Health Professions Council of South Africa

PROFESSIONAL BOARD FOR SPEECH, LANGUAGE AND HEARING PROFESSIONS

GUIDELINES FOR PRACTICE IN A CULTURALLY AND LINGUISTICALLY DIVERSE SOUTH AFRICA

2019

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DEFINITION OF TERMS

Bilingualism –the use of at least two languages.

Contextual relevance: Taking cognisance of various aspects related to the context such as structural, health, education and social systems within the country; consideration of a specific population in a specific setting (Pascoe & Norman, 2011).

Critical consciousness: "Learning to perceive social, political and economic contradictions and to take action against the oppressive elements of reality." (Freire, 1974, p.4); Critical pedagogy is concerned with transforming relations of power, which lead to the oppression of people (Aliakbari & Faraji, 2011).

Culture: People's way of life, "the sum total of norms and values espoused and cherished by a particular people" (Iraki, 2004, p.1), closely tied to identity, with specific cultural practices serving to demonstrate and enhance this identity (Nabudere, 2005).

Cultural awareness: A cognitive construct reflecting the thoughts and knowledge necessary to appreciate cultural differences and similarities, and the impact of cultural contexts on personal meaning and perspective taking (Schim & Doorenbos, 2010).

Cultural competence: "A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals to work effectively in cross-cultural situations." (Cross, et al, 1989); the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races and ethnic backgrounds in a way that recognizes, affirms, and values the worth of the individual and protects and preserves the dignity of each (Govender et al., 2017);

Cultural desire: The desire to practice in a culturally competent manner that motivates a healthcare professional to seek the knowledge, skills and encounters of cultural competency (Isaacs, et al., 2016).

Cultural encounters: Engagement opportunities between groups or individuals who identify themselves as having different cultural characteristics.

Cultural Intelligence: The ability to relate and work effectively in culturally diverse situations.

Cultural humility: A lifelong commitment to self-evaluation and development of mutually-beneficial and non-paternalistic clinical and advocacy partnerships with communities (Tervalon & Murray-Garcia, 1998); an integral part of cultural competence (~ Cultural competence).

Cultural knowledge: Knowledge that is created, maintained and re-created through continuous interaction of people in a community setting; contextually based knowledge derived from the specific historical context in which the actors are immersed (Sleeter, 1991).

Cultural relevance: Responsive service delivery approach grounded in the clinician displaying cultural competence.

Cultural safety: A respectful approach to nationality, culture, age, sex, gender and sexual orientation, political and religious beliefs; involving lifelong learning and continuing competence (Ball & Peltier, 2011; CAOT, 2011); analyses power imbalances, institutional discrimination, colonization and coloniality as they apply to health care (NAHO, 2008).

Cultural sensitivity: Sensitivity to multiple, interactive levels of influence (Coleman & Karraker, 1997, p. 75).

Cultural skill: The ability to sensitively and accurately engage the skills required for meaningful interactions between groups or individuals who identify themselves as having different cultural characteristics while not reducing the interaction to a set of technical skills.

Cultural Training: refers to all modes of training and education aimed at developing cultural competence; may include workshops, seminars, training courses, coaching, mentoring and formal qualifications (Bean, 2008).

deafness: the lowercase 'd' in 'deafness' is a term that refers to an audiological concept relating to hearing difficulties (Murray, Klinger, & McKinnon, 2007)

Deafness: The uppercase 'D' in 'Deaf' culture signifies cultural membership in a community with a shared language and experience (Murray et al., 2007).

Diversity: The full spectrum of human differences in relation to aspects which may include (but are not limited to) mode of communication, languages, ethnicities, culture, religion, abilities, gender, and sexual orientation.

Evidence based practice: The integration of clinical expertise, client values, and best available research evidence into the decision making process for client care (Sackett, 2002).

Language: A system of signs (verbal or otherwise) intended for communication.

Local knowledge: Knowledge that people in a given community have developed over time and tested over many years; dynamic knowledge adapted for the local context and embedded in community practices, institutions, relationships and rituals (FAO, 2004).

Multilingualism: Producing and/or understanding more than one language.

Multiculturalism: The co-existence of diverse cultures, where culture includes racial, religious, or traditional groups and is manifested in customary behaviours, cultural assumptions and values, patterns of thinking, and communicative styles.

1. PURPOSE

This document has two purposes. First it sets out a position statement regarding the training, mentoring, monitoring and consultation role of the speech-language therapy and audiology professions, and their response to the culturally and linguistically diverse population of South Africa. Second it aims to provide guidelines to support South African speech-language therapists and audiologists in providing a just, ethical, effective and relevant service. Five key aspirational principles are presented with practical guidelines and a set of resources to assist speech-language therapists and audiologists in following the principles.

2. POLICY FRAMEWORK

Speech-language therapists and audiologists working in South Africa practice within a particular legislative framework. The following policy and guideline documents have informed this guideline: Universal Declaration of Human Rights (United Nations, 1948), the Constitution of the Republic of South Africa (1996), National Language Policy Framework and the Use of Official Languages Act (2012) (Department of Arts & Culture, 2003), White Paper on the Rights of Persons with Disabilities (2016), the Health Professions Council of South Africa's (HPCSA) scope of practice document (1988) and Code of Ethics (2007). This guideline should be read in conjunction with this well-established framework (~Appendix A).

3. POSITION STATEMENT

The population of South Africa is richly diverse in language and culture. Speech-language therapists and audiologists strive to enhance communication in families and communities in a variety of settings while actively redressing the inequalities of the past and the resulting lack of services to many communities. The professions have a duty to ensure that their practice is

consistently responsive to the cultural and linguistic backgrounds of their clients, and in so doing maximize professional effectiveness in combination with evidence-based practice. It is the position of the HPCSA's Professional Board for Speech, Language and Hearing Professions that all users of speech-language therapy and audiology services have the right to receive linguistically and culturally appropriate services. The scopes of the professions require provision of services to "persons of all age groups, their families, and groups from diverse linguistic and cultural backgrounds" (Department of Health, 2011). All clinical interactions should be conducted in a language or mode of communication that the client can understand or has proficiency in. In instances where interaction is constrained by a language barrier, a formal and structured process must be put in place to overcome this (refer to Appendix B).

The professions play a key role in promoting the understanding of linguistic diversity and its value to society, by breaking down cultural barriers and stereotypes, challenging long-held assumptions and the dominant knowledge base and embracing diversity in all areas, such as culture, religion, sexual orientation, and disability. Academic training programmes should offer students and staff opportunities to reflect on their own developing linguistic and cultural critical consciousness as it relates to their clinical service provision, ultimately ensuring that they are equipped to provide relevant services to the population of South Africa. The professions have an imperative to draw on and document local knowledge as it pertains to their work and to advance research that can expand the evidence base and support the ethical and inclusive practice of speech language therapists in South Africa.

4. BACKGROUND

Developed with a strong awareness of past injustices, South Africa's progressive constitution emphasises a full spectrum of human rights. While the constitution celebrates many languages and cultures, speech-language therapists and audiologists may face challenges in translating these values into practice with a diverse clientele. Despite existing policy frameworks (~ Section

3 and Appendix A), they may experience day-to-day challenges in their practice not knowing how to work with clients with whom they do not share a common language and/or cultural frame of reference. Human rights are an essential underpinning of these guidelines and service provision in speech-language therapy and audiology would benefit from adopting a stance which recognises peoples' human rights in the setting and context in which the services are offered (McPherson, 2008).

South Africa's eleven official languages are isiZulu, isiXhosa, Sepedi, Setswana, Sesotho, Xitsonga, siSwati, Tshivenda, isiNdebele, English and Afrikaans. In March 2019, the Commission for Culture, Religion and Language celebrated the intention to amend the constitution to include South African Sign Language as a twelfth official language. The constitution specifies "all official languages must enjoy parity of esteem and must be treated equitably." Also, in recognition of the country's history in which indigenous languages did not enjoy the same status as English and Afrikaans, it specifies that the state must take "practical and positive measures to elevate and advance the use of these languages."

In addition to the official languages, many other languages are spoken. The South African constitution makes provision for mechanisms that will facilitate the development, use and respect of other languages that are used by communities in the country that are currently not afforded an official language status. Multilingualism is common and there is wide regional variation in the languages spoken with particular languages associated with specific geographic regions of the country. Each language has different varieties adding to further richness and complexity. Appendix C gives details of resources providing information about the different languages, regional variations and distribution, and changing dynamics of languages in South Africa. Although the country is not unique in terms of its linguistic diversity, in many countries the local indigenous languages are minority languages, often endangered. In South Africa, the majority languages are indigenous languages, but many are limited in terms of resources and English is typically described as the *lingua*

franca, although this is contested by some authors (Van der Walt & Evans, 2017).

Understanding and accepting the Deaf community as a linguistic and socio-cultural minority is also important for audiologists and speech-language therapists (Barnett, 2002). People who are deaf or hard of hearing are known to have altered health care use patterns and significant communication difficulties with health care professionals, often resulting in misunderstandings about their medical conditions or treatment recommendations (Meador & Zazove, 2005). The visual nature of sign language presents some unique challenges to speech and language therapists and audiologists which are specifically focused on in particular sections of this document.

South Africa's troubled history of institutionalised inequality and injustices brings with it a complex set of shifting power relations, and social and economic challenges. Our resource-constrained environment is a dynamic one, rich in opportunity but characterized by a quadruple burden of disease: the HIV/AIDS epidemic together with a high burden of tuberculosis; high maternal and child mortality; high levels of violence and injuries; and a growing burden of non-communicable diseases (Swanepoel, 2006). Against this backdrop speech-language therapists and audiologists have an important role to play, but are often outfaced by the challenges of the environment. This document sets out guiding principles for the professions to enable more effective practice with culturally and linguistically diverse populations. Research has shown that culturally appropriate services lead to greater servicer-user trust and better quality of care (LaVeist et al., 2008; Weech-Maldonado et al., 2012).

5. PRINCIPLES

We outline five main principles for speech-language therapists and audiologists working in culturally and linguistically diverse South Africa. The first principle emphasises contextual relevance as an overarching philosophy for more relevant practice that will lead to more effective management of

communication difficulties; Principle 2 focuses more specifically on assessment and intervention; Principle 3 is about the importance of local knowledge and calls for a shift in how the profession values it; Principle 4 focuses on clinical training, while Principle 5 has the lifelong development of critical consciousness as its focus. The five principles are summarised in figure 1 and discussed in further detail in the sections that follow together with guidelines that may be useful for following the principles.

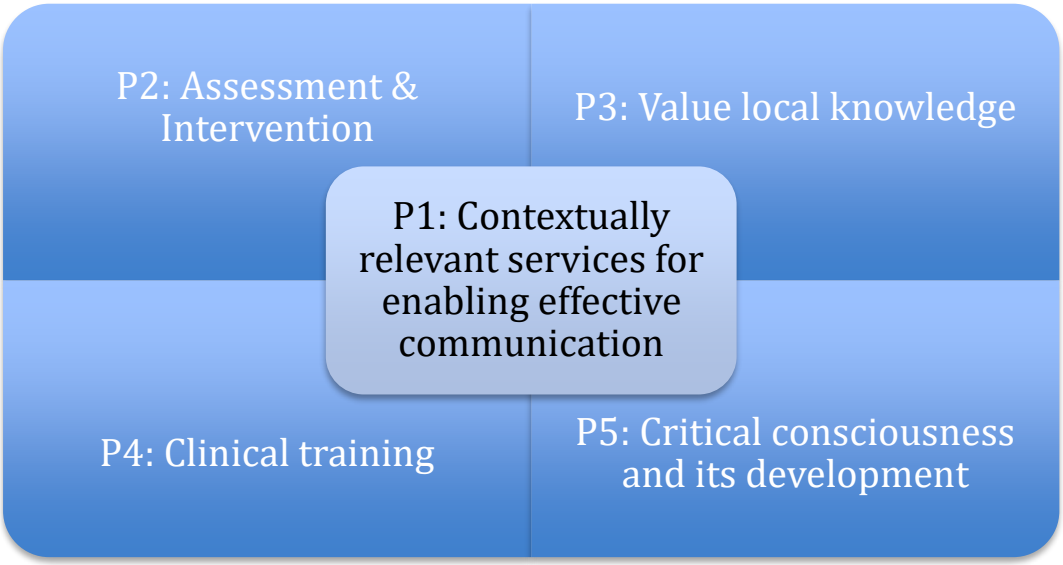

Figure 1: Summary of five key principles for speech-language therapists and audiologists working in culturally and linguistically diverse South Africa.

PRINCIPLE 1: Provision of services within the professions' scope of practice is contextually relevant

This guideline focuses on the general remit of speech-language therapists and audiologists to provide services that enable effective communication of their clients together with their families and communities. Contextual relevance means that they must provide this service in a way that takes specific linguistic, cultural and other personal and environmental factors into account. Speech-language therapists and audiologists must provide services that are responsive and attuned to their clients.

How can the professions achieve Principle 1? Recommendations include:

- Offer quality services irrespective of languages shared or cultural differences.
- Foster and promote an approach that is inclusive of all the people of South Africa,
- Celebrate and support diversity rather than seeing it as a problem. Cultural and linguistic diversity is important for a flourishing society (UNESCO, 2001).
- Build capacity around concepts of cultural and linguistic diversity, continually questioning your own practice and that of others, seeking to empower clients and colleagues and consulting with relevant stakeholders as needed.
- Use a theoretical framework to guide yourself and students (where applicable) in making sense of multiple factors that make individuals unique, e.g. the International Classification of Functioning, Disability and Health (ICF, World Health Organisation, 2007) or six principles of culturally competent practice (Verdon, McLeod, & Wong, 2015).
- Follow a graded approach in your practice (and with students where applicable) to develop cultural humility, moving from cultural awareness to application of cultural knowledge and skills in clinical encounters.
- Promote understanding of diversity and its value to society in all engagements, consistently striving to break down cultural barriers and stereotypes, and redress historical inequalities and social injustices. Perceived wisdom of the profession should be challenged where it is not pertinent for our context or where no evidence-base exists.
- Advocate for equity, access and relevance in all professional interactions. Speech-language therapy and audiology services should be accessible and relevant to all people of South Africa.

PRINCIPLE 2: Assessment and intervention take into account the influence/impact of culture and linguistic diversity

This guideline focuses on the specific activities of assessment and intervention and how these practices can be made more relevant and effective by taking life experiences and exposure such as cultural and linguistic factors of clients, families and communities into account. The goal of linguistically and culturally appropriate assessment and intervention is to afford fair and unbiased opportunities for people from all language and cultural groups who seek speech-language therapy and audiology services, to maintain and/or develop communicative competence in keeping with their full potential and the requirements of their particular life settings.

How can the professions achieve Principle 2? Recommendations include:

- Provide services that take into account the values and wishes of clients and families when deciding which language/s intervention and assessment should take place in.
- Acknowledge the importance of home language in all interactions and ensure all clients receive intervention (assessment, counselling, and therapy) in their home language or the language of their choice. Clients may feel more comfortable and empowered when using their first language. Health and social outcomes are better when individuals receive care in their home language, and when culture is taken into account people perceive health and social interventions as more meaningful and effective (Wafula & Snipes, 2014; Forehand & Kotchick, 2016).
- Guide families in making decisions about language choice by presenting available options in a non-biased manner that reflects a current understanding of best practice guidelines and available research evidence.
- Assess clients in all of their languages to arrive at a holistic understanding of their communication skills and difficulties;

Assessment reports should explicitly indicate the languages spoken by a client and provide background about their use and exposure so that readers are able to interpret assessment findings appropriately.

- Incorporate all a client's languages in intervention as appropriate, for example through the use of 'scaffolding' strategies (Gorman, 2015) and code switching (Pacheco et al., 2017; Ndebele, 2012; Yow et al., 2017).
- Adopt an asset-based approach when working with multilingual clients which may include appropriate use of professional interpreters and/or caregivers or family members (Eloff & Ebersöhn, 2001; Langdon & Quintinar-Sarellana, 2003). Where caregivers are assisting they need to be aware of the purpose of the assessment and properly briefed in accordance with best practice guidelines for use of interpreters (Langdon & Saenz, 2015).
- South African sign language, a visual language, is very different to all the other languages that are spoken. Limitations in the use of interpreters with this language are well documented, and children of deaf adults cannot be expected to undertake that role fully. This type of interpreting requires considerable training and expertise.
- The use of interpreters, whether for sign language or other languages, can inherently limit effective interaction. In South Africa the formal training and regulation of the various kinds of interpreters is not well developed. Speech-language therapists and audiologists should be aware of these limitations and ways to deal with it (Appendix B).
- Mediators, offering language and cultural mediation, should be considered for use by speech-language therapists and audiologists. Best practice guidelines on how to mediate cultural/linguistic barriers during a clinical encounter are summarised in Appendix B based on American Speech Language Hearing Association Guidelines, but formalisation of the language and culture mediators' role is needed in South Africa (de Andrade, 2015).

- Use assessments and therapy resources appropriate for the client in question. A client's performance on a standardized measure can only be compared to normative data if the client comes from the population for which the assessment was developed. Where standardised measures are used, careful consideration of experiential background and linguistic and cultural diversity must occur. Dynamic and criterion referenced assessments may be more appropriate in this context (Gorman, 2015; Carter et al., 2005).
- Assessment tools should not be translated from one language to another without careful consideration of the impact of cultural and linguistic diversity (content, form and use) and the purpose of assessment (Bornman et al., 2010). Appendix D lists further resources for teaching and learning about cultural and linguistic diversity. Appendix E references readings regarding contextually relevant assessment and intervention.
- Select appropriate models of assessment and service delivery which ensure a cultural fit and are in accordance with the beliefs and practices of the client.

PRINCIPLE 3: Training, clinical practice and research reflect and value local knowledge

This guideline is about the importance of valuing diversity, our own languages and cultures, and suggests ways in which we can encourage the exploration, documentation and researching of our own local situation to support contextually relevant practice.

How can the professions achieve Principle 3? Recommendations include:

- Acknowledge and take steps to address the urgent need for research into speech and language development and difficulties in the local context. This information is needed for both applied and theoretical reasons.

- Develop understanding of the meaning of communication difficulties for individuals, families and communities from multiple perspectives and backgrounds (Dikeman & Riquelme, 2002); as well as obtain basic information about clinical need, prevalence and availability of services which is needed for planning of locally relevant services (Swanepoel, 2006).
- Use findings from locally relevant research (~Appendix C) to inform curricula; acknowledge and interrogate colonial influence in all its forms (power, being and knowledge); and move towards a repositioning of the professions to better serve all South Africans.
- Encourage students and speech-language therapists/audiologists to undertake relevant research that focuses on cultural and linguistic diversity. These efforts should be valued by training institutions, professional bodies and employers who may offer support through funding, dedicated research time or opportunities to disseminate findings.
- Adopt an advocacy role in promoting, celebrating and sharing findings from local research. Following a graded approach may be helpful, for example moving from informal small group discussions of language, culture and local practice towards more formal projects. Local research should be presented on both local and international stages since we have contributions to make in both arenas.

PRINCIPLE 4: The cultural competence and humility of clinical educators and their own critical consciousness of linguistic and cultural diversity is key to development of future clinicians

This guideline focuses on the important role of clinical educators who have a key role to play in shaping the future professional practice of speech-language therapists and audiologists, and are well placed to serve as powerful, culturally competent role models.

How can the professions achieve Principle 4? Recommendations include:

- Develop your own critical consciousness and cultural humility, which can in turn facilitate the development of others.
- Keep abreast of recent developments in the field and model a critical approach to both assessment and intervention of diverse populations.
- Encourage students to view every interaction as a cultural experience and foster a safe climate for the development of cultural humility and increased critical consciousness of issues of diversity;
- Discourage a restricted compartmentalised approach to diversity and illustrate how it penetrates through all aspects of communication.
- Engage in reflective activities and encourage similar opportunities for students. Appendix F lists resources that may be helpful for personal development.
- Facilitate equity and access to speech-language therapy and audiology services resulting in a diverse caseload and encouraging a positive and asset-based approach at each clinical encounter.
- Encourage students to engage with their client's frame of reference rather than to remain in their own 'safe' world; assist students to use discourse narrative to challenge stereotypes and promote the 'risk' of the multi perspective identity embedded in critical discourse (Westby et al., 2003; Mkhize et al., 2014).

PRINCIPLE 5: Development of cultural humility and a critical consciousness regarding culture and language is vital for speech-language therapy and audiology curricula and as a lifelong development process for all professionals

This guideline focuses on the lifelong project of developing cultural competence and humility, and makes suggestions for undertaking this journey. The guideline acknowledges that the development of cultural humility is an ongoing process for both novice and experienced clinicians alike.

How can the professions achieve Principle 5? Recommendations include:

- Design, critique and implement curricula which demonstrate a tangible commitment to a journey towards cultural humility and developing critical consciousness of diversity; curricula should incorporate a comprehensive and integrated education model that will allow opportunities for clinical exposure in culturally and linguistically diverse environments and a supported approach to managing such encounters effectively;
- Critical examination of one's own cultural backgrounds and positionality (Anderson, 1992) or "knowing oneself" is an effective process to facilitate understanding and appreciation of cultural diversity. Such a process makes service providers better able to identify their own biases and assumptions, which in turns makes it less likely that they will impose their values and beliefs on to whom they are tasked to serve (Sakamoto & Pitner, 2005).
- Develop a critical approach to their consciousness of cultural and linguistic diversity so that they can integrate theory learned in formal settings into complex clinical practice; Reflective practice can bridge this gap.
- Use reflective practice activities to learn from their own experiences and those of others; A reflective journal focusing on the development of cultural humility would be helpful for all practitioners and may be included as part of the CPD portfolio required by the HPCSA for registration.
- Research and document the development of cultural humility and critical consciousness towards cultural and linguistic diversity in a range of settings
- Drive and support recruitment of a diverse pool of speech-language therapists and audiologists into the profession so that there is equitable representation of people from all language and cultural groups in

training programmes for the professions who represent the South Africa demographic.

6. Embedding the five principles in speech-language therapy and audiology curricula

Penn (2002, p. 96) noted: "In training clinicians, what is more important is to invite an attitude which will generalise to various intercultural situations, rather than be advised about the specifics". It is not possible to describe every situation in which clinicians will find themselves needing to draw on the five principles outlined in this document. A move away from technical competence towards contextual sensitivity suggests an improved congruence in our interactions with clients, families, and communities. To assist training institutions with the embedding of these five principles in their curricula we offer the following learning objectives, each one linked directly to the five principles, and summarized in Table 1. These objectives should not be limited to a particular course or year of study but should be embedded in every course. To assist with embedding the learning outcomes into courses and curricula, we devised (~Appendix G), a template for use by the universities.

Table 1: Learning outcomes based on the five principles for practice in culturally and linguistically diverse South Africa

Learning outcome	**Comments**
1. Adopt a questioning approach to the professions and what is taught in the training programmes.	Attitudinal change is key in developing a generation of contextually-relevant practitioners. This learning outcome requires students to question the status quo, asking: What knowledge? Whose knowledge? What/who gets privileged? Whose interests dominate? (UCT Curriculum Change Framework, 2018).

2. Basic proficiency in at least two additional local languages.	Since language cannot be divorced from culture, students should learn about language and culture together; Acquiring basic proficiency in languages will not mean that practitioners can serve all their clients in their first language, but it may encourage students to start a life-long journey of language learning and give them the confidence to communicate more effectively with their clients. Learning of another official South African language (other than home language, English [in institutions where medium of instruction is English] & South African Sign Language) and key aspects of the culture that goes with should be mandatory in all training programmes. The choice of language to be learned should be determined by the region/province of the country where the programme is based.
3. Independently access, read and participate in local research.	The professions need to grow a new generation of researchers who undertake contextually relevant research. This learning outcome is about students becoming empowered and comfortable with accessing and critiquing relevant local research, ultimately participating in the generation of new knowledge through this process.
4. Collaborates effectively with interpreters, translators and/or mediators.	Interpreters, translators and mediators have a vital role to play in clinical interactions. On graduating, students need to know when and how to collaborate effectively with this support. The best practice guidelines from ASHA are summarized in Appendix B and this information should be incorporated into South African curricula. Students need to be introduced to nuances of working through interpreters including to whom the interactions are directed, confidentiality in the presence of a third party, accuracy of translation, literal

	and metaphorical interpretations, contextual variation of interpretation and of language and criteria for selection of interpreters by clinicians.
5. Embarks on lifelong journey to develop critical consciousness.	This outcome is achieved when students start to engage with their client's frame of reference rather than remaining in their own 'safe' world; Development of critical consciousness involves a reflective awareness of the differences in power and privileges and the inequities that are embedded in social relationships and the fostering of a reorientation of perspective towards a commitment to social justice. A prerequisite for critical consciousness is critical self-reflection, i.e. not simply focusing on self, but "stepping back to understand one's own assumptions, biases, and values and shifting of one's gaze from self to others and conditions of injustice in the world" around them (Kumagi & Lypson, 2009). Students move in a graded way from cultural awareness to cultural humility towards cultural consciousness; a similar journey could be followed by clinicians who could record their reflections and experiences in the form of a reflective CPD log.

7. CONCLUSION

South Africa is one of the most diverse societies in the world. Linguistic and cultural diversity are some of the celebrated features of South African society and are considered one of its valuable assets. Recognizing the centrality of language and culture as essential building blocks of identity, individual rights and affirmation of human dignity, South African lawmakers have ensured that there is a clear legislative framework that upholds and affirms the multilingual and multicultural nature of South African society. However, despite the country having some of the most progressive laws that affirm diversity, the

majority of users of speech-language therapy and audiology services continue to face challenges when it comes to receiving linguistically and culturally appropriate services.

The main challenge stems from misalignment between the linguistic and cultural values of the service providers and those of the service users as well as the slow pace of transformation of services to rectify this misalignment. This position statement and guideline for speech-language therapists and audiologists seeks to respond to this urgent need. It is the position of the board that no one should be denied (or rendered services of inadequate quality) primarily because they do not speak the language of the clinician or they come from a cultural background that is different from that of the clinician. Providing linguistic and culturally appropriate services requires an investment in multicultural education by training institutions to prepare clinicians who are ready to practice cross culturally. It also requires a paradigm shift from clinicians to embrace the notion of justice: treating all clients in an equitable way that is appropriate for the context, their language and culture, and demonstrating openness to form true partnership with clients and interpreters/translators and mediators as needed. All clinicians need to engage in a process of critical self-reflection and be open to learn and understand *who* their clients are rather than *what* they are.

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APPENDIX A: POLICY DOCUMENTS AND OTHER RELEVANT GUIDELINES

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Department of Social Development White Paper on the Rights of Persons with Disabilities (2016) http://www.governmentpublications.lib.uct.ac.za/news/white-paper-rights-persons-disabilities

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APPENDIX B: GUIDELINES FOR WORKING WITH INTERPRETERS

This appendix is a summary of the ASHA guidelines for collaborating with interpreters. Please refer to the full document here: https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935334&section=Key_Issues

Interpreter: a person trained to convey spoken or signed communications from one language to another. Interpretation services may be provided in person; by phone or using videoconferencing services.

Translator: a person trained to translate written text from one language to another.

Cultural broker or mediator: a person knowledgeable about the client's/patient's culture and/or speech-language community. The broker passes cultural/community-related information between the client and the clinician in order to optimize services.

The formal training and inclusion of context mediators who serve as, amongst others, interpreters, has the possible benefit of providing real meaning in the interactions between audiologists and clients because "interpreting between languages involves more than a literal transposition of one language into another but rather an assimilation of the language, context, and meaning" (de Andrade, 2015, p. 400). Within specific interactions the mediator with the knowledge of client's context, including language and culture, "processes the vocabulary and grammatical structure of the words while considering the individual situation and the overall cultural context of the source language" and "then conceptualises the meaning and, using vocabulary and grammatical structure appropriate for the target language, reconstructs the meaning of the statement in a new cultural context" (Esposito, 2001, p. 570) (see figure 2).

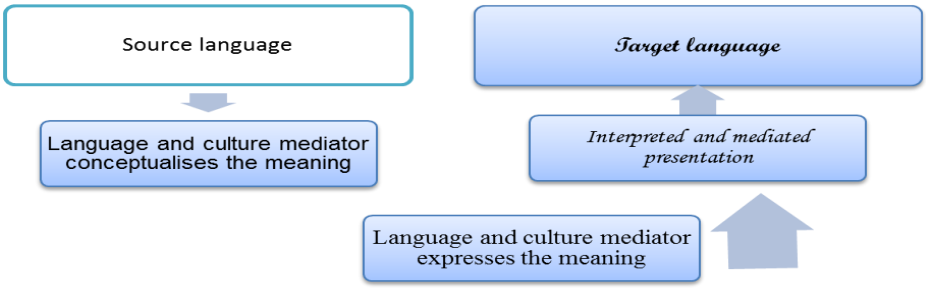

Figure 2: Mediation of language and culture in the interpretation of the source language into the target language (adapted from de Andrade, 2015; Esposito, 2001).

Roles and responsibilities

Clinicians are responsible for considering the goals of the session, discussing the client's/family's needs, evaluating the benefits of service in all language(s) necessary to facilitate the sessions goals, and determining the optimal interpreter to assist in the provision of services (Langdon & Saenz, 2016). Other roles and responsibilities of audiologists and SLPs when collaborating with interpreters include: identifying the appropriate language(s) of service for clients/patients/families, including identifying the preferred language for meetings, services, and written documentation; advocating for access to an interpreter, transliterator, or translator; making advance arrangements to ensure appropriate physical accommodations necessary for successful collaboration; seeking an interpreter who has appropriate knowledge and skills. It may be difficult for a clinician unfamiliar with the language to judge the quality of interpreting, transliteration, or translation services. Clinicians must do their best to ensure that services provided are reliable and must make every effort to become familiar with their clients' languages (e.g., language structures, phonemic inventory, how translation/interpretation may impact the message, etc.).

Individuals who serve as interpreters, transliterators, or translators include

- professionals with specific training in this area;
- bilingual assistants;

- bilingual professional staff from a health or education discipline other than communication disorders; and
- bilingual staff available within the facility but outside of health or education disciplines.

Bilingual assistants and professional staff must consider their linguistic proficiency in both languages being used, including their proficiency in the local dialect of the language(s) used by the client and family and their own knowledge and skills for interpreting. In some instances, there may be reasons why a family member or friend serves as an interpreter — either due to client preference or because all other efforts to locate an appropriate interpreter, have been exhausted. In addition, a facility may be unable to locate an individual who is able to meet the individual linguistic needs of the client. For example, family members may be the only source of information regarding speech patterns prior to a brain injury in a multilingual individual.

Family or friends acting as interpreters may present potential conflicts. The reliability of the interpretation may be compromised given the potential conflict of interest and likely limited training of the family member or friend. It is important to be mindful of risks in high-stakes situations, such as mediation, evaluations, or situations where cognitive capacity might be in question. Children may not possess the emotional maturity and sensitivity necessary to serve in the role to assist family members in the provision of services.

When using family members or friends in this role, the clinician should consider the following factors:

- Intent of the message (e.g., sharing a diagnosis of a cognitive-communication deficit, which may be met with resistance or a strong emotional response vs. providing safe swallowing techniques).
- Age of the family member providing interpretation, the position and role of that individual within the family structure, and his or her overall linguistic ability.

- The qualification of interpreters to provide services, be it in a school or a health care setting.

ASHA guidelines include specific suggestions for working with interpreters before, during and after the session. Funding for interpreters may come from a variety of sources, as clients are not expected to pay out of pocket for these services to ensure access to care.

Collaboration with an interpreter, and any observations regarding the impact of this on assessment and intervention should be documented in reports. Use of translated materials should also be indicated. This documentation provides an accurate record of clinical interaction and a legal record of the services provided.

APPENDIX C: INFORMATION ABOUT THE LANGUAGES OF SOUTH AFRICA

Demuth, K. (2007). Sesotho speech acquisition. Chapter in S. McLeod (Ed). *The international guide to speech acquisition*. Clifton Park, NY: Thomson Delmar Learning, pp. 528–538.

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Kunene Nicolas, R., & S. Ahmed. (2016). Lexical development of noun and predicate comprehension and production in isiZulu. *South African Journal of Communication Disorders* 63: 1–10.

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Mesthrie, R. (2017). Class, gender, and substrate erasure in sociolinguistic change: A sociophonetic study of schwa in deracializing South African English. *Language* 93: 314–346.

Naidoo, Y., A. Van der Merwe, E. Groenewald, & E. Naude. (2005). Development of speech sounds and syllable structure of words in Zulu-speaking children. *Southern African Linguistics and Applied Language Studies* 23: 59–70. http://dx.doi.org/10.2989/16073610509486374

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University of the Witwatersrand. Resources for Deaf and Hard of Hearing Persons: Sign Language

https://libguides.wits.ac.za/deaf_and_hardofhearing/signlanguage

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Van Rooy, B. (2008). Black South African English: Phonology. Chapter in R. Mesthrie (Ed). *A Handbook of varieties of English* (pp.177–187). Berlin: Mouton de Gruyter.

Appendix D: General resources for teaching and learning about cultural diversity

Adichie, C.N. (2009). The danger of a single story. https://www.youtube.com/watch?v=D9Ihs241zeg

Durrheim, K., Mtose, X., & Brown, L. (2011). *Race trouble: Race, identity and inequality in post-apartheid South Africa*. Scottsville: University of KwaZulu-Natal Press.

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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. doi: 10.1558/jircd.v5i1.1

Legg, C., & Penn, C. (2013). A stroke of misfortune: Cultural interpretations of aphasia in South Africa. *Aphasiology* 27: 126–144.

Mashiyi, N. (2014). Tertiary educators' reflections on language practices that enhance student learning and promote multilingualism. Chapter in L. Hibbert & C. Van der Walt (eds), *Multilingual universities in South Africa: Reflecting society in higher education. United Kingdom, Multilingual Matters*, pp.145–163.

May, S. (2011). Language rights: The "Cinderella" human right. *Journal of Human Rights*, *10*, 265–289.

Penn, C. (2014). Asking new questions and seeking new answers: The reality of aphasia practice in South Africa. *Topics in Language Disorders* 34: 168–181.

Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: A literature review. *Journal of Transcultural Nursing*, 26(3) 308–321. DOI: 10.1177/1043659614524790

Verdon, S., Wong, S. and McLeod, S. (2015a). Shared knowledge and mutual respect: Enhancing culturally competent practice through collaboration with families and communities. *Child Language Teaching and Therapy*. doi: 10.1177/0265659015620254

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APPENDIX E: GUIDELINES FOR ASSESSMENT AND THERAPY

Bornman, J., Sevcik, R. Romski, M. & Pae, H. (2010). Successfully translating language and culture when adapting assessment measures. *Journal of Policy and Practice in Intellectual Disabilities 7*: 111–118.

Dockrell, J. E., & Marshall, C. (2015). Measurement issues: Assessing language skills in young children. *Child and Adolescent Mental Health* 20: 116–125.

Friberg, J. C. (2010). Considerations for test selection: How do validity and reliability impact diagnostic decisions? *Child Language Teaching and Therapy* 26: 77–92.

Hartley, S., Murira, G., Mwangoma, M., Carter, J. & Newton, C. (2009). Using community/researcher partnerships to develop a culturally relevant intervention for children with communication disabilities in Kenya. *Disability and Rehabilitation* 31: 490–499.

McLeod, S., Verdon, S. and International Expert Panel on Multilingual Children's Speech (2017). 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*, 26: 691–708.

Mdlalo, T., P. Flack, P., and Joubert, R. (2016). Are South African Speech-Language Therapists adequately equipped to assess English Additional Language (EAL) speakers who are from an indigenous linguistic and cultural background? A profile and exploration of the current situation. *South African Journal of Communication Disorders* 63: 1–5.

APPENDIX F: PERSONAL DEVELOPMENT TOWARDS CULTURAL-COMPETENCE

American Speech Language and Hearing Association (ASHA). https://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Personal-Reflection.pdf

Balcazar, F. E., Suarez-Balcazar, Y., Taylor-Ritzler, T., & Keys, C. B. (2010). *Race, culture and disability: Rehabilitation science and practice*. Jones & Bartlett Publishers.

Bancroft, M. Listing of Cultural Competence Assessment Tools. mighealth.net/eu/images/0/0b/Banc.doc

Lubinski, R., & Matteliano, M. A. A Guide to Cultural Competence in the Curriculum.cirrie-sphhp.webapps.buffalo.edu/culture/curriculum/guides/speech.pdf

Rasmussen, T. (2006). *Diversity mosaic participant workbook: Developing cultural competence*. John Wiley & Sons.

APPENDIX G: TEMPLATE TO ASSIST IN COURSE-WIDE EMBEDDING OF LEARNING OUTCOMES

Course name:		
1. Adopt a questioning approach to the professions and what is taught in the training programmes.	*Teaching and learning activities:* *Knowledge; skills and attitude:* *Content:* *Assessment:*	Comments:
2. Basic proficiency in at least two additional local languages.	*Teaching and learning activities:* *Knowledge; skills and attitude:* *Content:* *Assessment:*	Comments:
3. Independently access, read and participate in local research.	*Teaching and learning activities:* *Knowledge; skills and attitude:* *Content:* *Assessment:*	Comments:
4. Collaborates effectively with interpreters,	*Teaching and learning activities:*	Comments:

translators and/or mediators.	*Knowledge; skills and attitude:* *Content:* *Assessment:*	
5. Embarks on lifelong journey to develop critical consciousness.	*Teaching and learning activities:* *Knowledge; skills and attitude:* *Content:* *Assessment:*	Comments:

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