice, this could entail critical reflection on power dynamics and problematic assumptions, for instance, that socially marginalised patients pose a threat to the health system.

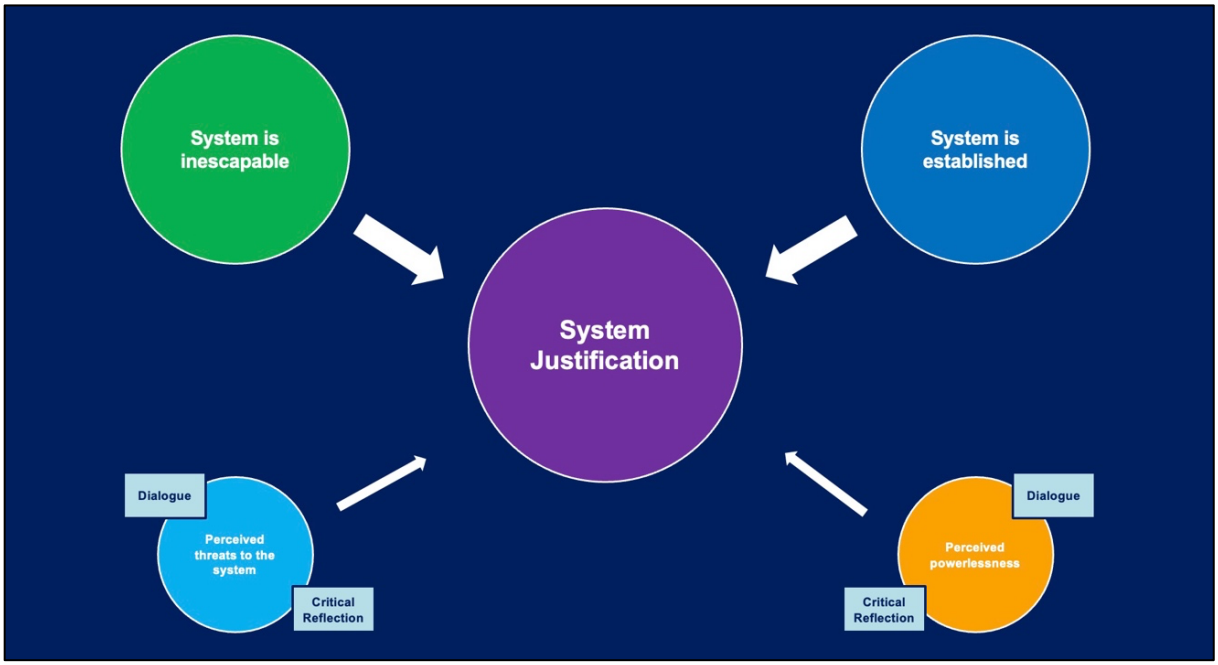

Figure 7: Moderating the strength of the system justification motive through dialogue and critical reflection

Those who challenge the status quo have a high tolerance for uncertainty: speaking up has consequences, exemplified by the loss of credibility and social rejection some privileged South Africans encountered when they expressed opposition to apartheid (Truth and Reconciliation Commission, 1998, 4), and the activist who shared that he was "*taking a risk*" by advocating for himself at a health facility. Socially marginalised patients on the receiving end of mistreatment may be reluctant to share their concerns for fear of repercussions. In contrast, activists assume the risks associated with advocacy and speak out, often with backing from aligned organisations. Notably, none of the nurses who agreed to join the CPAR group and explore this challenging and uncomfortable topic worked within government health facilities by the end of the study. It strikes me that perceived or actual risks associated with questioning the legitimacy of the public health system by those employed within it may have deterred some nurses from participating in this study, which helps explain why the recruitment of PHC facility nurses proved so difficult.

Pedagogical Approaches

Learning that occurs within and beyond the health facility is informed by prevailing stereotypes, hierarchies and (mis)perceptions regarding the underlying causes of systemic challenges. CPAR group dialogue affirms that learning is contingent upon context and that health equity will only be attained once systemic issues are remedied. Findings bolster prior research indicating that the traditional approach to in-service learning is ineffective (Simelane et al., 2018; Bluestone et al., 2013; Fox & Bennett, 1998) and support Gladwell's (2006) assertion that information and understanding are often conflated. Critical reflection on problematic assumptions is a promising alternative to the traditional didactic approach and may help shift perceptions of worthiness that legitimise the inequitable health system.

Formal Learning 'Solutions'

Though there have been "*so many workshops*," as stated in an early CPAR group session, little has changed. This finding reminds me of a training I developed at the behest of NDoH to introduce a particular leadership philosophy derived from the Global North. The half-day training for operational and district managers was intended to improve patient experience of care at PHC facilities. At the time, I wondered why such an approach was being adopted in the absence of follow-up sessions or measures to address systemic issues. As Nakkeeran et al. (2021) contend, "Focusing on behaviour as the only effective location to effect change fails to appreciate that most public health problems are interconnected to and nested within layers of health system challenges stemming from social and political contexts" (p.3). The leadership training proceeded, but, to my knowledge, did not improve patient care.

Though training may be appropriate if a problem results from a gap in knowledge or skills, it cannot address the operational issues that underlie systemic challenges highlighted throughout this study, such as understaffing. In-service training is nonetheless proposed as the solution to many health system challenges, including unequal treatment. Most training occurs once with no follow-up, precluding opportunities for reflection and the formation of learning communities. Trainees may be unaware of the purpose of a workshop before arrival and, therefore, unwilling or unable to engage. Moreover, the didactic approach employed in most in-service training conveys the message that "knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing," which preserves hierarchies and "negates education and knowledge as processes of inquiry" (Freire, 2005/1970, p.72).

CPAR group members identified counter-narratives put forward by government officials as another reason why stand-alone training does not effect change, a finding emphasised by the activist who questioned "*How the change might can come"* to workshop participants when negative messages conveyed by politicians *"is more than the information that they receive positively?".* Counter-narratives perpetuate stereotypes about the socially marginalised and amplify feelings of contempt for 'unworthy' others, who are then blamed for systemic problems such as lengthy queues and insufficient commodities. The same government that fails to condemn health inequity and xenophobia calls for in-service training about stigma and human rights, a 'do as I say, not as I do' mentality that yields little more than confusion. By challenging assumptions about the root causes of health system problems, educators and learners may deflect such counter-narratives and, ultimately, shift perceptions of patient worthiness.

Hill (2010) maintains that "most modern educators and professionals have emphasised a nonjudgmental egalitarianism in which clinicians' moral appraisals are taboo. Taboo or not, they are pervasive, and patients know this" (p.11). Clinicians know it, too, as evidenced by the participant who stated, *"We know as a nurse, we took a pledge that we will treat everyone equally without discrimination. But we don't do that".* If traditional in-service training neither improves health equity nor addresses a knowledge gap, why is it still the go-to 'solution' to address unequal treatment, and why is it rarely questioned or challenged? For one thing, it is easy to measure. Program managers can report the number of people trained ('butts in seats' in facilitation parlance) with ease and tout it as an achievement to donor and government stakeholders, even if it has no discernible effects. Stand-alone training also demands less from facilitators and learners than educational strategies that require active engagement over time. Moreover, conducting in-service workshops on health equity is easier than addressing systemic issues, including those that arise from "social hierarchies and power relations, and the resulting social oppressions and conflicts" (Nakkeeran et al., 2021, p.3). In short, it is simpler to justify

the current training approach than to address sociocultural and systemic problems that preclude the public health system from responding to the needs of both patients and staff.

Frenk et al. (2010) contend that the purpose of in-service education is to improve health system performance to meet patients' needs "in an equitable and efficient manner" (p.1950). It is clear these needs are not being met, yet the conventional approach remains in place, even though it may exacerbate systemic issues by removing clinicians from the PHC facility to attend off-site workshops (Simelane et al., 2018). Byrne & Tanesini (2015) call upon educators to make a "clear distinction between education as the acquisition of specific knowledge, skills and attitudes through a series of targeted educational interventions and education as personal transformation through purposeful experience and practice and personal commitment to change" (p.1260). Likewise, Ellis & Nolan (2004) argue "there is a need to look beyond the outcomes achieved at the end of a programme of study and to create both structures and mechanisms that not only support innovation and change but also encourage continued reflection and dialogue" (p.105). As an activist asserted in one of our sessions, it is time for NDoH, health sciences educators, and donors to *"challenge our methodology of teaching…and also to liberate the way we teach".*

Learners accustomed to didactic in-service training may be reluctant to try critical pedagogical methods: "It is as if students realize that the traditional memorize, regurgitate process of schooling is much 'easier' than being engaged and having to think critically about what it is they learn and the ramifications of such ways of knowing" (Generett, 2009, p.85). Although hooks (1994) acknowledges there is "some degree of pain involved in giving up old ways of thinking and knowing and learning new approaches" (p.43), she provides little in the way of guidance to educators who wish to implement engaged pedagogical techniques, but find it challenging to do so.

Tacit Learning

Findings suggest that tacit learning influences the perceptions that clinicians and patients have of one another, even in the absence of direct interaction ("*People are responding to nurses because of what they've been told").* Learning that occurs in the tea room and other informal settings may reinforce or contradict the equity proclamations enshrined in the nurses' pledge. Eraut (2004) asserts that "Public discourse about training not only neglects informal learning but denies complexity by over-simplifying the processes and outcomes of learning and the factors that give rise to it" (p.621). Manuti et al. (2015) contend that emphasis is placed on formal learning "despite the uncontested role of informal learning in the workplace" (p.11) because sending staff to workshops is easier than implementing organisational change. Failure to account for tacit learning is common amongst donor-funded organisations that report

training outputs without indicating whether learning has occurred or health outcomes have changed, a practice I encountered while working for health NGOs in South Africa and Zambia.

hooks (2003) maintains that democratic educators "assume that learning is never confined solely to an institutionalised classroom" (p.41). Likewise, McLaren (2022) states, "From the standpoint of critical pedagogy, teachers are not restricted to those in formal educational institutions" (p.2). Study findings confirm that teaching and learning often occur in informal settings outside the classroom. It is time for global health practitioners and educators to recognise tacit learning as both valid and vital. In practice, this means moving away from slide decks and training venues, and fostering opportunities for critical reflection within the workplace; in other words, establishing what hooks might call an engaged facility.

To unlearn traditional ways of thinking, hooks (2003) asserts that educators must "cultivate a spirit of hopefulness about the capacity of individuals to change" (p.90). Educators, too, have the capacity to change, especially when it comes to their pedagogical practice. Generett (2009) argues that "the transformation literature speaks most directly to the transformation of students as opposed to the transformation of *teacher educators*. One could incorrectly conclude from this that all professors, because they are teacher educators, have already been transformed" (p.84). Though it may at first seem daunting for educators to conceptualise in-service learning as anything other than a lecture, as an activist proclaimed in our final session, "*now we are in the new era".*

Dialogue

As a writer, I have long been interested in dialogue. Early attempts at short fiction were abandoned in favour of plays through which I could craft conversations between (albeit fictional) people. My efforts to write monologues proved equally challenging. Through backstage experience with theatrical productions, I learned that I am process- rather than product-oriented; I would prefer to attend rehearsals of a play than to see a performance. Likewise, I prefer learning activities that involve practice and participation over time rather than one-time training events. What is it about dialogue that is so compelling? How has it influenced my decision to incorporate theatrical and dialogical elements into this critical participatory action research project? The answer lies, in part, with active engagement and attentive listening, a fundamental skill for successful educators, performers and clinicians (Goldingay et al., 2013; Noddings, 2012; hooks, 1994).

Educators may choose to either deliver monologues or engage in dialogue. Most of the health sciences educators and trainers I have encountered utilise a lecture-based approach analogous to the banking concept described by Freire (2005/1970), whereby the instructor is

"the 'privileged' transmitter of knowledge" (hooks, 1994, p.85). The didactic method allows lecturers to maintain control over session content, both that which is conveyed and that which is not. Lectures often conflate teaching with presentations and offer a narrow vision of in-service learning. On the contrary, "In the engaged classroom, students learn the value of speaking and of dialogue, and they also learn to speak when they have something meaningful to contribute" (hooks, 2010, p.22). Educators who opt for a dialogue-based approach relinquish a modicum of control over the learning environment: the educator's role shifts from subject matter expert to facilitator (Mezirow, 1997), from "the-one-who-teaches" to one who is "taught in dialogue with the students, who in turn while being taught also teach" (Freire, 2005/1970, p.80). In so doing, the educator acknowledges that the teacher's voice is not the only one worth listening to and that learner engagement extends beyond "Any questions?".

Isaacs (1996) characterises dialogue as a "unique form of conversation with potential to improve collective inquiry processes, to produce coordinated action among collectives, and to bring about genuine social change" (p.20). He asserts that dialogue enables learners to develop "their capacity to hear and inquire into perspectives vastly different from their own" (Isaacs, 1996, p.21), which echoes Mezirow's (1997) contention that discourse is "central to making meaning" (p.10), and endorsement of "active dialogue with others to better understand the meaning of an experience" (Mezirow, 2000, p.10). According to Bohm et al. (1991), learning occurs through dialogue "not as the result of consuming a body of information or doctrine imparted by an authority, nor as a means of examining or criticising a particular theory or programme, but rather as part of an unfolding process of creative participation between peers" (p.1).

Mezirow (2009) acknowledges sociocultural factors such as power, race, and class and maintains that "these influences may be rationally assessed and social action taken appropriately when warranted" (pp.95-96). His dispassionate perspective suggests that all learners, regardless of social status or context, will be able to vocalise and critically examine their assumptions and then take steps to enact change. This leads me to question the degree to which transformative learning theory, as envisioned by Mezirow, applies in settings characterised by rigid social and systemic hierarchies. In contrast, engaged pedagogy encourages teachers and learners to consider power dynamics in the context of inequality and to develop a "clearer understanding of dominator culture and the particular dynamics of race, gender, class, and sexuality which emerge" (hooks, 2010, p.37). hooks (1989) conceives of dialogue as a process that enables learners to rise above efforts to objectify and dehumanise them: "Speaking becomes both a way to engage in active self-transformation and a rite of passage where one moves from being object to subject. Only as subjects can we speak. As objects, we remain voiceless - our beings defined and interpreted by others" (p.12).

Findings affirm that dialogue has the potential to unearth assumptions and beliefs that may remain below the surface in traditional learning environments. Though a promising alternative to formal training, proponents of dialogue often portray it as a process that will invariably transform learners, an optimistic perspective unlikely to hold in all settings. At the same time, the dialogical process is often described in vague terms, if it is described at all. This lack of specificity leaves educators on their own to determine how to facilitate dialogical experiences that help learners challenge assumptions, consider others' motivations, and move "from silence into speech" (hooks, 1989, p.9). In addition, Mezirow's (1997) conception of discourse as "a dialogue devoted to assessing reasons presented in support of competing interpretations by critically examining evidence, arguments, and alternative points of view" (p.6) leaves little room to consider how emotions influence our motives, assumptions, and behaviour. In response, Taylor (2001) calls upon educators who draw upon transformative learning theory to incorporate the exploration of emotions into discourse.

Dialogue in Action

Akin to hooks' (2010) assertion that conversations "always confront us with different ways of seeing and knowing" (p.46), Bohm et al. (1991) maintain that dialogue is "essentially a conversation between equals" (p.7) through which "collective learning takes place" (p.1). The topics raised in our sessions were not easy to discuss, yet CPAR group members stayed motivated despite logistical challenges and a sociocultural context in which some participants (nurses) rank higher along social and systemic hierarchies than others (cross-border migrants). Participants could have shared their opinions with me privately or dismissed the project as futile. However, they braved taxi strikes and power outages to attend sessions despite no financial incentive other than a transport allowance and a snack. Group morale remained high, and participants remained optimistic, even as we examined entrenched systemic challenges that seemed daunting and difficult to overcome.

What led this disparate group to stay motivated for an entire year – and to consider each other as equals – even though critical reflection can affect learners in "potentially undesirable ways" (Cooper et al., 2013, p.79)? Purposive sampling employed during recruitment likely resulted in the selection of participants eager to share their perspectives and explore a topic in which all were invested. Prolonged interaction may have led nurses and activists to question their assumptions about one another, especially when group members did not exhibit the stereotypical behaviour often attributed to them. In effect, participants may have experienced a disorienting dilemma "of which old ways of knowing cannot make sense" (Mezirow, 1990, p.5) when the actions of other members did not align with their preconceived notions.

This research project brought people on opposite sides of a contentious issue together to collaborate. It provided a space for respectful conversation and an opportunity to consider the motives and perspectives of others, crucial elements that, I believe, encouraged members to remain involved. Walker and Freemantle (2023) contend that sustainable change arises from small, "less visible responses that aim to knit connections between people, often across personal, political and ideological divides – from the ground up" (p.61). This study linked two disparate groups who otherwise may not have formed connections or engaged in dialogue. Participants' desire to learn from one another and sustain a partnership is evidenced by the fact that the conversation continued beyond our scheduled sessions, including ongoing communication through our WhatsApp group chat. In addition, a nurse has twice visited the refugee advocacy group led by two activists to speak with their members.

The fact that CPAR group members remained motivated and engaged affirms that recognition is central to the collaborative learning process. Throughout our sessions, nurses and activists shared examples of times when they were not heard, or their efforts were unacknowledged ("*we won't get no feedback"*; "*You will never get the compliments*") and when they were told, either directly or indirectly, they were not welcome *("They said, 'You don't belong here'")*. Conversely, members ensured that everyone's voice was heard and opinion recognised even when we disagreed, bolstering Bohm and Weinberg's (2004) assertion that a group engaged in dialogue "is not going to judge or condemn. It is simply going to look at all the opinions and assumptions and let them surface" (p.47). Contrary to the disconcerting anecdotes shared throughout this study, our interactions were characterised by mutual recognition, whereby "each party recognises the other's knowledge (and their own) as legitimate and worth listening to," an acknowledgement that does not come easily "In situations of historical hierarchies between groups" (Cooper et al., 2013, p.78).

Mezirow (2000) categorises trust, solidarity, security, and empathy as "essential preconditions for free full participation in discourse" (p.12), yet offers little advice to ensure these preconditions are met, let alone how to encourage participation within heterogeneous groups. On the contrary, Fiske (2019) maintains that people transcend stereotypes when they need one another to accomplish something they care about and argues that the best way to encourage people to get along is to place them on a team. This recommendation resonates with hooks' (2003) contention that power dynamics between dominant and subordinate groups "is altered when knowledge is shared in a way that reinforces mutual partnership" (p.91).

Equal Footing

Perceptions of worthiness are informed by assumptions that result in blame-shifting *("you already full [sic] the seats"; "Nurses always take the blame"*) and maintenance of social and

systemic hierarchies. Cooper et al. (2013) contend that "different forms of knowledge and different identities are so often placed on a hierarchy so that one person's perspective is deemed (often by both other and self) less valid or legitimate than the other's" (p.78). It is worth considering how differently our conversations could have played out, given the relative social positions of professional nurses and cross-border migrants in South Africa. Had group dynamics replicated those highlighted throughout the study, it is entirely possible that nurses would have dominated our conversations while activists remained silent.

This hypothetical scenario underscores Cooper et al.'s (2013) contention that those in positions of power may assume "their knowledge is better than the knowledge held by the poor, and that there is nothing to be learned by listening" (p.78). It also evokes the experience of the activist who expressed concerns to a clinician who *"stood and was beating the table to tell me that I cannot teach her how to do".* That this scenario did not occur is a testament to group members' willingness to engage in dialogue - a "collective way of opening up judgments and assumptions" (Bohm & Weinberg, 2004, p.53) - and to share frank and, at times, contentious thoughts with one another. It affirms that in dialogue, people relate to one another "as subjects, not objects" (Cooper et al., 2013, p.78), a notion that aligns with engaged pedagogy (hooks, 1989).

Bohm et al. (1991) maintain that "Hierarchy has no place in Dialogue" (p.7). When I reflect upon the CPAR group, I am struck by the fact that prevailing hierarchies were not replicated, a facet that hooks (2010) deems essential if learning communities are to succeed. I am left to contemplate how a similarly respectful and engaged dynamic might be fostered within future groups, especially those comprised of learners who occupy vastly different positions within a particular hierarchy. For instance, how might the participation of PHC facility physicians, cleaners, or security guards affect group dynamics? Considering this question leads me to conclude that hooks underestimates the degree to which learners in rigidly hierarchical environments such as the South African health system may be willing and able to "come to voice" (hooks, 1994, p.148).

Bohm et al. (1991) recommend that dialogue implemented within an organisation should "begin with an exploration of all the doubts and fears that participation will certainly raise" (p.8), an important suggestion for the PHC facility, in which "There may be a fear of expressing thoughts that might be seen as critical of those who are higher in the organisation or of norms within the organisational culture" (p.8). It does, however, lead me to question whether individuals who fear the repercussions of speaking aloud, especially those who occupy a lower position in an organisational hierarchy, will be willing to vocalise their concerns in the presence

of others. In such instances, it seems reasonable to provide an alternate means for participants to share their concerns, for example, in writing.

Listening with Intent

Assumptions invariably surface through dialogue. Bohm and Weinberg (2004) maintain that people engaged in dialogue may only realise they hold a particular assumption once another participant shares the opposite sentiment. Listening is, therefore, a crucial part of the dialogical process. Although speaking is essential, "the actual process of exploration occurs during listening" (Bohm et al., 1991, p.6). When I consider the factors that enabled our group to thrive, I return to the act of listening, which, when done with intent, signals respect. It is also worth noting that if a person is listening, s/he is not lecturing or delivering a monologue.

hooks (1989) asserts, "To know who listens, we must be in dialogue. We must be speaking with and not just speaking to" (p.16). Although we did not always agree, CPAR group members listened to one another intently, demonstrating how dialogue seeks not to conceal our differences but to provide a means to consider and reflect upon them (Isaacs, 1993). In this regard, our group embodied features of the dialogical relationship described by Cooper et al. (2013), whereby "the other is engaged with as an equal and in a nonauthoritarian way" (p.82). This display of mutual recognition was particularly salient when members reflected on statements made in prior sessions, as when activists referenced nurses' frustrations with rigid clinic hierarchies, which confirmed that individual voices were heard and had influenced the perspectives of others.

Participation in the CPAR group provided an opportunity for members to listen to those with whom we may not otherwise have interacted. For nurses, it meant listening to cross-border migrants, the embodiment of a stigmatised population devoid of status or power, and acknowledging they are worthy of being heard. For activists, participation meant listening to nurses, a cadre long associated with their mistreatment ("*We only showing the bad side of nurses because we're foreign nationals").* Listening with intent was crucial to the CPAR group process because in dialogue, "Each listener is able to reflect back to each speaker, and to the rest of the group, a view of some of the assumptions and unspoken implications of what is being expressed along with that which is being avoided" (Bohm et al., 1991, p.3). Prolonged dialogue allowed us to reflect upon each other's motives and assumptions rather than state our opinions, as might have occurred in a focus group discussion. It also enabled us to consider each other's perspectives, especially when participants assumed the role of PHC facility nurses (*"I've got my problem, and you [are] a burden on top of what I have already"*) and patients from the general population ("*They have to go back to their countries"*) in conversation and forum theatre scenes.

Health System Challenges

The tendency to attribute systemic failures to individuals suggests it is easier and safer to blame socially marginalised patients ("*I gonna leave here four o'clock because of you*") and clinicians *("it will always be nurses' fault"*) for challenges encountered within the health facility than to question the legitimacy of the system itself and take steps to improve it. Hixon et al. maintain that "To advocate for social justice, one must be familiar with the mechanisms of injustice, including its ideological and historical underpinnings" (p.164). Our dialogue gained momentum as the CPAR group began to explore the historical and sociocultural factors that give rise to unequal treatment. We concluded that, whereas the right to health enshrined in the Constitution of the Republic of South Africa applies to all (in theory, at least), "deservingness is always reckoned in relative terms" (Willen, 2012, p.814).

Participants highlighted numerous health system challenges that further inhibit equitable care, including issues related to motivation, supervision, staffing, accountability, and misbehaviour by clinicians and patients. That systemic problems surfaced so frequently reinforces that in-service training alone is unlikely to result in improved patient treatment or outcomes. Since this research project is situated within the field of health sciences education rather than public health, I have opted to emphasise the sheer number of systemic issues raised rather than delve into specific operational and administrative challenges.

Govender et al. (2022) argue that when considering mistreatment by clinicians, "it is important to recognise that many of these health workers are located lower in the organisational hierarchy, themselves overworked and abused in under-resourced and poorly supervised environments and overall dysfunctional health systems" (p.1). Findings suggest this is an apt description of PHC facility dynamics, as indicated by the nurse who highlighted supervisory power differentials: *"We can't confront them because they're superiors; we don't want to be disciplined. So, I will snap to the one that I'm seeing: the patient".* This statement also evokes Mizrahi's (1985) observation that health workers in the Global North "felt abused and neglected and therefore sought justification for projecting that perspective on to patients" (p.218).

According to Fassin (2008), "The pre-eminence of technique in the professional ethos under practical and material constraints results in the use of all sorts of tactics to avoid patients' queries, demands, even their mere presence" (p.268). Clinicians employed in the public health system in South Africa are motivated to Get Rid of Patients (Mizrahi, 1985) rather than care for them ("*Come tomorrow with the interpreter"; "In fact, do you have a folder here?")*. Roth (1972) maintains that people in service delivery positions "will apply the evaluations of social worth common to their culture and will modify their services with respect to those evaluations

unless discouraged from doing so by the organisational arrangements under which they work" (pp.840-841). He implies there is a need for operational and educational processes to promote equitable treatment throughout the health system rather than interventions focused solely on individual actors. This sentiment aligns with the perspective of the activist who asserted that individual clinicians are not to blame for patient mistreatment; rather, the situation "*is coming from above, from policymakers".* It is also the approach endorsed by the Lancet Global Health Commission on High Quality Health Systems in the SDG Era (Kruk et al., 2018).

I have no illusions that dialogue alone will solve the complex challenges facing the South African health system. Techniques arising from engaged pedagogy and transformative learning theory are insufficient to overcome entrenched operational, supervisory, and governance issues. This is understandable, as neither pedagogical approach was developed with the health system in mind. If they are to have any impact, learning strategies to curtail perceptions of (un)worthiness and decrease the system justification motive must be coupled with concrete actions to address the systemic challenges highlighted throughout this study.

Humanness

When health workers in South Africa mistreat or deny treatment to Africans seeking care, "they explicitly and implicitly dehumanise them, placing them on a lower rank in the global racist 'human hierarchy' that elevates whiteness at the expense of variously racialised black and brown populations" (Walker & Freemantle, 2023, p.7). Dehumanisation occurs when people are perceived to lack human qualities, such as higher cognition, or are considered to be objects that lack warmth (Haslam, 2006). Perception of others as high in warmth and competence is therefore humanising, exemplified by the nurse who recounted her arrival at a clinic for socially marginalised patients: *"When I got there, I found people. I found human beings"*.

Findings affirm that humane patient care is characterised by recognition (*"that person is still a human being")*. The same holds for PHC facility staff, who also wish to be seen and heard ("*They don't see us as caregivers")*. Humane care begins with attentiveness, hearing and acknowledging the needs expressed by those being attended (Noddings, 2012). Cassell (2004) maintains that failure to perceive patients as human beings reframes the body from subject to object and asserts, as does hooks (2010), that one way to promote humane care is to attend to people's stories; listening to the expressed needs and experiences of others is validating and confirms that they are worthy of being heard.

Whereas people in subordinate positions pay attention to the powerful, those in power often lack the motivation to attend to the powerless (Fiske, 1993), which has implications in the hierarchical PHC facility, where people wield varying degrees of power. hooks (1989) asserts

that “Understanding the harm and abuse we as black people can do to one another when we passively absorb and uncritically support notions of hierarchy, and working to construct alternative behaviour strengthens our compassion and deepens our care for one another” (p.69). Uncritical support of hierarchy was highlighted by nurses who described being admonished by fellow clinicians for providing “*VIP treatment*” or being “*too much of a mother*” to patients. In effect, nurse participants were chastised by their peers for providing humane care rather than adhering to their stereotypical role as moralisers and disciplinarians. Martimianakis and Hafferty (2016) contend that to remedy such challenges, attention must be paid to problems inherent within the health and education systems: “To address the causes instead of the symptoms of dehumanising learning environments and dehumanised care, we need to have an intentional focus on systems issues that actively generate the tensions within our learning environments” (p.279).

Shift The Narrative

The Worthiness Cascade depicts a process that, left uninterrupted, results in preservation of the unequal status quo. Intervention at any point has the potential to disrupt the cascade, thereby decreasing the likelihood that clinicians and patients will make determinations of worthiness that maintain inequality. hooks (1989) contends that “our first response when we are motivated to conform or compromise within structures that reinforce domination must be to engage in critical reflection. Only by challenging ourselves to push against oppressive boundaries do we make the radical alternative possible, expanding the realm and scope of critical inquiry” (p.81). Critical educators are well-suited to facilitate reflective learning processes that challenge problematic assumptions and the motive to uphold unequal systems.

Given that “we make assumptions about people, situations and organisations based on aggregated information whose provenance we cannot easily recall and may not even be able to describe” (Eraut, 2004, p.253), it is imperative to provide opportunities for critical reflection in any learning strategy designed to enact social change, including this one. Critical reflection allows learners to explore how and why we justify our beliefs (Mezirow, 2000), particularly those that bolster inequality. Cranton (2002) urges educators to nurture learners’ capacity to act upon their revised assumptions and asserts, “We cannot teach transformation. We often cannot even identify how or why it happens. But we can teach as though the possibility always exists that a student will have a transformative experience” (p.70).

hooks (2010) attests that “we all believe what we see from our perspective, and that the individual perspective is always limited” (p.50). Likewise, Bohm et al. (1991) contend that people believe “the way each of us interprets the world is the only sensible way in which it can be interpreted” (p.2). Reflection enables learners to consider multiple viewpoints (Stern et al.,

2008), an advantage highlighted by the activist who stated that our dialogue promoted learning because it offered "*another way of doing things than maybe dwelling on my way of doing"*. The CPAR group provided an opportunity for members to challenge our preconceived notions and to reflect upon the perspectives of others. As a result of our sessions, I, too, began to question my assumption that clinic staff are the sole source of patient mistreatment, an assumption that ultimately proved incorrect. It is unlikely this assumption would have been challenged had I engaged solely in internal conversation. I have come to realise that introspection only takes one so far: to challenge problematic assumptions, it is essential to provide learners with the opportunity to contemplate perspectives other than their own.

As study findings affirm, it is easier and safer to rationalise the status quo than to change it. Only those who consider the current state of affairs unacceptable will be motivated to disrupt the Worthiness Cascade. How, then, to convince people inclined to do things the way they have always been done - whether in the classroom or the PHC facility – that there is another way? Since those who believe the status quo is acceptable have little incentive to change it (Jost & Banaji, 1994), it follows that the impetus comes from the realisation that the current state of affairs is unacceptable after all. To acknowledge that the health or educational status quo is intolerable, we must be willing to consider alternate perspectives. This is no easy task, particularly for those in positions of power with low motivation to attend to those in subordinate positions. One way to move towards such a change is to reduce the motive to justify the status quo and the tendency to shift blame for systemic problems onto individuals. Critical reflection on perceptions and beliefs that moderate the strength of the system justification motive may prove a good place to start.

By encouraging learners to consider and reflect upon the motives that drive one's behaviour and the behaviour of others, educators help surface assumptions that perpetuate stereotypes and the rationalisation of mistreatment. Pedagogical techniques that spur educators and learners alike to question their assumptions about the root causes of systemic problems may, therefore, shift perceptions of worthiness. Implementing such learning processes in tandem with steps to resolve entrenched operational issues within the health system increases the likelihood that any resulting perspective shifts will endure.

Shared Talk

hooks (2010) maintains that "Many students often feel that they have no voice, that they have nothing to say that is worthy of being heard. This is why conversation becomes such a vital intervention, for it not only makes room for every voice, it also presupposes that all voices can be heard" (p.45). Likewise, Isaacs (1993) envisions dialogue as a collective inquiry into "the meaning embodied in a community of people" (p.2) and contends that it "compels the

realisation that most of what is significant to human beings is in one way or another created through shared talk" (Isaacs, 1996, p.29). I believe the opportunity for shared talk between two groups unlikely to engage outside of the health facility motivated our cohort to sustain a dialogue unhindered by social hierarchies. Reflection on my experience as a participant observer in this study leads me to concur with hooks' (2003) assertion that "Conversation is the central location of pedagogy for the democratic educator" (p.44).

Conversation between those who may not otherwise interact allows people to 'try on' different perspectives (Mezirow, 2000) and to examine the assumptions that emerge, especially when something unexpected occurs (Cranton & Roy, 2003). Engagement with someone who does not behave stereotypically, such as a cross-border migrant who exhibits warmth and competence, may lead others to question - or at least acknowledge - their motives and assumptions. It also humanises those previously considered less than human. This disorienting experience may be the jolt that educators, clinicians, and public health practitioners need to consider alternate approaches and may ultimately induce a shift in perspective, no matter how incremental.

According to Opotow (1990), "perceiving another as connected to oneself in any way can hinder moral exclusion. Belonging to the same community, perceiving another as a worthwhile being, or discerning any thread of connectedness creates bonds, even with strangers" (p.7). This statement evokes the forum theatre scene in which a patient attempted to diffuse a tense situation by reminding a fellow patient, "*We are Africans. We must help one another*". Cultivating a learning community within the PHC facility in which each member is heard and recognised may mitigate negative emotions and, ultimately, decrease the tendency of nurses and patients to take their anger and frustration out on one another. It also has the potential to satisfy the relational need for belonging, which may decrease the motive to justify unequal systems (Jost et al., 2012).

Stereotypes that reinforce perceptions of low warmth and competence lead to feelings of contempt and determinations of unworthiness that maintain hierarchies and the unequal status quo. Shifting perceptions of the socially marginalised from an undifferentiated group low in warmth and competence to individuals with distinct personalities and motivations is humanising and, therefore, essential to disrupting the Worthiness Cascade. Critical reflection on problematic assumptions and beliefs holds promise as a strategy to counter the motive to justify unequal systems and, through dialogue, "the sharing of speech and recognition" (hooks, 1989, p.6), take initial steps to challenge the status quo.

Providing The Container

I liken my role in the CPAR group to what Isaacs (1996) terms “providing the container”: finding ways to **“**lower transaction costs of interactions” and “shift the ground from one where the parties are seeking to make decisions or ‘fix’ the system to explore new options about what is creating the current system” (p.24). Providing the container means that I selected the participants who joined the group at the beginning of the study and determined when and where to meet. It entailed taking steps to “reduce the risk of all parties to interact and conduct legitimate inquiry into underlying images, norms and perceptions” (Isaacs, 1996, p.24). I tried my best to nurture an environment in which members felt welcome, recognised, and comfortable sharing their perspectives on a challenging topic. I acknowledge that, at times, my background in global health led me to focus on potential solutions to systemic issues, a habit I relinquished when my co-supervisor reminded me that this research undertaking is not a quality improvement project.

Participants deferred to me when making logistical decisions. It is possible that the provision of transport allowance resulted in a perceived power differential, as I was in control of resources, however small. At no point did I sense that group members were self-censoring their words or saying what they thought I wanted to hear. Participants were also willing to approach me with their concerns, as when a nurse questioned why our conversations focused on only one socially marginalised population.

Whether in person or online, our sessions always began with a check-in, during which each member shared a brief update with the rest of the group. This small act enabled us to get to know each other as people, as more than the labels ascribed to us. It also provided an opportunity for everyone to speak and acknowledge one another at the beginning of each session, setting a respectful tone for the conversation that followed. Check-ins helped foster the development of our learning community because “our capacity to generate excitement is deeply affected by our interest in one another, in hearing one another’s voices, in recognising one another’s presence" (hooks, 1994, p.8). Check-ins and forum theatre activities also provided moments of levity that made for a more relaxed and enjoyable learning experience despite the gravity of the topics at hand, which helped “reduce the risk of all parties to interact” (Isaacs, 1996, p.24).

Reflections on Positionality

At the end of nursing school in 2011, I read an article about a rural health organisation in India that trained illiterate women to become Village Health Workers (VHWs). The women met for weekly learning sessions, during which they engaged in dialogue with peers from nearby communities and staff to discuss issues that had arisen and to learn new skills. What set this initiative apart was that women selected to become VHWs came from the Dalit (Untouchable) caste. Occupying the lowest rung of the rigid social hierarchy in India, Dalits were considered nonpersons and prohibited from wearing shoes or touching those from higher castes (Rosenberg, 2008). As in South Africa, though the laws codifying this unjust system have been dismantled, many of the associated stereotypes, assumptions, and beliefs remain. Despite these barriers, VHWs provided life-saving health services to people belonging to other castes. That Dalit women could surmount such entrenched social stratification was, I thought, nothing short of remarkable. Though actively seeking an entry-level clinical position at the time, I felt compelled to reach out to the organisation and enquire whether they needed volunteers.

As with other cross-cultural experiences I have been fortunate to have, the time I spent in India furthered my understanding of the root causes of inequality within a specific context. It also piqued my interest in novel learning strategies to address health challenges in inherently unjust systems, an interest that ultimately led me to pursue this research project. In hindsight, I believe perceptions of highly socially marginalised Dalit women gradually shifted as a result of prolonged interaction with people from different castes, which ultimately led to a reassessment of underlying assumptions, norms, and beliefs. Engagement that transcended traditional roles and expectations – in this case, provision of health services by women occupying the lowest rung of the caste hierarchy – likely led to shifts in perceptions of warmth and competence that humanised those previously considered nonpersons. This extraordinary example gives me hope as I consider the challenge of shifting perceptions of worthiness in a different hierarchical context: the South African public health system.

The decision to carry out this study emanated from a nascent belief that when it comes to in-service learning, the way things have always been done is not good enough. This experience has confirmed my suspicion that the traditional sensitisation approach to address problematic attitudes and behaviour does not work. I have developed a more nuanced understanding of crucial concepts that are all too often described in generic terms devoid of context in educational settings (for instance, “stereotypes”) and gained clarity about the underlying causes of patient mistreatment and acceptance of the unequal status quo in South Africa.

My initial foray into critical participatory action research has helped me develop an appreciation for collaborative research methods that may be used to explore challenging topics in context. This project has also confirmed that much learning occurs tacitly outside the classroom, a factor that educators and global health practitioners like me must take into consideration. Though well-intentioned, I have learned that my efforts to do things differently as an instructional designer and trainer were insufficient to address the complex systemic and contextual issues inherent in resource-constrained settings. I have always been eager to propose nontraditional ideas regarding in-service education; I am now in a position to speak confidently rather than relying on a gut feeling that a novel learning approach might work.

Given the qualitative nature of this study, my participation has influenced both the data collected and its interpretation and analysis. As a foreign national and a registered nurse, my background aligns with that of fellow CPAR group members to some degree. However, in South Africa, my American passport and white skin colour confer upon me a status not afforded to other participants, all of whom are African. I do not know what it is like to enter the country as an asylum-seeker or refugee, and I have not experienced racial discrimination. Nor do I have first-hand experience as a clinician or patient in a public PHC facility. Embracing subjectivity allowed me to develop a relationship with fellow group members and to gain a deeper understanding of the factors that shape their perspectives, which provided insights I could not otherwise have attained from my privileged position. It also allowed me to acknowledge and question the assumptions I brought to the project.

As a participant observer, I served a dual role as CPAR group facilitator and member. Decisions I made as the facilitator influenced the composition of the group and the tenor of our sessions, which undoubtedly informed study findings, as did my decision to incorporate forum theatre into the process. Throughout our sessions, I reiterated that I was not the leader of the CPAR group but rather a co-researcher and participant who wished to learn from other members. I felt it necessary to highlight this point, especially as I am neither a South African nor a cross-border migrant.

I was pleased to have the opportunity to interact with participants in a meaningful way as a group member. I strove to provide input while inviting others to do most of the talking so as not to dominate our conversations. My input likely influenced findings, especially when I conveyed my opinion regarding traditional in-service learning and shared observations whilst on Lesvos. Serving in a dual role allowed me to challenge assumptions from two distinct vantage points. I believe it also increased the likelihood that group members perceived themselves as subjects rather than objects; that is, participants viewed themselves as co-investigators rather than the object of study. Yet, my participation may also be considered a limitation. It is possible that my

views had an undue influence on the content and direction of our conversations and may have led me to lend more weight to data aligned with my perspective.

6. Conclusions

Introduction

Health for All may only be attained through recognition of the inherent humanity of patients and the clinicians who serve them. In South Africa, the activation of stereotypes that depict the socially marginalised as low in warmth and competence predicts contempt, the feeling that someone is unworthy of respect. As a result, cross-border migrants and other marginalised groups are at risk of mistreatment when seeking health services and may be considered unworthy of care. Worthiness determinations justify dehumanising actions that harm patients, maintain hierarchies, and preserve the unequal status quo. Shifting perceptions of socially marginalised people from one-dimensional characters devoid of warmth and competence to distinct and dynamic individuals is humanising and, therefore, crucial to deterring the practice of triaging patients based on perceived worthiness.

Thirty years after the fall of apartheid, social and institutional hierarchies continue to perpetuate inequality and pit Africans against Africans. Study findings suggest it is easier and safer to blame clinicians and patients for systemic failures than to challenge the legitimacy of the system itself. Decreasing the motive to rationalise unequal systems is a prerequisite for social change. Critical educators who comprehend why teachers and learners may be motivated to justify the status quo may then apply pedagogical techniques to decrease the motivation. To disrupt the Worthiness Cascade, it is essential for learners to critically examine the assumptions that shape the (mis)perceptions and motives that underlie their behaviour and the behaviour of others. Given the multifaceted challenges facing the South African health system, any learning strategy to address mistreatment should be implemented concurrently with steps to address systemic issues that may not be remedied through education alone.

Findings underscore the link between health systems challenges and in-service learning: public health practitioners who fail to acknowledge the significance of tacit learning are unlikely to consider contextual factors that impede health systems strengthening initiatives. Likewise, educators who assume that a single didactic workshop will solve entrenched sociocultural and systemic problems do a disservice to both learners and patients. Although educators and trainers may be unable to remedy many of the operational issues highlighted throughout this study, they are well-placed to acknowledge them. Critical educators may go one step further by fostering an environment where learners can challenge assumptions and beliefs regarding the underlying causes of health inequity, consider the motives and perspectives of others, and deflect counter-narratives that rationalise unequal treatment.

The traditional sensitisation approach to in-service learning does not deter the stratification of patients by perceived worthiness. Reimagination of what in-service learning could and should entail is long overdue. Educators and trainers accustomed to doing things as they have always been done may be reluctant to try an unfamiliar method, especially one that relies on neither a curriculum nor slide decks. Yet, it is time for health sciences educators, public health practitioners, and donors to move away from "*the old system*" and reframe in-service learning as an ongoing process rather than a one-time event. Critical reflection on problematic assumptions and beliefs provides an alternative to the conventional didactic approach; it holds promise as a strategy to inhibit worthiness determinations and counter the motive to justify unequal systems. The process undertaken by the CPAR group offers a template for a learning strategy that may ultimately prove more effective than stand-alone training.

Global health practitioners and donors may find value in this study, especially as they consider programmatic strategies that transcend formal in-service training. Study findings will help educators explore and address similarly complex dynamics throughout the health system and other institutions that provide social services in resource-constrained settings. Findings may also benefit health science educators who teach physicians and allied health workers, as well as educators and trainers who promote health equity at the community level.

Recommendations

Providing the container – in other words, creating and maintaining a welcoming space in which learners wish to engage – is crucial if dialogue-based educational activities are to succeed. It is not enough to gather a group of participants in a room and hope for the best. Although the educator relinquishes some control over the process, it is not a free-for-all; actions may be taken to nurture an environment conducive to respectful conversation and critical reflection. Reframing the educator's role from subject matter expert to facilitator is an essential first step.

Providing the Container: Practical Steps

A key responsibility of the facilitator is to determine the composition of the group that will engage in dialogue. To guarantee a range of perspectives, it is imperative to invite participants who may not otherwise have the opportunity to explore the topic under consideration together. For example, the CPAR group comprised two parties that, though both deeply invested in the topic, entered the conversation with little understanding of the other's perspectives and motives. Although it may be challenging to identify individuals willing and able to participate over time (as was the case with our group), it is well worth the effort. It is also important to schedule dialogue at times that cause the least disruption to participants and

patients and to conduct sessions in a convenient location, preferably on-site. If prolonged dialogue is not feasible, facilitators may wish to incorporate opportunities for engagement into existing forums, such as facility health committee meetings attended by staff and community members.

Dialogue may only succeed if participation is voluntary. Contrary to what often occurs with traditional in-service training in South Africa, learners should join of their own volition. Any hint of obligation or coercion will reduce the likelihood of meaningful participation and reinforce the very hierarchies that dialogue seeks to avoid. Provision of information about the process in advance will enable potential participants to make an informed decision, as will assurances that facilitators seek a range of perspectives.

The dialogical approach will likely be unfamiliar to learners accustomed to traditional in-service training. Providing the container entails describing a collaborative learning process whereby participants actively engage with one another rather than passively listen to lectures. Participants should know the goal is to critically examine assumptions and perceptions that underpin systemic challenges rather than brainstorm ways to address them: in dialogue, it is the process that matters, not the product. That said, a deeper and more nuanced understanding of health systems issues in context will allow all involved to reconsider problematic assumptions and explore potential solutions.

In light of the historical and sociocultural factors emphasised throughout this study, proclaiming that learners are in a 'safe space' at the beginning of a session or creating a list of ground rules will not suffice. Rather, to promote mutual recognition, the facilitator should take steps to ensure that every participant feels welcome and comfortable through periodic communication with individual members, either verbally or in writing. Effective facilitators also guide and support learners without judgment, should a conversation become tense or participants express discomfort with the process. At the same time, facilitators need not seek group consensus nor shy away from conflict (Bohm et al., 1991).

CPAR group dynamics demonstrate the importance of encouraging learners in dialogue to share stories and personal experiences, express opinions (even those that may be unpopular), acknowledge and challenge assumptions, and respectfully disagree with one another. This may be easier said than done, especially early in the process; however, as learners spend more time together and interact in ways that depart from their traditional roles, those once reluctant to voice differing opinions may be more inclined to do so (Bohm et al., 1991). The use of an online messaging platform such as WhatsApp provides an additional way for learners to share stories,

opinions, resources, and information with one another. It also helps maintain group cohesion and momentum between sessions.

Step Into Another Role

Dialogue is a powerful educational tool that extends beyond convening a group of learners together to talk: there is more to dialogue than free-flowing conversation. My experience with the CPAR group confirms it is essential for facilitators to nurture a space in which learners are not only at liberty to talk and listen but to actively consider the perspectives of others. In practice, this means inviting people from dissimilar backgrounds to explore their motives and the motives of others through narrative, dialogical, or theatrical processes that encourage reflection on varied perspectives, free of judgment. It means encouraging learners to literally or figuratively step into another role, as when activists portrayed patients from the general population during forum theatre activities and when participants voiced the opinions of prototypical clinicians (*"They're giving us more burden, giving us more work"; "my plate is full")* and patients *("look at that nurse. Attitude"*) in conversation.

The embodiment of another character creates a certain distance that enables learners to consider alternate perspectives in a low-stakes environment, thereby reducing perceived risks of participation. Providing opportunities for learners to speak and act in the third person through activities such as forum theatre may help engage those who struggle to share their views in conversation. It also allows talkative group members to consider perspectives other than their own.

Long Story Short

This research project aimed to explore nurse perceptions of patient worthiness in South Africa and to identify learning strategies to deter the practice of triaging socially marginalised patients. Findings indicate that stereotypes ascribed to the socially marginalised shape perceptions of their relative deservingness, which, in turn, maintain hierarchies and shift blame for systemic failures onto individuals. Findings have been interpreted through the lens of social psychology and critical pedagogy, a novel approach that sheds light on the perceptions that bolster unjust systems and educational methods to challenge assumptions and beliefs that perpetuate inequality. I hope others may draw from the experience described and analysed here and apply relevant concepts to their settings, as when I applied what I learned in India to this project.

The status quo in South Africa has changed before; it can change again. The critical pedagogical approach employed throughout this study has the potential to shift perceptions of worthiness, decrease the motivation to justify unequal systems and improve the experience of patients and clinicians in overburdened health facilities. CPAR group dialogue affirms that critical reflection on the historical and sociocultural factors that help rationalise mistreatment provides a way to challenge beliefs that maintain the status quo. By encouraging individuals who otherwise may not interact to engage in dialogue, question their assumptions, and consider the perspectives of others, critical educators may disrupt the Worthiness Cascade and decrease the likelihood that some patients are considered less deserving of care than others.

Opportunities for Future Research

This study explored the perceptions of nurses and patients within public PHC facilities in Cape Town, South Africa. Findings do not include perceptions of other clinical and support staff present in the PHC facility, such as managers and supervisors, nor do they include perceptions of nurses who work in other levels of the health system or the for-profit sector. Since study findings suggest that social and systemic hierarchies strongly affect the workplace learning environment, excluding these personnel may be considered a limitation. Future research will help illuminate how group dynamics are impacted when dialogue participants hold vastly different positions within a particular social or organisational hierarchy (for example, physicians and cleaners) and may lead to the generation of tools to help facilitators anticipate and manage challenging situations that will inevitably arise.

It was beyond the scope of this project to consider nurse perceptions of all socially marginalised populations in South Africa. Further investigation will help determine the degree to which the critical pedagogic approach described here shifts perceptions of warmth and competence of other marginalised groups, including key populations such as transgender people and people in prisons. It will also be useful to assess whether the point at which the Worthiness Cascade is disrupted affects the likelihood that perceptions will shift. Determining which system justification moderators (for instance, perceived threats to the system) to emphasise in educational processes that aim to decrease the motive to justify the status quo will also prove beneficial.

Studies exploring ways to transform educators' conception of their role from lecturer to facilitator will be of value, as will research identifying additional pedagogical techniques that enable learners to challenge assumptions and consider the perspectives of others. Future studies may also guide strategies to promote the involvement of lay community members; determine recommended group size, composition, and session frequency; and assess how learners' readiness to change influences the dialogical process. Hybrid initiatives wherein

learning activities are implemented alongside actions to address systemic problems will also be worth examining, given that many NGOs responsible for in-service training implement operational health systems strengthening interventions as well. Additional areas of exploration include research to determine whether the dialogical approach utilised throughout this study shifts other perceptions that affect health care and outcomes; how a virtual dialogical process may affect group dynamics; and to what degree this learning process may differ in contexts either more or less hierarchical than the South African health system.

Appendix: Forum Theatre Scenes

CPAR group members engaged in forum theatre activities during the initial in-person session in March 2022 and a follow-up session conducted in November 2022. Participants selected and enacted the content of each scene using improvised dialogue. A summary of each scene is provided below.

Scene One

The first scene, performed during our initial session, depicts a scenario where a man seeks care for his wife, who is in labour but has no papers. This scenario followed a robust conversation about barriers faced by cross-border migrants seeking health care. Participants agreed upon the scenario before its extemporaneous enactment. An activist volunteered to portray the **Patient's Husband**, and a nurse assumed the **Nurse**'s role. In this scene, immediately following a request for assistance, the nurse enquires about the patient's documents, as indicated in the following excerpt:

Nurse: Does she have any ID? I need an ID. I need a document. I need identification.

Patient's Husband: No, I have nothing. I have nothing, only the paper.

Nurse: How did you come here without it? You know we need it in order to register her. We can't just open a file without that.

Patient's Husband: Yes, sorry, I do understand, but you know-

Nurse: I'm sorry.

Patient's Husband: -you know how the system work here in South Africa; we still-

Nurse: What happened?

Patient's Husband: -waiting for her joint family, and it has, Home Affairs they didn't respond as yet. But please, you can still use my paper, because she's my wife.

Nurse: Oh no. Can I see this? This is quite expired. We can't use that. We need a fresh one.

Patient's Husband: But you know-

Nurse: Can you make something? I can't help you. You either go to Home Affairs and wait until it opens-

Patient's Husband: But she is in labour!

Nurse: I don't know. Sort yourself out. Sort yourself out.

Upon conclusion of the scene, another participant stepped into the role of **Nurse**, and the scene was enacted again, with a different conclusion. In this version, the husband's plea for assistance was again met with a request for papers; however, the nurse acknowledged the situation, agreed to attend to the patient, and provided a solution to the registration issue:

Nurse: When the document is extended, please come back and show the paper so that I can register in the system-

Patient's Husband: Thank you very much.

Nurse: -because we need to register everything in the system.

Scene Two

The second scene was enacted during a subsequent session in November 2022, following a conversation that highlighted how clinicians and patients from the general population perceive socially marginalised patients. In this scene, patients in the queue complain about the long wait while a cross-border migrant is attended to in the consultation room. As with the earlier forum theatre activity, participants discussed the scene's content immediately before its enactment. In the first version of the scene, two activists assumed the role of disgruntled patients (**Patients A and B**), a third activist portrayed the cross-border migrant in the consultation room (**Patient C**), and a nurse played the **Nurse** role. The scene opened with two patients complaining about waiting times:

Patient A: Haibo.

Patient B: Why are they taking long?

Patient A: All this time, we could have been served, but this immigrant is taking too much time. Ay, no, man.

Patient B: Yeah, yeah.

Patient A: Haibo. Ah ah ah ah.

Nurse (*to **Patient C** in consultation room*): Okay, how long have you been having the pain? How long is this a problem?

Patient A: Sisi. Sisi. Ah ah. We need to look at this. These people have to go back. They have to go back to their countries. We don't need this. Haibo.

Midway through the scene, another nurse assumed the role of a third disgruntled patient (**Patient D**) who overhears the conversation taking place inside the consultation room, in which the cross-border migrant states that he has lost his clinic card:

Patient D: He doesn't even have a clinic card. We are sitting here with clinic cards. Yoh!

Patient B: You have to go back to DRC.

Nurse (*to **Patient C** in consultation room*): So now you are trying to say that you've been here since this morning.

Patient C: Yes.

Nurse: So it's only now you are being helped.

Patient C: Yes.

Patient A: Sisi, respect, man. They have their own nurses who can give them care.

The nurse in this scene treats the patient with respect, while the patients in the queue are disrespectful to both the cross-border migrant and the clinician. Upon conclusion of the scene, an activist volunteered to take on the role of the **Nurse**, another activist assumed the role of **Patient B**, and a nurse assumed the role of **Patient C** in the consultation room. The scene was then enacted again. In this version, a patient in the queue (**Patient A**) complains loudly while a fellow patient (**Patient B**) attempts to diffuse the situation, as illustrated in the following excerpt:

Patient A: [Grumbling]

Patient B: Hey. Be patient.

Patient A: They are taking long now.

Nurse (*to **Patient C** in consultation room*): We have securities outside who deal with the noise. And in here, we are seeing the morning patients.

Patient B: Your time will come. There are morning patients. They will attend to you. Be patient.

Nurse (*to **Patient C** in consultation room*): I want to give you a service, and you don't need to look at what is outside. Look at what is happening here. My role is to give you help, not to look at what is happening outside, because if I look at what is happening outside, I will not be able to-

Patient A: No, they have their own hospitals and clinics. They must find their own doctors.

Patient B: Don't you understand? We are Africans. We must help one another.

Patient A: No, my brother. It's not right.

Patient B: So, how do you feel if you find yourself in a foreign land?

Patient A: They must go back.

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