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Services for people with Communication Disabilities in Uganda: supporting a new Speech and Language Therapy profession

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Services for people with communication disability (PWCD), including speech and language therapists (SLTs), are scarce in countries of the global South. A SLT degree programme was established at Makerere University, Uganda, in 2008. In 2011, an innovative project was set up to provide in-service training and mentoring for graduates and staff of the programme. This paper describes the project and its evaluation over three years. Three types of input: direct training, face-to-face individual and group meetings, and remote mentoring, were provided to 26 participants and evaluated using written and verbal methods. The first two types of input were evaluated mainly positively, while remote mentoring received more mixed evaluations. Less positive evaluations were linked to factors including resourcing, cultural perceptions about professional roles and services, work patterns, power/status, engagement, perceptions of help-seeking, community recognition of the needs for services for PWCD. Findings suggest that participatory approaches, flexibility, reflexivity and open discussion with participants around support and work challenges, are important. Power gradients between white Northern 'experts' and relatively inexperienced East African SLTs, contributed to some challenges. Structural issues about degree programme structures and statutory bodies, provide lessons about the development of new services and professions in low-income settings.

Keywords: Communication Disability; Speech and Language Therapy; Mentoring; East Africa, Professional Development.

Introduction

People with communication disability (PWCD) is a term suggested by Hartley and Wirz (2002) who reported that it is easily understood by non-specialists in health, education and community development. Barrett and Marshall (2017:7) illustrate how 'a person with communication disability may have difficulties using and / or understanding spoken and/or signed language, which can affect their ability to communicate their thoughts, needs and feelings to others.' Communication disabilities are often poorly recognised and understood,

frequently invisible and vary in the underlying health condition, impairment and impact on a person's activities and participation (WHO, 2001). Communication disabilities are often inaccurately or incompletely represented in disability statistics (WHO and World Bank, 2011), although there are estimates from several countries, including Uganda, indicating that as many as half of all children with disabilities may have a communication disability (Hartley, 1998). Communication disabilities can have educational, economic, health and social consequences for individuals, their families and for society as a whole (Snowling et al., 2006).

There is global shortage of all types of specialist rehabilitation professionals, particularly in the global South (WHO and World Bank, 2011). In the global North, services for people with communication disabilities and their families/carers have historically been led by speech and language therapists/pathologists (SLTs) (RCSLT, n.d.), typically provided in healthcare, education or community rehabilitation settings. Interventions rely predominantly on an English language evidence base and on research carried out in the global North, with a resulting bias towards global north cultural and linguistic practices (RCSLT, 2011).

There has been limited debate about a broader range of non-professionalised ways to support PWCD and their families, particularly in the global South, in the absence of the sufficient SLTs (Hartley at al., 2009; Marshall et al., 2017). Wickenden (2013) discusses the usefulness of social models of disability (Shakespeare, 2014), the biopsychosocial of the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) model and Human Rights models (UN, 2007), and considers that a combination of these with services provided through Community Based Rehabilitation (CBR) (WHO, 2010), would best support the enabling and empowerment of PWCD alongside changes in societal attitudes. These approaches shift the focus towards acceptance, equity and recognition of disabled people, although arguably there is still a need for a specialised cadre of workers providing specific impairment-focussed advice and support.

In the global South, the profession of SLT is little understood and there is an acute lack of formal services for PWCD (Olusanya, 2006; Wylie et al., 2013, 2016), although this is changing slowly. Developments have been described, including in Uganda (Robinson et al., 2003; Barrett and Marshall, 2013). New services and training programmes are often supported by SLTs and others usually from global North countries, and vary in how closely they replicate those in the global North or are designed to suit the local context.

Where new SLT programmes have been established in the global South, little has been written about supporting graduates and teachers of this new profession. The World Report on Disability highlights the need for continuing education and professional support as an important way to incentivise and retain personnel (WHO and World Bank, 2011).

The Ugandan context

Until 2011, the situation in Uganda, in relation to services and support for PWCD, was typical of many countries in sub-Saharan Africa. There had been a minimal SLT presence in Uganda since 1986 provided by expatriate volunteers, but no Ugandan SLTs (Afako, 2012). These volunteers were mainly based at the National Teaching Hospital, providing a limited direct clinical service and training small numbers of assistants, CBR workers and teachers. This situation was recognised by some Ugandan paediatricians and Ear, Nose and Throat (ENT) doctors and service users as being unsustainable and insufficient to provide accessible services to the vast majority of the population who live in rural/ remote areas.

In 2008, after an extensive planning and a multi-agency consultation (Robinson et al., 2003), a Diploma in Speech and Language Therapy (later up-graded to a Bachelor's Degree), began at Makerere University. It was the first programme in East Africa and one of very few in sub-Saharan Africa, outside of South Africa. Students were taught by Makerere staff and expatriate volunteer SLTs who managed and delivered the programme. One challenge for the expatriate SLTs was their lack of knowledge of local languages, conceptions of disability and existing health/education structures. Furthermore, the path of transition from an expatriate programme to a Ugandan-led programme and profession appropriate to the local context and integrated with other services, was unclear.

A growing concern that graduates would experience uncertain employment situations and be expected to establish new services, led staff and the first author to design a programme of support and training for the first two cohorts of graduates and staff. Funding was secured from the Nuffield Foundation Africa programme. The overall aims of this project were to support the graduates of the Makerere University SLT programme and other practitioners in East Africa, to become competent and independent SLTs, able to lead the development of services for PWCD, and also to support the staff to deliver the SLT degree programme.

The objectives of this paper are to describe the project: its activities, participants' progress and engagement with the project, evaluation of the successes and challenges, and to consider implications for similar, future projects.

Project Description

The project began in 2011, originally for 22 months and was subsequently extended to 2015. Over the life of the project, three types of input were provided: face-to-face group training; remote individual mentoring; group/individual meetings and workplace visits. These are described in detail below. The project was led and managed by the first author, assisted by the

second. Both are British qualified SLTs and researchers in disability and communication disability in the UK and the global South. Training and workplace visits were also delivered by trainers from the UK, Australia and South Africa who had experience of supporting the development of services for PWCD in the global South and/or expertise in specific clinical areas and/or university programme management. Remote mentoring was provided by 15 mentors (some mentoring more than one participant): 14 were qualified and experienced SLTs based in the UK and West Africa; the 15th was a psychologist with many years of experience working with PWCD and teaching SLT students. All mentors had experience of working in the Global south.

Ethics

Ethical approval for the project was obtained from Manchester Metropolitan University's Ethics committee. Participants were all recent graduates or staff from Makerere University or other professionals working in the field of SLT and were not regarded as vulnerable. The data collected were not particularly personal or sensitive. All data (surveys, focus group transcripts etc.) were anonymised. No PWCD were directly involved in the project activities. A project steering group oversaw its activities. Participants joining the project all agreed to participate in its evaluation.

Methodology

Participants

In total, 26 participants took part in the project, 15 joining in October 2011 and the remainder joined subsequently. Nineteen were graduates of the SLT programme at Makerere University. Two SLTs from Kenya and two non-SLTs, who were not part of the original target group, requested to join the project. Eight of the 26 worked as university teachers on the SLT degree programme for part, or all of the period. See table 1.

Participants' transport and accommodation costs were met for the face-to-face training, as were internet costs, but '*per diem'* payments (allowances paid for attendance) were not.

Table 1: Mentoring project participants, by nationality and profession

Profession	**SLTs**	**Other**	**Total**
Nationality			
Ugandan	16	1 (non-SLT teaching on	17

		programme)	
Tanzanian	2	0	2
Rwandan	1	0	1
Kenyan	2	0	2
British	3	1 (unqualified specialist in Communication Disability)	4
Total	24	2	26

Project activities

1. *Face-to-face group training sessions on personal, professional and clinical skills topics.*

Training topics were identified by the project planning group and adjusted during the project as participants' needs changed. For example, training about clinical supervision of SLT students and about training others (parents, teachers, community workers) were reduced as few participants reported needing these skills. Six training workshops (three to five days), covered the following topics:

- Clinical audit: overview, uses and collective development of basic clinical audit tools.
- Basic screening/case history resources (2 sessions): collective development and subsequent revision of basic speech and language screening tests and case history forms for children and adults.
- Specific clinical topics: topic selection was in response to participants' requests and covered skills and/or theoretical knowledge in working with people with profound and multiple disabilities; acquired communication disabilities; augmentative and alternative communication (AAC); and dysphagia (eating and swallowing difficulties).
- Peer mentoring: purpose and use.
- Clinical supervision of students.

2. *Remote mentoring.*

Mentoring was conceptualised as an ongoing personal relationship between mentors and mentees, with mentors providing remote support (mainly by email/Skype), discussing clinical and professional issues, providing advice or signposting mentees to other people or resources. Each mentee was paired with a mentor, dependant on work settings and expertise. An introductory training about the concept of mentoring was delivered to mentees and a

suggested structured format for mentoring contacts and conversations introduced, to encourage a systematic approach and recording of the process.

3. *Face-to-face individual/group meetings and workplace visits.*

Individual and group meetings with project team members were held whenever external trainers visited Uganda. Early in the project, participants reported that they particularly appreciated one-to-one, face-to-face support. Initially, such requests were responded to on and ad hoc basis and later, in response to feedback, visiting trainers offered individual meetings and workplace visits. These meetings and workplace visits aimed to:

a. support individuals to reflect on and manage their work with clients, and to provide personal/professional support in their work contexts
b. build the capacity of the university staff to deliver the SLT degree programme, moving towards independence from significant external support
c. support participants to build the local professional group- the Association of SLTs in East Africa (ASaLTEA).

Evaluation of project activities

Evaluation of the three types of project activities was carried out at various points in the project cycle – most training activities were evaluated immediately after the activity; remote mentoring and evaluation of the whole project took place at the mid-point and end-point of the project. A range of evaluation methods were used, with an additional intention of demonstrating a variety of tools that participants could then use in their own work. Methods included types of verbal and written feedback, an adapted version of Outcome Mapping (Earl et al., 2001), written records (e.g. of mentoring conversations and clinical audit data), questionnaires (using both open-ended and closed-ended questions and Likert scale items), email feedback, focus groups and the trainers' own evaluations. Data were analysed as appropriate to the type of data collected, using simple descriptive statistics and content analysis. Variable attendance, particularly across the training sessions as well as low response rates for email-based evaluation, resulted in much of the evaluation data being based on inconsistent numbers, hence preventing detailed comparative and quantitative analysis. Some findings have therefore drawn on data from several types of evaluation that were synthesised and summarised in relation to key themes or activities. Trainers noted that participants appeared to enjoy exposure to the range of participatory teaching and evaluation methods.

Findings

In this section, data are presented on participants' career histories, progress and confidence across the period of the project, and findings from the evaluations of the three types of project activity.

Individual participants' career histories and progress

At the start of the project, 10 months after qualifying, the initial cohort of 12 Makerere University SLT graduates provided data in a written survey about their work. Eleven reported practising as SLTs, at least part-time. None were employed as SLTs in Ministry of Health posts, since these had not been established and the profession had not been recognised by the Ugandan Public Service Commission. They were creating and negotiating their new roles individually, often back in posts where they had previously been employed. This was very challenging, as no formal SLT roles or posts had been officially established and recognised in Uganda's public sector. At least four were self-employed, three working in third sector organisations as SLTs, and two were only practising SLT voluntarily or in addition to their other official job roles (e.g. as an Occupational Therapist or Medical Clinical Officer). Of the nine SLTs who joined the project in subsequent cohorts, all reported doing at least some SLT work, with two working privately (in hospitals and/or schools) and six doing mainly or solely SLT work.

By the end of the project, 20 out of 21 of the East African SLTs in the project were still practising SLT, at least part-time, despite the lack of official recognition or government sector jobs in Uganda. Only one of the original participants who subsequently left the project was anecdotally reported to be no longer practising as an SLT. Participants typically were doing a combination of different types of work. The main changes in work patterns between the start and end of the project were that two participants had established a new private practice and at least one had established a new clinical service (for people with dysphagia). At least half had begun some 'indirect work' e.g. training others and awareness-raising about communication disabilities. At least two were actively pursuing the goal of national recognition of the SLT profession, seen as a crucial step in promoting and gaining acknowledgement of their work and in establishing a formal career structure within the health and education sectors.

During the project, four of the 16 Ugandan SLT graduates left Uganda, either to work in other African countries (n=2) or the US (n=2). Several applied to study abroad (one successfully). The three non-Ugandan graduates all returned to their home countries in Africa to practise as SLTs. These data suggest that SLT graduates were able to practise their new profession and diversify somewhat, notwithstanding various challenges.

Participant confidence and personal development

Eighteen out of the 24 SLT participants completed a short survey, asking about their confidence as SLTs when they joined the project either in October 2011 (n=14) or in November 2012 (n=4) and again at the end of the project in March 2015. Numbers and individuals responding at each point varied. Although data could not be subjected to statistical data analysis due to the incomplete data set, responses suggest that participants' reported confidence increased. Levels of agreement with the statement: "I feel confident that I have the knowledge I need to manage my SLT work", ranged from 'not at all' to 'quite a lot' when they joined the project (n=18), but by the end of the project, all responded 'quite a lot' (n=9). Exemplar quotes at the start of the project: "I need more clinical exposure and guidance in my SLT work" and at the end of project: "I have greatly improved over the years with greater improvements especially having been involved in the mentoring project", support the quantitative data.

Participants also reported increased confidence in their interpersonal and management skills. At a focus group held in March 2014, one participant stated how:

> With the coming of the Nuffield Foundation project and the mentoring provided by my mentor, plus all the trainings we have gone through, I really now feel confident to develop the services of speech therapy in whichever setting I find myself in.

Some of the changes in job roles described above may also indicate growing confidence. At the end of the project, many however, remained concerned about their clinical skills, particularly in relation to working with specialist clinical populations. At the end of the project, participants (n=9) were asked to reflect on what they had learned from the project overall and what they learned from one other. "Increased confidence" was the most frequently mentioned (n=3). In relation to what they learned from one another, "creating assessments" was the most common (n=4), while other answers included "working in a new specialism" (n=3) and "teamwork" (n=2). These data suggest a growth in perceived abilities to work in a wider range of settings.

When asked about their future support needs, eight asked for further mentoring or training (particularly in relation to particular clinical specialisms) and three for specialist clinical supervision. This suggests a remaining focus on direct clinical work.

Evaluation of face-to-face training events

The 26 participants took part in one or more face-to-face training sessions, covering five key topics detailed below, with each training topic being evaluated separately. Despite initial

interest, some participants attended inconsistently. Reasons given included job roles/work pressures, individual interest and logistical factors, such as distant location and travel restrictions. There may also have been other financial constraints that were hinted at, but not stated explicitly. An overview of the findings from evaluation of the five training topics is given below.

a. Clinical Audit.

The need for training in auditing of clinical activities had emerged from anecdotal discussions about difficulties and inconsistencies in clinical record-keeping and the need to generate evidence that could be used to argue for increased services. Before and after training about the purpose and methods of clinical audit, participants were asked about their understanding of the concept and how it might be useful in their work. Prior to training, participants demonstrated variable understanding of clinical audit and its use. After training, all were able to describe clinical audit in a relevant and accurate way and demonstrated an understanding of a range of its uses. Ten months later, a focus group was held to discuss their subsequent use of clinical audit. A small proportion of participants reported using the basic clinical audit data collection form that had been devised by the group during the original training. More proactively, one participant reported collecting and using clinical audit data to argue the need for services and was a positive advocate for its use. Reasons for not using the clinical audit data collection forms included time pressures, other forms of data collection already being required in the workplace, confusion about the purpose of clinical case-notes in contrast to clinical audit, sensitivity around asking some questions (e.g. about child-spacing) and difficulties using an English form when working in other languages. These findings suggest varied learning, perceptions of the value of audit to them individually and possible linguistic and cultural adaptations needed to the audit forms that had been developed.

b. Development of basic assessment/case history resources.

An adapted form of Outcome Mapping (Earl et al., 2001), a very practical method of planning and evaluation that focuses on behaviour change, was introduced to encourage participants to set short, medium and long-term goals for developing their skills in using case history/interview forms and initial speech and language screening tests in their work settings. Eight months after delivering this training, evaluation (n=8) showed that all eight had used the case history forms that had been developed during training, six out of eight had used the screening tests developed, but only four out of eight had managed to evaluate and adapt these resources. All felt they had made ‘quite a lot’ or ‘a lot’ of progress towards using the developed resources to help them make SLT diagnoses and to write clearer, more focused reports. Six out of seven felt they had progressed in setting clearer, more transparent clinical goals. Although these quantitative data suggested positive use of the resources, verbal feedback in a focus group discussion, suggested that many participants struggled to use the

resources regularly as they felt they were too time-consuming and not fully relevant to their settings. This finding supports the use of multiple forms of evaluation.

As a result of the feedback above, the screening tests were revised during a subsequent training session, and new materials were provided for each participant. A visit to a local nursery where participants used the revised resources to assess children, provided opportunities to evaluate the resources further, and also to put into practice clinical peer-mentoring, where SLTs could support one another, share resources and problem-solve. Subsequent informal feedback suggested that the revised resources were being used more frequently– opportunities to 'own' materials and practise using them in a 'safe' setting, may be important to practitioners in this context.

c. Training on specific clinical groups

Training on specific clinical groups was evaluated as shown in Table 2 below. Although these data are limited, they suggest that participants were positive about training on specific clinical topics, perhaps partly because topic selection was responsive to participants' stated needs. Similar findings related to personal development and future needs (see above) suggest participants' preferences may have been specific clinical skills over other professional skills.

Table 2. Evaluation of specific clinical training

Topic	Modes of evaluation	Outcomes(N=14)
Working with people with profound and multiple disabilities.	Written questionnaire	Training at: right level: 13/14 interesting: 13/14 relevant: 13/14
Working with adults with acquired communication disabilities	Written questionnaire	right level: 13/13 interesting: 11/13 relevant: 10/13 (MD=1)
Alternative and Augmentative communication systems for people who have little or no speech (AAC)	Written questionnaire	right level: 12/14 interesting: 12/14 relevant: 14/14
Dysphagia	Adapted form of Outcome Mapping	Mean outcome: participants achieved mid-way between: 'a lot' and 'everything they hoped for'.

d. Clinical supervision of SLT students.

Written feedback on this two-day training revealed that many had not anticipated supervising future students. Much of the positive feedback related, not to clinical supervision per se, but to participants' new perspectives about learning to give feedback in a positive and constructive manner that was new to many of them and that contrasted with their prior experience of learning and teaching styles common in East Africa. Most reflected on the complexity of the clinical supervisory role, but were positive about the skills they had acquired. Subsequently, few had opportunities to supervise Makerere SLT students, which meant that the impact of this training could not be fully assessed. A small number have, more recently, supervised SLT students visiting from other countries.

e. Training in peer mentoring

At the end of the project, the peer mentoring component was evaluated by eight participants, all of whom had used peer mentoring. They reported that contact with their peer mentor sometimes occurred face-to-face with geographically local colleagues, but was mainly by electronic means with remote colleagues. Cost was often brought up as a barrier to peer contact. Anecdotal evidence suggested that the conversations were mainly focused around client management:

> Yeah, I got a chance to get visited, me in my clinic…we had time to share what they are doing in X (place), and what I'm doing in my clinic.

Overall evaluation of the face-to-face training sessions

Participants' overall evaluation of the training was obtained by means of a focus group. Comments were generally positive:

> The content has been really relevant because the programme has been very flexible.

> All the trainers…have been very sensitive to the needs and the things that are available in East Africa. They haven't tried to impose assessments or equipment and ideas from Europe.

Less positive comments were mainly about the need for more in-service training and lack of SLT resources, although they did not criticise the quality of what they had received:

> I feel we need more follow-up workshops… that's a big disadvantage about it, the whole programme.

Such comments can be useful to support requests for future programmes.

Evaluation of remote mentoring

Participants were asked to submit records, reporting on the number and nature of mentoring contacts every six months, but few participants provided these data. Informal feedback from mentors and mentees during training sessions and via email, suggested that Skype mentoring proved problematic for the majority of participants, and they opted instead to use a combination of email, phone, instant messaging, text and, where possible, face-to-face meetings when mentors (who were all based outside East Africa) visited their country. Some participants maintained regular contact with their mentor; others communicated more sporadically.

The mentoring was evaluated during a focus group (n=9), 28 months after the start of the project. All reported positively about the mentoring and stated that they would recommend it to others, although it is acknowledged that there may have been some courtesy bias. One mentee who had met his mentor (who had experience of working in East Africa) face-to-face said:

> Personally, my mentor has been amazing.

One who had not met their mentor face-to-face expressed how:

> I've not really been consistent contacting my mentor, but I contacted her some time back about one particular condition...I gave her around four conditions that really I'm struggling with.

Although the mentoring concept per se was viewed positively, the logistical aspects and technology required to facilitate it, were barriers to regular and sustained contact. The most common concerns about remote mentoring were the practical aspects of making contact: making time, time-zone differences, internet access and cost:

> I think a lot of challenge I had was, with my mentor, it was about the timing. At the time she told me she's free, for me I would be busy…And then when I'm back home, she's busy and the time I have no power at home.

> I prefer to use email rather than to use Skype. And sometimes when I needed to contact my mentor probably, you can't access Internet.

There was also a desire to interact with mentors face-to-face, which, for the most part was not possible.

One mentioned reticence about admitting needing help, perhaps hinting at cultural aspects in sharing problems:

> You don't take out what is in your house out to the public.

Despite these difficulties, they reported valuing mentoring:

> When you have just qualified...you feel you are not that confident enough…so I would tell them your mentor would be the best person to contact.
>
> Make time for the mentoring, because I know it's something I don't do.

These positive responses to remote mentoring need to be balanced against the practical challenges and cultural differences in communication styles considered.

Evaluation of face-to-face individual/group meetings and workplace visits

The take-up of individual and group meetings offered to university SLT staff was considerable during the first 15 months of the project. As well as meetings to discuss programme delivery and management, the trainers also ran a team-building workshop, supported a major curriculum review, helped to design and prepare teaching and materials, and gave guest lectures to undergraduate students. From 2013 onwards, the university SLT staff gradually shifted from a mixture of ex-patriate staff and short-term visiting volunteers to Ugandan SLT graduates appointed as academics. Requests for support in delivery of the degree programme gradually reduced. Support for the development of the Association of SLTs in East Africa (ASLTEA) followed the same pattern.

In contrast, the offer of individual meetings or workplace visits for clinical SLTs increased during the project and resulted in more than five visits to participants in their workplaces (mainly schools and hospitals) in Kampala and Dar es Salaam, Tanzania. Formal evaluation of this activity was not carried out, but informal feedback on these visits was always very positive:

> Thanks very much…for the wonderful time, that we had at XX school. I really loved

> it and gained a lot from the sessions and discussions we had together. I request that this should be extended to my colleagues as well.

This type of individualised and face-to-face support is valued, fits with feedback about remote mentoring discussed above, but is more resource intensive.

Finally, there were a number of positive unintended outcomes resulting from the project. During the project, at least four participants were supported to present papers at academic conferences or publish papers in professional or peer-reviewed journals (see Barrett and Marshall, 2013; Rochus et al., 2014; Wamukoota, 2014). Participants continue to receive online materials shared by trainers. Trainers have gained valuable experience in training and mentoring that is being used in other work in sub-Saharan Africa. These outcomes often go unrecorded, despite their added value.

Discussion

This project provided face-to-face training, remote mentoring, and workplace support for 26 professionals, aimed at supporting the development of services for PWCD in East Africa. The outcomes provide some valuable data about how different aspects of the project were viewed by participants. The findings and the authors' reflections highlight some of the challenges in implementing and evaluating such a project that may be useful in similar future projects.

Overall, participants reported increased professional confidence over the life of the project, although, of course, this change may not be ascribed solely to the project components, either individually or in combination. Most of the training that focused on specific clinical topics was viewed positively by the participants. It often revised, built on and reinforced what participants had been taught as undergraduates and addressed their priorities, which were mainly to deliver direct clinical services. Some of the proposed training was too ambitious for the stage of development of SLT/communication disability services. For example, although the SLTs' pre-qualification education had included preparation for work in community settings (i.e. beyond hospitals and schools) and to carry out population-based work (e.g. in awareness-raising and prevention), similar to other low-resource contexts where SLT has been newly introduced (e.g. Sri Lanka (Wickenden, personal communication), these graduates tended to focus mainly on one-to-one impairment-based work, at least for the first few years after qualification. This raises questions regarding opportunities and motivations for these SLTs to develop support for people with communication disabilities in broader settings, for example, by training CBR workers, raising awareness about communication disability and understanding attitudes (Marshall, 2000; Wickenden, 2013). It may be that the challenges of this kind of indirect work are too great for early career professionals who need to build their own clinical competence before adopting broader roles.

It is important to reflect on some of the unspoken and perhaps sensitive issues in relation to the development of new professions and services in the Global south, and the power gradients between white, Northern specialists and local newly qualified practitioners, in a little understood speciality. The authors were, of course, conscious of their position as 'outsiders', indeed as nationals of the ex-colonial power, as well as being experienced SLTs, and did not wish to impose their agenda, to which participants may simply have acquiesced, a point also made by Elder and Foley (2015). This tension of whether to provide support that derives from external ideas about how services 'should' look, or to respond to local SLTs' expressed immediate needs, is not easily resolvable. Part of the difficulty seems to be about the relative status of different types of knowledge. The East African SLTs have in-depth local knowledge of the local culture, attitudes to disability, how a new category of professional should or might work, and to types of help that would be acceptable in the community. The visiting 'experts' have knowledge of technical approaches and interventions which are tried and tested, but in different cultural and structural contexts. Resolving how these two types of knowledge can be mutually respected and beneficial in developing something new in an international development context, is complex, with many, difficult to disentangle sensitivities of power and status, being at play (Chambers 2017).

The authors also reflected on the challenges of making this a truly participatory project from the outset, despite differences in power and experience. One challenge was that the participants were still students when the project was designed. We aimed to be responsive and give participants a voice once the project had begun, but if they had been included more fully from the outset, perhaps some of the challenges encountered, for example inconsistent engagement with the project, may have been reduced. Achieving complete openness and equality in cross-cultural relationships is well recognized to be challenging (Gaventa and Cornwall, 2001).

A number of factors may have limited participants' full engagement in the project and these factors should be investigated further and considered in future similar projects. Achieving equal and productive dialogue can be difficult, particularly at a distance, and it may be that power hierarchies (related to factors such as gender, age, race, post-colonial understandings, experience, perceived expertise) contributed to some mentees' reticence actively to engage. Additionally, the fluid and uncertain contexts in which people were working, lack of awareness within the country about communication disability and the roles of SLT, lack of established public sector SLT posts and employer constraints, may have affected some participants' commitment and participation.

Resources such as screening tests and intervention materials, should be designed to be appropriate to the setting (Carter et al., 2005), although in practice they are often imported from other settings and may not be standardised or adapted for the new context. Therefore,

supporting participants to design and use resources that are truly appropriate for their work in the East African context, was a valid aim. The initial reluctance to use resources that they had developed, may indicate a need to develop participants' 'ownership' of and the confidence to use and adapt what they designed to suit their needs. Such design work should build in cyclical opportunities for participants to develop resources, test them out, reflect on their use, amend and develop them further. The status of foreign imported materials which appear 'official' and professional compared to locally made materials, may outweigh the latter's relative effectiveness.

The strategy of indirectly teaching multiple skills simultaneously during training (e.g. introducing new teaching and evaluation methods alongside content) was, anecdotally, viewed positively by participants, but this multi-level approach puts additional strain on trainers and was perhaps too 'embedded' to be clear to the participants. Furthermore, some methods of evaluation, notably Outcome Mapping, required considerable time to explain, and it was a challenging method to use when participants have little control over the content of the training and have had little exposure to more negotiated forms of evaluation. Judicious selection of evaluation methods is important.

Whilst not presented in the data above, incidental and informal evidence from the project led the authors to reflect that clearly negotiating with participants about length of the day, breaks, financial arrangements around travel costs and per diem to attend the training, are important in order to maximise goodwill and to avoid cultural misunderstandings. This supports issues regarding tensions around finances raised by Aldersey and Wenda (2015).

These data suggest that one-to-one remote mentoring may be valued when there is fast, reliable and affordable internet access, and/or when mentoring pairs can meet face-to-face to establish mutual trust and respect, and when mentors have some experience of their mentees' work contexts. As these may frequently be unfeasible, particularly for new professions, creative solutions need to be sought. The relationship between mentees and mentors is a sensitive and subtle one, and spending more time developing relationships and setting ground rules, for example about timely responses, and setting limits on what mentors can reasonably offer, may increase success. The power differences between mainly global North mentors with established professional status and inexperienced mentees from the global South, need open acknowledgement and discussion.

One-to-one support for the University staff in this project was generally under-utilised, particularly in the latter phases of the project and the reasons for this were not given during evaluations. Staff on new programmes may wish to demonstrate their ability to run programmes independently, and asking for help could be perceived as demonstrating weakness or failure. The concept of continuing professional development, where individuals at all stages of their careers benefit from ongoing learning and mentoring, may be less

familiar to them in a setting where hierarchy and status may be more fixed and important.

Workplace visits were viewed positively and are recommended for similar, future projects, preferably including opportunities to work collaboratively, provide feedback and to evaluate any resources developed. It is important to ensure however, that such visits are perceived as an opportunity for constructive dialogue and mutual learning, not as an assessment of competence. Such visits are also helpful to external trainers, enabling them to understand the contexts in which mentees are working.

Flexibility and responsiveness in all aspects of such a project (including participants opting in and out, and the ability to record unintended outcomes) are vital. This responsiveness may however negatively affect the ability to collect robust data. The needs of global North funders for data and the authors' need to publish papers with evidence of particular types and measures of 'success', need to be balanced with the needs of the people for whom the project was designed (Cornwall and Jewkes, 1995).

Data from this project, despite some limitations, provide valuable insights into the development of new rehabilitation professions and services in low-resource contexts where specialist services are a rare resource and may not be well understood. Many countries are identifying the need for specific impairment, disability and rehabilitation services and for professionals to provide them. An aspiration to establish services for PWCD, including those provided by SLTs, is increasing in many countries, as are other specialisms such as orthotics, audiology, psychology and specialist teachers. Those planning the development of new services and professions, frequently request support from colleagues in the global North where services are already established, although it is not always acknowledged that the structural and contextual differences are huge and replication from one place to another is challenging. Practitioners and academics from the global North can be of help to those developing new initiatives, but such requests should be approached sensitively. A truly participatory approach, careful preparation, flexible evaluation and a nuanced approach to relationship building are needed.

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