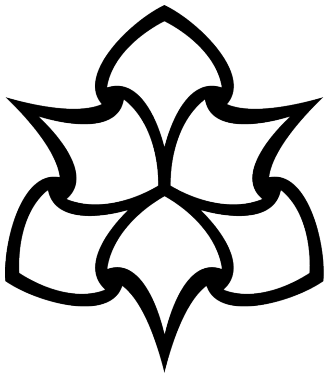

Title

Community service providers' roles in supporting communication disability rehabilitation in Majority World contexts: An example from Ghana.

Author and Affiliation Details

1. Dr Karen Wylie

   Lecturer

   School of Occupation Therapy, Social Work and Speech Pathology

   Curtin University

   GPO Box U1987, Perth

   Western Australia, 6845

2. A/Professor Bronwyn Davidson

   Associate Professor in Speech Pathology

   Department of Audiology and Speech Pathology

   The University of Melbourne

3. Dr Julie Marshall

   Reader in Communication Disability and Development

   Health Professions Department

   Manchester Metropolitan University

4. Ms Josephine Ohenewa Bampoe

   Clinical Tutor

   Department of Audiology, Speech and Language Therapy

   School of Biomedical and Allied Health Sciences

   University of Ghana

5. Mr Clement Amponsah

   Clinical Tutor

Department of Audiology, Speech and Language Therapy

School of Biomedical and Allied Health Sciences

University of Ghana

6. Professor Lindy McAllister

Professor Emerita

Faculty of Health Sciences

University of Sydney

Corresponding Author

Dr Karen Wylie

School of Occupation Therapy, Social Work and Speech Pathology

Curtin University

GPO Box U1987, Perth

Western Australia, 6845

Australia

Telephone: +61410148865

Email: kwyl1124@uni.sydney.edu.au

Running Head

Community services for rehabilitation

Keywords

Community services, speech-language pathology, developing countries, Sub-Saharan Africa, multidisciplinary

Abstract

Purpose: In Majority World countries, where speech-language pathology services are extremely limited, people with communication disabilities may seek help from a range of

service providers. This qualitative research aimed to explore the nature of community services offered to people with communication disabilities who seek help in Accra, Ghana.
Method: Semi-structured interviews were conducted with nine individuals from three professions: pastors (3), doctors (3), and herbalists (3) exploring services that they may offer to PWCD seeking help. Interviews were analysed using Thematic Network Analysis.
Result: Six global themes described beliefs about communication disability, types of intervention, explanations provided to people with communication disabilities, promoting communication, processes for selecting treatments, and links between service providers. Interventions encompassed physical, spiritual, psychosocial and environmental approaches, with the notion of plural beliefs interwoven through a number of themes.
Conclusion: In Ghana, and other Majority World contexts, service providers in sectors not commonly associated with communication disability rehabilitation may have important roles to play in supporting people with communication disabilities. Understanding the contributions of other service providers may assist the growing profession of speech-language pathology to collaborate across sectors, to develop specific, culturally responsive approaches to service development.
Keywords: community services, speech-language pathology, developing countries, sub-Saharan Africa, multidisciplinary

Introduction

Access to rehabilitation services for people with disabilities is integral to improving outcomes in education, employment and social inclusion (World Health Organization & World Bank, 2011). Despite a clearly identified need, there are substantial shortfalls in the availability of rehabilitation services globally, particularly in Majority World countries (World Health Organization & World Bank, 2011), including rehabilitation services for people with communication disabilities (PWCD).

Even when few formal rehabilitation services exist, it is likely that PWCD or their families in underserved communities will take action or seek help to address their concerns. Previous research in Accra, Ghana, identified that people with concerns about the communication abilities of a family member would be likely to seek help and advice in range of sectors, including the Western healthcare, religious and traditional belief sectors (Wylie et al., 2017). [Note: The traditional belief sector included herbalism, spiritualism, and fetishism (communication with the spirit world through the use of objects)]. Little, however, is known about the types of information and treatment that may be provided to PWCD when they seek help in these community sectors.

This paper considers a broad view of communication disability rehabilitation in a Majority World context, by exploring the contributions of community service providers in range of sectors in Accra, Ghana. It considers how the emerging profession of speech-language pathology (SLP) in Ghana and other Majority World countries, may benefit from understanding the broader service landscape, to support development of rehabilitation services that respond to culture and context, and support community capacity.

The Ghanaian context

Ghana is a tropical country situated along the Gulf of Guinea coast, with a population of approximately 28 million (World Bank, 2018). Two approaches to rehabilitation co-exist in Ghana: medical and community-based (Tinney, Chiodo, Haig & Wiredu, 2007; Tuakli-Wosornu & Haig, 2014). The former is typically provided by professionals with specialised knowledge, based in health settings, such as physiotherapists. Community-based rehabilitation (CBR) is delivered in the community, by CBR workers, and addresses the needs of people with disabilities across five domains: health, education, livelihood, social and empowerment (World Health Organization & World Bank, 2011). Both approaches are

insufficient in meeting the rehabilitation needs of the population in Ghana, including PWCD (Tinney et al., 2007; Tuakli-Wosornu & Haig, 2014).

Majority World countries, such as Ghana, face a complex range of development priorities impacting when and how rehabilitation services develop. Wickenden (2013) proposed a range of indicators that may signify country readiness for the development of communication disability rehabilitation services, including SLP. These included strengthening systems of governance; improvements in a range of economic, health and educational indicators; adoption of human rights policies; availability of specialised healthcare services; local expertise in relevant fields; and increasing disability advocacy. Ghana has made significant strides in development, and has experienced strong economic growth and twenty-five years of stable democracy (World Bank, 2018). Universal systems of primary education and basic healthcare have been established (Abukari, Kuyini & Mohammed, 2015). Disability activism is growing (Odoom & van Weelen, 2011) and Ghana's Disability Act has formalised rights for persons with disabilities (Government of Ghana, 2006).

Whilst the profession of SLP is well-established in countries of the Minority[1] World, there are few speech-language pathologists (SLPs) in sub-Saharan Africa (SSA) (Mulwafu, Ensink, Kuper, & Fagan, 2017). Ghana has been no exception, with a previously estimated SLP workforce of five or six (Mulwafu, et al. 2017; Owusu, 2016). However the establishment of local SLP training and registration of SLP by the Allied Health Professions Council, are contributing to the growth of the profession in Ghana (Owusu, 2016).

Whilst growth of SLP is one step towards improving the availability of rehabilitation for PWCD, it is important to recognise the limitations of the current small numbers of SLPs, in making meaningful contributions to rehabilitation. Developing rehabilitation services to meet the needs of PWCD in Majority World countries such as Ghana, requires a complex cross-sectoral strategy, extending far beyond training SLPs. To consider how SLP can

contribute appropriately to service development within Majority World countries, the profession has been prompted to engage in critical examination of approaches to rehabilitation (Kathard & Pillay, 2013; Wylie, McAllister, Davidson & Marshall, 2013).

Service delivery in speech-language pathology

Speech-language pathology services frequently focus on the provision of services to identified individuals experiencing difficulites with speech, language and swallowing (ASHA, 2016; Speech Pathology Australia, 2015). The International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001) provides an important framework to improve understanding about both the experience of disability of an individual and the range of approaches which may be used in rehabilitation (Ma, Threats & Worrall, 2008).) It highlights the dynamic interaction between the health condition/s of an individual, engagement in activities, participation within their community and the impact of personal and contextual factors. In this biopsychosocial model, rehabilitation cannot be considered separately from the community context, as an individual's experience of disability is embedded within their own beliefs and responses to disability, as well as the beliefs and responses of the community (Howe, 2008; O'Halloran & Larkins, 2008).

While the ICF focuses on the experience of disability at an individual level, the need for SLPs to undertake activities addressing the needs of populations, such as prevention, screening and advocacy, is well-recognised by professional organisations and the literature (ASHA, 2016; Law, Reilly, & Snow, 2013; Speech Pathology Australia, 2015). As SLP services develop in Majority World contexts, SLPs encounter immense unmet rehabilitation needs (Owusu, 2016). SLPs should prioritise population level approaches, to ensure that services and information are broadly accessible (Wylie et al., 2016, 2018, in press). Campbell et al. (2013) discuss dimensions of service coverage (listed below) that can support understanding of the development of services for PWCD in Majority World contexts.

Availability refers to the existence of services. While development of SLP training in Majority World countries is likely to contribute to service availability, the small size of the SLP workforce, and time taken to educate SLPs, is likely to mean that growth in services will continue to be slow (Wylie, McAllister, Davidson & Marshall, in press).

Accessibility refers to the ease of access to services. Whilst little information is available on the accessibility of SLP services in Ghana, research in SSA has identified a range of economic and geographical barriers to SLP services (Wylie, McAllister, Davidson & Marshall, 2018).

Acceptability considers whether sociocultural aspects of services are responsive to the community needs. The emergence of locally trained SLPs may increase the diversity of languages in which services may be provided. (Wylie, McAllister, Davidson & Marshall, 2016). More nuanced elements of sociocultural accessibility are likely to influence the acceptability of SLP services. This may include how a profession, underpinned by Western belief, is adapted to suit culture and context (Pillay & Kathard, 2015). Belief and tradition may influence service acceptability, including the uptake of rehabilitation (Semela, 2001; Wegner & Rhoda, 2015). Beliefs about disability in Ghana include a mix of the biomedical, religious and traditional (Odoom & van Weelen, 2011). In SSA, PWCD may seek help from services such as faith healers, or traditional medicine (Semela, 2001; Wegner & Rhoda, 2015).

Quality refers to the standards and competencies associated with service provision. Challenges to ongoing professional support/development of the SLP profession, impacting service quality and sustainability, have been previously described (Wylie et al., in press).

Community engagment in Majority World contexts

Pillay & Kathard (2015) described the need for the profession SLP to develop in culturally and contextually relevant ways. Part of the cultural imperative is to ensure that SLPs working

in Majority World contexts have the skills to develop "appropriate services rather than trained merely to provide technical skills in a predetermined way" (Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003, p. 320). In Majority World contexts in particular, community engagement, including training and supporting community services, is integral to the practice of SLP (Crowley et al., 2013).

Understanding the nature of existing rehabilitation services provided in the community is particularly relevant in contexts such as Ghana, where culture and beliefs, the service landscape amd patterns of service use are likely to differ from those of the Minority World. MacLachlan (2006) stressed the importance of understanding the service landscape as services develop, asserting that "multicultural care requires western-trained clinicians to ascertain where they 'fit in' to the overall system" (p. 33). Understanding current services that PWCD receive within the community may assist SLPs to recognise how their services may fit within the exisitng service landscape.

Purpose

Research in Ghana indicates that people would be likely to access a range of services if they experienced communication disability within their family (Wylie et al., 2017). There is, however, little information about what those service providers may do when working with PWCD. This research aimed to extend understanding of rehabilitation that may be offered to PWCD in Majority World counties, by exploring the nature of services provided to PWCD by community service providers in Accra, Ghana. The term 'services' in this research was used to represent the range of interventions, information and supports that may be offered to PWCD, and the processes used in planning and providing these services. This research did not attempt to assess the quality or efficacy of services provided within the community, but focused on describing the nature of services reportedly provided.

This qualitative study built on previous research describing the likely help-seeking behaviours of community members in relation to communication disability in Accra, Ghana (Wylie et al., 2017). The research adopted a critical-pragmatic philosophical position. (Feinberg, 2015). Pragmatically-oriented research begins with recognition of an issue in the community, however, critical pragmatism recognises that some situations are unlikely to be explored, if a dominant world-view is used (Feinberg, 2015). In the case of rehabilitation, most research is focused on formal services. This research sought to look beyond the Western view of rehabilitation, to include the perspectives of rarely-considered service providers.

Method

Participants and Sampling

As this research aimed to develop understanding of services offered by a range of community service providers, two key sampling decisions were made: (1) to include three professions commonly consulted by the community in this context (Wylie, et al. 2017), rather than exploring services provided by a single profession, and (2) to use maximum variation sampling, to recruit participants with a range of potentially important characteristics. The choice of professions was based on findings from previous research, indicating that the public in Accra would likely seek help from the Western healthcare, traditional belief, and religious sectors, with doctors, herbalists and pastors the most commonly identified service providers in each sector (Wylie et al., 2017).

A maximum variation sampling frame was developed for each profession by the local team and included: (1) doctors: years of experience and employment sector (government/private); (2) herbalists: years of experience and formality of training; and (3) pastors: years of experience, formality of training, and the nature of church (charismatic or traditional). Purposive sampling was used to recruit nine community service providers, three from each occupation. Gender was not used as a sampling criterion due to the prioritisation of other

characteristics. Eight participants were male and one female. Inclusion criteria required participants to be working within Greater Accra, over 18 years of age and able to be interviewed in one of three languages: Twi, Ga or English.

[insert Table I about here]

Recruitment

Participants were recruited using the extended networks of the research team but were not personally known to the researchers. Individuals were sent a participation information sheet via email or WhatsApp (2019, © WhatsApp Inc). Interested individuals were required to contact a member of the research team for further information about the research, and to ascertain if they met the inclusion criteria. Informed consent was obtained prior to each interview.

Reflexivity

As SLPs, from both inside and outside Ghana, we were conscious of the potential impact of our personal and professional backgrounds on interaction with participants and interpretation of the data, particularly in relation to professions that were less familiar to us, such as herbalism. Using data collectors who were sensitive to the cultural and linguistic nuances within interviews was deemed important; therefore, Ghanaian members of the team conducted the interviews. As less experienced researchers, they participated in nine hours of interview training with author one, based on the work of Minichiello, Aroni, and Hays (2008). Ways to foster openness for both participants and interviewers were addressed in interviewer training. Techniques included the use of mock interviews with reflection, debriefing, and extensive discussions about meaning when reviewing transcripts. Reflective logs and debriefings were used on conclusion of each interview.

Data collection

Semi-structured interviews were used to collect data. A topic guide was developed by the research team (see Appendix A), based upon existing research (Wylie et al., 2017) and guided by the research aims. The topic guide was piloted and revised to ensure topics were easy to understand. Interviews were conducted face-to-face in participants' workplaces and community settings, using the language requested by the participant, and were audio-recorded. The aim of the research was explained to participants, to encourage openness and promote fair dealing (Mays & Pope, 2000). Seven participants completed interviews in English and two in Ga.

Data analysis

Audio-data were transcribed verbatim. Ga interviews were professionally translated and reviewed by a multilingual member of the research team prior to analysis. Analysis was conducted using the English transcripts. Data were imported into NVivo (version 10) software. Thematic Network Analysis (TNA) (Attride-Stirling, 2001) was selected for data analysis as it offered a clear, process-driven approach to exploring themes within the data (Goldbart & Marshall, 2013).

TNA aims to "explore the understanding of an issue or the signification of an idea, rather than to reconcile conflicting definitions of a problem" (Attride-Stirling, 2001, p. 387). The focus of TNA on inclusive exploration was consistent with our aim of developing understanding of the nature of community services for PWCD provided by a diverse group of service providers. Three levels of themes are used in TNA to represent increasingly abstract concepts or propositions drawn from the data. Basic themes represent recurrent issues or ideas within coded data. Organising themes are mid-level themes that simultaneously cluster similar basic themes at a more abstract level, and segment the broader global theme into principal propositions or concepts. Global themes unite the organising themes, to make an

overall claim or an argument about the reality represented within the data, and are supported by the basic and organising themes (Attride-Stirling, 2001; Goldbart & Marshall, 2013). Themes across are linked into web-like thematic network diagrams, enabling visualisation of the themes across levels. Emergent thematic networks are subsequently described and explored, and patterns identified within and across the networks (Goldbart & Marshall, 2013).

The six steps of TNA (Attride-Stirling, 2001) were used to develop the thematic networks: data coding, identification of themes in a bottom-up manner (e.g. from basic to organising to global), construction of thematic networks, description and exploration of the themes, summarising the thematic networks and interpreting patterns within and across the networks. An initial coding framework was developed inductively via repeated reading of transcripts, with an iterative process used to extend and refine the coding framework. Coding was undertaken by the first author with a second author, experienced in qualitative research, reviewing coding in 50% of coded data to promote trustworthiness. Basic, organising and global themes, and thematic network diagrams were drafted, and repeatedly refined, by the two authors using a consensus approach. The resulting thematic network diagrams are presented in Appendix B. Each thematic network was described and summarised in turn. All networks were then collectively reviewed, in light of the research question. Findings from the networks were drawn together to produce an integrated representation of the nature of services provided to PWCD by this sample of community service providers in Accra, Ghana. This conceptualisation is presented within the discussion of this paper.

Ethical clearance for this study was provided by the University of Ghana, School of Biomedical and Allied Health Sciences, Ref SAHS – ET. /AA1A/20132014.

Result

Six thematic networks represented participants' reports of the nature of services they offer to PWCD. The global, organising and basic themes for each network are outlined in Table II. Thematic network diagrams are included as Appendix B. Each global theme is described below together with its constituent themes. Direct quotes have been used to illustrate the findings.

[insert Table II about here]

Global theme 1: Service providers recognise causes of communication disability across physical, spiritual and environmental dimensions.

Participants described causes of communication disability that clustered into four organising themes, three representing the physical, spiritual and environmental dimensions and one about the diversity of causes.

*Physical***:** Beliefs about physical causes were represented by using a range of biomedical descriptors (see Table II).

*Spiritual***:** Beliefs about spiritual causes were described within three basic themes, which included spiritual causes of communication disability; higher power controlling events and the belief that attitudes and actions have spiritual consequences.

> *More times you realise that the children will be walking naked wearing nothing, in the spiritual world when the spirits are moving around, and (if) they see such a thing, they will (be) following the child anywhere the child goes and sometimes take the child as their own*
>
> (Basic theme: spiritual causes, pastor 1).

> *When you are fond of eating outside it does disturb the unborn baby spiritually and materialises when the baby is born*
>
> (Basic theme: attitudes and actions have spiritual consequences, herbalist 3)

Environmental: Two participants indicated that environmental factors may contribute to communication disability.

> *When a child grows in a friendly environment it facilitates their speech but if there was a lot of fighting and screaming, the child withdraw(s)*
>
> (Basic theme: communication environment, pastor 2)

Diverse causes: The idea that there are many possible causes of communication disability was described by participants from two professions. The attribution of causation varied between participants. While some participants presented a singular view of causation (either physical or spiritual), others held dual beliefs (spiritual and physical), while others indicated plural belief (spiritual, physical, environment, diversity of causes). All participants indicated that families often hold spiritual beliefs about the cause of communication disabilities.

Global theme 2: Service providers intervene across physical, spiritual, psychosocial dimensions and within the communication environment.

The diversity of interventions undertaken by participants for communication disability was notable, with the organising themes representing four categories.

Spiritual: These included prayer to God and a range of other traditional spiritual treatments, centred in both formal religious processes, and traditional practices.

> *I have spiritual water that I have prepared, which I will use to wash his/her face and he will come back to his senses or his normal state.*
>
> (Basic theme: spiritual intervention, pastor 1)

Physical: Physical interventions were described by a range of participants and included medication, physiotherapy / massage and other topical treatments such as ointment.

Psychosocial: Psychosocial interventions included counselling, provision of emotional support and described the importance of creating and maintaining hope.

> *… counselling to have them not to lose hope, to trust God for a better situation.*

(Basic theme: create and maintain hope, pastor 2)

Communication environment: These interventions addressed the communication environment of the individual and included training caregivers and working directly with the family to promote communication.

> *… the person … is able to open up to you but then when he goes home … he's not able to relate well with the family. It means that you need to attend to the needs of the family too, so they begin to understand the patient… So, it's not about engaging the client alone but also you need to have interaction with the family*

(Basic theme: work with the family, pastor 2)

Global theme 3: Service providers explain about the past, the present and the future.

This global theme consisted of two organising themes that related to explanations across time

Explaining the past and the present: Participants reported providing explanations about the presenting issue, reflecting a more "near term" approach, in explaining the nature and cause of the issue and assessments/treatments.

> *Your main problem is you're bleeding in the brain. This is what has caused the paralysis.*

(Basic theme: explain the nature and cause of the issue, herbalist 2).

Explaining the future: The second organising theme reflected a forward-looking stance and encompassed explanations that may impact recovery or improvement, including the time required for recovery and emphasised that recovery could be influenced by the level of care, support and treatment.

> *There should be someone around to assist, to take him to the hospital or take him to the pastor or take him to the counsellor. If all these things come into place, some of them are able to recover.*

(Basic theme: recovery is influenced by care, support and treatment, pastor 2)

Global theme 4: Service providers promote communication and communication development

Participants described specific strategies or advice to promote communication that clustered into three organising themes.

Use of diverse modalities: Participants described enhancing communication using a range of modalities, including signing, reading, and writing, based on an individual's strengths.

Changes in interaction or communication style: Participants described changes in communication style to improve communication and promote development, using strategies such as allowing time for PWCD to communicate and encouraging repetition.

> *When their speech is coming, you realise that whatever you say, they say after you and things like that. You [need to] encourage them.*
>
> (Basic Theme: encourage or use repetition, doctor 3)

Stimulation: Using stimulating environments was seen to promote effective communication and communication development. This included the uses of the senses (through pictures or music); exposure to language (ongoing communication and watching TV) and promoting interaction (inclusion in community activities and events).

> *You stimulate… we'll use pictures and images and getting them to be able to identify things around them. But stimulate them as much as possible.*
>
> (Basic theme: use of colour, pictures and music, doctor 2)

Global theme 5: Service providers respond to the individual and their context to make decisions about services.

Four organising themes described processes used by participants in making decisions about services offered.

Information about the communication disability: Participants indicated that a clear understanding of the communication disability assisted in deciding on interventions.

Information about the individual: Participants indicated that individual factors, such as the availability of money, education, class, age, and the likelihood of interventions being accepted by families may influence decision-making about intervention.

Mediating influences: Mediating influences appeared to guide choices about interventions and clustered within three basic themes. For pastors specifically, seeking spiritual guidance about what to do appeared to support decision-making.

> *So, I will pray and then as part of the prayer I'm also discerning to know what next to do because there are times they have to get the inner promptings*
>
> (Basic theme: spiritual guidance, pastor 3)

Other participants described making choices based on their understanding of what may benefit the individual.

> … *So will it make an impact? You look at the child. This is a child with CP* (cerebral palsy). … *All you have to do is just refer to the appropriate quarters and get staff with good help. Not some unnecessary investigation.*
>
> (Basic theme: Consider what will have the best impact, doctor 3)

Participants also acknowledged that how they intervene might change over time.

> *With time, you change what you do. Because as time goes on, sometimes, in the early stages, you don't want to rush it. … So it's a gradual process.*
>
> (Basic theme: Interventions may change over time, herbalist 2)

Families make their own choices about treatments: Participants consistently acknowledged that PWCD /families make their own choices about treatment. There was widespread acknowledgement that PWCD may use treatments within other sectors, particularly combining spiritual and physical treatments, either sequentially or simultaneously.

> *They've tried other orthodox medications and now they are not seeing improvements, so they decide to come for herbal treatments.*

(Basic theme: Choices about timing of interventions, herbalist 1)

Participants made frequent reference to explicit talk about the use of other treatments,

> *You know, you tell the person prayer is good. You continue to pray at everything but [inf: also] look for solutions - so don't pray and just sit in your house and say okay, everything will be all right.*

(Basic theme: Service providers acknowledge the use of other treatments, herbalist 1)

Some participants appeared to value contributions of other sectors, whilst others indicated that the use of other treatments may be problematic.

> *They also believe in superstitions. It's also a problem. So, you have to tell them that this condition is medical. This condition is medical. Otherwise, they move from your place…. They will go to a pastor, they will go to a mallam, they will go traditional.*

(Note: A mallam is an Islamic scholar)

(Basic theme: Choices about treatment in other sectors, herbalist 1)

Global theme 6: Service providers link with other service providers – both within and across sectors.

This global theme represented service providers connecting with others to provide services to PWCD and included three organising themes.

Input from more than a single service provider: Participants emphasised the need for intervention from more than one provider.

> *Its teamwork. So we need each other, nurses, doctors, counsellors, pastors. It's not a one-man job. It's not for one person to do it all alone.*

(Basic theme: teamwork, pastor 2)

Participants described consulting directly with colleagues, specialists in their field and other occupational groups.

They [other herbalists] have their also own way of diagnosing and they have their own way of treatment. Issues like this, we have to… we send reports to them. They read and then they comment.

(Basic theme: seek opinion or advice to improve care, herbalist 3)

Connect PWCD to other services within and across sectors: Participants indicated connecting PWCD to a range of services, both within their own sector and beyond.

When you come to me and I can't cure the sickness you came with, I will tell you to (go to) the hospital and see the doctor.

(Basic theme: services in other sectors, herbalist 3)

Communication with other participants: Participants described the importance of communication in linking PWCD to other services, and described using telephone, email, writing and the use of clients as information conduits. Participants described the need for both two way communication and for follow-up when linking PWCD to other services.

So I wouldn't leave them with just a referral but I'll follow up with calling whoever is in charge. It's not like referring a case of malaria, because there are many… But for these ones, they are a little bit more, I would say - a little bit outstanding cases that you don't just close out on them

(Basic theme: follow-up with other service providers, doctor 1)

Two participants indicated that their individual relationships with other services providers were important in linking PWCD to other services.

You would likely have a certain relationship with whoever you are referring to. So unofficially, you could always get feedback.

(Basic theme: relationships influence communication with other service providers, doctor 1)

Discussion

This study explored the nature of rehabilitation services provided to PWCD in the community, by a sample of community service providers in Accra, Ghana. Findings offer insight into their contributions to rehabilitation services for PWCD, in a Majority World context where there are limited formal rehabilitation services. Community service providers described the nature of services provided to PWCD in a range of ways, including: their beliefs about communication disability (Global theme (GT) 1), activities undertaken with PWCD (GT 2, 3 & 4), processes used in decision-making (GT 5) and connecting with other service providers (GT 6). Participants' beliefs about communication disability causation spanned physical, spiritual and environmental dimensions (GT 1) and were reflected in their reported approaches to intervention explanation, and advice (GT 2 – 4). Linking to other service providers, both within their own sectors, and beyond, was seen to be important part of providing care.

This study found that service providers in Accra contribute directly to service delivery for PWCD in three ways: by providing direct interventions, offering explanations and by promoting a range of strategies to support communication and communication development.

Direct interventions (GT 2, 3 & 4)

Participants described providing interventions for PWCD across a range of dimensions (GT 2), consistent with domains within the ICF (World Health Organization, 2001). Physical interventions, such as massage and medication, appear to address the ICF body function and structure level (World Health Organization, 2001). Interventions, such as training caregivers, may influence environmental factors in the ICF, by attempting to alter the communication environment, although further information about the nature of these interventions is required. Psychosocial interventions, targeting issues such as coping styles or behavioural responses, may respond to personal factors, or the body structure and function level of the ICF, if the

issue is a sequela of the impairment (Howe, 2008). Whilst congruent with the ICF, some of these interventions require further investigation to determine their effectiveness. However, a framework such as the ICF may represent an opportunity for SLPs and community service providers to create a shared platform upon which discussions about interventions and supports for PWCD may be based. Whilst SLP services in Accra are extremely limited (Owusu, 2016), this research highlights the potential community-based services offer in both improving service availability and for sharing knowledge between providers.

This study also identified that interventions offered to PWCD in Accra extend beyond the physical world into the metaphysical realm, through the provision of spiritual services. Recognising and responding to beliefs about disability is likely to be important to improving the acceptability of services (MacLachlan, 2006, Campbell et al., 2013). Spiritually-oriented services are consistent with the widespread spiritual beliefs about disability causation in Ghana (Tuakli-Wosornu & Haig, 2014). Plural beliefs, where scientific/physical and spiritual/folklore beliefs coexist, were evident in this research [GT 1 (spiritual beliefs of service providers) and GT 5 (spiritual beliefs of families)] and are widespread in SSA (Bunning, Gona, Newton, & Hartley, 2017). For services to be culturally accessible, service providers must acknowledge plural beliefs within the community (MacLachlan, 2006). However, despite the inclusion of spirituality within the ICF (World Health Organization, 2001), SLPs rarely use interventions that address spiritual needs (Mathisen et al., 2015). Traversing spiritual-physical beliefs may be complex for professionals trained in Western approaches to disability, due to lack of training on how to address spiritual needs, concerns about limits to the scope of practice, and the gradual secularisation of disability services (Mathisen et al., 2015). If rehabilitation services aim to be culturally accessible in Majority World contexts such as Ghana, where spiritual beliefs are part of everyday life, then SLPs need to find ways to acknowledge and incorporate their clients' beliefs.

Mathisen et al. (2015) outlined ways that SLPs can explicitly incorporate spiritual elements into rehabilitation, including attempting to understand the spiritual beliefs and needs of each individual and referring appropriately. As the SLP profession grows in Ghana, SLPs may consider establishing professional links to foster collaboration and facilitate access to spiritual support services. Responding to personal beliefs, by ensuring that holistic rehabilitation needs are considered, may influence the sociocultural acceptability of services (Campbell et al., 2013).

Explanation (GT 3)

Participants indicated they provide explanations about what has happened, and what should happen in the future to support PWCD. Explanations may represent a process of helping families to understand more about the nature of communication disability, according to the belief frameworks of the service provider. PWCD integrate their beliefs and experiences to make sense of their situation and make choices about interventions (Bunning et al., 2017; Wegner & Rhoda, 2015). Explanations assist in creating a shared vision, which is an important part of establishing trust between clients and providers. Trust has been shown to impact people's engagement with services and has been associated with improved acceptability of interventions (MacLachlan, 2006). Service providers with well-established links in the community are likely to be trusted sources of information and support.

In Ghana, SLPs may seek to establish strong links with pastors, doctors and herbalists with pluralist orientations, to ensure that they are able to incorporate explanation of biomedical causes and the possible range of treatment approaches. Participants in this research indicated openness to cross-sectoral engagement to support PWCD (GT 6) and a number reported plural beliefs about the causes of communication disability (GT 1). Whilst not all service providers may be open to exploring alternative views, the acknowledgement of pluralism by participants, coupled with tailored decision-making about the needs of individual (GT 5)

support the potential for SLPs to engage with community service providers. SLPs in Majority World contexts, such as Ghana, may look beyond multidisciplinary relationships seen in Western-style rehabilitation, to build community capacity in broader domains such as religion and traditional belief, to reflect beliefs and preferences within the community.

Supporting communication and communication development (GT 4)

Participants indicated that they support communication and communication development, using a range of strategies to be enacted by PWCD and their families. Strategies appeared to promote functional communication and included encouragement of the use of diverse modalities, stimulation and changes in interaction style. Strategies described by participants that promote continued communication/interaction and enhance the effectiveness of communication within everyday activities, appear to align with activity and participation categories within the ICF (O'Halloran & Larkins, 2008). These strategies also resemble approaches used by SLPs. For example, SLPs working with children adapt the communication environment, by changing patterns of interaction and creating stimulating environments (Bunning, 2004). SLPs working with people with aphasia offer communication partner training to improve communicative interactions (Simmons-Mackie, Raymer, & Cherney, 2016). Such commonalities may offer a platform to find synergies between approaches used by SLPs and community service providers to foster engagement.

As services expand, SLPs may seek to enhance the work of existing providers in promoting communication strategies and communication development, by developing community resources and training. The role of SLPs in training others in the community has been identified as integral to providing services in Majority World contexts (Crowley et al., 2013) and offers potential in meeting population needs (Wylie et al. in press). SLPs within SSA have indicated that training health and education stakeholders is an important role (Wylie et al., 2018). This research supports the need for SLPs in Majority World contexts, such as

Ghana, to broaden the scope of training to include partners within other sectors. Whilst strategies promoted by service providers may not be as specialised as the interventions provided by SLPs, working with a range of providers to improve the quality of information, may prove a useful way for SLPs in Ghana to increase the availability, accessibility, and acceptability of information and services for PWCD.

Limitations and future research

The heterogeneous nature of participants may have contributed to the large number of thematic networks within this study. Further studies are required to extend or refine the preliminary findings in this exploratory study, and may include larger samples and in-depth exploration of services provided by particular professions and in other contexts. Interventions were described by participants and not directly observed. Given the findings about the diversity of beliefs regarding the causes of communication disability, future research may seek to understand any relationship between beliefs and intervention choices made by service providers. In-depth exploration of service providers' beliefs, and the link to decision-making was beyond the scope of this study.

Conclusion

Findings from this research highlight the diversity of interventions, explanations, and communication strategies, reported by doctors, herbalists and pastors, in supporting rehabilitation services for communication disability in Ghana. These align with a range of domains of the ICF. Rather than replicating models of practice from the Minority World, this research supports the need for SLPs in Ghana, and in other Majority World contexts, to understand the landscape of existing services, and preferences of the community, in order to consider the most effective ways to develop services that meet their needs. Findings highlight the impetus for the emerging profession of SLP in Ghana, and similar contexts, to collaborate with service providers across a range of sectors, to build upon the information and services

those sectors already provide, to improve the availability, acceptability and accessibility of information services for PWCD.

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

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