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Creating sustainable services: Minority world SLPs in majority world contexts

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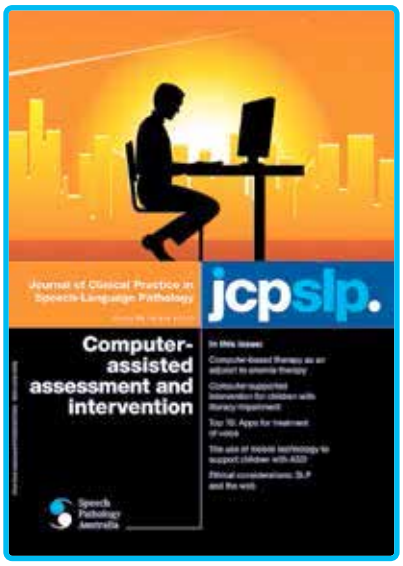

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From the editor

David Trembath

Speech-language pathology offers countless opportunities for those who are interested in working beyond geographical borders, across cultures, to understand and help address the needs of individuals with communication and swallowing difficulties at an international level. For me, the opportunity first arose during my undergraduate studies, via a self-guided study tour with two student colleagues through Nepal, Bangladesh, and India. At the time, these were often described as "developing" or "emerging" countries, terms that are now commonly replaced by "majority world" which captures the proportion of the world's people represented, and contrasts with the relatively small proportion living in "minority world" (otherwise described as "developed") countries. Our goal was to learn from experts in community-based rehabilitation who were working on the ground in villages, towns, and cities in the countries we visited to deliver timely, appropriate, and effective support to persons with developmental and acquired disability. How I wish we had available to us at the time the wealth of information presented in this issue of *JCPSLP* focused on minority world speech-language pathologists working in majority world contexts.

This issue is guest edited by Bea Staley and Suzanne C. Hopf, who have brought together an outstanding group of local and international authors to advance understanding of the opportunities and challenges associated with international work and collaboration. The issue is infused with personal reflections and insightful advice, both of which are critical to minority world SLPs working ethically and effectively in majority world contexts, and also discusses implications for all SLPs aiming to initiate and sustain mutually beneficial and rewarding partnerships, wherever these partnerships occur. A common theme across articles is the importance of "change" as a multidirectional process that leaves all people and parties in better positions as a result of the work together, for the benefit of one another.

In reflecting on this issue, which is the last under my editorship, as well as the work of the journal more broadly, the same theme emerges. The *JCPSLP* is a place where clinicians, researchers, and other members of the community come together to share knowledge, critical and clinical insights, and novel ideas to move our field forward. The journal works because authors, reviewers, members of the editorial committee, and the publication team understand the magnitude of "change" that can occur when the right information is given to the right people, at the right time; and generously volunteer their knowledge and skills to make it happen. I would like to sincerely thank all of those who contribute to the journal in this way, and extend my very best wishes to Dr Leigha Dark who will now take over as editor.

Contents

Special issue

A diverse global network of speech-language pathologists

Bea Staley and Suzanne C. Hopf

Bea Staley (top) and Suzanne C. Hopf

People in all countries have called for a development agenda that is more consistent with the realization of their human rights, and which reflects the day to day reality of their lives. (UNDG, 2014, p. iii)

This quote from the United Nations (United Nations Development Group [UNDG], 2014) ushered in a global conversation in which 4.5 million people from almost 100 countries discussed the "future world that people want" (2014, p. 1). As speech-language pathologists (SLPs) advocating for the human rights of people with communication and swallowing disabilities (PWCD) globally, we want our services to reflect the needs of the communities in which we work. There is considerable interest in the development of speech-language pathology in global regions experiencing poor availability and accessibility of speech, language and swallowing clinical services. This is particularly the case for services in majority-world countries. Consequently, this issue of *JCPSLP* discusses the varied roles of minority-world SLPs working with our colleagues in majority-world contexts.

There is a long history of minority-world clinicians working in varied international contexts. In the late 1990s SLPs (e.g., Hartley, 1998; Marshall, 1997) began to write about their work in majority-world contexts (e.g., Kenya and Uganda) and to develop frameworks for other SLPs to apply in their own work (e.g., Hartley & Wirz, 2002). These authors highlighted the need to document speech-language pathology work in new locations so that a knowledge base could be developed and drawn upon by other clinicians. The papers in this special issue build on the ideas of these SLPs and the many more published since.

Ensuring that the voices of the local context are heard is a recurrent theme of this issue. Nearly all of the articles presented include the voices of SLPs, or their local equivalent, native to the majority-world context discussed. For example, three papers from Vietnam provide insight into how the relatively new speech-language pathology profession is capitalising on past – and indeed continuing – minority-world SLP collaboration, and *indigenising* international speech-language pathology concepts and curricula for the local context. The Nguyen, Dien, Sheard, Xuan, Tâm, Văn Quyên, and Dao paper provides an account of the history and current clinical and advocacy practices of new graduate Vietnamese SLPs, while Pham, McLeod, and Xuan describe the process required for developing a speech assessment tool for the Vietnamese context. In Atherton, Davidson, and McAllister, a participatory research project reveals the voices of Vietnam's first SLP graduate cohort as they embark on the next stage of their professional development journey. All papers have in common a focus on future professional growth that involves international collaboration but importantly is not defined by that collaboration.

In the papers by McAllister, Woodward, and Nagarajan, and by Barrett, our lens turns to the lessons minority-world SLPs learn through international collaborative relationships. McAllister et al. describe the transformative learning experiences of volunteer minority world-SLPs in the role of clinical educator (CE) in Vietnam. The authors report that many skills learned by the CEs in Vietnam are readily transferable to the CEs' work environment in Australia (e.g., working with translators, developing intercultural competence). Barrett then draws upon experiences as a minority-world SLP in East Africa to critique whether available cultural competence theories can be applied to an increasingly mobile speech-language pathology workforce. Barrett suggests that current theories of cultural competence need to evolve to reflect changing concepts of culture.

As we think about change, this can be extended also to the way services and training SLPs has typically been conceptualized. Olszewski and Frank remind us that if communication is a basic human right – one we are passionately striving to work towards on a global scale – we may have to re-consider and re-envision the way we train service providers and implement services in our field. Olszewski and Frank describe an innovative model for training SLPs through NextGenU, a free online program which partners with organisations, governments and universities. Their paper suggests that technology may break down the financial and environmental barriers that often prevent people living in majority-world countries from receiving specialist training and pursuing careers that support PWCD.

What is abundantly clear in reading these papers is that no single framework for service development suits all contexts. For example, we see Wylie, Amponsah, Bampoe, and Owusu directly apply the social, environmental, and economic dimensions of sustainable development embodied in the Sustainable Development Goals (United Nations, 2015) to their own experiences in Ghana

collaborating with visiting minority-world SLPs, while maintaining their own caseloads and advocacy efforts.

Despite employing different frameworks, the authors in this collection consistently conclude that policies and solutions need to be locally and collaboratively derived and issue-orientated without merely transplanting best practices across countries.

From the papers presented it is evident that as a global profession we are beginning to establish networks committed to advocating for improved service availability and accessibility for all PWCD regardless of where they, or we, reside in our world. We are excited about innovative collaborations of SLPs, such as the International Communication Project (see http://www.internationalcommunicationproject.com), that highlight the work of SLPs in diverse locations and open up avenues for future dialogue. What we share here, are just a few of the stories of minority–majority world SLP clinical practices that are striving to change the way we work in varied contexts. We hope that these ideas translate or inspire others working (or thinking about working) in majority-world contexts to create a vibrant network of collaborative SLPs internationally.

References

Hartley, S. (1998). Service development to meet the needs of "people with communication disabilities" in developing countries. *Disability and Rehabilitation*, *20*(8), 277–284.

Hartley, S. D., & Wirz, S. L. (2002). Development of a "communication disability model" and its implication on service delivery in low-income countries. *Social Science & Medicine*, *54*(10), 1543–1557.

Marshall, J. (1997). Planning services for Tanzanian children with speech and language difficulties. *International Journal of Inclusive Education*, *1*(4), 357–372. doi:10.1080/1360311970010405

United Nations. (2015). *Sustainable development goals: 17 goals to transform our world*. Retrieved from http://www.un.org/sustainabledevelopment/sustainable-development-goals/

United Nations Development Group (2014). *Delivering the post-2015 development agenda*. Retrieved from: http://www.undp.org/content/undp/en/home/librarypage/mdg/delivering-the-post-2015-development-agenda.html

Dr. Bea Staley is a speech pathologist who has been working with young children and their families for 15 years. She has worked in Australia, Kenya, America and the Northern Mariana Islands. She is a lecturer in the School of Education at Charles Darwin University, where she teaches classes around diversity, disability and inclusion. **Suzanne C. Hopf** is an Australian speech-language pathologist that lives in the Republic of Fiji. Suzanne's PhD describes typical Fijian children's speech, language and literacy development, and how Fijians support children and adults with communication and swallowing disabilities.

Building collaboration

A participatory research initiative with Vietnam's first speech-language pathologists

Marie Atherton, Bronwyn Davidson, and Lindy McAllister

KEYWORDS
COLLABORATION
PARTICIPATORY ACTION RESEARCH
SPEECH-LANGUAGE PATHOLOGY
VIETNAM

THIS ARTICLE HAS BEEN PEER-REVIEWED

Marie Atherton (top), Bronwyn Davidson (centre), and Lindy McAllister

A group of Vietnam's first speech-language pathology graduates and the primary author, an Australian speech-language pathologist, are participating as co-researchers in an exploration of the emerging practice of speech-language pathology in Vietnam. This paper details the initial phases of this collaborative research program. A description of the research methodology and the rationale for utilising participatory action research are provided. Initial learnings from the research, including those relating to the vital role of the interpreter; challenges in developing a shared understanding of collaboration in research; and the impact of distance and technology are described. Speech-language pathologists from minority world contexts are encouraged to consider how they might develop partnerships with international colleagues to support collaborative initiatives to progress the practice of speech-language pathology in underserved communities.

Participatory action research (PAR) is an umbrella term for a heterogeneous group of research practices in which researchers and "the researched" work together to examine a situation (or problem) and identify strategies and actions to change the situation for the better (Kemmis, McTaggart & Nixon, 2013; Kingdon, Pain, & Kesby, 2007). PAR is situated within the genre of *action research*, a research approach credited to Kurt Lewin, a social psychologist, who demonstrated the benefit of workers participating in research that would inform decisions impacting their work (Lewin, 1946, as cited in Adelman, 1993). In the latter half of the twentieth century, Brazilian educator Paulo Freire further developed the concept of participation and collaboration in research by arguing that through participation in decisions regarding their lives, every person, regardless of the level of their impoverishment or disempowerment, could be empowered to make changes in their lives for the better (Friere, 1970). Critical to Friere's position was the value of conducting research *with* (not on) people as a means of creating and sharing new knowledge, and developing new insights into practices, situations, and processes that could be improved (Chaiklin, 2011).

PAR is considered a methodology in its own right rather than a set of research methods (Liamputtong, 2008). Through iterative cycles of reflecting, planning, engaging in action, and reflecting upon the outcomes/consequences of actions undertaken (Figure 1), researchers and those impacted by a problem develop new insights into the problem and how it might best be addressed. Findings from each cycle of the action spiral are fed into the next, with the overall aim being the identification of actions that effect positive practical change in relation to the issue of concern (Kemmis et al., 2013).

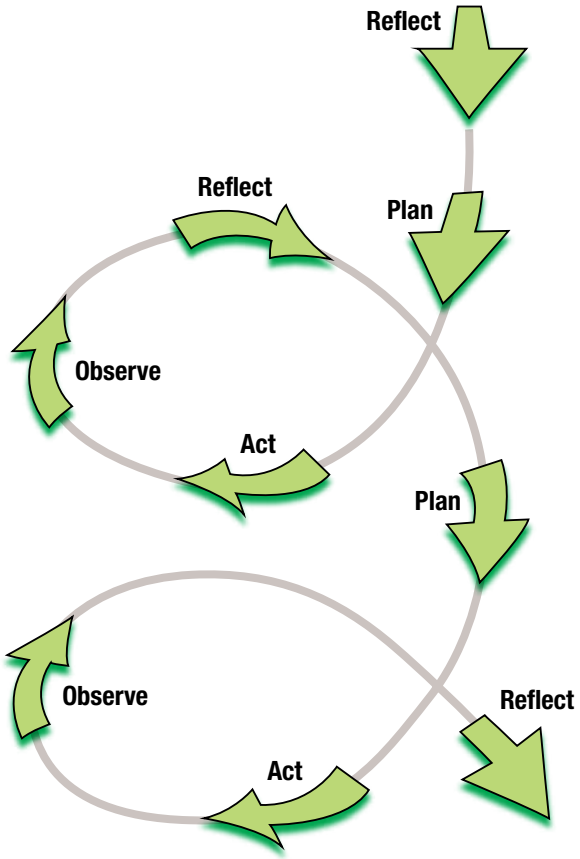

Figure 1. Action research cycles. Retrieved from http://cei.ust.hk/teaching-resources/action-research. Copyright 2010–2016 by Centre for Education Innovation, HKUST. Reprinted with permission.

PAR has been used in numerous contexts including human development, education, organisational change, and health (Kapoor & Jordan, 2009; Koch & Kralik, 2009). It has also been extensively used in cross-cultural contexts (Evans, Hole, Berg, Hutchinson, & Sookraj, 2009; Kramer-Roy, 2015; Pavlish, 2005). The utility of PAR to the practice of speech-language pathology (SLP) has also been described (Hersh, 2014; Hinckley, Boyle, Lombard, & Bartels-Tobin, 2014). Westby and Hwa-Froelich (2003) highlight the relevance of PAR to the development of culturally appropriate and context-specific SLP programs and services in majority world[1] countries, and offer recommendations for the conduct of PAR in international contexts. In an exploration of friendship and the experiences of persons with aphasia, PAR supported the development of tools to assist persons with aphasia communicate about friendship (Pound, 2013). The utility of collaborative research has also been described in relation to the care of persons with communication problems resulting from dementia (Müller & Guendouzi, 2009).

The use of participatory action research in the current research

This paper describes the application and evaluation of PAR as a methodology for exploring the practice of the emerging SLP profession in Vietnam. PAR in Vietnam has previously examined a range of social and community issues including stigma associated with HIV, gender-based violence, professional development needs of nurses, and public health and social services in rural Vietnam (Gaudine, Gien, Thuan, & Dung, 2009; Gien et al. 2007). To the authors' knowledge this is the first report describing PAR within the context of the SLP profession in Vietnam.

In September 2012, 18 Vietnamese students with undergraduate degrees in health-related professions (e.g., physiotherapy, medicine, nursing) graduated from a two-year postgraduate speech therapy training program at Pham Ngoc Thach University of Medicine (PNTU), in Ho Chi Minh City (HCMC), Vietnam, thereby becoming Vietnam's first locally trained speech-language pathologists qualified to work across the full scope of SLP practice.[2] The primary author was the coordinator of the 2010–12 PNTU SLP program and resided in HCMC. Upon returning to Australia, she remained in contact with the graduates and saw the conduct of research as one means of supporting their practice. The primary author was cognisant of a disparity in power between herself and the PNTU SLP graduates, and the potential for this to influence the authenticity of the research findings (Atherton, Davidson, & McAllister, 2016). As such, the active participation of the graduates in the research was considered crucial to enhancing the authenticity of data collection and analysis (Gaillard, 1994). Engaging in PAR would create the opportunity for the "voices" (Maguire, 2001) of the SLP graduates to be heard, for the research to be guided by *their* experiences and priorities rather than by preconceived notions the primary author may have had about the context of their work. Further, participation of the primary author and graduates as co-researchers would support the mutual development of research skills and the reporting of research outcomes. It was also hoped that opportunity would be created between the researcher and graduates for future research collaboration.

Context of the research

This collaborative research initiative forms part of a broader PhD research program undertaken by the primary author exploring the professional practice of Vietnam's first university qualified speech-language pathologists. It is not the intent of this paper to detail the emergence of the SLP profession in Vietnam (for further information see Atherton et al., 2016; Atherton, Dung, & Nhân, 2013; McAllister et al., 2013). Rather, this phase of the primary author's PhD research program sought to: (a) identify the nature of the SLP graduates' professional practice at 24 months following graduation (to be reported in a separate paper), and (b) introduce PAR as a means of identifying perceived barriers to the graduates' work. It was anticipated that completion of this phase of the research program would inform future collaborative research cycles in which avenues to address the perceived barriers to the graduates' practice could be trialled.

Participants

Acknowledging the Vietnamese graduates as best placed to describe the context in which they work and identify factors impacting their practice, the primary author travelled to HCMC, Vietnam in June 2014 to establish an "Advisory Group" (later named the "Participatory Research Group" [PRG]) comprising graduates from the 2010–12 PNTU SLP Training Program to advise the PhD research program over the next 24–30 months. Advisory groups have been previously described as strengthening the authenticity and validity of research-generated knowledge and enhancing the significance of research outcomes (Pound, 2013). Expressions of interest were sought from the18 SLP graduates to participate in individual interviews with the primary author and to participate as members of the PRG. Ethics approval was obtained for this study through the University of Melbourne, Behavioural and Social Sciences Human Ethics Committee.

Eight of the 18 graduates consented to participate in the research. All eight PRG members live and work in HCMC, and are typical of the 2010–12 cohort of SLP graduates in that they work predominantly within the acute public health system (one PRG member works in the disability sector). Caseloads are varied and include both adults and children with communication and swallowing disabilities.

Outcomes of collaboration

Three "cycles" of collaborative research were completed in 2014 (see Table 1) during which PRG members engaged in reflection upon their current professional practices and commenced the planning of actions to support their work. Key research concepts such as "reflection", "collaboration" and "participation" were discussed, and the initial research priorities of the PRG identified. Data was in the form of digital audio-recordings of interviews and meetings, transcripts of the English translation of the audio-recordings and meeting minutes, email correspondence, and the primary author's field notes and reflective diary. Pseudonyms replaced the names of the participants and interpreters as a means of de-identification.

The three cycles of this phase of the research program and the challenges conducting PAR in this context will now be described.

Cycle 1. Setting the scene

Cycle 1 involved individual interviews with the eight research participants and the formation of the PRG. Ms Mai, a Vietnamese interpreter well known to the participants and with knowledge of SLP practice, provided a summary of what was being said (consecutive interpretation) rather than a word-for-word translation (simultaneous interpretation), thereby avoiding potential for disruption to the dialogue

Table 1. Summary of participatory research cycles in 2014

Cycles of research 2014	Meetings	Data sources	Present
1. July 2014 Face-to-face meetings in Ho Chi Minh City, Vietnam	x8 semi-structured individual interviews Inaugural meeting of the PRG	Digital audio-recordings of interviews and meetings Transcripts of individual interviews & meeting minutes Email communication Field notes Reflective diary	Members of the PRG Primary researcher Experienced interpreter
2. July–October 2014 Skype meetings	x5 Skype meetings of the PRG		
3. October–November 2014 Face-to-face meetings in Ho Chi Minh City, Vietnam	x2 meetings of the PRG		

Figure 2. The inaugural meeting of the participatory research group

(Chen & Boore, 2010). The interviews were important for several reasons. First, the development of relationships, trust of the primary researcher, and a sense of safety in the research process are acknowledged as critical to research that seeks to be genuinely collaborative (Australian Council for International Development, 2016; Maiter, Simich, Jacobson, & Wise, 2008). The interviews provided opportunity for the researcher and the participants to re-establish their relationship. Second, preparation for collaborative research requires co-researchers to develop an understanding of the proposed research focus, methodology, anticipated time commitment, and timelines for the research (Kidd & Kral, 2005). Again, the interviews provided opportunity for the research participants to discuss these issues in detail prior to committing to the research. Third, it was anticipated that analysis of the interview transcripts would highlight themes characterising the evolving practice of the participants. The content of these interviews would also draw attention to the graduates' perceptions of opportunities and challenges to their practice, and their professional priorities for the following 12 months. This information would inform the initial discussions of the PRG and provide a focus for the future research.

The inaugural meeting of the PRG took place in HCMC, Vietnam on the 4 July 2014. The eight SLP graduates, Ms Mai (the interpreter) and the primary author were present. All PRG members consented to be photographed and for the photograph to be published (Figure 2).

The inaugural meeting of the PRG provided opportunity for the primary author and PRG members to meet for the first time as co-researchers and commence discussions as to the PRG's participation in the research. The overall aims of the research program were described, as were its stages and timeframe for completion. Initial discussion also focused upon research methodologies, including how quantitative and qualitative research differed, and where collaborative and PAR methodology was situated within the quantitative–qualitative paradigm. As commented by Mr Duc:

> *So usually when you do quantitative research you collect data, you analyse data, and then you have recommendations for the next stage. But I haven't done any qualitative research like this before, so I want to know whether it's the same … like stages. And you also do it in stages, so when you finish one stage you have recommendations … and prepare for the next stage?*

The primary author described PAR methodology as encompassing a range of research methods, from which focus of the conversation shifted to the legitimacy of qualitative research: "I don't know about other professions, but in the medical field usually people, they might not like to use it, do not really like to use qualitative … but in public health qualitative is accepted" (Mr Duc).

The PRG also sought to address a number of "logistical issues" such as the selection of a leader for the PRG, and the settings of "ground rules", including the number of PRG members required for a quorum, how confidentiality of group discussions would be maintained, the allocation of minute taking, and a "participation" rule:

> *There should be a rule like that, [to avoid a situation in which] one or two team members will talk about their opinions and everyone else will sit and quiet listening, and when the group comes to an agreement it looks like the ideas are just from one or two members. So I think we should have like a participation rule that the members who attend the meeting, all should participate in discussions.* (Mr An)

At the meeting's conclusion, a suggestion to progress the research via a live video calling program (Skype) was agreed to – PRG members were keen to trial communication options that would facilitate ongoing audio-visual interaction and collaboration with the primary author on her return to Australia.

The opportunity to discuss the research methodology afforded a number of key insights. The primary author had

assumed that given the undergraduate and postgraduate education completed by PRG members, there would be familiarity with both quantitative and qualitative research methodologies. This was not the case, and highlighted the importance of avoiding assumptions about the skills and knowledge of research partners. Further, discussion of the methodology drew attention to the importance of reviewing concepts through group dialogue in which mutual understanding might best be achieved.

The issue of ownership and future authorship of the project also arose at this meeting, and at later meetings of the PRG. The primary author was cognisant that the collaborative and participatory nature of the research created tension with the notion of a PhD research program being independent work, and thus raised this issue for discussion with the PRG. Further, PRG members voiced interest in joint authorship of publications arising from the research. Bournot-Trites and Belanger (2005) advise that issues of authority and ownership of research be resolved in advance of a study, and to this end, it was important that the primary author and PRG engage in conversation to address these issues.

The relevance of supporting group processes was also highlighted. Even at this early stage in the research, group interactions and practices were reflecting aspects of collaboration, and PRG members were drawing the focus to *their* priorities, including developing and supporting group cohesion and functioning. A number of authors have described the influence of sociocultural differences upon group interaction, patterns of participation, and perceptions of time upon cross-cultural research (Apentiik & Parpart, 2006; Laverack & Brown, 2003). As discussed by Liamputtong (2008), for research to be culturally sensitive "researchers must have a thorough understanding and knowledge of the culture, which includes extensive knowledge of social, familial, cultural, religious, historical and political backgrounds" (p. 4), and must work actively and consistently to ensure customs and cultural norms are respected and incorporated into research initiatives.

Cycle 2. The tyranny of distance

The second cycle of the research commenced on the primary author's return to Australia and comprised five Skype meetings at which the professional priorities of the PRG members were explored. To participate via Skype, PRG members sourced public venues with internet access. These were typically cafés, though on one occasion the PRG had convened in a hotel room, to the surprise of the primary author! While intended to support audio-visual communication between the PRG and the primary author, the internet connection for these meetings was often unreliable, resulting in generally poor visual and sound quality, audio delay, and signal drop out. Further, the many competing demands of PRG members resulted in some members not attending meetings and/or meetings commencing at a later time than planned (Table 2).

Despite these challenges, important outcomes were achieved from this cycle of research. After extended and at times animated group discussion in which the primary author acted as facilitator, the initial focus of the research was agreed to:

> *So the group discussed and they think they will do … that professional development is the priority. The group is thinking they want to do ongoing professional development … perhaps they will think of things that they can do themselves, or [they] can do in Vietnam to develop their profession, to develop their expertise, … and also they will identity the things they might need help [with] from Australia or from other organisations.* (Ms Mai summarising)

Methods and actions to examine this issue were also discussed:

> *Perhaps we are going to have a questionnaire to send to both groups [2012 and 2014 PNTU SLP graduates] to ask them four to five questions about what they are comfortable working with and what they are not comfortable working with to find out strengths and weaknesses of each graduate working in speech therapy.* (Ms Giang)

> *What are the graduates' abilities to provide assessment/treatment for patients? This could be found out by interviewing graduates about their workload – what do they think about their work, what they feel comfortable with, areas they do not have confidence in? When we interview the graduates of both groups we will find out what their challenges are in relation to their practice.* (Ms Bich)

It was also agreed that due to the unreliability of the internet connection, email communication would be increasingly used to support communication between PRG members and the primary author. Members of the PRG also indicated that given work and other obligations,

Table 2: Summary of Skype meetings in 2014

2014 Skype meetings	Number of PRG members present /8	Duration of meeting	Notes
1	6	70 minutes	Fair internet connection, intermittent picture & sound; delayed arrival of one PRG member.
2	6	90 minutes	Fair internet connection, intermittent picture & sound; delayed arrival of 2 PRG members.
3	6	60 minutes	Loss of Skype connection on several occasions - Instant messaging utilised during these periods; delayed arrival of 3 PRG members.
4	5	30 minutes	Poor internet connection - Instant messaging via Skype.
5	6	20 minutes	Poor internet connection - Instant messaging via Skype; delayed arrival of 2 PRG members.

communication via email would offer more flexibility in terms of their participation.

Momentum for the research slowed at this point. Sporadic email communication and the need for all communication to be translated influenced the frequency of contact. PRG members described their increasing workloads and other demands associated with their roles as "pioneers" of the SLP profession (e.g., training of staff in SLP) as influencing their ability to engage in the research. At least one member of the PRG commenced providing SLP services in a private capacity outside normal work hours.

A further issue arising was the introduction of Ms Tran to replace Ms Mai as interpreter. Notes from the primary author's reflective diary highlight to concerns as to how the research might be impacted, not only in terms of the quality of the interpretation and translation, but also with regard to group dynamics, interaction and collaboration (Figure 3).

> I am wondering how the introduction of Ms Tran to the research will play out this evening. Ms Mai was part of the research from its inception and familiar with the PRG and with the research plan, so introducing someone new may change dynamics. ??impact on collaboration
>
> A positive note – Ms Tran has been undertaking translation of resources for the PRG meeting … so hopefully an understanding of methodology and concepts – will need to follow this up.
>
> Am also wondering whether the difficulties with internet connection may deter Ms Tran from wanting to be involved in the research.
>
> (Dated 18 September 2014)

Figure 3. Notes from primary author's reflective diary

The use of Skype for real-time collaboration had been considered an ideal vehicle through which the active and participatory nature of the research could be supported. However, detailed planning, including consideration of "a second plan of attack", proved necessary when seeking to incorporate technology such as Skype into a setting where internet connection was unreliable. In addition, the demands arising from the role of members of the PRG as "pioneers" of the profession and increasing workloads, including the expansion of the profession into the private sector, were significant and had not been anticipated. The "tyranny of distance" was never more evident than during this cycle of the research, and facilitated key learnings with regard to the impact of technology, the increasing profile of the profession in Vietnam, and of the influence of local context upon the research.

Cycle 3. Revisiting collaboration

The third cycle of research collaboration was via two face-to-face meetings between the primary author and PRG in HCMC in October–November 2014. These meetings were important in re-establishing open and extended dialogue regarding the research, and supporting re-engagement of members of the PRG who had not maintained communication via email. The face-to-face meetings also provided opportunity for the primary author and the new interpreter to meet in person.

Revisiting the key research concepts of "reflection" and "collaboration" was another important outcome from this cycle of the research. The excerpt below is taken from the transcript of the English translation of a meeting in which the key concept of "reflection" is explored:

> *In the research, "reflect" means to think about your practice as speech therapists[3], and about the main issues you might wish to investigate further. Ms Tran, "reflect" in Vietnamese, how would you translate that?* (Primary author).
>
> [Ms Tran confers with PRG members]
>
> *I gave out to the group a translation that I think kind of pretty much covers the idea of "reflect" and I am asking to see what they think.* (Ms Tran)
>
> *It is similar to "reflect" in English….* (Ms Bich)
>
> *It means it's like a process of thinking back, and then speak out what you think.* (Ms Giang)
>
> [Further discussion between PRG members]
>
> *They are saying there is not a direct translation for "reflect". It is a very common thing to do in the West. And back when they were doing the course [PNTU Speech Therapy Training Program], the teachers, the lecturers were constantly asking them to reflect every time they write the report, every time they say something. The translation I gave out doesn't really cover the entire meaning of it.* (Ms Tran)

It is not within the scope of this paper to discuss the technical aspects or complexities of translation and interpretation in cross-cultural research (for further information see Squires, 2009; Temple & Young, 2004; Wong & Poon, 2010). However, the time spent revisiting key research concepts proved critical to heightening the understanding of the researcher, members of the PRG and the interpreter to the influence of language and culture upon the research. In particular, it was during these discussions that the primary author's assumption of concept equivalence between languages was challenged. The concepts of "reflection" and "collaboration" were identified by the interpreter and PRG as having different meanings in English and Vietnamese. Further, while the interpreter and members of the PRG are all Vietnamese, their individual interpretation of these concepts varied. Caretta (2015) and Turner (2010) draw attention to this latter issue, arguing that the gender, personal experiences, cultural influences, preconceptions, and belief systems of those involved in the research will influence the intended meaning of a concept, how individuals interpret the meaning of a concept, and how this meaning is communicated. Such insights highlighted how critical it is for all members of a research team to engage in dialogue as a means of facilitating mutual understanding of research principles, concepts and objectives.

Cycle 3 of the research also provided opportunity to consider how the research might progress into the future. The excerpt below, taken from the transcript of the English translation of one of the meetings, highlights PRG members' uncertainty as to the future direction of the research and its anticipated outcomes:

> *What is the project aiming to obtain? We know we want to identify our needs in professional development but are there any other aims?* (Ms Bich)
>
> *When we do this project, how do we measure its success?* (Mr Jach)

PAR has been described as a "messy process" (Primavera & Brodsky, 2004), requiring participants to not only conduct the research, but to learn from it and adapt as it progresses. The face-to-face meetings were a vehicle through which to address some of this uncertainty, and aimed to assist PRG members become more comfortable about this "messiness". At one of these meetings, the PRG developed their own representation of this research process, which they described as "The fish skeleton" (Figure 4):

> *So it [the research] is like a fish bone, a fish skeleton. So there are different problems and different reasons… they are the fish bones. The first one is overload [in work], not enough knowledge [referring to fish bone number two]. There are many problems and many reasons and we will look at that to prioritise which ones, and then we come up with solutions. And then which solution will resolve number one, number two, number three…* (Ms Tran summarising)
>
> *So you might come up with a solution for a problem and try it out to see if it works?* (Primary author)
>
> [Discussion between PRG members]
>
> *Yes. So they [the PRG] think "participants" defines it very well what they are doing. Because they are participating, they are the ones that come up with these and these and these [referring to the numbered fish bones], and prioritise these and come up with a solution. And you are just supporting them.* (Ms Tran summarising)

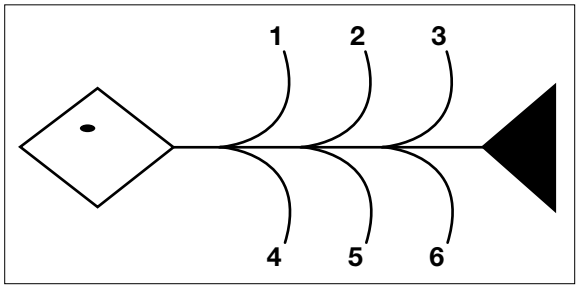

Figure 4. The fish skeleton

It was within these discussions that the title of the PRG was raised. The primary author had previously proposed that the PRG be referred to as the "Advisory Group". However the group indicated that this was not a suitable term. As summarised by Ms Tran:

> *For research, "advisory group" is not something that exists in the Vietnamese research. If you do the literal translation of advisory group, this means that people are higher than you are, telling you/advising you what to do, so that's not right in the Vietnamese context. They [PRG members] say they are part of the research, they are participating. So that describes the role very well.*

The term "participants" was agreed to and the term Participatory Research Group (PRG) adopted.

Another important outcome from this cycle of the research was discussion pertaining to issues of ethics in international research (for further detail regarding ethical considerations in international research, see Australian Council for International Development, 2016). Several of the PRG members reported their workplace directors had requested information about the role of PRG members in the research. PRG members sought reassurance from the primary author that their workplaces would not be identified in the research, nor would the research require the participation of clients receiving their services. The criticality of maintaining the confidentiality of research participants and of discussing with research participants how their engagement in the research may impact them was highlighted here. Further, in international contexts, language and cultural differences have the potential to impact understanding of research proposals and outcomes even when presented in participants' primary language (Brydon, 2006). A critical role for the PRG was highlighted here as members guided the primary author through this process so as to ensure safety in the conduct of the research.

Conclusion

This paper has described three cycles of one phase of a cross-cultural project in which participatory research methodology is being used to support international research in a majority world context. Interviews occurred at 24 months post-graduation to identify the nature of the graduates' professional practice, a PRG was established to guide the future research, and exploration of professional issues the PRG wished to investigate further was commenced. The engagement of the SLP graduates and primary author as co-researchers facilitated mutual learnings. The vital role of the interpreter as a member of the research team, the importance of repeated discussion of concepts to clarify understanding, and the impact of technology and local context upon communication and collaboration have been identified. The criticality of establishing open communication was highlighted in discussion of ethics and safety in research. Speech-language pathologists seeking to support service development in underserved and/or majority world contexts are encouraged to forge partnerships with international colleagues that arise from collaboration and support mutual learnings, for it will be within these contexts that initiatives may best meet the unique needs of culture and context. The next cycles in this research are evolving; and, it is anticipated that further inquiry into the barriers to the professional practice of SLP in Vietnam and actions to support this practice will follow. Opportunity will also be afforded for ongoing exploration of the dynamic of collaboration between the members of the PRG and primary author within a cross-cultural context.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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1 The terms "minority world" and "majority world" are frequently used in the literature to replace phrases such as developed/ underdeveloped countries, North/South, First World/Third World countries, industrialised/ emerging nations.

2 A further 15 students graduated in 2014.

3 In Vietnam, the profession of SLP is known as speech therapy.

References

Adelman, C. (1993). Kurt Lewin and the origins of action research. *Educational Action Research*, *1*(1), 7–24. doi:10.1080/0965079930010102

Apentiik, C., & Parpart, J. (2006). Working in different cultures: Issues of race, ethnicity and identity. In D. Vandana & R. Potter (Eds.), *Doing development research* (pp. 34–43). London, UK: Sage.

Australian Council for International Development. (2016). *Principles and guidelines for ethical research and evaluation in development*. Retrieved from https://acfid.asn.au/sites/site.acfid/files/resource_document/Principles-for-Ethical-Research-and-Evaluation-in-Development2016.pdf

Atherton, M., Davidson, B., & McAllister, L. (2016). Exploring the emerging profession of speech-language pathology in Vietnam through pioneering eyes. *International Journal of Speech-Language Pathology*. Advance online publication. doi:10.3109/17549507.2016.1159335

Atherton, M., Dung, N.T.N., & Nhân, V.H. (2013). The World Report on Disability in relation to the development of speech-language pathology in Viet Nam. *International Journal of Speech-Language Pathology*, *15*(1), 42–47. doi:10.3109/17549507.2012.743034

Bournot-Trites, M., & Belanger, J. (2005). Ethical dilemmas facing action researchers. *The Journal of Educational Thought*, *39*(2), 197–215.

Brydon, L. (2006). Ethical practices in doing development research. In D. Vandana, & R. Potter (Eds.), *Doing development research* (pp. 25–33). London, UK: Sage.

Caretta, M. (2015). Situated knowledge in cross-language research: A collaborative reflexive analysis of researcher, assistant and participant subjectivities. *Qualitative Research*, *15*(4), 489–505.

Chaiklin, S. (2011). Social scientific research and societal practice: Action research and cultural-historical research in methodological light from Kurt Lewin and Lev S. Vygotsky. *Mind, Culture and Activity*, *18*(2), 129–147. doi:10.1080/10749039.2010.513752

Chen, H., & Boore, J. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1–2), 234–239. doi:10.1111/j.1365-2702.2009.02896.x

Evans, M., Hole, R., Berg, L. D., Hutchinson, P., & Sookraj, D. (2009). Common insights, differing methodologies: Toward a fusion of indigenous methodologies, participatory action research, and white studies in an urban aboriginal research agenda. *Qualitative Inquiry*, *15*(5), 893–910.

Friere, P. (1970). *Pedagogy of the oppressed*. New York, NY: Herder and Herder.

Gaillard, J. F. (1994). North–south research partnership: Is collaboration possible between unequal partners? *Knowledge and Policy*, *7*(2), 31–63.

Gaudine, A., Gien, L., Thuan, T., & Dung, D. (2009). Developing culturally sensitive interventions for Vietnamese health issues: An action research approach. *Nursing and Health Sciences*, *11*(2), 150–153.

Gien, L., Taylor, S., Barter, K., Tiep, N., Mai, B.X., & Lan, N.T. (2007). Poverty reduction by improving health and social services in Vietnam. *Nursing and Health Sciences*, *9*, 304–309

Hersh, D. (2014). Participants, researchers and participatory research. *Journal of Clinical Practice in Speech-Language Pathology*, *16*(3), 123–126.

Hinckley, J., Boyle, E., Lombard, D., & Bartels-Tobin, L. (2014). Towards a consumer-informed research agenda for aphasia: Preliminary work. *Disability and Rehabilitation*, *36*(12), 1042–1050. doi: 10.3109/09638288.2013.829528

Kapoor, D., & Jordan, S. (2009). *Education, participatory action research and social change*. New York, NY: Palgrave Macmillan.

Kemmis, S., McTaggart, R., & Nixon, R. (2013). *The action research planner: Doing critical participatory action research*. Singapore: Springer Science & Business Media.

Kidd, S., & Kral, M. (2005). Practicing participatory action research. *Journal of Counseling Psychology*, *52*(2), 187–195.

Kingdon, S., Pain, R., & Kesby, M. (2007). *Participatory action research approaches and methods*. *Connecting people, participation and place*. Abingdon-on-Thames, UK: Routledge.

Koch, T., & Kralik, D. (2009). *Participatory action research in health care*. Oxford, UK: Blackwell Publishing Ltd.

Kramer-Roy, D. (2015). Using participatory and creative methods to facilitate emancipatory research with people facing multiple disadvantage: A role for health and care professionals. *Disability & Society*, *30*(8), 1207–1224. doi:10.1080/09687599.2015.1090955

Laverack, G., & Brown, K. (2003). Qualitative research in a cross-cultural context: Fijian experiences. *Qualitative Health Research*, *13*(3), 333–342. doi:10.1177/1049732302250129

Liamputtong, P. (Ed.). (2008). *Doing cross-cultural research: Ethical and methodological perspectives*. Dordrecht, Netherlands: Springer.

Maiter, S., Simich, L., Jacobson, N., & Wise, J. (2008). Reciprocity an ethic for community-based participatory action research. *Action Research*, *6*(3), 305–325. doi:19.1177/1476750307083720

Maguire, P. (2001). Uneven ground: Feminisms and action research. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (pp. 59–69). London, UK: Sage.

McAllister, L., Woodward, S., Atherton, M., Dung, N., Potvin, C., Huynh, B.,…Khanh, D. (2013). Vietnam's first qualified speech therapists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech- Language Pathology*, *15*(2), 75–79.

Müller, N., & Guendouzi, J. (2009). Discourses of dementia: A call for an ethnographic, action research approach to care in linguistically and culturally diverse environments. *Seminars in Speech and Language*, *30*(3), 198–206. doi:10.1055/s-0029-1225956

Pavlish, C. (2005). Refugee women's health: Collaborative inquiry with refugee women in Rwanda. *Health Care for Women International*, *26*(10), 880–896. doi:10.1080/07399330500301697

Pound, C. (2013). *An exploration of the friendship experiences of working-age adults with aphasia*. (Unpublished doctoral dissertation). Brunel University, UK.

Primavera, J., & Brodsky, A. (2004). Introduction to the special issue on the process of community research and action. *American Journal of Community Psychology*, *33*(3), 177–179. doi:10.1023/b:ajcp.0000027213.18639.30

Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies*, *46*(2), 277–287. doi:10.1016/j.ijnurstu.2008.08.006

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, *4*(2), 161–178. doi:10.1177/1468794104044430

Turner, S. (2010). Research note. The silenced assistant: Reflections of invisible interpreters and research assistants. *Asia Pacific Viewpoint*, *51*(2), 206–219.

Westby, C., & Hwa-Froelich, D. (2003). Considerations in participatory action research when working cross-culturally. *Folia Phoniatrica et Logopaedica*, *55*(6), 300–305. doi:10.1159/000073253

Wong, J., & Poon, M. (2010). Bringing translation out of the shadows: Translation as an issue of methodological significance in cross-cultural qualitative research. *Journal of Transcultural Nursing*, *21*(2), 151–158. doi:10.1177/1043659609357637

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Sustainable partnerships for communication disability rehabilitation in majority world countries

A message from the inside

Karen Wylie, Clement Amponsah, Josephine Ohenewa Bampoe, and Nana Akua Owusu

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THIS ARTICLE HAS BEEN PEER-REVIEWED

Karen Wylie (top) and Clement Amponsah

Rehabilitation services for people with communication disabilities (PWCD) in many majority-world countries are extremely limited, with speech-language pathology little known. Collaborations between clinicians and services in majority- and minority-world countries provide important contributions to developing rehabilitation services in the majority world for PWCD. The effectiveness of such partnerships may be influenced by a number of elements within the relationship. This paper presents insights from a group of majority-world speech-language pathologists (SLPs) in Ghana on establishing and maintaining links between majority- and minority-world services and clinicians. The framework of three sustainability dimensions (service environment, socio-cultural-political environment, and economic environment) is used to consider how SLP relationships across majority–minority worlds can be meaningful and lasting. Readers are encouraged to adopt the perspective of SLPs from within the country to consider the impact and sustainability of majority–minority world partnerships.

Globalisation and technological innovation has made linking with people from different geographical regions more possible than at any other time in history (Friedman, 2006). For service providers and people with communication disabilities (PWCD) in countries of the majority world, where services for communication disability are often extremely limited, it frequently means establishing relationships beyond their borders to assist with service provision, service development and improvement in quality. This article presents an insiders' perspective and discussion on relationships between clinicians and services across minority- and majority-world countries based on personal experiences of working in Ghana. The aims are twofold: (a) to encourage readers to view majority–minority world relationships through the lens of clinicians in the majority world and (b) to offer a range of observations from the authors' perspectives as "insiders" on relationship development and sustainability. This paper is not intended to provide a road map of how such relationships should operate; however, it provides a perspective of some of the complexities in developing and sustaining relationships to support development of sustainable services for communication disability.

Reflexivity statement

The authors of this paper are four speech-language pathologists (SLPs) living and working in Ghana, West Africa. Three are Ghanaian nationals, who trained in the United Kingdom (UK). One is a long-term expatriate in the region, who has lived in Ghana for four years and in the region for thirteen years. Together we work at a government hospital offering clinical speech-language pathology services. We also work together at a university to establish a training program for speech-language pathology. One of our group also runs an NGO focusing on early intervention and support for children with communication difficulties. Our regular and varied contact with SLPs who wish to come to Ghana to assist in the development of communication disability services prompted the writing of this paper. We recognise that our perceptions of the insider–outsider relationships may differ from the perceptions of those who visit.

While Ghana is rich in history and culture, it is not yet endowed with well-established rehabilitation systems for people with disabilities. Furthermore, although our country is foresighted and has an inclusive education policy (Ministry of Education, 2013), awareness of disability rights is still developing and services to support people with communication disability (PWCD) are severely stretched, with few speech-language pathology or communication disability services available in the country. Building services/systems for the future and improving awareness of communication disabilities is the focus of our work.

Our context

Ghana is well recognised as a leading nation of West Africa in areas including governance and economic development. Ghana is a lower middle income country and is ranked at 140 on the United Nations Development Programme (UNDP) Human Development Index (UNDP, 2015). It has a population of 26.4 million (UNDP, 2015) and is a multiparty democracy. In 1957, Ghana was the first sub-Saharan African country to achieve independence from its former colonial ruler Britain. While English is the official language of Ghana, Ghana has a large number of languages and dialects in use, with an estimated 25 to 43 main languages (National Commission on Culture, 2006). Currently, the

authors are aware of six practising SLPs in Ghana. Half are Ghanaian nationals, all were trained outside of Ghana and all are based in the capital city. There are no free speech-language pathology (SLP) services in the country and the National Health Insurance Scheme does not subsidise speech-language pathology (National Health Insurance Scheme, 2016). Clients frequently report travelling for many hours to attend services.

As in many majority-world nations, people with communication difficulties (PWCD) in Ghana require development of a range of rehabilitation services and supports, of which SLP is only one element (Wickenden, 2013). There are a range of people working with PWCD who provide important contributions to rehabilitation. Teachers, teaching assistants, therapists, therapy/educational aides (known locally as facilitators), community-based rehabilitation (CBR) workers, nurses, carers and parents all provide important work in this arena and are indispensable in providing a network of services and support for PWCD.

While every majority-world country and context differs, there are frequently common themes associated with service provision challenges. Often, there is a small workforce, no SLP training programs (Fagan & Jacobs, 2009), little professional development, and limited training for CBR or mid-tier workers in communication disability (World Bank & World Health Organization, 2011). Where SLP services exist, payment is often required and insurance cover for SLP is extremely limited. The community may have limited awareness of communication disability (Wickenden, 2013) and differing beliefs about the causes of communication disability (Ndung'u & Kinyua, 2009).

The insider perspective

Individuals frequently view a shared experience in differing ways, particularly when their context and cultural backgrounds differ (Nixon et al., 2015). Alternative perspectives can result in tensions within relationships that are frequently unarticulated (Nixon et al. 2015). One aim of this paper is to encourage readers to attempt to view visiting partnerships through the lens of an 'insider" – someone who may be there before minority-world SLPs arrive, support them during their work, then continues on after they leave – to enable more critical reflection of sustainable relationships.

To reflect on issues around partnerships for sustainable service development using an insider perspective, we encourage readers to consider a fictional vignette (Box A). This example offers the chance to reflect on some of the many issues that are present when an "outsider" visits a local service. Navigating relationships between services or clinicians in the majority and minority worlds can be complex, yet undoubtedly globalisation has resulted in dramatically more opportunities for collaboration (Friedman, 2006). With this edition of the journal focused on the theme "Minority-world SLPs in majority-world contexts", it is important to reflect on what contributes to effective partnerships between majority- and minority-world services.

How can minority-world SLPs assist development of sustainable services for PWCD in majority-world countries?

In the spirit of a local proverb in Akan "Nyansa nne eti kromu" [translation: *Wisdom is not the preserve of one*

Box A: Turning the tables: Insiders and outsiders – an example

Imagine that you are one of two SLPs and two assistants working in a government clinic in remote Australia. Budget cuts mean equipment is dated or non-existent. You offer services across a huge geographical area to a large population. A skilled and experienced speech-language pathologist from a well-resourced service in Africa offers to volunteer for 3 months. As services are stretched to the limit in your clinic, you are excited to have someone to help you improve services. In the weeks prior to arrival, you exchange emails and Skype calls. You help him/her to organise accommodation. You advise on transport, safety, the weather, the health system, and you collect the volunteer from the airport.

Your new colleague is generous in sharing their knowledge. Your service enhances training and expands clinical services. You are working on interesting projects and feel inspired by the rich clinical discussions. But there are challenges. The visiting practitioner struggles to understand how things happen in your context and seems to have an agenda for what is required, which doesn't match your view of the need. Given the visitor is more experienced, volunteering their time, and contributing resources, it is hard to argue. At a service level, there are small issues. The visiting practitioner has trouble with the language, so cannot work independently. Clients often don't understand what he/she means when explaining things, but are too polite to mention it. There are awkward moments – such as when the visiting practitioner tells clients to focus on giving instructions to their children rather than engaging in reciprocal play, or hints that the type of therapy you are offering may not be best practice. The visiting practitioner doesn't know how to do the things that are considered important in your context (e.g., making sure certain families have transport money or helping to find a school that will take their child). You understand that it is simply a difference to how things are done in Africa.

The visiting practitioner helps to train the assistants in a particular type of therapy. Everyone is excited about skill development. It is wonderful to make the connection, but all the things you need to organise for the visitor are added on top of your usual workload. The visiting practitioner returns to Africa and you are back juggling the demands of service provision to desperate clients, and the many other needs (e.g., awareness raising, training others, special projects to improve services, prevention work, and trying to build a profession). The visiting practitioner stays in touch for some months and sends some invaluable resources. The assistants need further support in adapting their new programs to the culture, and you struggle to support them and maintain your other work. After two months, another NGO from Africa offers to assist in the development of autism services and would like your involvement. You feel like you are still playing catch-up with your usual work. What is your response?

Josephine Ohenewa Bampoe (top), and Nana Akua Owusu

individual], we offer our own perspectives on how minority-world SLPs can best assist those in the majority world to develop sustainable services. Based on our experience of collaborations with minority-world stakeholders, we considered the question, "What do we believe is best practice for minority world SLPs to do, discuss or consider when visiting Ghana to assist in sustainable service development?"

Factors around sustainability are key to discussion of how minority-world SLPs can best assist those in the majority world to improve services for PWCD. Recently the United Nations (2015) adopted 17 sustainability goals for development. These goals address three commonly recognised dimensions of sustainable development: economic, environmental, and social and. In this paper we use these three sustainability dimensions to structure our views on partnerships between SLPs in minority- and majority-world countries. The following observations expressed are not intended to be exhaustive, but represent our observations from the field.

Economic sustainability factors

Economics

For sustainability, services need to be both economically viable and relevant to the needs of the population. Minority-world partners who seek understanding of the economic context, including factors such as service funding models, costs of services, service affordability, can make more informed choices about the nature of their involvement. Researching economic indicators and seeking information from majority-world partners can assist in understanding economic factors. For example, all SLP services in Ghana are fee paying, with costs varying enormously. Understanding the type of service you are partnering with, the types of clients who are able to access/afford the service, and the cost relative to other services can help give indications of the long-term sustainability and impact of partnering with a particular service.

Opportunity costs

Understanding the opportunity costs which may impact local counterparts (and which may not be immediately obvious) can assist in project planning and implementation. These factors may include:

1. How much money people attending training or therapy sacrifice due to loss of income, or indirect costs (such as transport) of meeting with you. Such costs can be significant when families are struggling to make ends meet.
2. Understanding of the time required by local service providers to plan for visits or projects, and what happens to existing, stretched services when additional time is needed to assist planned visits. That is, what do local staff stop doing to assist in organising international programs or visits? For example, past visiting programs in Ghana have taken a number of days of planning and organising. Due to the lack of administrative support, much of this time has been taken from clinical services. It is necessary to understand and weigh up the cost-benefit of such commitments.

Lobbying

Improvements in sustainability require developments in economic and social policy. Activism, for improvements to awareness, rights and services, forms a large part of disability engagement in majority world countries, including for SLPs (Wickenden, 2013). For minority world partners with higher level political influence, it is useful to consider if there is a strategic role to influence change in conjunction with majority-world partners. For example, in Ghana visiting minority-world partners have met with government officials or participated in media events in collaboration with the local team, assisting with the local agenda to build awareness of communication disability and lobbying for improved services. Such meetings are carefully planned as part of the partnership.

Environmental sustainability factors

Service environment

Investing time considering the wider service context when considering relationships and support in a majority-world country is prudent. Contacting a number of individuals or groups to ask questions about the range and types of services in the country (e.g., government, private and NGO services) provides a perspective of "the lay of the land", including population needs and how services are organised. For example, some independent SLP volunteers to Ghana have previously liaised with a range of services and clinicians to discuss the situation and need in Ghana, to determine how and when to partner with a particular organisation. Gaining such an overview of services and need in-country can assist visiting clinicians or organisations to determine where and how contributions to that country may be most beneficial. Such an approach also has the potential to increase communication between SLPs and organisations who may collaborate with them on projects during their visits.

Direct or indirect services

Working alongside a local partner will allow capacity building, enable the local partner to follow-up initiatives, and increase relevancy of services. Before providing direct clinical services, consider the relevance, appropriacy and sustainability of these services. Never offer direct clinical services alone, without planning how such services can be culturally relevant and sustained.

Professional networks

In Ghana, local SLPs routinely seek to engage with visiting minority-world SLPs. Creating these professional networks of practice is an effective way of building a knowledge and resource base in a country with limited services for communication disability. When visiting SLPs do not engage with other SLPs or providers in the country the potential to waste precious expertise and duplicate resources is increased.

Work environment

Attempt to understand the constraints of local staff, including SLPs. The reality of working in a majority-world country is often challenging, with huge clinical demands, low salaries, limited technology access (e.g., no reliable internet or work phone), underdeveloped systems, bureaucracy and sometimes unreliable basic services such as water and electricity. For example, in Ghana access to technology in government services is extremely limited. There is currently no internet access in the hospital speech-language pathology service and SLPs frequently use their own resources to contact international SLP colleagues. Limited access to technology can impact both finances (and therefore willingness to call/log on) and timeliness of responses for local staff which can sometimes be perceived negatively by minority-world partners. Projects with funding could consider limited support for the team to access appropriate resources.

Needs

In a context where services and resources are underdeveloped, there is always need for additional resources. Detailed discussions with local partners about needs and priorities are crucial to make sure resources brought in are high priority and relevant for use. For example, past majority-world visitors to Ghana have sent a list of items they are considering bringing, and we advised them which items are relevant and of high priority.

Socio-cultural-political sustainability factors

Transparency

Acknowledge motivations clearly as this sets the scene for the boundaries of the partnership. Engaging with SLP services in the majority world is done voluntarily and for a purpose with each partner benefitting from the relationship. Minority world SLP motivations may vary (e.g., travel, the chance to meet new people, international recognition, publications, recognition from your institution for developing international relationships, grant funding, service learning promoting cross-cultural competencies, or the opportunity to be regarded as "worldly" or "generous"). Stakeholders in majority-world countries benefit through improvements to services, funding, equipment or expertise. Transparent and open dialogue about motivations will enable partners in the majority world to understand the limitations of minority-world SLPs' involvement. For example, if SLP partners in Ghana understand that the motive of a visit includes positive publicity for your institution, they can plan local media engagements that may both meet this objective and build community awareness of local communication disability services.

Expertise

There are two types of expertise relevant to the practice of SLP in the majority world: (a) expertise in a particular clinical specialty, and (b) expertise in how to translate this knowledge to deliver culturally and contextually relevant services (Hyter, 2014; Pickering and McAllister, 2009) The second expertise is often referred to as "cultural competence" (Leadbeater & Litosseliti, 2014). However, when SLPs work outside situations with which they are familiar, cultural competence should be widened to include contextual competence. For example, an individual may be a clinical specialist in her or his home country, but face significant challenges translating that knowledge into practice in a different context where knowledge of local practices and services in the field of expertise is limited. SLP is a western profession (Pillay & Kathard, 2015), most often practised in contexts where there are networks of services for PWCD. Where the sociocultural context differs, consideration of the beliefs underpinning knowledge and practices of SLP services is important to begin to reframe practice (Hyter, 2014). This ensures services are "sustainable, culturally appropriate and nuanced" (Barrett & Marshall, 2013, p. 50). SLP practices in majority-world settings may differ from practices in the minority world, due to differing support systems, culture and population needs (Wickenden, 2013; Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003; Wylie, McAllister, Davidson, Marshall, & Law, 2014). Thus, working collaboratively with a local partner who can act as a cultural broker is vital. This should be someone who understands both the cultural context and understands the context of communication disability/SLP in that country and can assist in navigating the complex terrain.

Alternative support models

Historically, minority world SLPs' visits to Ghana have typically focused on supporting existing services and/or providing training. An alternative option is to support clinicians from the majority world to spend time in minority world services, and allow majority world clinicians to make judgements about adaptation of relevant practices or systems on return. This might include training sponsorships (Hutchins, 2015), or capacity-building partnerships grants (e.g., Department of Foreign Affairs and Trade, 2016; McAllister et al., 2013). For example, one Ghanaian clinician was recently sponsored to visit academic institutions in the UK to review processes for clinical education. This allowed the team member to view a range of programs and judge which processes may be best suited to the Ghanaian context

Priorities and mutual planning

The concept described by Hyter (2014) as cultural humility is an important start to creating an effective two-way dialogue and planning. Dialogue can help create an appropriate plan for potential placements or partnerships. Projects and desired outcomes need to be mutually negotiated, based on need, context, local resourcing with a high priority given to the expressed needs of the local partners. Self-determination is vital if developments are to be sustained in the long term. Just as SLPs from the minority world need to take time to build relationships and explore the needs and priorities of the majority world partners, majority world partners should work towards clarity and control regarding their priorities and needs. However, achieving such clarity and self-determination can be challenging due to subtle power dimensions in relationships (Sharpe & Dear, 2013). The subtle influences of neocolonialism frequently impact relationships when minority world SLPs engage in the majority world (Hickey, Archibald, McKenna, & Woods, 2012; Nixon et al., 2015). Recognition and acknowledgement of these power imbalances is part of successful collaborative engagement between majority- and minority-world SLPs.

Change and time

Change takes time and ongoing effort to anchor practices in the culture (Kotter, 1996). For sustainable development of services in majority world countries, long-lasting durable and evolving relationships count. One often-seen limitation of majority-minority world partnerships is the short-term nature of them. Partnerships that can be sustained over time offer potential to engender lasting change in systems, practices, and policy. While many SLPs visit majority-world countries with short-term objectives, lasting change may require a longer commitment. Advances in technology are opening windows for remote support – for example, the inclusion in professional development opportunities via videoconferencing platforms, or assistance with case reviews using smart phone video and audio technology.

Conclusion

It is not yet clear how sustainable and culturally appropriate services for communication disability will ultimately look in majority world countries. We are still learning how SLP can best contribute to the needs of PWCD in these varied contexts. Yet every engagement we have with SLPs from the minority world has the potential to shift the landscape. In this paper we have attempted to provide an insider perspective on minority-world – majority-world SLP engagement. We have offered our experiential view on

some of the factors that can contribute to effective engagement between minority-world and majority-world stakeholders in attempting to build sustainable services for PWCD. We believe that similar themes are likely to be evident in many majority-world countries where services and individuals from minority-world nations support development initiatives for majority-world countries. Effective partnerships between majority-world and minority-world stakeholders are crucial for development of services for PWCD. As insiders, we encourage those considering engagement in the majority world to strive for understanding across service, socio-cultural-political, and economic environments for effective partnerships.

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References

Barrett, H., & Marshall, J. (2013). Implementation of the World report on disability: Developing human resource capacity to meet the needs of people with communication disability in Uganda. *International Journal of Speech-Language Pathology*, *15*(1), 48–52. doi:10.3109/17549507.2012.743035

Department of Foreign Affairs and Trade. (2016). *Australia awards fellowships*. Retrieved from http://dfat.gov.au/people-to-people/australia-awards/Pages/australia-awards-fellowships.aspx

Fagan, J. J., & Jacobs, M. (2009). Survey of ENT services in Africa: need for a comprehensive intervention. *Global Health Action*, *2*(10). doi:10.3402/gha.v2i0.1932

Friedman, T. L. (2006). *The world is flat: A brief history of the twenty-first century*. Camberwell, Vic.: Penguin.

Hickey, E. M., Archibald, C., McKenna, M., & Woods, C. (2012). Ethical concerns in voluntourism in speech-language pathology & audiology. *Perspectives in Global Issues in Communication Sciences & Related Disorders*, *2*(2), 40–48.

Hutchins, S. D. (2015). SLP grad takes his skills back to Rwanda. *The ASHA Leader*, *20*(10), 24–25. doi:10.1044/leader.LML.20102015.24

Hyter, Y. D. (2014). A conceptual framework for responsive global engagement in communication sciences and disorders. *Topics in Language Disorders*, *34*(2), 103–120. doi: 110.1097/TLD.0000000000000015.

Kotter, J. P. (1996). *Leading change*. Boston, MA: Harvard Business School Press.

Leadbeater, C., & Litosseliti, L. (2014). The importance of cultural competence for speech and language therapists. *Journal of Interactional Research in Communication Disorders*, *5*(1), 1–26. doi:10.1558/jircd.v5i1.1

McAllister, L., Woodward, S., Atherton, M., Nguyen, T., , Potvin, C., Huynh, B., . . . Le Khanh, D. (2013). Viet Nam's first qualified speech therapists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech Language Pathology*, *15*(2), 75–79.

Ministry of Education. (2013). *Inclusive education policy*. Draft. Accra, Ghana: Republic of Ghana. Retrieved from http://www.voiceghana.org/downloads/MoE_IE_Policy_Final_Draft1.pdf

National Commission on Culture. (2006). *The people: Traditional language and orature*. Retrieved from http://www.ghanaculture.gov.gh/index1.php?linkid=240.

National Health Insurance Scheme. (2016). *Benefits package*. Retrieved from http://www.nhis.gov.gh/benefits.aspx

Ndung'u, R., & Kinyua, M. (2009). Cultural perspectives in language and speech disorders. *Disability Studies Quarterly*, *29*(4). Retreived from http://dsq-sds.org/article/view/986/1175

Nixon, S. A., Cockburn, L., Acheinegeh, R., Bradley, K., Cameron, D., Mue, P. N., . . . Gibson, B. E. (2015). Using postcolonial perspectives to consider rehabilitation with children with disabilities: The Bamenda–Toronto dialogue. *Disability and the Global South*, *2*(2), 570–589.

Pickering, M., & McAllister, L. (2000). A conceptual framework for linking and guiding domestic cross-cultural and international practice in speech-language pathology. *Advances in Speech Language Pathology*, *2*(2), 93–106.

Pillay, M., & Kathard, H. (2015). Decolonizing health professionals' education: Audiology and speech therapy in South Africa. *African Journal of Rhetoric*, 7, 193–227.

Sharpe, E., & Dear, S. (2013). Points of discomfort: Reflections on power and partnerships in international service-learning. *Michigan Journal of Community Service Learning*, *19*(2), 49–57.

United Nations. (2015). *Transforming our world. The 2030 agenda for sustainable development*. Geneva: United Nations. Retreived from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

United Nations Development Programme. (2015). *Human development reports: Ghana*. Retrieved from http://hdr.undp.org/en/countries/profiles/GHA

Wickenden, M. (2013). Widening the SLP lens: How can we improve the wellbeing of people with communication disabilities globally. *International Journal of Speech-Language Pathology*, *15*(1), 14–20. doi:10.3109/17549507.2012.726276

Wickenden, M., Hartley, S., Kariyakaranawa, S., & Kodikara, S. (2003). Teaching speech and language therapists in Sri Lanka: Issues in curriculum, culture and language. *Folia Phoniatr Logop*, *55*(6), 314–321. doi:10.1159/000073255

World Bank & World Health Organization. (2011). *World report on disability*. Geneva, Switzerland: World Health Organization.

Wylie, K., McAllister, L., Davidson, B., Marshall, J., & Law, J. (2014). Adopting public health approaches to communication disability: Challenges for the education of speech-language pathologists. *Folia Phoniatrica et Logopaedica*, *66*(4–5), 164–175.

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Professional and personal benefits of volunteering

Perspectives of international clinical educators of Vietnamese speech-language pathology students in Vietnam

Lindy McAllister, Sue Woodward, and Srivalli Nagarajan

Few studies have investigated the impact of volunteering on allied health professionals' personal and professional development. This paper presents the findings of a study exploring the volunteering experience of speech-language pathology (SLP) clinical educators in Vietnam. Twenty four volunteers placed through Trinh Foundation Australia provided clinical supervision to students in Vietnam's first SLP course during 2010–12. Returning volunteers were invited to complete a written survey and provide a short summary of their experience. Twelve surveys and six summaries were returned. These responses were analysed using content analysis and five categories were identified: motivations for volunteering, managing challenges associated with a different culture, language and working with interpreters, impact of the volunteer experience on professional development and clinical practice back home, and enhanced skills and interest in clinical education. Participants described the applicability of knowledge and skills gained in Vietnam to their practice in Australia.

> *I am a speech pathologist with over 30 years' experience in a number of different clinical settings including 12 years [in a specialist area]. … At this stage in my career I was thinking that maybe my days as a speech pathologist were coming to an end and I would pursue other interests. The idea of volunteering in any capacity had always interested me so when I discovered that there was an opportunity to actually use my speech pathology skills I was definitely interested. … Volunteering in Vietnam was an incredibly worthwhile experience which provided me with a challenge on both a personal and professional level, and allowed me to utilise my existing clinical skills and experience as a student educator to assist in a small way in the clinical education of the … Vietnamese students training to become speech pathologists.* (Lisa – returned volunteer speech-language pathologist to Vietnam)

The Australian Bureau of Statistics (2015) figures for 2014 revealed that 5.8 million people in Australia (31 per cent) reported they had volunteered in the previous 12 months, contributing 743 million hours to the community. There has also been significant growth in international volunteering in recent years (Baillie Smith & Laurie, 2011). As the opening vignette shows, volunteering internationally can have a profound impact on the volunteer. It can also have significant positive and sustainable impacts on host organisations and communities if volunteering programs are well designed and well managed (Sherraden, Lough & McBride, 2008; UNV, 2011). Conversely, negative impacts such as cultural imperialism, reinforcement of inequalities (Sherraden et al., 2008), and neocolonialism (Karle, Christensen, Gordon & Nystrup, 2008) can arise from poorly considered or managed volunteering. Volunteer tourism or voluntourism, where volunteers combine a holiday and tourism in a developing country with engagement in a short term, humanitarian project, has attracted considerable criticism in recent years (Palacios, 2010). These projects frequently do not require professional skills; for example, projects may simply require free labour from people without construction or engineering backgrounds to build a schoolroom, or a playground for an orphanage. Outcomes may not address community needs, or have sustainable outcomes for the host site, even though volunteers may experience a sense of well-being arising from their activities.

Lack of sustainability of volunteer endeavours has been critiqued (see for example Devereux, 2008). There is a lack of literature on the impacts and sustainable outcomes of volunteer programs generally (Sherraden et al., 2008), especially for health professionals engaging in knowledge and skills transfer designed to build capacity of host sites and training recipients (Meyer, 2013). Most of the existing literature pertains to medical and nursing/midwifery volunteers (e.g., Pieczynski, Laudanski, Speck, & McCunn, 2013). There are few studies about allied health volunteers, and to the best of our knowledge none about SLP volunteers. Hickey, McKenna, Woods, and Archibald (2014) noted that research is required into best practices for volunteering in SLP and audiology volunteers. This paper investigates the impacts on speech-language pathologists resulting from volunteering as clinical educators (CEs) for students in Vietnam's first SLP course. It is important to note that the evaluation of the impacts and outcomes from the perspectives of the Vietnamese partners is critical to

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avoid neocolonial practice (Karle et al., 2008) and ensure agencies and volunteers from minority world countries understand and enable sustainability (Osborn, Cutter, and Ullah, 2015). To this end, readers are referred to previous work (McAllister et al., 2013) in which the impact on the host site and the recipients of training by CE volunteers in Vietnam has been discussed. Furthermore, publications in review and preparation will explore in more depth Vietnamese perspectives on the contributions of volunteers.

Background

The volunteers involved in this study were sourced, placed and supported by Trinh Foundation Australia (TFA) which was established in 2008 to respond to requests for assistance in developing and delivering SLP training courses in Vietnam. The volunteers provided clinical supervision for students enrolled in the first 2-year postgraduate speech-language pathology training course at the University of Medicine Pham Ngoc Thach (UPNT) in Ho Chi Minh City (HCMC) in 2010–12. The structure and support arrangements, as well as students in the course, were described in McAllister and colleagues (2013).

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In line with best practices for volunteering (Hickey et al., 2014), TFA volunteers receive pre-departure briefing and return-to-Australia debriefing from TFA, as well as in-country support from full-time Australian volunteer speech-language pathologists at UPNT in HCMC. This paper focuses on survey responses from 12 volunteers who provided clinical supervision in the 2010–12 course. The volunteers went to Vietnam for periods ranging from 2–12 weeks. They supervised students on 1–3-week block placements in a range of clinical facilities. The volunteer CEs typically worked a 5-day week with groups of 2–4 students and fulfilled the normal roles of a clinical educator (e.g., reviewing client assessment reports and treatment plans, modelling techniques, observing student performance, providing feedback and formal assessment, coaching and tutoring). The volunteers were supported by TFA trained interpreters/translators in Vietnam to translate clinical education materials and interpret communication between the Australian SLP CEs, students and patients/families during the clinical placements.

Method

Ethics approval for this study was provided by the University of Sydney Human Research Ethics Committee (approval # 2014/231).

Recruitment

All 24 CE volunteers in the first course (September 2010 – August 2012) were emailed an invitation and participant information about the study. The 12 respondents were then emailed a survey, by a person not involved in supporting the volunteers. The invitation to participate was sent after the last clinical placement block, in October 2012. Participants were asked to return their surveys and summaries by email if they consented to participate.

Data collection

The survey comprised 4 questions presented in Table 1, along with an invitation to provide a 100 word summary of the experience. Twelve surveys were returned and analysed. Six optional summaries contributed by participants were not included in analysis; they were left "whole" for use as vignettes in the paper.

Table 1. Survey on experiences of volunteering as CEs for SLP students in Vietnam

1. Do you think your time in Vietnam gave you any insights into understanding another culture? What cross-cultural skills and knowledge did you develop as a result of your time in Vietnam? Have these been applicable to your professional work?
2. Do you think working in such a different and frequently challenging environment has given you any valuable insights into your personal strengths and weaknesses?
3. How has your role as a clinical educator in Vietnam impacted on your professional development?
4. Has working in Vietnam influenced your clinical practice in any way?

Data analysis

Survey responses to each question were collated. Because some emergent categories were identifiable in collations of responses to more than one question, all responses were collated and then analysed using content analysis (Hsieh & Shannon, 2005). Emerging categories were compared within an individual's survey data and across all participants' survey responses. Through a process of constant comparative analysis (see for example, Hewitt-Taylor, 2001), a final list of categories was developed and exemplar quotes from survey responses identified to illustrate these.

Results

As speech-language pathologists who have volunteered as CEs in Vietnam are known in the profession, ethics approval required that limited demographic information be collected to reduce the likelihood of identification and pseudonyms are used to report data in this paper. All participants were female, which is similar to the national gender demographic of speech-language pathologists (Health Workforce Australia, 2014). Years of experience as an SLP ranged from 2 to more than 30 years. The volunteers came from a range of adult and paediatric settings in hospitals, schools, disability settings and private practices in Australia and the United Kingdom.

Data analysis identified five categories of CE responses to their experiences in Vietnam. These categories, subcategories and illustrative extracts from the surveys are presented in this section. Extracts are drawn from all participants.

Motivations for becoming a volunteer clinical educator

Motivation for volunteering was mentioned by most participants, in terms of their desire to make a contribution to the development of the profession in Vietnam or "give back" what they had gained from their professional life.

> Fay: *I am basically retired. I was glad to take on the role of clinical educator in Vietnam as a way to contribute something of what I have been able to learn and develop myself over my career.*

> Anna: *[it] was a perfect opportunity to "give back" to the profession in a small way, as well as stretch myself by working/volunteering in a different culture and language for the first time.*

Managing challenges

All participants spoke about challenges and these were of two main types: confronting and learning to manage

language and cultural barriers; and learning to work with interpreters. Participants started to develop an understanding of what the acceptable norms are in Vietnamese culture in relation to learning and asking questions. Using the knowledge gained through several interactive discussions with students and colleagues, participants began to understand how to manage cultural differences particularly in relation to learning and teaching, as illustrated in the quotes below.

Julie: *… it was really only once I had been in Vietnam for a week or so that I started to see a little better the expected behaviours, beliefs, values, practices and customs. That is, I learned much more within the context of the culture. This was informed by observations, opportunities to de-brief with a colleague, and LOTS of opportunities to interact with the students and critically, discuss cultural differences with them …*

Helen: *With students, I needed to break down this barrier [of hierarchy and officialness] to encourage them to ask questions. There seemed to be a concept of "saving face" and a feeling that asking a question indicated not knowing something.*

The majority of students with whom participants worked had little English, and this presented numerous communication barriers. While the interpreters were able to assist with overcoming these barriers, the volunteers (as exemplified in Helen's quote) were aware that cultural differences existed in terms of power and hierarchy between teachers and students and that this impacted on what it was acceptable to communicate about.

Lucy: *Although a few of the students did have good English skills, I was aware that not all of them did. Initially when I spoke the students with the better English would reply before the interpreter could translate. I felt that that was a weakness on my part. I then focused on pausing after I spoke to allow the interpreter to translate. I was more assertive when students would reply in English and I requested them to speak in Vietnamese to help the other students in the group. I have worked with interpreters before in my job but not to the level that is required in Vietnam.*

Impact on professional development

The participants wrote about a number of positive impacts of the volunteer CE experience on their professional development. These impacts included reaffirmation of the depth of knowledge and experience gained over years of practice and also the recognition that clinical knowledge and practice change over the course of a career and hence the need to seek continuing professional development (see for example Anna) or further education.

Anna: *It made me very conscious of how much clinical knowledge and practice changes over time and has reinforced the need for ongoing professional development and clinical discussion.*

For some, the volunteer experience improved leadership skills and time management skills. For others it ignited or rekindled enthusiasm for the profession.

Lucy: *I feel that it has improved my leadership skills.*

Maria: *I suppose I'd become a bit jaded. But the time I had volunteering for Trinh really motivated me and revived my enthusiasm for the profession.*

Kerrie astutely commented on coming to understand what was achievable in short time frames and the issues around sustainable impact of development work such as this.

Kerrie: *I wanted to see … change "large scale and lots of it!" for the clients and families in Vietnam, which was not at all realistic, just a natural response to seeing a country and a health system where the speech pathology profession is so new. Being part of a longer term, more sustainable answer to the problem really helped me to see the value in patience.*

Impact on clinical practice in home country

The volunteers identified positive impacts of the Vietnam experience on their clinical practice in Australia. The impacts included less reliance on resources, tests and equipment, needing to "think outside the square", increased patience, observation skills and clinical reasoning. One volunteer specifically wrote about new theoretical knowledge she acquired as a result of the experience.

Maria: *Not having access to the "western" resources, equipment and standardised tests has meant that I have needed to rely on the limited resources available which I believe has helped me to think outside the square regarding therapy approaches and assessment [in Australia].*

Helen: *Working in Vietnam certainly raised awareness of CALD issues in health care. It encouraged me to pursue translating speech pathology written information (e.g., brochures) into different languages and to investigate working these themes into our health promotion practices [in Australia].*

Maggie: *I have gained a lot of theoretical knowledge through volunteering, in particular in the area of cochlear implant and parent implemented therapy. I have been able to use this new knowledge in my clinical practice [in Australia].*

Enhanced skills and interest in clinical education

The volunteering experience served to further develop skills and interest in clinical education. For some like Anna and Carol, there had been a long absence from engagement in clinical education. Some participants reported that the experience in Vietnam reminded them how much they enjoyed clinical education. Volunteers such as Anna and Stephanie wrote about how the experience helped refine their reflection, analytic and clinical teaching skills. These experiences are illustrated by the following quotes.

Anna: *It certainly reacquainted me with the pleasure of working with students again.*

Lucy: *Previously I have only worked with students in one-to-one blocks. This experience helped me work with 4–5 students at a time. It helped develop my time management skills.*

Stephanie: *I had to step back and reflect upon my actions and teaching methods and how they were impacting upon the students' ability to learn from me.*

Discussion

This paper presents new data on the experiences of speech-language pathologists who volunteered as CEs in a

newly established SLP course in Vietnam. Our data in relation to motivation for volunteering are consistent with the altruistic trend in volunteering noted by Meyer (2013). Humanitarian reasons, desire to learn about another culture and advancing career prospects are discussed as common motivators in other studies of volunteers (Palmer, 2002). While literature on voluntourism (Meyer, 2013; Palacios, 2010) reports the desire for a personal challenge as a common motivator, the 12 participants in this study were more likely to express wanting a professional challenge, while recognising they would also be personally challenged by the climate, cultural and language differences. Career advancement was not a motivator for participants in this study.

The participants in this study reported their experience of volunteering as CEs in Vietnam to be highly positive. The personal and professional benefits for the volunteers and their practice back in Australia have been highlighted in this paper. The range of impacts on participants' professional development was to some degree unexpected, but encouraging. We did not, for example, expect to find the experiences in Vietnam generating a recommitment to and passion for their profession. The transferability of new knowledge and skills gained in Vietnam back to their clinical practice in Australia is a significant finding. The re-engagement with clinical education, the pleasure and satisfaction reportedly gained, and the refinement of educator skills, were encouraging findings. The study participants also reported several benefits of volunteering for advancing their professional skills and interest in clinical education. Such results have implications for SLP in Australia, which relies on a growing community of skilled and enthusiastic CEs.

This study also identified a range of challenges experienced by participants. Anticipated challenges of managing language and cultural barriers and working with interpreters were mentioned. Challenges or barriers in relation to communication in culturally different contexts have also been identified in other studies (e.g., Pieczynski et al., 2013). There was some degree in this study of what Santoro and Major (2012) referred to as dissonance regarding culturally different communication styles and expectations about appropriate interactions, and the participants had to develop cultural knowledge and some degree of intercultural competence to fulfil their role as CEs. Some participants commented that the students proved to be generous cultural guides and cultural knowledge brokers.

Most participants in our study had at least a little prior experience in working with interpreters. However, the varying English abilities of the students, coupled with interpreting protocols regarding pausing to allow time for interpreting, created additional complexity for the participants in "teaching" students in the presence of interpreters. Some participants noted that their enhanced competence and confidence in working with interpreters would be an asset in their practice back in Australia.

The lack of resources identified as barriers in other studies (Pieczynski et al., 2013) for participants in this study became a trigger for creativity and development of new skills. The development of intercultural skills and improved ability to work in culturally and linguistically diverse environments were seen as highly applicable to practice in Australia, as were the enhanced skills in working with interpreters. The impact of the volunteer experience on the development of intercultural competence is not unexpected, given previous research with volunteers and with allied health students (Gribble, Dender, Lawrence, Manning, & Falkmer, 2014). Our findings suggest that volunteering in a professional capacity in Vietnam provides significant professional development of knowledge, skills and attributes needed for maintaining currency of practice and expanding leadership capacity.

The lack of other barriers mentioned in their responses may reflect the impact of good pre-departure briefings and in-country support, and support from the students and interpreters themselves. Alternatively, the participants, as a self-selected group, may already have been culturally adaptable and resilient individuals, or they chose not to reveal negative experiences. Our data does not allow us to examine these possibilities, and this is a limitation of this study which could be addressed in future studies using interviews rather than written surveys.

Another limitation of this study is the sample size (12), which, although typical of qualitative research, does not permit generalisation of findings beyond the context of the study. A further limitation of this paper is that it does not report on benefits or problems experienced by the students who received clinical education from the volunteers. These data are being analysed and the results will be reported in forthcoming publications.

Sustainability of impact is always an important consideration in volunteer programs. The transfer of the volunteers' knowledge and skills to the Vietnamese students has been reported to be of great benefit to the emerging SLP profession in Vietnam (McAllister et al., 2013). The groundwork has been laid for future self-sufficiency of the profession in Vietnam. In order to upskill the Vietnamese SLPs as CEs for the future, subsequent CE volunteers mentored graduates of the 2010–12 course in clinical blocks to co-supervise students in the 2012–14 course. It is this professional knowledge and skills transfer and the commitment to sustainable impact that distinguishes this volunteer experience from "feel good" but not sustainable, and sometimes ethically questionable voluntourism (Hickey et al., 2014). The volunteer experiences described in this paper suggest the volunteering provided a powerful continuing personal development experience and in some cases transformative learning experience, as the words from Stephanie reveal.

> *I volunteered with the Trinh Foundation as I have always wanted to volunteer overseas and saw the opportunity to do so in a field where I could put my skills as a speech pathologist into use. Working as a clinical educator taught me so much about the important role that cultural understanding plays in delivering services that meet the needs of the people we work with. It also taught me so much about my own culture and about myself as a clinician. I am so grateful that I got to experience this during the early years of my career so that the skills and knowledge I gained were able to shape the way that I approach my work within the field. I would highly recommend this experience to anyone wanting to make a contribution to the international profession and to extend themselves both personally and professionally.* (Stephanie – returned Australian volunteer speech-language pathologist to Vietnam)

References

Australian Bureau of Statistics. (2015). *General social survey: Summary results, Australia, 2014*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0

Baillie Smith, M. B., & Laurie, N. (2011). International volunteering and development: Global citizenship and neoliberal professionalism today. *Transactions of the Institute of British Geographers*, *36*(4), 545–599. doi:10.1111/j.1475-5661.2011.00436.x

Devereux, P. (2008). International volunteering for development and sustainability: Outdated paternalism or a radical response to globalisation? *Development in Practice*, *18*(3), 357–370. doi:10.1080/09614520802030409

Gribble, N., Dender, A., Lawrence, E., Manning, K., & Falkmer, T. (2014). International WIL placements: Their influence on student professional development, personal growth and cultural competence. *Asia-Pacific Journal of Cooperative Education*, *15*(2), 107–117.

Health Workforce Australia. (2014). *Australia's Health Workforce Series: Speech pathologists in focus*. Retrieved from http://www.hwa.gov.au/publication/speech-pathologists-focus-0

Hewitt-Taylor, J. (2001). Use of constant comparative analysis in qualitative research. *Nursing Standard*, *15*(42), 39–42. http://dx.doi.org/10.7748/ns2001.07.15.42.39.c3052

Hickey, E. M., McKenna, M., Woods, C., & Archibald, C. (2012). Ethical concerns in voluntourism in speech-language pathology and audiology. *SIG 17 Perspectives on Global Issues in Communication Sciences and Related Disorders*, *2*(2), 40–48. doi:10.1044/gics2.2.40

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Karle, H., Christensen, L., Gordon, D., & Nystrup, J. (2008). Neo-colonialism versus sound globalisation policy in medical education. *Medical Education*, *42*(10), 956–958. doi:10.1111/j.1365-2923.2008.03155.x

McAllister, L., Woodward, S., Atherton, M., Nguyen Thi Ngoc Dung, Potvin, C., Huynh Bich Thao, Le Thi Thanh Xuan, & Dien Le Khanh. (2013). VietNam's first qualified speech pathologists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech-Language Pathology*, *15*(2), 75–79.

Meyer, J. K. M. (2013). *"I came here to do something": Evaluating the motivations and ethical implications of international medical volunteers* (Bachelor of Arts thesis, The Colorado College).

Osborn, D., Cutter, A., & Ullah, F. (2015). *Universal sustainable development goals: Understanding the transformational challenge for developed countries*. Report of a study by stakeholder forum. Geneva: United Nations. Retrieved from https://sustainabledevelopment.un.org/content/documents/1684SF_-_SDG_Universality_Report_-_May_2015.pdf

Palacios C. M. (2010). Volunteer tourism, development and education in a postcolonial world: Conceiving global connections beyond aid. *Journal of Sustainable Tourism*, *18*(7), 861–878.

Palmer, M. (2002). On the pros and cons of volunteering abroad. *Development in Practice*, *12*(5), 637–643.

Pieczynski, L. M., Laudanski, K., Speck, R. M., & McCunn, M. (2013). Analysis of field reports from anaesthesia volunteers in low- to middle-income countries. *Medical Education*, *47*(10), 1029–1036. doi:10.1111/medu.12262

Santoro, N., & Major, J. (2012). Learning to be a culturally responsive teacher through international study trips: Transformation or tourism? *Teaching Education*, *23*(3), 309–322.

Sherraden, M., Lough, B., & McBride, A. (2008). Effects of international volunteering and service: Individual and institutional predictors. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, *19*(4), 395–421. doi:10.1007/s11266-008-9072-x

United Nations Volunteers. (2011). *State of the world's volunteerism report*. Geneva: Author.

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Development of the Vietnamese Speech Assessment

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Ben Phạm (top), Sharynne McLeod (centre), and Xuan Thi Thanh Le

Vietnamese is the official language of over 92 million people in Viet Nam and nearly four million diaspora including in Australia, USA, and Canada. To date, there are no standardised speech assessments for Vietnamese children. This paper outlines the development of the Vietnamese Speech Assessment (VSA) through collaboration between researchers in Viet Nam and Australia. The VSA contains all Vietnamese consonants, vowels and tones in at least two words with different sequence constraints. Further, the VSA was developed to be within the vocabulary range of young children, frequently used by Vietnamese people in different regions, picturable, and either a noun or verb. Picture stimuli were identified and the test was piloted with Vietnamese speakers of different ages who spoke different Vietnamese dialects. A score sheet was designed to include acceptable dialectal pronunciations, and to enable calculation of percentage of consonants/vowels/semivowels/tones correct and presence of phonological processes (patterns). The VSA is currently undergoing norming and standardisation.

Vietnamese is the official language spoken by over 92 million people in Viet Nam and by nearly four million diaspora including in Australia, USA, and Canada. The government of Viet Nam has implemented "The Developmental Standards for Children aged 5", and standard 15, item 65 is "to speak clearly" (The Viet Nam Ministry of Education and Training, 2010). Vietnamese professionals report they assess Vietnamese children's speech production by using informal measures to determine who meets the developmental standards (The Viet Nam Institute of Educational Sciences, 2014). To date, there are no standardised norm-referenced assessments of Vietnamese children's speech production (McLeod, 2012a; McLeod & Verdon, 2014), which has resulted in the creation of informal tools presented in book chapters, journal articles, unpublished dissertations, and on websites (Cameron & Watt, 2006; Cheng, 1991; Hwa-Froelich, Hodson, & Edwards, 2002; Nguyễn, 2011; Nguyễn & Phạm, 2014; Pham, 2009; Tang & Barlow, 2006; Vũ & Đặng, 2004), as well as tools developed by staff in a particular clinic/school/hospital/university for use in their own clinical practice (The Children's Hospital No. 1, 2013; Ducote, n.d.; Lê, 2013; West, 2000). Many of these tools are created to assess children who speak the southern Vietnamese dialect in Viet Nam, or other countries, and have limitations when used with people who speak the northern and central dialects of Vietnamese. This situation necessitated the development of the Vietnamese Speech Assessment (VSA) for research and clinical practice across Viet Nam and in other countries.

This paper outlines the creation of the VSA using psychometric standards for assessment in two stages: conceptualisation and operationalisation (Frytak, 2000) and has been written using the guidelines for test creation from McLeod (2012b). The VSA has been developed via collaboration between Ben Phạm, Xuan Thi Thanh Le and Sharynne McLeod, the Trinh Foundation and Charles Sturt University in Viet Nam and Australia (see Figure 1). Creation of the VSA would not be possible without extensive international collaboration between authors in these majority- and minority-world contexts drawing on the authors' expertise in Vietnamese phonetics and phonology, Vietnamese dialectal variants, child development, and test development. The authors met face-to-face on numerous occasions to listen to the production of consonants, vowels and tones by Vietnamese speakers, and to debate the benefits of different word choices. The three authors also undertook pilot testing and initial operationalisation of the tool together in Australia and Viet Nam, each transcribing, then discussing children's production of the words. The VSA would not have the same level of rigour if the three authors had not collaborated and cooperated extensively during the conceptualisation stage.

Stage 1. Conceptualisation of the Vietnamese Speech Assessment

Conceptualisation of an assessment tool refers to determining its purpose and scope, ensuring it measures what it intends to do through its properties and features (Frytak, 2000). Conceptualisation of an assessment begins with a statement of its purpose, intended population, target skill, and scope (McLeod, 2012b).

Figure 1. The authors of the Vietnamese Speech Assessment

Purpose

The current purpose of the VSA is to describe children's ability to produce consonants, semivowels, vowels, and tones in the northern, central, and southern Vietnamese dialects. Once normative data have been collected and analysed, the other purposes will be for diagnosis of speech sound disorders, to assist with goal setting for intervention, and to determine the outcomes of intervention.

Intended population

The VSA is designed for Vietnamese-speaking children ranging from 2;0 to 6;11 years who live in different regions of Viet Nam and in other countries. Children may be either monolingual or multilingual speakers. Examiners using the VSA should be speech-language pathologists, special educators, psychologists or other professionals who are Vietnamese native speakers with experience in Vietnamese phonetic transcription and working with children (Smit, 1986). It may be possible for non-Vietnamese-speaking speech-language pathologists to use the VSA with support from interpreters or family members (see McLeod, Verdon & IEPMCS, in press, for guidelines).

Target skill

The VSA has been designed as a picture-naming task to elicit single words.

Scope

The scope of the VSA includes the type of words selected and methods used to elicit target words. Six areas were considered to ensure the scope matched the purpose of VSA: phonotactic inventory, Vietnamese speech sounds, elicitation of each speech sound, word selection, presentation, and test administration.

Vietnamese phonotactic inventory

Almost all words in Vietnamese are monosyllabic. The Vietnamese syllable is the smallest unit of pronunciation and Vietnamese is a syllable-timed language (in contrast to English, which is a stress-timed language). The structure of the Vietnamese syllable is: $(C_1)(w_1)V(C_2/w_2)T$ where C1 is the initial consonant, w_1 is the medial semivowel, V is the main vowel, C_2 is the final consonant, w_2 is the final semivowel, and T is the tone (Phạm & McLeod, 2016). The vowel and the tone are the two compulsory components, whereas, the presence of the other components is optional. The VSA contains all Vietnamese speech sounds in every possible position in the Vietnamese syllable as follows: initial consonant, medial semivowel, main vowel, final consonant, final semivowel, and tone.

There are no consonant clusters in the Vietnamese language so that all Vietnamese speech sounds in the VSA are elicited in singleton contexts. Morphophonological contexts do not occur as the Vietnamese language does not use bounded morphemes to mark verb tense, aspect, or plurality (Pham, 2011). All stimuli in the VSA are monosyllabic words; the exception is the rare loan word for the initial consonant /p/ - *pa-tê* (pate). The classifiers, e.g., *cái* (inanimacy), *con* (animacy), are excluded although they commonly precede nouns (Pham & Kohnert, 2009; Tran, 2011). For example, the single word task elicited thỏ (rabbit) instead of con *thỏ*; and *chuông* (bell) instead of *cái chuông*.

Vietnamese speech sounds

The VSA includes all potential Vietnamese consonants, semivowels, vowels, and tones to assess speech production of Vietnamese-speaking children spoken in three main dialects. A comprehensive summary of all Vietnamese speech sounds in Standard Vietnamese and in

Northern, Central and Southern dialects was collated based on an extensive literature review (Phạm & McLeod, 2016). The following Vietnamese speech sounds were included in the VSA based on the review:

- 23 initial consonants in Standard Vietnamese /p, b, tʰ, t, d, ʈ, c, k, ʔ, m, n, ɲ, ŋ, f, v, s, ʂ, z, ʐ, x, ɣ, h, l/ and four variants including /ts, r/ in the Northern dialect and /w, j/ in the Southern dialect;
- 6 final consonants in Standard Vietnamese /p, t, k, m, n, ŋ/ and four variants across three dialects /c, ɲ, kᵖ, ŋᵐ/;
- 2 final semivowels /w, j/;
- 1 medial semivowel/approximant /w/ in Standard Vietnamese and three dialects;
- 16 vowels in Standard Vietnamese (including nine long singleton vowels /i, e, ɛ, ɯ, u, o, ɔ, ɤ, ɑ/, four short singleton vowels /ă, ɤ̆, ɛ̆, ɔ̆/, three diphthongs /ie, uo, ɯɤ/, and ten variants /ĭ, ɨ, ĕ, ŏ, ŭ, ɔː, oː, uː, ɛː, ɤː/ across three dialects;
- 6 tones in Standard Vietnamese and two variants of the tone 5 and 6 occurring in syllables ending by voiceless plosive consonants /p, t, k/ in three dialects.

Elicitation of each Vietnamese speech sound

Typically each speech sound is elicited in between one and five stimuli in single word sampling tools (McLeod, 2012b). Researchers have recommended there be at least two words in a single word task containing each phoneme in order to determine the consistency of production or phoneme stabilisation (Eisenberg & Hitchcock, 2010; Hua, 2002). Therefore, at least two stimuli were selected for each phoneme (consonants, vowels, and tones) shared across all dialects in the VSA. For example, the two selected words beginning with /k/ that were pronounced consistently across all dialects were: *kẹo* (candy) /kɛw⁶/, and *cổ* (neck) /ko⁴/. The authors attempted to avoid excessive use of any consonant, vowel, or tone within the word list.

The selection of words also took into consideration different phonetic contexts in Vietnamese. Different phoneme sequence constraints were considered so as to accommodate variability in terms of syllable shapes, rimes, phonotactic variants, and tones within the child's production rule system. It was important to accommodate the effect of coarticulation of front and back vowels on the production of initial and final consonants (Cao, 2006; Đoàn, 2003). Therefore, it was decided that the two words in the VSA containing the same initial consonants should be followed by a front and back vowel. For example, the selected words beginning with the initial consonant /b/ contained a front vowel *bi* (pumkin) /bi⁵/, and back vowel *bàng* (board) /bɑŋ⁴/. In addition, the VSA authors considered the effect of coarticulation of rounded and unrounded vowels on the production of final consonants /k, ŋ/ with back vowels (Cao, 2006; Đoàn, 2003). For example, the word *bụng* (belly) /bŭŋᵐ⁶/ was added to the set of words beginning with initial consonant /b/.

Word selection

Within the VSA the selected words met following criteria. They had to:

- be within the vocabulary range of Vietnamese-speaking children in Viet Nam, Australia, and USA so that children can produce the word spontaneously as often as possible;
- be used frequently by the entire population throughout Viet Nam. Therefore, words having lexical variants were excluded. For example, the word *mẹ* (mother) was not selected because of variants used in different regions such as *bầm*, *bu*, *má*, *mạ*, *mệ*, *mợ*, and *u*;
- be used currently in the speech of people within Viet Nam. For example, the traditional word for box was *rương*; however, it was not selected because *hộp* or *thùng* is used more commonly now;
- be culturally sensitive in both word choice and picture. For example, the word *đũa* (chopsticks) was selected rather than *dao* (knife) because seeing an image of a knife may scare young children;
- be picturable so young children can recognise the word easily and spontaneously name the word. The images were considered to be contrastable to differentiate meanings. For example, the word *gà* (chicken) was selected for the initial consonant /ɣ/ so the word *chim* (bird) was not selected for the initial consonant /c/ because of the possible confusion between these two images. Another example, the word *phở* (thinly sliced noodle soup) was seen as a good word choice containing the initial consonant /f/ but was not selected because of the possible confusion with the word *bún* (round noodle soup);
- be selected from basic syntactic forms such as nouns (66 out of 77 words) and verbs (11 out of 77 words).

Presentation

The VSA consists of 77 monosyllabic words represented by 77 colour pictures. The order of the word list was based on initial consonants. Proposed prototypes for the 77 pictures were discussed by the VSA authors, then were sent to a Vietnamese artist to be drawn. The 77 pictures were bound in a picture booklet. The front page displays a picture illustrating a word and the orthography of the word (see Figure 2). On the back page, there is a small picture of the word plus full phonetic transcriptions of Standard Vietnamese, Northern, Central, and Southern Vietnamese as well as the prompts to elicit the word (see Figure 3).

Test administration

The VSA was designed to be administered in a standardised manner. The assessment can be administered in research and clinical settings. Instructions will be

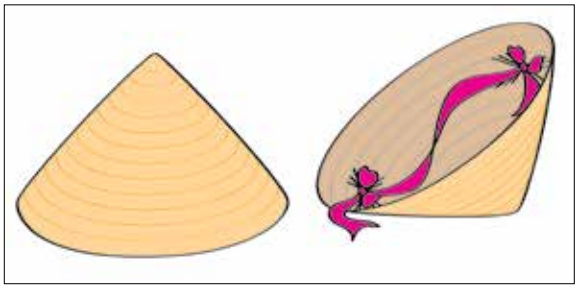

Figure 2. The front page for the stimulus item* nón *(cone hat).

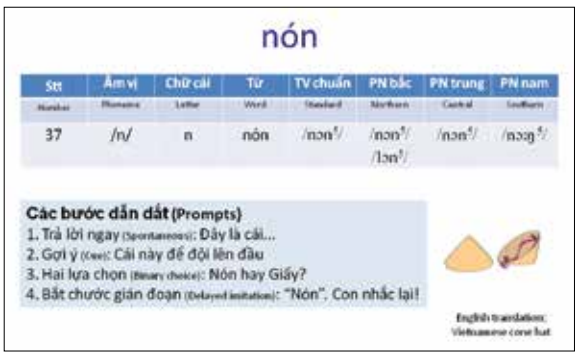

Figure 3. The back page for the stimulus item* nón *(cone hat).

provided in a manual to ensure that examiners follow the same testing procedures.

Cueing hierarchy

Examiners are required to give instructions following a four-step prompt hierarchy to elicit each target word: (a) open-ended question, (b) gap fill or content-related prompt, (c) binary choice (with the target word produced first), and (d) delayed imitation (e.g., "*Heart*. Repeat, please" (*Tim. Con nhắc lại*)). Children are encouraged to respond spontaneously by naming the picture at the first step as much as possible. The open-ended question used in step 1 for each target picture is "What's this?" Some target pictures will be asked differently to elicit the targeted response. For example, with the target picture of *elephant* (*voi*), the examiner asks the child "*Đây là con…*" (This is a [animacy word]…) so that the child can fill the target word after the animacy word produced by the examiner. If the examiner does not say the animacy/ inanimacy word, the child might say a compound word (animacy/inanimacy + target word, e.g., *con voi*) instead of saying the target word only (e.g., *voi*) because animacy/ inanimacy words commonly precede a noun in the Vietnamese language and are acquired early in young children (Pham & Kohnert, 2009; Tran, 2011). Before testing begins, it is useful to train the child to not include the classifier using common objects in the environment. If the child cannot label the picture, additional cues or content-related questions are provided to elicit the expected response. For example, a content-related question "What has a long trunk?" is asked to elicit a target word *voi* (*elephant*). If this step fails, the examiner will give a binary choice by presenting the target word first to participant, for example, "voi hay chân" (*elephant* or *leg*). If the participant does not respond to the binary choice, the examiner will provide the target word for imitation. A list of prompts and cues for each target word was also created to support the testing protocol.

Scoring, transcription, recording and analysis

A score form was created which includes columns for the word in orthography; the adult target in International Phonetic Alphabet for Standard Vietnamese, Northern, Central and Southern dialects; the child's production; and columns for scoring each phonological pattern.

Children are assessed individually. Examiners are required to transcribe children's responses online by using the International Phonetic Alphabet symbols. It is recommended that the transcriptions be based on the children's first attempt if possible. If children's first productions are not clear, then they are asked to repeat the words. The score form also requires examiners to mark the prompt or cueing level used for each response.

It is recommended that the children's responses be audio-recorded and/or video-recorded with the permission of children's caregivers and the school. A microphone should be placed close to the children's mouths (within 15 cm) and the video camera should be set up to record the children's faces. The recordings can be used to check reliability between examiners, and to record change in the children's speech over time. Video recordings can be used to check the children's productions of consonants and vowels that can be seen on the recording (e.g., bilabials).

The VSA score form provides a relational analysis (including percentages of consonants, semivowels, vowels and tones that are produced correctly) and an analysis of phonological processes/ patterns. Guidance in terms of scoring, transcription, recordings and analysis will be included in the manual to instruct for examiners in both research and clinical use.

Stage 2. Operationalisation of the Vietnamese Speech Assessment

Operationalisation is the evaluation and validation process of an assessment to ensure its validity and reliability (Frytak, 2000). The VSA is currently undergoing operationalisation. Eventually the VSA will contain consistent assessment materials, administration and scoring protocols. Once normative data have been collected and analysed, they will be added to the manual. Eventually the manual will also include information about validity (content, construct, predictive, concurrent) and reliability (internal consistency, test–retest reliability, intra- and inter-rater reliability).

To date, the VSA authors have considered the content validity for the VSA. Content validity refers to "the degree to which the items in the measure cover the domain of interest" (Frytak, 2000, p. 22). Content validity of the VSA was conducted first by a systematic examination of relevant literature and previously designed speech sampling tools to specify the initial test content. Second, professional judgement was used to define the test areas and to evaluate the relevance and representativeness of the test items with the target construct. The VSA was piloted by the design team on five adults and one child who were bilingual Vietnamese–English speakers to examine the relevance of the word list and scoresheet and to estimate length of the time required to complete the test. Adults completed the task in approximately 8–10 minutes, the child in about 20 minutes. After the initial pilot testing, some changes were made with to stimulus items (e.g., changing images for the word '*pin*' from torch to battery) and prompts (e.g., changing the cues for the word '*tết*' [Tet holiday]). Other psychometic properties (including internal consistency, test–retest reliability, inter- and intrarater reliability, criterion validity, construct validity, item analysis, sensitivity and specificity, standardisation) will be established in further steps to operationalise the VSA.

Conclusion

The development of a speech sampling tool requires two stages: conceptualisation and operationalisation. The conceptualisation of the VSA has been completed and work on the operationalisation is continuing. This paper provides an example of how to begin to undertake test development in a majority-world country.

References

Cameron, N., & Watt, C. (2006). *Vietnamese articulation test (VAT: Version I-II-III-IV)*. Flinders University, Adelaide, Australia: Author.

Cao, X. H. (2006). *Tiếng Việt mấy vấn đề ngữ âm-ngữ pháp-ngữ nghĩa* [Vietnamese: Some issues in phonology-syntax-semantics]. Thành phố Hồ Chí Minh, Việt Nam: Khoa học xã hội.

Cheng, L. L. (1991). *Assessing Asian language performance*. Oceanside, CA: Academic Communication Associates.

The Children's Hospital No.1. (2013). *Bộ Kiểm Tra Từ Đơn Bằng Hình Ảnh* [One–Picture Word List]. Thành phố Hồ Chí Minh, Việt Nam: Author.

Đoàn, T. T. (2003). *Ngữ âm tiếng Việt* [Vietnamese phonetics]. Hà Nội, Việt Nam: Đại học Quốc gia Hà Nội.

Ducote, C. (n.d.). *Operation Smile Vietnamese articulation screening test*. New Orleans, LA: Author.

Eisenberg, S. L., & Hitchcock, E. R. (2010). Using standardized tests to inventory consonant and vowel production: A comparison of 11 tests of articulation and phonology. *Language, Speech, and Hearing Services in Schools*, *41*(4), 488–503. doi:10.1044/0161-1461(2009/08-0125)

Frytak, J. (2000). Measurement. *Journal of Rehabilitation Outcomes*, *4*, 15–31.

Hua, Z. (2002). *Phonological development in specific contexts: Studies of Chinese-speaking children*. Clevedon, UK: Multilingual Matters.

Hwa-Froelich, D., Hodson, B. W., & Edwards, H. T. (2002). Characteristics of Vietnamese phonology. *American Journal of Speech-Language Pathology*, *11*(3), 264–273.

Lê, T. T. X. (2013). *Bộ Mẫu Đánh Giá Phát Âm* [Sample Tool for Articulation Assessment]. Bệnh viện Chỉnh hình và Phục hồi chức năng Thành phố Hồ Chí Minh, Việt Nam: Author.

McLeod, S. (2012a). Multilingual speech assessment. In S. McLeod & B. A. Goldstein (Eds.), *Multilingual apsects of speech sound disorders in children* (pp. 113–142). Bristol, UK: Multilingual Matters.

McLeod, S. (2012b). Translation to practice: Creating sampling tools to assess multilingual children's speech. In S. McLeod & B. A. Goldstein (Eds.), *Multilingual aspects of speech sound disorders in children* (pp. 144–153). Bristol, UK: Multilingual Matters.

McLeod, S., & Verdon, S. (2014). A review of 30 speech assessments in 19 languages other than English. *American Journal of Speech-Language Pathology*, *23*(4), 708–723.

McLeod, S., Verdon, S., & International Expert Panel on Multilingual Children's Speech (in press). Tutorial: Speech assessment for multilingual children who do not speak the same language(s) as the speech-language pathologist. *American Journal of Speech-Language Pathology*.

Nguyễn, T. L. K. (2011). Nội dung đánh giá khả năng phát âm âm tiết tiếng Việt của trẻ mẫu giáo [The assessment content of pronunciation ability of Vietnamese syllable of preschoolers]. *Ngôn ngữ* [Language], 9, 6–17.

Nguyễn, T. L. K., & Phạm, H. L. (2014). Lỗi phát âm âm tiết thường gặp ở trẻ 2–4 tuổi (tại thành phố Hồ Chí Minh) [Common errors of syllable pronounce in Vietnamese speaking children from 2–4 years old (in Ho Chi Minh city)]. *Tạp chí khoa học Trường Đại học Sư phạm Thành phố Hồ Chí Minh* [Journal of Educational Science of Ho Chi Minh City University of Pedagogy], 57(91), 9–21.

Phạm, B., Le, X. T. T., & McLeod, S. (2016). *Vietnamese speech assessment: Research version*. Bathurst, Australia: Author.

Phạm, B., & McLeod, S. (2016). Consonants, vowels and tones across Vietnamese dialects. *International Journal of Speech-Language Pathology*, *18*(2), 122–134. doi: 10.3109/17549507.2015.1101162

Pham, G. T. (2009). Vietnamese one-word articulation screener. Retrieved 3 March 2016 from http://www-rohan.sdsu.edu/~gtpham/vnspeech/downloads/VietnameseOneWordArticulationScreener.pdf

Pham, G. T. (2011). *Dual language development among Vietnamese-English bilingual children: Modeling trajectories and cross-linguistic associations within a dynamic systems framework*. (PhD thesis), University of Minnesota, Ann Arbor.

Pham, G. T., & Kohnert, K. (2009). A corpus-based analysis of Vietnamese classifiers con and cái. *Mon-Khmer Studies*, *38*, 1–11.

Smit, A. B. (1986). Ages of speech sound acquisition: Comparisons and critiques of several normative studies. *Language, Speech, and Hearing Services in Schools*, *17*(3), 175–186.

Tang, G., & Barlow, J. (2006). Characteristics of the sound systems of monolingual Vietnamese-speaking children with phonological impairment. *Clinical Linguistics and Phonetics*, *20*(6), 423–445.

Tran, J. (2011). *The acquisition of Vietnamese classifiers* (PhD thesis). University of Hawai'i at Manoa.

The Viet Nam Institute of Educational Sciences. (2014). Nghiên cứu đặc điểm phát triển của trẻ mẫu giáo 5 tuổi [Research on development characteristics of 5-year-old children]. Hà Nội, Việt Nam: The Vietnam Ministry of Education and Training.

The Viet Nam Ministry of Education and Training. (2010). *Bộ chuẩn phát triển trẻ em năm tuổi [The developmental standards for children aged five]*. Hà Nội, Việt Nam: Author Retrieved from http://congbao.chinhphu.vn/tai-ve-van-ban-so-23_2010_TT-BGD%C4%90T-(4781)?cbid=4778.

Vũ, T. B. H., & Đặng, T. T. H. (2004). *Âm ngữ trị liệu thực hành* [Clinical speech language pathology]. Hà Nội, Việt Nam: Y học.

West, M. (2000). *Vietnamese articulation test*. Adelaide Central Community Health Service, Adelaide, Australia: Author.

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Practice innovations from the emerging speech-language pathology profession in Vietnam

Vignettes illustrating indigenised and sustainable approaches

Nguyen Thi Ngoc Dung, Le Khanh Dien, Christine Sheard, Le Thi Thanh Xuan, Trà Thanh Tâm, Hoàng Văn Quyên, Le Thi Dao, and Lindy McAllister

This paper presents vignettes of innovations in speech-language pathology practice in Vietnam, and situates these in the larger context of global considerations impacting on speech-language pathology education and service delivery. The paper provides an introductory vignette setting the context for four more vignettes from speech-language pathologists in southern Vietnam. The graduates' vignettes illustrate a range of innovative, sustainable, indigenised and culturally relevant developments in speech-language pathology practice and education. Two vignettes highlight the use of volunteers and the available health and education workforce to develop sustainable new services for children and adults with communication disorders. Two vignettes illustrate innovative and culturally appropriate ways of indigenising curricula and approaches to educating the Vietnamese public and the existing health workforce about communication and swallowing disorders and speech-language pathology services. The paper invites readers to reflect on what speech-language pathology globally might learn from our colleagues in majority-world countries.

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THIS ARTICLE HAS BEEN PEER-REVIEWED

Collaborations between clinicians and academics in minority-world (developed) and majority-world (developing) countries have been successful in establishing speech-language pathology (SLP) education and services in many majority-world countries (for examples from nine such countries, see the *International Journal of Speech-Language Pathology*, 2013, vol. 15, issue 1). However, there is a risk of post-colonialism (Nixon et al., 2015) when minority-world curricula or practices are transferred into new SLP courses in majority-world countries. That is, what comes from minority-world countries can be privileged over local knowledge and practices, in the assumption that "west is best", even when it may not be culturally relevant or the knowledge applicable in new contexts. Therefore, it is important that SLP students in these new courses can interrogate "transplanted" information for its relevance and develop culturally relevant knowledge and clinical practice skills; that is, "indigenise" their knowledge and practices (see for example Hauser, Howlett, & Matthews, 2009). Furthermore, it is important that majority-world practitioners are able to share with minority-world clinicians innovative "indigenised" approaches to the problems they face in practice, to enable two-way learning (Walsh, 2016).

This paper presents vignettes highlighting innovation, indigenisation and plans for future development by graduates of two-year postgraduate courses in speech-language pathology, and where appropriate their Australian mentors. The first vignette in this paper comes from Vietnamese academic Dr Nguyen Thi Ngoc Dung, recognised as the champion for the development of speech-language pathology in southern Vietnam. Her leadership enabled the development of the two-year postgraduate course at University Pham Ngoc Thach. Four graduates of this course, known to be doing innovative work to develop SLP education and services, were approached to write four vignettes for the paper.

Vignette 1. Background to speech-language pathology education in south Vietnam

Prof Ngoc Dung, professor of ENT and former rector of the University Pham Ngoc Thach, Ho Chi Minh City

As an ENT doctor and former director of the ENT Hospital of Ho Chi Minh City (HCMC) I know that speech therapy[1] is vital in the treatment and rehabilitation of people with communication and swallowing impairments. Speech therapy training in HCMC started in 2009 with a short course run by Trinh Foundation Australia at the ENT Hospital for doctors, nurses and audiologists on aspects of speech therapy. Becoming rector of University Pham Ngoc Thach in HCMC enabled the development and delivery of two 2-year postgraduate courses (2010–12 and 2012–14) run at University Pham Ngoc Thach with support from Trinh Foundation Australia and Australian Volunteers International (see McAllister et al., 2013). Thirty-three graduates from those two courses have established speech therapy clinics and services, mostly in public hospitals, in Ho Chi Minh City, Hue, Hanoi, Vung Tau, Bau Loc and other provinces. With the management of the speech therapy office at University Pham Ngoc Thach, the support of Trinh Foundation Australia and Australian Volunteers for International

Nguyen Thi Ngoc Dung (top) and Le Khanh Dien

Development, these graduates have received continuing professional development in their workplaces from visiting lecturers and clinical mentors to develop their skills and knowledge base, research capacity and culturally appropriate resources in the Vietnamese language.

Vignette 2. Reflecting on the effects of an art group for people with brain dysfunction

Le Khanh Dien and Christine Sheard

Christine Sheard (top), Le Thi Thanh Xuan (centre) and Trà Thanh Tâm

People with communication disorders (PWCD) due to stroke or other acquired or congenital brain dysfunction often experience social exclusion (Dorze, Salois-Bellerose, Alepins, Croteau, & Halle, 2014; Douglas, 2013). However, by participating in groups run by speech-language pathologists, PWCD can be assisted to engage with others and increase their confidence (Ewing, 2007; Hawley & Newman, 2010; Holland, 2007; van der Gaag et al., 2005). Furthermore, making art also has been shown to help many people with disability to express their ideas and emotions via their participation in this meaningful life activity (American Art Therapy Association, 2013; Kim, Kim, Lee, & Chun, 2008; Parrish, 2014).

Combining the benefits of being in a group with other PWCD, but with a focus on producing art, inspired the first author during a visit to Sydney where he observed such a group established for people with aphasia. He was so impressed by the group's apparent effects on participants' attitudes and skills, he decided to establish one for a mixed group of his current speech therapy clients in Vietnam. With mentoring from the second author in Australia, he developed an Art Group program to extend beyond the existing impairment-focused speech therapy services at An Binh Hospital in HCMC. The program's aim was to offer socially restricted PWCD with varying brain dysfunction an opportunity to participate in a real-life social activity to learn new artistic skills and have natural communication, rather than remediation of their speech-language limitations. It was hoped this might produce positive changes in some factors (e.g., having good communication partners and independence in some meaningful life activities) commonly associated with quality of life (Douglas, 2013). This paper is a reflection on some informal but carefully gathered clinical data collected to assess the outcomes of the Art Group as perceived by its participants.

The Art Group was established in December 2013 for PWCD (including apraxia, aphasia, dysarthria, cognitive-communication difficulties and intellectual disability) who were also receiving concurrent speech therapy treatment. The invited participants were all known to have much restricted or virtually no meaningful social inclusion or communication beyond daily routine interactions with family or clinical appointments for their health needs. Art students from Sai Gon University were recruited to facilitate 2 hour, weekly art lessons and the program was overseen by the hospital speech therapists. Activities included simple colouring, painting and collage. Drawings or greeting cards were usually produced, with a focus on accepting and extending participants' free expression. Communicating about their art and having occasional parties for special occasions were also integral to this program.

Typically, six to 11 PWCD supported by up to six art students participated in the program. After 23 weeks the first author asked the seven regular long-term participants and six family members the same set of 16 author-generated informal questions that focused on obtaining each participant's *general perceptions of the impact of the group*, as well as their perceptions of any *social opportunities, self-confidence, communication* and/or *drawing skills* that they felt were related to their art group participation. Because the PWCD had limited expressive communication skills, most questions were closed questions, asked orally via a multiple-choice format with a large-font, written selection of simple, categorical or descriptive ratings to simplify the communication task. This informal, but systematic questioning also enabled the authors to readily target and compare the respondents' perceptions. In order to reflect on the effects of the Art Group as a therapy process, some of the most frequent and total group responses are reported here in a general manner as our aim was to assess the effect of the group from the PWCDs' perspectives. They should be interpreted as systematically acquired clinical information rather than research data.

From the questioning, all PWCDs reported positive feelings about attending the Art Group, and were mostly keen to attend each week. Those with acquired communication disorders liked that the Art Group gave them a chance to meet and talk with other people. This affirmed the clinicians' aim for establishing the group as a means for real-life socialisation.

The aspects of the group the participants spontaneously reported they enjoyed most related both to communicating and/or building their art skills. They typically liked to meet with people with shared interests and said that it was good to communicate in a cheerful environment. The clinicians agreed with the PWCDs' perceptions that Art Group made the PWCDs feel happy. Similarly all appeared and reported to be more confident when communicating. Family members also observed that the PWCDs generally initiated and engaged more in communication at home and with others, and appeared less self-conscious and more joyful as the group progressed. Several families also noted having more calm communication interactions over time.

There was a general perception that learning new skills to design and create art was most enjoyable. Participating in independent activities and having communication with others who listen have been associated with finding new identity, self-esteem and living successfully after brain injury (Brown, Worrall, Davidson, & Howe, 2012; Douglas, 2013). Clinicians and relatives typically observed that the PWCDs had more self-confidence in general as the group progressed and this was confirmed by the participants' responses.

Our conclusion from the clinical appraisal of participants' perceptions, which were affirmed by clinicians' and families' observations, is that participation in the Art Group provided an opportunity for most of these PWCDs to interact socially with others in natural and comfortable ways that appeared to improve their self-esteem, general cheerfulness and confidence. Learning new and creative skills and mixing in a comfortable environment with peers appeared to give participants an improved sense of personal well-being.

Our clinical observations and reports of the participants' perceptions could reflect clinician bias or a desire of the participants to please the first author. However, the concurrence between the observations of clinicians, relatives and participants suggests that the PWCDs' perceptions of increased socialisation opportunities,

improved self-confidence and satisfaction with new learning from this Art Group are sufficient to justify some formal research on conducting independently assessed clinical trials of this therapy process.

The volunteer participation of art students promoted wider community engagement and has ensured the economic viability and sustainability of the program. A public exhibition of participants' art was opened in October 2014. The attendance of high-ranking government officials and staff of several hospitals plus extensive media coverage has helped to raise public awareness of the potential possibilities for people to find meaningful lives after acquired or congenital brain dysfunction. This engagement of hospital and government officials is a strategic approach to ensuring support and sustainability of the program.

Vignette 3. A new model of public early intervention services with an interdisciplinary team

Le Thi Thanh Xuan

In Vietnam, most early intervention centres are private, with preschool teachers, psychologists or special education teachers on staff. Typically, a psychologist or doctor assesses children, and teachers develop and deliver an intervention plan, without parental involvement. Intervention goals are focused on cognitive and academic tasks, without attention to social, communication and speech development goals. Children from low and average income families rarely can afford to attend the centres, as fees range from 7 to 15 mill VND (about A$400–$870) per annum. In December 2014, the Orthopedics and Rehabilitation Hospital (ORH) of Ho Chi Minh City established public early intervention services for children with autism spectrum disorder (ASD) with staff from different professions involved, including speech therapists, psychologists, social workers, special education teachers, physiotherapists, and occupational therapists. A means-tested fee is charged ranging from 4–4.2mill VND (about A$233–$245). This fee includes lunch, morning/afternoon tea, and activity consumables.

The model at ORH is adapted from Australian interdisciplinary models for early intervention, which I observed on a study tour to Melbourne in mid-2015. I coach the ORH team to work collaboratively with each other and with parents to develop intervention goals targeting play, social, self-help, communication, and language goals for each child. Intervention is based on each child's current ability and interest, helping her or him to be active in interaction and initiating communication. There are currently 20 children attending three classes of early intervention services per week in groups of three to four children. Children attend class from 7:00 am to 16:00 pm; rest time is from 11:30 am to 14:00 pm. I train parents to use communication development approaches and AAC at home. The involvement of parents is indispensable and extends the intervention from the centre to the children's homes. We keep data on children's improvement to reflect on the impact of the early intervention service and modify it as needed.

With this interdisciplinary early intervention model, the staff has the advantage of increasing knowledge of other professions and sharing their skill set. Team meetings provide an opportunity for staff to share ideas for how to achieve the goals for each child, in order to maximise intervention outcomes. Staff are easily able to identify a child's unique strengths and needs, and determine what services are necessary to meet those needs. ORH is continuously developing, evaluating and refining this new model for early intervention services in Vietnam so that it can be introduced to other organisations in HCMC and southern Vietnam. When this new model is further developed and there are enough staff members, ORH will accept staff members from other organisations who wish to learn about, and implement, the model. Coaching and supported practice in other organisations will be provided.

This vignette illustrates one approach to indigenisation of a western model of good practice in early intervention to the Vietnamese context. In the absence of sufficient speech-language therapists, an available workforce of allied health and education professionals has been trained to deliver early intervention services which include foci on communication and social development. This training and deployment of existing workers also assists the sustainability of the service.

Vignette 4. Training basic paediatric speech therapy practical skills for staff at Đà Nẵng University of Medical Technology and Pharmacy

Trà Thanh Tâm and Hoàng Văn Quyên

In recent years, significant progress has been made in Vietnam in public health in terms of health professional expertise and service quality. Most of the 33 speech therapy graduates to date from University Pham Ngoc Thach work in Ho Chi Minh City. Rapidly developing cities such as Đà Nẵng have well-established medical services but do not yet have speech therapy education and services.

In order to increase availability of information about speech therapy and also accessibility to speech therapy services for people in central Vietnam, the authors, who are September 2012 graduates of the course at University Pham Ngoc Thach now working at Children's Hospital No.1 (CH No.1), HCMC, have developed and delivered a basic training program in speech therapy for physiotherapy lecturers at Đà Nẵng University of Medical Technology and Pharmacy (DUMPT). It was a challenge for us to ensure continuity of speech therapy services at CH No.1, while also preparing the course, and compiling training resources to meet the learning needs of participants in the upcoming training course. The participants had little concept of speech therapy so we had to consider this as well in our planning.

After a six-week theoretical training course in Đà Nẵng in 2014, we continued mentoring the participants by phone and email. In 2015, DUMTP sent four lecturers to CH No.1 to continue with the speech therapy clinical training. This clinical training block lasted six months. In the first two months, we helped participants synthesise knowledge they had learned in Đà Nẵng while providing new knowledge of speech therapy, such as (a) typical communication developmental milestones from infancy to 5 years, (b) speech therapy for children with cleft lip and palate, (c) speech therapy and intervention for feeding/eating in

Hoàng Văn Quyên (top), Le Thi Dao (centre) and Lindy McAllister

children with complex disabilities, (d) red flags for the need for speech therapy intervention for children with speech sound disorders, (e) augmentative and alternative communication, (f) working with parents, and (g) behavioural management.

In addition, we included the Đà Nẵng participants in clinical practice sessions with our patients. Thanks to our experience in working with Australian speech therapists during the clinical terms of the speech therapy training program at University Pham Ngoc Thach, we had accumulated experience that we could apply in the clinical training of the participants. We started by having them observe sessions, then plan for and deliver parts of session, gradually taking on responsibility for planning and delivering whole sessions under our supervision. Towards the end of the training block, we had them teach parents strategies to help their children develop language and manage their inappropriate behaviors at home.

By the end of the training course, the four participants had been involved in 600 sessions of speech therapy practice with more than 100 patients with language delay, ASD, cerebral palsy, hearing impairments, cleft lip and palate, and Down syndrome. At the end of the block, participants needed to achieve 70% as a pass on two theoretical and practical examinations, and submit one assessment report and one treatment report for patients they had managed. On completion of the course, the participants received a certificate issued by CH No.1 for completion of the course "Basic Paediatric Speech Therapy Practice".

Despite being faced with many challenges in terms of time and work pressure, we strive to provide high-quality training for colleagues throughout Vietnam in order to increase public awareness of the speech therapy profession and quality of speech therapy services provided to patients, and thereby, contribute to increasing the quality of life of patients with communication and swallowing disorders in Vietnam. This vignette illustrates indigenisation and cultural adaptation of a western curriculum for delivery in the Vietnamese context, making best use of the available Vietnamese health workforce to deliver sustainable services while a specialised speech-language pathology workforce is educated in Vietnam.

Vignette 5. Using all available media to educate professionals, students and the community

Le Thi Dao

I have been working in Ho Chi Minh City since 1987 as a physiotherapist, and since 2010 also as a speech therapist at Children's Hospital No.2. Because speech therapy is new in Vietnam, it is important to educate others about the profession and what we can offer. Since 2010, I have been promoting speech therapy to colleagues at the hospital and running information and education activities for the community. For example, I have been:

- Presenting at regular meetings with the hospital board of directors and heads of departments about topics such as "Introducing speech therapy in Vietnam" and "Speech therapy intervention methods"
- Introducing colleagues at the hospital to speech therapy by inviting them to observe speech therapy sessions and discuss cases.
- Running training sessions for teachers and parents on Saturday mornings on various topics, such as "ASD", "How to feed children with cerebral palsy", and "Developing language skills in children using picture stimulation". I have developed a number of resources for parents (e.g., books on helping children's language development).
- Teaching nurses and doctors at the Rehabilitation Hospital in Đà Nẵng about ASD, and then demonstrating and coaching them in skills such as how to observe a child, help a child make eye contact, increase attention, games to develop children's play skills.
- Teaching nursing and psychology students at universities in HCMC about rehabilitation for people with various communication disorders (hearing difficulties, speech sound disorders, stuttering, language disorders).
- Contributing articles about communication and swallowing disorders and speech therapy to hospital websites; for example articles on "Child language development processes", "Hoarse voice", "Fussy eaters"; and sharing articles on my Facebook page (see: https://www.facebook.com/lethi.dao.77/timeline).
- Participating in Vietnamese television talk shows. VTV9 channel has a talk show about children, which includes medical professionals and parents. My hospital's board of directors assigned me to present the topic on language development of children, how to identify problems and help children develop language. On HTV7 I was asked to introduce speech therapy in Vietnam and the types of disorders that need speech therapy intervention. I also talked about support Vietnam receives from Australian speech therapists and the Trinh Foundation.
- Collaborating with cleft lip and palate surgery groups. In trips to regional areas with Operation Smile, I coached teachers and medical staff about assessment and intervention methods for children with cleft lip and palate.

Focusing initial service development efforts on community education and advocacy activities as described has been essential to my experience as a newly qualified speech-language pathologist. The vignette illustrates culturally acceptable means to educate my colleagues. This has increased their knowledge and trust in this new profession of speech therapy and so they now refer clients to the speech therapy department. Clients also contact us directly and teachers in schools refer clients to us for intervention.

Discussion and conclusion

The vignettes presented have common elements for consideration. Significantly, they all focus on educating others, from the Art Group which educated family members and the general public through the engagement of art students and the launching of an art exhibition (Vignette 2) to educating a range of health and education professionals, university health students and the general public (vignettes 3–5). Li Thi Dao's education of the general public through television, Facebook and other media is impressive in its reach, creativity and generosity of time and effort. Educating others about the speech-language pathology profession and what it can offer is essential, and not just in a country newly establishing the profession and its services.

Vignettes 4 and 5 also highlight indigenisation of curricula and SLP resources. The authors adapted what they had

learned from minority-world lecturers and clinical educators at University Pham Ngoc Thach and integrated this in their own developing clinical practice to develop and deliver basic training in speech therapy to current and future health professionals and the general public. Their indigenised curricula and resources will be invaluable in the future Bachelor degree level education planned for Vietnam. Their experience as educators will contribute to local leadership and hence sustainability of these degrees.

Wylie, McAllister, Davidson, and Marshall (2013) discussed the inadequacy of current models of SLP service delivery for PWCD in the minority world for meeting the needs of all PWCD; the reach of SLP services needs to extend beyond what the speech-language pathologists themselves can achieve. The vignettes illustrate new models which extend the reach of services to PWCD by engaging staff not traditionally seen as agents of SLP intervention. For example, vignettes 3 and 4 describe the engagement of other allied health professionals and special education teachers to interprofessionally deliver early intervention services to children with communication disabilities and Vignette 2 describes how art students assist with running the Art Groups. Vignette 3 illustrates the use of what could be termed mid-tier workers, as recommended by the *World Report on Disability* (WHO and World Bank, 2011). In all cases the new models which extend reach have led to more children and families receiving SLP services than could have been achieved by the vignette authors alone. Furthermore, each is based around ongoing clinical support and mentoring to ensure sustainability and service quality. An essential next step will be to develop an evidence base for these approaches through formal evaluation and research programs to investigate the impact of these approaches on client outcomes.

Of interest is the high degree of institutional support the speech-language pathologists received from their employers to engage in these innovative practices. SLP staff from CH No.1 were given considerable time off work to travel to Đà Nẵng to teach and then to provide clinical training back in Ho Chi Minh City for the Đà Nẵng students. Le Thi Dao was encouraged by her hospital to appear on television to promote SLP. Le Thi Thanh Xuan was provided time release and financial support from her hospital to travel to Australia and learn about early interventions services. Le Khanh Dien was not only supported to develop the Art Group by his hospital but also supported to mount an art exhibition of his patients' work and to invite high-level government officials and television stations to cover the event. Speech-language pathologists in minority-world countries might well envy the high-level government commitment in Vietnam to developing SLP education and services. Sustained government commitment will of course be required over a long-time frame to embed SLP in the Vietnamese health care system.

In summary, the vignettes suggest that these speech-language pathologists have moved beyond imported minority-world curricula and SLP practice models to indigenise and create their own teaching and clinical practice approaches. The vignettes describe exciting innovations from the majority world in SLP service development, clinical services, educating others, and the use of media to promote the SLP profession and services, from which speech-language pathologists in minority-world countries can learn. Their innovations extend the reach of SLP services and are locally sustainable.

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1 Speech therapy is the term used in Vietnam.

References

American Art Therapy Association. (2013). What is art therapy? Retrieved from http://www.arttherapy.org/upload/whatisarttherapy.pdf

Brown, K., Worrall, L.E., Davidson, B., & Howe, T. (2012). Living successfully with aphasia: A qualitative meta-analysis of the perspectives of individuals with aphasia, family members, and speech-language pathologists. *International Journal of Speech-Language Pathology*, *14*(2), 141–155.

Dorze, G., Salois-Bellerose, E., Alepins, M., Croteau, C., & Halle, M-C. (2014). A description of the personal and environmental determinants of participation several years post-stroke according to the views of people who have aphasia. *Aphasiology*, *28*, 421–439.

Douglas, J. (2013). Conceptualizing self and maintaining social connection following severe traumatic brain injury. *Brain Injury*, *27*(1), 60–74.

Ewing, S. E. A. (2007). Group process, group dynamics, and group techniques with neurogenic communication disorders. In R. J. Elman (Ed.), *Group treatment of neurogenic communication disorders: The expert clinician's approach* (2nd ed.). Abingdon, Oxfordshire: Plural Publishing.

Hauser, V., Howlett, C., & Matthews, C. (2009). The place of indigenous knowledge in tertiary science education: A case study of Canadian practices in indigenizing the curriculum. *Australian Journal of Indigenous Education*, *38*, Supplement, 46–47.

Hawley, L.A., & Newman, J.K. (2010). Group interactive structured treatment (GIST): A social competence intervention for individuals with brain injury. *Brain Injury*, *24*(11), 1292–1297.

Holland, A. (2007). The power of aphasia groups: Celebrating Roger Ross. In R. J. Elman (Ed.), *Group treatment of neurogenic communication disorders: The expert clinician's approach* (2nd ed.). Abingdon, Oxfordshire: Plural Publishing.

Kim, S. H., Kim, M. Y., Lee J. H., & Chun, S. I. (2008). Art therapy outcomes in the rehabilitation treatment of a stroke patient: A case report. *Art Therapy: Journal of the American Art Therapy Association*, *25*(3), 129–133.

McAllister, L., Woodward, S., Atherton, M., Nguyen Thi Ngoc Dung, Potvin, C., Huynh Bich Thao, Le Thi Thanh Xuan, & Dien Le Khanh. (2013). Viet Nam's first qualified speech pathologists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech-Language Pathology*, *15*(2), 75–79.

Nixon, S. A., Cockburn, L., Acheinegeh, R., Bradley, K., Cameron, D., Mue, P. N., Samuel, N., & Gibson, B. E. (2015). Using postcolonial perspectives to consider rehabilitation with children with disabilities: The Bamenda-

Toronto dialogue. *Disability and the Global South*, *2*, 570–589.

Parrish, J. (2014). *Art and aphasia: A literary review and exhibition*. (Honors thesis). Western Michigan University, Kalamazoo, MI (2445).

van der Gaag, A., Smith, L., Davis, S., Moss, B., Cornelius, V., Laing, S., & Mowles, C. (2005). Therapy and support services for people with long-term stroke and aphasia and their relatives: A six-month follow-up study. *Clinical Rehabilitation*, *19*(4), 372–380.

Walsh, B. (2016). Two-way learning, creating a classroom culture of reciprocity, where teachers and students are learners first. Retrieved from https://www.gse.harvard.edu/news/uk/16/01/two-way-learning

World Health Organization and the World Bank. (2011). *World report on disability*. Geneva: World Health Organization.

Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in underserved populations. *International Journal of Speech Language Pathology*, *15*(1), 1–13.

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Building speech-language pathology capacity and colleagues across continents

Abbie Olszewski and Erica Frank

There is a lack of qualified speech-language pathology service providers to serve persons with communication difficulties globally. This paper discusses current speech-language pathology training models in countries across continents and the limitations of these models. We propose a new training model called the Democratically Open, Outstanding Hybrid of Internet-aided, Computer-aided, and Human-aided Education (DOOHICHE), which can be implemented in any country. The pros and cons of the DOOHICHE model are critically examined. Lastly, the future direction of the DOOHICHE model is discussed.

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There is a documented and substantial shortage of speech-language pathologists (SLPs) globally, including countries as diverse as Australia (Lowell, 2013), Fiji (Hopf, 2014), Ghana (Wylie, McAllister, Davidson, & Marshall, 2013), Malaysia (Ahmad, Ibrahim, Othman, & Vong, 2013), and South Africa (Weddington, 2002). Training future SLPs who can diagnose and treat persons with communication difficulties (PWCD) is widely recognised as important, given the ability to communicate effectively is a human right (Global Campaign for Free Expression, 2003; International Communication Project, n.d.; NJCCNPSD, 1992). However, building SLP capacity is difficult because it necessitates training in both content knowledge and clinical skills, often requiring skilled mentors to work individually or in small groups with SLPs who are in training.

Current solutions

Experts across the globe have begun to address the challenges of knowledge transfer and exchange to better serve PWCD (e.g., Ahmad et al., 2013; Cheng, 2013; Crowley et al., 2013). Cheng (2013) identified three models used in China: networking in close proximity, collaborating among different regions, and the use of technology. Working in Ghana, Crowley and colleagues (2013) used a biopsychosocial model, utilising interpreters to gather and share information to assess needs and make recommendations, delivering professional development, and collaborating with specialised teams. In Malaysia, Ahmad and colleagues (2013) developed local professional capacity and increased focus on improving knowledge, local evidence, and research. Although these models have built local speech-language pathology capacity in their respective countries, current models are limited in their ability to scale up, be accessible to a wide range of individuals, be affordable, be accessible, be sustainable, and to provide a wide scope of course offerings.

New solution

At NextGenU, we have developed an innovative clinical speech-language pathology training program model grounded in the workforce capacity-building framework to address current model limitations (Goldberg & Bryant, 2012; Somerville et al., 2015). This model is called a Democratically Open, Outstanding Hybrid of Internet-aided, Computer-aided, and Human-aided Education (DOOHICHE, pronounced "doohickey"). NextGenU offers these courses to any organisation (e.g., universities, hospitals, ministries) requiring access to content training in speech-language pathology (Goldberg & Bryant, 2012) through the DOOHICHE model, which allows training of groups (e.g., in a flipped classroom) or of individuals. Individual training is important, as individuals are foundational to building capacity in an organisation (Goldberg & Bryant, 2012). Once proficient, these well-trained individuals can function as local mentors and train additional students in their communities – the "human-aided" component.

The goal of the NextGenU speech-language pathology program is to give interested learners around the world practical and intellectual competencies to serve PWCD, and to empower these students to understand how these issues are addressed in their country, while interacting with a local and global community of peers and mentors to build a community of professionals who work with individuals with communicative disorders.

Pros and cons

The DOOHICHE model has the potential to be accessible and affordable to a larger number of students than current training models. The training courses are offered in 103 languages through Google Translate; hence, it is conceivable that it will reach a sizable number of students throughout the world. Although the courses are offered in a multitude of languages, translation of the content of the website through Google Translate may not be accurate. Because the courses are offered through the Internet,

Abbie Olszewski (top) and Erica Frank

anyone who has access to the Internet can take the courses. While the DOOHICHE model is free to learners, there are costs for computer and/or Internet access.

The DOOHICHE model is designed to be sustainable with a $16-million endowment (which adequately covers core expenses), slender operating costs, and volunteer course creators. Though NextGenU.org encourages local communities, policy-makers, organisations, and governments to eventually take "country-ownership" (Goldberg & Bryant, 2012) of all aspects of capacity building, it is unclear how local authorities will receive this model.

The DOOHICHE training model will train students in a wide variety of subject areas related to SLP. It is not dependent on specialised trainer availability and skills, but addresses many areas in depth, as it is created by experts in the field, and guided by an advisory committee, using resources from governments, peer-reviewed journals, specialty societies, and universities. However, students may have difficulty allocating time to courses, finding a peer, or selecting an appropriate mentor to support the didactic portion of the model.

Future direction

NextGenU's DOOHICHE model for building capacity in the global speech-language pathology workforce is in its infancy, as we are currently piloting our first course with students in Kenya. We are unclear about the model's strengths and limitations in addressing the ability to build speech-language pathology capacity on a global level. Our goal is to critically evaluate the DOOHICHE model by collecting data regarding the quality, accessibility, sustainability, affordability, and customisation of this model. The evaluative process for the model and each course will be ongoing and continually refined based on metrics and feedback.

Because we strive to make this a viable training program for future audiences, we welcome comments, feedback, and suggestions. We call on the SLP community to engage in a discussion via the *Journal of Clinical Practice in Speech-Language Pathology* on the feasibility and acceptability of NextGenU's DOOHICHE model training program for future speech-language pathologists worldwide.

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References

Ahmad, K., Ibrahim, H., Othman, B. F., & Vong, E. (2013). Addressing education of speech-language pathologists in the World Report on Disability: Development of a speech-language pathology program in Malaysia. *International Journal of Speech-Language Pathology*, *15*(1), 37–41. doi: 10.3109/17549507.2012.757709

Cheng, L. (2013). Knowledge transfer between minority and majority world settings and its application to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 65–68. doi:10.3109/17549507.2012.729862

Crowley, C., Baigorri, M., Ntim, C., Bukari, B., Oseibagyina, A., Kitcher, E., Paintsil, A., Ampomah, O. W., & Laing, A. (2013). Collaborations to address barriers for people with communication disabilities in Ghana: Considering the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 53–57. doi: 10.3109/17549507.2012.743036

Global Campaign for Free Expression. (2003). Article 19 Statement on the Right to Communicate. Retrieved from https://www.article19.org/data/files/pdfs/publications/right-to-communicate.pdf

Goldberg, J., & Bryant, M. (2012). Country ownership and capacity building: The next buzz words in health systems strengthening or a truly new approach to development? *BMC Public Health*, *12*, 1–9. doi:10.1186/1471-2458-12-531

Hopf, S. C. (2014). Services for children with communication disability in Fiji. *Journal of Clinical Practice in Speech-Language Pathology*, *16*(2), 81-86.

International Communication Project. (n.d.). The opportunity to communicate is a basic human right. Retrieved from http://www.internationalcommunicationproject.com/

Lowell, A. (2013). "From your own thinking you can't help us": Intercultural collaboration to address inequities in services for Indigenous Australians in response to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 101–105.

National Joint Committee for the Communicative Needs of Persons with Severe Disabilities. (1992). Guidelines for meeting the communication needs of persons with severe disabilities. Retrieved from: http://www.asha.org/policy/GL1992-00201/

Somerville, L., Davis, A., Elliiott, A., Terrill, D., Austin, N., & Philip, K. (2015). Building allied health workforce capacity: a strategic approach to workforce innovation. *Australian Health Review*, *39*, 264–270. doi:10.1071.AHI14211

Weddington, G. (2002). Speech-language pathology/audiology: Service delivery in rural and isolated regions of South Africa. *Folia Phoniatrica et Logopaedica*, *54*(2), 100–102.

Wylie, K., McAllister, L, Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in under-served populations. *International Journal of Speech-Language Pathology*, *15*(1), 1–13. doi:10.3109/17549507.2012.745164

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Applying theories of cultural competence to speech-language pathology practice in East Africa

Helen Barrett

As global mobility increases and populations diversify, challenges to delivering appropriate, responsive, ethical and effective SLP services have emerged and services users, practitioners and national bodies are increasingly calling for delivery of culturally sensitive services. It is therefore crucial to look beyond our own cultural reference points and adopt an attitude of open-minded and continuous learning about others in order to provide the best services to all clients. Models of cultural competence have been developed across the allied health professions and have been described as: practitioners' awareness, knowledge, skills, and sensitivity in relation to their clinical practice with people from cultural and linguistic backgrounds other than their own. This paper draws on the author's experience of working across east Africa, with reference to two frameworks for cultural competence which are applicable to speech-language pathology practice. The paper highlights the multifaceted and interactional nature of different dimensions of cultural competence and queries whether this is accurately represented in the current theoretical frameworks.

KEYWORDS
CULTURAL COMPETENCE
EAST AFRICA
SPEECH-LANGUAGE PATHOLOGY

THIS ARTICLE HAS BEEN PEER-REVIEWED

Helen Barrett

East Africa is a region defined by diversity, and the challenges to developing cultural competence for external speech-language pathologists are enormous. Not only is the ethnic and linguistic diversity in the region extensive, but explanatory models of disability are often heavily influenced by the medical profession, stigma surrounding disability, and religious and /or cultural beliefs (Barrett, 2013). Professional training courses and services to meet the needs of people with communication difficulties are emerging[1] but are in their infancy, are frequently facilitated by external speech-language pathologists and often require ongoing support once established (e.g., Robinson, Afako, Wickenden, & Hartley, 2003). It is therefore crucial that the external practitioners involved are culturally competent to deliver appropriate, responsive, ethical and effective support.

The need for a culturally competent profession

Many national speech-language pathology associations stress the need for professionals to offer appropriate and sensitive services to diverse client groups (e.g., ASHA 2011; RCSLT 2003; SPA, 2016), but more guidance is needed on *how* to fulfil these obligations, specifically regarding issues beyond bilingualism and multilingualism (Leadbeater & Litosseliti, 2014).

Much of the available literature exploring speech-language pathology with clients from a range of backgrounds describes practice in multicultural societies in the minority world[2] (e.g., Leadbeater & Litoselliti, 2014). However, literature is also emerging on how external speech-language pathologists working in the majority world can do so ethically and effectively (e.g., Crowley & Baigorri, 2011; Hickey, McKenna, Woods, & Archibald, 2014). Current literature addressing the needs of people with communication disabilities in the majority world primarily focuses on issues and methods of professional or service development (e.g., Wickenden, 2013; Wylie, McAllister, Davidson, & Marshall, 2013) and, though this literature identifies the need for speech-language pathology education programs and services to be developed using culturally appropriate methods (e.g., Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003), the question remains as to *how* external speech-language pathologists can develop competence to facilitate these processes effectively.

For speech-language pathologists to become sufficiently competent to practise internationally, it is essential to reflect upon motivations, skills and learning needs (Brown & Lehto, 2005; Hickey et al., 2014) and upon what cultural competence means in relation to their home, and overseas, practice. In addition, it is critical to consider the concept of cultural humility in relation to cultural competence; cultural humility being the acceptance that it is not possible to be fully knowledgeable about a culture other than that which one is born into (Levi, 2009; Walters, 2015). Practitioners must therefore understand that cultural competence and cultural humility are critical prerequisites to the delivery of appropriate, relevant and effective services and apply both concepts to their practice.

Table 1. Dimensions of culturally competent practice proposed by Sue et al. (1992).

Dimensions / Practitioner characteristics	Awareness and beliefs Clinician is:	Knowledge Clinician demonstrates:	Skills Clinician is:
Awareness of own assumptions, values and biases	Aware of own culture and its influence on beliefs about self, others and clinical practice	Knowledge of own culture and aspects of this that may impact upon service delivery to diverse populations	Aware of own skills and ability to adapt these to diverse populations. Aware of own learning needs in relation to skill development
Understanding of the worldview of the culturally different client	Aware that individuals have varied understandings of the world and that this may impact upon the conceptualisation of their difficulties and response to intervention. Respectful of difference in the face of own cultural values and beliefs.	Knowledge and understanding of different cultural interpretations of worldviews and understands that individuals within a culture may have individualised interpretations of their own culture(s). Desire to develop knowledge and understanding	Able to transform understanding of different worldviews into culturally sensitive and safe clinical practice
Use of appropriate intervention strategies	Aware of the need for flexibility, creativity and individualisation in intervention	Knowledge of how to adapt intervention strategies and techniques to a variety of populations using culturally appropriate and acceptable methods. Support-seeking from others with implicit cultural knowledge	Skilled in innovative, sensitive and safe intervention

Theoretical models of cultural competence

This section explores two prominent models of cultural competence and their application to trans-cultural speech-language pathology practice. The models were not specifically designed for speech-language pathologists, but can be applied to allied health professions more broadly.

Model 1. Sue, Arrendondo, and McDavis (1992)

Sue, Arrendondo, and Davis (1992) identified three dimensions necessary for cultural competence: (a) awareness/beliefs, (b) knowledge, and (c) skills. These three dimensions are complementary to three practitioner characteristics: (a) awareness of own assumptions, values and biases; (b) understanding of the worldview of the culturally different client; and (c) use of appropriate intervention strategies. The relationship between each dimension can be visualised in a matrix to represent the competencies required to be considered culturally proficient (Table 1).

In addition to their model of professional cultural competence, Sue et al. (1998) use the concept of "multi-dimensionality of identity" to define how individuals possess different identities at individual, group, and universal levels, with the potential to possess more than one identity at each level[3] (Ridley, Baker, & Hill, 2001). Moreover, they describe how these identities are interactive – a person may be socially limited or liberated by one or more of their identities at each level, depending on their experience. For example, a woman with a communication disability's participation in society *may* be limited by both her disability and her gender at group or universal level, but not at individual level. A person's experience at one level may, over time, alter identity at another, including the way a person views his/herself as an individual (Marsh & MacDonald-Holmes, 1990). For example, over time, a woman may perceive herself to be limited as an individual due to her social experience – her self-concept is altered. This theory highlights the importance of considering cultural competence as a multidimensional and fluid concept, requiring constant adaptation as we consider individuals within a culture. However, the stand-alone models currently do not reflect this essential relationship between practitioner awareness, knowledge and skills and their interaction with the individual client.

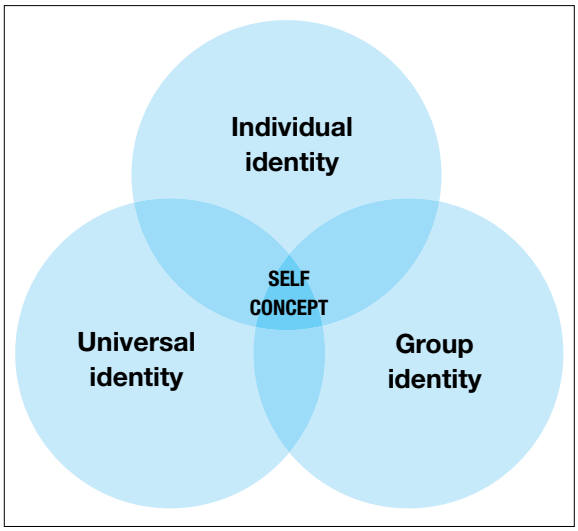

Figure 1. The interrelationship between levels of multidimensional identity and self-concept.

Model 2. Papadopolous, Tilki, and Taylor (1998)

Papadopolous, Tilki, and Taylor (1998) describe similar attributes for cultural competence as Sue et al. (1992) but also identify "cultural sensitivity" as a key component,

including supportive skills such as empathy, communication, trust, acceptance, and respect of the individual. Acknowledgement of a person's observable (and assumed) culture without a deeper understanding of individual cultural attributes can lead to tokenistic tolerance of diversity with complacency in implementing culturally sensitive practices (Cross, Bazron, Dennis, & Isaacs, 1989). For example, a company hires a "quota" of ethnically diverse staff, but does not adapt wider policies and practices. In contrast, culturally sensitive practice allows us to consider multidimensionality of identity and is fundamental to developing the more nuanced awareness, knowledge, and skills required to deliver culturally appropriate, responsible, ethical and effective services.

Application of a cultural competence framework to speech-language pathology practice

Although not designed as speech-language pathology-specific theoretical models, the cultural competence constructs of both Sue et al. (1992) and Papadopolous et al. (1998) may be applied to health professions more broadly. The models identify how practitioners should recognise and reflect upon their *own* attitudes, values, knowledge skills, and sensitivity, and consider how they can harness and develop these to work effectively in diverse environments. As acknowledged by IAHA (2015) and Papadopolous et al. (1998), the development of cultural competence is a continuous, never-ending process, requiring interaction and experience, alongside the development of knowledge of one's own, and other, cultures.

In the following note the author gives a personal interpretation of the models described above in relation to her own experience living and working in east Africa. Through exploration of four of the dimensions of culturally competent practice, the author aims to illustrate the ongoing development of her own cultural competence as a process of constant renewal and revision.

Developing cultural competence in east Africa: A personal reflection

Reflective statement

I have lived and worked in Africa at various points since 1999 and as a speech-language pathologist in east Africa permanently since 2008. My work has focused on training local practitioners and policy-makers to understand and address the needs of people with communication disabilities in local communities. During this time, I have experienced a steep learning curve in my own understanding of cultural competence and continue to adjust my practice with each new experience. The following section provides an analysis of my personal reflections. Specific themes that arise are then discussed with reference to theoretical concepts of cultural competence

Theme 1. Awareness and beliefs

Reflection: Having worked in Kenya, Uganda and Tanzania, I was surprised to find Rwanda very different to other countries in the region. My assumptions about the people and professional culture were significantly challenged. It was, essentially, a "culture shock" that took some time to adjust to, both personally and professionally.

The information we access before we arrive in a new country helps to form our early beliefs about the people and cultures we are about to encounter. However, it takes time to appreciate more fully how these cultures vary in their application to individuals and, over time, our awareness and beliefs change in line with experience.

New experiences help us to develop a heightened awareness of our own culture and we become aware of how aspects of our culture may change in the new environment. Moreover, we learn about how others perceive us and may have to re-evaluate some established stereotypes. How we communicate with a variety of individuals in our own language and across other languages also plays an important role in our ability to adapt to new transcultural challenges. We discover things about how we see ourselves, how we see others from our own culture and how we see people from cultures different from our own. This self-reflection helps us to appreciate similarities and differences and identify opportunities to overcome potential barriers to interaction and engagement, and is considered an essential part of both Sue et al.'s (1992) and Papadopolous et al.'s (1998) models.

Theme 2. Knowledge

Reflection: A family in Uganda had difficulty accepting alternative-augmentative communication (AAC) methods for their child. They resisted use of cards or charts, but valued a hand-drawn book of pictures using the same exercise book that other children used in school. It was important for me to understand social norms and values in the family's community and devise solutions to therapeutic dilemmas that were responsive to those values.

Knowledge, when coupled with experience, can translate into understanding that helps us to communicate and build relationships with individuals. We may conclude that knowledge continually grows and shapes our awareness, beliefs, and skill development and is balanced by our sensitivity and attitudes. Cultural knowledge and clinical knowledge also need to come together in new therapeutic environments; understanding the cultural applicability of our clinical knowledge to individuals from different backgrounds is critical to developing and providing culturally sensitive services. Furthermore, cultural humility – understanding that individuals are the gatekeepers of their own culture and that we must learn from them in an open-minded, flexible, creative, and patient way – allows us to shape knowledge into sensitively conceived, practical and meaningful skills (see Walters, 2015). However, this bidirectional learning process and breakdown of practitioner–client power relations is not represented in the models of clinical cultural competence discussed above.

Theme 3. Skills

Reflection: In Rwanda, I work with a British non-governmental organisation, Chance for Childhood, that has engaged international specialist speech-language pathologists (including myself) to help to develop the capacity of a team of local practitioners who go on to train teachers and assistants to support children with communication disability in schools and communities. In addition, they are supporting the development of national curricula in conjunction with development partners and the government (see Barrett, Turatsinze, & Marshall, 2016).

In east Africa, explanatory models of disability are often deficit-focused, though this is gradually changing. A biopsychosocial understanding of disability (WHO, 2001) is prevalent in the minority world and speech-language pathology professional culture and practice has developed in line with this model (Leadbeater & Litosseliti, 2014). External speech-language pathologists' biopsychosocially derived skills are therefore at risk of being in juxtaposition with both the conceptualisation of disability and health care delivery models predominant in east Africa. My experience has taught me that it takes time, skill, patience, flexibility and relationship-building, alongside reflection on both personal and professional beliefs and knowledge about explanatory models of disability, to work between the two paradigms. This relationship between knowledge and skill development is, again, bidirectional but is not represented as such in the models.

Understanding of the need to build local capacity is also critical to culturally competent practice (Barrett et al., 2016; Hickey et al., 2014; IAHA, 2015) – sustainability is key. In countries where local speech-language pathologists are either not available or in short supply, other professionals may benefit from skill-sharing[4] to enhance their practice with people with communication disabilities (Hartley, Murira, Mwangoma, Carter, & Newton, 2009). Consideration of communication disability as a broader public health issue, potentially best addressed with a population-based approach to service delivery, may be a potential solution to the skill deficit (Wylie, McAllister, Davidson, Marshall, & Law, 2014). This longer term approach requires advocacy from service users and providers, political will, and strategic planning from within to achieve change. It is therefore crucial that external speech-language pathologists have the appropriate understanding of the context, and resultant skills, to support local service users, providers, and advocates in this process.

Theme 4. Sensitivity

Reflection: In Kenya, Uganda and Rwanda, working with local organisations has allowed teams of local partners to build internal capacity and reach out to people in remote communities who would not otherwise access services. The partners explain communication difficulties in accessible and appropriate ways, are able to give locally contextualised examples and explanations in local languages, and use sustainable materials to make appropriate resources.

Cultural sensitivity is, arguably, the most salient part of the Papadopolous et al. (1998) model. The concept of cultural sensitivity resonates with that of cultural humility. It reaches beyond knowledge and deeper into the awareness that there is more to a person's culture than is, or can be, articulated (Hall, 1984; Levi, 2009). This implicit cultural information is rarely accessible to outsiders (Papadopolous et al., 1998) and that is a primary reason why it is imperative to work with local partners who do have access to, and are accepted at, these implicit cultural levels. It is therefore crucial that speech-language pathologists work with, and through, local practitioners who bring expertise beyond clinical skills and are uniquely positioned to access the communities to which they belong (see Hickey et al., 2014).

Summary

The concept of culture is continually evolving and it is therefore crucial that theoretical frameworks develop to reflect this change. However, the analysis provided suggests that the current frameworks of clinical cultural competence do not yet adequately reflect the multifaceted attributes required to work effectively with people from a range of backgrounds and require reconceptualisation.

The above reflection and analysis illustrates that cultural competence in clinical practice encompasses multidirectional interactions between individuals with multiple identities and their practitioners, with the awareness, knowledge and skills to offer effective and ethical services. In order to develop appropriate skills, cultural humility must underpin the development of awareness and knowledge of, and sensitivity towards, one's own, and other, cultures (including individual interpretations of these). As discussed, the theory of cultural humility dictates that competence is not an endpoint, but an evolving phenomenon (see Figure 2). In order for speech-language pathologists to deliver culturally appropriate,

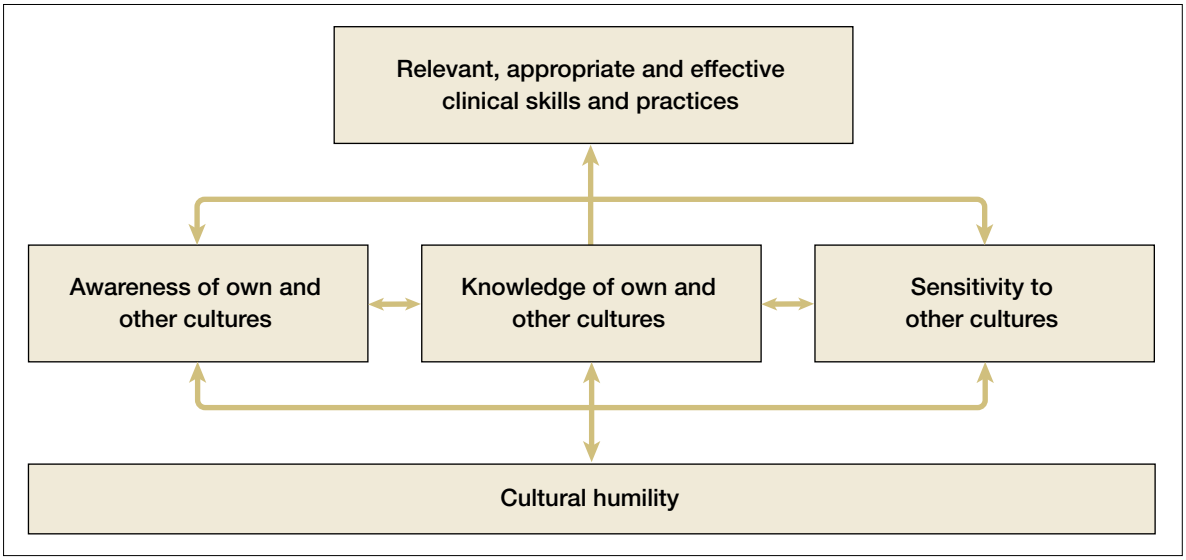

Figure 2. Towards an integrated model of cultural competence. Cultural humility underpins the development of awareness and knowledge of, and sensitivity towards, one's own and other cultures and the subsequent development of effective clinical skills. (Integrated model based on Sue et al., 1992; Papadopolous et al., 1998; and Walters, 2015)

relevant, responsive and effective services both at home and overseas, a wider recognition of the need for cultural competence to be grounded in the concept of humility needs to be a common and central concern of speech-language pathology governing bodies, training institutions, service providers. Ultimately, it needs to be championed by individual members of the profession.

It is vital that the speech-language pathologists contributing to service development in the majority world reflect upon both their motivations and their ability to provide appropriate input that is sensitive to the needs of local service users and providers (Hickey et al., 2014). Thus, practitioners need to reflect upon some widely accepted personal and professional cultural beliefs and be led by local partners to reach workable and realistic solutions to the challenges that they identify. Participatory and emancipatory research is therefore necessary to expound the needs of people with communication disabilities in different contexts, and what they, and their communities, feel is the most appropriate way forward to address those needs.

Conclusion

As global mobility increases, it has never been so important to look beyond our own cultural reference points and adopt an attitude of open-minded and continuous learning about others. As societies are becoming increasingly multicultural, awareness, knowledge, skills and sensitivity towards others are essential in speech-language pathology practice. However, the profession must ask if the current conceptualisations of cultural competence adequately represent the multidirectional interaction between all of the professional attributes required to work effectively with people from cultures vastly different from our own.

Ensuring appropriate training on cultural competence on speech-language pathology courses is an important step towards increasing trainees' awareness and knowledge about cultural diversity and its implications for effective clinical practice. However, sensitivity and skills come with experience and, arguably, the multifaceted dimensions of cultural competence are governed by an individual's ability to demonstrate cultural humility and by their own attitudes. Essentially, the onus lies with individuals to embrace diversity in both their personal and professional lives, critically appraise themselves and their practice, accept the unease that comes with stepping outside their comfort-zone with people from other cultures (Walters, 2015), and actively seek to develop their own interpretation of the term cultural competence.

1 Training courses are in place in Uganda, Kenya and Tanzania and under development in Rwanda.

2 Shalmani (2015) states: *"The term 'Majority world' highlights the fact that the majority of the world's population lives in these parts of the world traditionally referred to as 'developing'. The term 'Minority world' is similarly used to refer to those countries traditionally referred to as 'developed', where a minority of the world's population resides"*. The author recognises the problematic nature of using a "two world's approach" (Young, 2010), but has opted to use the above terms for clarity of argument.

3 Identities can include age, ethnicity, gender, linguistic background(s), national origin, religion, sexual orientation, socioeconomic status (see ASHA, 2013; Papadopolous et al. 1998).

4 Whereby people seek to exchange knowledge and skills to enhance each other's practice

References

American Speech-Language Hearing Association (ASHA). (2011). *Cultural competence in professional service delivery*. Retrieved from http://www.asha.org/policy/KS2004-00215.htm

American Speech-Language and Hearing Association (ASHA) Board of Ethics (2013). *Cultural and linguistic competence* [Issues in ethics]. Retrieved from http://www.asha.org/Practice/ethics/

Barrett, H. (2013). *"Education for all"? Access to primary-level education for children with complex learning disabilities in countries with "free primary education" in sub-Saharan Africa: A review of the literature*. (Unpublished master's thesis). University of Manchester, UK.

Barrett, H., Turatsinze, F., & Marshall, J. (2016). International working: strategic thinking achieves change. *RCSLT Bulletin*, *July*, 18–19.

Brown, S., & Lehto, X. (2005). Travelling with a purpose: understanding the motives and benefits of volunteer vacations. *Current Issues in Tourism*, *8*(6), 479–496

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*, Volume I. Washington, DC: CAASP Technical Assistance Center.

Crowley, C., & Baigorri, M. (2011). Effective approaches to international work: Substance and sustainability for speech-language pathology student groups. *Perspectives on Global Issues in Communication Sciences and Related Disorders*, *1*(1), 27–35.

Hall E. (1984). *The dance of life: the other dimension of time*. New York, NY: Anchor Press.

Hartley, S., Murira, G., Mwangoma, M., Carter, J., & Newton, C. (2009) Using community/researcher partnership to develop a culturally relevant intervention for children with communication disabilities in Kenya. *Journal of Health Services Research and Policy*, *31*, 490–499.

Hickey, E.M., McKenna, M., Woods, C., & Archibald, C. (2014). Ethical concerns in voluntourism in speech-language pathology and audiology. *Perspectives on Global Issues in Communication Sciences and Related Disorders*, *2*, 40–48.

Indigenous Allied Health Australia (IAHA). (2015). *Cultural responsiveness in action: An IAHA framework*. Australia: Author.

Leadbeater, C., & Litosseliti, L. (2014). The importance of cultural competence for speech and language therapists. *Journal of Interactional Research in Communication Disorders*, *5*,1–26.

Levi, A. (2009). The ethics of nursing student international clinical experiences. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, *38*(1), 94–99.

Marsh, H. W., and MacDonald-Holmes, I. W. (1990). Multidimensional self-concepts: Construct validation of responses by children. *American Educational Research Journal, 27*(1), 89–117.

Papadopolous, I., Tilki, M., & Taylor, G. (1998). *Transcultural care: A guide for healthcare professionals*. Wilts, UK: Quay Publications.

Ridley, C.R., Baker, D.M., & Hill, C.L. (2001). Critical issues concerning cultural competence. *The Counselling Psychologist*, *29*(6), 822–832.

Robinson, H., Afako, R., Wickenden, M., & Hartley, S. (2003). Preliminary planning for training speech and language therapists in Uganda. *Folia Phoniatrica et Logopaedica*, *55*, 322–328.

Royal College of Speech and Language Therapists (RCSLT) (2003). *Reference framework underpinning*

competence to practise. Retrieved from http://www.rcslt.org/docs/competencies_project.pdf

Shalmani, S. (2015). Why I use the term "majority world" instead of "developing countries" or "third world". Retrieved from https://sadafshallwani.net/2015/08/04/majority-world/

Speech Pathology Australia (SPA). (2016). *Working in a culturally and linguistically diverse society* (Position paper). Australia: Author.

Sue, D.W., Arrendondo, P., & McDavis, R.J., (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477–486.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T., Manese, J. E., Ponterotto, J. G. & Vasquez-Nutall, E. (1998). *Multicultural counseling competencies*. Thousand Oaks, CA: Sage Publications.

Walters, T. (2015). *Cultural humility: A hermeneutic literature review*. (Unpublished master's thesis). Auckland University of Technology, New Zealand.

Wickenden, M., Hartley, S., Kariyakaranawa, S., & Kodikara, S. (2003). Teaching speech and language therapists in Sri Lanka: Issues in curriculum, culture and language. *Folia Phoniatrica et Logopaedica*, *55*(6), 314–21.

Wickenden, M. (2013). Widening the SLP lens: How can we improve the wellbeing of people with communication difficulties globally? *International Journal of Speech-Language Pathology*, *15*(1), 14–20.

World Health Organization (2001). *International classification of functioning (ICF)*. Retrieved from http://www.who.int/classifications/icf/en/

Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). The World Report on Disability: An impetus to reconceptualise services for people with communication disability. *International Journal of Speech Language Pathology*, *15*(1), 118–126.

Wylie, K., McAllister, L., Davidson, B., Marshall, J., & Law, J. (2014). Adopting public health approaches to communication disability: Challenges for the education of speech-language pathologists. *Folia Phoniatrica et Logopaedica*, *66*, 164–175.

Young, H. (2010). Naming the world: Coming to terms with complexity. *Policy and Practice: A Development Education Review*. (Issue 10). Retrieved from http://www.developmenteducationreview.com/issue10-perspectives3

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"I can't believe you want to leave at lunch time"

A reflection on how narrative ethics may inform ethical practice in cross-cultural and majority-world contexts

Helen Smith

KEYWORDS
CULTURAL AND LINGUISTIC DIVERSITY
MAJORITY-WORLD VOLUNTEERING
NARRATIVE ETHICS

Helen Smith

In the mid 1990s for 2½ years I was a volunteer speech pathologist with Australian Volunteers International in a sub-Saharan African country. This story is based on my time working in country. This piece will use a narrative ethics framework (Speech Pathology Australia, 2014) to consider the story; the current story as I experienced it, a reflection on the background story from multiple perspectives and a reimagined future story. Finally, some considerations for ethical volunteering as speech pathologists in culturally and linguistically diverse majority-world contexts will be provided.

The current story

Sarah,[1] a hard- working and dedicated rehabilitation technician[2] returned one Monday from a rare funded professional development opportunity. She was the mother of two and the adoptive mother of three (her sister's children, adopted after her sister's death from HIV the year before), and it had taken a huge amount of organisation and personal commitment for Sarah to attend the course. (The course was based in a central location requiring 3–4 hours travel and several nights away from home.)

The course was funded and run by a service organisation from North America which had recruited volunteer specialists from their own country, provided them with travel and living expenses but no salary, so they could provide a week-long specialist training program to local health workers. The service organisation had also funded the travel and living expenses for the local health workers to attend. A rare and generous gift with the goal of improving the provision of specialist services to people in the country.

Sarah, a keen learner, was always motivated to improve her knowledge and skills. Therefore, I was surprised on the Monday morning following the course when my question asking how her course had been was met with a huge sigh and a look of despondency. Concerned, I asked Sarah what had happened.

Sarah started by expressing her delight in the amazing opportunity to develop her understanding of the specialist area. She was delighted that what she was required to do for patients at our hospital made more sense as the course rolled out.

Sarah, however, then expressed her frustrations. First, the "whole" course as outlined in the brochure had not been provided. Second, each day, regardless of the presenter, the content appeared very rushed, with no time to consolidate learning or to ask questions. Despite the speed of delivery, she commented the presenters were constantly complaining at their frustration that they couldn't fit in all the content they had planned.

Over lunch one day Sarah asked one of the facilitators why everything was being covered so quickly. While English was the official language for education and business, English was a second (or third language) for most of the attendees. The majority of the participants had a TAFE-level qualification and were finding it challenging to keep up. The facilitator responded to Sarah's question by saying:

> *You all had to travel on Tuesday. We had expected you to travel on Monday as it was a public holiday but none of you could be bothered to do that. And none of you will stay all day on Friday. You all want to leave at lunch time. So our carefully planned 4-day course is being squashed into 2½ days.*

Sarah commented she felt like the facilitator was saying she and her fellow participants didn't value the educational opportunity to improve the specialist services they would provide to their patients. Nothing could have been further from the truth. On reflection, Sarah wondered how she could have helped the facilitators change their perception of the participants. She was concerned about the facilitator's misperception that the participants were not motivated or were lazy. She wondered how this valued and valuable training could have been less than optimal because of such a lack of understanding. She did not feel empowered to continue the conversation as the facilitator rushed off to prepare for the next session. Sarah certainly did not feel valued or respected by the facilitator.

The background story

A narrative approach to ethical reasoning considers an individual's or cultural group's life story (Speech Pathology Australia, 2014). The values and experiences each participant brings to the story are considered. This allows both sets of voices in the story to be heard. Each person in the story arrives at the situation described from their own perspective. It is only through the consideration of these multifaceted perspectives that a new and deeper shared understanding can be reached.

The volunteer presenters had dedicated valuable vacation time to come to Africa to deliver training. They had spent many hours preparing the training program prior to their departure from home. They came with slides and handouts and workbooks. The timing of the trip had been made to accommodate the volunteers' usual summer holiday period to have the least impact on their own local

service provision. The volunteers were motivated to "do good" (Speech Pathology Australia, 2010) in coming to the country and providing the training. They too recognised the speed and lack of time available was affecting the quality of the training they were providing and were frustrated by the circumstances which prevented them maximising the training they had come so far to present.

What the presenters didn't understand was the cultural context. The "public holiday" so casually mentioned was not just any "holiday". It was an Anzac-day type celebration for the fallen freedom fighters from the recent independence war. In a politically nuanced country, being absent from your local "celebrations" could potentially endanger you and your extended family's reputation and security. Being absent – for example, travelling on that day – was just not an option for any local worker.

Similarly, the need to leave mid-day on Friday was not "skipping out". Most of the local participants would be taking long distance buses home. Bus stations after dark were not safe places for reputable people to be, particularly women on their own. Women in the bus station area after dark, especially on a Friday night, were at great risk from groups of drunken men at the end of their working week. Anything could (and frequently did) happen to lone people especially women, in such places. All local people knew this and were careful to ensure people attending courses would be out of the bus station area and home well before dark particularly on Fridays.

Potentially, based on the facilitators' feedback, there was a risk similar workshops would not be funded by the North American service organisation in future. This would mean both volunteers and participants would not have the opportunity for a rich cultural exchange and education that the volunteer program provided. There was also a risk that local organisations may not implement improved health care practices if the participants were unable to engage with the workshop content due to the structure and speed of the workshop.

Understanding the background stories of Sarah, her fellow students and the presenters provides useful insights into this revised story and assists consideration of how to move past the barriers expressed in the original story. The new perspectives gained during the reflection allow a future story to be reimagined with a more positive experience for all participants involved.

An ethical approach for future workshops

I would like to present the following strategies as ways to move forward and construct a positive future story.

Embedding volunteer programs

Having volunteer programs embedded in local services and at the behest of local services may go a long way to preventing similar misunderstandings and risks of harm. A local contact, involved in pre-planning, could have explained to the volunteer group before dates were determined why a proposed week was not suitable with respect to a culturally and politically important public holiday. A local contact could facilitate discussions around the need to finish by lunch time so participants could safely travel home, and explain fully the safety risk if this recommendation was not adhered to by participants. A local co-facilitator could also provide orientation to the volunteers to the English competency and education level of the group so the pace of the training program could maximise learning. It is also worth considering that if the timeframe for a volunteer educational program is not ideal, it may be of more benefit to focus on the quality of the content rather than quantity of information provided. This may facilitate new services or techniques being safely and confidently implemented in the new setting.

Considerations for volunteers

Good practice principles

The Irish Code of Good Practice for volunteer sending agencies (COMHLAMH, 2015, p. 6) outlines a number of principles relevant for consideration including:

- Volunteers participate in appropriate preparation, training and induction.
- Organisations take all practical steps to ensure the protection, safety and well-being of volunteers and the communities they work with.
- Organisations support volunteers to understand the wider context of development in which volunteering is taking place.

Consideration of these principles and of our own SPA Code of Ethics may facilitate an ethical approach to even very simple, short-term volunteer opportunities, such as the one described in this example, and maximise "the good" for all involved while upholding autonomy and respecting the beliefs and values of local communities. Using a narrative ethics framework to guide reflections on this "story" highlights the importance of listening to the perspectives of all, and illustrates the utility of the narrative approach in finding ethical solutions to cross-cultural and majority-world dilemmas.

Established volunteer organisations and programs

Speech Pathology Australia (SPA) supports the use of established organisations for speech pathologists wishing to volunteer in majority-world communities for philanthropic reasons (Speech Pathology Australia, 2015). The use of established volunteer organisations facilitates the access to appropriate orientation and support for speech pathologists.

Developing understanding of cultural and linguistic diversity

In addition SPA recommends that speech pathologists working in culturally and linguistically diverse environments (wherever they may be geographically) be familiar with the contents of the position statement "Working in a culturally and linguistically diverse society" (Speech Pathology Australia, 2009). This document highlights the requirement for speech pathologists to develop cross-cultural competence in order to provide culturally relevant and I would suggest ethical services.

The benefits of ethical volunteering

The development of new cultural knowledge and partnerships with people from other cultures is one of the joyful benefits of volunteering in a majority-world context in both short- and longer term programs. The personal and professional benefits are enormous and often life-changing. The benefits we gain from volunteering may far outweigh what we offer in return. In my experience, the Sarahs of the world also want to provide the best possible services for their patients. Sarah certainly appreciated the support to provide the highest standards of care for her patients within the context in which she worked. Her attitude and calm

resilience remains an inspiration to me. This story highlights the importance of listening to the perspectives of all and illustrates the utility of the narrative approach to ethical reflection in complex situations.

Acknowledgements

I would like to acknowledge the invaluable feedback and advice received from members of the ethics board Belinda Kenny, Suze Leitão, Trish Johnson and Patricia Bradd on earlier drafts of this paper.

1 Not her real name
2 Rehabilitation technicians are the equivalent of Certificate 4 Allied Health Assistants in Australia

References

COMHLAMH. (2015). *Irish code of good practice for volunteeer sending agencies*. Retrieved 3 June 2016, from www.comhlamh.org/code-of-good-practice-2-2/: http://www.comhlamh.org/code-of-good-practice-2-2/

Speech Pathology Australia. (2009). *Working in a culturally and linguistically diverse society*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2010). *Code of ethics*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2014). *Ethic education package*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2015). *Volunteering in speech pathology*. Melbourne, Vic.: Author.

Helen Smith is a senior member of SPA's Ethics Board. In the 1990s she volunteered with Australian Volunteers International.

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Webwords 56

Minority-world SLPs/SLTs in majority-world contexts

Caroline Bowen

The modes of service delivery, and the settings in which speech-language pathologists / speech and language therapists (SLPs/SLTs) work, are remarkably diverse. The "modes" can be push-in or pull-out in schools; hospital-, office- or clinic-based; face-to-face in the flesh, or face-to-face via telepractice; or "mobile" – boating, driving or flying between sites. The settings, at home and abroad, can be in aged-care facilities, charitable and philanthropic institutions, clients' or clinicians' own homes, community health centres, custodial or care facilities, early intervention centres, hospitals, missions, online, orphanages, preschools and schools, private practices, rehabilitation units, social enterprises, and university clinics, in the minority and majority worlds.

Altruists bitten by the travel bug

SLPs/SLTs, affected by some combination of altruistic values – around social justice, equity, freedom and wanting to make a contribution to the greater good – and the travel bug are often inspired to work in the majority world. They can do so for short periods, long periods, or in regular bursts, as interested onlookers, volunteers and paid employees. Their international workforce participation can involve study tours or fact-finding trips to become better informed about communication and swallowing disorders' services in the visited country or region, with no delivery of direct services, or with service delivery as an ancillary goal; international work experience for undergraduate and graduate students; information sharing-and-training-only missions; and sustained and sustainable direct service provision (Crowley & Biagorri, 2011) taking full advantage of local "social capital" in the host community. Where providing clinical services is concerned, sustainability is a central concern, with a "best practice" focus on upskilling local individuals to continue the work, with ongoing support, increasingly via the Internet (Salas-Provance, Marchino, & Escobedo, 2014).

Association support

SLP/SLT professional associations support international outreach and networking in various ways. For example, ASHA has two relevant Special Interest Groups: **SIG 14**[1] Cultural and Linguistic Diversity and **SIG 17**[2] Global Issues in Communication Sciences and Related Disorders, and Speech Pathology Australia has a closed Facebook **group**[3] for members interested in working in developing communities.

Recruiters

Recruitment agencies often tap into professionals' philanthropism and thirst for adventure with promises that the overseas experience will be "personally rewarding", taking advantage of (free) social media and the goodwill of individual practitioners to spread the word. Since 1998, speech-language-therapy dot com has attracted a flow of enquiries and requests for help, often relating to SLP/SLT services in the majority world and in remote places, partly as a consequence of the **professional interest**[4] section of the site. In the first half of 2016 alone, email from recruiters arrived directly from Bali, Bolivia, Cambodia, Ethiopia, Mongolia, Myanmar, Papua New Guinea, Peru, Romania, Rwanda, Ukraine and the US. This one was from the US:

> *I am recruiting an SLT (I do hope it might be YOU) and an OT who would like to live in Shenzhen for one year to train paraprofessionals on SLT and OT skills for ages 0–8 years old. China has just recognized the need for SLTs. No universities offer it as a major and few courses are offered except via other universities. A CEO of a rehab center for young children wants to offer services, but the therapists would have to speak Chinese, which has many variants. In the interim, the CEO seeks an SLT to train or share basic info to the current teachers/paraprofessionals who have worked with disabled children for years (very experienced and dedicated). Translators are available. If you have a better solution, please share. Please inform your wonderful network.*

For the record, the (somewhat misinformed) writer was directed to the Hong Kong Association of Speech Therapists (**HKAST**[5]), SLP/SLT academics in the Division of **Speech & Hearing Sciences**[6] at the University of Hong Kong, the Chinese International Speech-Language and Hearing Association (**CISHA**[7]), and to various personal contacts in the PRC. Another 2016 enquiry was from Africa:

> *We seek to recruit a Speech Pathologist to train rehab technician staff to provide the highest quality assessment and therapy services (with a main focus on AAC, ASD and speech) over 6 to 8 weeks in Malawi. We will pay airfares board and lodgings and meet-greet you in Lilongwe. Like so many of these enquiries, it came with an appeal for a six-figure "suggested sum".*

Again, factual information, and conservative advice were proffered, but as is also usual when an answer is not the one "hoped for", no further correspondence was received.

Volunteers or voluntourists?

The site also receives regular email from SLPs/SLTs and students, variously interested in working somewhere foreign, wanting an adventure, or seeking to contribute to the world community. Much of it betrays a breathtaking arrogance, a sense of superiority over potential host communities, little humility (Bleile, 2015), and scant cultural

competence and cultural sensitivity (Bowen, 2009). Here are five representative unedited samples:

Hi. I have very recently finished my BSc (honours) degree in Speech and Language therapy, acquiring many exportable skills at a prestigious British university. I would like to work as a speech therapist in ***Asia***[8] *(possibly Honk Kong or Singapore but anywhere else would be good too) since I think I would find it extremely interesting to work in that part of the world, especially since the profession is less developed in that continent. Can you put me in touch, as soon as possible, with contacts who can read English since I do not speak any overseas languages?*

After 30 years as an SLP in the schools, I am retiring. I have given my recent "SLP acquisitions" to younger colleagues and to the clinic at my alma mater. I am left with 3 large boxes of tests, texts and therapy manuals (Hanen, LinguiSystems, ProEd, HBJ, Super Duper, etc.) and materials (flash cards, etc.). They are not current enough, or in good enough condition for my young colleagues or the ____ University Clinic, as they are quite fussy. I hate to throw them in the trash and I wanted to know if you know of an SLP clinic or school service in the third world where they might be appreciated. I would be happy to donate them if the recipient covered p+h from MN.

Please allow me to introduce myself. I'm an S-LP from Canada who graduated from a top ranking university and I've been starting to consider a move to asia with hopes to work as an S-LP there. I stumbled across your website and wanted to ask you about availability of jobs for English speaking S-LPs in asia (e.g. thailand, malaysia, singapore, etc). I've emailed the malaysian speech pathology college etc to ask for information as I cannot seem to find any online postings for jobs. However, they do not respond to my many emails so I'm writing to you for your insights. You'd actually think they'd be glad of high quality input from a civilized country like mine with high S-LP standards. If I cannot find something that suits me in asia I am quite interested to work in africa if you can send any info for that area.

My background is that I am a CCC-SLP from the US and a member of AAPPSPA. I am interested in setting up a center in a city in the Asian region to work with young children 0–5 in Fiji, Japan, Sirrilancah, Vanuatu, South Korea, Siam or similar (not China, Bali, India, Pakistan or areas with too much poverty and disease or slums). If you would provide contacts in that area, that would be great. Also, any thoughts on working thru telepractice on accent modification with Asian adults wanting to improve their English pronunciation?

I am a 24-year-old German SLP student (for MA) speaking German and English urgently wishing for an internship in Thailand for three months in the summer, but I am not having too much luck finding a post. It will give me much happiness to work with poor children who have cleft palate in exchange for housing, meals, insurance and small stipend and flights to-from Munich. I am searching such an internship since 4 months without anybody answering or supporting me. I need this internship very much for my thesis. Thank you for your website.

Unfortunately, some of the cultural incompetence, self-serving motives (Salas-Provance et al., 2014) and attitudes implicit in the email spill over into the standards of clinical practice observed in developing communities, and in some underserved majority- and minority-world contexts, *and* with culturally and linguistically diverse client populations in the industrialised world (Scheffner Hammer, 2011), including in Australia.

Troubling scenes

Webwords is not immune to either the urge to volunteer or the travel bug, expressed as a love of **weekends away**[9], and trips to many parts of the world for work and leisure. In her work travels, she has been troubled to see fully qualified SLPs/SLTs "make do" with superseded, photocopied (from colour to black and white) and incomplete assessments; and tests and intervention materials translated from English to local languages and dialects. She has also witnessed colleagues employ culturally inappropriate materials, such as: the (British) Renfrew Action Picture Test for Zulu and Xhosa speakers; Brown's Stages (English) "norms" for morphological development applied to African, Asian and European languages; and picture resources, made for the UK and USA, used with Indigenous and non-Indigenous Australian, Filipino, Malaysian, New Zealand and South African children.

Some fully qualified SLPs/SLTs also engage, with mixed motives, in "importing" non-evidence-based methods for use by naïve practitioners with vulnerable populations, enjoying Big-Tobacco-style sponsorship.

The TalkTools® Blog for example, **records**[10] that four Australians, two SLPs and two OTs, volunteered for a week in November 2015 at the Dzherelo Centre, in Lviv, Ukraine. The "mission trip" was sponsored by TalkTools®, who also donated (their) merchandise to the centre. The SLPs taught staff how to use TalkTools® exercises and products, "to turn mealtimes into therapy to support the children in developing their oromotor skills. All of the children … required support with the strength and coordination of their jaw. Chewy Tubes with the pre-feeding chewy hierarchy were trialled successfully". Meetings were also held at the Lviv Catholic University, the Polytechnic University and the Military Hospital, where the sponsor's products may have been discussed in an approving light, with no mention of their lack of supporting evidence.

Standards

Ethical issues permeate each of these circumstances, relating to complex, even alien settings where barriers to E^3BP far outweigh the facilitators. Doing your best, as a qualified service provider in difficult situations, should not equate with knowingly advocating or delivering inferior service, especially when grateful, hospitable, and sometimes adoring recipients believe you offer "the best", and want you back.

Links

1. www.asha.org/SIG/14
2. www.asha.org/SIG/17
3. www.facebook.com/groups/SPAWWDC
4. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=20

5. www.speechtherapy.org.hk
6. www.hku.hk/speech
7. www.cisha.org.cn
8. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=54
9. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=162
10. http://blog.talktools.com/2016/slp-and-ot-trip-to-ukraine

References

Bleile, K. M. (2015). A Nicaraguan experience. In C. Bowen, *Children's speech sound disorders* (2nd ed.; pp. 157–160). Oxford: Wiley-Blackwell.

Bowen, C. (2009). Multiculturalism in communication sciences and disorders. *ACQuiring Knowledge in Speech, Language and Hearing*, *11*(1), 29–30.

Crowley, C. & Baigorri, M. (2011). Effective approaches to international work: Substance and sustainability for speech-language pathology student groups. *ASHA SIG 14 Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse (CLD) Populations*, *1*, 27–35.

Salas-Provance, M., Marchino, M., & Escobedo, M. (2014). Volunteerism: An anchor for global change through partnerships in learning and service. *ASHA SIG 17 Perspectives on Global Issues in Communication Sciences and Related Disorders*, *4*, 68–74.

Scheffner Hammer, C. (2011). Broadening our knowledge about diverse populations. *American Journal of Speech-Language Pathology*, *20*(2), 71–72.

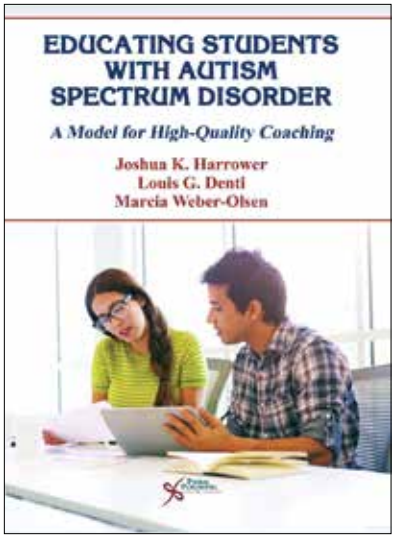
Webwords 56 is at www.speech-language-therapy.com with live links to featured and additional resources.

Resources reviews

Harrower, J. K., Denti, L. G., & Weber-Olsen, M. (2015). *Educating students with autism spectrum disorder: A model for high-quality coaching*. San Diego, CA: Plural Publishing; ISBN 978 1 59756 786 2; pp 245; A$69.95.

Keely Harper-Hill

I was delighted to be asked to review this book because, while speech-language pathologists (SLPs) have collaborated with educators for many years, coaching as a means of educator professional development is currently of particular interest. The book is structured clearly and consists of 13 chapters across three sections. The objectives of each chapter are listed at the chapter beginning and each chapter ends with an explicit summary and end-of-chapter questions. The first section (chapters 1–5) introduces educational coaching, briefly reviews and



describes coaching models, and places this information within the context of supporting students on the autism spectrum. The second section (chapters 6–8) considers the use of high-quality coaching in planning instruction for students on the autism spectrum. Delivering effective programming for these students is covered in the final section (chapters 9–13). Vignettes are woven throughout the chapters. The book is easy to read and the structure would enable the reader to "dip" into it rather than read it in its entirety. The authors are based in the United States and, as with many other disciplines, the reader needs to make adjustments to the content.

I do have several reservations, which stem from the ambitious scope of the 250-page book. The authors make a valiant effort to address two weighty topics: (a) educator coaching and (b) how to support students on the autism spectrum in the classroom. Within the sections on planning instructions and again in effective programming, these topics are integrated and applied to the assessment and intervention phases of supporting students in schools. I felt that the authors' effort to address these topics was undermined because more attention to both topics would be required to do them full justice. The authors' statement of purpose suggests a wide readership including coaches, as well as educators who are being coached, so that they can meet the needs of children on the spectrum. As I read the book, the scope of the intended readership became less clear. For example, the information on coaching may be of initial interest to the SLP who has very limited experience working collaboratively with educators. It may not, however, be sufficient to assist SLPs to translate specialist knowledge of autism to the classroom. Similarly, the information on autism could be useful to experienced education-based SLPs with limited experience with autism but I'm not sure they exist!

In conclusion, the book covers a wide array of issues relevant to coaching and could serve as a useful introductory text for student or early career SLPs working in education sectors. I suspect that any SLP with experience working with teachers or with reasonable experience in working with young people on the autism spectrum may find the content less beneficial due to the restricted depth of the content covered in this book.

Hallowell, B. (2016). *Aphasia and other acquired neurogenic language disorders: A guide for clinical excellence*. San Diego, CA: Plural Publishing; ISBN 978 1 59756 477 9; A$140

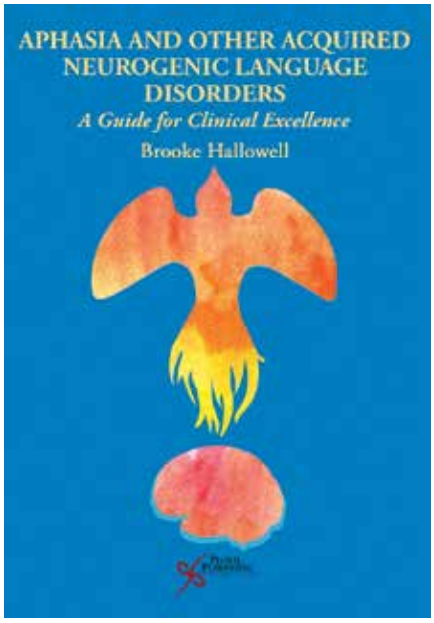
Dr Christopher Plant

There are many textbooks available to the speech-language pathologist on the topic of aphasia and related neurogenic language disorders. In *Aphasia and other acquired neurogenic language disorders: A guide for clinical excellence*, Brooke Hallowell aims to provide a unique perspective which will be of interest to students and practising clinicians alike. Throughout the text, Hallowell draws attention to what it takes to be an exceptional, person-centred clinician when working with such client populations. In working towards this aim, Hallowell succinctly sums up the text's approach by describing it as an evidence-based, how-to clinical guide.

This text contains eight sections and 33 clear, informative, and insightful chapters. Most chapters are also complemented by downloadable student and instructor resources. Each chapter opens with clear learning objectives and concludes with well-considered learning and reflection activities. This text therefore offers significant value for money.

The general structure of the text is fairly standard, moving from foundations and the nature of aphasia and cognitive-communication disorders in conditions such as traumatic brain injury, right hemisphere disorder, and dementia, through to assessment, and then general principles of intervention, followed by specific intervention approaches.

Along the way the topics explored reflect current trends and priority areas such as language in the context of ageing, cultural competence in view of increasing immigration patterns, apps for intervention, and complementary and integrative approaches to intervention.



Even within chapters that explore familiar topics, such as the ICF and its application to aphasia and cognitive-communication, assessment tools and methods, and theories and approaches to intervention, Hallowell offers unique perspectives through combining discussion of current research with insights gained from clinical experience. These insights help the text achieve its aim of promoting the idea of an excellent clinician by providing information that few other textbooks draw explicit attention to. A simple example of this comes early on where Hallowell discusses the sometimes quirky and humorous nature of errors in aphasia and the shared appreciation of these instances between the person with aphasia and speech-language pathologist. Similarly, chapters describing specific intervention approaches for different aspects of language rehabilitation are particularly clear and helpful, in providing a simple step-by-step guide to implementation, along with general principles and an overview of the research evidence.

As with many texts published by Plural, there is perhaps a slight emphasis on research evidence generated within the United States in preference to other parts of the world, although this is not to say that the research cited is not high quality. Some readers may also have only a passing interest when discussion turns to issues around reimbursement, Medicare, and Medicaid, although Hallowell is mindful to acknowledge differences in health care systems across major English-speaking countries such as Australia and the United Kingdom.

Overall, there is a lot to appreciate about this new and ambitious text. Although many other texts may explore the nature, description, assessment, and intervention of aphasia in much finer and rigorous detail, few, if any, texts offer such an effective and engaging balance between current knowledge and clinical insight.

JCPSLP notes to authors

The *Journal of Clinical Practice in Speech-Language Pathology* is the major clinical publication of Speech Pathology Australia. Each issue of *JCPSLP* aims to contain a range of high quality material that appeals to a broad membership base. *JCPSLP* is published three times each year, in March, July, and November.

Issue	Copy deadline (peer review)	Theme*
Number 2, 2017	1 December 2016	Communication and Connection – Valuing Aboriginal and Torres Strait Islander perspectives.
Number 3, 2017	13 April 2017	To be announced. Check website for updates
Number 1, 2018	1 August 2017	To be announced. Check website for updates

* articles on other topics are also welcome

General
Material submitted must be your original work. Any direct quotations or material used from other sources must be credited in full. If copyright clearance is required to use material included in your article, please supply evidence that this has been obtained.

Ethical approval
All manuscripts in which information about a person and/or organisation is presented must be accompanied by evidence of approval by an authorised ethics committee. This includes clinical insights, ethical conversations, manuscripts presenting the results of quality assurance and improvement activities within workplace settings, and research manuscripts.

Themes
Each issue of *JCPSLP* contains a set of articles relating to a particular theme, as well as a selection of articles reflecting broader speech pathology practice. The Editorial Board selects a theme for each journal, and these themes can be suggested by members of Speech Pathology Australia at any time. Manuscripts on any topic relevant to speech pathology practice can be submitted to *JCPSLP* at any time.

Length
Manuscripts must not exceed 3500 words (including tables and a maximum of 30 references). Longer manuscripts may be accepted at the discretion of the editor. It is highly recommended that authors contact the editor prior to submitting longer manuscripts.

Types of Submissions
When submitting your article to *JCPSLP*, please indicate the type of submission:
- Tutorial: Educational/narrative discussion on topics of interest to clinicians. This should include a brief overview of the current literature, as well as a section containing clinical implications.
- Review: Critical appraisal of the research literature in an area of research-practice that is relevant to practising speech pathologists.
- Clinical Insights: Articles that may be of primary clinical interest but may not have a traditional research format. Case studies, descriptions of clinical programs, and innovative clinical services and activities are among the possibilities.
- Research: Research articles with clear clinical relevance. These submissions will be judged on the review of the literature (including a rationale), methodology, statistical analyses, and a clear discussion directed to a clinical readership.

Peer review
Manuscripts submitted to *JCPSLP* undergo a double blind peer-review process. Regular columns (e.g., Webwords, Top 10, resource reviews) undergo editorial review. For peer-reviewed articles, *JCPSLP* uses a double-blind peer-review process, in which the anonymous manuscript is sent to two reviewers. The authors are provided with information from the review process. Often, authors are invited to revise and/or resubmit their work, as indicated by the reviewers. Occasionally, the reviewers request to re-review the revised manuscript. In some instances, a paper will be rejected for publication. The editor's decision is final. The sentence "This article has been peer-reviewed" will appear after the title for all peer-reviewed articles published in *JCPSLP*.

Format and style
All submissions must be Word documents formatted in accordance with the following guidelines:
- All text should be 12 point Times New Roman, double spaced (except figures and tables), left justified.
- A maximum of five levels of heading (preferable 2-3 levels) should be used:
  1. Centered, boldface, uppercase and lowercase heading
  2. Left-aligned, boldface, uppercase and lowercase heading
  3. Indented, boldface, sentence case heading with a period. Begin body text after the period.
  4. Indented, boldface, italicised, sentence case heading with a period. Begin body text after the period.
  5. Indented, italicised, sentence case heading with a period. Begin body text after the period.
- Please use the terms 'speech-language pathology' and 'speech-language pathologist' (abbreviated to SLP) throughout article.
- Do not include images within the text of the article – send photos as separate attachments, digital images should be of high quality and preferably be sent as uncompressed TIF or EPS images.
- Use only one space after punctuation, including full stops.
- Use a comma before 'and' in a series of three or more items (e.g., "The toys included a ball, bucket, and puzzle)
- Clear and concise writing is best. Use short sentences and paragraphs and plain English. Please reduce bias in language as much as possible (i.e., avoid stereotypical terms, refer to participants, rather than subjects, and be sensitive to racial and ethnic identity).
- Reproduce any quotations exactly as they appear in the original and provide the page number(s) for the pages you have quoted from.
- References, which should be key references only, must follow the American Psychological Association (APA, 6th edition) (2009) style. For further details on correct referencing, visit http://owl.english.purdue.edu/owl/resource/560/01/
- Tables and Figures: If there are to be tables or figures within your article, these should be presented on separate pages with a clear indication of where they are to appear in the article (in text indicate where the figure or table should be inserted). All tables and figures should be numbered. Figures should be presented as camera-ready art. Please ensure figures and tables appear at the end of your article with each table or figure on a separate page.

Documents to be submitted
1. Manuscript featuring:
   a. Title
   b. Author names and affiliations (will not be forwarded for peer review)
   c. Up to 6 key words
   d. Abstract (maximum 150 words)
   e. Main body of text (**main body must not include any identifying information**)
   f. Reference list (maximum 30)
   g. Tables (if relevant)
   h. Figures (if relevant)
   i. Appendixes (if relevant)
   j. Acknowledgements if relevant (will not be forwarded for peer review)
2. Author submission form (to be downloaded from *JCPSLP* website)
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Creating sustainable services: Minority world SLPs in majority world contexts

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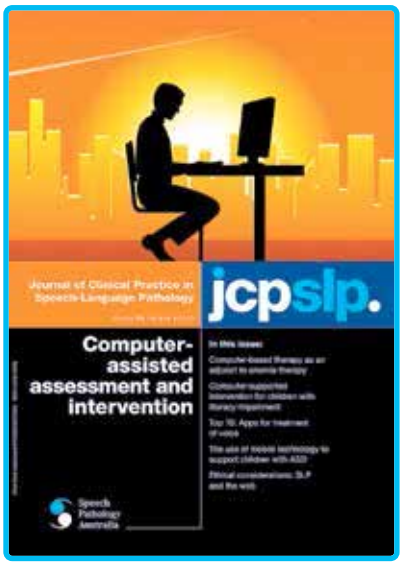

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From the editor

David Trembath

Speech-language pathology offers countless opportunities for those who are interested in working beyond geographical borders, across cultures, to understand and help address the needs of individuals with communication and swallowing difficulties at an international level. For me, the opportunity first arose during my undergraduate studies, via a self-guided study tour with two student colleagues through Nepal, Bangladesh, and India. At the time, these were often described as "developing" or "emerging" countries, terms that are now commonly replaced by "majority world" which captures the proportion of the world's people represented, and contrasts with the relatively small proportion living in "minority world" (otherwise described as "developed") countries. Our goal was to learn from experts in community-based rehabilitation who were working on the ground in villages, towns, and cities in the countries we visited to deliver timely, appropriate, and effective support to persons with developmental and acquired disability. How I wish we had available to us at the time the wealth of information presented in this issue of *JCPSLP* focused on minority world speech-language pathologists working in majority world contexts.

This issue is guest edited by Bea Staley and Suzanne C. Hopf, who have brought together an outstanding group of local and international authors to advance understanding of the opportunities and challenges associated with international work and collaboration. The issue is infused with personal reflections and insightful advice, both of which are critical to minority world SLPs working ethically and effectively in majority world contexts, and also discusses implications for all SLPs aiming to initiate and sustain mutually beneficial and rewarding partnerships, wherever these partnerships occur. A common theme across articles is the importance of "change" as a multidirectional process that leaves all people and parties in better positions as a result of the work together, for the benefit of one another.

In reflecting on this issue, which is the last under my editorship, as well as the work of the journal more broadly, the same theme emerges. The *JCPSLP* is a place where clinicians, researchers, and other members of the community come together to share knowledge, critical and clinical insights, and novel ideas to move our field forward. The journal works because authors, reviewers, members of the editorial committee, and the publication team understand the magnitude of "change" that can occur when the right information is given to the right people, at the right time; and generously volunteer their knowledge and skills to make it happen. I would like to sincerely thank all of those who contribute to the journal in this way, and extend my very best wishes to Dr Leigha Dark who will now take over as editor.

Contents

Special issue

A diverse global network of speech-language pathologists

Bea Staley and Suzanne C. Hopf

Bea Staley (top) and Suzanne C. Hopf

People in all countries have called for a development agenda that is more consistent with the realization of their human rights, and which reflects the day to day reality of their lives. (UNDG, 2014, p. iii)

This quote from the United Nations (United Nations Development Group [UNDG], 2014) ushered in a global conversation in which 4.5 million people from almost 100 countries discussed the "future world that people want" (2014, p. 1). As speech-language pathologists (SLPs) advocating for the human rights of people with communication and swallowing disabilities (PWCD) globally, we want our services to reflect the needs of the communities in which we work. There is considerable interest in the development of speech-language pathology in global regions experiencing poor availability and accessibility of speech, language and swallowing clinical services. This is particularly the case for services in majority-world countries. Consequently, this issue of *JCPSLP* discusses the varied roles of minority-world SLPs working with our colleagues in majority-world contexts.

There is a long history of minority-world clinicians working in varied international contexts. In the late 1990s SLPs (e.g., Hartley, 1998; Marshall, 1997) began to write about their work in majority-world contexts (e.g., Kenya and Uganda) and to develop frameworks for other SLPs to apply in their own work (e.g., Hartley & Wirz, 2002). These authors highlighted the need to document speech-language pathology work in new locations so that a knowledge base could be developed and drawn upon by other clinicians. The papers in this special issue build on the ideas of these SLPs and the many more published since.

Ensuring that the voices of the local context are heard is a recurrent theme of this issue. Nearly all of the articles presented include the voices of SLPs, or their local equivalent, native to the majority-world context discussed. For example, three papers from Vietnam provide insight into how the relatively new speech-language pathology profession is capitalising on past – and indeed continuing – minority-world SLP collaboration, and *indigenising* international speech-language pathology concepts and curricula for the local context. The Nguyen, Dien, Sheard, Xuan, Tâm, Văn Quyên, and Dao paper provides an account of the history and current clinical and advocacy practices of new graduate Vietnamese SLPs, while Pham, McLeod, and Xuan describe the process required for developing a speech assessment tool for the Vietnamese context. In Atherton, Davidson, and McAllister, a participatory research project reveals the voices of Vietnam's first SLP graduate cohort as they embark on the next stage of their professional development journey. All papers have in common a focus on future professional growth that involves international collaboration but importantly is not defined by that collaboration.

In the papers by McAllister, Woodward, and Nagarajan, and by Barrett, our lens turns to the lessons minority-world SLPs learn through international collaborative relationships. McAllister et al. describe the transformative learning experiences of volunteer minority world-SLPs in the role of clinical educator (CE) in Vietnam. The authors report that many skills learned by the CEs in Vietnam are readily transferable to the CEs' work environment in Australia (e.g., working with translators, developing intercultural competence). Barrett then draws upon experiences as a minority-world SLP in East Africa to critique whether available cultural competence theories can be applied to an increasingly mobile speech-language pathology workforce. Barrett suggests that current theories of cultural competence need to evolve to reflect changing concepts of culture.

As we think about change, this can be extended also to the way services and training SLPs has typically been conceptualized. Olszewski and Frank remind us that if communication is a basic human right – one we are passionately striving to work towards on a global scale – we may have to re-consider and re-envision the way we train service providers and implement services in our field. Olszewski and Frank describe an innovative model for training SLPs through NextGenU, a free online program which partners with organisations, governments and universities. Their paper suggests that technology may break down the financial and environmental barriers that often prevent people living in majority-world countries from receiving specialist training and pursuing careers that support PWCD.

What is abundantly clear in reading these papers is that no single framework for service development suits all contexts. For example, we see Wylie, Amponsah, Bampoe, and Owusu directly apply the social, environmental, and economic dimensions of sustainable development embodied in the Sustainable Development Goals (United Nations, 2015) to their own experiences in Ghana

collaborating with visiting minority-world SLPs, while maintaining their own caseloads and advocacy efforts.

Despite employing different frameworks, the authors in this collection consistently conclude that policies and solutions need to be locally and collaboratively derived and issue-orientated without merely transplanting best practices across countries.

From the papers presented it is evident that as a global profession we are beginning to establish networks committed to advocating for improved service availability and accessibility for all PWCD regardless of where they, or we, reside in our world. We are excited about innovative collaborations of SLPs, such as the International Communication Project (see http://www.internationalcommunicationproject.com), that highlight the work of SLPs in diverse locations and open up avenues for future dialogue. What we share here, are just a few of the stories of minority–majority world SLP clinical practices that are striving to change the way we work in varied contexts. We hope that these ideas translate or inspire others working (or thinking about working) in majority-world contexts to create a vibrant network of collaborative SLPs internationally.

References

Hartley, S. (1998). Service development to meet the needs of "people with communication disabilities" in developing countries. *Disability and Rehabilitation*, *20*(8), 277–284.

Hartley, S. D., & Wirz, S. L. (2002). Development of a "communication disability model" and its implication on service delivery in low-income countries. *Social Science & Medicine*, *54*(10), 1543–1557.

Marshall, J. (1997). Planning services for Tanzanian children with speech and language difficulties. *International Journal of Inclusive Education*, *1*(4), 357–372. doi:10.1080/1360311970010405

United Nations. (2015). *Sustainable development goals: 17 goals to transform our world*. Retrieved from http://www.un.org/sustainabledevelopment/sustainable-development-goals/

United Nations Development Group (2014). *Delivering the post-2015 development agenda*. Retrieved from: http://www.undp.org/content/undp/en/home/librarypage/mdg/delivering-the-post-2015-development-agenda.html

Dr. Bea Staley is a speech pathologist who has been working with young children and their families for 15 years. She has worked in Australia, Kenya, America and the Northern Mariana Islands. She is a lecturer in the School of Education at Charles Darwin University, where she teaches classes around diversity, disability and inclusion. **Suzanne C. Hopf** is an Australian speech-language pathologist that lives in the Republic of Fiji. Suzanne's PhD describes typical Fijian children's speech, language and literacy development, and how Fijians support children and adults with communication and swallowing disabilities.

Building collaboration

A participatory research initiative with Vietnam's first speech-language pathologists

Marie Atherton, Bronwyn Davidson, and Lindy McAllister

KEYWORDS
COLLABORATION
PARTICIPATORY ACTION RESEARCH
SPEECH-LANGUAGE PATHOLOGY
VIETNAM

THIS ARTICLE HAS BEEN PEER-REVIEWED

Marie Atherton (top), Bronwyn Davidson (centre), and Lindy McAllister

A group of Vietnam's first speech-language pathology graduates and the primary author, an Australian speech-language pathologist, are participating as co-researchers in an exploration of the emerging practice of speech-language pathology in Vietnam. This paper details the initial phases of this collaborative research program. A description of the research methodology and the rationale for utilising participatory action research are provided. Initial learnings from the research, including those relating to the vital role of the interpreter; challenges in developing a shared understanding of collaboration in research; and the impact of distance and technology are described. Speech-language pathologists from minority world contexts are encouraged to consider how they might develop partnerships with international colleagues to support collaborative initiatives to progress the practice of speech-language pathology in underserved communities.

Participatory action research (PAR) is an umbrella term for a heterogeneous group of research practices in which researchers and "the researched" work together to examine a situation (or problem) and identify strategies and actions to change the situation for the better (Kemmis, McTaggart & Nixon, 2013; Kingdon, Pain, & Kesby, 2007). PAR is situated within the genre of *action research*, a research approach credited to Kurt Lewin, a social psychologist, who demonstrated the benefit of workers participating in research that would inform decisions impacting their work (Lewin, 1946, as cited in Adelman, 1993). In the latter half of the twentieth century, Brazilian educator Paulo Freire further developed the concept of participation and collaboration in research by arguing that through participation in decisions regarding their lives, every person, regardless of the level of their impoverishment or disempowerment, could be empowered to make changes in their lives for the better (Friere, 1970). Critical to Friere's position was the value of conducting research *with* (not on) people as a means of creating and sharing new knowledge, and developing new insights into practices, situations, and processes that could be improved (Chaiklin, 2011).

PAR is considered a methodology in its own right rather than a set of research methods (Liamputtong, 2008). Through iterative cycles of reflecting, planning, engaging in action, and reflecting upon the outcomes/consequences of actions undertaken (Figure 1), researchers and those impacted by a problem develop new insights into the problem and how it might best be addressed. Findings from each cycle of the action spiral are fed into the next, with the overall aim being the identification of actions that effect positive practical change in relation to the issue of concern (Kemmis et al., 2013).

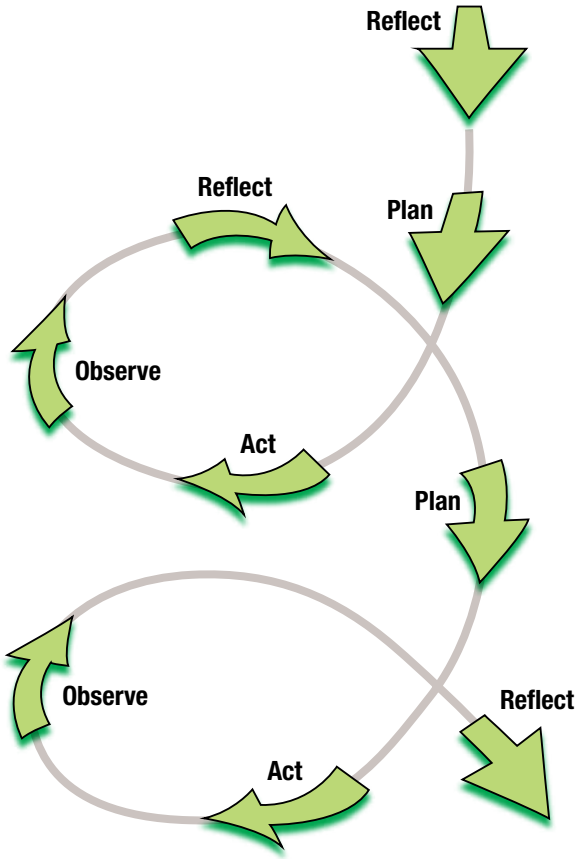

Figure 1. Action research cycles. Retrieved from http://cei.ust.hk/teaching-resources/action-research. Copyright 2010–2016 by Centre for Education Innovation, HKUST. Reprinted with permission.

PAR has been used in numerous contexts including human development, education, organisational change, and health (Kapoor & Jordan, 2009; Koch & Kralik, 2009). It has also been extensively used in cross-cultural contexts (Evans, Hole, Berg, Hutchinson, & Sookraj, 2009; Kramer-Roy, 2015; Pavlish, 2005). The utility of PAR to the practice of speech-language pathology (SLP) has also been described (Hersh, 2014; Hinckley, Boyle, Lombard, & Bartels-Tobin, 2014). Westby and Hwa-Froelich (2003) highlight the relevance of PAR to the development of culturally appropriate and context-specific SLP programs and services in majority world[1] countries, and offer recommendations for the conduct of PAR in international contexts. In an exploration of friendship and the experiences of persons with aphasia, PAR supported the development of tools to assist persons with aphasia communicate about friendship (Pound, 2013). The utility of collaborative research has also been described in relation to the care of persons with communication problems resulting from dementia (Müller & Guendouzi, 2009).

The use of participatory action research in the current research

This paper describes the application and evaluation of PAR as a methodology for exploring the practice of the emerging SLP profession in Vietnam. PAR in Vietnam has previously examined a range of social and community issues including stigma associated with HIV, gender-based violence, professional development needs of nurses, and public health and social services in rural Vietnam (Gaudine, Gien, Thuan, & Dung, 2009; Gien et al. 2007). To the authors' knowledge this is the first report describing PAR within the context of the SLP profession in Vietnam.

In September 2012, 18 Vietnamese students with undergraduate degrees in health-related professions (e.g., physiotherapy, medicine, nursing) graduated from a two-year postgraduate speech therapy training program at Pham Ngoc Thach University of Medicine (PNTU), in Ho Chi Minh City (HCMC), Vietnam, thereby becoming Vietnam's first locally trained speech-language pathologists qualified to work across the full scope of SLP practice.[2] The primary author was the coordinator of the 2010–12 PNTU SLP program and resided in HCMC. Upon returning to Australia, she remained in contact with the graduates and saw the conduct of research as one means of supporting their practice. The primary author was cognisant of a disparity in power between herself and the PNTU SLP graduates, and the potential for this to influence the authenticity of the research findings (Atherton, Davidson, & McAllister, 2016). As such, the active participation of the graduates in the research was considered crucial to enhancing the authenticity of data collection and analysis (Gaillard, 1994). Engaging in PAR would create the opportunity for the "voices" (Maguire, 2001) of the SLP graduates to be heard, for the research to be guided by *their* experiences and priorities rather than by preconceived notions the primary author may have had about the context of their work. Further, participation of the primary author and graduates as co-researchers would support the mutual development of research skills and the reporting of research outcomes. It was also hoped that opportunity would be created between the researcher and graduates for future research collaboration.

Context of the research

This collaborative research initiative forms part of a broader PhD research program undertaken by the primary author exploring the professional practice of Vietnam's first university qualified speech-language pathologists. It is not the intent of this paper to detail the emergence of the SLP profession in Vietnam (for further information see Atherton et al., 2016; Atherton, Dung, & Nhân, 2013; McAllister et al., 2013). Rather, this phase of the primary author's PhD research program sought to: (a) identify the nature of the SLP graduates' professional practice at 24 months following graduation (to be reported in a separate paper), and (b) introduce PAR as a means of identifying perceived barriers to the graduates' work. It was anticipated that completion of this phase of the research program would inform future collaborative research cycles in which avenues to address the perceived barriers to the graduates' practice could be trialled.

Participants

Acknowledging the Vietnamese graduates as best placed to describe the context in which they work and identify factors impacting their practice, the primary author travelled to HCMC, Vietnam in June 2014 to establish an "Advisory Group" (later named the "Participatory Research Group" [PRG]) comprising graduates from the 2010–12 PNTU SLP Training Program to advise the PhD research program over the next 24–30 months. Advisory groups have been previously described as strengthening the authenticity and validity of research-generated knowledge and enhancing the significance of research outcomes (Pound, 2013). Expressions of interest were sought from the18 SLP graduates to participate in individual interviews with the primary author and to participate as members of the PRG. Ethics approval was obtained for this study through the University of Melbourne, Behavioural and Social Sciences Human Ethics Committee.

Eight of the 18 graduates consented to participate in the research. All eight PRG members live and work in HCMC, and are typical of the 2010–12 cohort of SLP graduates in that they work predominantly within the acute public health system (one PRG member works in the disability sector). Caseloads are varied and include both adults and children with communication and swallowing disabilities.

Outcomes of collaboration

Three "cycles" of collaborative research were completed in 2014 (see Table 1) during which PRG members engaged in reflection upon their current professional practices and commenced the planning of actions to support their work. Key research concepts such as "reflection", "collaboration" and "participation" were discussed, and the initial research priorities of the PRG identified. Data was in the form of digital audio-recordings of interviews and meetings, transcripts of the English translation of the audio-recordings and meeting minutes, email correspondence, and the primary author's field notes and reflective diary. Pseudonyms replaced the names of the participants and interpreters as a means of de-identification.

The three cycles of this phase of the research program and the challenges conducting PAR in this context will now be described.

Cycle 1. Setting the scene

Cycle 1 involved individual interviews with the eight research participants and the formation of the PRG. Ms Mai, a Vietnamese interpreter well known to the participants and with knowledge of SLP practice, provided a summary of what was being said (consecutive interpretation) rather than a word-for-word translation (simultaneous interpretation), thereby avoiding potential for disruption to the dialogue

Table 1. Summary of participatory research cycles in 2014

Cycles of research 2014	Meetings	Data sources	Present
1. July 2014 Face-to-face meetings in Ho Chi Minh City, Vietnam	x8 semi-structured individual interviews Inaugural meeting of the PRG	Digital audio-recordings of interviews and meetings Transcripts of individual interviews & meeting minutes Email communication Field notes Reflective diary	Members of the PRG Primary researcher Experienced interpreter
2. July–October 2014 Skype meetings	x5 Skype meetings of the PRG		
3. October–November 2014 Face-to-face meetings in Ho Chi Minh City, Vietnam	x2 meetings of the PRG		

Figure 2. The inaugural meeting of the participatory research group

(Chen & Boore, 2010). The interviews were important for several reasons. First, the development of relationships, trust of the primary researcher, and a sense of safety in the research process are acknowledged as critical to research that seeks to be genuinely collaborative (Australian Council for International Development, 2016; Maiter, Simich, Jacobson, & Wise, 2008). The interviews provided opportunity for the researcher and the participants to re-establish their relationship. Second, preparation for collaborative research requires co-researchers to develop an understanding of the proposed research focus, methodology, anticipated time commitment, and timelines for the research (Kidd & Kral, 2005). Again, the interviews provided opportunity for the research participants to discuss these issues in detail prior to committing to the research. Third, it was anticipated that analysis of the interview transcripts would highlight themes characterising the evolving practice of the participants. The content of these interviews would also draw attention to the graduates' perceptions of opportunities and challenges to their practice, and their professional priorities for the following 12 months. This information would inform the initial discussions of the PRG and provide a focus for the future research.

The inaugural meeting of the PRG took place in HCMC, Vietnam on the 4 July 2014. The eight SLP graduates, Ms Mai (the interpreter) and the primary author were present. All PRG members consented to be photographed and for the photograph to be published (Figure 2).

The inaugural meeting of the PRG provided opportunity for the primary author and PRG members to meet for the first time as co-researchers and commence discussions as to the PRG's participation in the research. The overall aims of the research program were described, as were its stages and timeframe for completion. Initial discussion also focused upon research methodologies, including how quantitative and qualitative research differed, and where collaborative and PAR methodology was situated within the quantitative–qualitative paradigm. As commented by Mr Duc:

> *So usually when you do quantitative research you collect data, you analyse data, and then you have recommendations for the next stage. But I haven't done any qualitative research like this before, so I want to know whether it's the same … like stages. And you also do it in stages, so when you finish one stage you have recommendations … and prepare for the next stage?*

The primary author described PAR methodology as encompassing a range of research methods, from which focus of the conversation shifted to the legitimacy of qualitative research: "I don't know about other professions, but in the medical field usually people, they might not like to use it, do not really like to use qualitative … but in public health qualitative is accepted" (Mr Duc).

The PRG also sought to address a number of "logistical issues" such as the selection of a leader for the PRG, and the settings of "ground rules", including the number of PRG members required for a quorum, how confidentiality of group discussions would be maintained, the allocation of minute taking, and a "participation" rule:

> *There should be a rule like that, [to avoid a situation in which] one or two team members will talk about their opinions and everyone else will sit and quiet listening, and when the group comes to an agreement it looks like the ideas are just from one or two members. So I think we should have like a participation rule that the members who attend the meeting, all should participate in discussions.* (Mr An)

At the meeting's conclusion, a suggestion to progress the research via a live video calling program (Skype) was agreed to – PRG members were keen to trial communication options that would facilitate ongoing audio-visual interaction and collaboration with the primary author on her return to Australia.

The opportunity to discuss the research methodology afforded a number of key insights. The primary author had

assumed that given the undergraduate and postgraduate education completed by PRG members, there would be familiarity with both quantitative and qualitative research methodologies. This was not the case, and highlighted the importance of avoiding assumptions about the skills and knowledge of research partners. Further, discussion of the methodology drew attention to the importance of reviewing concepts through group dialogue in which mutual understanding might best be achieved.

The issue of ownership and future authorship of the project also arose at this meeting, and at later meetings of the PRG. The primary author was cognisant that the collaborative and participatory nature of the research created tension with the notion of a PhD research program being independent work, and thus raised this issue for discussion with the PRG. Further, PRG members voiced interest in joint authorship of publications arising from the research. Bournot-Trites and Belanger (2005) advise that issues of authority and ownership of research be resolved in advance of a study, and to this end, it was important that the primary author and PRG engage in conversation to address these issues.

The relevance of supporting group processes was also highlighted. Even at this early stage in the research, group interactions and practices were reflecting aspects of collaboration, and PRG members were drawing the focus to *their* priorities, including developing and supporting group cohesion and functioning. A number of authors have described the influence of sociocultural differences upon group interaction, patterns of participation, and perceptions of time upon cross-cultural research (Apentiik & Parpart, 2006; Laverack & Brown, 2003). As discussed by Liamputtong (2008), for research to be culturally sensitive "researchers must have a thorough understanding and knowledge of the culture, which includes extensive knowledge of social, familial, cultural, religious, historical and political backgrounds" (p. 4), and must work actively and consistently to ensure customs and cultural norms are respected and incorporated into research initiatives.

Cycle 2. The tyranny of distance

The second cycle of the research commenced on the primary author's return to Australia and comprised five Skype meetings at which the professional priorities of the PRG members were explored. To participate via Skype, PRG members sourced public venues with internet access. These were typically cafés, though on one occasion the PRG had convened in a hotel room, to the surprise of the primary author! While intended to support audio-visual communication between the PRG and the primary author, the internet connection for these meetings was often unreliable, resulting in generally poor visual and sound quality, audio delay, and signal drop out. Further, the many competing demands of PRG members resulted in some members not attending meetings and/or meetings commencing at a later time than planned (Table 2).

Despite these challenges, important outcomes were achieved from this cycle of research. After extended and at times animated group discussion in which the primary author acted as facilitator, the initial focus of the research was agreed to:

> *So the group discussed and they think they will do … that professional development is the priority. The group is thinking they want to do ongoing professional development … perhaps they will think of things that they can do themselves, or [they] can do in Vietnam to develop their profession, to develop their expertise, … and also they will identity the things they might need help [with] from Australia or from other organisations.* (Ms Mai summarising)

Methods and actions to examine this issue were also discussed:

> *Perhaps we are going to have a questionnaire to send to both groups [2012 and 2014 PNTU SLP graduates] to ask them four to five questions about what they are comfortable working with and what they are not comfortable working with to find out strengths and weaknesses of each graduate working in speech therapy.* (Ms Giang)

> *What are the graduates' abilities to provide assessment/treatment for patients? This could be found out by interviewing graduates about their workload – what do they think about their work, what they feel comfortable with, areas they do not have confidence in? When we interview the graduates of both groups we will find out what their challenges are in relation to their practice.* (Ms Bich)

It was also agreed that due to the unreliability of the internet connection, email communication would be increasingly used to support communication between PRG members and the primary author. Members of the PRG also indicated that given work and other obligations,

Table 2: Summary of Skype meetings in 2014

2014 Skype meetings	Number of PRG members present /8	Duration of meeting	Notes
1	6	70 minutes	Fair internet connection, intermittent picture & sound; delayed arrival of one PRG member.
2	6	90 minutes	Fair internet connection, intermittent picture & sound; delayed arrival of 2 PRG members.
3	6	60 minutes	Loss of Skype connection on several occasions - Instant messaging utilised during these periods; delayed arrival of 3 PRG members.
4	5	30 minutes	Poor internet connection - Instant messaging via Skype.
5	6	20 minutes	Poor internet connection - Instant messaging via Skype; delayed arrival of 2 PRG members.

communication via email would offer more flexibility in terms of their participation.

Momentum for the research slowed at this point. Sporadic email communication and the need for all communication to be translated influenced the frequency of contact. PRG members described their increasing workloads and other demands associated with their roles as "pioneers" of the SLP profession (e.g., training of staff in SLP) as influencing their ability to engage in the research. At least one member of the PRG commenced providing SLP services in a private capacity outside normal work hours.

A further issue arising was the introduction of Ms Tran to replace Ms Mai as interpreter. Notes from the primary author's reflective diary highlight to concerns as to how the research might be impacted, not only in terms of the quality of the interpretation and translation, but also with regard to group dynamics, interaction and collaboration (Figure 3).

> I am wondering how the introduction of Ms Tran to the research will play out this evening. Ms Mai was part of the research from its inception and familiar with the PRG and with the research plan, so introducing someone new may change dynamics. ??impact on collaboration
>
> A positive note – Ms Tran has been undertaking translation of resources for the PRG meeting … so hopefully an understanding of methodology and concepts – will need to follow this up.
>
> Am also wondering whether the difficulties with internet connection may deter Ms Tran from wanting to be involved in the research.
>
> (Dated 18 September 2014)

Figure 3. Notes from primary author's reflective diary

The use of Skype for real-time collaboration had been considered an ideal vehicle through which the active and participatory nature of the research could be supported. However, detailed planning, including consideration of "a second plan of attack", proved necessary when seeking to incorporate technology such as Skype into a setting where internet connection was unreliable. In addition, the demands arising from the role of members of the PRG as "pioneers" of the profession and increasing workloads, including the expansion of the profession into the private sector, were significant and had not been anticipated. The "tyranny of distance" was never more evident than during this cycle of the research, and facilitated key learnings with regard to the impact of technology, the increasing profile of the profession in Vietnam, and of the influence of local context upon the research.

Cycle 3. Revisiting collaboration

The third cycle of research collaboration was via two face-to-face meetings between the primary author and PRG in HCMC in October–November 2014. These meetings were important in re-establishing open and extended dialogue regarding the research, and supporting re-engagement of members of the PRG who had not maintained communication via email. The face-to-face meetings also provided opportunity for the primary author and the new interpreter to meet in person.

Revisiting the key research concepts of "reflection" and "collaboration" was another important outcome from this cycle of the research. The excerpt below is taken from the transcript of the English translation of a meeting in which the key concept of "reflection" is explored:

> *In the research, "reflect" means to think about your practice as speech therapists[3], and about the main issues you might wish to investigate further. Ms Tran, "reflect" in Vietnamese, how would you translate that?* (Primary author).
>
> [Ms Tran confers with PRG members]
>
> *I gave out to the group a translation that I think kind of pretty much covers the idea of "reflect" and I am asking to see what they think.* (Ms Tran)
>
> *It is similar to "reflect" in English….* (Ms Bich)
>
> *It means it's like a process of thinking back, and then speak out what you think.* (Ms Giang)
>
> [Further discussion between PRG members]
>
> *They are saying there is not a direct translation for "reflect". It is a very common thing to do in the West. And back when they were doing the course [PNTU Speech Therapy Training Program], the teachers, the lecturers were constantly asking them to reflect every time they write the report, every time they say something. The translation I gave out doesn't really cover the entire meaning of it.* (Ms Tran)

It is not within the scope of this paper to discuss the technical aspects or complexities of translation and interpretation in cross-cultural research (for further information see Squires, 2009; Temple & Young, 2004; Wong & Poon, 2010). However, the time spent revisiting key research concepts proved critical to heightening the understanding of the researcher, members of the PRG and the interpreter to the influence of language and culture upon the research. In particular, it was during these discussions that the primary author's assumption of concept equivalence between languages was challenged. The concepts of "reflection" and "collaboration" were identified by the interpreter and PRG as having different meanings in English and Vietnamese. Further, while the interpreter and members of the PRG are all Vietnamese, their individual interpretation of these concepts varied. Caretta (2015) and Turner (2010) draw attention to this latter issue, arguing that the gender, personal experiences, cultural influences, preconceptions, and belief systems of those involved in the research will influence the intended meaning of a concept, how individuals interpret the meaning of a concept, and how this meaning is communicated. Such insights highlighted how critical it is for all members of a research team to engage in dialogue as a means of facilitating mutual understanding of research principles, concepts and objectives.

Cycle 3 of the research also provided opportunity to consider how the research might progress into the future. The excerpt below, taken from the transcript of the English translation of one of the meetings, highlights PRG members' uncertainty as to the future direction of the research and its anticipated outcomes:

> *What is the project aiming to obtain? We know we want to identify our needs in professional development but are there any other aims?* (Ms Bich)
>
> *When we do this project, how do we measure its success?* (Mr Jach)

PAR has been described as a "messy process" (Primavera & Brodsky, 2004), requiring participants to not only conduct the research, but to learn from it and adapt as it progresses. The face-to-face meetings were a vehicle through which to address some of this uncertainty, and aimed to assist PRG members become more comfortable about this "messiness". At one of these meetings, the PRG developed their own representation of this research process, which they described as "The fish skeleton" (Figure 4):

> *So it [the research] is like a fish bone, a fish skeleton. So there are different problems and different reasons… they are the fish bones. The first one is overload [in work], not enough knowledge [referring to fish bone number two]. There are many problems and many reasons and we will look at that to prioritise which ones, and then we come up with solutions. And then which solution will resolve number one, number two, number three…* (Ms Tran summarising)
>
> *So you might come up with a solution for a problem and try it out to see if it works?* (Primary author)
>
> [Discussion between PRG members]
>
> *Yes. So they [the PRG] think "participants" defines it very well what they are doing. Because they are participating, they are the ones that come up with these and these and these [referring to the numbered fish bones], and prioritise these and come up with a solution. And you are just supporting them.* (Ms Tran summarising)

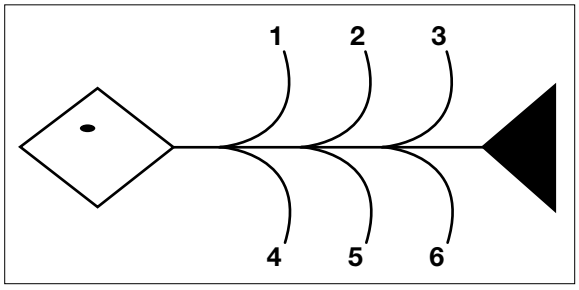

Figure 4. The fish skeleton

It was within these discussions that the title of the PRG was raised. The primary author had previously proposed that the PRG be referred to as the "Advisory Group". However the group indicated that this was not a suitable term. As summarised by Ms Tran:

> *For research, "advisory group" is not something that exists in the Vietnamese research. If you do the literal translation of advisory group, this means that people are higher than you are, telling you/advising you what to do, so that's not right in the Vietnamese context. They [PRG members] say they are part of the research, they are participating. So that describes the role very well.*

The term "participants" was agreed to and the term Participatory Research Group (PRG) adopted.

Another important outcome from this cycle of the research was discussion pertaining to issues of ethics in international research (for further detail regarding ethical considerations in international research, see Australian Council for International Development, 2016). Several of the PRG members reported their workplace directors had requested information about the role of PRG members in the research. PRG members sought reassurance from the primary author that their workplaces would not be identified in the research, nor would the research require the participation of clients receiving their services. The criticality of maintaining the confidentiality of research participants and of discussing with research participants how their engagement in the research may impact them was highlighted here. Further, in international contexts, language and cultural differences have the potential to impact understanding of research proposals and outcomes even when presented in participants' primary language (Brydon, 2006). A critical role for the PRG was highlighted here as members guided the primary author through this process so as to ensure safety in the conduct of the research.

Conclusion

This paper has described three cycles of one phase of a cross-cultural project in which participatory research methodology is being used to support international research in a majority world context. Interviews occurred at 24 months post-graduation to identify the nature of the graduates' professional practice, a PRG was established to guide the future research, and exploration of professional issues the PRG wished to investigate further was commenced. The engagement of the SLP graduates and primary author as co-researchers facilitated mutual learnings. The vital role of the interpreter as a member of the research team, the importance of repeated discussion of concepts to clarify understanding, and the impact of technology and local context upon communication and collaboration have been identified. The criticality of establishing open communication was highlighted in discussion of ethics and safety in research. Speech-language pathologists seeking to support service development in underserved and/or majority world contexts are encouraged to forge partnerships with international colleagues that arise from collaboration and support mutual learnings, for it will be within these contexts that initiatives may best meet the unique needs of culture and context. The next cycles in this research are evolving; and, it is anticipated that further inquiry into the barriers to the professional practice of SLP in Vietnam and actions to support this practice will follow. Opportunity will also be afforded for ongoing exploration of the dynamic of collaboration between the members of the PRG and primary author within a cross-cultural context.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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1 The terms "minority world" and "majority world" are frequently used in the literature to replace phrases such as developed/ underdeveloped countries, North/South, First World/Third World countries, industrialised/ emerging nations.

2 A further 15 students graduated in 2014.

3 In Vietnam, the profession of SLP is known as speech therapy.

References

Adelman, C. (1993). Kurt Lewin and the origins of action research. *Educational Action Research*, *1*(1), 7–24. doi:10.1080/0965079930010102

Apentiik, C., & Parpart, J. (2006). Working in different cultures: Issues of race, ethnicity and identity. In D. Vandana & R. Potter (Eds.), *Doing development research* (pp. 34–43). London, UK: Sage.

Australian Council for International Development. (2016). *Principles and guidelines for ethical research and evaluation in development*. Retrieved from https://acfid.asn.au/sites/site.acfid/files/resource_document/Principles-for-Ethical-Research-and-Evaluation-in-Development2016.pdf

Atherton, M., Davidson, B., & McAllister, L. (2016). Exploring the emerging profession of speech-language pathology in Vietnam through pioneering eyes. *International Journal of Speech-Language Pathology*. Advance online publication. doi:10.3109/17549507.2016.1159335

Atherton, M., Dung, N.T.N., & Nhân, V.H. (2013). The World Report on Disability in relation to the development of speech-language pathology in Viet Nam. *International Journal of Speech-Language Pathology*, *15*(1), 42–47. doi:10.3109/17549507.2012.743034

Bournot-Trites, M., & Belanger, J. (2005). Ethical dilemmas facing action researchers. *The Journal of Educational Thought*, *39*(2), 197–215.

Brydon, L. (2006). Ethical practices in doing development research. In D. Vandana, & R. Potter (Eds.), *Doing development research* (pp. 25–33). London, UK: Sage.

Caretta, M. (2015). Situated knowledge in cross-language research: A collaborative reflexive analysis of researcher, assistant and participant subjectivities. *Qualitative Research*, *15*(4), 489–505.

Chaiklin, S. (2011). Social scientific research and societal practice: Action research and cultural-historical research in methodological light from Kurt Lewin and Lev S. Vygotsky. *Mind, Culture and Activity*, *18*(2), 129–147. doi:10.1080/10749039.2010.513752

Chen, H., & Boore, J. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1–2), 234–239. doi:10.1111/j.1365-2702.2009.02896.x

Evans, M., Hole, R., Berg, L. D., Hutchinson, P., & Sookraj, D. (2009). Common insights, differing methodologies: Toward a fusion of indigenous methodologies, participatory action research, and white studies in an urban aboriginal research agenda. *Qualitative Inquiry*, *15*(5), 893–910.

Friere, P. (1970). *Pedagogy of the oppressed*. New York, NY: Herder and Herder.

Gaillard, J. F. (1994). North–south research partnership: Is collaboration possible between unequal partners? *Knowledge and Policy*, *7*(2), 31–63.

Gaudine, A., Gien, L., Thuan, T., & Dung, D. (2009). Developing culturally sensitive interventions for Vietnamese health issues: An action research approach. *Nursing and Health Sciences*, *11*(2), 150–153.

Gien, L., Taylor, S., Barter, K., Tiep, N., Mai, B.X., & Lan, N.T. (2007). Poverty reduction by improving health and social services in Vietnam. *Nursing and Health Sciences*, *9*, 304–309

Hersh, D. (2014). Participants, researchers and participatory research. *Journal of Clinical Practice in Speech-Language Pathology*, *16*(3), 123–126.

Hinckley, J., Boyle, E., Lombard, D., & Bartels-Tobin, L. (2014). Towards a consumer-informed research agenda for aphasia: Preliminary work. *Disability and Rehabilitation*, *36*(12), 1042–1050. doi: 10.3109/09638288.2013.829528

Kapoor, D., & Jordan, S. (2009). *Education, participatory action research and social change*. New York, NY: Palgrave Macmillan.

Kemmis, S., McTaggart, R., & Nixon, R. (2013). *The action research planner: Doing critical participatory action research*. Singapore: Springer Science & Business Media.

Kidd, S., & Kral, M. (2005). Practicing participatory action research. *Journal of Counseling Psychology*, *52*(2), 187–195.

Kingdon, S., Pain, R., & Kesby, M. (2007). *Participatory action research approaches and methods*. *Connecting people, participation and place*. Abingdon-on-Thames, UK: Routledge.

Koch, T., & Kralik, D. (2009). *Participatory action research in health care*. Oxford, UK: Blackwell Publishing Ltd.

Kramer-Roy, D. (2015). Using participatory and creative methods to facilitate emancipatory research with people facing multiple disadvantage: A role for health and care professionals. *Disability & Society*, *30*(8), 1207–1224. doi:10.1080/09687599.2015.1090955

Laverack, G., & Brown, K. (2003). Qualitative research in a cross-cultural context: Fijian experiences. *Qualitative Health Research*, *13*(3), 333–342. doi:10.1177/1049732302250129

Liamputtong, P. (Ed.). (2008). *Doing cross-cultural research: Ethical and methodological perspectives*. Dordrecht, Netherlands: Springer.

Maiter, S., Simich, L., Jacobson, N., & Wise, J. (2008). Reciprocity an ethic for community-based participatory action research. *Action Research*, *6*(3), 305–325. doi:19.1177/1476750307083720

Maguire, P. (2001). Uneven ground: Feminisms and action research. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (pp. 59–69). London, UK: Sage.

McAllister, L., Woodward, S., Atherton, M., Dung, N., Potvin, C., Huynh, B.,…Khanh, D. (2013). Vietnam's first qualified speech therapists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech- Language Pathology*, *15*(2), 75–79.

Müller, N., & Guendouzi, J. (2009). Discourses of dementia: A call for an ethnographic, action research approach to care in linguistically and culturally diverse environments. *Seminars in Speech and Language*, *30*(3), 198–206. doi:10.1055/s-0029-1225956

Pavlish, C. (2005). Refugee women's health: Collaborative inquiry with refugee women in Rwanda. *Health Care for Women International*, *26*(10), 880–896. doi:10.1080/07399330500301697

Pound, C. (2013). *An exploration of the friendship experiences of working-age adults with aphasia*. (Unpublished doctoral dissertation). Brunel University, UK.

Primavera, J., & Brodsky, A. (2004). Introduction to the special issue on the process of community research and action. *American Journal of Community Psychology*, *33*(3), 177–179. doi:10.1023/b:ajcp.0000027213.18639.30

Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies*, *46*(2), 277–287. doi:10.1016/j.ijnurstu.2008.08.006

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, *4*(2), 161–178. doi:10.1177/1468794104044430

Turner, S. (2010). Research note. The silenced assistant: Reflections of invisible interpreters and research assistants. *Asia Pacific Viewpoint*, *51*(2), 206–219.

Westby, C., & Hwa-Froelich, D. (2003). Considerations in participatory action research when working cross-culturally. *Folia Phoniatrica et Logopaedica*, *55*(6), 300–305. doi:10.1159/000073253

Wong, J., & Poon, M. (2010). Bringing translation out of the shadows: Translation as an issue of methodological significance in cross-cultural qualitative research. *Journal of Transcultural Nursing*, *21*(2), 151–158. doi:10.1177/1043659609357637

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Sustainable partnerships for communication disability rehabilitation in majority world countries

A message from the inside

Karen Wylie, Clement Amponsah, Josephine Ohenewa Bampoe, and Nana Akua Owusu

KEYWORDS
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THIS ARTICLE HAS BEEN PEER-REVIEWED

Karen Wylie (top) and Clement Amponsah

Rehabilitation services for people with communication disabilities (PWCD) in many majority-world countries are extremely limited, with speech-language pathology little known. Collaborations between clinicians and services in majority- and minority-world countries provide important contributions to developing rehabilitation services in the majority world for PWCD. The effectiveness of such partnerships may be influenced by a number of elements within the relationship. This paper presents insights from a group of majority-world speech-language pathologists (SLPs) in Ghana on establishing and maintaining links between majority- and minority-world services and clinicians. The framework of three sustainability dimensions (service environment, socio-cultural-political environment, and economic environment) is used to consider how SLP relationships across majority–minority worlds can be meaningful and lasting. Readers are encouraged to adopt the perspective of SLPs from within the country to consider the impact and sustainability of majority–minority world partnerships.

Globalisation and technological innovation has made linking with people from different geographical regions more possible than at any other time in history (Friedman, 2006). For service providers and people with communication disabilities (PWCD) in countries of the majority world, where services for communication disability are often extremely limited, it frequently means establishing relationships beyond their borders to assist with service provision, service development and improvement in quality. This article presents an insiders' perspective and discussion on relationships between clinicians and services across minority- and majority-world countries based on personal experiences of working in Ghana. The aims are twofold: (a) to encourage readers to view majority–minority world relationships through the lens of clinicians in the majority world and (b) to offer a range of observations from the authors' perspectives as "insiders" on relationship development and sustainability. This paper is not intended to provide a road map of how such relationships should operate; however, it provides a perspective of some of the complexities in developing and sustaining relationships to support development of sustainable services for communication disability.

Reflexivity statement

The authors of this paper are four speech-language pathologists (SLPs) living and working in Ghana, West Africa. Three are Ghanaian nationals, who trained in the United Kingdom (UK). One is a long-term expatriate in the region, who has lived in Ghana for four years and in the region for thirteen years. Together we work at a government hospital offering clinical speech-language pathology services. We also work together at a university to establish a training program for speech-language pathology. One of our group also runs an NGO focusing on early intervention and support for children with communication difficulties. Our regular and varied contact with SLPs who wish to come to Ghana to assist in the development of communication disability services prompted the writing of this paper. We recognise that our perceptions of the insider–outsider relationships may differ from the perceptions of those who visit.

While Ghana is rich in history and culture, it is not yet endowed with well-established rehabilitation systems for people with disabilities. Furthermore, although our country is foresighted and has an inclusive education policy (Ministry of Education, 2013), awareness of disability rights is still developing and services to support people with communication disability (PWCD) are severely stretched, with few speech-language pathology or communication disability services available in the country. Building services/systems for the future and improving awareness of communication disabilities is the focus of our work.

Our context

Ghana is well recognised as a leading nation of West Africa in areas including governance and economic development. Ghana is a lower middle income country and is ranked at 140 on the United Nations Development Programme (UNDP) Human Development Index (UNDP, 2015). It has a population of 26.4 million (UNDP, 2015) and is a multiparty democracy. In 1957, Ghana was the first sub-Saharan African country to achieve independence from its former colonial ruler Britain. While English is the official language of Ghana, Ghana has a large number of languages and dialects in use, with an estimated 25 to 43 main languages (National Commission on Culture, 2006). Currently, the

authors are aware of six practising SLPs in Ghana. Half are Ghanaian nationals, all were trained outside of Ghana and all are based in the capital city. There are no free speech-language pathology (SLP) services in the country and the National Health Insurance Scheme does not subsidise speech-language pathology (National Health Insurance Scheme, 2016). Clients frequently report travelling for many hours to attend services.

As in many majority-world nations, people with communication difficulties (PWCD) in Ghana require development of a range of rehabilitation services and supports, of which SLP is only one element (Wickenden, 2013). There are a range of people working with PWCD who provide important contributions to rehabilitation. Teachers, teaching assistants, therapists, therapy/educational aides (known locally as facilitators), community-based rehabilitation (CBR) workers, nurses, carers and parents all provide important work in this arena and are indispensable in providing a network of services and support for PWCD.

While every majority-world country and context differs, there are frequently common themes associated with service provision challenges. Often, there is a small workforce, no SLP training programs (Fagan & Jacobs, 2009), little professional development, and limited training for CBR or mid-tier workers in communication disability (World Bank & World Health Organization, 2011). Where SLP services exist, payment is often required and insurance cover for SLP is extremely limited. The community may have limited awareness of communication disability (Wickenden, 2013) and differing beliefs about the causes of communication disability (Ndung'u & Kinyua, 2009).

The insider perspective

Individuals frequently view a shared experience in differing ways, particularly when their context and cultural backgrounds differ (Nixon et al., 2015). Alternative perspectives can result in tensions within relationships that are frequently unarticulated (Nixon et al. 2015). One aim of this paper is to encourage readers to attempt to view visiting partnerships through the lens of an 'insider" – someone who may be there before minority-world SLPs arrive, support them during their work, then continues on after they leave – to enable more critical reflection of sustainable relationships.

To reflect on issues around partnerships for sustainable service development using an insider perspective, we encourage readers to consider a fictional vignette (Box A). This example offers the chance to reflect on some of the many issues that are present when an "outsider" visits a local service. Navigating relationships between services or clinicians in the majority and minority worlds can be complex, yet undoubtedly globalisation has resulted in dramatically more opportunities for collaboration (Friedman, 2006). With this edition of the journal focused on the theme "Minority-world SLPs in majority-world contexts", it is important to reflect on what contributes to effective partnerships between majority- and minority-world services.

How can minority-world SLPs assist development of sustainable services for PWCD in majority-world countries?

In the spirit of a local proverb in Akan "Nyansa nne eti kromu" [translation: *Wisdom is not the preserve of one*

Box A: Turning the tables: Insiders and outsiders – an example

Imagine that you are one of two SLPs and two assistants working in a government clinic in remote Australia. Budget cuts mean equipment is dated or non-existent. You offer services across a huge geographical area to a large population. A skilled and experienced speech-language pathologist from a well-resourced service in Africa offers to volunteer for 3 months. As services are stretched to the limit in your clinic, you are excited to have someone to help you improve services. In the weeks prior to arrival, you exchange emails and Skype calls. You help him/her to organise accommodation. You advise on transport, safety, the weather, the health system, and you collect the volunteer from the airport.

Your new colleague is generous in sharing their knowledge. Your service enhances training and expands clinical services. You are working on interesting projects and feel inspired by the rich clinical discussions. But there are challenges. The visiting practitioner struggles to understand how things happen in your context and seems to have an agenda for what is required, which doesn't match your view of the need. Given the visitor is more experienced, volunteering their time, and contributing resources, it is hard to argue. At a service level, there are small issues. The visiting practitioner has trouble with the language, so cannot work independently. Clients often don't understand what he/she means when explaining things, but are too polite to mention it. There are awkward moments – such as when the visiting practitioner tells clients to focus on giving instructions to their children rather than engaging in reciprocal play, or hints that the type of therapy you are offering may not be best practice. The visiting practitioner doesn't know how to do the things that are considered important in your context (e.g., making sure certain families have transport money or helping to find a school that will take their child). You understand that it is simply a difference to how things are done in Africa.

The visiting practitioner helps to train the assistants in a particular type of therapy. Everyone is excited about skill development. It is wonderful to make the connection, but all the things you need to organise for the visitor are added on top of your usual workload. The visiting practitioner returns to Africa and you are back juggling the demands of service provision to desperate clients, and the many other needs (e.g., awareness raising, training others, special projects to improve services, prevention work, and trying to build a profession). The visiting practitioner stays in touch for some months and sends some invaluable resources. The assistants need further support in adapting their new programs to the culture, and you struggle to support them and maintain your other work. After two months, another NGO from Africa offers to assist in the development of autism services and would like your involvement. You feel like you are still playing catch-up with your usual work. What is your response?

Josephine Ohenewa Bampoe (top), and Nana Akua Owusu

individual], we offer our own perspectives on how minority-world SLPs can best assist those in the majority world to develop sustainable services. Based on our experience of collaborations with minority-world stakeholders, we considered the question, "What do we believe is best practice for minority world SLPs to do, discuss or consider when visiting Ghana to assist in sustainable service development?"

Factors around sustainability are key to discussion of how minority-world SLPs can best assist those in the majority world to improve services for PWCD. Recently the United Nations (2015) adopted 17 sustainability goals for development. These goals address three commonly recognised dimensions of sustainable development: economic, environmental, and social and. In this paper we use these three sustainability dimensions to structure our views on partnerships between SLPs in minority- and majority-world countries. The following observations expressed are not intended to be exhaustive, but represent our observations from the field.

Economic sustainability factors

Economics

For sustainability, services need to be both economically viable and relevant to the needs of the population. Minority-world partners who seek understanding of the economic context, including factors such as service funding models, costs of services, service affordability, can make more informed choices about the nature of their involvement. Researching economic indicators and seeking information from majority-world partners can assist in understanding economic factors. For example, all SLP services in Ghana are fee paying, with costs varying enormously. Understanding the type of service you are partnering with, the types of clients who are able to access/afford the service, and the cost relative to other services can help give indications of the long-term sustainability and impact of partnering with a particular service.

Opportunity costs

Understanding the opportunity costs which may impact local counterparts (and which may not be immediately obvious) can assist in project planning and implementation. These factors may include:

1. How much money people attending training or therapy sacrifice due to loss of income, or indirect costs (such as transport) of meeting with you. Such costs can be significant when families are struggling to make ends meet.
2. Understanding of the time required by local service providers to plan for visits or projects, and what happens to existing, stretched services when additional time is needed to assist planned visits. That is, what do local staff stop doing to assist in organising international programs or visits? For example, past visiting programs in Ghana have taken a number of days of planning and organising. Due to the lack of administrative support, much of this time has been taken from clinical services. It is necessary to understand and weigh up the cost-benefit of such commitments.

Lobbying

Improvements in sustainability require developments in economic and social policy. Activism, for improvements to awareness, rights and services, forms a large part of disability engagement in majority world countries, including for SLPs (Wickenden, 2013). For minority world partners with higher level political influence, it is useful to consider if there is a strategic role to influence change in conjunction with majority-world partners. For example, in Ghana visiting minority-world partners have met with government officials or participated in media events in collaboration with the local team, assisting with the local agenda to build awareness of communication disability and lobbying for improved services. Such meetings are carefully planned as part of the partnership.

Environmental sustainability factors

Service environment

Investing time considering the wider service context when considering relationships and support in a majority-world country is prudent. Contacting a number of individuals or groups to ask questions about the range and types of services in the country (e.g., government, private and NGO services) provides a perspective of "the lay of the land", including population needs and how services are organised. For example, some independent SLP volunteers to Ghana have previously liaised with a range of services and clinicians to discuss the situation and need in Ghana, to determine how and when to partner with a particular organisation. Gaining such an overview of services and need in-country can assist visiting clinicians or organisations to determine where and how contributions to that country may be most beneficial. Such an approach also has the potential to increase communication between SLPs and organisations who may collaborate with them on projects during their visits.

Direct or indirect services

Working alongside a local partner will allow capacity building, enable the local partner to follow-up initiatives, and increase relevancy of services. Before providing direct clinical services, consider the relevance, appropriacy and sustainability of these services. Never offer direct clinical services alone, without planning how such services can be culturally relevant and sustained.

Professional networks

In Ghana, local SLPs routinely seek to engage with visiting minority-world SLPs. Creating these professional networks of practice is an effective way of building a knowledge and resource base in a country with limited services for communication disability. When visiting SLPs do not engage with other SLPs or providers in the country the potential to waste precious expertise and duplicate resources is increased.

Work environment

Attempt to understand the constraints of local staff, including SLPs. The reality of working in a majority-world country is often challenging, with huge clinical demands, low salaries, limited technology access (e.g., no reliable internet or work phone), underdeveloped systems, bureaucracy and sometimes unreliable basic services such as water and electricity. For example, in Ghana access to technology in government services is extremely limited. There is currently no internet access in the hospital speech-language pathology service and SLPs frequently use their own resources to contact international SLP colleagues. Limited access to technology can impact both finances (and therefore willingness to call/log on) and timeliness of responses for local staff which can sometimes be perceived negatively by minority-world partners. Projects with funding could consider limited support for the team to access appropriate resources.

Needs

In a context where services and resources are underdeveloped, there is always need for additional resources. Detailed discussions with local partners about needs and priorities are crucial to make sure resources brought in are high priority and relevant for use. For example, past majority-world visitors to Ghana have sent a list of items they are considering bringing, and we advised them which items are relevant and of high priority.

Socio-cultural-political sustainability factors

Transparency

Acknowledge motivations clearly as this sets the scene for the boundaries of the partnership. Engaging with SLP services in the majority world is done voluntarily and for a purpose with each partner benefitting from the relationship. Minority world SLP motivations may vary (e.g., travel, the chance to meet new people, international recognition, publications, recognition from your institution for developing international relationships, grant funding, service learning promoting cross-cultural competencies, or the opportunity to be regarded as "worldly" or "generous"). Stakeholders in majority-world countries benefit through improvements to services, funding, equipment or expertise. Transparent and open dialogue about motivations will enable partners in the majority world to understand the limitations of minority-world SLPs' involvement. For example, if SLP partners in Ghana understand that the motive of a visit includes positive publicity for your institution, they can plan local media engagements that may both meet this objective and build community awareness of local communication disability services.

Expertise

There are two types of expertise relevant to the practice of SLP in the majority world: (a) expertise in a particular clinical specialty, and (b) expertise in how to translate this knowledge to deliver culturally and contextually relevant services (Hyter, 2014; Pickering and McAllister, 2009) The second expertise is often referred to as "cultural competence" (Leadbeater & Litosseliti, 2014). However, when SLPs work outside situations with which they are familiar, cultural competence should be widened to include contextual competence. For example, an individual may be a clinical specialist in her or his home country, but face significant challenges translating that knowledge into practice in a different context where knowledge of local practices and services in the field of expertise is limited. SLP is a western profession (Pillay & Kathard, 2015), most often practised in contexts where there are networks of services for PWCD. Where the sociocultural context differs, consideration of the beliefs underpinning knowledge and practices of SLP services is important to begin to reframe practice (Hyter, 2014). This ensures services are "sustainable, culturally appropriate and nuanced" (Barrett & Marshall, 2013, p. 50). SLP practices in majority-world settings may differ from practices in the minority world, due to differing support systems, culture and population needs (Wickenden, 2013; Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003; Wylie, McAllister, Davidson, Marshall, & Law, 2014). Thus, working collaboratively with a local partner who can act as a cultural broker is vital. This should be someone who understands both the cultural context and understands the context of communication disability/SLP in that country and can assist in navigating the complex terrain.

Alternative support models

Historically, minority world SLPs' visits to Ghana have typically focused on supporting existing services and/or providing training. An alternative option is to support clinicians from the majority world to spend time in minority world services, and allow majority world clinicians to make judgements about adaptation of relevant practices or systems on return. This might include training sponsorships (Hutchins, 2015), or capacity-building partnerships grants (e.g., Department of Foreign Affairs and Trade, 2016; McAllister et al., 2013). For example, one Ghanaian clinician was recently sponsored to visit academic institutions in the UK to review processes for clinical education. This allowed the team member to view a range of programs and judge which processes may be best suited to the Ghanaian context

Priorities and mutual planning

The concept described by Hyter (2014) as cultural humility is an important start to creating an effective two-way dialogue and planning. Dialogue can help create an appropriate plan for potential placements or partnerships. Projects and desired outcomes need to be mutually negotiated, based on need, context, local resourcing with a high priority given to the expressed needs of the local partners. Self-determination is vital if developments are to be sustained in the long term. Just as SLPs from the minority world need to take time to build relationships and explore the needs and priorities of the majority world partners, majority world partners should work towards clarity and control regarding their priorities and needs. However, achieving such clarity and self-determination can be challenging due to subtle power dimensions in relationships (Sharpe & Dear, 2013). The subtle influences of neocolonialism frequently impact relationships when minority world SLPs engage in the majority world (Hickey, Archibald, McKenna, & Woods, 2012; Nixon et al., 2015). Recognition and acknowledgement of these power imbalances is part of successful collaborative engagement between majority- and minority-world SLPs.

Change and time

Change takes time and ongoing effort to anchor practices in the culture (Kotter, 1996). For sustainable development of services in majority world countries, long-lasting durable and evolving relationships count. One often-seen limitation of majority-minority world partnerships is the short-term nature of them. Partnerships that can be sustained over time offer potential to engender lasting change in systems, practices, and policy. While many SLPs visit majority-world countries with short-term objectives, lasting change may require a longer commitment. Advances in technology are opening windows for remote support – for example, the inclusion in professional development opportunities via videoconferencing platforms, or assistance with case reviews using smart phone video and audio technology.

Conclusion

It is not yet clear how sustainable and culturally appropriate services for communication disability will ultimately look in majority world countries. We are still learning how SLP can best contribute to the needs of PWCD in these varied contexts. Yet every engagement we have with SLPs from the minority world has the potential to shift the landscape. In this paper we have attempted to provide an insider perspective on minority-world – majority-world SLP engagement. We have offered our experiential view on

some of the factors that can contribute to effective engagement between minority-world and majority-world stakeholders in attempting to build sustainable services for PWCD. We believe that similar themes are likely to be evident in many majority-world countries where services and individuals from minority-world nations support development initiatives for majority-world countries. Effective partnerships between majority-world and minority-world stakeholders are crucial for development of services for PWCD. As insiders, we encourage those considering engagement in the majority world to strive for understanding across service, socio-cultural-political, and economic environments for effective partnerships.

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References

Barrett, H., & Marshall, J. (2013). Implementation of the World report on disability: Developing human resource capacity to meet the needs of people with communication disability in Uganda. *International Journal of Speech-Language Pathology*, *15*(1), 48–52. doi:10.3109/17549507.2012.743035

Department of Foreign Affairs and Trade. (2016). *Australia awards fellowships*. Retrieved from http://dfat.gov.au/people-to-people/australia-awards/Pages/australia-awards-fellowships.aspx

Fagan, J. J., & Jacobs, M. (2009). Survey of ENT services in Africa: need for a comprehensive intervention. *Global Health Action*, *2*(10). doi:10.3402/gha.v2i0.1932

Friedman, T. L. (2006). *The world is flat: A brief history of the twenty-first century*. Camberwell, Vic.: Penguin.

Hickey, E. M., Archibald, C., McKenna, M., & Woods, C. (2012). Ethical concerns in voluntourism in speech-language pathology & audiology. *Perspectives in Global Issues in Communication Sciences & Related Disorders*, *2*(2), 40–48.

Hutchins, S. D. (2015). SLP grad takes his skills back to Rwanda. *The ASHA Leader*, *20*(10), 24–25. doi:10.1044/leader.LML.20102015.24

Hyter, Y. D. (2014). A conceptual framework for responsive global engagement in communication sciences and disorders. *Topics in Language Disorders*, *34*(2), 103–120. doi: 110.1097/TLD.0000000000000015.

Kotter, J. P. (1996). *Leading change*. Boston, MA: Harvard Business School Press.

Leadbeater, C., & Litosseliti, L. (2014). The importance of cultural competence for speech and language therapists. *Journal of Interactional Research in Communication Disorders*, *5*(1), 1–26. doi:10.1558/jircd.v5i1.1

McAllister, L., Woodward, S., Atherton, M., Nguyen, T., , Potvin, C., Huynh, B., . . . Le Khanh, D. (2013). Viet Nam's first qualified speech therapists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech Language Pathology*, *15*(2), 75–79.

Ministry of Education. (2013). *Inclusive education policy*. Draft. Accra, Ghana: Republic of Ghana. Retrieved from http://www.voiceghana.org/downloads/MoE_IE_Policy_Final_Draft1.pdf

National Commission on Culture. (2006). *The people: Traditional language and orature*. Retrieved from http://www.ghanaculture.gov.gh/index1.php?linkid=240.

National Health Insurance Scheme. (2016). *Benefits package*. Retrieved from http://www.nhis.gov.gh/benefits.aspx

Ndung'u, R., & Kinyua, M. (2009). Cultural perspectives in language and speech disorders. *Disability Studies Quarterly*, *29*(4). Retreived from http://dsq-sds.org/article/view/986/1175

Nixon, S. A., Cockburn, L., Acheinegeh, R., Bradley, K., Cameron, D., Mue, P. N., . . . Gibson, B. E. (2015). Using postcolonial perspectives to consider rehabilitation with children with disabilities: The Bamenda–Toronto dialogue. *Disability and the Global South*, *2*(2), 570–589.

Pickering, M., & McAllister, L. (2000). A conceptual framework for linking and guiding domestic cross-cultural and international practice in speech-language pathology. *Advances in Speech Language Pathology*, *2*(2), 93–106.

Pillay, M., & Kathard, H. (2015). Decolonizing health professionals' education: Audiology and speech therapy in South Africa. *African Journal of Rhetoric*, 7, 193–227.

Sharpe, E., & Dear, S. (2013). Points of discomfort: Reflections on power and partnerships in international service-learning. *Michigan Journal of Community Service Learning*, *19*(2), 49–57.

United Nations. (2015). *Transforming our world. The 2030 agenda for sustainable development*. Geneva: United Nations. Retreived from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

United Nations Development Programme. (2015). *Human development reports: Ghana*. Retrieved from http://hdr.undp.org/en/countries/profiles/GHA

Wickenden, M. (2013). Widening the SLP lens: How can we improve the wellbeing of people with communication disabilities globally. *International Journal of Speech-Language Pathology*, *15*(1), 14–20. doi:10.3109/17549507.2012.726276

Wickenden, M., Hartley, S., Kariyakaranawa, S., & Kodikara, S. (2003). Teaching speech and language therapists in Sri Lanka: Issues in curriculum, culture and language. *Folia Phoniatr Logop*, *55*(6), 314–321. doi:10.1159/000073255

World Bank & World Health Organization. (2011). *World report on disability*. Geneva, Switzerland: World Health Organization.

Wylie, K., McAllister, L., Davidson, B., Marshall, J., & Law, J. (2014). Adopting public health approaches to communication disability: Challenges for the education of speech-language pathologists. *Folia Phoniatrica et Logopaedica*, *66*(4–5), 164–175.

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Professional and personal benefits of volunteering

Perspectives of international clinical educators of Vietnamese speech-language pathology students in Vietnam

Lindy McAllister, Sue Woodward, and Srivalli Nagarajan

Few studies have investigated the impact of volunteering on allied health professionals' personal and professional development. This paper presents the findings of a study exploring the volunteering experience of speech-language pathology (SLP) clinical educators in Vietnam. Twenty four volunteers placed through Trinh Foundation Australia provided clinical supervision to students in Vietnam's first SLP course during 2010–12. Returning volunteers were invited to complete a written survey and provide a short summary of their experience. Twelve surveys and six summaries were returned. These responses were analysed using content analysis and five categories were identified: motivations for volunteering, managing challenges associated with a different culture, language and working with interpreters, impact of the volunteer experience on professional development and clinical practice back home, and enhanced skills and interest in clinical education. Participants described the applicability of knowledge and skills gained in Vietnam to their practice in Australia.

> *I am a speech pathologist with over 30 years' experience in a number of different clinical settings including 12 years [in a specialist area]. … At this stage in my career I was thinking that maybe my days as a speech pathologist were coming to an end and I would pursue other interests. The idea of volunteering in any capacity had always interested me so when I discovered that there was an opportunity to actually use my speech pathology skills I was definitely interested. … Volunteering in Vietnam was an incredibly worthwhile experience which provided me with a challenge on both a personal and professional level, and allowed me to utilise my existing clinical skills and experience as a student educator to assist in a small way in the clinical education of the … Vietnamese students training to become speech pathologists.* (Lisa – returned volunteer speech-language pathologist to Vietnam)

The Australian Bureau of Statistics (2015) figures for 2014 revealed that 5.8 million people in Australia (31 per cent) reported they had volunteered in the previous 12 months, contributing 743 million hours to the community. There has also been significant growth in international volunteering in recent years (Baillie Smith & Laurie, 2011). As the opening vignette shows, volunteering internationally can have a profound impact on the volunteer. It can also have significant positive and sustainable impacts on host organisations and communities if volunteering programs are well designed and well managed (Sherraden, Lough & McBride, 2008; UNV, 2011). Conversely, negative impacts such as cultural imperialism, reinforcement of inequalities (Sherraden et al., 2008), and neocolonialism (Karle, Christensen, Gordon & Nystrup, 2008) can arise from poorly considered or managed volunteering. Volunteer tourism or voluntourism, where volunteers combine a holiday and tourism in a developing country with engagement in a short term, humanitarian project, has attracted considerable criticism in recent years (Palacios, 2010). These projects frequently do not require professional skills; for example, projects may simply require free labour from people without construction or engineering backgrounds to build a schoolroom, or a playground for an orphanage. Outcomes may not address community needs, or have sustainable outcomes for the host site, even though volunteers may experience a sense of well-being arising from their activities.

Lack of sustainability of volunteer endeavours has been critiqued (see for example Devereux, 2008). There is a lack of literature on the impacts and sustainable outcomes of volunteer programs generally (Sherraden et al., 2008), especially for health professionals engaging in knowledge and skills transfer designed to build capacity of host sites and training recipients (Meyer, 2013). Most of the existing literature pertains to medical and nursing/midwifery volunteers (e.g., Pieczynski, Laudanski, Speck, & McCunn, 2013). There are few studies about allied health volunteers, and to the best of our knowledge none about SLP volunteers. Hickey, McKenna, Woods, and Archibald (2014) noted that research is required into best practices for volunteering in SLP and audiology volunteers. This paper investigates the impacts on speech-language pathologists resulting from volunteering as clinical educators (CEs) for students in Vietnam's first SLP course. It is important to note that the evaluation of the impacts and outcomes from the perspectives of the Vietnamese partners is critical to

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avoid neocolonial practice (Karle et al., 2008) and ensure agencies and volunteers from minority world countries understand and enable sustainability (Osborn, Cutter, and Ullah, 2015). To this end, readers are referred to previous work (McAllister et al., 2013) in which the impact on the host site and the recipients of training by CE volunteers in Vietnam has been discussed. Furthermore, publications in review and preparation will explore in more depth Vietnamese perspectives on the contributions of volunteers.

Background

The volunteers involved in this study were sourced, placed and supported by Trinh Foundation Australia (TFA) which was established in 2008 to respond to requests for assistance in developing and delivering SLP training courses in Vietnam. The volunteers provided clinical supervision for students enrolled in the first 2-year postgraduate speech-language pathology training course at the University of Medicine Pham Ngoc Thach (UPNT) in Ho Chi Minh City (HCMC) in 2010–12. The structure and support arrangements, as well as students in the course, were described in McAllister and colleagues (2013).

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In line with best practices for volunteering (Hickey et al., 2014), TFA volunteers receive pre-departure briefing and return-to-Australia debriefing from TFA, as well as in-country support from full-time Australian volunteer speech-language pathologists at UPNT in HCMC. This paper focuses on survey responses from 12 volunteers who provided clinical supervision in the 2010–12 course. The volunteers went to Vietnam for periods ranging from 2–12 weeks. They supervised students on 1–3-week block placements in a range of clinical facilities. The volunteer CEs typically worked a 5-day week with groups of 2–4 students and fulfilled the normal roles of a clinical educator (e.g., reviewing client assessment reports and treatment plans, modelling techniques, observing student performance, providing feedback and formal assessment, coaching and tutoring). The volunteers were supported by TFA trained interpreters/translators in Vietnam to translate clinical education materials and interpret communication between the Australian SLP CEs, students and patients/families during the clinical placements.

Method

Ethics approval for this study was provided by the University of Sydney Human Research Ethics Committee (approval # 2014/231).

Recruitment

All 24 CE volunteers in the first course (September 2010 – August 2012) were emailed an invitation and participant information about the study. The 12 respondents were then emailed a survey, by a person not involved in supporting the volunteers. The invitation to participate was sent after the last clinical placement block, in October 2012. Participants were asked to return their surveys and summaries by email if they consented to participate.

Data collection

The survey comprised 4 questions presented in Table 1, along with an invitation to provide a 100 word summary of the experience. Twelve surveys were returned and analysed. Six optional summaries contributed by participants were not included in analysis; they were left "whole" for use as vignettes in the paper.

Table 1. Survey on experiences of volunteering as CEs for SLP students in Vietnam

1. Do you think your time in Vietnam gave you any insights into understanding another culture? What cross-cultural skills and knowledge did you develop as a result of your time in Vietnam? Have these been applicable to your professional work?
2. Do you think working in such a different and frequently challenging environment has given you any valuable insights into your personal strengths and weaknesses?
3. How has your role as a clinical educator in Vietnam impacted on your professional development?
4. Has working in Vietnam influenced your clinical practice in any way?

Data analysis

Survey responses to each question were collated. Because some emergent categories were identifiable in collations of responses to more than one question, all responses were collated and then analysed using content analysis (Hsieh & Shannon, 2005). Emerging categories were compared within an individual's survey data and across all participants' survey responses. Through a process of constant comparative analysis (see for example, Hewitt-Taylor, 2001), a final list of categories was developed and exemplar quotes from survey responses identified to illustrate these.

Results

As speech-language pathologists who have volunteered as CEs in Vietnam are known in the profession, ethics approval required that limited demographic information be collected to reduce the likelihood of identification and pseudonyms are used to report data in this paper. All participants were female, which is similar to the national gender demographic of speech-language pathologists (Health Workforce Australia, 2014). Years of experience as an SLP ranged from 2 to more than 30 years. The volunteers came from a range of adult and paediatric settings in hospitals, schools, disability settings and private practices in Australia and the United Kingdom.

Data analysis identified five categories of CE responses to their experiences in Vietnam. These categories, subcategories and illustrative extracts from the surveys are presented in this section. Extracts are drawn from all participants.

Motivations for becoming a volunteer clinical educator

Motivation for volunteering was mentioned by most participants, in terms of their desire to make a contribution to the development of the profession in Vietnam or "give back" what they had gained from their professional life.

> Fay: *I am basically retired. I was glad to take on the role of clinical educator in Vietnam as a way to contribute something of what I have been able to learn and develop myself over my career.*

> Anna: *[it] was a perfect opportunity to "give back" to the profession in a small way, as well as stretch myself by working/volunteering in a different culture and language for the first time.*

Managing challenges

All participants spoke about challenges and these were of two main types: confronting and learning to manage

language and cultural barriers; and learning to work with interpreters. Participants started to develop an understanding of what the acceptable norms are in Vietnamese culture in relation to learning and asking questions. Using the knowledge gained through several interactive discussions with students and colleagues, participants began to understand how to manage cultural differences particularly in relation to learning and teaching, as illustrated in the quotes below.

Julie: *… it was really only once I had been in Vietnam for a week or so that I started to see a little better the expected behaviours, beliefs, values, practices and customs. That is, I learned much more within the context of the culture. This was informed by observations, opportunities to de-brief with a colleague, and LOTS of opportunities to interact with the students and critically, discuss cultural differences with them …*

Helen: *With students, I needed to break down this barrier [of hierarchy and officialness] to encourage them to ask questions. There seemed to be a concept of "saving face" and a feeling that asking a question indicated not knowing something.*

The majority of students with whom participants worked had little English, and this presented numerous communication barriers. While the interpreters were able to assist with overcoming these barriers, the volunteers (as exemplified in Helen's quote) were aware that cultural differences existed in terms of power and hierarchy between teachers and students and that this impacted on what it was acceptable to communicate about.

Lucy: *Although a few of the students did have good English skills, I was aware that not all of them did. Initially when I spoke the students with the better English would reply before the interpreter could translate. I felt that that was a weakness on my part. I then focused on pausing after I spoke to allow the interpreter to translate. I was more assertive when students would reply in English and I requested them to speak in Vietnamese to help the other students in the group. I have worked with interpreters before in my job but not to the level that is required in Vietnam.*

Impact on professional development

The participants wrote about a number of positive impacts of the volunteer CE experience on their professional development. These impacts included reaffirmation of the depth of knowledge and experience gained over years of practice and also the recognition that clinical knowledge and practice change over the course of a career and hence the need to seek continuing professional development (see for example Anna) or further education.

Anna: *It made me very conscious of how much clinical knowledge and practice changes over time and has reinforced the need for ongoing professional development and clinical discussion.*

For some, the volunteer experience improved leadership skills and time management skills. For others it ignited or rekindled enthusiasm for the profession.

Lucy: *I feel that it has improved my leadership skills.*

Maria: *I suppose I'd become a bit jaded. But the time I had volunteering for Trinh really motivated me and revived my enthusiasm for the profession.*

Kerrie astutely commented on coming to understand what was achievable in short time frames and the issues around sustainable impact of development work such as this.

Kerrie: *I wanted to see … change "large scale and lots of it!" for the clients and families in Vietnam, which was not at all realistic, just a natural response to seeing a country and a health system where the speech pathology profession is so new. Being part of a longer term, more sustainable answer to the problem really helped me to see the value in patience.*

Impact on clinical practice in home country

The volunteers identified positive impacts of the Vietnam experience on their clinical practice in Australia. The impacts included less reliance on resources, tests and equipment, needing to "think outside the square", increased patience, observation skills and clinical reasoning. One volunteer specifically wrote about new theoretical knowledge she acquired as a result of the experience.

Maria: *Not having access to the "western" resources, equipment and standardised tests has meant that I have needed to rely on the limited resources available which I believe has helped me to think outside the square regarding therapy approaches and assessment [in Australia].*

Helen: *Working in Vietnam certainly raised awareness of CALD issues in health care. It encouraged me to pursue translating speech pathology written information (e.g., brochures) into different languages and to investigate working these themes into our health promotion practices [in Australia].*

Maggie: *I have gained a lot of theoretical knowledge through volunteering, in particular in the area of cochlear implant and parent implemented therapy. I have been able to use this new knowledge in my clinical practice [in Australia].*

Enhanced skills and interest in clinical education

The volunteering experience served to further develop skills and interest in clinical education. For some like Anna and Carol, there had been a long absence from engagement in clinical education. Some participants reported that the experience in Vietnam reminded them how much they enjoyed clinical education. Volunteers such as Anna and Stephanie wrote about how the experience helped refine their reflection, analytic and clinical teaching skills. These experiences are illustrated by the following quotes.

Anna: *It certainly reacquainted me with the pleasure of working with students again.*

Lucy: *Previously I have only worked with students in one-to-one blocks. This experience helped me work with 4–5 students at a time. It helped develop my time management skills.*

Stephanie: *I had to step back and reflect upon my actions and teaching methods and how they were impacting upon the students' ability to learn from me.*

Discussion

This paper presents new data on the experiences of speech-language pathologists who volunteered as CEs in a

newly established SLP course in Vietnam. Our data in relation to motivation for volunteering are consistent with the altruistic trend in volunteering noted by Meyer (2013). Humanitarian reasons, desire to learn about another culture and advancing career prospects are discussed as common motivators in other studies of volunteers (Palmer, 2002). While literature on voluntourism (Meyer, 2013; Palacios, 2010) reports the desire for a personal challenge as a common motivator, the 12 participants in this study were more likely to express wanting a professional challenge, while recognising they would also be personally challenged by the climate, cultural and language differences. Career advancement was not a motivator for participants in this study.

The participants in this study reported their experience of volunteering as CEs in Vietnam to be highly positive. The personal and professional benefits for the volunteers and their practice back in Australia have been highlighted in this paper. The range of impacts on participants' professional development was to some degree unexpected, but encouraging. We did not, for example, expect to find the experiences in Vietnam generating a recommitment to and passion for their profession. The transferability of new knowledge and skills gained in Vietnam back to their clinical practice in Australia is a significant finding. The re-engagement with clinical education, the pleasure and satisfaction reportedly gained, and the refinement of educator skills, were encouraging findings. The study participants also reported several benefits of volunteering for advancing their professional skills and interest in clinical education. Such results have implications for SLP in Australia, which relies on a growing community of skilled and enthusiastic CEs.

This study also identified a range of challenges experienced by participants. Anticipated challenges of managing language and cultural barriers and working with interpreters were mentioned. Challenges or barriers in relation to communication in culturally different contexts have also been identified in other studies (e.g., Pieczynski et al., 2013). There was some degree in this study of what Santoro and Major (2012) referred to as dissonance regarding culturally different communication styles and expectations about appropriate interactions, and the participants had to develop cultural knowledge and some degree of intercultural competence to fulfil their role as CEs. Some participants commented that the students proved to be generous cultural guides and cultural knowledge brokers.

Most participants in our study had at least a little prior experience in working with interpreters. However, the varying English abilities of the students, coupled with interpreting protocols regarding pausing to allow time for interpreting, created additional complexity for the participants in "teaching" students in the presence of interpreters. Some participants noted that their enhanced competence and confidence in working with interpreters would be an asset in their practice back in Australia.

The lack of resources identified as barriers in other studies (Pieczynski et al., 2013) for participants in this study became a trigger for creativity and development of new skills. The development of intercultural skills and improved ability to work in culturally and linguistically diverse environments were seen as highly applicable to practice in Australia, as were the enhanced skills in working with interpreters. The impact of the volunteer experience on the development of intercultural competence is not unexpected, given previous research with volunteers and with allied health students (Gribble, Dender, Lawrence, Manning, & Falkmer, 2014). Our findings suggest that volunteering in a professional capacity in Vietnam provides significant professional development of knowledge, skills and attributes needed for maintaining currency of practice and expanding leadership capacity.

The lack of other barriers mentioned in their responses may reflect the impact of good pre-departure briefings and in-country support, and support from the students and interpreters themselves. Alternatively, the participants, as a self-selected group, may already have been culturally adaptable and resilient individuals, or they chose not to reveal negative experiences. Our data does not allow us to examine these possibilities, and this is a limitation of this study which could be addressed in future studies using interviews rather than written surveys.

Another limitation of this study is the sample size (12), which, although typical of qualitative research, does not permit generalisation of findings beyond the context of the study. A further limitation of this paper is that it does not report on benefits or problems experienced by the students who received clinical education from the volunteers. These data are being analysed and the results will be reported in forthcoming publications.

Sustainability of impact is always an important consideration in volunteer programs. The transfer of the volunteers' knowledge and skills to the Vietnamese students has been reported to be of great benefit to the emerging SLP profession in Vietnam (McAllister et al., 2013). The groundwork has been laid for future self-sufficiency of the profession in Vietnam. In order to upskill the Vietnamese SLPs as CEs for the future, subsequent CE volunteers mentored graduates of the 2010–12 course in clinical blocks to co-supervise students in the 2012–14 course. It is this professional knowledge and skills transfer and the commitment to sustainable impact that distinguishes this volunteer experience from "feel good" but not sustainable, and sometimes ethically questionable voluntourism (Hickey et al., 2014). The volunteer experiences described in this paper suggest the volunteering provided a powerful continuing personal development experience and in some cases transformative learning experience, as the words from Stephanie reveal.

> *I volunteered with the Trinh Foundation as I have always wanted to volunteer overseas and saw the opportunity to do so in a field where I could put my skills as a speech pathologist into use. Working as a clinical educator taught me so much about the important role that cultural understanding plays in delivering services that meet the needs of the people we work with. It also taught me so much about my own culture and about myself as a clinician. I am so grateful that I got to experience this during the early years of my career so that the skills and knowledge I gained were able to shape the way that I approach my work within the field. I would highly recommend this experience to anyone wanting to make a contribution to the international profession and to extend themselves both personally and professionally.* (Stephanie – returned Australian volunteer speech-language pathologist to Vietnam)

References

Australian Bureau of Statistics. (2015). *General social survey: Summary results, Australia, 2014*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0

Baillie Smith, M. B., & Laurie, N. (2011). International volunteering and development: Global citizenship and neoliberal professionalism today. *Transactions of the Institute of British Geographers*, *36*(4), 545–599. doi:10.1111/j.1475-5661.2011.00436.x

Devereux, P. (2008). International volunteering for development and sustainability: Outdated paternalism or a radical response to globalisation? *Development in Practice*, *18*(3), 357–370. doi:10.1080/09614520802030409

Gribble, N., Dender, A., Lawrence, E., Manning, K., & Falkmer, T. (2014). International WIL placements: Their influence on student professional development, personal growth and cultural competence. *Asia-Pacific Journal of Cooperative Education*, *15*(2), 107–117.

Health Workforce Australia. (2014). *Australia's Health Workforce Series: Speech pathologists in focus*. Retrieved from http://www.hwa.gov.au/publication/speech-pathologists-focus-0

Hewitt-Taylor, J. (2001). Use of constant comparative analysis in qualitative research. *Nursing Standard*, *15*(42), 39–42. http://dx.doi.org/10.7748/ns2001.07.15.42.39.c3052

Hickey, E. M., McKenna, M., Woods, C., & Archibald, C. (2012). Ethical concerns in voluntourism in speech-language pathology and audiology. *SIG 17 Perspectives on Global Issues in Communication Sciences and Related Disorders*, *2*(2), 40–48. doi:10.1044/gics2.2.40

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Karle, H., Christensen, L., Gordon, D., & Nystrup, J. (2008). Neo-colonialism versus sound globalisation policy in medical education. *Medical Education*, *42*(10), 956–958. doi:10.1111/j.1365-2923.2008.03155.x

McAllister, L., Woodward, S., Atherton, M., Nguyen Thi Ngoc Dung, Potvin, C., Huynh Bich Thao, Le Thi Thanh Xuan, & Dien Le Khanh. (2013). VietNam's first qualified speech pathologists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech-Language Pathology*, *15*(2), 75–79.

Meyer, J. K. M. (2013). *"I came here to do something": Evaluating the motivations and ethical implications of international medical volunteers* (Bachelor of Arts thesis, The Colorado College).

Osborn, D., Cutter, A., & Ullah, F. (2015). *Universal sustainable development goals: Understanding the transformational challenge for developed countries*. Report of a study by stakeholder forum. Geneva: United Nations. Retrieved from https://sustainabledevelopment.un.org/content/documents/1684SF_-_SDG_Universality_Report_-_May_2015.pdf

Palacios C. M. (2010). Volunteer tourism, development and education in a postcolonial world: Conceiving global connections beyond aid. *Journal of Sustainable Tourism*, *18*(7), 861–878.

Palmer, M. (2002). On the pros and cons of volunteering abroad. *Development in Practice*, *12*(5), 637–643.

Pieczynski, L. M., Laudanski, K., Speck, R. M., & McCunn, M. (2013). Analysis of field reports from anaesthesia volunteers in low- to middle-income countries. *Medical Education*, *47*(10), 1029–1036. doi:10.1111/medu.12262

Santoro, N., & Major, J. (2012). Learning to be a culturally responsive teacher through international study trips: Transformation or tourism? *Teaching Education*, *23*(3), 309–322.

Sherraden, M., Lough, B., & McBride, A. (2008). Effects of international volunteering and service: Individual and institutional predictors. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, *19*(4), 395–421. doi:10.1007/s11266-008-9072-x

United Nations Volunteers. (2011). *State of the world's volunteerism report*. Geneva: Author.

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Development of the Vietnamese Speech Assessment

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Ben Phạm (top), Sharynne McLeod (centre), and Xuan Thi Thanh Le

Vietnamese is the official language of over 92 million people in Viet Nam and nearly four million diaspora including in Australia, USA, and Canada. To date, there are no standardised speech assessments for Vietnamese children. This paper outlines the development of the Vietnamese Speech Assessment (VSA) through collaboration between researchers in Viet Nam and Australia. The VSA contains all Vietnamese consonants, vowels and tones in at least two words with different sequence constraints. Further, the VSA was developed to be within the vocabulary range of young children, frequently used by Vietnamese people in different regions, picturable, and either a noun or verb. Picture stimuli were identified and the test was piloted with Vietnamese speakers of different ages who spoke different Vietnamese dialects. A score sheet was designed to include acceptable dialectal pronunciations, and to enable calculation of percentage of consonants/vowels/semivowels/tones correct and presence of phonological processes (patterns). The VSA is currently undergoing norming and standardisation.

Vietnamese is the official language spoken by over 92 million people in Viet Nam and by nearly four million diaspora including in Australia, USA, and Canada. The government of Viet Nam has implemented "The Developmental Standards for Children aged 5", and standard 15, item 65 is "to speak clearly" (The Viet Nam Ministry of Education and Training, 2010). Vietnamese professionals report they assess Vietnamese children's speech production by using informal measures to determine who meets the developmental standards (The Viet Nam Institute of Educational Sciences, 2014). To date, there are no standardised norm-referenced assessments of Vietnamese children's speech production (McLeod, 2012a; McLeod & Verdon, 2014), which has resulted in the creation of informal tools presented in book chapters, journal articles, unpublished dissertations, and on websites (Cameron & Watt, 2006; Cheng, 1991; Hwa-Froelich, Hodson, & Edwards, 2002; Nguyễn, 2011; Nguyễn & Phạm, 2014; Pham, 2009; Tang & Barlow, 2006; Vũ & Đặng, 2004), as well as tools developed by staff in a particular clinic/school/hospital/university for use in their own clinical practice (The Children's Hospital No. 1, 2013; Ducote, n.d.; Lê, 2013; West, 2000). Many of these tools are created to assess children who speak the southern Vietnamese dialect in Viet Nam, or other countries, and have limitations when used with people who speak the northern and central dialects of Vietnamese. This situation necessitated the development of the Vietnamese Speech Assessment (VSA) for research and clinical practice across Viet Nam and in other countries.

This paper outlines the creation of the VSA using psychometric standards for assessment in two stages: conceptualisation and operationalisation (Frytak, 2000) and has been written using the guidelines for test creation from McLeod (2012b). The VSA has been developed via collaboration between Ben Phạm, Xuan Thi Thanh Le and Sharynne McLeod, the Trinh Foundation and Charles Sturt University in Viet Nam and Australia (see Figure 1). Creation of the VSA would not be possible without extensive international collaboration between authors in these majority- and minority-world contexts drawing on the authors' expertise in Vietnamese phonetics and phonology, Vietnamese dialectal variants, child development, and test development. The authors met face-to-face on numerous occasions to listen to the production of consonants, vowels and tones by Vietnamese speakers, and to debate the benefits of different word choices. The three authors also undertook pilot testing and initial operationalisation of the tool together in Australia and Viet Nam, each transcribing, then discussing children's production of the words. The VSA would not have the same level of rigour if the three authors had not collaborated and cooperated extensively during the conceptualisation stage.

Stage 1. Conceptualisation of the Vietnamese Speech Assessment

Conceptualisation of an assessment tool refers to determining its purpose and scope, ensuring it measures what it intends to do through its properties and features (Frytak, 2000). Conceptualisation of an assessment begins with a statement of its purpose, intended population, target skill, and scope (McLeod, 2012b).

Figure 1. The authors of the Vietnamese Speech Assessment

Purpose

The current purpose of the VSA is to describe children's ability to produce consonants, semivowels, vowels, and tones in the northern, central, and southern Vietnamese dialects. Once normative data have been collected and analysed, the other purposes will be for diagnosis of speech sound disorders, to assist with goal setting for intervention, and to determine the outcomes of intervention.

Intended population

The VSA is designed for Vietnamese-speaking children ranging from 2;0 to 6;11 years who live in different regions of Viet Nam and in other countries. Children may be either monolingual or multilingual speakers. Examiners using the VSA should be speech-language pathologists, special educators, psychologists or other professionals who are Vietnamese native speakers with experience in Vietnamese phonetic transcription and working with children (Smit, 1986). It may be possible for non-Vietnamese-speaking speech-language pathologists to use the VSA with support from interpreters or family members (see McLeod, Verdon & IEPMCS, in press, for guidelines).

Target skill

The VSA has been designed as a picture-naming task to elicit single words.

Scope

The scope of the VSA includes the type of words selected and methods used to elicit target words. Six areas were considered to ensure the scope matched the purpose of VSA: phonotactic inventory, Vietnamese speech sounds, elicitation of each speech sound, word selection, presentation, and test administration.

Vietnamese phonotactic inventory

Almost all words in Vietnamese are monosyllabic. The Vietnamese syllable is the smallest unit of pronunciation and Vietnamese is a syllable-timed language (in contrast to English, which is a stress-timed language). The structure of the Vietnamese syllable is: $(C_1)(w_1)V(C_2/w_2)T$ where C1 is the initial consonant, w_1 is the medial semivowel, V is the main vowel, C_2 is the final consonant, w_2 is the final semivowel, and T is the tone (Phạm & McLeod, 2016). The vowel and the tone are the two compulsory components, whereas, the presence of the other components is optional. The VSA contains all Vietnamese speech sounds in every possible position in the Vietnamese syllable as follows: initial consonant, medial semivowel, main vowel, final consonant, final semivowel, and tone.

There are no consonant clusters in the Vietnamese language so that all Vietnamese speech sounds in the VSA are elicited in singleton contexts. Morphophonological contexts do not occur as the Vietnamese language does not use bounded morphemes to mark verb tense, aspect, or plurality (Pham, 2011). All stimuli in the VSA are monosyllabic words; the exception is the rare loan word for the initial consonant /p/ - *pa-tê* (pate). The classifiers, e.g., *cái* (inanimacy), *con* (animacy), are excluded although they commonly precede nouns (Pham & Kohnert, 2009; Tran, 2011). For example, the single word task elicited thỏ (rabbit) instead of con *thỏ*; and *chuông* (bell) instead of *cái chuông*.

Vietnamese speech sounds

The VSA includes all potential Vietnamese consonants, semivowels, vowels, and tones to assess speech production of Vietnamese-speaking children spoken in three main dialects. A comprehensive summary of all Vietnamese speech sounds in Standard Vietnamese and in

Northern, Central and Southern dialects was collated based on an extensive literature review (Phạm & McLeod, 2016). The following Vietnamese speech sounds were included in the VSA based on the review:

- 23 initial consonants in Standard Vietnamese /p, b, ʈʰ, t, d, ʈ, c, k, ʔ, m, n, ɲ, ŋ, f, v, s, ʂ, z, ʐ, x, ɣ, h, l/ and four variants including /ts, r/ in the Northern dialect and /w, j/ in the Southern dialect;
- 6 final consonants in Standard Vietnamese /p, t, k, m, n, ŋ/ and four variants across three dialects /c, ɲ, kᵖ, ŋᵐ/;
- 2 final semivowels /w, j/;
- 1 medial semivowel/approximant /w/ in Standard Vietnamese and three dialects;
- 16 vowels in Standard Vietnamese (including nine long singleton vowels /i, e, ɛ, ɯ, u, o, ɔ, ɤ, ɑ/, four short singleton vowels /ă, ɤ̆, ɛ̆, ɔ̆/, three diphthongs /ie, uo, ɯɤ/, and ten variants /ĭ, ɨ, ĕ, ŏ, ŭ, ɔː, oː, uː, ɛː, ɤː/ across three dialects;
- 6 tones in Standard Vietnamese and two variants of the tone 5 and 6 occurring in syllables ending by voiceless plosive consonants /p, t, k/ in three dialects.

Elicitation of each Vietnamese speech sound

Typically each speech sound is elicited in between one and five stimuli in single word sampling tools (McLeod, 2012b). Researchers have recommended there be at least two words in a single word task containing each phoneme in order to determine the consistency of production or phoneme stabilisation (Eisenberg & Hitchcock, 2010; Hua, 2002). Therefore, at least two stimuli were selected for each phoneme (consonants, vowels, and tones) shared across all dialects in the VSA. For example, the two selected words beginning with /k/ that were pronounced consistently across all dialects were: *kẹo* (candy) /kɛw⁶/, and *cổ* (neck) /ko⁴/. The authors attempted to avoid excessive use of any consonant, vowel, or tone within the word list.

The selection of words also took into consideration different phonetic contexts in Vietnamese. Different phoneme sequence constraints were considered so as to accommodate variability in terms of syllable shapes, rimes, phonotactic variants, and tones within the child's production rule system. It was important to accommodate the effect of coarticulation of front and back vowels on the production of initial and final consonants (Cao, 2006; Đoàn, 2003). Therefore, it was decided that the two words in the VSA containing the same initial consonants should be followed by a front and back vowel. For example, the selected words beginning with the initial consonant /b/ contained a front vowel *bí* (pumkin) /bi⁵/, and back vowel *bảng* (board) /bɑŋ⁴/. In addition, the VSA authors considered the effect of coarticulation of rounded and unrounded vowels on the production of final consonants /k, ŋ/ with back vowels (Cao, 2006; Đoàn, 2003). For example, the word *bụng* (belly) /bŭŋᵐ⁶/ was added to the set of words beginning with initial consonant /b/.

Word selection

Within the VSA the selected words met following criteria. They had to:

- be within the vocabulary range of Vietnamese-speaking children in Viet Nam, Australia, and USA so that children can produce the word spontaneously as often as possible;
- be used frequently by the entire population throughout Viet Nam. Therefore, words having lexical variants were excluded. For example, the word mẹ (mother) was not selected because of variants used in different regions such as *bầm*, *bu*, *má*, *mạ*, *mệ*, *mợ*, and *u*;
- be used currently in the speech of people within Viet Nam. For example, the traditional word for box was *rương*; however, it was not selected because *hộp* or *thùng* is used more commonly now;
- be culturally sensitive in both word choice and picture. For example, the word *đũa* (chopsticks) was selected rather than *dao* (knife) because seeing an image of a knife may scare young children;
- be picturable so young children can recognise the word easily and spontaneously name the word. The images were considered to be contrastable to differentiate meanings. For example, the word *gà* (chicken) was selected for the initial consonant /ɣ/ so the word *chim* (bird) was not selected for the initial consonant /c/ because of the possible confusion between these two images. Another example, the word *phở* (thinly sliced noodle soup) was seen as a good word choice containing the initial consonant /f/ but was not selected because of the possible confusion with the word *bún* (round noodle soup);
- be selected from basic syntactic forms such as nouns (66 out of 77 words) and verbs (11 out of 77 words).

Presentation

The VSA consists of 77 monosyllabic words represented by 77 colour pictures. The order of the word list was based on initial consonants. Proposed prototypes for the 77 pictures were discussed by the VSA authors, then were sent to a Vietnamese artist to be drawn. The 77 pictures were bound in a picture booklet. The front page displays a picture illustrating a word and the orthography of the word (see Figure 2). On the back page, there is a small picture of the word plus full phonetic transcriptions of Standard Vietnamese, Northern, Central, and Southern Vietnamese as well as the prompts to elicit the word (see Figure 3).

Test administration

The VSA was designed to be administered in a standardised manner. The assessment can be administered in research and clinical settings. Instructions will be

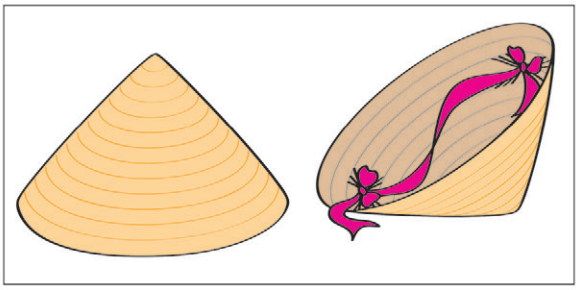

Figure 2. The front page for the stimulus item* nón *(cone hat).

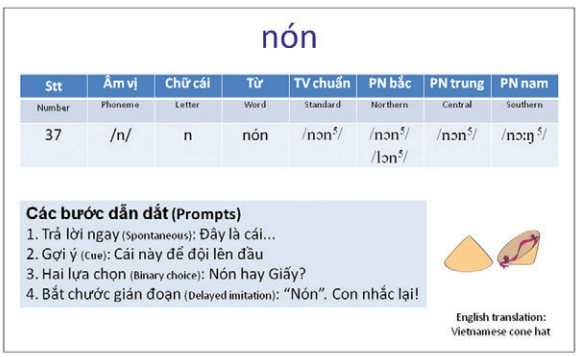

Figure 3. The back page for the stimulus item* nón *(cone hat).

provided in a manual to ensure that examiners follow the same testing procedures.

Cueing hierarchy

Examiners are required to give instructions following a four-step prompt hierarchy to elicit each target word: (a) open-ended question, (b) gap fill or content-related prompt, (c) binary choice (with the target word produced first), and (d) delayed imitation (e.g., "*Heart*. Repeat, please" (*Tim. Con nhắc lại*)). Children are encouraged to respond spontaneously by naming the picture at the first step as much as possible. The open-ended question used in step 1 for each target picture is "What's this?" Some target pictures will be asked differently to elicit the targeted response. For example, with the target picture of *elephant* (*voi*), the examiner asks the child "*Đây là con…*" (This is a [animacy word]…) so that the child can fill the target word after the animacy word produced by the examiner. If the examiner does not say the animacy/ inanimacy word, the child might say a compound word (animacy/inanimacy + target word, e.g., *con voi*) instead of saying the target word only (e.g., *voi*) because animacy/ inanimacy words commonly precede a noun in the Vietnamese language and are acquired early in young children (Pham & Kohnert, 2009; Tran, 2011). Before testing begins, it is useful to train the child to not include the classifier using common objects in the environment. If the child cannot label the picture, additional cues or content-related questions are provided to elicit the expected response. For example, a content-related question "What has a long trunk?" is asked to elicit a target word *voi* (*elephant*). If this step fails, the examiner will give a binary choice by presenting the target word first to participant, for example, "voi hay chân" (*elephant* or *leg*). If the participant does not respond to the binary choice, the examiner will provide the target word for imitation. A list of prompts and cues for each target word was also created to support the testing protocol.

Scoring, transcription, recording and analysis

A score form was created which includes columns for the word in orthography; the adult target in International Phonetic Alphabet for Standard Vietnamese, Northern, Central and Southern dialects; the child's production; and columns for scoring each phonological pattern.

Children are assessed individually. Examiners are required to transcribe children's responses online by using the International Phonetic Alphabet symbols. It is recommended that the transcriptions be based on the children's first attempt if possible. If children's first productions are not clear, then they are asked to repeat the words. The score form also requires examiners to mark the prompt or cueing level used for each response.

It is recommended that the children's responses be audio-recorded and/or video-recorded with the permission of children's caregivers and the school. A microphone should be placed close to the children's mouths (within 15 cm) and the video camera should be set up to record the children's faces. The recordings can be used to check reliability between examiners, and to record change in the children's speech over time. Video recordings can be used to check the children's productions of consonants and vowels that can be seen on the recording (e.g., bilabials).

The VSA score form provides a relational analysis (including percentages of consonants, semivowels, vowels and tones that are produced correctly) and an analysis of phonological processes/ patterns. Guidance in terms of scoring, transcription, recordings and analysis will be included in the manual to instruct for examiners in both research and clinical use.

Stage 2. Operationalisation of the Vietnamese Speech Assessment

Operationalisation is the evaluation and validation process of an assessment to ensure its validity and reliability (Frytak, 2000). The VSA is currently undergoing operationalisation. Eventually the VSA will contain consistent assessment materials, administration and scoring protocols. Once normative data have been collected and analysed, they will be added to the manual. Eventually the manual will also include information about validity (content, construct, predictive, concurrent) and reliability (internal consistency, test–retest reliability, intra- and inter-rater reliability).

To date, the VSA authors have considered the content validity for the VSA. Content validity refers to "the degree to which the items in the measure cover the domain of interest" (Frytak, 2000, p. 22). Content validity of the VSA was conducted first by a systematic examination of relevant literature and previously designed speech sampling tools to specify the initial test content. Second, professional judgement was used to define the test areas and to evaluate the relevance and representativeness of the test items with the target construct. The VSA was piloted by the design team on five adults and one child who were bilingual Vietnamese–English speakers to examine the relevance of the word list and scoresheet and to estimate length of the time required to complete the test. Adults completed the task in approximately 8–10 minutes, the child in about 20 minutes. After the initial pilot testing, some changes were made with to stimulus items (e.g., changing images for the word '*pin*' from torch to battery) and prompts (e.g., changing the cues for the word '*tết*' [Tet holiday]). Other psychometic properties (including internal consistency, test–retest reliability, inter- and intrarater reliability, criterion validity, construct validity, item analysis, sensitivity and specificity, standardisation) will be established in further steps to operationalise the VSA.

Conclusion

The development of a speech sampling tool requires two stages: conceptualisation and operationalisation. The conceptualisation of the VSA has been completed and work on the operationalisation is continuing. This paper provides an example of how to begin to undertake test development in a majority-world country.

References

Cameron, N., & Watt, C. (2006). *Vietnamese articulation test (VAT: Version I-II-III-IV)*. Flinders University, Adelaide, Australia: Author.

Cao, X. H. (2006). *Tiếng Việt mấy vấn đề ngữ âm-ngữ pháp-ngữ nghĩa* [Vietnamese: Some issues in phonology-syntax-semantics]. Thành phố Hồ Chí Minh, Việt Nam: Khoa học xã hội.

Cheng, L. L. (1991). *Assessing Asian language performance*. Oceanside, CA: Academic Communication Associates.

The Children's Hospital No.1. (2013). *Bộ Kiểm Tra Từ Đơn Bằng Hình Ảnh* [One–Picture Word List]. Thành phố Hồ Chí Minh, Việt Nam: Author.

Đoàn, T. T. (2003). *Ngữ âm tiếng Việt* [Vietnamese phonetics]. Hà Nội, Việt Nam: Đại học Quốc gia Hà Nội.

Ducote, C. (n.d.). *Operation Smile Vietnamese articulation screening test*. New Orleans, LA: Author.

Eisenberg, S. L., & Hitchcock, E. R. (2010). Using standardized tests to inventory consonant and vowel production: A comparison of 11 tests of articulation and phonology. *Language, Speech, and Hearing Services in Schools*, *41*(4), 488–503. doi:10.1044/0161-1461(2009/08-0125)

Frytak, J. (2000). Measurement. *Journal of Rehabilitation Outcomes*, *4*, 15–31.

Hua, Z. (2002). *Phonological development in specific contexts: Studies of Chinese-speaking children*. Clevedon, UK: Multilingual Matters.

Hwa-Froelich, D., Hodson, B. W., & Edwards, H. T. (2002). Characteristics of Vietnamese phonology. *American Journal of Speech-Language Pathology*, *11*(3), 264–273.

Lê, T. T. X. (2013). *Bộ Mẫu Đánh Giá Phát Âm* [Sample Tool for Articulation Assessment]. Bệnh viện Chỉnh hình và Phục hồi chức năng Thành phố Hồ Chí Minh, Việt Nam: Author.

McLeod, S. (2012a). Multilingual speech assessment. In S. McLeod & B. A. Goldstein (Eds.), *Multilingual apsects of speech sound disorders in children* (pp. 113–142). Bristol, UK: Multilingual Matters.

McLeod, S. (2012b). Translation to practice: Creating sampling tools to assess multilingual children's speech. In S. McLeod & B. A. Goldstein (Eds.), *Multilingual aspects of speech sound disorders in children* (pp. 144–153). Bristol, UK: Multilingual Matters.

McLeod, S., & Verdon, S. (2014). A review of 30 speech assessments in 19 languages other than English. *American Journal of Speech-Language Pathology*, *23*(4), 708–723.

McLeod, S., Verdon, S., & International Expert Panel on Multilingual Children's Speech (in press). Tutorial: Speech assessment for multilingual children who do not speak the same language(s) as the speech-language pathologist. *American Journal of Speech-Language Pathology*.

Nguyễn, T. L. K. (2011). Nội dung đánh giá khả năng phát âm âm tiết tiếng Việt của trẻ mẫu giáo [The assessment content of pronunciation ability of Vietnamese syllable of preschoolers]. *Ngôn ngữ* [Language], 9, 6–17.

Nguyễn, T. L. K., & Phạm, H. L. (2014). Lỗi phát âm âm tiết thường gặp ở trẻ 2–4 tuổi (tại thành phố Hồ Chí Minh) [Common errors of syllable pronounce in Vietnamese speaking children from 2–4 years old (in Ho Chi Minh city)]. *Tạp chí khoa học Trường Đại học Sư phạm Thành phố Hồ Chí Minh* [Journal of Educational Science of Ho Chi Minh City University of Pedagogy], 57(91), 9–21.

Phạm, B., Le, X. T. T., & McLeod, S. (2016). *Vietnamese speech assessment: Research version*. Bathurst, Australia: Author.

Phạm, B., & McLeod, S. (2016). Consonants, vowels and tones across Vietnamese dialects. *International Journal of Speech-Language Pathology*, *18*(2), 122–134. doi: 10.3109/17549507.2015.1101162

Pham, G. T. (2009). Vietnamese one-word articulation screener. Retrieved 3 March 2016 from http://www-rohan.sdsu.edu/~gtpham/vnspeech/downloads/VietnameseOneWordArticulationScreener.pdf

Pham, G. T. (2011). *Dual language development among Vietnamese-English bilingual children: Modeling trajectories and cross-linguistic associations within a dynamic systems framework*. (PhD thesis), University of Minnesota, Ann Arbor.

Pham, G. T., & Kohnert, K. (2009). A corpus-based analysis of Vietnamese classifiers con and cái. *Mon-Khmer Studies*, *38*, 1–11.

Smit, A. B. (1986). Ages of speech sound acquisition: Comparisons and critiques of several normative studies. *Language, Speech, and Hearing Services in Schools*, *17*(3), 175–186.

Tang, G., & Barlow, J. (2006). Characteristics of the sound systems of monolingual Vietnamese-speaking children with phonological impairment. *Clinical Linguistics and Phonetics*, *20*(6), 423–445.

Tran, J. (2011). *The acquisition of Vietnamese classifiers* (PhD thesis). University of Hawai'i at Manoa.

The Viet Nam Institute of Educational Sciences. (2014). Nghiên cứu đặc điểm phát triển của trẻ mẫu giáo 5 tuổi [Research on development characteristics of 5-year-old children]. Hà Nội, Việt Nam: The Vietnam Ministry of Education and Training.

The Viet Nam Ministry of Education and Training. (2010). *Bộ chuẩn phát triển trẻ em năm tuổi [The developmental standards for children aged five]*. Hà Nội, Việt Nam: Author Retrieved from http://congbao.chinhphu.vn/tai-ve-van-ban-so-23_2010_TT-BGD%C4%90T-(4781)?cbid=4778.

Vũ, T. B. H., & Đặng, T. T. H. (2004). *Âm ngữ trị liệu thực hành* [Clinical speech language pathology]. Hà Nội, Việt Nam: Y học.

West, M. (2000). *Vietnamese articulation test*. Adelaide Central Community Health Service, Adelaide, Australia: Author.

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Practice innovations from the emerging speech-language pathology profession in Vietnam

Vignettes illustrating indigenised and sustainable approaches

Nguyen Thi Ngoc Dung, Le Khanh Dien, Christine Sheard, Le Thi Thanh Xuan, Trà Thanh Tâm, Hoàng Văn Quyên, Le Thi Dao, and Lindy McAllister

This paper presents vignettes of innovations in speech-language pathology practice in Vietnam, and situates these in the larger context of global considerations impacting on speech-language pathology education and service delivery. The paper provides an introductory vignette setting the context for four more vignettes from speech-language pathologists in southern Vietnam. The graduates' vignettes illustrate a range of innovative, sustainable, indigenised and culturally relevant developments in speech-language pathology practice and education. Two vignettes highlight the use of volunteers and the available health and education workforce to develop sustainable new services for children and adults with communication disorders. Two vignettes illustrate innovative and culturally appropriate ways of indigenising curricula and approaches to educating the Vietnamese public and the existing health workforce about communication and swallowing disorders and speech-language pathology services. The paper invites readers to reflect on what speech-language pathology globally might learn from our colleagues in majority-world countries.

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VIETNAM

THIS ARTICLE HAS BEEN PEER-REVIEWED

Collaborations between clinicians and academics in minority-world (developed) and majority-world (developing) countries have been successful in establishing speech-language pathology (SLP) education and services in many majority-world countries (for examples from nine such countries, see the *International Journal of Speech-Language Pathology*, 2013, vol. 15, issue 1). However, there is a risk of post-colonialism (Nixon et al., 2015) when minority-world curricula or practices are transferred into new SLP courses in majority-world countries. That is, what comes from minority-world countries can be privileged over local knowledge and practices, in the assumption that "west is best", even when it may not be culturally relevant or the knowledge applicable in new contexts. Therefore, it is important that SLP students in these new courses can interrogate "transplanted" information for its relevance and develop culturally relevant knowledge and clinical practice skills; that is, "indigenise" their knowledge and practices (see for example Hauser, Howlett, & Matthews, 2009). Furthermore, it is important that majority-world practitioners are able to share with minority-world clinicians innovative "indigenised" approaches to the problems they face in practice, to enable two-way learning (Walsh, 2016).

This paper presents vignettes highlighting innovation, indigenisation and plans for future development by graduates of two-year postgraduate courses in speech-language pathology, and where appropriate their Australian mentors. The first vignette in this paper comes from Vietnamese academic Dr Nguyen Thi Ngoc Dung, recognised as the champion for the development of speech-language pathology in southern Vietnam. Her leadership enabled the development of the two-year postgraduate course at University Pham Ngoc Thach. Four graduates of this course, known to be doing innovative work to develop SLP education and services, were approached to write four vignettes for the paper.

Vignette 1. Background to speech-language pathology education in south Vietnam

Prof Ngoc Dung, professor of ENT and former rector of the University Pham Ngoc Thach, Ho Chi Minh City

As an ENT doctor and former director of the ENT Hospital of Ho Chi Minh City (HCMC) I know that speech therapy[1] is vital in the treatment and rehabilitation of people with communication and swallowing impairments. Speech therapy training in HCMC started in 2009 with a short course run by Trinh Foundation Australia at the ENT Hospital for doctors, nurses and audiologists on aspects of speech therapy. Becoming rector of University Pham Ngoc Thach in HCMC enabled the development and delivery of two 2-year postgraduate courses (2010–12 and 2012–14) run at University Pham Ngoc Thach with support from Trinh Foundation Australia and Australian Volunteers International (see McAllister et al., 2013). Thirty-three graduates from those two courses have established speech therapy clinics and services, mostly in public hospitals, in Ho Chi Minh City, Hue, Hanoi, Vung Tau, Bau Loc and other provinces. With the management of the speech therapy office at University Pham Ngoc Thach, the support of Trinh Foundation Australia and Australian Volunteers for International

Nguyen Thi Ngoc Dung (top) and Le Khanh Dien

Development, these graduates have received continuing professional development in their workplaces from visiting lecturers and clinical mentors to develop their skills and knowledge base, research capacity and culturally appropriate resources in the Vietnamese language.

Vignette 2. Reflecting on the effects of an art group for people with brain dysfunction

Le Khanh Dien and Christine Sheard

People with communication disorders (PWCD) due to stroke or other acquired or congenital brain dysfunction often experience social exclusion (Dorze, Salois-Bellerose, Alepins, Croteau, & Halle, 2014; Douglas, 2013). However, by participating in groups run by speech-language pathologists, PWCD can be assisted to engage with others and increase their confidence (Ewing, 2007; Hawley & Newman, 2010; Holland, 2007; van der Gaag et al., 2005). Furthermore, making art also has been shown to help many people with disability to express their ideas and emotions via their participation in this meaningful life activity (American Art Therapy Association, 2013; Kim, Kim, Lee, & Chun, 2008; Parrish, 2014).

Christine Sheard (top), Le Thi Thanh Xuan (centre) and Trà Thanh Tâm

Combining the benefits of being in a group with other PWCD, but with a focus on producing art, inspired the first author during a visit to Sydney where he observed such a group established for people with aphasia. He was so impressed by the group's apparent effects on participants' attitudes and skills, he decided to establish one for a mixed group of his current speech therapy clients in Vietnam. With mentoring from the second author in Australia, he developed an Art Group program to extend beyond the existing impairment-focused speech therapy services at An Binh Hospital in HCMC. The program's aim was to offer socially restricted PWCD with varying brain dysfunction an opportunity to participate in a real-life social activity to learn new artistic skills and have natural communication, rather than remediation of their speech-language limitations. It was hoped this might produce positive changes in some factors (e.g., having good communication partners and independence in some meaningful life activities) commonly associated with quality of life (Douglas, 2013). This paper is a reflection on some informal but carefully gathered clinical data collected to assess the outcomes of the Art Group as perceived by its participants.

The Art Group was established in December 2013 for PWCD (including apraxia, aphasia, dysarthria, cognitive-communication difficulties and intellectual disability) who were also receiving concurrent speech therapy treatment. The invited participants were all known to have much restricted or virtually no meaningful social inclusion or communication beyond daily routine interactions with family or clinical appointments for their health needs. Art students from Sai Gon University were recruited to facilitate 2 hour, weekly art lessons and the program was overseen by the hospital speech therapists. Activities included simple colouring, painting and collage. Drawings or greeting cards were usually produced, with a focus on accepting and extending participants' free expression. Communicating about their art and having occasional parties for special occasions were also integral to this program.

Typically, six to 11 PWCD supported by up to six art students participated in the program. After 23 weeks the first author asked the seven regular long-term participants and six family members the same set of 16 author-generated informal questions that focused on obtaining each participant's *general perceptions of the impact of the group*, as well as their perceptions of any *social opportunities, self-confidence, communication* and/or *drawing skills* that they felt were related to their art group participation. Because the PWCD had limited expressive communication skills, most questions were closed questions, asked orally via a multiple-choice format with a large-font, written selection of simple, categorical or descriptive ratings to simplify the communication task. This informal, but systematic questioning also enabled the authors to readily target and compare the respondents' perceptions. In order to reflect on the effects of the Art Group as a therapy process, some of the most frequent and total group responses are reported here in a general manner as our aim was to assess the effect of the group from the PWCDs' perspectives. They should be interpreted as systematically acquired clinical information rather than research data.

From the questioning, all PWCDs reported positive feelings about attending the Art Group, and were mostly keen to attend each week. Those with acquired communication disorders liked that the Art Group gave them a chance to meet and talk with other people. This affirmed the clinicians' aim for establishing the group as a means for real-life socialisation.

The aspects of the group the participants spontaneously reported they enjoyed most related both to communicating and/or building their art skills. They typically liked to meet with people with shared interests and said that it was good to communicate in a cheerful environment. The clinicians agreed with the PWCDs' perceptions that Art Group made the PWCDs feel happy. Similarly all appeared and reported to be more confident when communicating. Family members also observed that the PWCDs generally initiated and engaged more in communication at home and with others, and appeared less self-conscious and more joyful as the group progressed. Several families also noted having more calm communication interactions over time.

There was a general perception that learning new skills to design and create art was most enjoyable. Participating in independent activities and having communication with others who listen have been associated with finding new identity, self-esteem and living successfully after brain injury (Brown, Worrall, Davidson, & Howe, 2012; Douglas, 2013). Clinicians and relatives typically observed that the PWCDs had more self-confidence in general as the group progressed and this was confirmed by the participants' responses.

Our conclusion from the clinical appraisal of participants' perceptions, which were affirmed by clinicians' and families' observations, is that participation in the Art Group provided an opportunity for most of these PWCDs to interact socially with others in natural and comfortable ways that appeared to improve their self-esteem, general cheerfulness and confidence. Learning new and creative skills and mixing in a comfortable environment with peers appeared to give participants an improved sense of personal well-being.

Our clinical observations and reports of the participants' perceptions could reflect clinician bias or a desire of the participants to please the first author. However, the concurrence between the observations of clinicians, relatives and participants suggests that the PWCDs' perceptions of increased socialisation opportunities,

improved self-confidence and satisfaction with new learning from this Art Group are sufficient to justify some formal research on conducting independently assessed clinical trials of this therapy process.

The volunteer participation of art students promoted wider community engagement and has ensured the economic viability and sustainability of the program. A public exhibition of participants' art was opened in October 2014. The attendance of high-ranking government officials and staff of several hospitals plus extensive media coverage has helped to raise public awareness of the potential possibilities for people to find meaningful lives after acquired or congenital brain dysfunction. This engagement of hospital and government officials is a strategic approach to ensuring support and sustainability of the program.

Vignette 3. A new model of public early intervention services with an interdisciplinary team

Le Thi Thanh Xuan

In Vietnam, most early intervention centres are private, with preschool teachers, psychologists or special education teachers on staff. Typically, a psychologist or doctor assesses children, and teachers develop and deliver an intervention plan, without parental involvement. Intervention goals are focused on cognitive and academic tasks, without attention to social, communication and speech development goals. Children from low and average income families rarely can afford to attend the centres, as fees range from 7 to 15 mill VND (about A$400–$870) per annum. In December 2014, the Orthopedics and Rehabilitation Hospital (ORH) of Ho Chi Minh City established public early intervention services for children with autism spectrum disorder (ASD) with staff from different professions involved, including speech therapists, psychologists, social workers, special education teachers, physiotherapists, and occupational therapists. A means-tested fee is charged ranging from 4–4.2mill VND (about A$233–$245). This fee includes lunch, morning/afternoon tea, and activity consumables.

The model at ORH is adapted from Australian interdisciplinary models for early intervention, which I observed on a study tour to Melbourne in mid-2015. I coach the ORH team to work collaboratively with each other and with parents to develop intervention goals targeting play, social, self-help, communication, and language goals for each child. Intervention is based on each child's current ability and interest, helping her or him to be active in interaction and initiating communication. There are currently 20 children attending three classes of early intervention services per week in groups of three to four children. Children attend class from 7:00 am to 16:00 pm; rest time is from 11:30 am to 14:00 pm. I train parents to use communication development approaches and AAC at home. The involvement of parents is indispensable and extends the intervention from the centre to the children's homes. We keep data on children's improvement to reflect on the impact of the early intervention service and modify it as needed.

With this interdisciplinary early intervention model, the staff has the advantage of increasing knowledge of other professions and sharing their skill set. Team meetings provide an opportunity for staff to share ideas for how to achieve the goals for each child, in order to maximise intervention outcomes. Staff are easily able to identify a child's unique strengths and needs, and determine what services are necessary to meet those needs. ORH is continuously developing, evaluating and refining this new model for early intervention services in Vietnam so that it can be introduced to other organisations in HCMC and southern Vietnam. When this new model is further developed and there are enough staff members, ORH will accept staff members from other organisations who wish to learn about, and implement, the model. Coaching and supported practice in other organisations will be provided.

This vignette illustrates one approach to indigenisation of a western model of good practice in early intervention to the Vietnamese context. In the absence of sufficient speech-language therapists, an available workforce of allied health and education professionals has been trained to deliver early intervention services which include foci on communication and social development. This training and deployment of existing workers also assists the sustainability of the service.

Vignette 4. Training basic paediatric speech therapy practical skills for staff at Đà Nẵng University of Medical Technology and Pharmacy

Trà Thanh Tâm and Hoàng Văn Quyên

In recent years, significant progress has been made in Vietnam in public health in terms of health professional expertise and service quality. Most of the 33 speech therapy graduates to date from University Pham Ngoc Thach work in Ho Chi Minh City. Rapidly developing cities such as Đà Nẵng have well-established medical services but do not yet have speech therapy education and services.

In order to increase availability of information about speech therapy and also accessibility to speech therapy services for people in central Vietnam, the authors, who are September 2012 graduates of the course at University Pham Ngoc Thach now working at Children's Hospital No.1 (CH No.1), HCMC, have developed and delivered a basic training program in speech therapy for physiotherapy lecturers at Đà Nẵng University of Medical Technology and Pharmacy (DUMPT). It was a challenge for us to ensure continuity of speech therapy services at CH No.1, while also preparing the course, and compiling training resources to meet the learning needs of participants in the upcoming training course. The participants had little concept of speech therapy so we had to consider this as well in our planning.

After a six-week theoretical training course in Đà Nẵng in 2014, we continued mentoring the participants by phone and email. In 2015, DUMTP sent four lecturers to CH No.1 to continue with the speech therapy clinical training. This clinical training block lasted six months. In the first two months, we helped participants synthesise knowledge they had learned in Đà Nẵng while providing new knowledge of speech therapy, such as (a) typical communication developmental milestones from infancy to 5 years, (b) speech therapy for children with cleft lip and palate, (c) speech therapy and intervention for feeding/eating in

Hoàng Văn Quyên (top), Le Thi Dao (centre) and Lindy McAllister

children with complex disabilities, (d) red flags for the need for speech therapy intervention for children with speech sound disorders, (e) augmentative and alternative communication, (f) working with parents, and (g) behavioural management.

In addition, we included the Đà Nẵng participants in clinical practice sessions with our patients. Thanks to our experience in working with Australian speech therapists during the clinical terms of the speech therapy training program at University Pham Ngoc Thach, we had accumulated experience that we could apply in the clinical training of the participants. We started by having them observe sessions, then plan for and deliver parts of session, gradually taking on responsibility for planning and delivering whole sessions under our supervision. Towards the end of the training block, we had them teach parents strategies to help their children develop language and manage their inappropriate behaviors at home.

By the end of the training course, the four participants had been involved in 600 sessions of speech therapy practice with more than 100 patients with language delay, ASD, cerebral palsy, hearing impairments, cleft lip and palate, and Down syndrome. At the end of the block, participants needed to achieve 70% as a pass on two theoretical and practical examinations, and submit one assessment report and one treatment report for patients they had managed. On completion of the course, the participants received a certificate issued by CH No.1 for completion of the course "Basic Paediatric Speech Therapy Practice".

Despite being faced with many challenges in terms of time and work pressure, we strive to provide high-quality training for colleagues throughout Vietnam in order to increase public awareness of the speech therapy profession and quality of speech therapy services provided to patients, and thereby, contribute to increasing the quality of life of patients with communication and swallowing disorders in Vietnam. This vignette illustrates indigenisation and cultural adaptation of a western curriculum for delivery in the Vietnamese context, making best use of the available Vietnamese health workforce to deliver sustainable services while a specialised speech-language pathology workforce is educated in Vietnam.

Vignette 5. Using all available media to educate professionals, students and the community

Le Thi Dao

I have been working in Ho Chi Minh City since 1987 as a physiotherapist, and since 2010 also as a speech therapist at Children's Hospital No.2. Because speech therapy is new in Vietnam, it is important to educate others about the profession and what we can offer. Since 2010, I have been promoting speech therapy to colleagues at the hospital and running information and education activities for the community. For example, I have been:

- Presenting at regular meetings with the hospital board of directors and heads of departments about topics such as "Introducing speech therapy in Vietnam" and "Speech therapy intervention methods"
- Introducing colleagues at the hospital to speech therapy by inviting them to observe speech therapy sessions and discuss cases.
- Running training sessions for teachers and parents on Saturday mornings on various topics, such as "ASD", "How to feed children with cerebral palsy", and "Developing language skills in children using picture stimulation". I have developed a number of resources for parents (e.g., books on helping children's language development).
- Teaching nurses and doctors at the Rehabilitation Hospital in Đà Nẵng about ASD, and then demonstrating and coaching them in skills such as how to observe a child, help a child make eye contact, increase attention, games to develop children's play skills.
- Teaching nursing and psychology students at universities in HCMC about rehabilitation for people with various communication disorders (hearing difficulties, speech sound disorders, stuttering, language disorders).
- Contributing articles about communication and swallowing disorders and speech therapy to hospital websites; for example articles on "Child language development processes", "Hoarse voice", "Fussy eaters"; and sharing articles on my Facebook page (see: https://www.facebook.com/lethi.dao.77/timeline).
- Participating in Vietnamese television talk shows. VTV9 channel has a talk show about children, which includes medical professionals and parents. My hospital's board of directors assigned me to present the topic on language development of children, how to identify problems and help children develop language. On HTV7 I was asked to introduce speech therapy in Vietnam and the types of disorders that need speech therapy intervention. I also talked about support Vietnam receives from Australian speech therapists and the Trinh Foundation.
- Collaborating with cleft lip and palate surgery groups. In trips to regional areas with Operation Smile, I coached teachers and medical staff about assessment and intervention methods for children with cleft lip and palate.

Focusing initial service development efforts on community education and advocacy activities as described has been essential to my experience as a newly qualified speech-language pathologist. The vignette illustrates culturally acceptable means to educate my colleagues. This has increased their knowledge and trust in this new profession of speech therapy and so they now refer clients to the speech therapy department. Clients also contact us directly and teachers in schools refer clients to us for intervention.

Discussion and conclusion

The vignettes presented have common elements for consideration. Significantly, they all focus on educating others, from the Art Group which educated family members and the general public through the engagement of art students and the launching of an art exhibition (Vignette 2) to educating a range of health and education professionals, university health students and the general public (vignettes 3–5). Li Thi Dao's education of the general public through television, Facebook and other media is impressive in its reach, creativity and generosity of time and effort. Educating others about the speech-language pathology profession and what it can offer is essential, and not just in a country newly establishing the profession and its services.

Vignettes 4 and 5 also highlight indigenisation of curricula and SLP resources. The authors adapted what they had

learned from minority-world lecturers and clinical educators at University Pham Ngoc Thach and integrated this in their own developing clinical practice to develop and deliver basic training in speech therapy to current and future health professionals and the general public. Their indigenised curricula and resources will be invaluable in the future Bachelor degree level education planned for Vietnam. Their experience as educators will contribute to local leadership and hence sustainability of these degrees.

Wylie, McAllister, Davidson, and Marshall (2013) discussed the inadequacy of current models of SLP service delivery for PWCD in the minority world for meeting the needs of all PWCD; the reach of SLP services needs to extend beyond what the speech-language pathologists themselves can achieve. The vignettes illustrate new models which extend the reach of services to PWCD by engaging staff not traditionally seen as agents of SLP intervention. For example, vignettes 3 and 4 describe the engagement of other allied health professionals and special education teachers to interprofessionally deliver early intervention services to children with communication disabilities and Vignette 2 describes how art students assist with running the Art Groups. Vignette 3 illustrates the use of what could be termed mid-tier workers, as recommended by the *World Report on Disability* (WHO and World Bank, 2011). In all cases the new models which extend reach have led to more children and families receiving SLP services than could have been achieved by the vignette authors alone. Furthermore, each is based around ongoing clinical support and mentoring to ensure sustainability and service quality. An essential next step will be to develop an evidence base for these approaches through formal evaluation and research programs to investigate the impact of these approaches on client outcomes.

Of interest is the high degree of institutional support the speech-language pathologists received from their employers to engage in these innovative practices. SLP staff from CH No.1 were given considerable time off work to travel to Đà Nẵng to teach and then to provide clinical training back in Ho Chi Minh City for the Đà Nẵng students. Le Thi Dao was encouraged by her hospital to appear on television to promote SLP. Le Thi Thanh Xuan was provided time release and financial support from her hospital to travel to Australia and learn about early interventions services. Le Khanh Dien was not only supported to develop the Art Group by his hospital but also supported to mount an art exhibition of his patients' work and to invite high-level government officials and television stations to cover the event. Speech-language pathologists in minority-world countries might well envy the high-level government commitment in Vietnam to developing SLP education and services. Sustained government commitment will of course be required over a long-time frame to embed SLP in the Vietnamese health care system.

In summary, the vignettes suggest that these speech-language pathologists have moved beyond imported minority-world curricula and SLP practice models to indigenise and create their own teaching and clinical practice approaches. The vignettes describe exciting innovations from the majority world in SLP service development, clinical services, educating others, and the use of media to promote the SLP profession and services, from which speech-language pathologists in minority-world countries can learn. Their innovations extend the reach of SLP services and are locally sustainable.

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1 Speech therapy is the term used in Vietnam.

References

American Art Therapy Association. (2013). What is art therapy? Retrieved from http://www.arttherapy.org/upload/whatisarttherapy.pdf

Brown, K., Worrall, L.E., Davidson, B., & Howe, T. (2012). Living successfully with aphasia: A qualitative meta-analysis of the perspectives of individuals with aphasia, family members, and speech-language pathologists. *International Journal of Speech-Language Pathology*, *14*(2), 141–155.

Dorze, G., Salois-Bellerose, E., Alepins, M., Croteau, C., & Halle, M-C. (2014). A description of the personal and environmental determinants of participation several years post-stroke according to the views of people who have aphasia. *Aphasiology*, *28*, 421–439.

Douglas, J. (2013). Conceptualizing self and maintaining social connection following severe traumatic brain injury. *Brain Injury*, *27*(1), 60–74.

Ewing, S. E. A. (2007). Group process, group dynamics, and group techniques with neurogenic communication disorders. In R. J. Elman (Ed.), *Group treatment of neurogenic communication disorders: The expert clinician's approach* (2nd ed.). Abingdon, Oxfordshire: Plural Publishing.

Hauser, V., Howlett, C., & Matthews, C. (2009). The place of indigenous knowledge in tertiary science education: A case study of Canadian practices in indigenizing the curriculum. *Australian Journal of Indigenous Education*, *38*, Supplement, 46–47.

Hawley, L.A., & Newman, J.K. (2010). Group interactive structured treatment (GIST): A social competence intervention for individuals with brain injury. *Brain Injury*, *24*(11), 1292–1297.

Holland, A. (2007). The power of aphasia groups: Celebrating Roger Ross. In R. J. Elman (Ed.), *Group treatment of neurogenic communication disorders: The expert clinician's approach* (2nd ed.). Abingdon, Oxfordshire: Plural Publishing.

Kim, S. H., Kim, M. Y., Lee J. H., & Chun, S. I. (2008). Art therapy outcomes in the rehabilitation treatment of a stroke patient: A case report. *Art Therapy: Journal of the American Art Therapy Association*, *25*(3), 129–133.

McAllister, L., Woodward, S., Atherton, M., Nguyen Thi Ngoc Dung, Potvin, C., Huynh Bich Thao, Le Thi Thanh Xuan, & Dien Le Khanh. (2013). Viet Nam's first qualified speech pathologists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech-Language Pathology*, *15*(2), 75–79.

Nixon, S. A., Cockburn, L., Acheinegeh, R., Bradley, K., Cameron, D., Mue, P. N., Samuel, N., & Gibson, B. E. (2015). Using postcolonial perspectives to consider rehabilitation with children with disabilities: The Bamenda-

Toronto dialogue. *Disability and the Global South*, *2*, 570–589.

Parrish, J. (2014). *Art and aphasia: A literary review and exhibition*. (Honors thesis). Western Michigan University, Kalamazoo, MI (2445).

van der Gaag, A., Smith, L., Davis, S., Moss, B., Cornelius, V., Laing, S., & Mowles, C. (2005). Therapy and support services for people with long-term stroke and aphasia and their relatives: A six-month follow-up study. *Clinical Rehabilitation*, *19*(4), 372–380.

Walsh, B. (2016). Two-way learning, creating a classroom culture of reciprocity, where teachers and students are learners first. Retrieved from https://www.gse.harvard.edu/news/uk/16/01/two-way-learning

World Health Organization and the World Bank. (2011). *World report on disability*. Geneva: World Health Organization.

Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in underserved populations. *International Journal of Speech Language Pathology*, *15*(1), 1–13.

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Building speech-language pathology capacity and colleagues across continents

Abbie Olszewski and Erica Frank

There is a lack of qualified speech-language pathology service providers to serve persons with communication difficulties globally. This paper discusses current speech-language pathology training models in countries across continents and the limitations of these models. We propose a new training model called the Democratically Open, Outstanding Hybrid of Internet-aided, Computer-aided, and Human-aided Education (DOOHICHE), which can be implemented in any country. The pros and cons of the DOOHICHE model are critically examined. Lastly, the future direction of the DOOHICHE model is discussed.

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There is a documented and substantial shortage of speech-language pathologists (SLPs) globally, including countries as diverse as Australia (Lowell, 2013), Fiji (Hopf, 2014), Ghana (Wylie, McAllister, Davidson, & Marshall, 2013), Malaysia (Ahmad, Ibrahim, Othman, & Vong, 2013), and South Africa (Weddington, 2002). Training future SLPs who can diagnose and treat persons with communication difficulties (PWCD) is widely recognised as important, given the ability to communicate effectively is a human right (Global Campaign for Free Expression, 2003; International Communication Project, n.d.; NJCCNPSD, 1992). However, building SLP capacity is difficult because it necessitates training in both content knowledge and clinical skills, often requiring skilled mentors to work individually or in small groups with SLPs who are in training.

Current solutions

Experts across the globe have begun to address the challenges of knowledge transfer and exchange to better serve PWCD (e.g., Ahmad et al., 2013; Cheng, 2013; Crowley et al., 2013). Cheng (2013) identified three models used in China: networking in close proximity, collaborating among different regions, and the use of technology. Working in Ghana, Crowley and colleagues (2013) used a biopsychosocial model, utilising interpreters to gather and share information to assess needs and make recommendations, delivering professional development, and collaborating with specialised teams. In Malaysia, Ahmad and colleagues (2013) developed local professional capacity and increased focus on improving knowledge, local evidence, and research. Although these models have built local speech-language pathology capacity in their respective countries, current models are limited in their ability to scale up, be accessible to a wide range of individuals, be affordable, be accessible, be sustainable, and to provide a wide scope of course offerings.

New solution

At NextGenU, we have developed an innovative clinical speech-language pathology training program model grounded in the workforce capacity-building framework to address current model limitations (Goldberg & Bryant, 2012; Somerville et al., 2015). This model is called a Democratically Open, Outstanding Hybrid of Internet-aided, Computer-aided, and Human-aided Education (DOOHICHE, pronounced "doohickey"). NextGenU offers these courses to any organisation (e.g., universities, hospitals, ministries) requiring access to content training in speech-language pathology (Goldberg & Bryant, 2012) through the DOOHICHE model, which allows training of groups (e.g., in a flipped classroom) or of individuals. Individual training is important, as individuals are foundational to building capacity in an organisation (Goldberg & Bryant, 2012). Once proficient, these well-trained individuals can function as local mentors and train additional students in their communities – the "human-aided" component.

The goal of the NextGenU speech-language pathology program is to give interested learners around the world practical and intellectual competencies to serve PWCD, and to empower these students to understand how these issues are addressed in their country, while interacting with a local and global community of peers and mentors to build a community of professionals who work with individuals with communicative disorders.

Pros and cons

The DOOHICHE model has the potential to be accessible and affordable to a larger number of students than current training models. The training courses are offered in 103 languages through Google Translate; hence, it is conceivable that it will reach a sizable number of students throughout the world. Although the courses are offered in a multitude of languages, translation of the content of the website through Google Translate may not be accurate. Because the courses are offered through the Internet,

Abbie Olszewski (top) and Erica Frank

anyone who has access to the Internet can take the courses. While the DOOHICHE model is free to learners, there are costs for computer and/or Internet access.

The DOOHICHE model is designed to be sustainable with a $16-million endowment (which adequately covers core expenses), slender operating costs, and volunteer course creators. Though NextGenU.org encourages local communities, policy-makers, organisations, and governments to eventually take "country-ownership" (Goldberg & Bryant, 2012) of all aspects of capacity building, it is unclear how local authorities will receive this model.

The DOOHICHE training model will train students in a wide variety of subject areas related to SLP. It is not dependent on specialised trainer availability and skills, but addresses many areas in depth, as it is created by experts in the field, and guided by an advisory committee, using resources from governments, peer-reviewed journals, specialty societies, and universities. However, students may have difficulty allocating time to courses, finding a peer, or selecting an appropriate mentor to support the didactic portion of the model.

Future direction

NextGenU's DOOHICHE model for building capacity in the global speech-language pathology workforce is in its infancy, as we are currently piloting our first course with students in Kenya. We are unclear about the model's strengths and limitations in addressing the ability to build speech-language pathology capacity on a global level. Our goal is to critically evaluate the DOOHICHE model by collecting data regarding the quality, accessibility, sustainability, affordability, and customisation of this model. The evaluative process for the model and each course will be ongoing and continually refined based on metrics and feedback.

Because we strive to make this a viable training program for future audiences, we welcome comments, feedback, and suggestions. We call on the SLP community to engage in a discussion via the *Journal of Clinical Practice in Speech-Language Pathology* on the feasibility and acceptability of NextGenU's DOOHICHE model training program for future speech-language pathologists worldwide.

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References

Ahmad, K., Ibrahim, H., Othman, B. F., & Vong, E. (2013). Addressing education of speech-language pathologists in the World Report on Disability: Development of a speech-language pathology program in Malaysia. *International Journal of Speech-Language Pathology*, *15*(1), 37–41. doi: 10.3109/17549507.2012.757709

Cheng, L. (2013). Knowledge transfer between minority and majority world settings and its application to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 65–68. doi:10.3109/17549507.2012.729862

Crowley, C., Baigorri, M., Ntim, C., Bukari, B., Oseibagyina, A., Kitcher, E., Paintsil, A., Ampomah, O. W., & Laing, A. (2013). Collaborations to address barriers for people with communication disabilities in Ghana: Considering the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 53–57. doi: 10.3109/17549507.2012.743036

Global Campaign for Free Expression. (2003). Article 19 Statement on the Right to Communicate. Retrieved from https://www.article19.org/data/files/pdfs/publications/right-to-communicate.pdf

Goldberg, J., & Bryant, M. (2012). Country ownership and capacity building: The next buzz words in health systems strengthening or a truly new approach to development? *BMC Public Health*, *12*, 1–9. doi:10.1186/1471-2458-12-531

Hopf, S. C. (2014). Services for children with communication disability in Fiji. *Journal of Clinical Practice in Speech-Language Pathology*, *16*(2), 81-86.

International Communication Project. (n.d.). The opportunity to communicate is a basic human right. Retrieved from http://www.internationalcommunicationproject.com/

Lowell, A. (2013). "From your own thinking you can't help us": Intercultural collaboration to address inequities in services for Indigenous Australians in response to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 101–105.

National Joint Committee for the Communicative Needs of Persons with Severe Disabilities. (1992). Guidelines for meeting the communication needs of persons with severe disabilities. Retrieved from: http://www.asha.org/policy/GL1992-00201/

Somerville, L., Davis, A., Elliiott, A., Terrill, D., Austin, N., & Philip, K. (2015). Building allied health workforce capacity: a strategic approach to workforce innovation. *Australian Health Review*, *39*, 264–270. doi:10.1071.AHI14211

Weddington, G. (2002). Speech-language pathology/audiology: Service delivery in rural and isolated regions of South Africa. *Folia Phoniatrica et Logopaedica*, *54*(2), 100–102.

Wylie, K., McAllister, L, Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in under-served populations. *International Journal of Speech-Language Pathology*, *15*(1), 1–13. doi:10.3109/17549507.2012.745164

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Applying theories of cultural competence to speech-language pathology practice in East Africa

Helen Barrett

As global mobility increases and populations diversify, challenges to delivering appropriate, responsive, ethical and effective SLP services have emerged and services users, practitioners and national bodies are increasingly calling for delivery of culturally sensitive services. It is therefore crucial to look beyond our own cultural reference points and adopt an attitude of open-minded and continuous learning about others in order to provide the best services to all clients. Models of cultural competence have been developed across the allied health professions and have been described as: practitioners' awareness, knowledge, skills, and sensitivity in relation to their clinical practice with people from cultural and linguistic backgrounds other than their own. This paper draws on the author's experience of working across east Africa, with reference to two frameworks for cultural competence which are applicable to speech-language pathology practice. The paper highlights the multifaceted and interactional nature of different dimensions of cultural competence and queries whether this is accurately represented in the current theoretical frameworks.

KEYWORDS
CULTURAL COMPETENCE
EAST AFRICA
SPEECH-LANGUAGE PATHOLOGY

THIS ARTICLE HAS BEEN PEER-REVIEWED

Helen Barrett

East Africa is a region defined by diversity, and the challenges to developing cultural competence for external speech-language pathologists are enormous. Not only is the ethnic and linguistic diversity in the region extensive, but explanatory models of disability are often heavily influenced by the medical profession, stigma surrounding disability, and religious and /or cultural beliefs (Barrett, 2013). Professional training courses and services to meet the needs of people with communication difficulties are emerging[1] but are in their infancy, are frequently facilitated by external speech-language pathologists and often require ongoing support once established (e.g., Robinson, Afako, Wickenden, & Hartley, 2003). It is therefore crucial that the external practitioners involved are culturally competent to deliver appropriate, responsive, ethical and effective support.

The need for a culturally competent profession

Many national speech-language pathology associations stress the need for professionals to offer appropriate and sensitive services to diverse client groups (e.g., ASHA 2011; RCSLT 2003; SPA, 2016), but more guidance is needed on *how* to fulfil these obligations, specifically regarding issues beyond bilingualism and multilingualism (Leadbeater & Litosseliti, 2014).

Much of the available literature exploring speech-language pathology with clients from a range of backgrounds describes practice in multicultural societies in the minority world[2] (e.g., Leadbeater & Litoselliti, 2014). However, literature is also emerging on how external speech-language pathologists working in the majority world can do so ethically and effectively (e.g., Crowley & Baigorri, 2011; Hickey, McKenna, Woods, & Archibald, 2014). Current literature addressing the needs of people with communication disabilities in the majority world primarily focuses on issues and methods of professional or service development (e.g., Wickenden, 2013; Wylie, McAllister, Davidson, & Marshall, 2013) and, though this literature identifies the need for speech-language pathology education programs and services to be developed using culturally appropriate methods (e.g., Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003), the question remains as to *how* external speech-language pathologists can develop competence to facilitate these processes effectively.

For speech-language pathologists to become sufficiently competent to practise internationally, it is essential to reflect upon motivations, skills and learning needs (Brown & Lehto, 2005; Hickey et al., 2014) and upon what cultural competence means in relation to their home, and overseas, practice. In addition, it is critical to consider the concept of cultural humility in relation to cultural competence; cultural humility being the acceptance that it is not possible to be fully knowledgeable about a culture other than that which one is born into (Levi, 2009; Walters, 2015). Practitioners must therefore understand that cultural competence and cultural humility are critical prerequisites to the delivery of appropriate, relevant and effective services and apply both concepts to their practice.

Table 1. Dimensions of culturally competent practice proposed by Sue et al. (1992).

Dimensions / Practitioner characteristics	Awareness and beliefs Clinician is:	Knowledge Clinician demonstrates:	Skills Clinician is:
Awareness of own assumptions, values and biases	Aware of own culture and its influence on beliefs about self, others and clinical practice	Knowledge of own culture and aspects of this that may impact upon service delivery to diverse populations	Aware of own skills and ability to adapt these to diverse populations. Aware of own learning needs in relation to skill development
Understanding of the worldview of the culturally different client	Aware that individuals have varied understandings of the world and that this may impact upon the conceptualisation of their difficulties and response to intervention. Respectful of difference in the face of own cultural values and beliefs.	Knowledge and understanding of different cultural interpretations of worldviews and understands that individuals within a culture may have individualised interpretations of their own culture(s). Desire to develop knowledge and understanding	Able to transform understanding of different worldviews into culturally sensitive and safe clinical practice
Use of appropriate intervention strategies	Aware of the need for flexibility, creativity and individualisation in intervention	Knowledge of how to adapt intervention strategies and techniques to a variety of populations using culturally appropriate and acceptable methods. Support-seeking from others with implicit cultural knowledge	Skilled in innovative, sensitive and safe intervention

Theoretical models of cultural competence

This section explores two prominent models of cultural competence and their application to trans-cultural speech-language pathology practice. The models were not specifically designed for speech-language pathologists, but can be applied to allied health professions more broadly.

Model 1. Sue, Arrendondo, and McDavis (1992)

Sue, Arrendondo, and Davis (1992) identified three dimensions necessary for cultural competence: (a) awareness/beliefs, (b) knowledge, and (c) skills. These three dimensions are complementary to three practitioner characteristics: (a) awareness of own assumptions, values and biases; (b) understanding of the worldview of the culturally different client; and (c) use of appropriate intervention strategies. The relationship between each dimension can be visualised in a matrix to represent the competencies required to be considered culturally proficient (Table 1).

In addition to their model of professional cultural competence, Sue et al. (1998) use the concept of "multi-dimensionality of identity" to define how individuals possess different identities at individual, group, and universal levels, with the potential to possess more than one identity at each level[3] (Ridley, Baker, & Hill, 2001). Moreover, they describe how these identities are interactive – a person may be socially limited or liberated by one or more of their identities at each level, depending on their experience. For example, a woman with a communication disability's participation in society *may* be limited by both her disability and her gender at group or universal level, but not at individual level. A person's experience at one level may, over time, alter identity at another, including the way a person views his/herself as an individual (Marsh & MacDonald-Holmes, 1990). For example, over time, a woman may perceive herself to be limited as an individual due to her social experience – her self-concept is altered. This theory highlights the importance of considering cultural competence as a multidimensional and fluid concept, requiring constant adaptation as we consider individuals within a culture. However, the stand-alone models currently do not reflect this essential relationship between practitioner awareness, knowledge and skills and their interaction with the individual client.

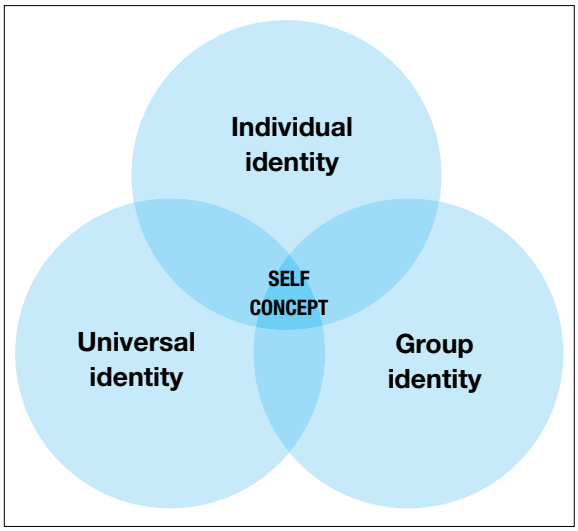

Figure 1. The interrelationship between levels of multidimensional identity and self-concept.

Model 2. Papadopolous, Tilki, and Taylor (1998)

Papadopolous, Tilki, and Taylor (1998) describe similar attributes for cultural competence as Sue et al. (1992) but also identify "cultural sensitivity" as a key component,

including supportive skills such as empathy, communication, trust, acceptance, and respect of the individual. Acknowledgement of a person's observable (and assumed) culture without a deeper understanding of individual cultural attributes can lead to tokenistic tolerance of diversity with complacency in implementing culturally sensitive practices (Cross, Bazron, Dennis, & Isaacs, 1989). For example, a company hires a "quota" of ethnically diverse staff, but does not adapt wider policies and practices. In contrast, culturally sensitive practice allows us to consider multidimensionality of identity and is fundamental to developing the more nuanced awareness, knowledge, and skills required to deliver culturally appropriate, responsible, ethical and effective services.

Application of a cultural competence framework to speech-language pathology practice

Although not designed as speech-language pathology-specific theoretical models, the cultural competence constructs of both Sue et al. (1992) and Papadopolous et al. (1998) may be applied to health professions more broadly. The models identify how practitioners should recognise and reflect upon their *own* attitudes, values, knowledge skills, and sensitivity, and consider how they can harness and develop these to work effectively in diverse environments. As acknowledged by IAHA (2015) and Papadopolous et al. (1998), the development of cultural competence is a continuous, never-ending process, requiring interaction and experience, alongside the development of knowledge of one's own, and other, cultures.

In the following note the author gives a personal interpretation of the models described above in relation to her own experience living and working in east Africa. Through exploration of four of the dimensions of culturally competent practice, the author aims to illustrate the ongoing development of her own cultural competence as a process of constant renewal and revision.

Developing cultural competence in east Africa: A personal reflection

Reflective statement

I have lived and worked in Africa at various points since 1999 and as a speech-language pathologist in east Africa permanently since 2008. My work has focused on training local practitioners and policy-makers to understand and address the needs of people with communication disabilities in local communities. During this time, I have experienced a steep learning curve in my own understanding of cultural competence and continue to adjust my practice with each new experience. The following section provides an analysis of my personal reflections. Specific themes that arise are then discussed with reference to theoretical concepts of cultural competence

Theme 1. Awareness and beliefs

Reflection: Having worked in Kenya, Uganda and Tanzania, I was surprised to find Rwanda very different to other countries in the region. My assumptions about the people and professional culture were significantly challenged. It was, essentially, a "culture shock" that took some time to adjust to, both personally and professionally.

The information we access before we arrive in a new country helps to form our early beliefs about the people and cultures we are about to encounter. However, it takes time to appreciate more fully how these cultures vary in their application to individuals and, over time, our awareness and beliefs change in line with experience.

New experiences help us to develop a heightened awareness of our own culture and we become aware of how aspects of our culture may change in the new environment. Moreover, we learn about how others perceive us and may have to re-evaluate some established stereotypes. How we communicate with a variety of individuals in our own language and across other languages also plays an important role in our ability to adapt to new transcultural challenges. We discover things about how we see ourselves, how we see others from our own culture and how we see people from cultures different from our own. This self-reflection helps us to appreciate similarities and differences and identify opportunities to overcome potential barriers to interaction and engagement, and is considered an essential part of both Sue et al.'s (1992) and Papadopolous et al.'s (1998) models.

Theme 2. Knowledge

Reflection: A family in Uganda had difficulty accepting alternative-augmentative communication (AAC) methods for their child. They resisted use of cards or charts, but valued a hand-drawn book of pictures using the same exercise book that other children used in school. It was important for me to understand social norms and values in the family's community and devise solutions to therapeutic dilemmas that were responsive to those values.

Knowledge, when coupled with experience, can translate into understanding that helps us to communicate and build relationships with individuals. We may conclude that knowledge continually grows and shapes our awareness, beliefs, and skill development and is balanced by our sensitivity and attitudes. Cultural knowledge and clinical knowledge also need to come together in new therapeutic environments; understanding the cultural applicability of our clinical knowledge to individuals from different backgrounds is critical to developing and providing culturally sensitive services. Furthermore, cultural humility – understanding that individuals are the gatekeepers of their own culture and that we must learn from them in an open-minded, flexible, creative, and patient way – allows us to shape knowledge into sensitively conceived, practical and meaningful skills (see Walters, 2015). However, this bidirectional learning process and breakdown of practitioner–client power relations is not represented in the models of clinical cultural competence discussed above.

Theme 3. Skills

Reflection: In Rwanda, I work with a British non-governmental organisation, Chance for Childhood, that has engaged international specialist speech-language pathologists (including myself) to help to develop the capacity of a team of local practitioners who go on to train teachers and assistants to support children with communication disability in schools and communities. In addition, they are supporting the development of national curricula in conjunction with development partners and the government (see Barrett, Turatsinze, & Marshall, 2016).

In east Africa, explanatory models of disability are often deficit-focused, though this is gradually changing. A biopsychosocial understanding of disability (WHO, 2001) is prevalent in the minority world and speech-language pathology professional culture and practice has developed in line with this model (Leadbeater & Litosseliti, 2014). External speech-language pathologists' biopsychosocially derived skills are therefore at risk of being in juxtaposition with both the conceptualisation of disability and health care delivery models predominant in east Africa. My experience has taught me that it takes time, skill, patience, flexibility and relationship-building, alongside reflection on both personal and professional beliefs and knowledge about explanatory models of disability, to work between the two paradigms. This relationship between knowledge and skill development is, again, bidirectional but is not represented as such in the models.

Understanding of the need to build local capacity is also critical to culturally competent practice (Barrett et al., 2016; Hickey et al., 2014; IAHA, 2015) – sustainability is key. In countries where local speech-language pathologists are either not available or in short supply, other professionals may benefit from skill-sharing[4] to enhance their practice with people with communication disabilities (Hartley, Murira, Mwangoma, Carter, & Newton, 2009). Consideration of communication disability as a broader public health issue, potentially best addressed with a population-based approach to service delivery, may be a potential solution to the skill deficit (Wylie, McAllister, Davidson, Marshall, & Law, 2014). This longer term approach requires advocacy from service users and providers, political will, and strategic planning from within to achieve change. It is therefore crucial that external speech-language pathologists have the appropriate understanding of the context, and resultant skills, to support local service users, providers, and advocates in this process.

Theme 4. Sensitivity

Reflection: In Kenya, Uganda and Rwanda, working with local organisations has allowed teams of local partners to build internal capacity and reach out to people in remote communities who would not otherwise access services. The partners explain communication difficulties in accessible and appropriate ways, are able to give locally contextualised examples and explanations in local languages, and use sustainable materials to make appropriate resources.

Cultural sensitivity is, arguably, the most salient part of the Papadopolous et al. (1998) model. The concept of cultural sensitivity resonates with that of cultural humility. It reaches beyond knowledge and deeper into the awareness that there is more to a person's culture than is, or can be, articulated (Hall, 1984; Levi, 2009). This implicit cultural information is rarely accessible to outsiders (Papadopolous et al., 1998) and that is a primary reason why it is imperative to work with local partners who do have access to, and are accepted at, these implicit cultural levels. It is therefore crucial that speech-language pathologists work with, and through, local practitioners who bring expertise beyond clinical skills and are uniquely positioned to access the communities to which they belong (see Hickey et al., 2014).

Summary

The concept of culture is continually evolving and it is therefore crucial that theoretical frameworks develop to reflect this change. However, the analysis provided suggests that the current frameworks of clinical cultural competence do not yet adequately reflect the multifaceted attributes required to work effectively with people from a range of backgrounds and require reconceptualisation.

The above reflection and analysis illustrates that cultural competence in clinical practice encompasses multidirectional interactions between individuals with multiple identities and their practitioners, with the awareness, knowledge and skills to offer effective and ethical services. In order to develop appropriate skills, cultural humility must underpin the development of awareness and knowledge of, and sensitivity towards, one's own, and other, cultures (including individual interpretations of these). As discussed, the theory of cultural humility dictates that competence is not an endpoint, but an evolving phenomenon (see Figure 2). In order for speech-language pathologists to deliver culturally appropriate,

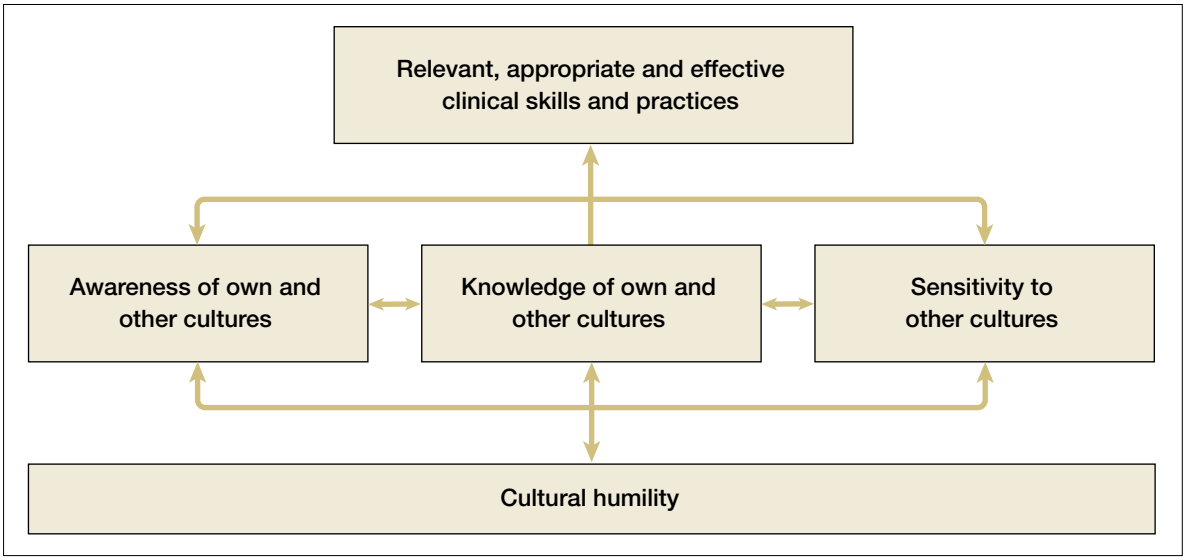

Figure 2. Towards an integrated model of cultural competence. Cultural humility underpins the development of awareness and knowledge of, and sensitivity towards, one's own and other cultures and the subsequent development of effective clinical skills. (Integrated model based on Sue et al., 1992; Papadopolous et al., 1998; and Walters, 2015)

relevant, responsive and effective services both at home and overseas, a wider recognition of the need for cultural competence to be grounded in the concept of humility needs to be a common and central concern of speech-language pathology governing bodies, training institutions, service providers. Ultimately, it needs to be championed by individual members of the profession.

It is vital that the speech-language pathologists contributing to service development in the majority world reflect upon both their motivations and their ability to provide appropriate input that is sensitive to the needs of local service users and providers (Hickey et al., 2014). Thus, practitioners need to reflect upon some widely accepted personal and professional cultural beliefs and be led by local partners to reach workable and realistic solutions to the challenges that they identify. Participatory and emancipatory research is therefore necessary to expound the needs of people with communication disabilities in different contexts, and what they, and their communities, feel is the most appropriate way forward to address those needs.

Conclusion

As global mobility increases, it has never been so important to look beyond our own cultural reference points and adopt an attitude of open-minded and continuous learning about others. As societies are becoming increasingly multicultural, awareness, knowledge, skills and sensitivity towards others are essential in speech-language pathology practice. However, the profession must ask if the current conceptualisations of cultural competence adequately represent the multidirectional interaction between all of the professional attributes required to work effectively with people from cultures vastly different from our own.

Ensuring appropriate training on cultural competence on speech-language pathology courses is an important step towards increasing trainees' awareness and knowledge about cultural diversity and its implications for effective clinical practice. However, sensitivity and skills come with experience and, arguably, the multifaceted dimensions of cultural competence are governed by an individual's ability to demonstrate cultural humility and by their own attitudes. Essentially, the onus lies with individuals to embrace diversity in both their personal and professional lives, critically appraise themselves and their practice, accept the unease that comes with stepping outside their comfort-zone with people from other cultures (Walters, 2015), and actively seek to develop their own interpretation of the term cultural competence.

1 Training courses are in place in Uganda, Kenya and Tanzania and under development in Rwanda.

2 Shalmani (2015) states: *"The term 'Majority world' highlights the fact that the majority of the world's population lives in these parts of the world traditionally referred to as 'developing'. The term 'Minority world' is similarly used to refer to those countries traditionally referred to as 'developed', where a minority of the world's population resides"*. The author recognises the problematic nature of using a "two world's approach" (Young, 2010), but has opted to use the above terms for clarity of argument.

3 Identities can include age, ethnicity, gender, linguistic background(s), national origin, religion, sexual orientation, socioeconomic status (see ASHA, 2013; Papadopolous et al. 1998).

4 Whereby people seek to exchange knowledge and skills to enhance each other's practice

References

American Speech-Language Hearing Association (ASHA). (2011). *Cultural competence in professional service delivery*. Retrieved from http://www.asha.org/policy/KS2004-00215.htm

American Speech-Language and Hearing Association (ASHA) Board of Ethics (2013). *Cultural and linguistic competence* [Issues in ethics]. Retrieved from http://www.asha.org/Practice/ethics/

Barrett, H. (2013). *"Education for all"? Access to primary-level education for children with complex learning disabilities in countries with "free primary education" in sub-Saharan Africa: A review of the literature*. (Unpublished master's thesis). University of Manchester, UK.

Barrett, H., Turatsinze, F., & Marshall, J. (2016). International working: strategic thinking achieves change. *RCSLT Bulletin*, *July*, 18–19.

Brown, S., & Lehto, X. (2005). Travelling with a purpose: understanding the motives and benefits of volunteer vacations. *Current Issues in Tourism*, *8*(6), 479–496

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*, Volume I. Washington, DC: CAASP Technical Assistance Center.

Crowley, C., & Baigorri, M. (2011). Effective approaches to international work: Substance and sustainability for speech-language pathology student groups. *Perspectives on Global Issues in Communication Sciences and Related Disorders*, *1*(1), 27–35.

Hall E. (1984). *The dance of life: the other dimension of time*. New York, NY: Anchor Press.

Hartley, S., Murira, G., Mwangoma, M., Carter, J., & Newton, C. (2009) Using community/researcher partnership to develop a culturally relevant intervention for children with communication disabilities in Kenya. *Journal of Health Services Research and Policy*, *31*, 490–499.

Hickey, E.M., McKenna, M., Woods, C., & Archibald, C. (2014). Ethical concerns in voluntourism in speech-language pathology and audiology. *Perspectives on Global Issues in Communication Sciences and Related Disorders*, *2*, 40–48.

Indigenous Allied Health Australia (IAHA). (2015). *Cultural responsiveness in action: An IAHA framework*. Australia: Author.

Leadbeater, C., & Litosseliti, L. (2014). The importance of cultural competence for speech and language therapists. *Journal of Interactional Research in Communication Disorders*, *5*,1–26.

Levi, A. (2009). The ethics of nursing student international clinical experiences. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, *38*(1), 94–99.

Marsh, H. W., and MacDonald-Holmes, I. W. (1990). Multidimensional self-concepts: Construct validation of responses by children. *American Educational Research Journal, 27*(1), 89–117.

Papadopolous, I., Tilki, M., & Taylor, G. (1998). *Transcultural care: A guide for healthcare professionals*. Wilts, UK: Quay Publications.

Ridley, C.R., Baker, D.M., & Hill, C.L. (2001). Critical issues concerning cultural competence. *The Counselling Psychologist*, *29*(6), 822–832.

Robinson, H., Afako, R., Wickenden, M., & Hartley, S. (2003). Preliminary planning for training speech and language therapists in Uganda. *Folia Phoniatrica et Logopaedica*, *55*, 322–328.

Royal College of Speech and Language Therapists (RCSLT) (2003). *Reference framework underpinning*

competence to practise. Retrieved from http://www.rcslt.org/docs/competencies_project.pdf

Shalmani, S. (2015). Why I use the term "majority world" instead of "developing countries" or "third world". Retrieved from https://sadafshallwani.net/2015/08/04/majority-world/

Speech Pathology Australia (SPA). (2016). *Working in a culturally and linguistically diverse society* (Position paper). Australia: Author.

Sue, D.W., Arrendondo, P., & McDavis, R.J., (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477–486.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T., Manese, J. E., Ponterotto, J. G. & Vasquez-Nutall, E. (1998). *Multicultural counseling competencies*. Thousand Oaks, CA: Sage Publications.

Walters, T. (2015). *Cultural humility: A hermeneutic literature review*. (Unpublished master's thesis). Auckland University of Technology, New Zealand.

Wickenden, M., Hartley, S., Kariyakaranawa, S., & Kodikara, S. (2003). Teaching speech and language therapists in Sri Lanka: Issues in curriculum, culture and language. *Folia Phoniatrica et Logopaedica*, *55*(6), 314–21.

Wickenden, M. (2013). Widening the SLP lens: How can we improve the wellbeing of people with communication difficulties globally? *International Journal of Speech-Language Pathology*, *15*(1), 14–20.

World Health Organization (2001). *International classification of functioning (ICF)*. Retrieved from http://www.who.int/classifications/icf/en/

Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). The World Report on Disability: An impetus to reconceptualise services for people with communication disability. *International Journal of Speech Language Pathology*, *15*(1), 118–126.

Wylie, K., McAllister, L., Davidson, B., Marshall, J., & Law, J. (2014). Adopting public health approaches to communication disability: Challenges for the education of speech-language pathologists. *Folia Phoniatrica et Logopaedica*, *66*, 164–175.

Young, H. (2010). Naming the world: Coming to terms with complexity. *Policy and Practice: A Development Education Review*. (Issue 10). Retrieved from http://www.developmenteducationreview.com/issue10-perspectives3

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"I can't believe you want to leave at lunch time"

A reflection on how narrative ethics may inform ethical practice in cross-cultural and majority-world contexts

Helen Smith

KEYWORDS
CULTURAL AND LINGUISTIC DIVERSITY
MAJORITY-WORLD VOLUNTEERING
NARRATIVE ETHICS

Helen Smith

In the mid 1990s for 2½ years I was a volunteer speech pathologist with Australian Volunteers International in a sub-Saharan African country. This story is based on my time working in country. This piece will use a narrative ethics framework (Speech Pathology Australia, 2014) to consider the story; the current story as I experienced it, a reflection on the background story from multiple perspectives and a reimagined future story. Finally, some considerations for ethical volunteering as speech pathologists in culturally and linguistically diverse majority-world contexts will be provided.

The current story

Sarah,[1] a hard- working and dedicated rehabilitation technician[2] returned one Monday from a rare funded professional development opportunity. She was the mother of two and the adoptive mother of three (her sister's children, adopted after her sister's death from HIV the year before), and it had taken a huge amount of organisation and personal commitment for Sarah to attend the course. (The course was based in a central location requiring 3–4 hours travel and several nights away from home.)

The course was funded and run by a service organisation from North America which had recruited volunteer specialists from their own country, provided them with travel and living expenses but no salary, so they could provide a week-long specialist training program to local health workers. The service organisation had also funded the travel and living expenses for the local health workers to attend. A rare and generous gift with the goal of improving the provision of specialist services to people in the country.

Sarah, a keen learner, was always motivated to improve her knowledge and skills. Therefore, I was surprised on the Monday morning following the course when my question asking how her course had been was met with a huge sigh and a look of despondency. Concerned, I asked Sarah what had happened.

Sarah started by expressing her delight in the amazing opportunity to develop her understanding of the specialist area. She was delighted that what she was required to do for patients at our hospital made more sense as the course rolled out.

Sarah, however, then expressed her frustrations. First, the "whole" course as outlined in the brochure had not been provided. Second, each day, regardless of the presenter, the content appeared very rushed, with no time to consolidate learning or to ask questions. Despite the speed of delivery, she commented the presenters were constantly complaining at their frustration that they couldn't fit in all the content they had planned.

Over lunch one day Sarah asked one of the facilitators why everything was being covered so quickly. While English was the official language for education and business, English was a second (or third language) for most of the attendees. The majority of the participants had a TAFE-level qualification and were finding it challenging to keep up. The facilitator responded to Sarah's question by saying:

> *You all had to travel on Tuesday. We had expected you to travel on Monday as it was a public holiday but none of you could be bothered to do that. And none of you will stay all day on Friday. You all want to leave at lunch time. So our carefully planned 4-day course is being squashed into 2½ days.*

Sarah commented she felt like the facilitator was saying she and her fellow participants didn't value the educational opportunity to improve the specialist services they would provide to their patients. Nothing could have been further from the truth. On reflection, Sarah wondered how she could have helped the facilitators change their perception of the participants. She was concerned about the facilitator's misperception that the participants were not motivated or were lazy. She wondered how this valued and valuable training could have been less than optimal because of such a lack of understanding. She did not feel empowered to continue the conversation as the facilitator rushed off to prepare for the next session. Sarah certainly did not feel valued or respected by the facilitator.

The background story

A narrative approach to ethical reasoning considers an individual's or cultural group's life story (Speech Pathology Australia, 2014). The values and experiences each participant brings to the story are considered. This allows both sets of voices in the story to be heard. Each person in the story arrives at the situation described from their own perspective. It is only through the consideration of these multifaceted perspectives that a new and deeper shared understanding can be reached.

The volunteer presenters had dedicated valuable vacation time to come to Africa to deliver training. They had spent many hours preparing the training program prior to their departure from home. They came with slides and handouts and workbooks. The timing of the trip had been made to accommodate the volunteers' usual summer holiday period to have the least impact on their own local

service provision. The volunteers were motivated to "do good" (Speech Pathology Australia, 2010) in coming to the country and providing the training. They too recognised the speed and lack of time available was affecting the quality of the training they were providing and were frustrated by the circumstances which prevented them maximising the training they had come so far to present.

What the presenters didn't understand was the cultural context. The "public holiday" so casually mentioned was not just any "holiday". It was an Anzac-day type celebration for the fallen freedom fighters from the recent independence war. In a politically nuanced country, being absent from your local "celebrations" could potentially endanger you and your extended family's reputation and security. Being absent – for example, travelling on that day – was just not an option for any local worker.

Similarly, the need to leave mid-day on Friday was not "skipping out". Most of the local participants would be taking long distance buses home. Bus stations after dark were not safe places for reputable people to be, particularly women on their own. Women in the bus station area after dark, especially on a Friday night, were at great risk from groups of drunken men at the end of their working week. Anything could (and frequently did) happen to lone people especially women, in such places. All local people knew this and were careful to ensure people attending courses would be out of the bus station area and home well before dark particularly on Fridays.

Potentially, based on the facilitators' feedback, there was a risk similar workshops would not be funded by the North American service organisation in future. This would mean both volunteers and participants would not have the opportunity for a rich cultural exchange and education that the volunteer program provided. There was also a risk that local organisations may not implement improved health care practices if the participants were unable to engage with the workshop content due to the structure and speed of the workshop.

Understanding the background stories of Sarah, her fellow students and the presenters provides useful insights into this revised story and assists consideration of how to move past the barriers expressed in the original story. The new perspectives gained during the reflection allow a future story to be reimagined with a more positive experience for all participants involved.

An ethical approach for future workshops

I would like to present the following strategies as ways to move forward and construct a positive future story.

Embedding volunteer programs

Having volunteer programs embedded in local services and at the behest of local services may go a long way to preventing similar misunderstandings and risks of harm. A local contact, involved in pre-planning, could have explained to the volunteer group before dates were determined why a proposed week was not suitable with respect to a culturally and politically important public holiday. A local contact could facilitate discussions around the need to finish by lunch time so participants could safely travel home, and explain fully the safety risk if this recommendation was not adhered to by participants. A local co-facilitator could also provide orientation to the volunteers to the English competency and education level of the group so the pace of the training program could maximise learning. It is also worth considering that if the timeframe for a volunteer educational program is not ideal, it may be of more benefit to focus on the quality of the content rather than quantity of information provided. This may facilitate new services or techniques being safely and confidently implemented in the new setting.

Considerations for volunteers

Good practice principles

The Irish Code of Good Practice for volunteer sending agencies (COMHLAMH, 2015, p. 6) outlines a number of principles relevant for consideration including:

- Volunteers participate in appropriate preparation, training and induction.
- Organisations take all practical steps to ensure the protection, safety and well-being of volunteers and the communities they work with.
- Organisations support volunteers to understand the wider context of development in which volunteering is taking place.

Consideration of these principles and of our own SPA Code of Ethics may facilitate an ethical approach to even very simple, short-term volunteer opportunities, such as the one described in this example, and maximise "the good" for all involved while upholding autonomy and respecting the beliefs and values of local communities. Using a narrative ethics framework to guide reflections on this "story" highlights the importance of listening to the perspectives of all, and illustrates the utility of the narrative approach in finding ethical solutions to cross-cultural and majority-world dilemmas.

Established volunteer organisations and programs

Speech Pathology Australia (SPA) supports the use of established organisations for speech pathologists wishing to volunteer in majority-world communities for philanthropic reasons (Speech Pathology Australia, 2015). The use of established volunteer organisations facilitates the access to appropriate orientation and support for speech pathologists.

Developing understanding of cultural and linguistic diversity

In addition SPA recommends that speech pathologists working in culturally and linguistically diverse environments (wherever they may be geographically) be familiar with the contents of the position statement "Working in a culturally and linguistically diverse society" (Speech Pathology Australia, 2009). This document highlights the requirement for speech pathologists to develop cross-cultural competence in order to provide culturally relevant and I would suggest ethical services.

The benefits of ethical volunteering

The development of new cultural knowledge and partnerships with people from other cultures is one of the joyful benefits of volunteering in a majority-world context in both short- and longer term programs. The personal and professional benefits are enormous and often life-changing. The benefits we gain from volunteering may far outweigh what we offer in return. In my experience, the Sarahs of the world also want to provide the best possible services for their patients. Sarah certainly appreciated the support to provide the highest standards of care for her patients within the context in which she worked. Her attitude and calm

resilience remains an inspiration to me. This story highlights the importance of listening to the perspectives of all and illustrates the utility of the narrative approach to ethical reflection in complex situations.

Acknowledgements

I would like to acknowledge the invaluable feedback and advice received from members of the ethics board Belinda Kenny, Suze Leitão, Trish Johnson and Patricia Bradd on earlier drafts of this paper.

1 Not her real name
2 Rehabilitation technicians are the equivalent of Certificate 4 Allied Health Assistants in Australia

References

COMHLAMH. (2015). *Irish code of good practice for volunteeer sending agencies*. Retrieved 3 June 2016, from www.comhlamh.org/code-of-good-practice-2-2/: http://www.comhlamh.org/code-of-good-practice-2-2/

Speech Pathology Australia. (2009). *Working in a culturally and linguistically diverse society*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2010). *Code of ethics*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2014). *Ethic education package*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2015). *Volunteering in speech pathology*. Melbourne, Vic.: Author.

Helen Smith is a senior member of SPA's Ethics Board. In the 1990s she volunteered with Australian Volunteers International.

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Webwords 56

Minority-world SLPs/SLTs in majority-world contexts

Caroline Bowen

The modes of service delivery, and the settings in which speech-language pathologists / speech and language therapists (SLPs/SLTs) work, are remarkably diverse. The "modes" can be push-in or pull-out in schools; hospital-, office- or clinic-based; face-to-face in the flesh, or face-to-face via telepractice; or "mobile" – boating, driving or flying between sites. The settings, at home and abroad, can be in aged-care facilities, charitable and philanthropic institutions, clients' or clinicians' own homes, community health centres, custodial or care facilities, early intervention centres, hospitals, missions, online, orphanages, preschools and schools, private practices, rehabilitation units, social enterprises, and university clinics, in the minority and majority worlds.

Altruists bitten by the travel bug

SLPs/SLTs, affected by some combination of altruistic values – around social justice, equity, freedom and wanting to make a contribution to the greater good – and the travel bug are often inspired to work in the majority world. They can do so for short periods, long periods, or in regular bursts, as interested onlookers, volunteers and paid employees. Their international workforce participation can involve study tours or fact-finding trips to become better informed about communication and swallowing disorders' services in the visited country or region, with no delivery of direct services, or with service delivery as an ancillary goal; international work experience for undergraduate and graduate students; information sharing-and-training-only missions; and sustained and sustainable direct service provision (Crowley & Biagorri, 2011) taking full advantage of local "social capital" in the host community. Where providing clinical services is concerned, sustainability is a central concern, with a "best practice" focus on upskilling local individuals to continue the work, with ongoing support, increasingly via the Internet (Salas-Provance, Marchino, & Escobedo, 2014).

Association support

SLP/SLT professional associations support international outreach and networking in various ways. For example, ASHA has two relevant Special Interest Groups: **SIG 14**[1] Cultural and Linguistic Diversity and **SIG 17**[2] Global Issues in Communication Sciences and Related Disorders, and Speech Pathology Australia has a closed Facebook **group**[3] for members interested in working in developing communities.

Recruiters

Recruitment agencies often tap into professionals' philanthropism and thirst for adventure with promises that the overseas experience will be "personally rewarding", taking advantage of (free) social media and the goodwill of individual practitioners to spread the word. Since 1998, speech-language-therapy dot com has attracted a flow of enquiries and requests for help, often relating to SLP/SLT services in the majority world and in remote places, partly as a consequence of the **professional interest**[4] section of the site. In the first half of 2016 alone, email from recruiters arrived directly from Bali, Bolivia, Cambodia, Ethiopia, Mongolia, Myanmar, Papua New Guinea, Peru, Romania, Rwanda, Ukraine and the US. This one was from the US:

> *I am recruiting an SLT (I do hope it might be YOU) and an OT who would like to live in Shenzhen for one year to train paraprofessionals on SLT and OT skills for ages 0–8 years old. China has just recognized the need for SLTs. No universities offer it as a major and few courses are offered except via other universities. A CEO of a rehab center for young children wants to offer services, but the therapists would have to speak Chinese, which has many variants. In the interim, the CEO seeks an SLT to train or share basic info to the current teachers/paraprofessionals who have worked with disabled children for years (very experienced and dedicated). Translators are available. If you have a better solution, please share. Please inform your wonderful network.*

For the record, the (somewhat misinformed) writer was directed to the Hong Kong Association of Speech Therapists (**HKAST**[5]), SLP/SLT academics in the Division of **Speech & Hearing Sciences**[6] at the University of Hong Kong, the Chinese International Speech-Language and Hearing Association (**CISHA**[7]), and to various personal contacts in the PRC. Another 2016 enquiry was from Africa:

> *We seek to recruit a Speech Pathologist to train rehab technician staff to provide the highest quality assessment and therapy services (with a main focus on AAC, ASD and speech) over 6 to 8 weeks in Malawi. We will pay airfares board and lodgings and meet-greet you in Lilongwe. Like so many of these enquiries, it came with an appeal for a six-figure "suggested sum".*

Again, factual information, and conservative advice were proffered, but as is also usual when an answer is not the one "hoped for", no further correspondence was received.

Volunteers or voluntourists?

The site also receives regular email from SLPs/SLTs and students, variously interested in working somewhere foreign, wanting an adventure, or seeking to contribute to the world community. Much of it betrays a breathtaking arrogance, a sense of superiority over potential host communities, little humility (Bleile, 2015), and scant cultural

competence and cultural sensitivity (Bowen, 2009). Here are five representative unedited samples:

Hi. I have very recently finished my BSc (honours) degree in Speech and Language therapy, acquiring many exportable skills at a prestigious British university. I would like to work as a speech therapist in ***Asia***[8] *(possibly Honk Kong or Singapore but anywhere else would be good too) since I think I would find it extremely interesting to work in that part of the world, especially since the profession is less developed in that continent. Can you put me in touch, as soon as possible, with contacts who can read English since I do not speak any overseas languages?*

After 30 years as an SLP in the schools, I am retiring. I have given my recent "SLP acquisitions" to younger colleagues and to the clinic at my alma mater. I am left with 3 large boxes of tests, texts and therapy manuals (Hanen, LinguiSystems, ProEd, HBJ, Super Duper, etc.) and materials (flash cards, etc.). They are not current enough, or in good enough condition for my young colleagues or the ____ University Clinic, as they are quite fussy. I hate to throw them in the trash and I wanted to know if you know of an SLP clinic or school service in the third world where they might be appreciated. I would be happy to donate them if the recipient covered p+h from MN.

Please allow me to introduce myself. I'm an S-LP from Canada who graduated from a top ranking university and I've been starting to consider a move to asia with hopes to work as an S-LP there. I stumbled across your website and wanted to ask you about availability of jobs for English speaking S-LPs in asia (e.g. thailand, malaysia, singapore, etc). I've emailed the malaysian speech pathology college etc to ask for information as I cannot seem to find any online postings for jobs. However, they do not respond to my many emails so I'm writing to you for your insights. You'd actually think they'd be glad of high quality input from a civilized country like mine with high S-LP standards. If I cannot find something that suits me in asia I am quite interested to work in africa if you can send any info for that area.

My background is that I am a CCC-SLP from the US and a member of AAPPSPA. I am interested in setting up a center in a city in the Asian region to work with young children 0–5 in Fiji, Japan, Sirrilancah, Vanuatu, South Korea, Siam or similar (not China, Bali, India, Pakistan or areas with too much poverty and disease or slums). If you would provide contacts in that area, that would be great. Also, any thoughts on working thru telepractice on accent modification with Asian adults wanting to improve their English pronunciation?

I am a 24-year-old German SLP student (for MA) speaking German and English urgently wishing for an internship in Thailand for three months in the summer, but I am not having too much luck finding a post. It will give me much happiness to work with poor children who have cleft palate in exchange for housing, meals, insurance and small stipend and flights to-from Munich. I am searching such an internship since 4 months without anybody answering or supporting me. I need this internship very much for my thesis. Thank you for your website.

Unfortunately, some of the cultural incompetence, self-serving motives (Salas-Provance et al., 2014) and attitudes implicit in the email spill over into the standards of clinical practice observed in developing communities, and in some underserved majority- and minority-world contexts, *and* with culturally and linguistically diverse client populations in the industrialised world (Scheffner Hammer, 2011), including in Australia.

Troubling scenes

Webwords is not immune to either the urge to volunteer or the travel bug, expressed as a love of **weekends away**[9], and trips to many parts of the world for work and leisure. In her work travels, she has been troubled to see fully qualified SLPs/SLTs "make do" with superseded, photocopied (from colour to black and white) and incomplete assessments; and tests and intervention materials translated from English to local languages and dialects. She has also witnessed colleagues employ culturally inappropriate materials, such as: the (British) Renfrew Action Picture Test for Zulu and Xhosa speakers; Brown's Stages (English) "norms" for morphological development applied to African, Asian and European languages; and picture resources, made for the UK and USA, used with Indigenous and non-Indigenous Australian, Filipino, Malaysian, New Zealand and South African children.

Some fully qualified SLPs/SLTs also engage, with mixed motives, in "importing" non-evidence-based methods for use by naïve practitioners with vulnerable populations, enjoying Big-Tobacco-style sponsorship.

The TalkTools® Blog for example, **records**[10] that four Australians, two SLPs and two OTs, volunteered for a week in November 2015 at the Dzherelo Centre, in Lviv, Ukraine. The "mission trip" was sponsored by TalkTools®, who also donated (their) merchandise to the centre. The SLPs taught staff how to use TalkTools® exercises and products, "to turn mealtimes into therapy to support the children in developing their oromotor skills. All of the children … required support with the strength and coordination of their jaw. Chewy Tubes with the pre-feeding chewy hierarchy were trialled successfully". Meetings were also held at the Lviv Catholic University, the Polytechnic University and the Military Hospital, where the sponsor's products may have been discussed in an approving light, with no mention of their lack of supporting evidence.

Standards

Ethical issues permeate each of these circumstances, relating to complex, even alien settings where barriers to E^3BP far outweigh the facilitators. Doing your best, as a qualified service provider in difficult situations, should not equate with knowingly advocating or delivering inferior service, especially when grateful, hospitable, and sometimes adoring recipients believe you offer "the best", and want you back.

Links

1. www.asha.org/SIG/14
2. www.asha.org/SIG/17
3. www.facebook.com/groups/SPAWWDC
4. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=20

5. www.speechtherapy.org.hk
6. www.hku.hk/speech
7. www.cisha.org.cn
8. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=54
9. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=162
10. http://blog.talktools.com/2016/slp-and-ot-trip-to-ukraine

References

Bleile, K. M. (2015). A Nicaraguan experience. In C. Bowen, *Children's speech sound disorders* (2nd ed.; pp. 157–160). Oxford: Wiley-Blackwell.

Bowen, C. (2009). Multiculturalism in communication sciences and disorders. *ACQuiring Knowledge in Speech, Language and Hearing*, *11*(1), 29–30.

Crowley, C. & Baigorri, M. (2011). Effective approaches to international work: Substance and sustainability for speech-language pathology student groups. *ASHA SIG 14 Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse (CLD) Populations*, *1*, 27–35.

Salas-Provance, M., Marchino, M., & Escobedo, M. (2014). Volunteerism: An anchor for global change through partnerships in learning and service. *ASHA SIG 17 Perspectives on Global Issues in Communication Sciences and Related Disorders*, *4*, 68–74.

Scheffner Hammer, C. (2011). Broadening our knowledge about diverse populations. *American Journal of Speech-Language Pathology*, *20*(2), 71–72.

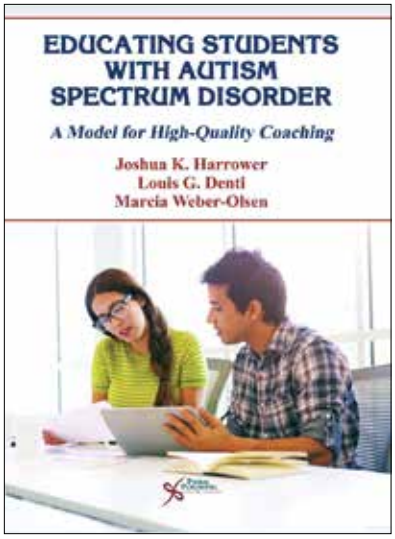
Webwords 56 is at www.speech-language-therapy.com with live links to featured and additional resources.

Resources reviews

Harrower, J. K., Denti, L. G., & Weber-Olsen, M. (2015). *Educating students with autism spectrum disorder: A model for high-quality coaching*. San Diego, CA: Plural Publishing; ISBN 978 1 59756 786 2; pp 245; A$69.95.

Keely Harper-Hill

I was delighted to be asked to review this book because, while speech-language pathologists (SLPs) have collaborated with educators for many years, coaching as a means of educator professional development is currently of particular interest. The book is structured clearly and consists of 13 chapters across three sections. The objectives of each chapter are listed at the chapter beginning and each chapter ends with an explicit summary and end-of-chapter questions. The first section (chapters 1–5) introduces educational coaching, briefly reviews and



describes coaching models, and places this information within the context of supporting students on the autism spectrum. The second section (chapters 6–8) considers the use of high-quality coaching in planning instruction for students on the autism spectrum. Delivering effective programming for these students is covered in the final section (chapters 9–13). Vignettes are woven throughout the chapters. The book is easy to read and the structure would enable the reader to "dip" into it rather than read it in its entirety. The authors are based in the United States and, as with many other disciplines, the reader needs to make adjustments to the content.

I do have several reservations, which stem from the ambitious scope of the 250-page book. The authors make a valiant effort to address two weighty topics: (a) educator coaching and (b) how to support students on the autism spectrum in the classroom. Within the sections on planning instructions and again in effective programming, these topics are integrated and applied to the assessment and intervention phases of supporting students in schools. I felt that the authors' effort to address these topics was undermined because more attention to both topics would be required to do them full justice. The authors' statement of purpose suggests a wide readership including coaches, as well as educators who are being coached, so that they can meet the needs of children on the spectrum. As I read the book, the scope of the intended readership became less clear. For example, the information on coaching may be of initial interest to the SLP who has very limited experience working collaboratively with educators. It may not, however, be sufficient to assist SLPs to translate specialist knowledge of autism to the classroom. Similarly, the information on autism could be useful to experienced education-based SLPs with limited experience with autism but I'm not sure they exist!

In conclusion, the book covers a wide array of issues relevant to coaching and could serve as a useful introductory text for student or early career SLPs working in education sectors. I suspect that any SLP with experience working with teachers or with reasonable experience in working with young people on the autism spectrum may find the content less beneficial due to the restricted depth of the content covered in this book.

Hallowell, B. (2016). *Aphasia and other acquired neurogenic language disorders: A guide for clinical excellence*. San Diego, CA: Plural Publishing; ISBN 978 1 59756 477 9; A$140

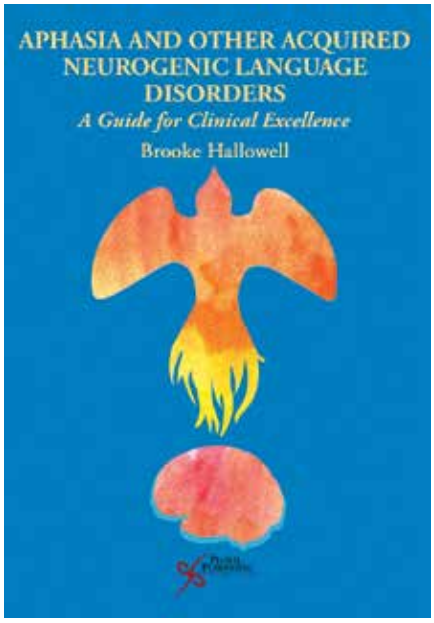
Dr Christopher Plant

There are many textbooks available to the speech-language pathologist on the topic of aphasia and related neurogenic language disorders. In *Aphasia and other acquired neurogenic language disorders: A guide for clinical excellence*, Brooke Hallowell aims to provide a unique perspective which will be of interest to students and practising clinicians alike. Throughout the text, Hallowell draws attention to what it takes to be an exceptional, person-centred clinician when working with such client populations. In working towards this aim, Hallowell succinctly sums up the text's approach by describing it as an evidence-based, how-to clinical guide.

This text contains eight sections and 33 clear, informative, and insightful chapters. Most chapters are also complemented by downloadable student and instructor resources. Each chapter opens with clear learning objectives and concludes with well-considered learning and reflection activities. This text therefore offers significant value for money.

The general structure of the text is fairly standard, moving from foundations and the nature of aphasia and cognitive-communication disorders in conditions such as traumatic brain injury, right hemisphere disorder, and dementia, through to assessment, and then general principles of intervention, followed by specific intervention approaches.

Along the way the topics explored reflect current trends and priority areas such as language in the context of ageing, cultural competence in view of increasing immigration patterns, apps for intervention, and complementary and integrative approaches to intervention.



Even within chapters that explore familiar topics, such as the ICF and its application to aphasia and cognitive-communication, assessment tools and methods, and theories and approaches to intervention, Hallowell offers unique perspectives through combining discussion of current research with insights gained from clinical experience. These insights help the text achieve its aim of promoting the idea of an excellent clinician by providing information that few other textbooks draw explicit attention to. A simple example of this comes early on where Hallowell discusses the sometimes quirky and humorous nature of errors in aphasia and the shared appreciation of these instances between the person with aphasia and speech-language pathologist. Similarly, chapters describing specific intervention approaches for different aspects of language rehabilitation are particularly clear and helpful, in providing a simple step-by-step guide to implementation, along with general principles and an overview of the research evidence.

As with many texts published by Plural, there is perhaps a slight emphasis on research evidence generated within the United States in preference to other parts of the world, although this is not to say that the research cited is not high quality. Some readers may also have only a passing interest when discussion turns to issues around reimbursement, Medicare, and Medicaid, although Hallowell is mindful to acknowledge differences in health care systems across major English-speaking countries such as Australia and the United Kingdom.

Overall, there is a lot to appreciate about this new and ambitious text. Although many other texts may explore the nature, description, assessment, and intervention of aphasia in much finer and rigorous detail, few, if any, texts offer such an effective and engaging balance between current knowledge and clinical insight.

JCPSLP notes to authors

The *Journal of Clinical Practice in Speech-Language Pathology* is the major clinical publication of Speech Pathology Australia. Each issue of *JCPSLP* aims to contain a range of high quality material that appeals to a broad membership base. *JCPSLP* is published three times each year, in March, July, and November.

Issue	Copy deadline (peer review)	Theme*
Number 2, 2017	1 December 2016	Communication and Connection – Valuing Aboriginal and Torres Strait Islander perspectives.
Number 3, 2017	13 April 2017	To be announced. Check website for updates
Number 1, 2018	1 August 2017	To be announced. Check website for updates

* articles on other topics are also welcome

General
Material submitted must be your original work. Any direct quotations or material used from other sources must be credited in full. If copyright clearance is required to use material included in your article, please supply evidence that this has been obtained.

Ethical approval
All manuscripts in which information about a person and/or organisation is presented must be accompanied by evidence of approval by an authorised ethics committee. This includes clinical insights, ethical conversations, manuscripts presenting the results of quality assurance and improvement activities within workplace settings, and research manuscripts.

Themes
Each issue of *JCPSLP* contains a set of articles relating to a particular theme, as well as a selection of articles reflecting broader speech pathology practice. The Editorial Board selects a theme for each journal, and these themes can be suggested by members of Speech Pathology Australia at any time. Manuscripts on any topic relevant to speech pathology practice can be submitted to *JCPSLP* at any time.

Length
Manuscripts must not exceed 3500 words (including tables and a maximum of 30 references). Longer manuscripts may be accepted at the discretion of the editor. It is highly recommended that authors contact the editor prior to submitting longer manuscripts.

Types of Submissions
When submitting your article to *JCPSLP*, please indicate the type of submission:
- Tutorial: Educational/narrative discussion on topics of interest to clinicians. This should include a brief overview of the current literature, as well as a section containing clinical implications.
- Review: Critical appraisal of the research literature in an area of research-practice that is relevant to practising speech pathologists.
- Clinical Insights: Articles that may be of primary clinical interest but may not have a traditional research format. Case studies, descriptions of clinical programs, and innovative clinical services and activities are among the possibilities.
- Research: Research articles with clear clinical relevance. These submissions will be judged on the review of the literature (including a rationale), methodology, statistical analyses, and a clear discussion directed to a clinical readership.

Peer review
Manuscripts submitted to *JCPSLP* undergo a double blind peer-review process. Regular columns (e.g., Webwords, Top 10, resource reviews) undergo editorial review. For peer-reviewed articles, *JCPSLP* uses a double-blind peer-review process, in which the anonymous manuscript is sent to two reviewers. The authors are provided with information from the review process. Often, authors are invited to revise and/or resubmit their work, as indicated by the reviewers. Occasionally, the reviewers request to re-review the revised manuscript. In some instances, a paper will be rejected for publication. The editor's decision is final. The sentence "This article has been peer-reviewed" will appear after the title for all peer-reviewed articles published in *JCPSLP*.

Format and style
All submissions must be Word documents formatted in accordance with the following guidelines:
- All text should be 12 point Times New Roman, double spaced (except figures and tables), left justified.
- A maximum of five levels of heading (preferable 2-3 levels) should be used:
  1. Centered, boldface, uppercase and lowercase heading
  2. Left-aligned, boldface, uppercase and lowercase heading
  3. Indented, boldface, sentence case heading with a period. Begin body text after the period.
  4. Indented, boldface, italicised, sentence case heading with a period. Begin body text after the period.
  5. Indented, italicised, sentence case heading with a period. Begin body text after the period.
- Please use the terms 'speech-language pathology' and 'speech-language pathologist' (abbreviated to SLP) throughout article.
- Do not include images within the text of the article – send photos as separate attachments, digital images should be of high quality and preferably be sent as uncompressed TIF or EPS images.
- Use only one space after punctuation, including full stops.
- Use a comma before 'and' in a series of three or more items (e.g., "The toys included a ball, bucket, and puzzle)
- Clear and concise writing is best. Use short sentences and paragraphs and plain English. Please reduce bias in language as much as possible (i.e., avoid stereotypical terms, refer to participants, rather than subjects, and be sensitive to racial and ethnic identity).
- Reproduce any quotations exactly as they appear in the original and provide the page number(s) for the pages you have quoted from.
- References, which should be key references only, must follow the American Psychological Association (APA, 6th edition) (2009) style. For further details on correct referencing, visit http://owl.english.purdue.edu/owl/resource/560/01/
- Tables and Figures: If there are to be tables or figures within your article, these should be presented on separate pages with a clear indication of where they are to appear in the article (in text indicate where the figure or table should be inserted). All tables and figures should be numbered. Figures should be presented as camera-ready art. Please ensure figures and tables appear at the end of your article with each table or figure on a separate page.

Documents to be submitted
1. Manuscript featuring:
   a. Title
   b. Author names and affiliations (will not be forwarded for peer review)
   c. Up to 6 key words
   d. Abstract (maximum 150 words)
   e. Main body of text (**main body must not include any identifying information**)
   f. Reference list (maximum 30)
   g. Tables (if relevant)
   h. Figures (if relevant)
   i. Appendixes (if relevant)
   j. Acknowledgements if relevant (will not be forwarded for peer review)
2. Author submission form (to be downloaded from *JCPSLP* website)
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Creating sustainable services: Minority world SLPs in majority world contexts

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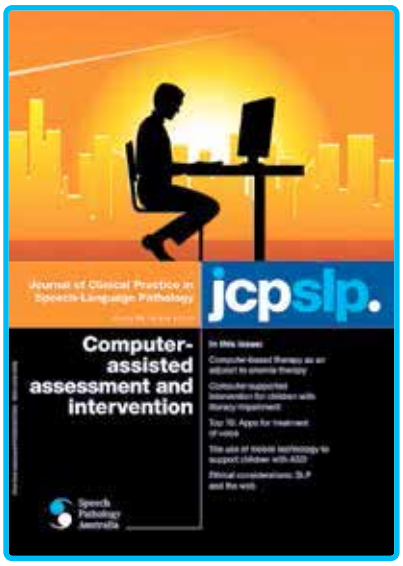

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From the editor

David Trembath

Speech-language pathology offers countless opportunities for those who are interested in working beyond geographical borders, across cultures, to understand and help address the needs of individuals with communication and swallowing difficulties at an international level. For me, the opportunity first arose during my undergraduate studies, via a self-guided study tour with two student colleagues through Nepal, Bangladesh, and India. At the time, these were often described as "developing" or "emerging" countries, terms that are now commonly replaced by "majority world" which captures the proportion of the world's people represented, and contrasts with the relatively small proportion living in "minority world" (otherwise described as "developed") countries. Our goal was to learn from experts in community-based rehabilitation who were working on the ground in villages, towns, and cities in the countries we visited to deliver timely, appropriate, and effective support to persons with developmental and acquired disability. How I wish we had available to us at the time the wealth of information presented in this issue of *JCPSLP* focused on minority world speech-language pathologists working in majority world contexts.

This issue is guest edited by Bea Staley and Suzanne C. Hopf, who have brought together an outstanding group of local and international authors to advance understanding of the opportunities and challenges associated with international work and collaboration. The issue is infused with personal reflections and insightful advice, both of which are critical to minority world SLPs working ethically and effectively in majority world contexts, and also discusses implications for all SLPs aiming to initiate and sustain mutually beneficial and rewarding partnerships, wherever these partnerships occur. A common theme across articles is the importance of "change" as a multidirectional process that leaves all people and parties in better positions as a result of the work together, for the benefit of one another.

In reflecting on this issue, which is the last under my editorship, as well as the work of the journal more broadly, the same theme emerges. The *JCPSLP* is a place where clinicians, researchers, and other members of the community come together to share knowledge, critical and clinical insights, and novel ideas to move our field forward. The journal works because authors, reviewers, members of the editorial committee, and the publication team understand the magnitude of "change" that can occur when the right information is given to the right people, at the right time; and generously volunteer their knowledge and skills to make it happen. I would like to sincerely thank all of those who contribute to the journal in this way, and extend my very best wishes to Dr Leigha Dark who will now take over as editor.

Contents

Special issue

A diverse global network of speech-language pathologists

Bea Staley and Suzanne C. Hopf

Bea Staley (top) and Suzanne C. Hopf

People in all countries have called for a development agenda that is more consistent with the realization of their human rights, and which reflects the day to day reality of their lives. (UNDG, 2014, p. iii)

This quote from the United Nations (United Nations Development Group [UNDG], 2014) ushered in a global conversation in which 4.5 million people from almost 100 countries discussed the "future world that people want" (2014, p. 1). As speech-language pathologists (SLPs) advocating for the human rights of people with communication and swallowing disabilities (PWCD) globally, we want our services to reflect the needs of the communities in which we work. There is considerable interest in the development of speech-language pathology in global regions experiencing poor availability and accessibility of speech, language and swallowing clinical services. This is particularly the case for services in majority-world countries. Consequently, this issue of *JCPSLP* discusses the varied roles of minority-world SLPs working with our colleagues in majority-world contexts.

There is a long history of minority-world clinicians working in varied international contexts. In the late 1990s SLPs (e.g., Hartley, 1998; Marshall, 1997) began to write about their work in majority-world contexts (e.g., Kenya and Uganda) and to develop frameworks for other SLPs to apply in their own work (e.g., Hartley & Wirz, 2002). These authors highlighted the need to document speech-language pathology work in new locations so that a knowledge base could be developed and drawn upon by other clinicians. The papers in this special issue build on the ideas of these SLPs and the many more published since.

Ensuring that the voices of the local context are heard is a recurrent theme of this issue. Nearly all of the articles presented include the voices of SLPs, or their local equivalent, native to the majority-world context discussed. For example, three papers from Vietnam provide insight into how the relatively new speech-language pathology profession is capitalising on past – and indeed continuing – minority-world SLP collaboration, and *indigenising* international speech-language pathology concepts and curricula for the local context. The Nguyen, Dien, Sheard, Xuan, Tâm, Văn Quyên, and Dao paper provides an account of the history and current clinical and advocacy practices of new graduate Vietnamese SLPs, while Pham, McLeod, and Xuan describe the process required for developing a speech assessment tool for the Vietnamese context. In Atherton, Davidson, and McAllister, a participatory research project reveals the voices of Vietnam's first SLP graduate cohort as they embark on the next stage of their professional development journey. All papers have in common a focus on future professional growth that involves international collaboration but importantly is not defined by that collaboration.

In the papers by McAllister, Woodward, and Nagarajan, and by Barrett, our lens turns to the lessons minority-world SLPs learn through international collaborative relationships. McAllister et al. describe the transformative learning experiences of volunteer minority world-SLPs in the role of clinical educator (CE) in Vietnam. The authors report that many skills learned by the CEs in Vietnam are readily transferable to the CEs' work environment in Australia (e.g., working with translators, developing intercultural competence). Barrett then draws upon experiences as a minority-world SLP in East Africa to critique whether available cultural competence theories can be applied to an increasingly mobile speech-language pathology workforce. Barrett suggests that current theories of cultural competence need to evolve to reflect changing concepts of culture.

As we think about change, this can be extended also to the way services and training SLPs has typically been conceptualized. Olszewski and Frank remind us that if communication is a basic human right – one we are passionately striving to work towards on a global scale – we may have to re-consider and re-envision the way we train service providers and implement services in our field. Olszewski and Frank describe an innovative model for training SLPs through NextGenU, a free online program which partners with organisations, governments and universities. Their paper suggests that technology may break down the financial and environmental barriers that often prevent people living in majority-world countries from receiving specialist training and pursuing careers that support PWCD.

What is abundantly clear in reading these papers is that no single framework for service development suits all contexts. For example, we see Wylie, Amponsah, Bampoe, and Owusu directly apply the social, environmental, and economic dimensions of sustainable development embodied in the Sustainable Development Goals (United Nations, 2015) to their own experiences in Ghana

collaborating with visiting minority-world SLPs, while maintaining their own caseloads and advocacy efforts.

Despite employing different frameworks, the authors in this collection consistently conclude that policies and solutions need to be locally and collaboratively derived and issue-orientated without merely transplanting best practices across countries.

From the papers presented it is evident that as a global profession we are beginning to establish networks committed to advocating for improved service availability and accessibility for all PWCD regardless of where they, or we, reside in our world. We are excited about innovative collaborations of SLPs, such as the International Communication Project (see http://www.internationalcommunicationproject.com), that highlight the work of SLPs in diverse locations and open up avenues for future dialogue. What we share here, are just a few of the stories of minority–majority world SLP clinical practices that are striving to change the way we work in varied contexts. We hope that these ideas translate or inspire others working (or thinking about working) in majority-world contexts to create a vibrant network of collaborative SLPs internationally.

References

Hartley, S. (1998). Service development to meet the needs of "people with communication disabilities" in developing countries. *Disability and Rehabilitation*, *20*(8), 277–284.

Hartley, S. D., & Wirz, S. L. (2002). Development of a "communication disability model" and its implication on service delivery in low-income countries. *Social Science & Medicine*, *54*(10), 1543–1557.

Marshall, J. (1997). Planning services for Tanzanian children with speech and language difficulties. *International Journal of Inclusive Education*, *1*(4), 357–372. doi:10.1080/1360311970010405

United Nations. (2015). *Sustainable development goals: 17 goals to transform our world*. Retrieved from http://www.un.org/sustainabledevelopment/sustainable-development-goals/

United Nations Development Group (2014). *Delivering the post-2015 development agenda*. Retrieved from: http://www.undp.org/content/undp/en/home/librarypage/mdg/delivering-the-post-2015-development-agenda.html

Dr. Bea Staley is a speech pathologist who has been working with young children and their families for 15 years. She has worked in Australia, Kenya, America and the Northern Mariana Islands. She is a lecturer in the School of Education at Charles Darwin University, where she teaches classes around diversity, disability and inclusion. **Suzanne C. Hopf** is an Australian speech-language pathologist that lives in the Republic of Fiji. Suzanne's PhD describes typical Fijian children's speech, language and literacy development, and how Fijians support children and adults with communication and swallowing disabilities.

Building collaboration

A participatory research initiative with Vietnam's first speech-language pathologists

Marie Atherton, Bronwyn Davidson, and Lindy McAllister

KEYWORDS
COLLABORATION
PARTICIPATORY ACTION RESEARCH
SPEECH-LANGUAGE PATHOLOGY
VIETNAM

THIS ARTICLE HAS BEEN PEER-REVIEWED

Marie Atherton (top), Bronwyn Davidson (centre), and Lindy McAllister

A group of Vietnam's first speech-language pathology graduates and the primary author, an Australian speech-language pathologist, are participating as co-researchers in an exploration of the emerging practice of speech-language pathology in Vietnam. This paper details the initial phases of this collaborative research program. A description of the research methodology and the rationale for utilising participatory action research are provided. Initial learnings from the research, including those relating to the vital role of the interpreter; challenges in developing a shared understanding of collaboration in research; and the impact of distance and technology are described. Speech-language pathologists from minority world contexts are encouraged to consider how they might develop partnerships with international colleagues to support collaborative initiatives to progress the practice of speech-language pathology in underserved communities.

Participatory action research (PAR) is an umbrella term for a heterogeneous group of research practices in which researchers and "the researched" work together to examine a situation (or problem) and identify strategies and actions to change the situation for the better (Kemmis, McTaggart & Nixon, 2013; Kingdon, Pain, & Kesby, 2007). PAR is situated within the genre of *action research*, a research approach credited to Kurt Lewin, a social psychologist, who demonstrated the benefit of workers participating in research that would inform decisions impacting their work (Lewin, 1946, as cited in Adelman, 1993). In the latter half of the twentieth century, Brazilian educator Paulo Freire further developed the concept of participation and collaboration in research by arguing that through participation in decisions regarding their lives, every person, regardless of the level of their impoverishment or disempowerment, could be empowered to make changes in their lives for the better (Friere, 1970). Critical to Friere's position was the value of conducting research *with* (not on) people as a means of creating and sharing new knowledge, and developing new insights into practices, situations, and processes that could be improved (Chaiklin, 2011).

PAR is considered a methodology in its own right rather than a set of research methods (Liamputtong, 2008). Through iterative cycles of reflecting, planning, engaging in action, and reflecting upon the outcomes/consequences of actions undertaken (Figure 1), researchers and those impacted by a problem develop new insights into the problem and how it might best be addressed. Findings from each cycle of the action spiral are fed into the next, with the overall aim being the identification of actions that effect positive practical change in relation to the issue of concern (Kemmis et al., 2013).

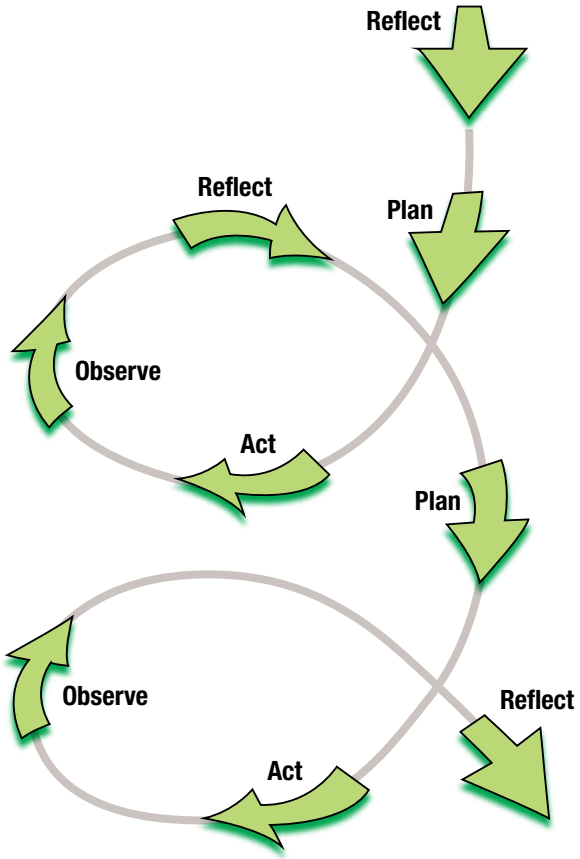

Figure 1. Action research cycles. Retrieved from http://cei.ust.hk/teaching-resources/action-research. Copyright 2010–2016 by Centre for Education Innovation, HKUST. Reprinted with permission.

PAR has been used in numerous contexts including human development, education, organisational change, and health (Kapoor & Jordan, 2009; Koch & Kralik, 2009). It has also been extensively used in cross-cultural contexts (Evans, Hole, Berg, Hutchinson, & Sookraj, 2009; Kramer-Roy, 2015; Pavlish, 2005). The utility of PAR to the practice of speech-language pathology (SLP) has also been described (Hersh, 2014; Hinckley, Boyle, Lombard, & Bartels-Tobin, 2014). Westby and Hwa-Froelich (2003) highlight the relevance of PAR to the development of culturally appropriate and context-specific SLP programs and services in majority world[1] countries, and offer recommendations for the conduct of PAR in international contexts. In an exploration of friendship and the experiences of persons with aphasia, PAR supported the development of tools to assist persons with aphasia communicate about friendship (Pound, 2013). The utility of collaborative research has also been described in relation to the care of persons with communication problems resulting from dementia (Müller & Guendouzi, 2009).

The use of participatory action research in the current research

This paper describes the application and evaluation of PAR as a methodology for exploring the practice of the emerging SLP profession in Vietnam. PAR in Vietnam has previously examined a range of social and community issues including stigma associated with HIV, gender-based violence, professional development needs of nurses, and public health and social services in rural Vietnam (Gaudine, Gien, Thuan, & Dung, 2009; Gien et al. 2007). To the authors' knowledge this is the first report describing PAR within the context of the SLP profession in Vietnam.

In September 2012, 18 Vietnamese students with undergraduate degrees in health-related professions (e.g., physiotherapy, medicine, nursing) graduated from a two-year postgraduate speech therapy training program at Pham Ngoc Thach University of Medicine (PNTU), in Ho Chi Minh City (HCMC), Vietnam, thereby becoming Vietnam's first locally trained speech-language pathologists qualified to work across the full scope of SLP practice.[2] The primary author was the coordinator of the 2010–12 PNTU SLP program and resided in HCMC. Upon returning to Australia, she remained in contact with the graduates and saw the conduct of research as one means of supporting their practice. The primary author was cognisant of a disparity in power between herself and the PNTU SLP graduates, and the potential for this to influence the authenticity of the research findings (Atherton, Davidson, & McAllister, 2016). As such, the active participation of the graduates in the research was considered crucial to enhancing the authenticity of data collection and analysis (Gaillard, 1994). Engaging in PAR would create the opportunity for the "voices" (Maguire, 2001) of the SLP graduates to be heard, for the research to be guided by *their* experiences and priorities rather than by preconceived notions the primary author may have had about the context of their work. Further, participation of the primary author and graduates as co-researchers would support the mutual development of research skills and the reporting of research outcomes. It was also hoped that opportunity would be created between the researcher and graduates for future research collaboration.

Context of the research

This collaborative research initiative forms part of a broader PhD research program undertaken by the primary author exploring the professional practice of Vietnam's first university qualified speech-language pathologists. It is not the intent of this paper to detail the emergence of the SLP profession in Vietnam (for further information see Atherton et al., 2016; Atherton, Dung, & Nhân, 2013; McAllister et al., 2013). Rather, this phase of the primary author's PhD research program sought to: (a) identify the nature of the SLP graduates' professional practice at 24 months following graduation (to be reported in a separate paper), and (b) introduce PAR as a means of identifying perceived barriers to the graduates' work. It was anticipated that completion of this phase of the research program would inform future collaborative research cycles in which avenues to address the perceived barriers to the graduates' practice could be trialled.

Participants

Acknowledging the Vietnamese graduates as best placed to describe the context in which they work and identify factors impacting their practice, the primary author travelled to HCMC, Vietnam in June 2014 to establish an "Advisory Group" (later named the "Participatory Research Group" [PRG]) comprising graduates from the 2010–12 PNTU SLP Training Program to advise the PhD research program over the next 24–30 months. Advisory groups have been previously described as strengthening the authenticity and validity of research-generated knowledge and enhancing the significance of research outcomes (Pound, 2013). Expressions of interest were sought from the18 SLP graduates to participate in individual interviews with the primary author and to participate as members of the PRG. Ethics approval was obtained for this study through the University of Melbourne, Behavioural and Social Sciences Human Ethics Committee.

Eight of the 18 graduates consented to participate in the research. All eight PRG members live and work in HCMC, and are typical of the 2010–12 cohort of SLP graduates in that they work predominantly within the acute public health system (one PRG member works in the disability sector). Caseloads are varied and include both adults and children with communication and swallowing disabilities.

Outcomes of collaboration

Three "cycles" of collaborative research were completed in 2014 (see Table 1) during which PRG members engaged in reflection upon their current professional practices and commenced the planning of actions to support their work. Key research concepts such as "reflection", "collaboration" and "participation" were discussed, and the initial research priorities of the PRG identified. Data was in the form of digital audio-recordings of interviews and meetings, transcripts of the English translation of the audio-recordings and meeting minutes, email correspondence, and the primary author's field notes and reflective diary. Pseudonyms replaced the names of the participants and interpreters as a means of de-identification.

The three cycles of this phase of the research program and the challenges conducting PAR in this context will now be described.

Cycle 1. Setting the scene

Cycle 1 involved individual interviews with the eight research participants and the formation of the PRG. Ms Mai, a Vietnamese interpreter well known to the participants and with knowledge of SLP practice, provided a summary of what was being said (consecutive interpretation) rather than a word-for-word translation (simultaneous interpretation), thereby avoiding potential for disruption to the dialogue

Table 1. Summary of participatory research cycles in 2014

Cycles of research 2014	Meetings	Data sources	Present
1. July 2014 Face-to-face meetings in Ho Chi Minh City, Vietnam	x8 semi-structured individual interviews Inaugural meeting of the PRG	Digital audio-recordings of interviews and meetings Transcripts of individual interviews & meeting minutes Email communication Field notes Reflective diary	Members of the PRG Primary researcher Experienced interpreter
2. July–October 2014 Skype meetings	x5 Skype meetings of the PRG		
3. October–November 2014 Face-to-face meetings in Ho Chi Minh City, Vietnam	x2 meetings of the PRG		

Figure 2. The inaugural meeting of the participatory research group

(Chen & Boore, 2010). The interviews were important for several reasons. First, the development of relationships, trust of the primary researcher, and a sense of safety in the research process are acknowledged as critical to research that seeks to be genuinely collaborative (Australian Council for International Development, 2016; Maiter, Simich, Jacobson, & Wise, 2008). The interviews provided opportunity for the researcher and the participants to re-establish their relationship. Second, preparation for collaborative research requires co-researchers to develop an understanding of the proposed research focus, methodology, anticipated time commitment, and timelines for the research (Kidd & Kral, 2005). Again, the interviews provided opportunity for the research participants to discuss these issues in detail prior to committing to the research. Third, it was anticipated that analysis of the interview transcripts would highlight themes characterising the evolving practice of the participants. The content of these interviews would also draw attention to the graduates' perceptions of opportunities and challenges to their practice, and their professional priorities for the following 12 months. This information would inform the initial discussions of the PRG and provide a focus for the future research.

The inaugural meeting of the PRG took place in HCMC, Vietnam on the 4 July 2014. The eight SLP graduates, Ms Mai (the interpreter) and the primary author were present. All PRG members consented to be photographed and for the photograph to be published (Figure 2).

The inaugural meeting of the PRG provided opportunity for the primary author and PRG members to meet for the first time as co-researchers and commence discussions as to the PRG's participation in the research. The overall aims of the research program were described, as were its stages and timeframe for completion. Initial discussion also focused upon research methodologies, including how quantitative and qualitative research differed, and where collaborative and PAR methodology was situated within the quantitative–qualitative paradigm. As commented by Mr Duc:

> *So usually when you do quantitative research you collect data, you analyse data, and then you have recommendations for the next stage. But I haven't done any qualitative research like this before, so I want to know whether it's the same … like stages. And you also do it in stages, so when you finish one stage you have recommendations … and prepare for the next stage?*

The primary author described PAR methodology as encompassing a range of research methods, from which focus of the conversation shifted to the legitimacy of qualitative research: "I don't know about other professions, but in the medical field usually people, they might not like to use it, do not really like to use qualitative … but in public health qualitative is accepted" (Mr Duc).

The PRG also sought to address a number of "logistical issues" such as the selection of a leader for the PRG, and the settings of "ground rules", including the number of PRG members required for a quorum, how confidentiality of group discussions would be maintained, the allocation of minute taking, and a "participation" rule:

> *There should be a rule like that, [to avoid a situation in which] one or two team members will talk about their opinions and everyone else will sit and quiet listening, and when the group comes to an agreement it looks like the ideas are just from one or two members. So I think we should have like a participation rule that the members who attend the meeting, all should participate in discussions.* (Mr An)

At the meeting's conclusion, a suggestion to progress the research via a live video calling program (Skype) was agreed to – PRG members were keen to trial communication options that would facilitate ongoing audio-visual interaction and collaboration with the primary author on her return to Australia.

The opportunity to discuss the research methodology afforded a number of key insights. The primary author had

assumed that given the undergraduate and postgraduate education completed by PRG members, there would be familiarity with both quantitative and qualitative research methodologies. This was not the case, and highlighted the importance of avoiding assumptions about the skills and knowledge of research partners. Further, discussion of the methodology drew attention to the importance of reviewing concepts through group dialogue in which mutual understanding might best be achieved.

The issue of ownership and future authorship of the project also arose at this meeting, and at later meetings of the PRG. The primary author was cognisant that the collaborative and participatory nature of the research created tension with the notion of a PhD research program being independent work, and thus raised this issue for discussion with the PRG. Further, PRG members voiced interest in joint authorship of publications arising from the research. Bournot-Trites and Belanger (2005) advise that issues of authority and ownership of research be resolved in advance of a study, and to this end, it was important that the primary author and PRG engage in conversation to address these issues.

The relevance of supporting group processes was also highlighted. Even at this early stage in the research, group interactions and practices were reflecting aspects of collaboration, and PRG members were drawing the focus to *their* priorities, including developing and supporting group cohesion and functioning. A number of authors have described the influence of sociocultural differences upon group interaction, patterns of participation, and perceptions of time upon cross-cultural research (Apentiik & Parpart, 2006; Laverack & Brown, 2003). As discussed by Liamputtong (2008), for research to be culturally sensitive "researchers must have a thorough understanding and knowledge of the culture, which includes extensive knowledge of social, familial, cultural, religious, historical and political backgrounds" (p. 4), and must work actively and consistently to ensure customs and cultural norms are respected and incorporated into research initiatives.

Cycle 2. The tyranny of distance

The second cycle of the research commenced on the primary author's return to Australia and comprised five Skype meetings at which the professional priorities of the PRG members were explored. To participate via Skype, PRG members sourced public venues with internet access. These were typically cafés, though on one occasion the PRG had convened in a hotel room, to the surprise of the primary author! While intended to support audio-visual communication between the PRG and the primary author, the internet connection for these meetings was often unreliable, resulting in generally poor visual and sound quality, audio delay, and signal drop out. Further, the many competing demands of PRG members resulted in some members not attending meetings and/or meetings commencing at a later time than planned (Table 2).

Despite these challenges, important outcomes were achieved from this cycle of research. After extended and at times animated group discussion in which the primary author acted as facilitator, the initial focus of the research was agreed to:

> *So the group discussed and they think they will do … that professional development is the priority. The group is thinking they want to do ongoing professional development … perhaps they will think of things that they can do themselves, or [they] can do in Vietnam to develop their profession, to develop their expertise, … and also they will identity the things they might need help [with] from Australia or from other organisations.* (Ms Mai summarising)

Methods and actions to examine this issue were also discussed:

> *Perhaps we are going to have a questionnaire to send to both groups [2012 and 2014 PNTU SLP graduates] to ask them four to five questions about what they are comfortable working with and what they are not comfortable working with to find out strengths and weaknesses of each graduate working in speech therapy.* (Ms Giang)

> *What are the graduates' abilities to provide assessment/treatment for patients? This could be found out by interviewing graduates about their workload – what do they think about their work, what they feel comfortable with, areas they do not have confidence in? When we interview the graduates of both groups we will find out what their challenges are in relation to their practice.* (Ms Bich)

It was also agreed that due to the unreliability of the internet connection, email communication would be increasingly used to support communication between PRG members and the primary author. Members of the PRG also indicated that given work and other obligations,

Table 2: Summary of Skype meetings in 2014

2014 Skype meetings	Number of PRG members present /8	Duration of meeting	Notes
1	6	70 minutes	Fair internet connection, intermittent picture & sound; delayed arrival of one PRG member.
2	6	90 minutes	Fair internet connection, intermittent picture & sound; delayed arrival of 2 PRG members.
3	6	60 minutes	Loss of Skype connection on several occasions - Instant messaging utilised during these periods; delayed arrival of 3 PRG members.
4	5	30 minutes	Poor internet connection - Instant messaging via Skype.
5	6	20 minutes	Poor internet connection - Instant messaging via Skype; delayed arrival of 2 PRG members.

communication via email would offer more flexibility in terms of their participation.

Momentum for the research slowed at this point. Sporadic email communication and the need for all communication to be translated influenced the frequency of contact. PRG members described their increasing workloads and other demands associated with their roles as "pioneers" of the SLP profession (e.g., training of staff in SLP) as influencing their ability to engage in the research. At least one member of the PRG commenced providing SLP services in a private capacity outside normal work hours.

A further issue arising was the introduction of Ms Tran to replace Ms Mai as interpreter. Notes from the primary author's reflective diary highlight to concerns as to how the research might be impacted, not only in terms of the quality of the interpretation and translation, but also with regard to group dynamics, interaction and collaboration (Figure 3).

> I am wondering how the introduction of Ms Tran to the research will play out this evening. Ms Mai was part of the research from its inception and familiar with the PRG and with the research plan, so introducing someone new may change dynamics. ??impact on collaboration
>
> A positive note – Ms Tran has been undertaking translation of resources for the PRG meeting … so hopefully an understanding of methodology and concepts – will need to follow this up.
>
> Am also wondering whether the difficulties with internet connection may deter Ms Tran from wanting to be involved in the research.
>
> (Dated 18 September 2014)

Figure 3. Notes from primary author's reflective diary

The use of Skype for real-time collaboration had been considered an ideal vehicle through which the active and participatory nature of the research could be supported. However, detailed planning, including consideration of "a second plan of attack", proved necessary when seeking to incorporate technology such as Skype into a setting where internet connection was unreliable. In addition, the demands arising from the role of members of the PRG as "pioneers" of the profession and increasing workloads, including the expansion of the profession into the private sector, were significant and had not been anticipated. The "tyranny of distance" was never more evident than during this cycle of the research, and facilitated key learnings with regard to the impact of technology, the increasing profile of the profession in Vietnam, and of the influence of local context upon the research.

Cycle 3. Revisiting collaboration

The third cycle of research collaboration was via two face-to-face meetings between the primary author and PRG in HCMC in October–November 2014. These meetings were important in re-establishing open and extended dialogue regarding the research, and supporting re-engagement of members of the PRG who had not maintained communication via email. The face-to-face meetings also provided opportunity for the primary author and the new interpreter to meet in person.

Revisiting the key research concepts of "reflection" and "collaboration" was another important outcome from this cycle of the research. The excerpt below is taken from the transcript of the English translation of a meeting in which the key concept of "reflection" is explored:

> *In the research, "reflect" means to think about your practice as speech therapists[3], and about the main issues you might wish to investigate further. Ms Tran, "reflect" in Vietnamese, how would you translate that?* (Primary author).
>
> [Ms Tran confers with PRG members]
>
> *I gave out to the group a translation that I think kind of pretty much covers the idea of "reflect" and I am asking to see what they think.* (Ms Tran)
>
> *It is similar to "reflect" in English….* (Ms Bich)
>
> *It means it's like a process of thinking back, and then speak out what you think.* (Ms Giang)
>
> [Further discussion between PRG members]
>
> *They are saying there is not a direct translation for "reflect". It is a very common thing to do in the West. And back when they were doing the course [PNTU Speech Therapy Training Program], the teachers, the lecturers were constantly asking them to reflect every time they write the report, every time they say something. The translation I gave out doesn't really cover the entire meaning of it.* (Ms Tran)

It is not within the scope of this paper to discuss the technical aspects or complexities of translation and interpretation in cross-cultural research (for further information see Squires, 2009; Temple & Young, 2004; Wong & Poon, 2010). However, the time spent revisiting key research concepts proved critical to heightening the understanding of the researcher, members of the PRG and the interpreter to the influence of language and culture upon the research. In particular, it was during these discussions that the primary author's assumption of concept equivalence between languages was challenged. The concepts of "reflection" and "collaboration" were identified by the interpreter and PRG as having different meanings in English and Vietnamese. Further, while the interpreter and members of the PRG are all Vietnamese, their individual interpretation of these concepts varied. Caretta (2015) and Turner (2010) draw attention to this latter issue, arguing that the gender, personal experiences, cultural influences, preconceptions, and belief systems of those involved in the research will influence the intended meaning of a concept, how individuals interpret the meaning of a concept, and how this meaning is communicated. Such insights highlighted how critical it is for all members of a research team to engage in dialogue as a means of facilitating mutual understanding of research principles, concepts and objectives.

Cycle 3 of the research also provided opportunity to consider how the research might progress into the future. The excerpt below, taken from the transcript of the English translation of one of the meetings, highlights PRG members' uncertainty as to the future direction of the research and its anticipated outcomes:

> *What is the project aiming to obtain? We know we want to identify our needs in professional development but are there any other aims?* (Ms Bich)
>
> *When we do this project, how do we measure its success?* (Mr Jach)

PAR has been described as a "messy process" (Primavera & Brodsky, 2004), requiring participants to not only conduct the research, but to learn from it and adapt as it progresses. The face-to-face meetings were a vehicle through which to address some of this uncertainty, and aimed to assist PRG members become more comfortable about this "messiness". At one of these meetings, the PRG developed their own representation of this research process, which they described as "The fish skeleton" (Figure 4):

> *So it [the research] is like a fish bone, a fish skeleton. So there are different problems and different reasons… they are the fish bones. The first one is overload [in work], not enough knowledge [referring to fish bone number two]. There are many problems and many reasons and we will look at that to prioritise which ones, and then we come up with solutions. And then which solution will resolve number one, number two, number three…* (Ms Tran summarising)
>
> *So you might come up with a solution for a problem and try it out to see if it works?* (Primary author)
>
> [Discussion between PRG members]
>
> *Yes. So they [the PRG] think "participants" defines it very well what they are doing. Because they are participating, they are the ones that come up with these and these and these [referring to the numbered fish bones], and prioritise these and come up with a solution. And you are just supporting them.* (Ms Tran summarising)

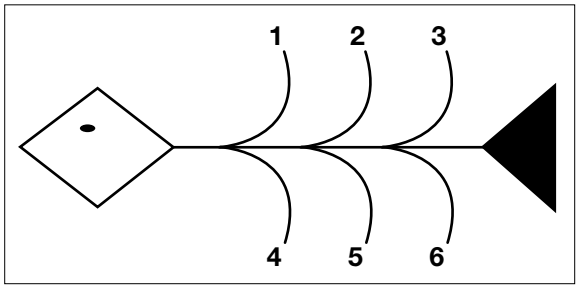

Figure 4. The fish skeleton

It was within these discussions that the title of the PRG was raised. The primary author had previously proposed that the PRG be referred to as the "Advisory Group". However the group indicated that this was not a suitable term. As summarised by Ms Tran:

> *For research, "advisory group" is not something that exists in the Vietnamese research. If you do the literal translation of advisory group, this means that people are higher than you are, telling you/advising you what to do, so that's not right in the Vietnamese context. They [PRG members] say they are part of the research, they are participating. So that describes the role very well.*

The term "participants" was agreed to and the term Participatory Research Group (PRG) adopted.

Another important outcome from this cycle of the research was discussion pertaining to issues of ethics in international research (for further detail regarding ethical considerations in international research, see Australian Council for International Development, 2016). Several of the PRG members reported their workplace directors had requested information about the role of PRG members in the research. PRG members sought reassurance from the primary author that their workplaces would not be identified in the research, nor would the research require the participation of clients receiving their services. The criticality of maintaining the confidentiality of research participants and of discussing with research participants how their engagement in the research may impact them was highlighted here. Further, in international contexts, language and cultural differences have the potential to impact understanding of research proposals and outcomes even when presented in participants' primary language (Brydon, 2006). A critical role for the PRG was highlighted here as members guided the primary author through this process so as to ensure safety in the conduct of the research.

Conclusion

This paper has described three cycles of one phase of a cross-cultural project in which participatory research methodology is being used to support international research in a majority world context. Interviews occurred at 24 months post-graduation to identify the nature of the graduates' professional practice, a PRG was established to guide the future research, and exploration of professional issues the PRG wished to investigate further was commenced. The engagement of the SLP graduates and primary author as co-researchers facilitated mutual learnings. The vital role of the interpreter as a member of the research team, the importance of repeated discussion of concepts to clarify understanding, and the impact of technology and local context upon communication and collaboration have been identified. The criticality of establishing open communication was highlighted in discussion of ethics and safety in research. Speech-language pathologists seeking to support service development in underserved and/or majority world contexts are encouraged to forge partnerships with international colleagues that arise from collaboration and support mutual learnings, for it will be within these contexts that initiatives may best meet the unique needs of culture and context. The next cycles in this research are evolving; and, it is anticipated that further inquiry into the barriers to the professional practice of SLP in Vietnam and actions to support this practice will follow. Opportunity will also be afforded for ongoing exploration of the dynamic of collaboration between the members of the PRG and primary author within a cross-cultural context.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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1 The terms "minority world" and "majority world" are frequently used in the literature to replace phrases such as developed/ underdeveloped countries, North/South, First World/Third World countries, industrialised/ emerging nations.

2 A further 15 students graduated in 2014.

3 In Vietnam, the profession of SLP is known as speech therapy.

References

Adelman, C. (1993). Kurt Lewin and the origins of action research. *Educational Action Research*, *1*(1), 7–24. doi:10.1080/0965079930010102

Apentiik, C., & Parpart, J. (2006). Working in different cultures: Issues of race, ethnicity and identity. In D. Vandana & R. Potter (Eds.), *Doing development research* (pp. 34–43). London, UK: Sage.

Australian Council for International Development. (2016). *Principles and guidelines for ethical research and evaluation in development*. Retrieved from https://acfid.asn.au/sites/site.acfid/files/resource_document/Principles-for-Ethical-Research-and-Evaluation-in-Development2016.pdf

Atherton, M., Davidson, B., & McAllister, L. (2016). Exploring the emerging profession of speech-language pathology in Vietnam through pioneering eyes. *International Journal of Speech-Language Pathology*. Advance online publication. doi:10.3109/17549507.2016.1159335

Atherton, M., Dung, N.T.N., & Nhân, V.H. (2013). The World Report on Disability in relation to the development of speech-language pathology in Viet Nam. *International Journal of Speech-Language Pathology*, *15*(1), 42–47. doi:10.3109/17549507.2012.743034

Bournot-Trites, M., & Belanger, J. (2005). Ethical dilemmas facing action researchers. *The Journal of Educational Thought*, *39*(2), 197–215.

Brydon, L. (2006). Ethical practices in doing development research. In D. Vandana, & R. Potter (Eds.), *Doing development research* (pp. 25–33). London, UK: Sage.

Caretta, M. (2015). Situated knowledge in cross-language research: A collaborative reflexive analysis of researcher, assistant and participant subjectivities. *Qualitative Research*, *15*(4), 489–505.

Chaiklin, S. (2011). Social scientific research and societal practice: Action research and cultural-historical research in methodological light from Kurt Lewin and Lev S. Vygotsky. *Mind, Culture and Activity*, *18*(2), 129–147. doi:10.1080/10749039.2010.513752

Chen, H., & Boore, J. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1–2), 234–239. doi:10.1111/j.1365-2702.2009.02896.x

Evans, M., Hole, R., Berg, L. D., Hutchinson, P., & Sookraj, D. (2009). Common insights, differing methodologies: Toward a fusion of indigenous methodologies, participatory action research, and white studies in an urban aboriginal research agenda. *Qualitative Inquiry*, *15*(5), 893–910.

Friere, P. (1970). *Pedagogy of the oppressed*. New York, NY: Herder and Herder.

Gaillard, J. F. (1994). North–south research partnership: Is collaboration possible between unequal partners? *Knowledge and Policy*, *7*(2), 31–63.

Gaudine, A., Gien, L., Thuan, T., & Dung, D. (2009). Developing culturally sensitive interventions for Vietnamese health issues: An action research approach. *Nursing and Health Sciences*, *11*(2), 150–153.

Gien, L., Taylor, S., Barter, K., Tiep, N., Mai, B.X., & Lan, N.T. (2007). Poverty reduction by improving health and social services in Vietnam. *Nursing and Health Sciences*, *9*, 304–309

Hersh, D. (2014). Participants, researchers and participatory research. *Journal of Clinical Practice in Speech-Language Pathology*, *16*(3), 123–126.

Hinckley, J., Boyle, E., Lombard, D., & Bartels-Tobin, L. (2014). Towards a consumer-informed research agenda for aphasia: Preliminary work. *Disability and Rehabilitation*, *36*(12), 1042–1050. doi: 10.3109/09638288.2013.829528

Kapoor, D., & Jordan, S. (2009). *Education, participatory action research and social change*. New York, NY: Palgrave Macmillan.

Kemmis, S., McTaggart, R., & Nixon, R. (2013). *The action research planner: Doing critical participatory action research*. Singapore: Springer Science & Business Media.

Kidd, S., & Kral, M. (2005). Practicing participatory action research. *Journal of Counseling Psychology*, *52*(2), 187–195.

Kingdon, S., Pain, R., & Kesby, M. (2007). *Participatory action research approaches and methods*. *Connecting people, participation and place*. Abingdon-on-Thames, UK: Routledge.

Koch, T., & Kralik, D. (2009). *Participatory action research in health care*. Oxford, UK: Blackwell Publishing Ltd.

Kramer-Roy, D. (2015). Using participatory and creative methods to facilitate emancipatory research with people facing multiple disadvantage: A role for health and care professionals. *Disability & Society*, *30*(8), 1207–1224. doi:10.1080/09687599.2015.1090955

Laverack, G., & Brown, K. (2003). Qualitative research in a cross-cultural context: Fijian experiences. *Qualitative Health Research*, *13*(3), 333–342. doi:10.1177/1049732302250129

Liamputtong, P. (Ed.). (2008). *Doing cross-cultural research: Ethical and methodological perspectives*. Dordrecht, Netherlands: Springer.

Maiter, S., Simich, L., Jacobson, N., & Wise, J. (2008). Reciprocity an ethic for community-based participatory action research. *Action Research*, *6*(3), 305–325. doi:19.1177/1476750307083720

Maguire, P. (2001). Uneven ground: Feminisms and action research. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (pp. 59–69). London, UK: Sage.

McAllister, L., Woodward, S., Atherton, M., Dung, N., Potvin, C., Huynh, B.,…Khanh, D. (2013). Vietnam's first qualified speech therapists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech- Language Pathology*, *15*(2), 75–79.

Müller, N., & Guendouzi, J. (2009). Discourses of dementia: A call for an ethnographic, action research approach to care in linguistically and culturally diverse environments. *Seminars in Speech and Language*, *30*(3), 198–206. doi:10.1055/s-0029-1225956

Pavlish, C. (2005). Refugee women's health: Collaborative inquiry with refugee women in Rwanda. *Health Care for Women International*, *26*(10), 880–896. doi:10.1080/07399330500301697

Pound, C. (2013). *An exploration of the friendship experiences of working-age adults with aphasia*. (Unpublished doctoral dissertation). Brunel University, UK.

Primavera, J., & Brodsky, A. (2004). Introduction to the special issue on the process of community research and action. *American Journal of Community Psychology*, *33*(3), 177–179. doi:10.1023/b:ajcp.0000027213.18639.30

Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies*, *46*(2), 277–287. doi:10.1016/j.ijnurstu.2008.08.006

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, *4*(2), 161–178. doi:10.1177/1468794104044430

Turner, S. (2010). Research note. The silenced assistant: Reflections of invisible interpreters and research assistants. *Asia Pacific Viewpoint*, *51*(2), 206–219.

Westby, C., & Hwa-Froelich, D. (2003). Considerations in participatory action research when working cross-culturally. *Folia Phoniatrica et Logopaedica*, *55*(6), 300–305. doi:10.1159/000073253

Wong, J., & Poon, M. (2010). Bringing translation out of the shadows: Translation as an issue of methodological significance in cross-cultural qualitative research. *Journal of Transcultural Nursing*, *21*(2), 151–158. doi:10.1177/1043659609357637

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Sustainable partnerships for communication disability rehabilitation in majority world countries

A message from the inside

Karen Wylie, Clement Amponsah, Josephine Ohenewa Bampoe, and Nana Akua Owusu

KEYWORDS
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THIS ARTICLE HAS BEEN PEER-REVIEWED

Karen Wylie (top) and Clement Amponsah

Rehabilitation services for people with communication disabilities (PWCD) in many majority-world countries are extremely limited, with speech-language pathology little known. Collaborations between clinicians and services in majority- and minority-world countries provide important contributions to developing rehabilitation services in the majority world for PWCD. The effectiveness of such partnerships may be influenced by a number of elements within the relationship. This paper presents insights from a group of majority-world speech-language pathologists (SLPs) in Ghana on establishing and maintaining links between majority- and minority-world services and clinicians. The framework of three sustainability dimensions (service environment, socio-cultural-political environment, and economic environment) is used to consider how SLP relationships across majority–minority worlds can be meaningful and lasting. Readers are encouraged to adopt the perspective of SLPs from within the country to consider the impact and sustainability of majority–minority world partnerships.

Globalisation and technological innovation has made linking with people from different geographical regions more possible than at any other time in history (Friedman, 2006). For service providers and people with communication disabilities (PWCD) in countries of the majority world, where services for communication disability are often extremely limited, it frequently means establishing relationships beyond their borders to assist with service provision, service development and improvement in quality. This article presents an insiders' perspective and discussion on relationships between clinicians and services across minority- and majority-world countries based on personal experiences of working in Ghana. The aims are twofold: (a) to encourage readers to view majority–minority world relationships through the lens of clinicians in the majority world and (b) to offer a range of observations from the authors' perspectives as "insiders" on relationship development and sustainability. This paper is not intended to provide a road map of how such relationships should operate; however, it provides a perspective of some of the complexities in developing and sustaining relationships to support development of sustainable services for communication disability.

Reflexivity statement

The authors of this paper are four speech-language pathologists (SLPs) living and working in Ghana, West Africa. Three are Ghanaian nationals, who trained in the United Kingdom (UK). One is a long-term expatriate in the region, who has lived in Ghana for four years and in the region for thirteen years. Together we work at a government hospital offering clinical speech-language pathology services. We also work together at a university to establish a training program for speech-language pathology. One of our group also runs an NGO focusing on early intervention and support for children with communication difficulties. Our regular and varied contact with SLPs who wish to come to Ghana to assist in the development of communication disability services prompted the writing of this paper. We recognise that our perceptions of the insider–outsider relationships may differ from the perceptions of those who visit.

While Ghana is rich in history and culture, it is not yet endowed with well-established rehabilitation systems for people with disabilities. Furthermore, although our country is foresighted and has an inclusive education policy (Ministry of Education, 2013), awareness of disability rights is still developing and services to support people with communication disability (PWCD) are severely stretched, with few speech-language pathology or communication disability services available in the country. Building services/systems for the future and improving awareness of communication disabilities is the focus of our work.

Our context

Ghana is well recognised as a leading nation of West Africa in areas including governance and economic development. Ghana is a lower middle income country and is ranked at 140 on the United Nations Development Programme (UNDP) Human Development Index (UNDP, 2015). It has a population of 26.4 million (UNDP, 2015) and is a multiparty democracy. In 1957, Ghana was the first sub-Saharan African country to achieve independence from its former colonial ruler Britain. While English is the official language of Ghana, Ghana has a large number of languages and dialects in use, with an estimated 25 to 43 main languages (National Commission on Culture, 2006). Currently, the

authors are aware of six practising SLPs in Ghana. Half are Ghanaian nationals, all were trained outside of Ghana and all are based in the capital city. There are no free speech-language pathology (SLP) services in the country and the National Health Insurance Scheme does not subsidise speech-language pathology (National Health Insurance Scheme, 2016). Clients frequently report travelling for many hours to attend services.

As in many majority-world nations, people with communication difficulties (PWCD) in Ghana require development of a range of rehabilitation services and supports, of which SLP is only one element (Wickenden, 2013). There are a range of people working with PWCD who provide important contributions to rehabilitation. Teachers, teaching assistants, therapists, therapy/educational aides (known locally as facilitators), community-based rehabilitation (CBR) workers, nurses, carers and parents all provide important work in this arena and are indispensable in providing a network of services and support for PWCD.

While every majority-world country and context differs, there are frequently common themes associated with service provision challenges. Often, there is a small workforce, no SLP training programs (Fagan & Jacobs, 2009), little professional development, and limited training for CBR or mid-tier workers in communication disability (World Bank & World Health Organization, 2011). Where SLP services exist, payment is often required and insurance cover for SLP is extremely limited. The community may have limited awareness of communication disability (Wickenden, 2013) and differing beliefs about the causes of communication disability (Ndung'u & Kinyua, 2009).

The insider perspective

Individuals frequently view a shared experience in differing ways, particularly when their context and cultural backgrounds differ (Nixon et al., 2015). Alternative perspectives can result in tensions within relationships that are frequently unarticulated (Nixon et al. 2015). One aim of this paper is to encourage readers to attempt to view visiting partnerships through the lens of an 'insider" – someone who may be there before minority-world SLPs arrive, support them during their work, then continues on after they leave – to enable more critical reflection of sustainable relationships.

To reflect on issues around partnerships for sustainable service development using an insider perspective, we encourage readers to consider a fictional vignette (Box A). This example offers the chance to reflect on some of the many issues that are present when an "outsider" visits a local service. Navigating relationships between services or clinicians in the majority and minority worlds can be complex, yet undoubtedly globalisation has resulted in dramatically more opportunities for collaboration (Friedman, 2006). With this edition of the journal focused on the theme "Minority-world SLPs in majority-world contexts", it is important to reflect on what contributes to effective partnerships between majority- and minority-world services.

How can minority-world SLPs assist development of sustainable services for PWCD in majority-world countries?

In the spirit of a local proverb in Akan "Nyansa nne eti kromu" [translation: *Wisdom is not the preserve of one*

Box A: Turning the tables: Insiders and outsiders – an example

Imagine that you are one of two SLPs and two assistants working in a government clinic in remote Australia. Budget cuts mean equipment is dated or non-existent. You offer services across a huge geographical area to a large population. A skilled and experienced speech-language pathologist from a well-resourced service in Africa offers to volunteer for 3 months. As services are stretched to the limit in your clinic, you are excited to have someone to help you improve services. In the weeks prior to arrival, you exchange emails and Skype calls. You help him/her to organise accommodation. You advise on transport, safety, the weather, the health system, and you collect the volunteer from the airport.

Your new colleague is generous in sharing their knowledge. Your service enhances training and expands clinical services. You are working on interesting projects and feel inspired by the rich clinical discussions. But there are challenges. The visiting practitioner struggles to understand how things happen in your context and seems to have an agenda for what is required, which doesn't match your view of the need. Given the visitor is more experienced, volunteering their time, and contributing resources, it is hard to argue. At a service level, there are small issues. The visiting practitioner has trouble with the language, so cannot work independently. Clients often don't understand what he/she means when explaining things, but are too polite to mention it. There are awkward moments – such as when the visiting practitioner tells clients to focus on giving instructions to their children rather than engaging in reciprocal play, or hints that the type of therapy you are offering may not be best practice. The visiting practitioner doesn't know how to do the things that are considered important in your context (e.g., making sure certain families have transport money or helping to find a school that will take their child). You understand that it is simply a difference to how things are done in Africa.

The visiting practitioner helps to train the assistants in a particular type of therapy. Everyone is excited about skill development. It is wonderful to make the connection, but all the things you need to organise for the visitor are added on top of your usual workload. The visiting practitioner returns to Africa and you are back juggling the demands of service provision to desperate clients, and the many other needs (e.g., awareness raising, training others, special projects to improve services, prevention work, and trying to build a profession). The visiting practitioner stays in touch for some months and sends some invaluable resources. The assistants need further support in adapting their new programs to the culture, and you struggle to support them and maintain your other work. After two months, another NGO from Africa offers to assist in the development of autism services and would like your involvement. You feel like you are still playing catch-up with your usual work. What is your response?

Josephine Ohenewa Bampoe (top), and Nana Akua Owusu

individual], we offer our own perspectives on how minority-world SLPs can best assist those in the majority world to develop sustainable services. Based on our experience of collaborations with minority-world stakeholders, we considered the question, "What do we believe is best practice for minority world SLPs to do, discuss or consider when visiting Ghana to assist in sustainable service development?"

Factors around sustainability are key to discussion of how minority-world SLPs can best assist those in the majority world to improve services for PWCD. Recently the United Nations (2015) adopted 17 sustainability goals for development. These goals address three commonly recognised dimensions of sustainable development: economic, environmental, and social and. In this paper we use these three sustainability dimensions to structure our views on partnerships between SLPs in minority- and majority-world countries. The following observations expressed are not intended to be exhaustive, but represent our observations from the field.

Economic sustainability factors

Economics

For sustainability, services need to be both economically viable and relevant to the needs of the population. Minority-world partners who seek understanding of the economic context, including factors such as service funding models, costs of services, service affordability, can make more informed choices about the nature of their involvement. Researching economic indicators and seeking information from majority-world partners can assist in understanding economic factors. For example, all SLP services in Ghana are fee paying, with costs varying enormously. Understanding the type of service you are partnering with, the types of clients who are able to access/afford the service, and the cost relative to other services can help give indications of the long-term sustainability and impact of partnering with a particular service.

Opportunity costs

Understanding the opportunity costs which may impact local counterparts (and which may not be immediately obvious) can assist in project planning and implementation. These factors may include:

1. How much money people attending training or therapy sacrifice due to loss of income, or indirect costs (such as transport) of meeting with you. Such costs can be significant when families are struggling to make ends meet.
2. Understanding of the time required by local service providers to plan for visits or projects, and what happens to existing, stretched services when additional time is needed to assist planned visits. That is, what do local staff stop doing to assist in organising international programs or visits? For example, past visiting programs in Ghana have taken a number of days of planning and organising. Due to the lack of administrative support, much of this time has been taken from clinical services. It is necessary to understand and weigh up the cost-benefit of such commitments.

Lobbying

Improvements in sustainability require developments in economic and social policy. Activism, for improvements to awareness, rights and services, forms a large part of disability engagement in majority world countries, including for SLPs (Wickenden, 2013). For minority world partners with higher level political influence, it is useful to consider if there is a strategic role to influence change in conjunction with majority-world partners. For example, in Ghana visiting minority-world partners have met with government officials or participated in media events in collaboration with the local team, assisting with the local agenda to build awareness of communication disability and lobbying for improved services. Such meetings are carefully planned as part of the partnership.

Environmental sustainability factors

Service environment

Investing time considering the wider service context when considering relationships and support in a majority-world country is prudent. Contacting a number of individuals or groups to ask questions about the range and types of services in the country (e.g., government, private and NGO services) provides a perspective of "the lay of the land", including population needs and how services are organised. For example, some independent SLP volunteers to Ghana have previously liaised with a range of services and clinicians to discuss the situation and need in Ghana, to determine how and when to partner with a particular organisation. Gaining such an overview of services and need in-country can assist visiting clinicians or organisations to determine where and how contributions to that country may be most beneficial. Such an approach also has the potential to increase communication between SLPs and organisations who may collaborate with them on projects during their visits.

Direct or indirect services

Working alongside a local partner will allow capacity building, enable the local partner to follow-up initiatives, and increase relevancy of services. Before providing direct clinical services, consider the relevance, appropriacy and sustainability of these services. Never offer direct clinical services alone, without planning how such services can be culturally relevant and sustained.

Professional networks

In Ghana, local SLPs routinely seek to engage with visiting minority-world SLPs. Creating these professional networks of practice is an effective way of building a knowledge and resource base in a country with limited services for communication disability. When visiting SLPs do not engage with other SLPs or providers in the country the potential to waste precious expertise and duplicate resources is increased.

Work environment

Attempt to understand the constraints of local staff, including SLPs. The reality of working in a majority-world country is often challenging, with huge clinical demands, low salaries, limited technology access (e.g., no reliable internet or work phone), underdeveloped systems, bureaucracy and sometimes unreliable basic services such as water and electricity. For example, in Ghana access to technology in government services is extremely limited. There is currently no internet access in the hospital speech-language pathology service and SLPs frequently use their own resources to contact international SLP colleagues. Limited access to technology can impact both finances (and therefore willingness to call/log on) and timeliness of responses for local staff which can sometimes be perceived negatively by minority-world partners. Projects with funding could consider limited support for the team to access appropriate resources.

Needs

In a context where services and resources are underdeveloped, there is always need for additional resources. Detailed discussions with local partners about needs and priorities are crucial to make sure resources brought in are high priority and relevant for use. For example, past majority-world visitors to Ghana have sent a list of items they are considering bringing, and we advised them which items are relevant and of high priority.

Socio-cultural-political sustainability factors

Transparency

Acknowledge motivations clearly as this sets the scene for the boundaries of the partnership. Engaging with SLP services in the majority world is done voluntarily and for a purpose with each partner benefitting from the relationship. Minority world SLP motivations may vary (e.g., travel, the chance to meet new people, international recognition, publications, recognition from your institution for developing international relationships, grant funding, service learning promoting cross-cultural competencies, or the opportunity to be regarded as "worldly" or "generous"). Stakeholders in majority-world countries benefit through improvements to services, funding, equipment or expertise. Transparent and open dialogue about motivations will enable partners in the majority world to understand the limitations of minority-world SLPs' involvement. For example, if SLP partners in Ghana understand that the motive of a visit includes positive publicity for your institution, they can plan local media engagements that may both meet this objective and build community awareness of local communication disability services.

Expertise

There are two types of expertise relevant to the practice of SLP in the majority world: (a) expertise in a particular clinical specialty, and (b) expertise in how to translate this knowledge to deliver culturally and contextually relevant services (Hyter, 2014; Pickering and McAllister, 2009) The second expertise is often referred to as "cultural competence" (Leadbeater & Litosseliti, 2014). However, when SLPs work outside situations with which they are familiar, cultural competence should be widened to include contextual competence. For example, an individual may be a clinical specialist in her or his home country, but face significant challenges translating that knowledge into practice in a different context where knowledge of local practices and services in the field of expertise is limited. SLP is a western profession (Pillay & Kathard, 2015), most often practised in contexts where there are networks of services for PWCD. Where the sociocultural context differs, consideration of the beliefs underpinning knowledge and practices of SLP services is important to begin to reframe practice (Hyter, 2014). This ensures services are "sustainable, culturally appropriate and nuanced" (Barrett & Marshall, 2013, p. 50). SLP practices in majority-world settings may differ from practices in the minority world, due to differing support systems, culture and population needs (Wickenden, 2013; Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003; Wylie, McAllister, Davidson, Marshall, & Law, 2014). Thus, working collaboratively with a local partner who can act as a cultural broker is vital. This should be someone who understands both the cultural context and understands the context of communication disability/SLP in that country and can assist in navigating the complex terrain.

Alternative support models

Historically, minority world SLPs' visits to Ghana have typically focused on supporting existing services and/or providing training. An alternative option is to support clinicians from the majority world to spend time in minority world services, and allow majority world clinicians to make judgements about adaptation of relevant practices or systems on return. This might include training sponsorships (Hutchins, 2015), or capacity-building partnerships grants (e.g., Department of Foreign Affairs and Trade, 2016; McAllister et al., 2013). For example, one Ghanaian clinician was recently sponsored to visit academic institutions in the UK to review processes for clinical education. This allowed the team member to view a range of programs and judge which processes may be best suited to the Ghanaian context

Priorities and mutual planning

The concept described by Hyter (2014) as cultural humility is an important start to creating an effective two-way dialogue and planning. Dialogue can help create an appropriate plan for potential placements or partnerships. Projects and desired outcomes need to be mutually negotiated, based on need, context, local resourcing with a high priority given to the expressed needs of the local partners. Self-determination is vital if developments are to be sustained in the long term. Just as SLPs from the minority world need to take time to build relationships and explore the needs and priorities of the majority world partners, majority world partners should work towards clarity and control regarding their priorities and needs. However, achieving such clarity and self-determination can be challenging due to subtle power dimensions in relationships (Sharpe & Dear, 2013). The subtle influences of neocolonialism frequently impact relationships when minority world SLPs engage in the majority world (Hickey, Archibald, McKenna, & Woods, 2012; Nixon et al., 2015). Recognition and acknowledgement of these power imbalances is part of successful collaborative engagement between majority- and minority-world SLPs.

Change and time

Change takes time and ongoing effort to anchor practices in the culture (Kotter, 1996). For sustainable development of services in majority world countries, long-lasting durable and evolving relationships count. One often-seen limitation of majority-minority world partnerships is the short-term nature of them. Partnerships that can be sustained over time offer potential to engender lasting change in systems, practices, and policy. While many SLPs visit majority-world countries with short-term objectives, lasting change may require a longer commitment. Advances in technology are opening windows for remote support – for example, the inclusion in professional development opportunities via videoconferencing platforms, or assistance with case reviews using smart phone video and audio technology.

Conclusion

It is not yet clear how sustainable and culturally appropriate services for communication disability will ultimately look in majority world countries. We are still learning how SLP can best contribute to the needs of PWCD in these varied contexts. Yet every engagement we have with SLPs from the minority world has the potential to shift the landscape. In this paper we have attempted to provide an insider perspective on minority-world – majority-world SLP engagement. We have offered our experiential view on

some of the factors that can contribute to effective engagement between minority-world and majority-world stakeholders in attempting to build sustainable services for PWCD. We believe that similar themes are likely to be evident in many majority-world countries where services and individuals from minority-world nations support development initiatives for majority-world countries. Effective partnerships between majority-world and minority-world stakeholders are crucial for development of services for PWCD. As insiders, we encourage those considering engagement in the majority world to strive for understanding across service, socio-cultural-political, and economic environments for effective partnerships.

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References

Barrett, H., & Marshall, J. (2013). Implementation of the World report on disability: Developing human resource capacity to meet the needs of people with communication disability in Uganda. *International Journal of Speech-Language Pathology*, *15*(1), 48–52. doi:10.3109/17549507.2012.743035

Department of Foreign Affairs and Trade. (2016). *Australia awards fellowships*. Retrieved from http://dfat.gov.au/people-to-people/australia-awards/Pages/australia-awards-fellowships.aspx

Fagan, J. J., & Jacobs, M. (2009). Survey of ENT services in Africa: need for a comprehensive intervention. *Global Health Action*, *2*(10). doi:10.3402/gha.v2i0.1932

Friedman, T. L. (2006). *The world is flat: A brief history of the twenty-first century*. Camberwell, Vic.: Penguin.

Hickey, E. M., Archibald, C., McKenna, M., & Woods, C. (2012). Ethical concerns in voluntourism in speech-language pathology & audiology. *Perspectives in Global Issues in Communication Sciences & Related Disorders*, *2*(2), 40–48.

Hutchins, S. D. (2015). SLP grad takes his skills back to Rwanda. *The ASHA Leader*, *20*(10), 24–25. doi:10.1044/leader.LML.20102015.24

Hyter, Y. D. (2014). A conceptual framework for responsive global engagement in communication sciences and disorders. *Topics in Language Disorders*, *34*(2), 103–120. doi: 110.1097/TLD.0000000000000015.

Kotter, J. P. (1996). *Leading change*. Boston, MA: Harvard Business School Press.

Leadbeater, C., & Litosseliti, L. (2014). The importance of cultural competence for speech and language therapists. *Journal of Interactional Research in Communication Disorders*, *5*(1), 1–26. doi:10.1558/jircd.v5i1.1

McAllister, L., Woodward, S., Atherton, M., Nguyen, T., , Potvin, C., Huynh, B., . . . Le Khanh, D. (2013). Viet Nam's first qualified speech therapists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech Language Pathology*, *15*(2), 75–79.

Ministry of Education. (2013). *Inclusive education policy*. Draft. Accra, Ghana: Republic of Ghana. Retrieved from http://www.voiceghana.org/downloads/MoE_IE_Policy_Final_Draft1.pdf

National Commission on Culture. (2006). *The people: Traditional language and orature*. Retrieved from http://www.ghanaculture.gov.gh/index1.php?linkid=240.

National Health Insurance Scheme. (2016). *Benefits package*. Retrieved from http://www.nhis.gov.gh/benefits.aspx

Ndung'u, R., & Kinyua, M. (2009). Cultural perspectives in language and speech disorders. *Disability Studies Quarterly*, *29*(4). Retreived from http://dsq-sds.org/article/view/986/1175

Nixon, S. A., Cockburn, L., Acheinegeh, R., Bradley, K., Cameron, D., Mue, P. N., . . . Gibson, B. E. (2015). Using postcolonial perspectives to consider rehabilitation with children with disabilities: The Bamenda–Toronto dialogue. *Disability and the Global South*, *2*(2), 570–589.

Pickering, M., & McAllister, L. (2000). A conceptual framework for linking and guiding domestic cross-cultural and international practice in speech-language pathology. *Advances in Speech Language Pathology*, *2*(2), 93–106.

Pillay, M., & Kathard, H. (2015). Decolonizing health professionals' education: Audiology and speech therapy in South Africa. *African Journal of Rhetoric*, 7, 193–227.

Sharpe, E., & Dear, S. (2013). Points of discomfort: Reflections on power and partnerships in international service-learning. *Michigan Journal of Community Service Learning*, *19*(2), 49–57.

United Nations. (2015). *Transforming our world. The 2030 agenda for sustainable development*. Geneva: United Nations. Retreived from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

United Nations Development Programme. (2015). *Human development reports: Ghana*. Retrieved from http://hdr.undp.org/en/countries/profiles/GHA

Wickenden, M. (2013). Widening the SLP lens: How can we improve the wellbeing of people with communication disabilities globally. *International Journal of Speech-Language Pathology*, *15*(1), 14–20. doi:10.3109/17549507.2012.726276

Wickenden, M., Hartley, S., Kariyakaranawa, S., & Kodikara, S. (2003). Teaching speech and language therapists in Sri Lanka: Issues in curriculum, culture and language. *Folia Phoniatr Logop*, *55*(6), 314–321. doi:10.1159/000073255

World Bank & World Health Organization. (2011). *World report on disability*. Geneva, Switzerland: World Health Organization.

Wylie, K., McAllister, L., Davidson, B., Marshall, J., & Law, J. (2014). Adopting public health approaches to communication disability: Challenges for the education of speech-language pathologists. *Folia Phoniatrica et Logopaedica*, *66*(4–5), 164–175.

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Professional and personal benefits of volunteering

Perspectives of international clinical educators of Vietnamese speech-language pathology students in Vietnam

Lindy McAllister, Sue Woodward, and Srivalli Nagarajan

Few studies have investigated the impact of volunteering on allied health professionals' personal and professional development. This paper presents the findings of a study exploring the volunteering experience of speech-language pathology (SLP) clinical educators in Vietnam. Twenty four volunteers placed through Trinh Foundation Australia provided clinical supervision to students in Vietnam's first SLP course during 2010–12. Returning volunteers were invited to complete a written survey and provide a short summary of their experience. Twelve surveys and six summaries were returned. These responses were analysed using content analysis and five categories were identified: motivations for volunteering, managing challenges associated with a different culture, language and working with interpreters, impact of the volunteer experience on professional development and clinical practice back home, and enhanced skills and interest in clinical education. Participants described the applicability of knowledge and skills gained in Vietnam to their practice in Australia.

> *I am a speech pathologist with over 30 years' experience in a number of different clinical settings including 12 years [in a specialist area]. … At this stage in my career I was thinking that maybe my days as a speech pathologist were coming to an end and I would pursue other interests. The idea of volunteering in any capacity had always interested me so when I discovered that there was an opportunity to actually use my speech pathology skills I was definitely interested. … Volunteering in Vietnam was an incredibly worthwhile experience which provided me with a challenge on both a personal and professional level, and allowed me to utilise my existing clinical skills and experience as a student educator to assist in a small way in the clinical education of the … Vietnamese students training to become speech pathologists.* (Lisa – returned volunteer speech-language pathologist to Vietnam)

The Australian Bureau of Statistics (2015) figures for 2014 revealed that 5.8 million people in Australia (31 per cent) reported they had volunteered in the previous 12 months, contributing 743 million hours to the community. There has also been significant growth in international volunteering in recent years (Baillie Smith & Laurie, 2011). As the opening vignette shows, volunteering internationally can have a profound impact on the volunteer. It can also have significant positive and sustainable impacts on host organisations and communities if volunteering programs are well designed and well managed (Sherraden, Lough & McBride, 2008; UNV, 2011). Conversely, negative impacts such as cultural imperialism, reinforcement of inequalities (Sherraden et al., 2008), and neocolonialism (Karle, Christensen, Gordon & Nystrup, 2008) can arise from poorly considered or managed volunteering. Volunteer tourism or voluntourism, where volunteers combine a holiday and tourism in a developing country with engagement in a short term, humanitarian project, has attracted considerable criticism in recent years (Palacios, 2010). These projects frequently do not require professional skills; for example, projects may simply require free labour from people without construction or engineering backgrounds to build a schoolroom, or a playground for an orphanage. Outcomes may not address community needs, or have sustainable outcomes for the host site, even though volunteers may experience a sense of well-being arising from their activities.

Lack of sustainability of volunteer endeavours has been critiqued (see for example Devereux, 2008). There is a lack of literature on the impacts and sustainable outcomes of volunteer programs generally (Sherraden et al., 2008), especially for health professionals engaging in knowledge and skills transfer designed to build capacity of host sites and training recipients (Meyer, 2013). Most of the existing literature pertains to medical and nursing/midwifery volunteers (e.g., Pieczynski, Laudanski, Speck, & McCunn, 2013). There are few studies about allied health volunteers, and to the best of our knowledge none about SLP volunteers. Hickey, McKenna, Woods, and Archibald (2014) noted that research is required into best practices for volunteering in SLP and audiology volunteers. This paper investigates the impacts on speech-language pathologists resulting from volunteering as clinical educators (CEs) for students in Vietnam's first SLP course. It is important to note that the evaluation of the impacts and outcomes from the perspectives of the Vietnamese partners is critical to

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avoid neocolonial practice (Karle et al., 2008) and ensure agencies and volunteers from minority world countries understand and enable sustainability (Osborn, Cutter, and Ullah, 2015). To this end, readers are referred to previous work (McAllister et al., 2013) in which the impact on the host site and the recipients of training by CE volunteers in Vietnam has been discussed. Furthermore, publications in review and preparation will explore in more depth Vietnamese perspectives on the contributions of volunteers.

Background

The volunteers involved in this study were sourced, placed and supported by Trinh Foundation Australia (TFA) which was established in 2008 to respond to requests for assistance in developing and delivering SLP training courses in Vietnam. The volunteers provided clinical supervision for students enrolled in the first 2-year postgraduate speech-language pathology training course at the University of Medicine Pham Ngoc Thach (UPNT) in Ho Chi Minh City (HCMC) in 2010–12. The structure and support arrangements, as well as students in the course, were described in McAllister and colleagues (2013).

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In line with best practices for volunteering (Hickey et al., 2014), TFA volunteers receive pre-departure briefing and return-to-Australia debriefing from TFA, as well as in-country support from full-time Australian volunteer speech-language pathologists at UPNT in HCMC. This paper focuses on survey responses from 12 volunteers who provided clinical supervision in the 2010–12 course. The volunteers went to Vietnam for periods ranging from 2–12 weeks. They supervised students on 1–3-week block placements in a range of clinical facilities. The volunteer CEs typically worked a 5-day week with groups of 2–4 students and fulfilled the normal roles of a clinical educator (e.g., reviewing client assessment reports and treatment plans, modelling techniques, observing student performance, providing feedback and formal assessment, coaching and tutoring). The volunteers were supported by TFA trained interpreters/translators in Vietnam to translate clinical education materials and interpret communication between the Australian SLP CEs, students and patients/families during the clinical placements.

Method

Ethics approval for this study was provided by the University of Sydney Human Research Ethics Committee (approval # 2014/231).

Recruitment

All 24 CE volunteers in the first course (September 2010 – August 2012) were emailed an invitation and participant information about the study. The 12 respondents were then emailed a survey, by a person not involved in supporting the volunteers. The invitation to participate was sent after the last clinical placement block, in October 2012. Participants were asked to return their surveys and summaries by email if they consented to participate.

Data collection

The survey comprised 4 questions presented in Table 1, along with an invitation to provide a 100 word summary of the experience. Twelve surveys were returned and analysed. Six optional summaries contributed by participants were not included in analysis; they were left "whole" for use as vignettes in the paper.

Table 1. Survey on experiences of volunteering as CEs for SLP students in Vietnam

1. Do you think your time in Vietnam gave you any insights into understanding another culture? What cross-cultural skills and knowledge did you develop as a result of your time in Vietnam? Have these been applicable to your professional work?
2. Do you think working in such a different and frequently challenging environment has given you any valuable insights into your personal strengths and weaknesses?
3. How has your role as a clinical educator in Vietnam impacted on your professional development?
4. Has working in Vietnam influenced your clinical practice in any way?

Data analysis

Survey responses to each question were collated. Because some emergent categories were identifiable in collations of responses to more than one question, all responses were collated and then analysed using content analysis (Hsieh & Shannon, 2005). Emerging categories were compared within an individual's survey data and across all participants' survey responses. Through a process of constant comparative analysis (see for example, Hewitt-Taylor, 2001), a final list of categories was developed and exemplar quotes from survey responses identified to illustrate these.

Results

As speech-language pathologists who have volunteered as CEs in Vietnam are known in the profession, ethics approval required that limited demographic information be collected to reduce the likelihood of identification and pseudonyms are used to report data in this paper. All participants were female, which is similar to the national gender demographic of speech-language pathologists (Health Workforce Australia, 2014). Years of experience as an SLP ranged from 2 to more than 30 years. The volunteers came from a range of adult and paediatric settings in hospitals, schools, disability settings and private practices in Australia and the United Kingdom.

Data analysis identified five categories of CE responses to their experiences in Vietnam. These categories, subcategories and illustrative extracts from the surveys are presented in this section. Extracts are drawn from all participants.

Motivations for becoming a volunteer clinical educator

Motivation for volunteering was mentioned by most participants, in terms of their desire to make a contribution to the development of the profession in Vietnam or "give back" what they had gained from their professional life.

> Fay: *I am basically retired. I was glad to take on the role of clinical educator in Vietnam as a way to contribute something of what I have been able to learn and develop myself over my career.*

> Anna: *[it] was a perfect opportunity to "give back" to the profession in a small way, as well as stretch myself by working/volunteering in a different culture and language for the first time.*

Managing challenges

All participants spoke about challenges and these were of two main types: confronting and learning to manage

language and cultural barriers; and learning to work with interpreters. Participants started to develop an understanding of what the acceptable norms are in Vietnamese culture in relation to learning and asking questions. Using the knowledge gained through several interactive discussions with students and colleagues, participants began to understand how to manage cultural differences particularly in relation to learning and teaching, as illustrated in the quotes below.

Julie: *… it was really only once I had been in Vietnam for a week or so that I started to see a little better the expected behaviours, beliefs, values, practices and customs. That is, I learned much more within the context of the culture. This was informed by observations, opportunities to de-brief with a colleague, and LOTS of opportunities to interact with the students and critically, discuss cultural differences with them …*

Helen: *With students, I needed to break down this barrier [of hierarchy and officialness] to encourage them to ask questions. There seemed to be a concept of "saving face" and a feeling that asking a question indicated not knowing something.*

The majority of students with whom participants worked had little English, and this presented numerous communication barriers. While the interpreters were able to assist with overcoming these barriers, the volunteers (as exemplified in Helen's quote) were aware that cultural differences existed in terms of power and hierarchy between teachers and students and that this impacted on what it was acceptable to communicate about.

Lucy: *Although a few of the students did have good English skills, I was aware that not all of them did. Initially when I spoke the students with the better English would reply before the interpreter could translate. I felt that that was a weakness on my part. I then focused on pausing after I spoke to allow the interpreter to translate. I was more assertive when students would reply in English and I requested them to speak in Vietnamese to help the other students in the group. I have worked with interpreters before in my job but not to the level that is required in Vietnam.*

Impact on professional development

The participants wrote about a number of positive impacts of the volunteer CE experience on their professional development. These impacts included reaffirmation of the depth of knowledge and experience gained over years of practice and also the recognition that clinical knowledge and practice change over the course of a career and hence the need to seek continuing professional development (see for example Anna) or further education.

Anna: *It made me very conscious of how much clinical knowledge and practice changes over time and has reinforced the need for ongoing professional development and clinical discussion.*

For some, the volunteer experience improved leadership skills and time management skills. For others it ignited or rekindled enthusiasm for the profession.

Lucy: *I feel that it has improved my leadership skills.*

Maria: *I suppose I'd become a bit jaded. But the time I had volunteering for Trinh really motivated me and revived my enthusiasm for the profession.*

Kerrie astutely commented on coming to understand what was achievable in short time frames and the issues around sustainable impact of development work such as this.

Kerrie: *I wanted to see … change "large scale and lots of it!" for the clients and families in Vietnam, which was not at all realistic, just a natural response to seeing a country and a health system where the speech pathology profession is so new. Being part of a longer term, more sustainable answer to the problem really helped me to see the value in patience.*

Impact on clinical practice in home country

The volunteers identified positive impacts of the Vietnam experience on their clinical practice in Australia. The impacts included less reliance on resources, tests and equipment, needing to "think outside the square", increased patience, observation skills and clinical reasoning. One volunteer specifically wrote about new theoretical knowledge she acquired as a result of the experience.

Maria: *Not having access to the "western" resources, equipment and standardised tests has meant that I have needed to rely on the limited resources available which I believe has helped me to think outside the square regarding therapy approaches and assessment [in Australia].*

Helen: *Working in Vietnam certainly raised awareness of CALD issues in health care. It encouraged me to pursue translating speech pathology written information (e.g., brochures) into different languages and to investigate working these themes into our health promotion practices [in Australia].*

Maggie: *I have gained a lot of theoretical knowledge through volunteering, in particular in the area of cochlear implant and parent implemented therapy. I have been able to use this new knowledge in my clinical practice [in Australia].*

Enhanced skills and interest in clinical education

The volunteering experience served to further develop skills and interest in clinical education. For some like Anna and Carol, there had been a long absence from engagement in clinical education. Some participants reported that the experience in Vietnam reminded them how much they enjoyed clinical education. Volunteers such as Anna and Stephanie wrote about how the experience helped refine their reflection, analytic and clinical teaching skills. These experiences are illustrated by the following quotes.

Anna: *It certainly reacquainted me with the pleasure of working with students again.*

Lucy: *Previously I have only worked with students in one-to-one blocks. This experience helped me work with 4–5 students at a time. It helped develop my time management skills.*

Stephanie: *I had to step back and reflect upon my actions and teaching methods and how they were impacting upon the students' ability to learn from me.*

Discussion

This paper presents new data on the experiences of speech-language pathologists who volunteered as CEs in a

newly established SLP course in Vietnam. Our data in relation to motivation for volunteering are consistent with the altruistic trend in volunteering noted by Meyer (2013). Humanitarian reasons, desire to learn about another culture and advancing career prospects are discussed as common motivators in other studies of volunteers (Palmer, 2002). While literature on voluntourism (Meyer, 2013; Palacios, 2010) reports the desire for a personal challenge as a common motivator, the 12 participants in this study were more likely to express wanting a professional challenge, while recognising they would also be personally challenged by the climate, cultural and language differences. Career advancement was not a motivator for participants in this study.

The participants in this study reported their experience of volunteering as CEs in Vietnam to be highly positive. The personal and professional benefits for the volunteers and their practice back in Australia have been highlighted in this paper. The range of impacts on participants' professional development was to some degree unexpected, but encouraging. We did not, for example, expect to find the experiences in Vietnam generating a recommitment to and passion for their profession. The transferability of new knowledge and skills gained in Vietnam back to their clinical practice in Australia is a significant finding. The re-engagement with clinical education, the pleasure and satisfaction reportedly gained, and the refinement of educator skills, were encouraging findings. The study participants also reported several benefits of volunteering for advancing their professional skills and interest in clinical education. Such results have implications for SLP in Australia, which relies on a growing community of skilled and enthusiastic CEs.

This study also identified a range of challenges experienced by participants. Anticipated challenges of managing language and cultural barriers and working with interpreters were mentioned. Challenges or barriers in relation to communication in culturally different contexts have also been identified in other studies (e.g., Pieczynski et al., 2013). There was some degree in this study of what Santoro and Major (2012) referred to as dissonance regarding culturally different communication styles and expectations about appropriate interactions, and the participants had to develop cultural knowledge and some degree of intercultural competence to fulfil their role as CEs. Some participants commented that the students proved to be generous cultural guides and cultural knowledge brokers.

Most participants in our study had at least a little prior experience in working with interpreters. However, the varying English abilities of the students, coupled with interpreting protocols regarding pausing to allow time for interpreting, created additional complexity for the participants in "teaching" students in the presence of interpreters. Some participants noted that their enhanced competence and confidence in working with interpreters would be an asset in their practice back in Australia.

The lack of resources identified as barriers in other studies (Pieczynski et al., 2013) for participants in this study became a trigger for creativity and development of new skills. The development of intercultural skills and improved ability to work in culturally and linguistically diverse environments were seen as highly applicable to practice in Australia, as were the enhanced skills in working with interpreters. The impact of the volunteer experience on the development of intercultural competence is not unexpected, given previous research with volunteers and with allied health students (Gribble, Dender, Lawrence, Manning, & Falkmer, 2014). Our findings suggest that volunteering in a professional capacity in Vietnam provides significant professional development of knowledge, skills and attributes needed for maintaining currency of practice and expanding leadership capacity.

The lack of other barriers mentioned in their responses may reflect the impact of good pre-departure briefings and in-country support, and support from the students and interpreters themselves. Alternatively, the participants, as a self-selected group, may already have been culturally adaptable and resilient individuals, or they chose not to reveal negative experiences. Our data does not allow us to examine these possibilities, and this is a limitation of this study which could be addressed in future studies using interviews rather than written surveys.

Another limitation of this study is the sample size (12), which, although typical of qualitative research, does not permit generalisation of findings beyond the context of the study. A further limitation of this paper is that it does not report on benefits or problems experienced by the students who received clinical education from the volunteers. These data are being analysed and the results will be reported in forthcoming publications.

Sustainability of impact is always an important consideration in volunteer programs. The transfer of the volunteers' knowledge and skills to the Vietnamese students has been reported to be of great benefit to the emerging SLP profession in Vietnam (McAllister et al., 2013). The groundwork has been laid for future self-sufficiency of the profession in Vietnam. In order to upskill the Vietnamese SLPs as CEs for the future, subsequent CE volunteers mentored graduates of the 2010–12 course in clinical blocks to co-supervise students in the 2012–14 course. It is this professional knowledge and skills transfer and the commitment to sustainable impact that distinguishes this volunteer experience from "feel good" but not sustainable, and sometimes ethically questionable voluntourism (Hickey et al., 2014). The volunteer experiences described in this paper suggest the volunteering provided a powerful continuing personal development experience and in some cases transformative learning experience, as the words from Stephanie reveal.

> *I volunteered with the Trinh Foundation as I have always wanted to volunteer overseas and saw the opportunity to do so in a field where I could put my skills as a speech pathologist into use. Working as a clinical educator taught me so much about the important role that cultural understanding plays in delivering services that meet the needs of the people we work with. It also taught me so much about my own culture and about myself as a clinician. I am so grateful that I got to experience this during the early years of my career so that the skills and knowledge I gained were able to shape the way that I approach my work within the field. I would highly recommend this experience to anyone wanting to make a contribution to the international profession and to extend themselves both personally and professionally.* (Stephanie – returned Australian volunteer speech-language pathologist to Vietnam)

References

Australian Bureau of Statistics. (2015). *General social survey: Summary results, Australia, 2014*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0

Baillie Smith, M. B., & Laurie, N. (2011). International volunteering and development: Global citizenship and neoliberal professionalism today. *Transactions of the Institute of British Geographers*, *36*(4), 545–599. doi:10.1111/j.1475-5661.2011.00436.x

Devereux, P. (2008). International volunteering for development and sustainability: Outdated paternalism or a radical response to globalisation? *Development in Practice*, *18*(3), 357–370. doi:10.1080/09614520802030409

Gribble, N., Dender, A., Lawrence, E., Manning, K., & Falkmer, T. (2014). International WIL placements: Their influence on student professional development, personal growth and cultural competence. *Asia-Pacific Journal of Cooperative Education*, *15*(2), 107–117.

Health Workforce Australia. (2014). *Australia's Health Workforce Series: Speech pathologists in focus*. Retrieved from http://www.hwa.gov.au/publication/speech-pathologists-focus-0

Hewitt-Taylor, J. (2001). Use of constant comparative analysis in qualitative research. *Nursing Standard*, *15*(42), 39–42. http://dx.doi.org/10.7748/ns2001.07.15.42.39.c3052

Hickey, E. M., McKenna, M., Woods, C., & Archibald, C. (2012). Ethical concerns in voluntourism in speech-language pathology and audiology. *SIG 17 Perspectives on Global Issues in Communication Sciences and Related Disorders*, *2*(2), 40–48. doi:10.1044/gics2.2.40

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Karle, H., Christensen, L., Gordon, D., & Nystrup, J. (2008). Neo-colonialism versus sound globalisation policy in medical education. *Medical Education*, *42*(10), 956–958. doi:10.1111/j.1365-2923.2008.03155.x

McAllister, L., Woodward, S., Atherton, M., Nguyen Thi Ngoc Dung, Potvin, C., Huynh Bich Thao, Le Thi Thanh Xuan, & Dien Le Khanh. (2013). VietNam's first qualified speech pathologists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech-Language Pathology*, *15*(2), 75–79.

Meyer, J. K. M. (2013). *"I came here to do something": Evaluating the motivations and ethical implications of international medical volunteers* (Bachelor of Arts thesis, The Colorado College).

Osborn, D., Cutter, A., & Ullah, F. (2015). *Universal sustainable development goals: Understanding the transformational challenge for developed countries*. Report of a study by stakeholder forum. Geneva: United Nations. Retrieved from https://sustainabledevelopment.un.org/content/documents/1684SF_-_SDG_Universality_Report_-_May_2015.pdf

Palacios C. M. (2010). Volunteer tourism, development and education in a postcolonial world: Conceiving global connections beyond aid. *Journal of Sustainable Tourism*, *18*(7), 861–878.

Palmer, M. (2002). On the pros and cons of volunteering abroad. *Development in Practice*, *12*(5), 637–643.

Pieczynski, L. M., Laudanski, K., Speck, R. M., & McCunn, M. (2013). Analysis of field reports from anaesthesia volunteers in low- to middle-income countries. *Medical Education*, *47*(10), 1029–1036. doi:10.1111/medu.12262

Santoro, N., & Major, J. (2012). Learning to be a culturally responsive teacher through international study trips: Transformation or tourism? *Teaching Education*, *23*(3), 309–322.

Sherraden, M., Lough, B., & McBride, A. (2008). Effects of international volunteering and service: Individual and institutional predictors. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, *19*(4), 395–421. doi:10.1007/s11266-008-9072-x

United Nations Volunteers. (2011). *State of the world's volunteerism report*. Geneva: Author.

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Development of the Vietnamese Speech Assessment

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Ben Phạm (top), Sharynne McLeod (centre), and Xuan Thi Thanh Le

Vietnamese is the official language of over 92 million people in Viet Nam and nearly four million diaspora including in Australia, USA, and Canada. To date, there are no standardised speech assessments for Vietnamese children. This paper outlines the development of the Vietnamese Speech Assessment (VSA) through collaboration between researchers in Viet Nam and Australia. The VSA contains all Vietnamese consonants, vowels and tones in at least two words with different sequence constraints. Further, the VSA was developed to be within the vocabulary range of young children, frequently used by Vietnamese people in different regions, picturable, and either a noun or verb. Picture stimuli were identified and the test was piloted with Vietnamese speakers of different ages who spoke different Vietnamese dialects. A score sheet was designed to include acceptable dialectal pronunciations, and to enable calculation of percentage of consonants/vowels/semivowels/tones correct and presence of phonological processes (patterns). The VSA is currently undergoing norming and standardisation.

Vietnamese is the official language spoken by over 92 million people in Viet Nam and by nearly four million diaspora including in Australia, USA, and Canada. The government of Viet Nam has implemented "The Developmental Standards for Children aged 5", and standard 15, item 65 is "to speak clearly" (The Viet Nam Ministry of Education and Training, 2010). Vietnamese professionals report they assess Vietnamese children's speech production by using informal measures to determine who meets the developmental standards (The Viet Nam Institute of Educational Sciences, 2014). To date, there are no standardised norm-referenced assessments of Vietnamese children's speech production (McLeod, 2012a; McLeod & Verdon, 2014), which has resulted in the creation of informal tools presented in book chapters, journal articles, unpublished dissertations, and on websites (Cameron & Watt, 2006; Cheng, 1991; Hwa-Froelich, Hodson, & Edwards, 2002; Nguyễn, 2011; Nguyễn & Phạm, 2014; Pham, 2009; Tang & Barlow, 2006; Vũ & Đặng, 2004), as well as tools developed by staff in a particular clinic/school/hospital/university for use in their own clinical practice (The Children's Hospital No. 1, 2013; Ducote, n.d.; Lê, 2013; West, 2000). Many of these tools are created to assess children who speak the southern Vietnamese dialect in Viet Nam, or other countries, and have limitations when used with people who speak the northern and central dialects of Vietnamese. This situation necessitated the development of the Vietnamese Speech Assessment (VSA) for research and clinical practice across Viet Nam and in other countries.

This paper outlines the creation of the VSA using psychometric standards for assessment in two stages: conceptualisation and operationalisation (Frytak, 2000) and has been written using the guidelines for test creation from McLeod (2012b). The VSA has been developed via collaboration between Ben Phạm, Xuan Thi Thanh Le and Sharynne McLeod, the Trinh Foundation and Charles Sturt University in Viet Nam and Australia (see Figure 1). Creation of the VSA would not be possible without extensive international collaboration between authors in these majority- and minority-world contexts drawing on the authors' expertise in Vietnamese phonetics and phonology, Vietnamese dialectal variants, child development, and test development. The authors met face-to-face on numerous occasions to listen to the production of consonants, vowels and tones by Vietnamese speakers, and to debate the benefits of different word choices. The three authors also undertook pilot testing and initial operationalisation of the tool together in Australia and Viet Nam, each transcribing, then discussing children's production of the words. The VSA would not have the same level of rigour if the three authors had not collaborated and cooperated extensively during the conceptualisation stage.

Stage 1. Conceptualisation of the Vietnamese Speech Assessment

Conceptualisation of an assessment tool refers to determining its purpose and scope, ensuring it measures what it intends to do through its properties and features (Frytak, 2000). Conceptualisation of an assessment begins with a statement of its purpose, intended population, target skill, and scope (McLeod, 2012b).

Figure 1. The authors of the Vietnamese Speech Assessment

Purpose

The current purpose of the VSA is to describe children's ability to produce consonants, semivowels, vowels, and tones in the northern, central, and southern Vietnamese dialects. Once normative data have been collected and analysed, the other purposes will be for diagnosis of speech sound disorders, to assist with goal setting for intervention, and to determine the outcomes of intervention.

Intended population

The VSA is designed for Vietnamese-speaking children ranging from 2;0 to 6;11 years who live in different regions of Viet Nam and in other countries. Children may be either monolingual or multilingual speakers. Examiners using the VSA should be speech-language pathologists, special educators, psychologists or other professionals who are Vietnamese native speakers with experience in Vietnamese phonetic transcription and working with children (Smit, 1986). It may be possible for non-Vietnamese-speaking speech-language pathologists to use the VSA with support from interpreters or family members (see McLeod, Verdon & IEPMCS, in press, for guidelines).

Target skill

The VSA has been designed as a picture-naming task to elicit single words.

Scope

The scope of the VSA includes the type of words selected and methods used to elicit target words. Six areas were considered to ensure the scope matched the purpose of VSA: phonotactic inventory, Vietnamese speech sounds, elicitation of each speech sound, word selection, presentation, and test administration.

Vietnamese phonotactic inventory

Almost all words in Vietnamese are monosyllabic. The Vietnamese syllable is the smallest unit of pronunciation and Vietnamese is a syllable-timed language (in contrast to English, which is a stress-timed language). The structure of the Vietnamese syllable is: $(C_1)(w_1)V(C_2/w_2)T$ where C1 is the initial consonant, w_1 is the medial semivowel, V is the main vowel, C_2 is the final consonant, w_2 is the final semivowel, and T is the tone (Phạm & McLeod, 2016). The vowel and the tone are the two compulsory components, whereas, the presence of the other components is optional. The VSA contains all Vietnamese speech sounds in every possible position in the Vietnamese syllable as follows: initial consonant, medial semivowel, main vowel, final consonant, final semivowel, and tone.

There are no consonant clusters in the Vietnamese language so that all Vietnamese speech sounds in the VSA are elicited in singleton contexts. Morphophonological contexts do not occur as the Vietnamese language does not use bounded morphemes to mark verb tense, aspect, or plurality (Pham, 2011). All stimuli in the VSA are monosyllabic words; the exception is the rare loan word for the initial consonant /p/ - *pa-tê* (pate). The classifiers, e.g., *cái* (inanimacy), *con* (animacy), are excluded although they commonly precede nouns (Pham & Kohnert, 2009; Tran, 2011). For example, the single word task elicited thỏ (rabbit) instead of con *thỏ*; and *chuông* (bell) instead of *cái chuông*.

Vietnamese speech sounds

The VSA includes all potential Vietnamese consonants, semivowels, vowels, and tones to assess speech production of Vietnamese-speaking children spoken in three main dialects. A comprehensive summary of all Vietnamese speech sounds in Standard Vietnamese and in

Northern, Central and Southern dialects was collated based on an extensive literature review (Phạm & McLeod, 2016). The following Vietnamese speech sounds were included in the VSA based on the review:

- 23 initial consonants in Standard Vietnamese /p, b, ʈʰ, t, d, ʈ, c, k, ʔ, m, n, ɲ, ŋ, f, v, s, ʂ, z, ʐ, x, ɣ, h, l/ and four variants including /ts, r/ in the Northern dialect and /w, j/ in the Southern dialect;
- 6 final consonants in Standard Vietnamese /p, t, k, m, n, ŋ/ and four variants across three dialects /c, ɲ, kᵖ, ŋᵐ/;
- 2 final semivowels /w, j/;
- 1 medial semivowel/approximant /w/ in Standard Vietnamese and three dialects;
- 16 vowels in Standard Vietnamese (including nine long singleton vowels /i, e, ɛ, ɯ, u, o, ɔ, ɤ, ɑ/, four short singleton vowels /ă, ɤ̆, ɛ̆, ɔ̆/, three diphthongs /ie, uo, ɯɤ/, and ten variants /ĭ, ɨ, ĕ, ŏ, ŭ, ɔː, oː, uː, ɛː, ɤː/ across three dialects;
- 6 tones in Standard Vietnamese and two variants of the tone 5 and 6 occurring in syllables ending by voiceless plosive consonants /p, t, k/ in three dialects.

Elicitation of each Vietnamese speech sound

Typically each speech sound is elicited in between one and five stimuli in single word sampling tools (McLeod, 2012b). Researchers have recommended there be at least two words in a single word task containing each phoneme in order to determine the consistency of production or phoneme stabilisation (Eisenberg & Hitchcock, 2010; Hua, 2002). Therefore, at least two stimuli were selected for each phoneme (consonants, vowels, and tones) shared across all dialects in the VSA. For example, the two selected words beginning with /k/ that were pronounced consistently across all dialects were: *kẹo* (candy) /kɛw⁶/, and *cổ* (neck) /ko⁴/. The authors attempted to avoid excessive use of any consonant, vowel, or tone within the word list.

The selection of words also took into consideration different phonetic contexts in Vietnamese. Different phoneme sequence constraints were considered so as to accommodate variability in terms of syllable shapes, rimes, phonotactic variants, and tones within the child's production rule system. It was important to accommodate the effect of coarticulation of front and back vowels on the production of initial and final consonants (Cao, 2006; Đoàn, 2003). Therefore, it was decided that the two words in the VSA containing the same initial consonants should be followed by a front and back vowel. For example, the selected words beginning with the initial consonant /b/ contained a front vowel *bí* (pumkin) /bi⁵/, and back vowel *bảng* (board) /bɑŋ⁴/. In addition, the VSA authors considered the effect of coarticulation of rounded and unrounded vowels on the production of final consonants /k, ŋ/ with back vowels (Cao, 2006; Đoàn, 2003). For example, the word *bụng* (belly) /bŭŋᵐ⁶/ was added to the set of words beginning with initial consonant /b/.

Word selection

Within the VSA the selected words met following criteria. They had to:

- be within the vocabulary range of Vietnamese-speaking children in Viet Nam, Australia, and USA so that children can produce the word spontaneously as often as possible;
- be used frequently by the entire population throughout Viet Nam. Therefore, words having lexical variants were excluded. For example, the word mẹ (mother) was not selected because of variants used in different regions such as *bầm*, *bu*, *má*, *mạ*, *mệ*, *mợ*, and *u*;
- be used currently in the speech of people within Viet Nam. For example, the traditional word for box was *rương*; however, it was not selected because *hộp* or *thùng* is used more commonly now;
- be culturally sensitive in both word choice and picture. For example, the word *đũa* (chopsticks) was selected rather than *dao* (knife) because seeing an image of a knife may scare young children;
- be picturable so young children can recognise the word easily and spontaneously name the word. The images were considered to be contrastable to differentiate meanings. For example, the word *gà* (chicken) was selected for the initial consonant /ɣ/ so the word *chim* (bird) was not selected for the initial consonant /c/ because of the possible confusion between these two images. Another example, the word *phở* (thinly sliced noodle soup) was seen as a good word choice containing the initial consonant /f/ but was not selected because of the possible confusion with the word *bún* (round noodle soup);
- be selected from basic syntactic forms such as nouns (66 out of 77 words) and verbs (11 out of 77 words).

Presentation

The VSA consists of 77 monosyllabic words represented by 77 colour pictures. The order of the word list was based on initial consonants. Proposed prototypes for the 77 pictures were discussed by the VSA authors, then were sent to a Vietnamese artist to be drawn. The 77 pictures were bound in a picture booklet. The front page displays a picture illustrating a word and the orthography of the word (see Figure 2). On the back page, there is a small picture of the word plus full phonetic transcriptions of Standard Vietnamese, Northern, Central, and Southern Vietnamese as well as the prompts to elicit the word (see Figure 3).

Test administration

The VSA was designed to be administered in a standardised manner. The assessment can be administered in research and clinical settings. Instructions will be

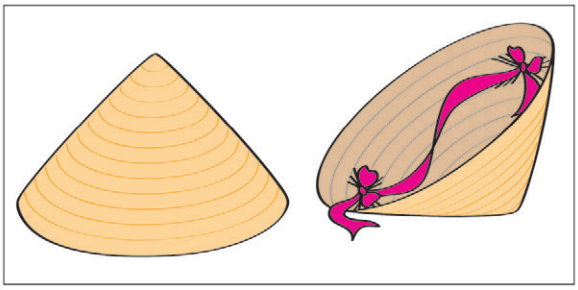

Figure 2. The front page for the stimulus item* nón *(cone hat).

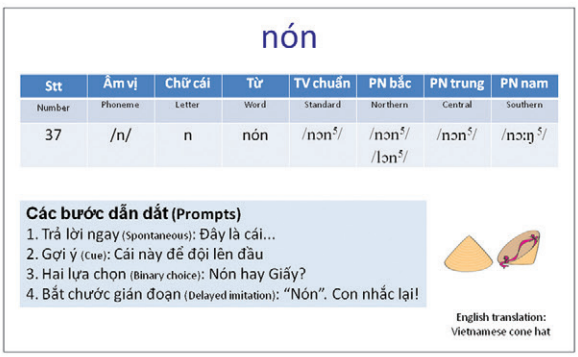

Figure 3. The back page for the stimulus item* nón *(cone hat).

provided in a manual to ensure that examiners follow the same testing procedures.

Cueing hierarchy

Examiners are required to give instructions following a four-step prompt hierarchy to elicit each target word: (a) open-ended question, (b) gap fill or content-related prompt, (c) binary choice (with the target word produced first), and (d) delayed imitation (e.g., "*Heart*. Repeat, please" (*Tim. Con nhắc lại*)). Children are encouraged to respond spontaneously by naming the picture at the first step as much as possible. The open-ended question used in step 1 for each target picture is "What's this?" Some target pictures will be asked differently to elicit the targeted response. For example, with the target picture of *elephant* (*voi*), the examiner asks the child "*Đây là con…*" (This is a [animacy word]…) so that the child can fill the target word after the animacy word produced by the examiner. If the examiner does not say the animacy/ inanimacy word, the child might say a compound word (animacy/inanimacy + target word, e.g., *con voi*) instead of saying the target word only (e.g., *voi*) because animacy/ inanimacy words commonly precede a noun in the Vietnamese language and are acquired early in young children (Pham & Kohnert, 2009; Tran, 2011). Before testing begins, it is useful to train the child to not include the classifier using common objects in the environment. If the child cannot label the picture, additional cues or content-related questions are provided to elicit the expected response. For example, a content-related question "What has a long trunk?" is asked to elicit a target word *voi* (*elephant*). If this step fails, the examiner will give a binary choice by presenting the target word first to participant, for example, "voi hay chân" (*elephant* or *leg*). If the participant does not respond to the binary choice, the examiner will provide the target word for imitation. A list of prompts and cues for each target word was also created to support the testing protocol.

Scoring, transcription, recording and analysis

A score form was created which includes columns for the word in orthography; the adult target in International Phonetic Alphabet for Standard Vietnamese, Northern, Central and Southern dialects; the child's production; and columns for scoring each phonological pattern.

Children are assessed individually. Examiners are required to transcribe children's responses online by using the International Phonetic Alphabet symbols. It is recommended that the transcriptions be based on the children's first attempt if possible. If children's first productions are not clear, then they are asked to repeat the words. The score form also requires examiners to mark the prompt or cueing level used for each response.

It is recommended that the children's responses be audio-recorded and/or video-recorded with the permission of children's caregivers and the school. A microphone should be placed close to the children's mouths (within 15 cm) and the video camera should be set up to record the children's faces. The recordings can be used to check reliability between examiners, and to record change in the children's speech over time. Video recordings can be used to check the children's productions of consonants and vowels that can be seen on the recording (e.g., bilabials).

The VSA score form provides a relational analysis (including percentages of consonants, semivowels, vowels and tones that are produced correctly) and an analysis of phonological processes/ patterns. Guidance in terms of scoring, transcription, recordings and analysis will be included in the manual to instruct for examiners in both research and clinical use.

Stage 2. Operationalisation of the Vietnamese Speech Assessment

Operationalisation is the evaluation and validation process of an assessment to ensure its validity and reliability (Frytak, 2000). The VSA is currently undergoing operationalisation. Eventually the VSA will contain consistent assessment materials, administration and scoring protocols. Once normative data have been collected and analysed, they will be added to the manual. Eventually the manual will also include information about validity (content, construct, predictive, concurrent) and reliability (internal consistency, test–retest reliability, intra- and inter-rater reliability).

To date, the VSA authors have considered the content validity for the VSA. Content validity refers to "the degree to which the items in the measure cover the domain of interest" (Frytak, 2000, p. 22). Content validity of the VSA was conducted first by a systematic examination of relevant literature and previously designed speech sampling tools to specify the initial test content. Second, professional judgement was used to define the test areas and to evaluate the relevance and representativeness of the test items with the target construct. The VSA was piloted by the design team on five adults and one child who were bilingual Vietnamese–English speakers to examine the relevance of the word list and scoresheet and to estimate length of the time required to complete the test. Adults completed the task in approximately 8–10 minutes, the child in about 20 minutes. After the initial pilot testing, some changes were made with to stimulus items (e.g., changing images for the word '*pin*' from torch to battery) and prompts (e.g., changing the cues for the word '*tết*' [Tet holiday]). Other psychometic properties (including internal consistency, test–retest reliability, inter- and intrarater reliability, criterion validity, construct validity, item analysis, sensitivity and specificity, standardisation) will be established in further steps to operationalise the VSA.

Conclusion

The development of a speech sampling tool requires two stages: conceptualisation and operationalisation. The conceptualisation of the VSA has been completed and work on the operationalisation is continuing. This paper provides an example of how to begin to undertake test development in a majority-world country.

References

Cameron, N., & Watt, C. (2006). *Vietnamese articulation test (VAT: Version I-II-III-IV)*. Flinders University, Adelaide, Australia: Author.

Cao, X. H. (2006). *Tiếng Việt mấy vấn đề ngữ âm-ngữ pháp-ngữ nghĩa* [Vietnamese: Some issues in phonology-syntax-semantics]. Thành phố Hồ Chí Minh, Việt Nam: Khoa học xã hội.

Cheng, L. L. (1991). *Assessing Asian language performance*. Oceanside, CA: Academic Communication Associates.

The Children's Hospital No.1. (2013). *Bộ Kiểm Tra Từ Đơn Bằng Hình Ảnh* [One–Picture Word List]. Thành phố Hồ Chí Minh, Việt Nam: Author.

Đoàn, T. T. (2003). *Ngữ âm tiếng Việt* [Vietnamese phonetics]. Hà Nội, Việt Nam: Đại học Quốc gia Hà Nội.

Ducote, C. (n.d.). *Operation Smile Vietnamese articulation screening test*. New Orleans, LA: Author.

Eisenberg, S. L., & Hitchcock, E. R. (2010). Using standardized tests to inventory consonant and vowel production: A comparison of 11 tests of articulation and phonology. *Language, Speech, and Hearing Services in Schools*, *41*(4), 488–503. doi:10.1044/0161-1461(2009/08-0125)

Frytak, J. (2000). Measurement. *Journal of Rehabilitation Outcomes*, *4*, 15–31.

Hua, Z. (2002). *Phonological development in specific contexts: Studies of Chinese-speaking children*. Clevedon, UK: Multilingual Matters.

Hwa-Froelich, D., Hodson, B. W., & Edwards, H. T. (2002). Characteristics of Vietnamese phonology. *American Journal of Speech-Language Pathology*, *11*(3), 264–273.

Lê, T. T. X. (2013). *Bộ Mẫu Đánh Giá Phát Âm* [Sample Tool for Articulation Assessment]. Bệnh viện Chỉnh hình và Phục hồi chức năng Thành phố Hồ Chí Minh, Việt Nam: Author.

McLeod, S. (2012a). Multilingual speech assessment. In S. McLeod & B. A. Goldstein (Eds.), *Multilingual apsects of speech sound disorders in children* (pp. 113–142). Bristol, UK: Multilingual Matters.

McLeod, S. (2012b). Translation to practice: Creating sampling tools to assess multilingual children's speech. In S. McLeod & B. A. Goldstein (Eds.), *Multilingual aspects of speech sound disorders in children* (pp. 144–153). Bristol, UK: Multilingual Matters.

McLeod, S., & Verdon, S. (2014). A review of 30 speech assessments in 19 languages other than English. *American Journal of Speech-Language Pathology*, *23*(4), 708–723.

McLeod, S., Verdon, S., & International Expert Panel on Multilingual Children's Speech (in press). Tutorial: Speech assessment for multilingual children who do not speak the same language(s) as the speech-language pathologist. *American Journal of Speech-Language Pathology*.

Nguyễn, T. L. K. (2011). Nội dung đánh giá khả năng phát âm âm tiết tiếng Việt của trẻ mẫu giáo [The assessment content of pronunciation ability of Vietnamese syllable of preschoolers]. *Ngôn ngữ* [Language], 9, 6–17.

Nguyễn, T. L. K., & Phạm, H. L. (2014). Lỗi phát âm âm tiết thường gặp ở trẻ 2–4 tuổi (tại thành phố Hồ Chí Minh) [Common errors of syllable pronounce in Vietnamese speaking children from 2–4 years old (in Ho Chi Minh city)]. *Tạp chí khoa học Trường Đại học Sư phạm Thành phố Hồ Chí Minh* [Journal of Educational Science of Ho Chi Minh City University of Pedagogy], 57(91), 9–21.

Phạm, B., Le, X. T. T., & McLeod, S. (2016). *Vietnamese speech assessment: Research version*. Bathurst, Australia: Author.

Phạm, B., & McLeod, S. (2016). Consonants, vowels and tones across Vietnamese dialects. *International Journal of Speech-Language Pathology*, *18*(2), 122–134. doi: 10.3109/17549507.2015.1101162

Pham, G. T. (2009). Vietnamese one-word articulation screener. Retrieved 3 March 2016 from http://www-rohan.sdsu.edu/~gtpham/vnspeech/downloads/VietnameseOneWordArticulationScreener.pdf

Pham, G. T. (2011). *Dual language development among Vietnamese-English bilingual children: Modeling trajectories and cross-linguistic associations within a dynamic systems framework*. (PhD thesis), University of Minnesota, Ann Arbor.

Pham, G. T., & Kohnert, K. (2009). A corpus-based analysis of Vietnamese classifiers con and cái. *Mon-Khmer Studies*, *38*, 1–11.

Smit, A. B. (1986). Ages of speech sound acquisition: Comparisons and critiques of several normative studies. *Language, Speech, and Hearing Services in Schools*, *17*(3), 175–186.

Tang, G., & Barlow, J. (2006). Characteristics of the sound systems of monolingual Vietnamese-speaking children with phonological impairment. *Clinical Linguistics and Phonetics*, *20*(6), 423–445.

Tran, J. (2011). *The acquisition of Vietnamese classifiers* (PhD thesis). University of Hawai'i at Manoa.

The Viet Nam Institute of Educational Sciences. (2014). Nghiên cứu đặc điểm phát triển của trẻ mẫu giáo 5 tuổi [Research on development characteristics of 5-year-old children]. Hà Nội, Việt Nam: The Vietnam Ministry of Education and Training.

The Viet Nam Ministry of Education and Training. (2010). *Bộ chuẩn phát triển trẻ em năm tuổi [The developmental standards for children aged five]*. Hà Nội, Việt Nam: Author Retrieved from http://congbao.chinhphu.vn/tai-ve-van-ban-so-23_2010_TT-BGD%C4%90T-(4781)?cbid=4778.

Vũ, T. B. H., & Đặng, T. T. H. (2004). *Âm ngữ trị liệu thực hành* [Clinical speech language pathology]. Hà Nội, Việt Nam: Y học.

West, M. (2000). *Vietnamese articulation test*. Adelaide Central Community Health Service, Adelaide, Australia: Author.

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Practice innovations from the emerging speech-language pathology profession in Vietnam

Vignettes illustrating indigenised and sustainable approaches

Nguyen Thi Ngoc Dung, Le Khanh Dien, Christine Sheard, Le Thi Thanh Xuan, Trà Thanh Tâm, Hoàng Văn Quyên, Le Thi Dao, and Lindy McAllister

This paper presents vignettes of innovations in speech-language pathology practice in Vietnam, and situates these in the larger context of global considerations impacting on speech-language pathology education and service delivery. The paper provides an introductory vignette setting the context for four more vignettes from speech-language pathologists in southern Vietnam. The graduates' vignettes illustrate a range of innovative, sustainable, indigenised and culturally relevant developments in speech-language pathology practice and education. Two vignettes highlight the use of volunteers and the available health and education workforce to develop sustainable new services for children and adults with communication disorders. Two vignettes illustrate innovative and culturally appropriate ways of indigenising curricula and approaches to educating the Vietnamese public and the existing health workforce about communication and swallowing disorders and speech-language pathology services. The paper invites readers to reflect on what speech-language pathology globally might learn from our colleagues in majority-world countries.

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VIETNAM

THIS ARTICLE HAS BEEN PEER-REVIEWED

Collaborations between clinicians and academics in minority-world (developed) and majority-world (developing) countries have been successful in establishing speech-language pathology (SLP) education and services in many majority-world countries (for examples from nine such countries, see the *International Journal of Speech-Language Pathology*, 2013, vol. 15, issue 1). However, there is a risk of post-colonialism (Nixon et al., 2015) when minority-world curricula or practices are transferred into new SLP courses in majority-world countries. That is, what comes from minority-world countries can be privileged over local knowledge and practices, in the assumption that "west is best", even when it may not be culturally relevant or the knowledge applicable in new contexts. Therefore, it is important that SLP students in these new courses can interrogate "transplanted" information for its relevance and develop culturally relevant knowledge and clinical practice skills; that is, "indigenise" their knowledge and practices (see for example Hauser, Howlett, & Matthews, 2009). Furthermore, it is important that majority-world practitioners are able to share with minority-world clinicians innovative "indigenised" approaches to the problems they face in practice, to enable two-way learning (Walsh, 2016).

This paper presents vignettes highlighting innovation, indigenisation and plans for future development by graduates of two-year postgraduate courses in speech-language pathology, and where appropriate their Australian mentors. The first vignette in this paper comes from Vietnamese academic Dr Nguyen Thi Ngoc Dung, recognised as the champion for the development of speech-language pathology in southern Vietnam. Her leadership enabled the development of the two-year postgraduate course at University Pham Ngoc Thach. Four graduates of this course, known to be doing innovative work to develop SLP education and services, were approached to write four vignettes for the paper.

Vignette 1. Background to speech-language pathology education in south Vietnam

Prof Ngoc Dung, professor of ENT and former rector of the University Pham Ngoc Thach, Ho Chi Minh City

As an ENT doctor and former director of the ENT Hospital of Ho Chi Minh City (HCMC) I know that speech therapy[1] is vital in the treatment and rehabilitation of people with communication and swallowing impairments. Speech therapy training in HCMC started in 2009 with a short course run by Trinh Foundation Australia at the ENT Hospital for doctors, nurses and audiologists on aspects of speech therapy. Becoming rector of University Pham Ngoc Thach in HCMC enabled the development and delivery of two 2-year postgraduate courses (2010–12 and 2012–14) run at University Pham Ngoc Thach with support from Trinh Foundation Australia and Australian Volunteers International (see McAllister et al., 2013). Thirty-three graduates from those two courses have established speech therapy clinics and services, mostly in public hospitals, in Ho Chi Minh City, Hue, Hanoi, Vung Tau, Bau Loc and other provinces. With the management of the speech therapy office at University Pham Ngoc Thach, the support of Trinh Foundation Australia and Australian Volunteers for International

Nguyen Thi Ngoc Dung (top) and Le Khanh Dien

Development, these graduates have received continuing professional development in their workplaces from visiting lecturers and clinical mentors to develop their skills and knowledge base, research capacity and culturally appropriate resources in the Vietnamese language.

Vignette 2. Reflecting on the effects of an art group for people with brain dysfunction

Le Khanh Dien and Christine Sheard

Christine Sheard (top), Le Thi Thanh Xuan (centre) and Trà Thanh Tâm

People with communication disorders (PWCD) due to stroke or other acquired or congenital brain dysfunction often experience social exclusion (Dorze, Salois-Bellerose, Alepins, Croteau, & Halle, 2014; Douglas, 2013). However, by participating in groups run by speech-language pathologists, PWCD can be assisted to engage with others and increase their confidence (Ewing, 2007; Hawley & Newman, 2010; Holland, 2007; van der Gaag et al., 2005). Furthermore, making art also has been shown to help many people with disability to express their ideas and emotions via their participation in this meaningful life activity (American Art Therapy Association, 2013; Kim, Kim, Lee, & Chun, 2008; Parrish, 2014).

Combining the benefits of being in a group with other PWCD, but with a focus on producing art, inspired the first author during a visit to Sydney where he observed such a group established for people with aphasia. He was so impressed by the group's apparent effects on participants' attitudes and skills, he decided to establish one for a mixed group of his current speech therapy clients in Vietnam. With mentoring from the second author in Australia, he developed an Art Group program to extend beyond the existing impairment-focused speech therapy services at An Binh Hospital in HCMC. The program's aim was to offer socially restricted PWCD with varying brain dysfunction an opportunity to participate in a real-life social activity to learn new artistic skills and have natural communication, rather than remediation of their speech-language limitations. It was hoped this might produce positive changes in some factors (e.g., having good communication partners and independence in some meaningful life activities) commonly associated with quality of life (Douglas, 2013). This paper is a reflection on some informal but carefully gathered clinical data collected to assess the outcomes of the Art Group as perceived by its participants.

The Art Group was established in December 2013 for PWCD (including apraxia, aphasia, dysarthria, cognitive-communication difficulties and intellectual disability) who were also receiving concurrent speech therapy treatment. The invited participants were all known to have much restricted or virtually no meaningful social inclusion or communication beyond daily routine interactions with family or clinical appointments for their health needs. Art students from Sai Gon University were recruited to facilitate 2 hour, weekly art lessons and the program was overseen by the hospital speech therapists. Activities included simple colouring, painting and collage. Drawings or greeting cards were usually produced, with a focus on accepting and extending participants' free expression. Communicating about their art and having occasional parties for special occasions were also integral to this program.

Typically, six to 11 PWCD supported by up to six art students participated in the program. After 23 weeks the first author asked the seven regular long-term participants and six family members the same set of 16 author-generated informal questions that focused on obtaining each participant's *general perceptions of the impact of the group*, as well as their perceptions of any *social opportunities, self-confidence, communication* and/or *drawing skills* that they felt were related to their art group participation. Because the PWCD had limited expressive communication skills, most questions were closed questions, asked orally via a multiple-choice format with a large-font, written selection of simple, categorical or descriptive ratings to simplify the communication task. This informal, but systematic questioning also enabled the authors to readily target and compare the respondents' perceptions. In order to reflect on the effects of the Art Group as a therapy process, some of the most frequent and total group responses are reported here in a general manner as our aim was to assess the effect of the group from the PWCDs' perspectives. They should be interpreted as systematically acquired clinical information rather than research data.

From the questioning, all PWCDs reported positive feelings about attending the Art Group, and were mostly keen to attend each week. Those with acquired communication disorders liked that the Art Group gave them a chance to meet and talk with other people. This affirmed the clinicians' aim for establishing the group as a means for real-life socialisation.

The aspects of the group the participants spontaneously reported they enjoyed most related both to communicating and/or building their art skills. They typically liked to meet with people with shared interests and said that it was good to communicate in a cheerful environment. The clinicians agreed with the PWCDs' perceptions that Art Group made the PWCDs feel happy. Similarly all appeared and reported to be more confident when communicating. Family members also observed that the PWCDs generally initiated and engaged more in communication at home and with others, and appeared less self-conscious and more joyful as the group progressed. Several families also noted having more calm communication interactions over time.

There was a general perception that learning new skills to design and create art was most enjoyable. Participating in independent activities and having communication with others who listen have been associated with finding new identity, self-esteem and living successfully after brain injury (Brown, Worrall, Davidson, & Howe, 2012; Douglas, 2013). Clinicians and relatives typically observed that the PWCDs had more self-confidence in general as the group progressed and this was confirmed by the participants' responses.

Our conclusion from the clinical appraisal of participants' perceptions, which were affirmed by clinicians' and families' observations, is that participation in the Art Group provided an opportunity for most of these PWCDs to interact socially with others in natural and comfortable ways that appeared to improve their self-esteem, general cheerfulness and confidence. Learning new and creative skills and mixing in a comfortable environment with peers appeared to give participants an improved sense of personal well-being.

Our clinical observations and reports of the participants' perceptions could reflect clinician bias or a desire of the participants to please the first author. However, the concurrence between the observations of clinicians, relatives and participants suggests that the PWCDs' perceptions of increased socialisation opportunities,

improved self-confidence and satisfaction with new learning from this Art Group are sufficient to justify some formal research on conducting independently assessed clinical trials of this therapy process.

The volunteer participation of art students promoted wider community engagement and has ensured the economic viability and sustainability of the program. A public exhibition of participants' art was opened in October 2014. The attendance of high-ranking government officials and staff of several hospitals plus extensive media coverage has helped to raise public awareness of the potential possibilities for people to find meaningful lives after acquired or congenital brain dysfunction. This engagement of hospital and government officials is a strategic approach to ensuring support and sustainability of the program.

Vignette 3. A new model of public early intervention services with an interdisciplinary team

Le Thi Thanh Xuan

In Vietnam, most early intervention centres are private, with preschool teachers, psychologists or special education teachers on staff. Typically, a psychologist or doctor assesses children, and teachers develop and deliver an intervention plan, without parental involvement. Intervention goals are focused on cognitive and academic tasks, without attention to social, communication and speech development goals. Children from low and average income families rarely can afford to attend the centres, as fees range from 7 to 15 mill VND (about A$400–$870) per annum. In December 2014, the Orthopedics and Rehabilitation Hospital (ORH) of Ho Chi Minh City established public early intervention services for children with autism spectrum disorder (ASD) with staff from different professions involved, including speech therapists, psychologists, social workers, special education teachers, physiotherapists, and occupational therapists. A means-tested fee is charged ranging from 4–4.2mill VND (about A$233–$245). This fee includes lunch, morning/afternoon tea, and activity consumables.

The model at ORH is adapted from Australian interdisciplinary models for early intervention, which I observed on a study tour to Melbourne in mid-2015. I coach the ORH team to work collaboratively with each other and with parents to develop intervention goals targeting play, social, self-help, communication, and language goals for each child. Intervention is based on each child's current ability and interest, helping her or him to be active in interaction and initiating communication. There are currently 20 children attending three classes of early intervention services per week in groups of three to four children. Children attend class from 7:00 am to 16:00 pm; rest time is from 11:30 am to 14:00 pm. I train parents to use communication development approaches and AAC at home. The involvement of parents is indispensable and extends the intervention from the centre to the children's homes. We keep data on children's improvement to reflect on the impact of the early intervention service and modify it as needed.

With this interdisciplinary early intervention model, the staff has the advantage of increasing knowledge of other professions and sharing their skill set. Team meetings provide an opportunity for staff to share ideas for how to achieve the goals for each child, in order to maximise intervention outcomes. Staff are easily able to identify a child's unique strengths and needs, and determine what services are necessary to meet those needs. ORH is continuously developing, evaluating and refining this new model for early intervention services in Vietnam so that it can be introduced to other organisations in HCMC and southern Vietnam. When this new model is further developed and there are enough staff members, ORH will accept staff members from other organisations who wish to learn about, and implement, the model. Coaching and supported practice in other organisations will be provided.

This vignette illustrates one approach to indigenisation of a western model of good practice in early intervention to the Vietnamese context. In the absence of sufficient speech-language therapists, an available workforce of allied health and education professionals has been trained to deliver early intervention services which include foci on communication and social development. This training and deployment of existing workers also assists the sustainability of the service.

Vignette 4. Training basic paediatric speech therapy practical skills for staff at Đà Nẵng University of Medical Technology and Pharmacy

Trà Thanh Tâm and Hoàng Văn Quyên

In recent years, significant progress has been made in Vietnam in public health in terms of health professional expertise and service quality. Most of the 33 speech therapy graduates to date from University Pham Ngoc Thach work in Ho Chi Minh City. Rapidly developing cities such as Đà Nẵng have well-established medical services but do not yet have speech therapy education and services.

In order to increase availability of information about speech therapy and also accessibility to speech therapy services for people in central Vietnam, the authors, who are September 2012 graduates of the course at University Pham Ngoc Thach now working at Children's Hospital No.1 (CH No.1), HCMC, have developed and delivered a basic training program in speech therapy for physiotherapy lecturers at Đà Nẵng University of Medical Technology and Pharmacy (DUMPT). It was a challenge for us to ensure continuity of speech therapy services at CH No.1, while also preparing the course, and compiling training resources to meet the learning needs of participants in the upcoming training course. The participants had little concept of speech therapy so we had to consider this as well in our planning.

After a six-week theoretical training course in Đà Nẵng in 2014, we continued mentoring the participants by phone and email. In 2015, DUMTP sent four lecturers to CH No.1 to continue with the speech therapy clinical training. This clinical training block lasted six months. In the first two months, we helped participants synthesise knowledge they had learned in Đà Nẵng while providing new knowledge of speech therapy, such as (a) typical communication developmental milestones from infancy to 5 years, (b) speech therapy for children with cleft lip and palate, (c) speech therapy and intervention for feeding/eating in

Hoàng Văn Quyên (top), Le Thi Dao (centre) and Lindy McAllister

children with complex disabilities, (d) red flags for the need for speech therapy intervention for children with speech sound disorders, (e) augmentative and alternative communication, (f) working with parents, and (g) behavioural management.

In addition, we included the Đà Nẵng participants in clinical practice sessions with our patients. Thanks to our experience in working with Australian speech therapists during the clinical terms of the speech therapy training program at University Pham Ngoc Thach, we had accumulated experience that we could apply in the clinical training of the participants. We started by having them observe sessions, then plan for and deliver parts of session, gradually taking on responsibility for planning and delivering whole sessions under our supervision. Towards the end of the training block, we had them teach parents strategies to help their children develop language and manage their inappropriate behaviors at home.

By the end of the training course, the four participants had been involved in 600 sessions of speech therapy practice with more than 100 patients with language delay, ASD, cerebral palsy, hearing impairments, cleft lip and palate, and Down syndrome. At the end of the block, participants needed to achieve 70% as a pass on two theoretical and practical examinations, and submit one assessment report and one treatment report for patients they had managed. On completion of the course, the participants received a certificate issued by CH No.1 for completion of the course "Basic Paediatric Speech Therapy Practice".

Despite being faced with many challenges in terms of time and work pressure, we strive to provide high-quality training for colleagues throughout Vietnam in order to increase public awareness of the speech therapy profession and quality of speech therapy services provided to patients, and thereby, contribute to increasing the quality of life of patients with communication and swallowing disorders in Vietnam. This vignette illustrates indigenisation and cultural adaptation of a western curriculum for delivery in the Vietnamese context, making best use of the available Vietnamese health workforce to deliver sustainable services while a specialised speech-language pathology workforce is educated in Vietnam.

Vignette 5. Using all available media to educate professionals, students and the community

Le Thi Dao

I have been working in Ho Chi Minh City since 1987 as a physiotherapist, and since 2010 also as a speech therapist at Children's Hospital No.2. Because speech therapy is new in Vietnam, it is important to educate others about the profession and what we can offer. Since 2010, I have been promoting speech therapy to colleagues at the hospital and running information and education activities for the community. For example, I have been:

- Presenting at regular meetings with the hospital board of directors and heads of departments about topics such as "Introducing speech therapy in Vietnam" and "Speech therapy intervention methods"
- Introducing colleagues at the hospital to speech therapy by inviting them to observe speech therapy sessions and discuss cases.
- Running training sessions for teachers and parents on Saturday mornings on various topics, such as "ASD", "How to feed children with cerebral palsy", and "Developing language skills in children using picture stimulation". I have developed a number of resources for parents (e.g., books on helping children's language development).
- Teaching nurses and doctors at the Rehabilitation Hospital in Đà Nẵng about ASD, and then demonstrating and coaching them in skills such as how to observe a child, help a child make eye contact, increase attention, games to develop children's play skills.
- Teaching nursing and psychology students at universities in HCMC about rehabilitation for people with various communication disorders (hearing difficulties, speech sound disorders, stuttering, language disorders).
- Contributing articles about communication and swallowing disorders and speech therapy to hospital websites; for example articles on "Child language development processes", "Hoarse voice", "Fussy eaters"; and sharing articles on my Facebook page (see: https://www.facebook.com/lethi.dao.77/timeline).
- Participating in Vietnamese television talk shows. VTV9 channel has a talk show about children, which includes medical professionals and parents. My hospital's board of directors assigned me to present the topic on language development of children, how to identify problems and help children develop language. On HTV7 I was asked to introduce speech therapy in Vietnam and the types of disorders that need speech therapy intervention. I also talked about support Vietnam receives from Australian speech therapists and the Trinh Foundation.
- Collaborating with cleft lip and palate surgery groups. In trips to regional areas with Operation Smile, I coached teachers and medical staff about assessment and intervention methods for children with cleft lip and palate.

Focusing initial service development efforts on community education and advocacy activities as described has been essential to my experience as a newly qualified speech-language pathologist. The vignette illustrates culturally acceptable means to educate my colleagues. This has increased their knowledge and trust in this new profession of speech therapy and so they now refer clients to the speech therapy department. Clients also contact us directly and teachers in schools refer clients to us for intervention.

Discussion and conclusion

The vignettes presented have common elements for consideration. Significantly, they all focus on educating others, from the Art Group which educated family members and the general public through the engagement of art students and the launching of an art exhibition (Vignette 2) to educating a range of health and education professionals, university health students and the general public (vignettes 3–5). Li Thi Dao's education of the general public through television, Facebook and other media is impressive in its reach, creativity and generosity of time and effort. Educating others about the speech-language pathology profession and what it can offer is essential, and not just in a country newly establishing the profession and its services.

Vignettes 4 and 5 also highlight indigenisation of curricula and SLP resources. The authors adapted what they had

learned from minority-world lecturers and clinical educators at University Pham Ngoc Thach and integrated this in their own developing clinical practice to develop and deliver basic training in speech therapy to current and future health professionals and the general public. Their indigenised curricula and resources will be invaluable in the future Bachelor degree level education planned for Vietnam. Their experience as educators will contribute to local leadership and hence sustainability of these degrees.

Wylie, McAllister, Davidson, and Marshall (2013) discussed the inadequacy of current models of SLP service delivery for PWCD in the minority world for meeting the needs of all PWCD; the reach of SLP services needs to extend beyond what the speech-language pathologists themselves can achieve. The vignettes illustrate new models which extend the reach of services to PWCD by engaging staff not traditionally seen as agents of SLP intervention. For example, vignettes 3 and 4 describe the engagement of other allied health professionals and special education teachers to interprofessionally deliver early intervention services to children with communication disabilities and Vignette 2 describes how art students assist with running the Art Groups. Vignette 3 illustrates the use of what could be termed mid-tier workers, as recommended by the *World Report on Disability* (WHO and World Bank, 2011). In all cases the new models which extend reach have led to more children and families receiving SLP services than could have been achieved by the vignette authors alone. Furthermore, each is based around ongoing clinical support and mentoring to ensure sustainability and service quality. An essential next step will be to develop an evidence base for these approaches through formal evaluation and research programs to investigate the impact of these approaches on client outcomes.

Of interest is the high degree of institutional support the speech-language pathologists received from their employers to engage in these innovative practices. SLP staff from CH No.1 were given considerable time off work to travel to Đà Nẵng to teach and then to provide clinical training back in Ho Chi Minh City for the Đà Nẵng students. Le Thi Dao was encouraged by her hospital to appear on television to promote SLP. Le Thi Thanh Xuan was provided time release and financial support from her hospital to travel to Australia and learn about early interventions services. Le Khanh Dien was not only supported to develop the Art Group by his hospital but also supported to mount an art exhibition of his patients' work and to invite high-level government officials and television stations to cover the event. Speech-language pathologists in minority-world countries might well envy the high-level government commitment in Vietnam to developing SLP education and services. Sustained government commitment will of course be required over a long-time frame to embed SLP in the Vietnamese health care system.

In summary, the vignettes suggest that these speech-language pathologists have moved beyond imported minority-world curricula and SLP practice models to indigenise and create their own teaching and clinical practice approaches. The vignettes describe exciting innovations from the majority world in SLP service development, clinical services, educating others, and the use of media to promote the SLP profession and services, from which speech-language pathologists in minority-world countries can learn. Their innovations extend the reach of SLP services and are locally sustainable.

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1 Speech therapy is the term used in Vietnam.

References

American Art Therapy Association. (2013). What is art therapy? Retrieved from http://www.arttherapy.org/upload/whatisarttherapy.pdf

Brown, K., Worrall, L.E., Davidson, B., & Howe, T. (2012). Living successfully with aphasia: A qualitative meta-analysis of the perspectives of individuals with aphasia, family members, and speech-language pathologists. *International Journal of Speech-Language Pathology*, *14*(2), 141–155.

Dorze, G., Salois-Bellerose, E., Alepins, M., Croteau, C., & Halle, M-C. (2014). A description of the personal and environmental determinants of participation several years post-stroke according to the views of people who have aphasia. *Aphasiology*, *28*, 421–439.

Douglas, J. (2013). Conceptualizing self and maintaining social connection following severe traumatic brain injury. *Brain Injury*, *27*(1), 60–74.

Ewing, S. E. A. (2007). Group process, group dynamics, and group techniques with neurogenic communication disorders. In R. J. Elman (Ed.), *Group treatment of neurogenic communication disorders: The expert clinician's approach* (2nd ed.). Abingdon, Oxfordshire: Plural Publishing.

Hauser, V., Howlett, C., & Matthews, C. (2009). The place of indigenous knowledge in tertiary science education: A case study of Canadian practices in indigenizing the curriculum. *Australian Journal of Indigenous Education*, *38*, Supplement, 46–47.

Hawley, L.A., & Newman, J.K. (2010). Group interactive structured treatment (GIST): A social competence intervention for individuals with brain injury. *Brain Injury*, *24*(11), 1292–1297.

Holland, A. (2007). The power of aphasia groups: Celebrating Roger Ross. In R. J. Elman (Ed.), *Group treatment of neurogenic communication disorders: The expert clinician's approach* (2nd ed.). Abingdon, Oxfordshire: Plural Publishing.

Kim, S. H., Kim, M. Y., Lee J. H., & Chun, S. I. (2008). Art therapy outcomes in the rehabilitation treatment of a stroke patient: A case report. *Art Therapy: Journal of the American Art Therapy Association*, *25*(3), 129–133.

McAllister, L., Woodward, S., Atherton, M., Nguyen Thi Ngoc Dung, Potvin, C., Huynh Bich Thao, Le Thi Thanh Xuan, & Dien Le Khanh. (2013). Viet Nam's first qualified speech pathologists: The outcome of a collaborative international partnership. *Journal of Clinical Practice in Speech-Language Pathology*, *15*(2), 75–79.

Nixon, S. A., Cockburn, L., Acheinegeh, R., Bradley, K., Cameron, D., Mue, P. N., Samuel, N., & Gibson, B. E. (2015). Using postcolonial perspectives to consider rehabilitation with children with disabilities: The Bamenda-

Toronto dialogue. *Disability and the Global South*, *2*, 570–589.

Parrish, J. (2014). *Art and aphasia: A literary review and exhibition*. (Honors thesis). Western Michigan University, Kalamazoo, MI (2445).

van der Gaag, A., Smith, L., Davis, S., Moss, B., Cornelius, V., Laing, S., & Mowles, C. (2005). Therapy and support services for people with long-term stroke and aphasia and their relatives: A six-month follow-up study. *Clinical Rehabilitation*, *19*(4), 372–380.

Walsh, B. (2016). Two-way learning, creating a classroom culture of reciprocity, where teachers and students are learners first. Retrieved from https://www.gse.harvard.edu/news/uk/16/01/two-way-learning

World Health Organization and the World Bank. (2011). *World report on disability*. Geneva: World Health Organization.

Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in underserved populations. *International Journal of Speech Language Pathology*, *15*(1), 1–13.

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Building speech-language pathology capacity and colleagues across continents

Abbie Olszewski and Erica Frank

There is a lack of qualified speech-language pathology service providers to serve persons with communication difficulties globally. This paper discusses current speech-language pathology training models in countries across continents and the limitations of these models. We propose a new training model called the Democratically Open, Outstanding Hybrid of Internet-aided, Computer-aided, and Human-aided Education (DOOHICHE), which can be implemented in any country. The pros and cons of the DOOHICHE model are critically examined. Lastly, the future direction of the DOOHICHE model is discussed.

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There is a documented and substantial shortage of speech-language pathologists (SLPs) globally, including countries as diverse as Australia (Lowell, 2013), Fiji (Hopf, 2014), Ghana (Wylie, McAllister, Davidson, & Marshall, 2013), Malaysia (Ahmad, Ibrahim, Othman, & Vong, 2013), and South Africa (Weddington, 2002). Training future SLPs who can diagnose and treat persons with communication difficulties (PWCD) is widely recognised as important, given the ability to communicate effectively is a human right (Global Campaign for Free Expression, 2003; International Communication Project, n.d.; NJCCNPSD, 1992). However, building SLP capacity is difficult because it necessitates training in both content knowledge and clinical skills, often requiring skilled mentors to work individually or in small groups with SLPs who are in training.

Current solutions

Experts across the globe have begun to address the challenges of knowledge transfer and exchange to better serve PWCD (e.g., Ahmad et al., 2013; Cheng, 2013; Crowley et al., 2013). Cheng (2013) identified three models used in China: networking in close proximity, collaborating among different regions, and the use of technology. Working in Ghana, Crowley and colleagues (2013) used a biopsychosocial model, utilising interpreters to gather and share information to assess needs and make recommendations, delivering professional development, and collaborating with specialised teams. In Malaysia, Ahmad and colleagues (2013) developed local professional capacity and increased focus on improving knowledge, local evidence, and research. Although these models have built local speech-language pathology capacity in their respective countries, current models are limited in their ability to scale up, be accessible to a wide range of individuals, be affordable, be accessible, be sustainable, and to provide a wide scope of course offerings.

New solution

At NextGenU, we have developed an innovative clinical speech-language pathology training program model grounded in the workforce capacity-building framework to address current model limitations (Goldberg & Bryant, 2012; Somerville et al., 2015). This model is called a Democratically Open, Outstanding Hybrid of Internet-aided, Computer-aided, and Human-aided Education (DOOHICHE, pronounced "doohickey"). NextGenU offers these courses to any organisation (e.g., universities, hospitals, ministries) requiring access to content training in speech-language pathology (Goldberg & Bryant, 2012) through the DOOHICHE model, which allows training of groups (e.g., in a flipped classroom) or of individuals. Individual training is important, as individuals are foundational to building capacity in an organisation (Goldberg & Bryant, 2012). Once proficient, these well-trained individuals can function as local mentors and train additional students in their communities – the "human-aided" component.

The goal of the NextGenU speech-language pathology program is to give interested learners around the world practical and intellectual competencies to serve PWCD, and to empower these students to understand how these issues are addressed in their country, while interacting with a local and global community of peers and mentors to build a community of professionals who work with individuals with communicative disorders.

Pros and cons

The DOOHICHE model has the potential to be accessible and affordable to a larger number of students than current training models. The training courses are offered in 103 languages through Google Translate; hence, it is conceivable that it will reach a sizable number of students throughout the world. Although the courses are offered in a multitude of languages, translation of the content of the website through Google Translate may not be accurate. Because the courses are offered through the Internet,

Abbie Olszewski (top) and Erica Frank

anyone who has access to the Internet can take the courses. While the DOOHICHE model is free to learners, there are costs for computer and/or Internet access.

The DOOHICHE model is designed to be sustainable with a $16-million endowment (which adequately covers core expenses), slender operating costs, and volunteer course creators. Though NextGenU.org encourages local communities, policy-makers, organisations, and governments to eventually take "country-ownership" (Goldberg & Bryant, 2012) of all aspects of capacity building, it is unclear how local authorities will receive this model.

The DOOHICHE training model will train students in a wide variety of subject areas related to SLP. It is not dependent on specialised trainer availability and skills, but addresses many areas in depth, as it is created by experts in the field, and guided by an advisory committee, using resources from governments, peer-reviewed journals, specialty societies, and universities. However, students may have difficulty allocating time to courses, finding a peer, or selecting an appropriate mentor to support the didactic portion of the model.

Future direction

NextGenU's DOOHICHE model for building capacity in the global speech-language pathology workforce is in its infancy, as we are currently piloting our first course with students in Kenya. We are unclear about the model's strengths and limitations in addressing the ability to build speech-language pathology capacity on a global level. Our goal is to critically evaluate the DOOHICHE model by collecting data regarding the quality, accessibility, sustainability, affordability, and customisation of this model. The evaluative process for the model and each course will be ongoing and continually refined based on metrics and feedback.

Because we strive to make this a viable training program for future audiences, we welcome comments, feedback, and suggestions. We call on the SLP community to engage in a discussion via the *Journal of Clinical Practice in Speech-Language Pathology* on the feasibility and acceptability of NextGenU's DOOHICHE model training program for future speech-language pathologists worldwide.

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References

Ahmad, K., Ibrahim, H., Othman, B. F., & Vong, E. (2013). Addressing education of speech-language pathologists in the World Report on Disability: Development of a speech-language pathology program in Malaysia. *International Journal of Speech-Language Pathology*, *15*(1), 37–41. doi: 10.3109/17549507.2012.757709

Cheng, L. (2013). Knowledge transfer between minority and majority world settings and its application to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 65–68. doi:10.3109/17549507.2012.729862

Crowley, C., Baigorri, M., Ntim, C., Bukari, B., Oseibagyina, A., Kitcher, E., Paintsil, A., Ampomah, O. W., & Laing, A. (2013). Collaborations to address barriers for people with communication disabilities in Ghana: Considering the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 53–57. doi: 10.3109/17549507.2012.743036

Global Campaign for Free Expression. (2003). Article 19 Statement on the Right to Communicate. Retrieved from https://www.article19.org/data/files/pdfs/publications/right-to-communicate.pdf

Goldberg, J., & Bryant, M. (2012). Country ownership and capacity building: The next buzz words in health systems strengthening or a truly new approach to development? *BMC Public Health*, *12*, 1–9. doi:10.1186/1471-2458-12-531

Hopf, S. C. (2014). Services for children with communication disability in Fiji. *Journal of Clinical Practice in Speech-Language Pathology*, *16*(2), 81-86.

International Communication Project. (n.d.). The opportunity to communicate is a basic human right. Retrieved from http://www.internationalcommunicationproject.com/

Lowell, A. (2013). "From your own thinking you can't help us": Intercultural collaboration to address inequities in services for Indigenous Australians in response to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 101–105.

National Joint Committee for the Communicative Needs of Persons with Severe Disabilities. (1992). Guidelines for meeting the communication needs of persons with severe disabilities. Retrieved from: http://www.asha.org/policy/GL1992-00201/

Somerville, L., Davis, A., Elliiott, A., Terrill, D., Austin, N., & Philip, K. (2015). Building allied health workforce capacity: a strategic approach to workforce innovation. *Australian Health Review*, *39*, 264–270. doi:10.1071.AHI14211

Weddington, G. (2002). Speech-language pathology/audiology: Service delivery in rural and isolated regions of South Africa. *Folia Phoniatrica et Logopaedica*, *54*(2), 100–102.

Wylie, K., McAllister, L, Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in under-served populations. *International Journal of Speech-Language Pathology*, *15*(1), 1–13. doi:10.3109/17549507.2012.745164

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Applying theories of cultural competence to speech-language pathology practice in East Africa

Helen Barrett

As global mobility increases and populations diversify, challenges to delivering appropriate, responsive, ethical and effective SLP services have emerged and services users, practitioners and national bodies are increasingly calling for delivery of culturally sensitive services. It is therefore crucial to look beyond our own cultural reference points and adopt an attitude of open-minded and continuous learning about others in order to provide the best services to all clients. Models of cultural competence have been developed across the allied health professions and have been described as: practitioners' awareness, knowledge, skills, and sensitivity in relation to their clinical practice with people from cultural and linguistic backgrounds other than their own. This paper draws on the author's experience of working across east Africa, with reference to two frameworks for cultural competence which are applicable to speech-language pathology practice. The paper highlights the multifaceted and interactional nature of different dimensions of cultural competence and queries whether this is accurately represented in the current theoretical frameworks.

KEYWORDS
CULTURAL COMPETENCE
EAST AFRICA
SPEECH-LANGUAGE PATHOLOGY

THIS ARTICLE HAS BEEN PEER-REVIEWED

Helen Barrett

East Africa is a region defined by diversity, and the challenges to developing cultural competence for external speech-language pathologists are enormous. Not only is the ethnic and linguistic diversity in the region extensive, but explanatory models of disability are often heavily influenced by the medical profession, stigma surrounding disability, and religious and /or cultural beliefs (Barrett, 2013). Professional training courses and services to meet the needs of people with communication difficulties are emerging[1] but are in their infancy, are frequently facilitated by external speech-language pathologists and often require ongoing support once established (e.g., Robinson, Afako, Wickenden, & Hartley, 2003). It is therefore crucial that the external practitioners involved are culturally competent to deliver appropriate, responsive, ethical and effective support.

The need for a culturally competent profession

Many national speech-language pathology associations stress the need for professionals to offer appropriate and sensitive services to diverse client groups (e.g., ASHA 2011; RCSLT 2003; SPA, 2016), but more guidance is needed on *how* to fulfil these obligations, specifically regarding issues beyond bilingualism and multilingualism (Leadbeater & Litosseliti, 2014).

Much of the available literature exploring speech-language pathology with clients from a range of backgrounds describes practice in multicultural societies in the minority world[2] (e.g., Leadbeater & Litoselliti, 2014). However, literature is also emerging on how external speech-language pathologists working in the majority world can do so ethically and effectively (e.g., Crowley & Baigorri, 2011; Hickey, McKenna, Woods, & Archibald, 2014). Current literature addressing the needs of people with communication disabilities in the majority world primarily focuses on issues and methods of professional or service development (e.g., Wickenden, 2013; Wylie, McAllister, Davidson, & Marshall, 2013) and, though this literature identifies the need for speech-language pathology education programs and services to be developed using culturally appropriate methods (e.g., Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003), the question remains as to *how* external speech-language pathologists can develop competence to facilitate these processes effectively.

For speech-language pathologists to become sufficiently competent to practise internationally, it is essential to reflect upon motivations, skills and learning needs (Brown & Lehto, 2005; Hickey et al., 2014) and upon what cultural competence means in relation to their home, and overseas, practice. In addition, it is critical to consider the concept of cultural humility in relation to cultural competence; cultural humility being the acceptance that it is not possible to be fully knowledgeable about a culture other than that which one is born into (Levi, 2009; Walters, 2015). Practitioners must therefore understand that cultural competence and cultural humility are critical prerequisites to the delivery of appropriate, relevant and effective services and apply both concepts to their practice.

Table 1. Dimensions of culturally competent practice proposed by Sue et al. (1992).

Dimensions / Practitioner characteristics	Awareness and beliefs Clinician is:	Knowledge Clinician demonstrates:	Skills Clinician is:
Awareness of own assumptions, values and biases	Aware of own culture and its influence on beliefs about self, others and clinical practice	Knowledge of own culture and aspects of this that may impact upon service delivery to diverse populations	Aware of own skills and ability to adapt these to diverse populations. Aware of own learning needs in relation to skill development
Understanding of the worldview of the culturally different client	Aware that individuals have varied understandings of the world and that this may impact upon the conceptualisation of their difficulties and response to intervention. Respectful of difference in the face of own cultural values and beliefs.	Knowledge and understanding of different cultural interpretations of worldviews and understands that individuals within a culture may have individualised interpretations of their own culture(s). Desire to develop knowledge and understanding	Able to transform understanding of different worldviews into culturally sensitive and safe clinical practice
Use of appropriate intervention strategies	Aware of the need for flexibility, creativity and individualisation in intervention	Knowledge of how to adapt intervention strategies and techniques to a variety of populations using culturally appropriate and acceptable methods. Support-seeking from others with implicit cultural knowledge	Skilled in innovative, sensitive and safe intervention

Theoretical models of cultural competence

This section explores two prominent models of cultural competence and their application to trans-cultural speech-language pathology practice. The models were not specifically designed for speech-language pathologists, but can be applied to allied health professions more broadly.

Model 1. Sue, Arrendondo, and McDavis (1992)

Sue, Arrendondo, and Davis (1992) identified three dimensions necessary for cultural competence: (a) awareness/beliefs, (b) knowledge, and (c) skills. These three dimensions are complementary to three practitioner characteristics: (a) awareness of own assumptions, values and biases; (b) understanding of the worldview of the culturally different client; and (c) use of appropriate intervention strategies. The relationship between each dimension can be visualised in a matrix to represent the competencies required to be considered culturally proficient (Table 1).

In addition to their model of professional cultural competence, Sue et al. (1998) use the concept of "multi-dimensionality of identity" to define how individuals possess different identities at individual, group, and universal levels, with the potential to possess more than one identity at each level[3] (Ridley, Baker, & Hill, 2001). Moreover, they describe how these identities are interactive – a person may be socially limited or liberated by one or more of their identities at each level, depending on their experience. For example, a woman with a communication disability's participation in society *may* be limited by both her disability and her gender at group or universal level, but not at individual level. A person's experience at one level may, over time, alter identity at another, including the way a person views his/herself as an individual (Marsh & MacDonald-Holmes, 1990). For example, over time, a woman may perceive herself to be limited as an individual due to her social experience – her self-concept is altered. This theory highlights the importance of considering cultural competence as a multidimensional and fluid concept, requiring constant adaptation as we consider individuals within a culture. However, the stand-alone models currently do not reflect this essential relationship between practitioner awareness, knowledge and skills and their interaction with the individual client.

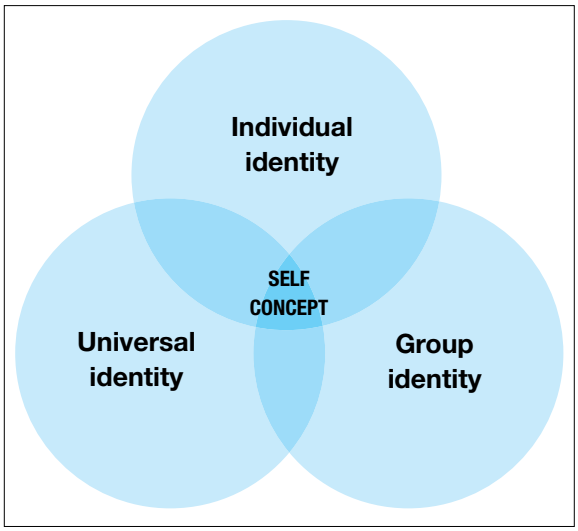

Figure 1. The interrelationship between levels of multidimensional identity and self-concept.

Model 2. Papadopolous, Tilki, and Taylor (1998)

Papadopolous, Tilki, and Taylor (1998) describe similar attributes for cultural competence as Sue et al. (1992) but also identify "cultural sensitivity" as a key component,

including supportive skills such as empathy, communication, trust, acceptance, and respect of the individual. Acknowledgement of a person's observable (and assumed) culture without a deeper understanding of individual cultural attributes can lead to tokenistic tolerance of diversity with complacency in implementing culturally sensitive practices (Cross, Bazron, Dennis, & Isaacs, 1989). For example, a company hires a "quota" of ethnically diverse staff, but does not adapt wider policies and practices. In contrast, culturally sensitive practice allows us to consider multidimensionality of identity and is fundamental to developing the more nuanced awareness, knowledge, and skills required to deliver culturally appropriate, responsible, ethical and effective services.

Application of a cultural competence framework to speech-language pathology practice

Although not designed as speech-language pathology-specific theoretical models, the cultural competence constructs of both Sue et al. (1992) and Papadopolous et al. (1998) may be applied to health professions more broadly. The models identify how practitioners should recognise and reflect upon their *own* attitudes, values, knowledge skills, and sensitivity, and consider how they can harness and develop these to work effectively in diverse environments. As acknowledged by IAHA (2015) and Papadopolous et al. (1998), the development of cultural competence is a continuous, never-ending process, requiring interaction and experience, alongside the development of knowledge of one's own, and other, cultures.

In the following note the author gives a personal interpretation of the models described above in relation to her own experience living and working in east Africa. Through exploration of four of the dimensions of culturally competent practice, the author aims to illustrate the ongoing development of her own cultural competence as a process of constant renewal and revision.

Developing cultural competence in east Africa: A personal reflection

Reflective statement

I have lived and worked in Africa at various points since 1999 and as a speech-language pathologist in east Africa permanently since 2008. My work has focused on training local practitioners and policy-makers to understand and address the needs of people with communication disabilities in local communities. During this time, I have experienced a steep learning curve in my own understanding of cultural competence and continue to adjust my practice with each new experience. The following section provides an analysis of my personal reflections. Specific themes that arise are then discussed with reference to theoretical concepts of cultural competence

Theme 1. Awareness and beliefs

Reflection: Having worked in Kenya, Uganda and Tanzania, I was surprised to find Rwanda very different to other countries in the region. My assumptions about the people and professional culture were significantly challenged. It was, essentially, a "culture shock" that took some time to adjust to, both personally and professionally.

The information we access before we arrive in a new country helps to form our early beliefs about the people and cultures we are about to encounter. However, it takes time to appreciate more fully how these cultures vary in their application to individuals and, over time, our awareness and beliefs change in line with experience.

New experiences help us to develop a heightened awareness of our own culture and we become aware of how aspects of our culture may change in the new environment. Moreover, we learn about how others perceive us and may have to re-evaluate some established stereotypes. How we communicate with a variety of individuals in our own language and across other languages also plays an important role in our ability to adapt to new transcultural challenges. We discover things about how we see ourselves, how we see others from our own culture and how we see people from cultures different from our own. This self-reflection helps us to appreciate similarities and differences and identify opportunities to overcome potential barriers to interaction and engagement, and is considered an essential part of both Sue et al.'s (1992) and Papadopolous et al.'s (1998) models.

Theme 2. Knowledge

Reflection: A family in Uganda had difficulty accepting alternative-augmentative communication (AAC) methods for their child. They resisted use of cards or charts, but valued a hand-drawn book of pictures using the same exercise book that other children used in school. It was important for me to understand social norms and values in the family's community and devise solutions to therapeutic dilemmas that were responsive to those values.

Knowledge, when coupled with experience, can translate into understanding that helps us to communicate and build relationships with individuals. We may conclude that knowledge continually grows and shapes our awareness, beliefs, and skill development and is balanced by our sensitivity and attitudes. Cultural knowledge and clinical knowledge also need to come together in new therapeutic environments; understanding the cultural applicability of our clinical knowledge to individuals from different backgrounds is critical to developing and providing culturally sensitive services. Furthermore, cultural humility – understanding that individuals are the gatekeepers of their own culture and that we must learn from them in an open-minded, flexible, creative, and patient way – allows us to shape knowledge into sensitively conceived, practical and meaningful skills (see Walters, 2015). However, this bidirectional learning process and breakdown of practitioner–client power relations is not represented in the models of clinical cultural competence discussed above.

Theme 3. Skills

Reflection: In Rwanda, I work with a British non-governmental organisation, Chance for Childhood, that has engaged international specialist speech-language pathologists (including myself) to help to develop the capacity of a team of local practitioners who go on to train teachers and assistants to support children with communication disability in schools and communities. In addition, they are supporting the development of national curricula in conjunction with development partners and the government (see Barrett, Turatsinze, & Marshall, 2016).

In east Africa, explanatory models of disability are often deficit-focused, though this is gradually changing. A biopsychosocial understanding of disability (WHO, 2001) is prevalent in the minority world and speech-language pathology professional culture and practice has developed in line with this model (Leadbeater & Litosseliti, 2014). External speech-language pathologists' biopsychosocially derived skills are therefore at risk of being in juxtaposition with both the conceptualisation of disability and health care delivery models predominant in east Africa. My experience has taught me that it takes time, skill, patience, flexibility and relationship-building, alongside reflection on both personal and professional beliefs and knowledge about explanatory models of disability, to work between the two paradigms. This relationship between knowledge and skill development is, again, bidirectional but is not represented as such in the models.

Understanding of the need to build local capacity is also critical to culturally competent practice (Barrett et al., 2016; Hickey et al., 2014; IAHA, 2015) – sustainability is key. In countries where local speech-language pathologists are either not available or in short supply, other professionals may benefit from skill-sharing[4] to enhance their practice with people with communication disabilities (Hartley, Murira, Mwangoma, Carter, & Newton, 2009). Consideration of communication disability as a broader public health issue, potentially best addressed with a population-based approach to service delivery, may be a potential solution to the skill deficit (Wylie, McAllister, Davidson, Marshall, & Law, 2014). This longer term approach requires advocacy from service users and providers, political will, and strategic planning from within to achieve change. It is therefore crucial that external speech-language pathologists have the appropriate understanding of the context, and resultant skills, to support local service users, providers, and advocates in this process.

Theme 4. Sensitivity

Reflection: In Kenya, Uganda and Rwanda, working with local organisations has allowed teams of local partners to build internal capacity and reach out to people in remote communities who would not otherwise access services. The partners explain communication difficulties in accessible and appropriate ways, are able to give locally contextualised examples and explanations in local languages, and use sustainable materials to make appropriate resources.

Cultural sensitivity is, arguably, the most salient part of the Papadopolous et al. (1998) model. The concept of cultural sensitivity resonates with that of cultural humility. It reaches beyond knowledge and deeper into the awareness that there is more to a person's culture than is, or can be, articulated (Hall, 1984; Levi, 2009). This implicit cultural information is rarely accessible to outsiders (Papadopolous et al., 1998) and that is a primary reason why it is imperative to work with local partners who do have access to, and are accepted at, these implicit cultural levels. It is therefore crucial that speech-language pathologists work with, and through, local practitioners who bring expertise beyond clinical skills and are uniquely positioned to access the communities to which they belong (see Hickey et al., 2014).

Summary

The concept of culture is continually evolving and it is therefore crucial that theoretical frameworks develop to reflect this change. However, the analysis provided suggests that the current frameworks of clinical cultural competence do not yet adequately reflect the multifaceted attributes required to work effectively with people from a range of backgrounds and require reconceptualisation.

The above reflection and analysis illustrates that cultural competence in clinical practice encompasses multidirectional interactions between individuals with multiple identities and their practitioners, with the awareness, knowledge and skills to offer effective and ethical services. In order to develop appropriate skills, cultural humility must underpin the development of awareness and knowledge of, and sensitivity towards, one's own, and other, cultures (including individual interpretations of these). As discussed, the theory of cultural humility dictates that competence is not an endpoint, but an evolving phenomenon (see Figure 2). In order for speech-language pathologists to deliver culturally appropriate,

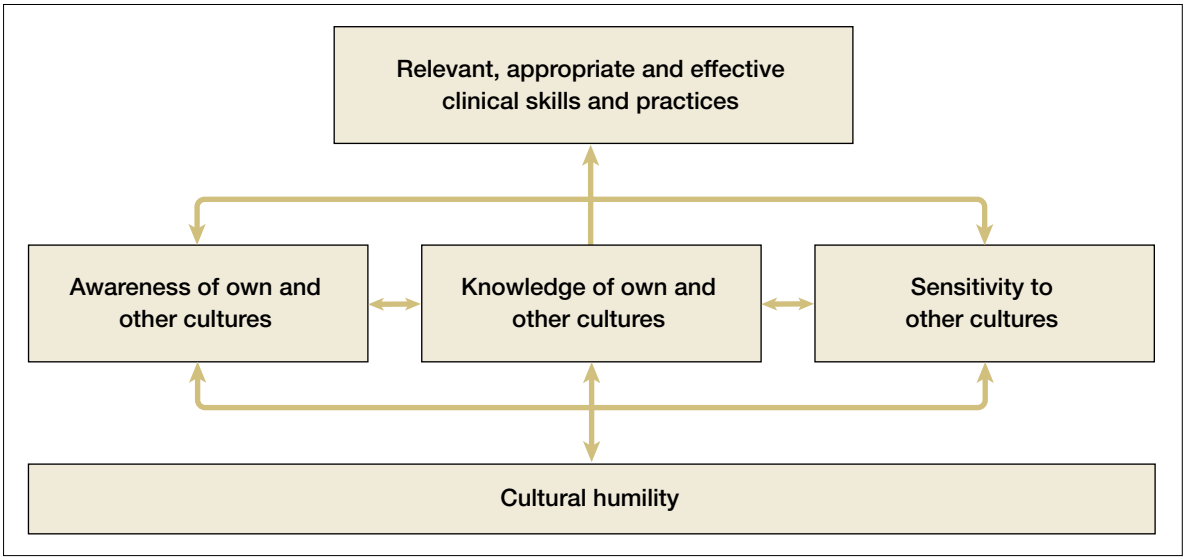

Figure 2. Towards an integrated model of cultural competence. Cultural humility underpins the development of awareness and knowledge of, and sensitivity towards, one's own and other cultures and the subsequent development of effective clinical skills. (Integrated model based on Sue et al., 1992; Papadopolous et al., 1998; and Walters, 2015)

relevant, responsive and effective services both at home and overseas, a wider recognition of the need for cultural competence to be grounded in the concept of humility needs to be a common and central concern of speech-language pathology governing bodies, training institutions, service providers. Ultimately, it needs to be championed by individual members of the profession.

It is vital that the speech-language pathologists contributing to service development in the majority world reflect upon both their motivations and their ability to provide appropriate input that is sensitive to the needs of local service users and providers (Hickey et al., 2014). Thus, practitioners need to reflect upon some widely accepted personal and professional cultural beliefs and be led by local partners to reach workable and realistic solutions to the challenges that they identify. Participatory and emancipatory research is therefore necessary to expound the needs of people with communication disabilities in different contexts, and what they, and their communities, feel is the most appropriate way forward to address those needs.

Conclusion

As global mobility increases, it has never been so important to look beyond our own cultural reference points and adopt an attitude of open-minded and continuous learning about others. As societies are becoming increasingly multicultural, awareness, knowledge, skills and sensitivity towards others are essential in speech-language pathology practice. However, the profession must ask if the current conceptualisations of cultural competence adequately represent the multidirectional interaction between all of the professional attributes required to work effectively with people from cultures vastly different from our own.

Ensuring appropriate training on cultural competence on speech-language pathology courses is an important step towards increasing trainees' awareness and knowledge about cultural diversity and its implications for effective clinical practice. However, sensitivity and skills come with experience and, arguably, the multifaceted dimensions of cultural competence are governed by an individual's ability to demonstrate cultural humility and by their own attitudes. Essentially, the onus lies with individuals to embrace diversity in both their personal and professional lives, critically appraise themselves and their practice, accept the unease that comes with stepping outside their comfort-zone with people from other cultures (Walters, 2015), and actively seek to develop their own interpretation of the term cultural competence.

1 Training courses are in place in Uganda, Kenya and Tanzania and under development in Rwanda.

2 Shalmani (2015) states: *"The term 'Majority world' highlights the fact that the majority of the world's population lives in these parts of the world traditionally referred to as 'developing'. The term 'Minority world' is similarly used to refer to those countries traditionally referred to as 'developed', where a minority of the world's population resides"*. The author recognises the problematic nature of using a "two world's approach" (Young, 2010), but has opted to use the above terms for clarity of argument.

3 Identities can include age, ethnicity, gender, linguistic background(s), national origin, religion, sexual orientation, socioeconomic status (see ASHA, 2013; Papadopolous et al. 1998).

4 Whereby people seek to exchange knowledge and skills to enhance each other's practice

References

American Speech-Language Hearing Association (ASHA). (2011). *Cultural competence in professional service delivery*. Retrieved from http://www.asha.org/policy/KS2004-00215.htm

American Speech-Language and Hearing Association (ASHA) Board of Ethics (2013). *Cultural and linguistic competence* [Issues in ethics]. Retrieved from http://www.asha.org/Practice/ethics/

Barrett, H. (2013). *"Education for all"? Access to primary-level education for children with complex learning disabilities in countries with "free primary education" in sub-Saharan Africa: A review of the literature*. (Unpublished master's thesis). University of Manchester, UK.

Barrett, H., Turatsinze, F., & Marshall, J. (2016). International working: strategic thinking achieves change. *RCSLT Bulletin*, *July*, 18–19.

Brown, S., & Lehto, X. (2005). Travelling with a purpose: understanding the motives and benefits of volunteer vacations. *Current Issues in Tourism*, *8*(6), 479–496

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*, Volume I. Washington, DC: CAASP Technical Assistance Center.

Crowley, C., & Baigorri, M. (2011). Effective approaches to international work: Substance and sustainability for speech-language pathology student groups. *Perspectives on Global Issues in Communication Sciences and Related Disorders*, *1*(1), 27–35.

Hall E. (1984). *The dance of life: the other dimension of time*. New York, NY: Anchor Press.

Hartley, S., Murira, G., Mwangoma, M., Carter, J., & Newton, C. (2009) Using community/researcher partnership to develop a culturally relevant intervention for children with communication disabilities in Kenya. *Journal of Health Services Research and Policy*, *31*, 490–499.

Hickey, E.M., McKenna, M., Woods, C., & Archibald, C. (2014). Ethical concerns in voluntourism in speech-language pathology and audiology. *Perspectives on Global Issues in Communication Sciences and Related Disorders*, *2*, 40–48.

Indigenous Allied Health Australia (IAHA). (2015). *Cultural responsiveness in action: An IAHA framework*. Australia: Author.

Leadbeater, C., & Litosseliti, L. (2014). The importance of cultural competence for speech and language therapists. *Journal of Interactional Research in Communication Disorders*, *5*,1–26.

Levi, A. (2009). The ethics of nursing student international clinical experiences. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, *38*(1), 94–99.

Marsh, H. W., and MacDonald-Holmes, I. W. (1990). Multidimensional self-concepts: Construct validation of responses by children. *American Educational Research Journal, 27*(1), 89–117.

Papadopolous, I., Tilki, M., & Taylor, G. (1998). *Transcultural care: A guide for healthcare professionals*. Wilts, UK: Quay Publications.

Ridley, C.R., Baker, D.M., & Hill, C.L. (2001). Critical issues concerning cultural competence. *The Counselling Psychologist*, *29*(6), 822–832.

Robinson, H., Afako, R., Wickenden, M., & Hartley, S. (2003). Preliminary planning for training speech and language therapists in Uganda. *Folia Phoniatrica et Logopaedica*, *55*, 322–328.

Royal College of Speech and Language Therapists (RCSLT) (2003). *Reference framework underpinning*

competence to practise. Retrieved from http://www.rcslt.org/docs/competencies_project.pdf

Shalmani, S. (2015). Why I use the term "majority world" instead of "developing countries" or "third world". Retrieved from https://sadafshallwani.net/2015/08/04/majority-world/

Speech Pathology Australia (SPA). (2016). *Working in a culturally and linguistically diverse society* (Position paper). Australia: Author.

Sue, D.W., Arrendondo, P., & McDavis, R.J., (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477–486.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T., Manese, J. E., Ponterotto, J. G. & Vasquez-Nutall, E. (1998). *Multicultural counseling competencies*. Thousand Oaks, CA: Sage Publications.

Walters, T. (2015). *Cultural humility: A hermeneutic literature review*. (Unpublished master's thesis). Auckland University of Technology, New Zealand.

Wickenden, M., Hartley, S., Kariyakaranawa, S., & Kodikara, S. (2003). Teaching speech and language therapists in Sri Lanka: Issues in curriculum, culture and language. *Folia Phoniatrica et Logopaedica*, *55*(6), 314–21.

Wickenden, M. (2013). Widening the SLP lens: How can we improve the wellbeing of people with communication difficulties globally? *International Journal of Speech-Language Pathology*, *15*(1), 14–20.

World Health Organization (2001). *International classification of functioning (ICF)*. Retrieved from http://www.who.int/classifications/icf/en/

Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). The World Report on Disability: An impetus to reconceptualise services for people with communication disability. *International Journal of Speech Language Pathology*, *15*(1), 118–126.

Wylie, K., McAllister, L., Davidson, B., Marshall, J., & Law, J. (2014). Adopting public health approaches to communication disability: Challenges for the education of speech-language pathologists. *Folia Phoniatrica et Logopaedica*, *66*, 164–175.

Young, H. (2010). Naming the world: Coming to terms with complexity. *Policy and Practice: A Development Education Review*. (Issue 10). Retrieved from http://www.developmenteducationreview.com/issue10-perspectives3

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"I can't believe you want to leave at lunch time"

A reflection on how narrative ethics may inform ethical practice in cross-cultural and majority-world contexts

Helen Smith

KEYWORDS
CULTURAL AND LINGUISTIC DIVERSITY
MAJORITY-WORLD VOLUNTEERING
NARRATIVE ETHICS

Helen Smith

In the mid 1990s for 2½ years I was a volunteer speech pathologist with Australian Volunteers International in a sub-Saharan African country. This story is based on my time working in country. This piece will use a narrative ethics framework (Speech Pathology Australia, 2014) to consider the story; the current story as I experienced it, a reflection on the background story from multiple perspectives and a reimagined future story. Finally, some considerations for ethical volunteering as speech pathologists in culturally and linguistically diverse majority-world contexts will be provided.

The current story

Sarah,[1] a hard- working and dedicated rehabilitation technician[2] returned one Monday from a rare funded professional development opportunity. She was the mother of two and the adoptive mother of three (her sister's children, adopted after her sister's death from HIV the year before), and it had taken a huge amount of organisation and personal commitment for Sarah to attend the course. (The course was based in a central location requiring 3–4 hours travel and several nights away from home.)

The course was funded and run by a service organisation from North America which had recruited volunteer specialists from their own country, provided them with travel and living expenses but no salary, so they could provide a week-long specialist training program to local health workers. The service organisation had also funded the travel and living expenses for the local health workers to attend. A rare and generous gift with the goal of improving the provision of specialist services to people in the country.

Sarah, a keen learner, was always motivated to improve her knowledge and skills. Therefore, I was surprised on the Monday morning following the course when my question asking how her course had been was met with a huge sigh and a look of despondency. Concerned, I asked Sarah what had happened.

Sarah started by expressing her delight in the amazing opportunity to develop her understanding of the specialist area. She was delighted that what she was required to do for patients at our hospital made more sense as the course rolled out.

Sarah, however, then expressed her frustrations. First, the "whole" course as outlined in the brochure had not been provided. Second, each day, regardless of the presenter, the content appeared very rushed, with no time to consolidate learning or to ask questions. Despite the speed of delivery, she commented the presenters were constantly complaining at their frustration that they couldn't fit in all the content they had planned.

Over lunch one day Sarah asked one of the facilitators why everything was being covered so quickly. While English was the official language for education and business, English was a second (or third language) for most of the attendees. The majority of the participants had a TAFE-level qualification and were finding it challenging to keep up. The facilitator responded to Sarah's question by saying:

> *You all had to travel on Tuesday. We had expected you to travel on Monday as it was a public holiday but none of you could be bothered to do that. And none of you will stay all day on Friday. You all want to leave at lunch time. So our carefully planned 4-day course is being squashed into 2½ days.*

Sarah commented she felt like the facilitator was saying she and her fellow participants didn't value the educational opportunity to improve the specialist services they would provide to their patients. Nothing could have been further from the truth. On reflection, Sarah wondered how she could have helped the facilitators change their perception of the participants. She was concerned about the facilitator's misperception that the participants were not motivated or were lazy. She wondered how this valued and valuable training could have been less than optimal because of such a lack of understanding. She did not feel empowered to continue the conversation as the facilitator rushed off to prepare for the next session. Sarah certainly did not feel valued or respected by the facilitator.

The background story

A narrative approach to ethical reasoning considers an individual's or cultural group's life story (Speech Pathology Australia, 2014). The values and experiences each participant brings to the story are considered. This allows both sets of voices in the story to be heard. Each person in the story arrives at the situation described from their own perspective. It is only through the consideration of these multifaceted perspectives that a new and deeper shared understanding can be reached.

The volunteer presenters had dedicated valuable vacation time to come to Africa to deliver training. They had spent many hours preparing the training program prior to their departure from home. They came with slides and handouts and workbooks. The timing of the trip had been made to accommodate the volunteers' usual summer holiday period to have the least impact on their own local

service provision. The volunteers were motivated to "do good" (Speech Pathology Australia, 2010) in coming to the country and providing the training. They too recognised the speed and lack of time available was affecting the quality of the training they were providing and were frustrated by the circumstances which prevented them maximising the training they had come so far to present.

What the presenters didn't understand was the cultural context. The "public holiday" so casually mentioned was not just any "holiday". It was an Anzac-day type celebration for the fallen freedom fighters from the recent independence war. In a politically nuanced country, being absent from your local "celebrations" could potentially endanger you and your extended family's reputation and security. Being absent – for example, travelling on that day – was just not an option for any local worker.

Similarly, the need to leave mid-day on Friday was not "skipping out". Most of the local participants would be taking long distance buses home. Bus stations after dark were not safe places for reputable people to be, particularly women on their own. Women in the bus station area after dark, especially on a Friday night, were at great risk from groups of drunken men at the end of their working week. Anything could (and frequently did) happen to lone people especially women, in such places. All local people knew this and were careful to ensure people attending courses would be out of the bus station area and home well before dark particularly on Fridays.

Potentially, based on the facilitators' feedback, there was a risk similar workshops would not be funded by the North American service organisation in future. This would mean both volunteers and participants would not have the opportunity for a rich cultural exchange and education that the volunteer program provided. There was also a risk that local organisations may not implement improved health care practices if the participants were unable to engage with the workshop content due to the structure and speed of the workshop.

Understanding the background stories of Sarah, her fellow students and the presenters provides useful insights into this revised story and assists consideration of how to move past the barriers expressed in the original story. The new perspectives gained during the reflection allow a future story to be reimagined with a more positive experience for all participants involved.

An ethical approach for future workshops

I would like to present the following strategies as ways to move forward and construct a positive future story.

Embedding volunteer programs

Having volunteer programs embedded in local services and at the behest of local services may go a long way to preventing similar misunderstandings and risks of harm. A local contact, involved in pre-planning, could have explained to the volunteer group before dates were determined why a proposed week was not suitable with respect to a culturally and politically important public holiday. A local contact could facilitate discussions around the need to finish by lunch time so participants could safely travel home, and explain fully the safety risk if this recommendation was not adhered to by participants. A local co-facilitator could also provide orientation to the volunteers to the English competency and education level of the group so the pace of the training program could maximise learning. It is also worth considering that if the timeframe for a volunteer educational program is not ideal, it may be of more benefit to focus on the quality of the content rather than quantity of information provided. This may facilitate new services or techniques being safely and confidently implemented in the new setting.

Considerations for volunteers

Good practice principles

The Irish Code of Good Practice for volunteer sending agencies (COMHLAMH, 2015, p. 6) outlines a number of principles relevant for consideration including:

- Volunteers participate in appropriate preparation, training and induction.
- Organisations take all practical steps to ensure the protection, safety and well-being of volunteers and the communities they work with.
- Organisations support volunteers to understand the wider context of development in which volunteering is taking place.

Consideration of these principles and of our own SPA Code of Ethics may facilitate an ethical approach to even very simple, short-term volunteer opportunities, such as the one described in this example, and maximise "the good" for all involved while upholding autonomy and respecting the beliefs and values of local communities. Using a narrative ethics framework to guide reflections on this "story" highlights the importance of listening to the perspectives of all, and illustrates the utility of the narrative approach in finding ethical solutions to cross-cultural and majority-world dilemmas.

Established volunteer organisations and programs

Speech Pathology Australia (SPA) supports the use of established organisations for speech pathologists wishing to volunteer in majority-world communities for philanthropic reasons (Speech Pathology Australia, 2015). The use of established volunteer organisations facilitates the access to appropriate orientation and support for speech pathologists.

Developing understanding of cultural and linguistic diversity

In addition SPA recommends that speech pathologists working in culturally and linguistically diverse environments (wherever they may be geographically) be familiar with the contents of the position statement "Working in a culturally and linguistically diverse society" (Speech Pathology Australia, 2009). This document highlights the requirement for speech pathologists to develop cross-cultural competence in order to provide culturally relevant and I would suggest ethical services.

The benefits of ethical volunteering

The development of new cultural knowledge and partnerships with people from other cultures is one of the joyful benefits of volunteering in a majority-world context in both short- and longer term programs. The personal and professional benefits are enormous and often life-changing. The benefits we gain from volunteering may far outweigh what we offer in return. In my experience, the Sarahs of the world also want to provide the best possible services for their patients. Sarah certainly appreciated the support to provide the highest standards of care for her patients within the context in which she worked. Her attitude and calm

resilience remains an inspiration to me. This story highlights the importance of listening to the perspectives of all and illustrates the utility of the narrative approach to ethical reflection in complex situations.

Acknowledgements

I would like to acknowledge the invaluable feedback and advice received from members of the ethics board Belinda Kenny, Suze Leitão, Trish Johnson and Patricia Bradd on earlier drafts of this paper.

1 Not her real name
2 Rehabilitation technicians are the equivalent of Certificate 4 Allied Health Assistants in Australia

References

COMHLAMH. (2015). *Irish code of good practice for volunteeer sending agencies*. Retrieved 3 June 2016, from www.comhlamh.org/code-of-good-practice-2-2/: http://www.comhlamh.org/code-of-good-practice-2-2/

Speech Pathology Australia. (2009). *Working in a culturally and linguistically diverse society*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2010). *Code of ethics*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2014). *Ethic education package*. Melbourne, Vic.: Author.

Speech Pathology Australia. (2015). *Volunteering in speech pathology*. Melbourne, Vic.: Author.

Helen Smith is a senior member of SPA's Ethics Board. In the 1990s she volunteered with Australian Volunteers International.

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Webwords 56

Minority-world SLPs/SLTs in majority-world contexts

Caroline Bowen

The modes of service delivery, and the settings in which speech-language pathologists / speech and language therapists (SLPs/SLTs) work, are remarkably diverse. The "modes" can be push-in or pull-out in schools; hospital-, office- or clinic-based; face-to-face in the flesh, or face-to-face via telepractice; or "mobile" – boating, driving or flying between sites. The settings, at home and abroad, can be in aged-care facilities, charitable and philanthropic institutions, clients' or clinicians' own homes, community health centres, custodial or care facilities, early intervention centres, hospitals, missions, online, orphanages, preschools and schools, private practices, rehabilitation units, social enterprises, and university clinics, in the minority and majority worlds.

Altruists bitten by the travel bug

SLPs/SLTs, affected by some combination of altruistic values – around social justice, equity, freedom and wanting to make a contribution to the greater good – and the travel bug are often inspired to work in the majority world. They can do so for short periods, long periods, or in regular bursts, as interested onlookers, volunteers and paid employees. Their international workforce participation can involve study tours or fact-finding trips to become better informed about communication and swallowing disorders' services in the visited country or region, with no delivery of direct services, or with service delivery as an ancillary goal; international work experience for undergraduate and graduate students; information sharing-and-training-only missions; and sustained and sustainable direct service provision (Crowley & Biagorri, 2011) taking full advantage of local "social capital" in the host community. Where providing clinical services is concerned, sustainability is a central concern, with a "best practice" focus on upskilling local individuals to continue the work, with ongoing support, increasingly via the Internet (Salas-Provance, Marchino, & Escobedo, 2014).

Association support

SLP/SLT professional associations support international outreach and networking in various ways. For example, ASHA has two relevant Special Interest Groups: **SIG 14**[1] Cultural and Linguistic Diversity and **SIG 17**[2] Global Issues in Communication Sciences and Related Disorders, and Speech Pathology Australia has a closed Facebook **group**[3] for members interested in working in developing communities.

Recruiters

Recruitment agencies often tap into professionals' philanthropism and thirst for adventure with promises that the overseas experience will be "personally rewarding", taking advantage of (free) social media and the goodwill of individual practitioners to spread the word. Since 1998, speech-language-therapy dot com has attracted a flow of enquiries and requests for help, often relating to SLP/SLT services in the majority world and in remote places, partly as a consequence of the **professional interest**[4] section of the site. In the first half of 2016 alone, email from recruiters arrived directly from Bali, Bolivia, Cambodia, Ethiopia, Mongolia, Myanmar, Papua New Guinea, Peru, Romania, Rwanda, Ukraine and the US. This one was from the US:

> *I am recruiting an SLT (I do hope it might be YOU) and an OT who would like to live in Shenzhen for one year to train paraprofessionals on SLT and OT skills for ages 0–8 years old. China has just recognized the need for SLTs. No universities offer it as a major and few courses are offered except via other universities. A CEO of a rehab center for young children wants to offer services, but the therapists would have to speak Chinese, which has many variants. In the interim, the CEO seeks an SLT to train or share basic info to the current teachers/paraprofessionals who have worked with disabled children for years (very experienced and dedicated). Translators are available. If you have a better solution, please share. Please inform your wonderful network.*

For the record, the (somewhat misinformed) writer was directed to the Hong Kong Association of Speech Therapists (**HKAST**[5]), SLP/SLT academics in the Division of **Speech & Hearing Sciences**[6] at the University of Hong Kong, the Chinese International Speech-Language and Hearing Association (**CISHA**[7]), and to various personal contacts in the PRC. Another 2016 enquiry was from Africa:

> *We seek to recruit a Speech Pathologist to train rehab technician staff to provide the highest quality assessment and therapy services (with a main focus on AAC, ASD and speech) over 6 to 8 weeks in Malawi. We will pay airfares board and lodgings and meet-greet you in Lilongwe. Like so many of these enquiries, it came with an appeal for a six-figure "suggested sum".*

Again, factual information, and conservative advice were proffered, but as is also usual when an answer is not the one "hoped for", no further correspondence was received.

Volunteers or voluntourists?

The site also receives regular email from SLPs/SLTs and students, variously interested in working somewhere foreign, wanting an adventure, or seeking to contribute to the world community. Much of it betrays a breathtaking arrogance, a sense of superiority over potential host communities, little humility (Bleile, 2015), and scant cultural

competence and cultural sensitivity (Bowen, 2009). Here are five representative unedited samples:

Hi. I have very recently finished my BSc (honours) degree in Speech and Language therapy, acquiring many exportable skills at a prestigious British university. I would like to work as a speech therapist in ***Asia***[8] *(possibly Honk Kong or Singapore but anywhere else would be good too) since I think I would find it extremely interesting to work in that part of the world, especially since the profession is less developed in that continent. Can you put me in touch, as soon as possible, with contacts who can read English since I do not speak any overseas languages?*

After 30 years as an SLP in the schools, I am retiring. I have given my recent "SLP acquisitions" to younger colleagues and to the clinic at my alma mater. I am left with 3 large boxes of tests, texts and therapy manuals (Hanen, LinguiSystems, ProEd, HBJ, Super Duper, etc.) and materials (flash cards, etc.). They are not current enough, or in good enough condition for my young colleagues or the ____ University Clinic, as they are quite fussy. I hate to throw them in the trash and I wanted to know if you know of an SLP clinic or school service in the third world where they might be appreciated. I would be happy to donate them if the recipient covered p+h from MN.

Please allow me to introduce myself. I'm an S-LP from Canada who graduated from a top ranking university and I've been starting to consider a move to asia with hopes to work as an S-LP there. I stumbled across your website and wanted to ask you about availability of jobs for English speaking S-LPs in asia (e.g. thailand, malaysia, singapore, etc). I've emailed the malaysian speech pathology college etc to ask for information as I cannot seem to find any online postings for jobs. However, they do not respond to my many emails so I'm writing to you for your insights. You'd actually think they'd be glad of high quality input from a civilized country like mine with high S-LP standards. If I cannot find something that suits me in asia I am quite interested to work in africa if you can send any info for that area.

My background is that I am a CCC-SLP from the US and a member of AAPPSPA. I am interested in setting up a center in a city in the Asian region to work with young children 0–5 in Fiji, Japan, Sirrilancah, Vanuatu, South Korea, Siam or similar (not China, Bali, India, Pakistan or areas with too much poverty and disease or slums). If you would provide contacts in that area, that would be great. Also, any thoughts on working thru telepractice on accent modification with Asian adults wanting to improve their English pronunciation?

I am a 24-year-old German SLP student (for MA) speaking German and English urgently wishing for an internship in Thailand for three months in the summer, but I am not having too much luck finding a post. It will give me much happiness to work with poor children who have cleft palate in exchange for housing, meals, insurance and small stipend and flights to-from Munich. I am searching such an internship since 4 months without anybody answering or supporting me. I need this internship very much for my thesis. Thank you for your website.

Unfortunately, some of the cultural incompetence, self-serving motives (Salas-Provance et al., 2014) and attitudes implicit in the email spill over into the standards of clinical practice observed in developing communities, and in some underserved majority- and minority-world contexts, *and* with culturally and linguistically diverse client populations in the industrialised world (Scheffner Hammer, 2011), including in Australia.

Troubling scenes

Webwords is not immune to either the urge to volunteer or the travel bug, expressed as a love of **weekends away**[9], and trips to many parts of the world for work and leisure. In her work travels, she has been troubled to see fully qualified SLPs/SLTs "make do" with superseded, photocopied (from colour to black and white) and incomplete assessments; and tests and intervention materials translated from English to local languages and dialects. She has also witnessed colleagues employ culturally inappropriate materials, such as: the (British) Renfrew Action Picture Test for Zulu and Xhosa speakers; Brown's Stages (English) "norms" for morphological development applied to African, Asian and European languages; and picture resources, made for the UK and USA, used with Indigenous and non-Indigenous Australian, Filipino, Malaysian, New Zealand and South African children.

Some fully qualified SLPs/SLTs also engage, with mixed motives, in "importing" non-evidence-based methods for use by naïve practitioners with vulnerable populations, enjoying Big-Tobacco-style sponsorship.

The TalkTools® Blog for example, **records**[10] that four Australians, two SLPs and two OTs, volunteered for a week in November 2015 at the Dzherelo Centre, in Lviv, Ukraine. The "mission trip" was sponsored by TalkTools®, who also donated (their) merchandise to the centre. The SLPs taught staff how to use TalkTools® exercises and products, "to turn mealtimes into therapy to support the children in developing their oromotor skills. All of the children … required support with the strength and coordination of their jaw. Chewy Tubes with the pre-feeding chewy hierarchy were trialled successfully". Meetings were also held at the Lviv Catholic University, the Polytechnic University and the Military Hospital, where the sponsor's products may have been discussed in an approving light, with no mention of their lack of supporting evidence.

Standards

Ethical issues permeate each of these circumstances, relating to complex, even alien settings where barriers to E^3BP far outweigh the facilitators. Doing your best, as a qualified service provider in difficult situations, should not equate with knowingly advocating or delivering inferior service, especially when grateful, hospitable, and sometimes adoring recipients believe you offer "the best", and want you back.

Links

1. www.asha.org/SIG/14
2. www.asha.org/SIG/17
3. www.facebook.com/groups/SPAWWDC
4. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=20

5. www.speechtherapy.org.hk
6. www.hku.hk/speech
7. www.cisha.org.cn
8. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=54
9. www.speech-language-therapy.com/index.php?option=com_content&view=article&id=162
10. http://blog.talktools.com/2016/slp-and-ot-trip-to-ukraine

References

Bleile, K. M. (2015). A Nicaraguan experience. In C. Bowen, *Children's speech sound disorders* (2nd ed.; pp. 157–160). Oxford: Wiley-Blackwell.

Bowen, C. (2009). Multiculturalism in communication sciences and disorders. *ACQuiring Knowledge in Speech, Language and Hearing*, *11*(1), 29–30.

Crowley, C. & Baigorri, M. (2011). Effective approaches to international work: Substance and sustainability for speech-language pathology student groups. *ASHA SIG 14 Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse (CLD) Populations*, *1*, 27–35.

Salas-Provance, M., Marchino, M., & Escobedo, M. (2014). Volunteerism: An anchor for global change through partnerships in learning and service. *ASHA SIG 17 Perspectives on Global Issues in Communication Sciences and Related Disorders*, *4*, 68–74.

Scheffner Hammer, C. (2011). Broadening our knowledge about diverse populations. *American Journal of Speech-Language Pathology*, *20*(2), 71–72.

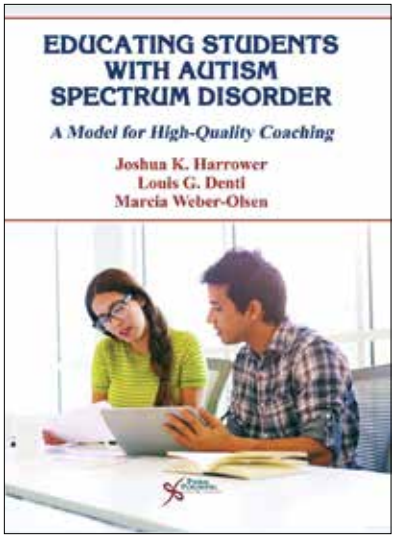
Webwords 56 is at www.speech-language-therapy.com with live links to featured and additional resources.

Resources reviews

Harrower, J. K., Denti, L. G., & Weber-Olsen, M. (2015). *Educating students with autism spectrum disorder: A model for high-quality coaching*. San Diego, CA: Plural Publishing; ISBN 978 1 59756 786 2; pp 245; A$69.95.

Keely Harper-Hill

I was delighted to be asked to review this book because, while speech-language pathologists (SLPs) have collaborated with educators for many years, coaching as a means of educator professional development is currently of particular interest. The book is structured clearly and consists of 13 chapters across three sections. The objectives of each chapter are listed at the chapter beginning and each chapter ends with an explicit summary and end-of-chapter questions. The first section (chapters 1–5) introduces educational coaching, briefly reviews and



describes coaching models, and places this information within the context of supporting students on the autism spectrum. The second section (chapters 6–8) considers the use of high-quality coaching in planning instruction for students on the autism spectrum. Delivering effective programming for these students is covered in the final section (chapters 9–13). Vignettes are woven throughout the chapters. The book is easy to read and the structure would enable the reader to "dip" into it rather than read it in its entirety. The authors are based in the United States and, as with many other disciplines, the reader needs to make adjustments to the content.

I do have several reservations, which stem from the ambitious scope of the 250-page book. The authors make a valiant effort to address two weighty topics: (a) educator coaching and (b) how to support students on the autism spectrum in the classroom. Within the sections on planning instructions and again in effective programming, these topics are integrated and applied to the assessment and intervention phases of supporting students in schools. I felt that the authors' effort to address these topics was undermined because more attention to both topics would be required to do them full justice. The authors' statement of purpose suggests a wide readership including coaches, as well as educators who are being coached, so that they can meet the needs of children on the spectrum. As I read the book, the scope of the intended readership became less clear. For example, the information on coaching may be of initial interest to the SLP who has very limited experience working collaboratively with educators. It may not, however, be sufficient to assist SLPs to translate specialist knowledge of autism to the classroom. Similarly, the information on autism could be useful to experienced education-based SLPs with limited experience with autism but I'm not sure they exist!

In conclusion, the book covers a wide array of issues relevant to coaching and could serve as a useful introductory text for student or early career SLPs working in education sectors. I suspect that any SLP with experience working with teachers or with reasonable experience in working with young people on the autism spectrum may find the content less beneficial due to the restricted depth of the content covered in this book.

Hallowell, B. (2016). *Aphasia and other acquired neurogenic language disorders: A guide for clinical excellence*. San Diego, CA: Plural Publishing; ISBN 978 1 59756 477 9; A$140

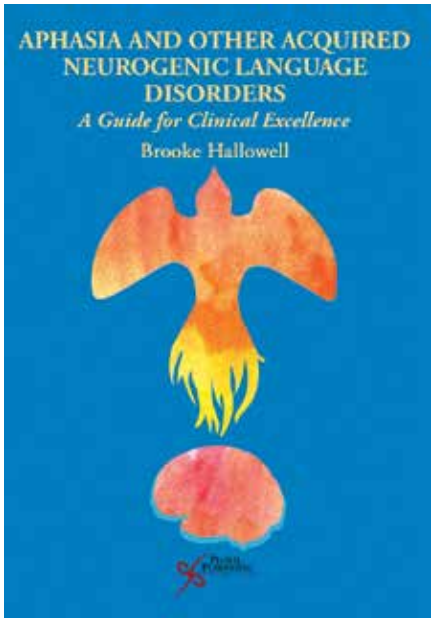
Dr Christopher Plant

There are many textbooks available to the speech-language pathologist on the topic of aphasia and related neurogenic language disorders. In *Aphasia and other acquired neurogenic language disorders: A guide for clinical excellence*, Brooke Hallowell aims to provide a unique perspective which will be of interest to students and practising clinicians alike. Throughout the text, Hallowell draws attention to what it takes to be an exceptional, person-centred clinician when working with such client populations. In working towards this aim, Hallowell succinctly sums up the text's approach by describing it as an evidence-based, how-to clinical guide.

This text contains eight sections and 33 clear, informative, and insightful chapters. Most chapters are also complemented by downloadable student and instructor resources. Each chapter opens with clear learning objectives and concludes with well-considered learning and reflection activities. This text therefore offers significant value for money.

The general structure of the text is fairly standard, moving from foundations and the nature of aphasia and cognitive-communication disorders in conditions such as traumatic brain injury, right hemisphere disorder, and dementia, through to assessment, and then general principles of intervention, followed by specific intervention approaches.

Along the way the topics explored reflect current trends and priority areas such as language in the context of ageing, cultural competence in view of increasing immigration patterns, apps for intervention, and complementary and integrative approaches to intervention.



Even within chapters that explore familiar topics, such as the ICF and its application to aphasia and cognitive-communication, assessment tools and methods, and theories and approaches to intervention, Hallowell offers unique perspectives through combining discussion of current research with insights gained from clinical experience. These insights help the text achieve its aim of promoting the idea of an excellent clinician by providing information that few other textbooks draw explicit attention to. A simple example of this comes early on where Hallowell discusses the sometimes quirky and humorous nature of errors in aphasia and the shared appreciation of these instances between the person with aphasia and speech-language pathologist. Similarly, chapters describing specific intervention approaches for different aspects of language rehabilitation are particularly clear and helpful, in providing a simple step-by-step guide to implementation, along with general principles and an overview of the research evidence.

As with many texts published by Plural, there is perhaps a slight emphasis on research evidence generated within the United States in preference to other parts of the world, although this is not to say that the research cited is not high quality. Some readers may also have only a passing interest when discussion turns to issues around reimbursement, Medicare, and Medicaid, although Hallowell is mindful to acknowledge differences in health care systems across major English-speaking countries such as Australia and the United Kingdom.

Overall, there is a lot to appreciate about this new and ambitious text. Although many other texts may explore the nature, description, assessment, and intervention of aphasia in much finer and rigorous detail, few, if any, texts offer such an effective and engaging balance between current knowledge and clinical insight.

JCPSLP notes to authors

The *Journal of Clinical Practice in Speech-Language Pathology* is the major clinical publication of Speech Pathology Australia. Each issue of *JCPSLP* aims to contain a range of high quality material that appeals to a broad membership base. *JCPSLP* is published three times each year, in March, July, and November.

Issue	Copy deadline (peer review)	Theme*
Number 2, 2017	1 December 2016	Communication and Connection – Valuing Aboriginal and Torres Strait Islander perspectives.
Number 3, 2017	13 April 2017	To be announced. Check website for updates
Number 1, 2018	1 August 2017	To be announced. Check website for updates

* articles on other topics are also welcome

General
Material submitted must be your original work. Any direct quotations or material used from other sources must be credited in full. If copyright clearance is required to use material included in your article, please supply evidence that this has been obtained.

Ethical approval
All manuscripts in which information about a person and/or organisation is presented must be accompanied by evidence of approval by an authorised ethics committee. This includes clinical insights, ethical conversations, manuscripts presenting the results of quality assurance and improvement activities within workplace settings, and research manuscripts.

Themes
Each issue of *JCPSLP* contains a set of articles relating to a particular theme, as well as a selection of articles reflecting broader speech pathology practice. The Editorial Board selects a theme for each journal, and these themes can be suggested by members of Speech Pathology Australia at any time. Manuscripts on any topic relevant to speech pathology practice can be submitted to *JCPSLP* at any time.

Length
Manuscripts must not exceed 3500 words (including tables and a maximum of 30 references). Longer manuscripts may be accepted at the discretion of the editor. It is highly recommended that authors contact the editor prior to submitting longer manuscripts.

Types of Submissions
When submitting your article to *JCPSLP*, please indicate the type of submission:
- Tutorial: Educational/narrative discussion on topics of interest to clinicians. This should include a brief overview of the current literature, as well as a section containing clinical implications.
- Review: Critical appraisal of the research literature in an area of research-practice that is relevant to practising speech pathologists.
- Clinical Insights: Articles that may be of primary clinical interest but may not have a traditional research format. Case studies, descriptions of clinical programs, and innovative clinical services and activities are among the possibilities.
- Research: Research articles with clear clinical relevance. These submissions will be judged on the review of the literature (including a rationale), methodology, statistical analyses, and a clear discussion directed to a clinical readership.

Peer review
Manuscripts submitted to *JCPSLP* undergo a double blind peer-review process. Regular columns (e.g., Webwords, Top 10, resource reviews) undergo editorial review. For peer-reviewed articles, *JCPSLP* uses a double-blind peer-review process, in which the anonymous manuscript is sent to two reviewers. The authors are provided with information from the review process. Often, authors are invited to revise and/or resubmit their work, as indicated by the reviewers. Occasionally, the reviewers request to re-review the revised manuscript. In some instances, a paper will be rejected for publication. The editor's decision is final. The sentence "This article has been peer-reviewed" will appear after the title for all peer-reviewed articles published in *JCPSLP*.

Format and style
All submissions must be Word documents formatted in accordance with the following guidelines:
- All text should be 12 point Times New Roman, double spaced (except figures and tables), left justified.
- A maximum of five levels of heading (preferable 2-3 levels) should be used:
  1. Centered, boldface, uppercase and lowercase heading
  2. Left-aligned, boldface, uppercase and lowercase heading
  3. Indented, boldface, sentence case heading with a period. Begin body text after the period.
  4. Indented, boldface, italicised, sentence case heading with a period. Begin body text after the period.
  5. Indented, italicised, sentence case heading with a period. Begin body text after the period.
- Please use the terms 'speech-language pathology' and 'speech-language pathologist' (abbreviated to SLP) throughout article.
- Do not include images within the text of the article – send photos as separate attachments, digital images should be of high quality and preferably be sent as uncompressed TIF or EPS images.
- Use only one space after punctuation, including full stops.
- Use a comma before 'and' in a series of three or more items (e.g., "The toys included a ball, bucket, and puzzle)
- Clear and concise writing is best. Use short sentences and paragraphs and plain English. Please reduce bias in language as much as possible (i.e., avoid stereotypical terms, refer to participants, rather than subjects, and be sensitive to racial and ethnic identity).
- Reproduce any quotations exactly as they appear in the original and provide the page number(s) for the pages you have quoted from.
- References, which should be key references only, must follow the American Psychological Association (APA, 6th edition) (2009) style. For further details on correct referencing, visit http://owl.english.purdue.edu/owl/resource/560/01/
- Tables and Figures: If there are to be tables or figures within your article, these should be presented on separate pages with a clear indication of where they are to appear in the article (in text indicate where the figure or table should be inserted). All tables and figures should be numbered. Figures should be presented as camera-ready art. Please ensure figures and tables appear at the end of your article with each table or figure on a separate page.

Documents to be submitted
1. Manuscript featuring:
   a. Title
   b. Author names and affiliations (will not be forwarded for peer review)
   c. Up to 6 key words
   d. Abstract (maximum 150 words)
   e. Main body of text (**main body must not include any identifying information**)
   f. Reference list (maximum 30)
   g. Tables (if relevant)
   h. Figures (if relevant)
   i. Appendixes (if relevant)
   j. Acknowledgements if relevant (will not be forwarded for peer review)
2. Author submission form (to be downloaded from *JCPSLP* website)
3. A colour photograph of each author (to be included in manuscript if accepted for publication)

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