

Experiences within pharmacies: Reflections of persons with visual impairment in South Africa

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Abstract

Healthcare access poses particular challenges to individuals with visual impairments, particularly regarding pharmaceutical products and services. In this study, we showcase how the context of a low- and middle-income country poses particularly compromising experiences within pharmacies for persons with visual impairments. The current study explores the experiences and needs of 21 participants with visual impairments within pharmacies. Through the lens of the relational ethics of care, we demonstrate, first, the importance of a trusting relationship between individuals with visual impairments and pharmacy staff as well as the responsibility that rests on participants to establish the aforementioned trusting relationship, and second, shameful experiences within the pharmacy, centring around threats to privacy. In many respects, a collaborative relationship between pharmacy staff and their visually impaired clientele results in a satisfactory experience for the latter. However, as far as sensitive information, services and products are concerned, participants generally feel vulnerable and uncomfortably visible.

Keywords: Access to healthcare, pharmaceutical products, pharmaceutical services, visual impairment, South Africa, Interpretative Phenomenological Analysis

Points of Interest

- We explore the experiences within pharmacies of 21 South Africans with visual impairments.
- We demonstrate that a collaborative relationship between pharmacy staff and their visually impaired clientele leads to a satisfactory experience for the latter.

- We furthermore show that shameful experiences within the pharmacy largely centre around threats to privacy.
- We recommend training for pharmacy staff members to raise their awareness and sensitivity towards visually impaired clientele.

Introduction

In 2006, the United Nations released its well-known *Convention on the Rights of Persons with Disabilities* (United Nations [UN] 2006), which has since been ratified by 150 countries. These countries, including South Africa, thus formally indicate their commitment to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’ (UN 2006, Article 1). While these rights include the right to access healthcare services without discrimination, access to healthcare remains a global concern for persons with disabilities (Kentab et al. 2019; McKinney, McKinney, and Swartz 2021). Healthcare access poses particular challenges to individuals with visual impairments, particularly when using pharmaceutical products and services (Apoorva, Vasundara, and Umadevi 2017; Cheng et al. 2018; Kentab et al. 2019; Killick et al. 2018). One such challenge is the ability – or mostly lack thereof – to read medication labels and information leaflets (Alhusein et al. 2018; Wakeham et al. 2017). Apart from these practical challenges regarding medication use, persons with visual impairments are often reliant on the attitudes of staff within the pharmacy (Dagnachew, Meshesha, and Mekonen 2021; Devkota et al. 2017). Yet, studies show that pharmacy staff do not receive training in working with people with visual impairment, leaving them ill-equipped to cater for the specific needs of these clients. This is astounding given that 43.8 million people globally are blind, and an additional 295.05

million are visually impaired, with higher prevalence in low- and middle-income countries (Burton et al. 2021). Clearly, if access to pharmaceutical services and products is limited or lacking for those living with visual impairment, the consequent negative impact on their lives will be significant.

Indeed, a recent systematic review identified the need for future research that would promote ‘the safe and effective use of medicines and the delivery of pharmaceutical care services to people with visual impairment’ (Kentab et al. 2019, 1400). In light of the above, the current study aims to explore the pharmaceutical care experiences and needs of 21 participants with visual impairments. In doing so, we aim to answer the following research question: What are the experiences and needs of visually impaired persons within the pharmacy context in South Africa? Our study contributes to existing knowledge in three ways: 1) We focus specifically on South Africa, a low- and middle-income country. This focus allows us to identify the challenges of access to healthcare in pharmacies, thus revealing experiences of access to healthcare outside the bounds of more researched healthcare settings such as hospitals and clinics. We demonstrate how the context of a low- and middle-income country greatly compromises the experience within pharmacy contexts for persons with visual impairments due to poverty, inaccessible transport, corruption and high levels of disability stigma (Dagnachew et al. 2021; Eide et al. 2015; McKinney, McKinney, and Swartz 2021); 2) We highlight the actual and perceived fear of encountering shameful experiences while in the pharmacy context, and the consequent need for building trusting relationships with pharmacy staff; and 3) We elucidate the additional work required of visually impaired clientele in having their needs met within the pharmacy context.

To this end, we will first briefly outline ‘Ethics of care’ as our theoretical lens. We will then provide an overview of our qualitative study conducted amongst visually impaired South Africans. Thereafter, we will outline and discuss our key findings, highlighting the need for

building trusting relationships while also addressing privacy challenges. Finally, we will offer some concluding remarks.

Literature review: The relational ethics of care

‘Ethics of care’ is grounded in feminist theory and was first developed by Carol Gilligan in the early 1980s (Gilligan 1982). This approach to ethics highlights the role of, and need for, relationships in the giving and receiving of care. Building on Gilligan’s work, many authors have advocated that relationships and context should guide moral decision-making and action. Tomaselli et al. (2020) consider relationships when they write that ethics, in the broadest sense, entails ‘doing the right thing, establishing the right kind of relationships and/or destroying what is wrong’ (Tomaselli et al. 2020, Background para. 4).

Yet, what does ‘the right kind of relationship’ mean in the context of care relationships? At its core, care relationships require an in-depth, embodied understanding of care recipients – something that is only attainable through dialogue between care providers and care recipients (Evans 2004; Pollard 2015; Tomaselli et al. 2020). Effective dialogue requires all parties to listen and to respond – to be open and responsive (Evans 2004; Kittay 2011). When care providers truly and openly listen to care recipients, they will come to know the unique needs and context of each individual (Pollard 2015). As Bergum and Dossetor (2003, 125) write, ‘through relationships with others we can listen for some new tones, new ideas, new music’. In this way, it will become possible to respond ‘heart to heart – responding in ways that are fitting to the rhythm of the other person and what is needed in the moment – unexpected, exciting’ (Bergum and Dossetor 2003, 125). Responding to the unique needs of others therefore requires improvisation – it is not to follow a predefined script or a set of rules, but rather to respond to the needs of each unique individual flexibly, spontaneously and authentically from moment to moment (Bergum and Dossetor 2003).

While the ethics of care literature originally focussed on mothering and the need to consider different voices, it has since been applied widely, being included in many studies on ethics and responsibility within organisations (Anastasiadis and Zeyen 2021; Caldwell and Karri 2005; Pullen and Rhodes 2015; Tronto 2010). This stream of literature aims to generate insights into how organisations, through their staff, are able to care for their stakeholders. In this paper, we use this lens to make sense of the experiences within pharmacies of individuals with visual impairments. Considering the personal and intimate nature of (some) pharmaceutical services and products, we argue that any such interaction should be based on care so as to provide the right service to customers, thus optimally addressing their medical, emotional and personal needs.

Methodology

Research design

In this qualitative investigation, we explored the experiences within pharmacies of 21 South African participants with visual impairments. We designed this study according to the qualitative principles of the interpretative phenomenological analysis (IPA) approach. IPA is a qualitative research framework that offers an in-depth, meaningful interpretation of lived experience (Smith and Osborn 2015). It becomes possible for IPA researchers to provide rich, contextual narratives of lived experience through skilfully combining the theoretical perspectives of phenomenology, hermeneutics and ideography (Smith and Fieldsend 2021; Smith, Flowers, and Larkin 2009).

Semi-structured interviews afforded us the opportunity to listen to the lived experiences of participants (phenomenology), while IPA assisted us in interpreting their stories (hermeneutics) (Smith and Fieldsend 2021). In our final write-up, we included verbatim quotes of the participants in order to honour each individual story (ideography).

Sampling, recruitment and participants

We recruited participants through our current networks. We posted an invitation on Facebook and potential participants responded to this invitation by contacting us directly. In addition, we made use of snowball sampling, i.e., we asked participants to inform other potential participants of this study (these potential participants then contacted one of the investigators to express their interest in participating in the study).

In order to participate, participants needed to meet the following inclusion criteria: 1) be at least 18 years old; 2) be visually impaired or blind; and 3) be resident in South Africa.

Twenty-one individuals participated in this study. Their age ranged from 27 to 58 years of age, and nine were male while 12 were female. All participants had a severe visual impairment – none could read printed material.

Data collection

Before interviews commenced, we received ethical clearance from the University of Johannesburg's research committee to conduct this research. The IPA approach informed the structure of the interviews and shaped the interpretation of findings (Oxley 2016; Smith and Osborn 2015). Since IPA is largely based on phenomenology and the exploration of lived experience, one semi-structured interview was conducted with each participant. We chose semi-structured interviews with open-ended questions as these facilitate empathy and rapport and thus create a safe environment for participants to freely share their stories (Magaldi and Berler 2020; Smith, Flowers, and Larkin 2009). A further, strong motivation for using semi-structured interviews was to give a 'voice to the voiceless' (Atkinson and Silverman 1997, 311). It is widely noted that, where research about persons with disabilities does exist, it often alienates them by failing to reflect their own perspectives (Goode 2007). In this study, we

encouraged participants to share their life stories. In so doing, the misrepresentation, alienation and under-representation of disabled persons was potentially counteracted (Affleck, Glass, and Macdonald 2013).

Amongst others, we posed the following open-ended questions to the participants:

- Tell me about your experiences of pharmacies as a visually impaired person in South Africa?
- Tell me about your experience inside the pharmacy? Can you provide examples of either positive or negative experiences, or both?
- Do you have any experiences of using pharmaceutical services? If so, how did you experience the accessibility of these services as a visually impaired person? Possible prompts: was the provision of these services provided in a manner that protected your privacy? Were the staff mindful of, and sensitive to, your needs as a visually impaired person?

Prior to the semi-structured interviews, we posed biographical questions to the participants, including their age range, their gender, their education and employment, and their specific visual impairment. Interviews were captured on two audio recorders and transcribed verbatim. We conducted interviews in the first quarter of 2021. South Africa was still under various lockdown and social distancing regulations at the time. As a consequence, we conducted our interviews via Zoom. As all members of the research team are also visually impaired, we were very quickly able to build a trusting rapport with our participants despite the virtual environment.

Data analysis

Within IPA research, hermeneutics/interpretation and idiography shape and inform the analysis of findings. While semi-structured interviews illuminate the lived experience (the phenomenology) of participants, analysis allows for an interpreted account of these experiences (Smith and Osborn 2015). According to the philosophy of IPA, participants recount their stories in an already interpreted way. We therefore did not hear their 'raw' experiences; we heard how they made sense of their experiences. Having listened to their life stories, we interpreted their already interpreted experiences. We therefore engaged in a double hermeneutic where we made sense of the meaning-saturated stories of participants (Smith, Flowers, and Larkin 2009).

For interpretation and analysis, we followed the steps of IPA as outlined by Smith, Flowers, and Larkin (2009). First, we engaged in 'within-case analysis', as described by Smith, Flowers, and Larkin (2009). This entailed reading and re-reading each transcript, while adding notes and comments to pertinent lines. Thereafter, we used the interview transcript and notes to search for themes within the interview. Based on these themes, we proceeded to reconstruct the story so that it accurately reflected the interpreted account of the participant. We then moved to the next transcript and repeated the afore-mentioned steps. Following analysis of each interview, we engaged in 'a cross-case analysis' (Smith, Flowers, and Larkin 2009). In other words, we searched for themes across the transcripts. In this way, we were able to tell the recollected stories of all participants. In the final write-up, we included verbatim quotes of participants to support the findings and to ensure that the single stories of participants could be heard. In IPA terms, this focus on the particular is known as 'idiography'.

Trustworthiness

In pursuit of the qualitative trustworthiness of the study, four criteria, as proposed by Guba (cited in Shento 2004), were considered. These four criteria correspond to positivistic research methods and include: (a) credibility (this corresponds to internal validity), (b) transferability (this is similar to the quantitative construct of external validity), (c) dependability (this corresponds to reliability), and (d) confirmability (this is better known as objectivity by the positivistic researcher). We will discuss how these four criteria were applied in conducting this research.

Credibility is achieved when the findings of a study are communicated in such a way as to reflect reality (Morrow 2005; Shento 2004). Many researchers suggest that reflexivity enhances and strengthens the credibility of qualitative studies (Shento 2004). Reflexivity refers to the ongoing critical reflection on oneself as researcher and the acknowledgement and exploitation of one's subjective reality (Smith and Osborn 2015). Therefore, we continually reflected upon our subjective taken-for-granted lifeworlds and the way our lifeworlds might compromise or enhance the credibility of our findings. For example, both authors are blind. We conjecture that sharing lived experience, not only of disability but of visual impairment, was beneficial to the study, as participants felt more comfortable talking to us, thus facilitating rapport-building. We may, therefore, have gained valuable inside information from the participants due to our obvious insider perspective (Jones and Bartunek 2021). On the other hand, the danger existed that we might shape the realities of participants, both during data collection and analysis, through the lens of our subjective world. However, we attempted to maintain credibility through open acknowledgment of our biases within the research, ongoing reflexive commentary in the study and discussions amongst ourselves as co-researchers (serving as peer supervision) (Shento 2004).

In the same vein, confirmability refers to our objectivity as researchers. Although we acknowledge that it is impossible to keep the research findings completely free of our own perspectives, the disclosure of our biases once again lends confirmability to this study.

A study is transferrable if readers are able to generalise the findings to contexts other than that within which the study was conducted (Morrow 2005; Shento 2004). We argue that our findings are transferable as they concur with findings of research conducted into different consumer experiences in other contexts, such as retailers and restaurants (Dias de Faria, Ferreira da Silva, and Brantes Ferreira 2012; Falchetti, Ponchio, and Botelho 2016).

Dependability was ensured through an explicit and detailed report of the research process, thus making it possible to repeat the study (Morrow 2005; Shento 2004). In this study, an unambiguous, step-by-step description of the research design and methodology, including data collection and analysis procedures, was discussed, as well as a reflective appraisal of the effectiveness of these procedures (Shento 2004).

Findings

Two main themes emerged from the stories of the participants. The first theme demonstrates the importance of a trusting relationship between individuals with visual impairments and pharmacy staff. In this theme, we highlight the responsibility that rested on participants to establish the afore-mentioned trusting relationship. The second theme illuminates participants' shameful experiences within the pharmacy context. These experiences largely centre around threats to privacy. We show that many participants experienced shame while purchasing certain sensitive items (like female hygiene products) and when accessing certain services (such as pregnancy tests).

Establishing a trusting relationship

The stories of the participants indicate that building a trusting relationship with pharmacy staff was often a prerequisite for obtaining effective service within a pharmacy. Pharmacy staff were usually unfamiliar with disabled persons and therefore a trusting relationship did not exist from the outset:

If they see you for the first time, then they are not going to know what to do with you.

(Peter, male, 28, white)

The extract above raises the question whether pharmacy staff receive adequate training in working with disabled individuals. Since they often 'didn't know what to do with' disabled persons, it is unsurprising that many participants observed that pharmacy staff were initially anxious in relating to them:

But now you get there and the people are like they either tell you too little about what they are doing or they are completely too anxious. (Jason, male, 31, white)

In light of the above, participants reported that building a trusting relationship with pharmacy staff required some self-advocacy and desensitisation on their part. This meant that they needed to explain, in detail, exactly what information and practical assistance they required:

We had to do a bit of sensitisation, or whatever you want to call it, especially Jennifer [participant's wife]. When she gets one of her medications she has to ask the pharmacist now where day one is, and can you mark day one for me so I know when to drink day one and when to drink day thirty. So stuff like that is actually dependent on the kind of help. People do not always realise what is needed. (Mike, male, 49, white)

Generally, participants reported that, once pharmacy staff got to know them and their needs, they became more comfortable and their anxiety seemed to dissipate:

All the staff that works there knows you by this stage, it's almost as if everyone is very comfortable with you, like everyone knows that nothing is going to happen to them if they are normal with you. (Zandi, female, 29, white)

Following the work our participants had to put in to become better known by staff, most reported that they received the information they needed:

Previously our pharmacy was a one-man operation, Peter. And Peter would actually chat with you and he would ask you, now why did the doctor prescribe this, and do you know there is something better or something cheaper or something generic, and these are the side-effects. And that was nice. (Mike, male, 49, white)

From the stories of the participants it seems that once pharmacy staff openly listened to their unique needs and context, they were able to exceed the needs that were communicated to them. Not only did they explain medication use and side-effects, but they improvised in innovative ways to make medical products accessible for their visually impaired customers:

The pharmacist at the time told me that he didn't have, I think it was a, he didn't have any 3ml syringes for us, but he did have 5ml syringes. So what he then did – and he did this completely out of his own accord and took the initiative – he pulled the syringe out to the 3ml mark and then he took a scalpel or something and he got the inside of the thing you usually pull out, and he marked it. So if you pulled it out and you felt it with your nail you would know from the mark that you are exactly at 3ml. I thought it was very nifty, and from then on, whenever one of the pharmacists came to

me and said they didn't really have the right size syringes, I would ask them to make the mark because it was really a nifty idea. (Jackie, female, 40, white)

I usually got my medication, ninety percent of it, at a local pharmacy where you knew there was an eighty percent chance that you would see pharmacist X or pharmacist A. And you know, as they got to know me they were very specific. Uncle William always took my hand; he would say, 'Uncle John, I cannot put this on in braille for you now, but I would very much like to,' and then he always made a pen mark or a hole or, he was very inventive. 'Now about this box, it is ...', and that 'You have to use this like so', and 'This box is like this', then he made a mark on it, and 'That one you have to use like this'. It's what comes from having a personal relationship with your pharmacist, and they know what your needs are. (John, male, 58, white)

It is therefore not surprising that Rachel observed:

Once they know who you are and what your needs are, then they've got your back.
(Rachel, female, 30, white)

This theme demonstrates that the participants needed to build a trusting relationship with pharmacy staff in order to obtain exactly what they needed. This often entailed explaining their needs to pharmacy staff. Viewed from the perspective of the relational ethics of care, it is evident that most staff genuinely listened to the unique needs of the participants and responded spontaneously and innovatively. Not only did they respond to what was specifically communicated, but they improvised and 'thought out of the box' in order to make products accessible to the participants.

Is this a private space?

Despite the positive prospect of building a trusting relationship with pharmacy staff, many participants described the ever-imminent possibility of shameful or embarrassing experiences in being required to make public their private information:

... and you do not know who's in there. As I mentioned, everyone in the area knows us, so my butcher could walk in there [into the pharmacy] and he could hear I am buying X Y Z, and first of all, he has a good idea of what stuff costs so he knows what you are spending on medication, and he knows then what medication you are on so he knows what underlying medical conditions you might have. (Mike, male, 49, white)

What Mike described was the fact that he would not be aware whether someone familiar was getting a glimpse into his private life through his pharmaceutical purchases. From the accounts of some participants, it was evident that pharmacy staff did not consider ways to ensure the privacy of their blind clientele. As Kate remarked,

There is no procedure for how to deal with things like this. Where maybe, if you said, 'Oh, I'm blind,' and they realised, oh, I need to get this information from you verbally, can we go sit down in a quiet corner, where umm, you know, you and the person working at the pharmacy could have a nice private discussion and you could, you could speak to them. So that, that sort of thing doesn't exist, so there is very little privacy, you just have to speak, you are in a queue, there is people behind you, there is the next counter and then, so there's also people there next to you. You are literally surrounded by people and you have to speak up. (Kate, female, 36, black).

While some participants primarily relayed the potential for shame, some recalled actual deeply shameful experiences within the pharmacy. Kate, for example, recalled buying sanitary towels:

When you go to buy the sanitary towels or something ... find myself praying to God that I get a female attendant. Because, I would hate to put a man through that. Now, the other day, I actually got a male attendant. But I just bit the bullet and said, 'I am going to do it', and it was awful because he had to read to me the different types.

(Kate, female, 36, black)

It is widely known amongst scholars that menstruation and the menstruating body is shrouded in shame and stigma (Olson et al. 2022). Kate's words are poignant confirmation of this. She was concerned – not for herself – but that her menstruating, visually impaired body would inflict something – possibly shame – on the male shop assistant.

Rachel echoed this gendered-induced shame when she recalled purchasing a pregnancy test:

So then, of course, the cashier will now also happen to be male. (Rachel, female, 30, white)

Some of the participants expressed concern that they were highly visible, very recognisable and that they would be devalued or demeaned. After Rachel purchased a pregnancy test, she was concerned that pharmacy staff would recognise her as the person who made that purchase:

And so now you know that whole thing of, ooh, he's looking at me now through different eyes, and because , as a blind person, you already are terribly conspicuous. So you know now that six months later he is still going to remember, oh there's the blind girl with the guide dog, the one who bought the pregnancy test. You know, so,

it's about that anonymity, even though people might not know your name, they are still going to recognise you and know who you are. (Rachel, female, 30, white)

Rachel further elaborated on the shame evoked by this experience:

On that particular day I actually had to do several walks of shame. The walk of shame to the nurse where I had to state my case, then the walk of shame to the till to buy the pregnancy test, then to the bathroom and back, and then all the way back to the nurse's office again. The whole experience really was psychologically damaging for me. (Rachel, female, 30, white)

As described above, some participants felt overly exposed, as if someone had discovered a terrible secret about them. Not only did they feel ashamed because of a specific reportedly embarrassing purchase, but their disabled bodies exacerbated their vulnerability to recognition and ridicule. As Kate stated:

There is already judgment on you being blind; people maybe also think you are innocent or you are not allowed to do certain things. (Kate, female, 36, black)

In order to protect themselves against shame, many participants employed various strategies. Kate, for example, bought a year's supply of female hygiene products:

And so what I did is, I bought a year's supply, saying, 'Let's never do that again!,' [laughs]. (Kate, female, 36, black)

In this theme, many participants voiced concern regarding the potential threat to their privacy within pharmacies. Apart from other clientele potentially overhearing sensitive information, some participants recalled real shameful experiences within pharmacies. The latter often had

the added layer of gendered-induced shame when, for example, buying pregnancy tests from a male pharmacist. These shameful experiences – coupled with their disability - often made participants feel highly visible. This over-visibility seemed to have intensified the aforementioned shameful experiences. Strategies were often employed to avoid or minimise repeating “shameful purchases”.

Discussion

The findings of the study reveal that rapport and a trusting relationship with pharmaceutical staff, lead to a positive experience for persons with visual impairments within pharmacies. However, the latter were required to initiate the work needed to build these trusting and necessary relationships, and to educate staff members regarding their specific needs. It rested upon them to be willing to share details about their conditions as well as their unique needs. Effective dialogue between the participants and pharmacy staff evidentially leads to a trusting relationship. And, as the relational ethics of care predict, this dialogue in turn leads to a deep, embodied understanding of what the participants need (Evans 2004; Pollard 2015). Initially it was required of the participants to state their needs, and once they had done so, it became possible for pharmacy staff to meaningfully assist them. After all, ‘Help is a collaboration, a shared participation in a common enterprise’ (Shakespeare 2000, 88).

Having said this, communication within pharmacies also had the potential to threaten the privacy of participants. Although Bednarczyk et al. (2010) revealed a general lack of privacy in pharmacies and the incidental disclosure of private information, what the participants in the current study described contributed another dimension to this issue. While nondisabled persons’ private information could be overheard by other clientele within the pharmacy, they could see not only who was in the pharmacy, but also who was within hearing distance, and could thus control who overheard their conversation with the pharmacy staff. From the

accounts of the participants it become evident that their privacy can be breached by their not noticing others nearby, by being unaware of others looking at the products they are holding, by holding a prescription in a way that others can read it without their knowing and through the need for extended conversations with staff that might reveal private information which they would not want others to know. As Husso (2008, 377) theorises: ‘shame happens in specific bodies in particular places’. In this instances shame happens to disabled bodies within pharmacies.

Rose Richards, an academic with chronic kidney disease, writes of shame, ‘Shame makes you at once appear highly visible and also to disappear or to scramble to cover yourself to preserve your decency’ (Richards 2019, 271). Similarly, participants of this study reported feeling overvisible and conspicuous. In order to “cover themselves” they employed strategies to minimise or avoid shameful experiences. For example, in the results section Kate reported that she bought an extensive amount of sanitary towels to delay the shameful reoccurrence of a male assistant helping her to buy it.

Thus, our findings reveal that buying pharmaceutical products is, potentially, a contradictory experience for clientele with visual impairment. On the one hand, they need to invest time and effort to build trusting relationships with staff and to educate them about their needs. On the other hand, they nonetheless go into each experience with the fear of feeling shamed. It thus seems that trusting relationships are a necessity, but persons with visual impairment are not able to fully overcome the risk and fear of experiences of shame when buying products in a pharmacy.

Conclusion

This article described the experiences within pharmacies of 21 visually impaired persons. Firstly, it was important for participants to build a trusting relationship with the pharmacy staff. This often required stating their needs in a very detailed and specific manner. Once such a trusting relationship had been established, staff typically exceeded what was expected of them and responded in innovative ways to meet the needs of their visually impaired clientele. This does, however, raise the question of whether pharmacy staff receive sufficient training regarding, and exposure to, disabled persons. As many participants observed that staff were initially ‘flustered’ and ‘anxious’, it seems that they lacked this essential training, thus placing the responsibility on their visually impaired clientele to educate them in this regard.

Secondly, the participants relayed deeply shameful experiences within the pharmacy context. At times, they felt vulnerable and concerned that their private needs were on display. They reported that their disabled bodies were overly visible and this, combined with what they deemed ‘embarrassing’ purchases, made them feel exposed and ashamed.

In many respects, a collaborative relationship between pharmacy staff and their visually impaired clientele thus led to a satisfactory experience for the latter. However, as far as sensitive information, services and products are concerned, participants generally felt vulnerable and over-visible.

This research contributes to our understanding of the healthcare experiences of disabled, and specifically visually impaired, clientele. It sheds light on the complex challenges that visually impaired clientele need to navigate and the amount of additional work they have to put in so as to safely access healthcare. While we acknowledge that additional work due to disability is known in disability studies (Patsavas 2014), our study underpins this and furthers evidence of this dynamic by showcasing the diverse forms of work necessary in a pharmacy context. Our ethics of care lens assisted us in elucidating the importance of relationships between clientele

and staff. Moreover, the fact that persons with visual impairments are not able to build relationships with other clients in the pharmacy is one reason for their experiences of shame. As there is no communication between clientele, visually impaired clientele cannot communicate to other clients their need for privacy.

Future research should aim to further understand these experiences in more diverse contexts.

We are aware that our sample is biased towards the experience of primarily white South Africans, despite being a minority in the country. Furthermore, it would be interesting to better understand pharmacy experiences in more rural contexts. For pharmacy practitioners, we recommend training for staff members in awareness regarding the needs of visually impaired clientele upfront, as well as considering layouts of pharmacies regarding merchandise and private consultations, or other measures that can be taken to support visually impaired clientele in their pursuit of privacy.

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The authors report there are no competing interests to declare.

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