CULTURALLY RESPONSIVE PRACTICE:

PERCEPTIONS AND PRACTICES OF SPEECH AND LANGUAGE THERAPISTS IN GHANA

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THIS RESEARCH DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON, IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF SCIENCE IN SPEECH AND LANGUAGE THERAPY

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DECLARATION

I, Vivian Kaetochukwu Asomba, do hereby declare that this dissertation which is being submitted in fulfillment of the requirements for the award of Master of Science degree in Speech and Language Therapy is the result of my own research performed under supervision, and that except where otherwise other sources are acknowledged and duly referenced, this work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

I hereby give permission for the Department of Audiology, Speech and Language Therapy to seek dissemination/publication of the dissertation in any appropriate format. Authorship in core such circumstances to be jointly held between me as the first author and the research supervisors as subsequent authors.

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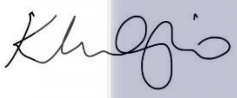
Signed:  Date: 23-Jan-2023

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ABSTRACT

The profession of speech-language therapy has been growing globally, with training programs developing in several majority world countries, including Ghana. However, speech-language therapy emanated from western tradition, including beliefs about disability and child-rearing. There has been limited investigation into how speech-language therapists from a non-western cultural tradition navigate the western foundations of the profession and the cultures within their own countries. This qualitative study explored perceptions of speech- language therapists in Ghana about the role culture plays in service provision and how they attempt to respond to this cultural divide.

Aim: The aim of this study was to explore the understanding of locally trained speech and language therapists (SLTs) about culture; why they think being culturally responsive is important; and to explore how they adapt western speech and language therapy practices to provide services tailored to the needs of their clients and families.

Methods: Twelve locally trained Ghanian speech-language therapist were recruited through convenience sampling. Semi-structured interviews were conducted. Interviews explored beliefs about the importance of culture in speech-language therapy, and the ways in which participants incorporated consideration of culture into delivery of services. Data were analyzed using Thematic Network Analysis.

Result: Three interconnected global themes represented the ways participants reported understanding and navigating culture to provide culturally responsive services: the centrality of culture in constructing a shared understanding of, and response to communication disability; the perception of culture as integral to creating a shared understanding; and the constant cultural translation/adaption required to make interventions meaningful to families.

Conclusion: Even though speech-language pathologists in Ghana are 'local', the origin of the

profession and diversity of clients they support means that consideration of culture is central within therapeutic interactions. Considering culture supports speech-language therapists to provide services that are meaningful and relevant to people with communication disability and their families.

Learning Outcome: To enhance understanding of the complexity of cultural adaptations required by speech-language therapists in majority world contexts.

DEDICATION

This study is dedicated to God Almighty who is my strength and fortress and to my amazing family for their love, support and sacrifices throughout this academic pursuit. Also, to my parents late Barrister James Ikechukwu Ezenwata and late Mrs. Marian Njideka Ifeanyi-Ezenwata, for laying the foundation of faith, hard work, and tenacity in my life.

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I say a very big thank to all the speech-language therapists in Ghana, particularly those who participated in this study, thank you for giving your time and contributing to this work, may God almighty bless you richly in Jesus' name, Amen. I would also like to thank the entire faculty member of the department of Audiology, Speech and Language Therapy, School of Allied Health, especially the H.O.D Dr. Ewurama Owusu, Ms. Nana-Akua Owusu, Mr. Clement Amponsah, for their contributions and advice towards this research work. To the SLT team at Korle-Bu Teaching Hospital, I say thank you for all your support and mentorship throughout my placements and for allowing me to leverage your networks to gain the support needed for the completion of this masterpiece. More so, to my classmates, especially Stella Ayivor and Emmanuel Addo, thank you for sharing your perspectives and gearing me up to the finish line.

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TABLE OF CONTENT

DECLARATION i
ABSTRACT ii
DEDICATION iv
ACKNOWLEDGEMENT v
TABLE OF CONTENT vi
LIST OF FIGURES viii
LIST OF TABLES ix
LIST OF ABRIVIATIONS x
CHAPTER ONE 1
INTRODUCTION 1
1.1 CULTURAL RESPONSITIVITY AND THE ROLE OF CULTURE IN SLT 1
1.2 PROBLEM STATEMENT 3
1.3 SIGNIFICANCE OF STUDY 3
1.4 AIM/PURPOSE/GOAL OF THE STUDY 3
1.5 SPECIFIC OBJECTIVES 4
1.6 RESEARCH QUESTIONS 4
CHAPTER TWO 5
LITERTURE REVIEW 5
2.1 FOUNDATIONAL SLT PROFESSION PRACTICES 5
2.2 LANGUAGE DEVELOPMENT IN CHILDREN AND IMPLICATIONS OF SLT PRACTICES IN MULTILINGUAL CHILDREN 7
2.3 CULTURALLY RESPONSIVE PRACTICES 9
2.4 THEORETICAL FRAMEWORKS 10
CHAPTER THREE 12
METHODOLOGY 12
3.1 INTRODUCTION 12
3.2 STUDY SITES 12
3.3 STUDY DESIGN 12
3.4 STUDY POPULATION 12
3.5 SAMPLING SIZE AND TECHNIQUE 13
3.6 INSTRUMENT FOR DATA COLLECTION 15
3.7 PROCEDURE FOR DATA COLLECTION 15
3.8 ETHICAL CONSIDERATION 16
3.9 DATA MANAGEMENT AND ANALYSIS 16
3.10 TRUSTWORTHINESS 19

CHAPTER FOUR 21
RESULTS 21
4.1 INTRODUCTION 21
4.1.1 . Thematic Network: Global Theme 1. Culture is a way of life that influences what we know about the world and how we interact with it. 22
4.1.1.1 Organizing Theme 1.1. Knowing About the World 23
4.1.1.2 Organising Theme 1.2. Doing: A Demonstration of Culture 24
4.1.2 Thematic Network: Global Theme 2. Culture is Integral to Creating a Shared Understanding. 25
4.1.2.1 Organizing Theme 2.1. Culture Influences How Clients and Families Respond to Speech and Language Therapy Services 26
4.1.2.2 Organizing Theme 2.2. Cultural Understanding Supports Clinical Reasoning In SLT 29
4.1.3 Thematic Network: Global Theme 3. SLTs Attempt to Use Their Cultural Understanding of Clients and Families to Make Clinical Practices Culturally Responsive 32
4.1.3.1 Organizing theme 3.1. SLTs develop and use cultural understanding about families as part of their clinical reasoning and decisions. 33
4.1.3.2 Organizing theme 3.2. SLTs attempt to use tools and resources they see as relevant to the child and the family's culture (resources) 38
4.1.3.3 Organizing theme 3.3. SLTs Use Their Understanding of a Family's Culture to Develop Therapeutic Relationships 42
CHAPTER FIVE 46
DISCUSION 46
5.1 INTRODUCTION 46
5.2 DEFINING CULTURE (KNOWLEDGE) 46
5.3 PERCEPTIONS OF THE IMPORTANCE OF CULTURAL RESPONSIVITY (ATTITUDE). 47
5.4 BEING CULTURALLY RESPONSIVE IN PRACTICE (BEHAVIOUR) 50
CHAPTER SIX 55
CONCLUSION, LIMITATIONS AND RECOMMENDATION 55
6.1 INTRODUCTION 55
6.2 CONCLUSION 55
6.3 LIMITATIONS 55
6.4 RECOMMENDATION 56
REFERENCE 57
APPENDICES 64
APPENDIX I: RECRUITMENT FLIER 64
APPENDIX II: INFORMATION SHEET 65
APPENDIX III: INFORMED CONSENT FORM 68
APPENDIX IV: INTERVIEW TOPIC GUIDE 69
APPENDIX V: ETHICAL CLEARANCE 74
APPENDIX VI: COREQ (CONSOLIDATED CRITERIA FOR REPORTING QUALITATIVE RESEARCH) CHECKLIST REPORT 75

LIST OF FIGURES

Figure 1	-	Structure of a thematic network
Figure 2	-	Thematic network: Global Theme 1
Figure 3	-	Thematic network: Global Theme 2
Figure 4	-	Thematic network: Global Theme 3

LIST OF TABLES

Table 1 - Demography of participants

Table 2 - Thematic networks: Global, Organizing and Basic themes

LIST OF ABRIVIATIONS

ASHA	-	American Speech Language and Hearing Association
SLT	-	Speech and Language Therapy/Therapist
CRP	-	Culturally Responsive Practice
LMICs	-	Low-middle income countries
AHPC	-	Allied Health Professions Council of Ghana

CHAPTER ONE

INTRODUCTION

This chapter provides an overview of western epistemological foundation of speech and language therapy profession, the role of culture in delivery of speech-language therapy and the need for culturally responsive practice. Additionally, it describes the Ghana context, the problem statement, significance of the study, aims and objectives of the study.

1.1 CULTURAL RESPONSITIVITY AND THE ROLE OF CULTURE IN SLT

Culturally responsive practice (CRP) is the ability of health providers and organizations to deliver health care services that meet the cultural, social, and religious needs of patients and their families, (Swihart, Yarrarapu, & Martin, 2022). CRP is an important consideration guiding practice within the speech-language pathology profession (ASHA, 2004) which allows speech-language therapists (SLTs) to provide services with an understanding, appreciation, and respect for the unique cultural and linguistic attributes of the individuals they serve (Leininger, 2002; Sue, 2001). Historically, most of the speech-language therapy profession throughout the English-speaking world is built upon a foundation of 'White' cultural perspectives (Hopf, Crowe, Verdon, Blake, & Mcleod, 2021). As such, the values, cultural expectations including childrearing practices, conception of disability (Pillay & Kathard, 2015; Wylie et al., 2017; 2020) and linguistic norms of the western world have become inherent in the practices of the speech-language therapy profession (Farrugia-Bernard, 2018). SLT practices for example, in United States, Canada and Australia are premised on monolingual English Language Speakers (Staley, Hickey, Rochus, Musasizi, & Gibson, 2021), which results in mismatch between the "linguistic homogeneity of the profession and the linguistic diversity of its clientele" (Caesar & Kohler, 2007). Pillay and Kathard, (2015) suggested that culturally responsive practice is critical when implementing practices with families where beliefs and practices may differ to the western origins of the interventions.

Ghana is an example of one such country where the profession of speech and language pathology,

has been introduced, but the families receiving services may have differing childrearing and disability beliefs to those upon which many treatments are grounded. Ghana is a multilingual society and has about eighty languages and around 75 ethnocultural/native (The Bureau of Ghana Languages- BGL, 2013). It is a tropical country situated along the Gulf of Guinea coast, (World Bank, 2021) with Accra as its capital. The population of Ghana is approximately 31 million people (World Bank, 2021) of which 1 in 15 may have a communication disability (Hudson et al., 2020).

Recent establishment of local SLT training and licensure of SLTs by the Allied Health Professions Council (AHPC), are contributing to the growth of the profession in Ghana (Owusu, 2016) with about 35 practicing SLTs across the country presently (Ghana Gazette, 16th July, 2021). Currently, the University of Ghana receives external support from SLTs in the UK, Australia, and USA, (Hudson et al., 2020). This may likely embed further proliferation of western knowledge and practices in the speech-language therapy profession in Ghana. Wylie et al. (2017, 2020) pointed that in Ghana, as in much of Sub-Sahara Africa, Eurocentric approaches to the management of disease and disability have been adopted. Therefore, cultural responsiveness is a vital practice necessary to mitigate these disparities faced by non-mainstream culturally and linguistically diverse communities with communication disorders.

Adapting traditional speech pathology professional practices is also warranted in high-income western countries when providing services to multicultural and multilingual communities. In the United States, Maul (2015) investigated perceptions and practices of SLPs regarding modifications of usual practices when interacting with culturally and linguistically diverse clients. Findings show that languages spoken, and working with interpreters, are barriers, while respect for cultural differences, positive interaction with family members aided culturally responsive practice. In Ghana, it is unclear to what extent Western practices or other more culturally relevant practices are being used. Since locally trained SLPs have been licensed to practice across the country, this qualitative research investigates how western resources and approaches are adapted to suit the needs, beliefs,

and values of the local families they serve.

1.2 PROBLEM STATEMENT

Speech and language therapy profession is underpinned by western belief (Pillay & Kathard, 2015). SLT practices for example, in United States, Canada and Australia are premised on monolingual English language speakers and pediatric intervention in speech-language therapy profession are founded on western perspectives on child development or rearing (Staley et al., 2021). It is vital for the profession of SLT in majority world countries, to develop in culturally and contextually relevant way (Pillay & Kathard, 2015). Part of the cultural imperative is to ensure that SLTs working in Majority World contexts engage in culturally responsiveness to provide appropriate services rather than trained merely to provide technical skills in a predetermined way" (Wickenden, Hartley, Kariyakaranawa, & Kodikara, 2003). However, since the inception of the SLT profession in Ghana, there has been no investigation to know to what extent Western practices or other more culturally relevant practices are being used when interacting with persons with communication disability and their families in Ghana.

1.3 SIGNIFICANCE OF STUDY

This study provides information on (1) the understanding of SLTs about culture and the specific culture of the client and their family and (2) how Ghanian SLTs adapt western oriented practices to make them responsive to local cultures. This information will be used to shape education for SLTs in Ghana in the future. Ultimately, this may support the development of assessment and intervention techniques that are culturally relevant for individuals with communication disability in Ghana.

1.4 AIM/PURPOSE/GOAL OF THE STUDY

The aim of this study is threefold:

- To explore what Ghanaian SLTs understand as culture
- To explore the SLTs perceptions of culturally responsivity

- To explore how SLTs describe adapting western speech therapy practices to deliver culturally responsive services.

1.5 SPECIFIC OBJECTIVES

Specifically, the study will:

- Investigate how currently practicing SLTs in Ghana define culture (knowledge).
- Describe the perceptions of SLTs in Ghana about the importance of cultural responsivity (attitude).
- Investigate how SLTs in Ghana report adapting western SLT practices when providing services to persons with communication disability and their families within the Ghanaian context (behavior).

1.6 RESEARCH QUESTIONS

- How do currently practicing SLTs in Ghana define culture (knowledge)?
- What are the perceptions of SLTs in Ghana about the importance of cultural responsivity (attitude)?
- How do SLTs in Ghana report adapting western speech therapy practices when providing services to persons with communication disability and their families within the Ghanaian context (behavior)?

CHAPTER TWO

LITERTURE REVIEW

2.1 FOUNDATIONAL SLT PROFESSION PRACTICES

Cultural Foundations and Implication for SLT Practice

The profession of speech and language therapy (SLT) is conceptualized on epistemologies and theories developed around white middle class experiences and understandings of the world (Hyter, 2022; Pillay & Kathard, 2018). As a result, cultural expectations, and linguistic norms of the white, have become embedded in the practices of the profession across the globe (Hopf et al., 2021), which does not reflect the linguistic and cultural diversity of the population in Majority world countries (Pascoe & Norman, 2011). Culture consists of the 'learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways' (Leininger, 1991). Culture involves both explicit variables such as food, clothing, language, and implicit variables, including 'age and gender roles within families, child-rearing practices, religious and spiritual beliefs, educational values, fears, and attitudes' (Battle, 2011). Several researchers (Mcleod et al., 2017; Semela, 2001; Wegner & Rhoda, 2015) have discussed the influences of culture on family's values, religion, language preference, kin structure, child-rearing practices, roles and responsibilities of family members and perception of health and the perception of disability. Nonetheless, Eurocentric beliefs continue to underpin many speech-language interventions, such as western parenting approaches including parent-child style of play (Pillay & Kathard, 2015; Wylie et al., 2017). Programs that utilize Parent-Child Interaction (PCI), such as the Hanen program (Johnson, 2013; Klatte Harding, & Roulstone, 2019) are also based upon assumptions that parents are the child's primary caregiver and that the family values the child being talkative. These beliefs are not necessarily shared or accepted by families from other countries (Kleeck, 1994). For example, In Ghana, children are expected to show respect for their elders and listen respectively (Nyarko, 2014). It is necessary that SLTs working with clients and families from culturally and

linguistically diverse community or country to understand that clients may possess culturally based world views which may differ from theirs (Eckermann et al., 2010) and/or from their professional recommendations (Kenny, Lincoln, & Balandin, 2010), to ensure appropriate holistic care and client-centered practice (Mathisen et al., 2015).

Linguistics Foundations and Implications for Practice

Linguistic knowledge of communication and its disorders are also derived from Indo-European languages such as English, French, German (Pillay, 2003) and this knowledge underpins judgments of 'normality' by SLT professionals. Important questions to consider are whether each individual-client has their performance compared with the norms of a population that is representative of them, and whether norms used are truly representative of overall abilities of the population (Pascoe & Norman, 2011)? For example, a study conducted by Stanczak, Stanczak, & Awadalla (2001) found that typical Sudanese adults attained scores on the Arabic version of the Expanded Trail Making Test that were like those attained by US adults with brain damage. Bedore, Lisa, Peña, & Elizabeth (2008) further noted, that lack of understanding of what can be expected of young dual language learners in children may lead specialists to interpret bilingual children language performance as symptomatic of delay or even impairment when, in fact, it is typical of dual language learning. In addition, issues of determining language difference and or disorders in assessment findings is also an example of challenges posed by linguistics homogeneity of speech therapy profession (Smith, Summers, Mueller, Carillo, & Villaneda 2018). This is evident that culture, and familiarity with the type of testing material (Carter et al., 2005) and language development environments (Bedore et al., 2008) can influence performance outcomes.

The linguistic homogeneity of SLT profession also poses a challenge when the same ideas are addressed in another culture in speech therapy intervention strategies. Vocabulary, stereotypical concepts, high-frequency words, body language and gestures differ between cultures and languages (Pascoe & Norman, 2011). For instance, a well-recognized therapeutic strategy such as cuing words

using the initial consonant sound as for English (Greenwood, Grassly, Hickin, & Best 2010) may not work well with languages which typically begin with a vowel sound (Gxilishe, 2011).

In addition, one-on-one individual therapy approaches that historically informed the work in speech therapy may result in services that are inaccessible, unaffordable, and unattainable in countries in Sub Sahara Africa such as Ghana (Abrahams, Kathard, Harty, & Pillay, 2019.; Wylie, Bampoe, Amponsah, & Owusu, 2016) due to socio-contextual factors. Given the multicultural and multilingual characteristics and peculiar social context of the Ghanaian society, these existing health and educational disparities faced by non-mainstream culturally and linguistically diverse communities with communication disorders are equally evident.

2.2 LANGUAGE DEVELOPMENT IN CHILDREN AND IMPLICATIONS OF SLT PRACTICES IN MULTILINGUAL CHILDREN

Language is a social phenomenon and is inextricably linked with cultural identity (Al-Harbi, 2019.; Paradis, Genesee & Crago 2011). Physical immersion in a particular linguistic environment and interaction has a significant role in language acquisition, (Al-Harbi, 2019.; Paradis, et al., 2011,) Children begin to acquire the language in their environment in the first three years of life, progressing through key stages of language development, (De Keyser & Larson-Hall, 2005).

The first stage of language acquisition in children is their innate predisposition for vocalization. In this stage children babble and coo, primarily, to exercise the articulatory organs in an experimentally random and playful manner, typically occurs in the first 6-months of life (Tomasello & Bates, 2001). The language (s) that the caregiver(s) use is the primary linguistic environment from which children acquire their language. According to Lieven and Tomasello (2008), between the ages of six to nine months children begin to babble in a pattern that is like the patterns of adult speech. At first, what predominates are nasal /m/, /n/ and /ng/ as well as the voiced stops /b/, /d/ and /g/. Children then progress to the one-word stage around the age of 1 (Lieven & Tomasello, 2008). At this stage, children use only one word (including made-up words) to refer to random things and, at times, to substitute for a complete sentence. For example, toddlers in this stage may imply “I am hungry” by saying “eat”.

Also, vocabulary acquired at this stage tend to be concrete words (e.g., 'car' and 'ball'). By the age of 1 year and 8 months, the two-word stage begins, during which children begin to represent an entity with two words, albeit without morphological and syntactic markers, but with a unique word order. For example, the utterance "dada chair" could mean "dad is sitting on the chair," "that's my dad's chair" or "Dad, could you put me on the chair?" The next stage of language development as stipulated by Lieven and Tomasello (2008) is the telegraphic stage which occurs between the ages of 2–2½ years. In this stage, children may only say about 50 words, and use rudimentary sentences, that is, word series without grammar. For example, a child may say to her mother "I good girl, but can understand many more complex sentences. This process of language development continues to puberty and is considered a critical period of language acquisition (Spada, & Lightbown, 2004)

Bilingual children, particularly those who acquire two languages from birth (simultaneously) are found to acquire their target languages in correspondence, with their same-age monolingual children (Bedore, et al., 2008; Paradis et al., 2011). However, there is heterogeneity in language experiences or skills among young bilingual children which makes it possible for them to lag behind monolingual children of the same age, particularly in vocabulary and grammatical development when each language is measured separately (Hoff, & Core, 2013). This variability among young bilingual children further makes it virtually impossible to identify a single reference group for standardized testing of bilingual children (Thordardottir., Rothenberg., Rivard., & Naves, 2006). Yet, standardized tests are generally required for establishing language disability and to differentiate language disorders from language difference in young bilingual children. Further, it is well established that using monolingual norms to assess one of a bilingual child's languages offers a limited view of language development, a practice, that results in an underestimate of bilingual children's overall language knowledge, and over-identifies children at risk for language impairment (Thordardottir, et al., 2006). It is generally recommended that bilingual children be assessed in both of their languages. However, specific procedures for such bilingual assessment and for interpretation of the results are lacking

(Thordardottir, et al., 2006). Refining the notion of typical vs impaired language, as well as addressing the issues of determining language difference and or disorders in assessment findings (Smith et al., 2018), requires that SLTs understand the cultural and appropriate language development expectations (Bedore et al, 2008), of the children they support.

2.3 CULTURALLY RESPONSIVE PRACTICES

Abrahams et al. (2019) assert that traditional SLT practices are a project of coloniality and argues the need to question, critique and rethink these professional practices. This requires the speech and language therapist to engage in reflexive, culturally responsive practice, in order to consider how to more effectively engage with individuals with communication difficulties and their families to achieve the best possible outcomes (ASHA, 2014). Verdon (2020) noted that therapeutic relationships and mutual understanding with families are an important part of engaging in culturally responsive practice. According to Melvin, Meyer, and Scarinci, (2020), engagement is enhanced when: "1) engagement is both a state and a process; 2) parents are supported to engage with intervention when they build trusting relationships with speech-language therapist; 3) parents are supported to engage with intervention when open, two-way communication is established; and 4) parents are supported to engage in intervention when speech-language therapists work together with them in sessions" (p.2665). Nyantakyi and Oetting, (2023), suggested that being responsive to the various culturally diverse needs of Ghanaians helps the SLT to efficiently partner with clients and their families. Nyantakyi and Oetting, (2023), described three culturally responsive strategies including empathy, affirmation, and additive or complementary expertise used regularly by SLT's in serving the diverse multi- ethnic population of Ghana. Being culturally responsive is complex and requires a range of skills, attitudes, and processes. In 2015, Verdon, McLeod, & Wong developed six principles of culturally competent practice. These include: (1) identification of culturally appropriate and mutually motivating therapy goals, (2) knowledge of languages and culture, (3) use of culturally appropriate resources, (4) consideration of the cultural, social, and political context, (5) consultation with families

and communities, and (6) collaboration between professionals. While the term culturally competent has been largely replaced by the term culturally responsive, the principles continue to be relevant to everyday clinical practice. Zingelman, Pearce, & Saxton (2021) also, explored the perceptions of speech-language therapists with regards to culturally responsive service delivery and assessment practices, when working with Aboriginal and Torres Strait Islander children in Australia. They identified insufficient knowledge, training, and experience as a major barrier to the SLTs' skills to cultural responsiveness. Other barriers included the impacts of colonization, accessibility, and policy. Critiquing the service provision model in western Kenya, Staley et al. (2021), investigated the successes and challenges of speech and language therapy delivery using Hyter's (2014) framework for responsive cultural engagement, by examining three clinical case studies. Their study illustrated that services designed with local knowledge, away from the direct one-on-one model of care that is common in the minority world, may be a better way to deliver a more valid, relevant, and culturally acceptable practice, that is tailored specifically to the cultural context of the individual and the community.

Insights from above empirical studies, particularly Staley et al. (2021) and Zingelman et al. (2021) show that indeed foundational practices in the SLT profession can frustrate delivery of services that are culturally responsive, valid, and relevant. Therefore, considering the unique multilingual and multicultural Ghanaian communities, few trained SLTs and limited structures to support the emerging speech and language profession in Ghana, it is timely and crucial to explore the perspectives and practices speech therapists in Ghana engage in meeting the needs of individuals with communication disability as informed by the specific dynamics of their client' context.

2.4 THEORETICAL FRAMEWORKS

Valente, Paredes, and Poppe, (1998), noted that actions and activities of individuals are influenced by a complex mix of what they believe (their attitude), what they know (their knowledge) and how they enact this (their behavior). Thus, in exploring the perceptions and the practices of SLTs in Ghana

about culturally responsivity, we employed Schrader & Lawless' (2004) framework of knowledge, attitudes, & behaviors, in framing the questions. The findings were also framed using the Verdon et al. (2015) six principles of culturally competent practice. The use of this framework enabled a clear interpretation of the ways that the overarching principles are enacted in Ghana, which represents a unique, social, cultural, and political context.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the method used in this study This includes the study setting and research design; participants and inclusion or exclusion criteria for participation; sampling methods; data collection procedures; the instrument used and data analysis and interpretation processes.

3.2 STUDY SITES

The study was conducted in Ghana, with participants located within Accra the capital and outside of Accra. These participants worked either at hospitals, inclusive mainstream schools or in non-governmental organizations that cater for people with disability. Participants were able to be interviewed in places convenient for them, or opted for online or telephone interviews. Data was collected from participants in places that were convenient for them. Three (n=3) interviews were conducted at the participants place of work while nine (n=9) others were conducted via online Zoom meetings.

3.3 STUDY DESIGN

This study used a qualitative descriptive design to explore the knowledge, attitudes, and behaviors of SLTs about culturally responsive practice in speech and language therapy (Chafe, 2017; Sandelowski, 2000, 2010). Qualitative description was considered relevant to the enquiry as it allows consideration of experiences and perceptions (Creswell, 2007; Sandelowski, 2000, 2010) enabling the researcher to gain a deeper understanding of the phenomenon under investigation (Doyle, McCabe, Keogh, Brady, & McCann, 2020). Descriptive research design is a highly relevant approach to explore clinical issues that can contribute to change and quality improvement in practice settings (Chafe, 2017).

3.4 STUDY POPULATION

The study population was Ghanaian trained speech and language therapists currently working with

children with communication disability in Ghana.

Inclusion Criteria

This study sought to understand the experiences and perspectives of the new workforce of Ghanaian speech and language therapists. To be eligible to participate in the study, participants were required to:

- have received university qualification in speech and language therapy within Ghana.
- be licensed as a speech and language therapist by the Allied Health Professions Council of Ghana at the time of the interview.
- be working as a speech and language therapist in Ghana at the time of the interview.
- be Ghanaian nationals.
- have at least 1-year post-graduation work experience.

Exclusion Criteria

Participants were excluded from this research if:

- they received university qualifications in speech and language therapy outside of Ghana
- they did not meet the inclusion criteria.

3.5 SAMPLING SIZE AND TECHNIQUE

Twelve (12) speech and language therapists participated in this study. Sample size in qualitative research is often small, given the deep, detailed analysis that is central to its practice (Hennink & Kaiser, 2022). Furthermore, speech and language therapy in Ghana is a very small profession with 35 SLTs currently registered with the (AHPC) of Ghana (Ghana Gazette No. 66, 2022). The sample size represents just over one-third of the population of SLTs in Ghana. Small sample sizes in interview-based research, reflective of numbers in this study have been shown to produce saturation (Hennink,

Kaiser, & Marconi, 2017).

Participants were recruited using convenience sampling allowing the researcher to invite participants that are opportunistically available about access, location, time, and willingness (Lopez & Whitehead 2013). Recruitment Flyers (Appendix I) were distributed to speech and language therapists in Ghana, using the personal networks of the student researcher and supervisors to inform SLTs in Ghana about the study. Interested parties contacted the student researcher. The Participant Information Sheet (Appendix II) and consent forms (Appendix III) that described the study in detail, were provided. If consent forms were signed and returned, interview times were scheduled with each participant and conducted by the student researcher. Characteristics of these participants including information regarding age, language(s) they speak fluently, type of degree, the location where they work etc. are represented in the table below. All the participants are multilingual with English and Twi as mostly spoken languages. The participants were between the ages of 20-49 with 11 of the 12 participants working in greater Accra and with children living with speech and language disorder.

Table 1. Demography of participants

Participant	Age	Languages Spoken	Year of Graduation	University A;ended	Degree Earned	Work Location	Work Organization	Work Client Group
P-001	20-29	English, Twi,	2020	UG	MSc	Outside Accra	Hospital	Speech Disorder, Language Disorder Multimodal Communication Voice, Stammering
P-002	30-39	English, Twi	2017	UHAS	BSc	Accra	School	Speech Disorder, Language Disorder Multimodal Communication Voice, Stammering
P-003	30-39	English, Twi	2018	UG	MSc	Accra	Hospital, School	Speech Disorder, Language Disorder Multimodal Communication Voice, Stammering
P-004	30-39	English, Twi	2018	UG	MSc	Accra	Hospital, School	Speech Disorder, Language Disorder Stammering, Cleft
P-005	20-29	English, Twi, Hausa	2020	UG	MSc	Accra	Hospital	Speech Disorder, Language Disorder, Stammering, AAC
P-006	20-29	English, Ewe	2019	UHAS	BSc	Accra	Hospital, School	Speech Disorder, Language Disorder, AAC

P-007	30-39	English, Twi, Ga, Ewe	2018	UG	MSc	Accra	Hospital	Speech Disorder, Language Disorder, Voice, Head & Neck, Stammering Dysphagia
P-008	20-29	English, Twi, Ga, Fanti, Dagbani	2018	UHAS	BSc	Accra	School	Speech Disorder, Language Disorder, Stammering Dysphagia, AAC
P-009	30-39	English, Twi, Ga, Ewe	2018	UG	MSc	Accra	Hospital	Speech Disorder, Language Disorder, Dysphagia, AAC, Cleft
P-010	30-39	English, Twi, Ga	2020	UG	MSc	Accra	School	Speech Disorder, Language Disorder, Stammering, AAC
P-011	40-49	English, Twi, Ewe	2020	UG	MSc	Accra	Hospital	Speech Disorder, Language Disorder, Stammering, AAC, Cleft
P-012	40-49	English, Twi, Fanti	2018	UG	MSc	Accra	Hospital, School	Speech Disorder, Language Disorder, Stammering, AAC, Cleft

3.6 INSTRUMENT FOR DATA COLLECTION

Semi-structured interviews were used to collect data, giving participants the opportunity to represent their ideas using own words (Schutt, 2018). Semi-structured interviews are useful in exploring a person's beliefs, experiences, and perspectives (Bachman & Schutt, 2020). A purpose-designed topic guide (Roberts, 2020; Tong et al., 2007), (Appendix IV) based on key concepts from previous literature and developed in collaboration with research supervisors, according to the principles developed by Roberts (2020), was used to guide questioning to enable consistency in interview processes. Basic demographic information, listed in the topic guide (Appendix IV) was collected as part of the interview questioning. The ability to describe the sample is important in qualitative research to ensure transparency, and promote rigor (Tong et al., 2007).

3.7 PROCEDURE FOR DATA COLLECTION

In-depth interviews were conducted from 5th October to 31st October 2022, with each of the twelve (12) participants. Participants selected dates and settings that were convenient for them. Each interview took between 30-45 minutes. All interviews were conducted in English language for consistency. Interviews were recorded, with consent, to enable accurate transcription and data

analysis. Responses were transcribed verbatim, and coding commenced concurrently with data collection. Concurrent data collection and coding is vital to review if data saturation is occurring (Tong et al., 2007).

3.8 ETHICAL CONSIDERATION

Permission to carry out the study was sought from Ethics and Protocol Review Committee (EPRC) of the School of Biomedical and Allied Health Sciences (SBAHS), to ensure all ethical protocols were addressed. Approval was granted on the fifteenth (15^{th}) of September 2022 (SBAHS/AA/ASLT/10874176/2021-2022). Thus, this study adhered to the ethical standards (APPENDIX V), provided by the EPRC of SBAHS of the University of Ghana.

Prior to data collection, the researcher provided clear information about the study to the participants and sought voluntary informed consent for participation. Participants were informed that they could opt out at any point during the study without any reason and consequences. The researcher ensured anonymity of participants' identities and the confidentiality of their personal data. Interviews were held in a private location. Participant IDs rather than identifying information were used on all transcripts. Only the research team had access to the transcripts. All publications, including the thesis, did not contain identifying information. The researcher also ensured that participants were not exposed to any form of harm as a result of undertaking this study. Light refreshments such as water, soft drink and biscuits were provided to participants who opted for face-to-face interview after the interview session. A summary of findings of this research will be made available to all SLTs in Ghana, including participants. It is anticipated that this information may be beneficial to their clinical decision making when working with families or persons with communication disability from diverse backgrounds

3.9 DATA MANAGEMENT AND ANALYSIS

Audio recorded data were transferred to a computer immediately following data collection. All original audio and transcription files were password protected and backed up regularly. Hard copies

of documents, such as printed transcripts were stored in a locked cabinet. Thematic Network Analysis (TNA) (Attride-Stirling, 2001) was used to analyze the data and develop a map of key ideas or themes represented in the data. Thematic Network Analysis 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). Thematic Network Analysis uses six analytic phases to enable consistency and transparency in theme development (Goldbart & Marshall, 2014; Hersh et al., 2021).

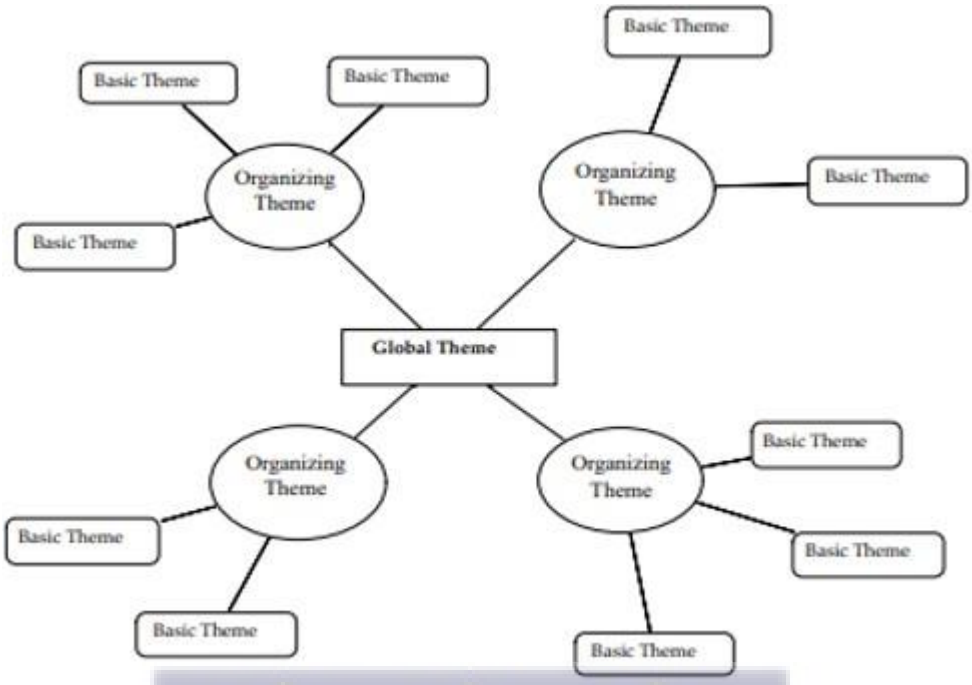
The six steps of TNA (Attride-Stirling, 2001) used to develop themes and theme relationships were as follows:

1. Coding the material: Data were imported and coded using NVivo software (QSR International, 2022). The text was broken up into manageable and meaningful segments. Inductive coding (Skjott, Linneberg & Korsgaard, 2019), with codes representing meaning embedded within the transcripts, was used to undertake preliminary coding of 33% of the sample (four interviews). Codes represented key ideas linked to the three research objectives – knowledge of culture, importance of culture to clinical practice and processes used by SLTs to respond to culture. A preliminary coding framework was developed and revised iteratively during coding of the remainder of the data. Each code had explicit boundaries (definitions), and codes were not interchangeable or overlapping. No new codes were developed in the last three interviews, indicating saturation was likely to be reached.
2. Theme identification: Next, coded segments of text were repeatedly read, re-read, and reviewed to begin to extract key ideas, looking for underlying patterns. Preliminary themes were drafted and refined, gradually building key ideas into basic or key themes. This iterative process helped to reduce the data to a series of meaningful themes representing key ideas within the text, that related to the research objectives.
3. Construction of the thematic networks: A thematic network is developed starting from the Basic Themes and working inwards toward a Global Theme. The basic themes identified

provide the fountainhead for the thematic networks. The following process was used.

- Basic Themes: Codes were reviewed and grouped into preliminary Basic Themes, representing a central idea. Basic themes were reviewed and revised, reflecting content from the coded segments. Basic themes are the lowest-order theme derived.
- Organizing Theme: Basic Themes were clustered into similar issues, drawing together key notions within the grouped Basic Themes. Names were generated and refined by the wider research team. Organizing themes are more abstract than basic themes and more revealing of what is going on in the texts.
- Global Theme: Global Themes are super-ordinate themes that draw together the key ideas in the data. Organizing Themes reviewed and grouped considering their constituent Basic Themes, and brought together to illustrate a single conclusion about the research questions. Once the Global Themes were developed and reviewed by the team, the thematic networks (linking together basic, organizing, and global themes) were presented graphically.

Figure 1: Structure of a thematic network



4. Describing the thematic network: Once the thematic networks were refined, the student researcher described the networks in text. This is presented in the results section of the thesis, supported by illustrative quotes from the original transcripts/data to support the analysis.

5. Summarizing thematic networks: A summary of the themes within each network, and links to relevant theory exploring key concepts are discussed.

6. Interpreting patterns: Interpreting patterns is also discussion of the thesis.

3.10 TRUSTWORTHINESS

Trustworthiness can be described as procedures in which researchers engage to create confidence within their research (Norman & King 2020). Lincoln et al. (1985) highlighted four criteria promoting trustworthiness. These include credibility, transferability, dependability, and confirmability.

- Credibility: In this research credibility was promoted using multiple investigators and theoretical triangulation. Multiple researchers were involved in the review of the analyses. Coding, of the data and the subsequent theme development were reviewed by research supervisors, experienced in qualitative research, promoting trustworthiness and rigor

(Tong et al., 2007).

- Transferability: A second factor for trustworthiness offered by (Lincoln et al., 1985) is transferability. While qualitative research design, such as this, does not aim for replicability, we believe that the patterns and descriptions from this research may be applicable to another context. This is because thick descriptions such as contextual information about the field work site. Participants and the organizations where they work were well stipulated and described.
- Dependability: In this study, there were regular communication events such as debriefings and collaborative review. This supported the dependability of findings, particularly during coding of data, construction of themes, analysis, and interpretation of data.
- Confirmability: Confirmability means how close the research findings were to objective reality. The data was checked and rechecked throughout data collection and analysis. Clear coding schema was used to identify the patterns in analysis. Members of the research team were all familiar with the context, provided feedback on the coding and themes and discussed any possible bias, prior to data analysis.

To support the quality of research design, conduct and reporting, the 32-item COREQ consolidated reporting criteria (Tong, Sainsbury, & Craig, 2007) provided a guide for the quality of the research project, particularly in conducting and reporting its findings.

CHAPTER FOUR

RESULTS

4.1 INTRODUCTION

This investigation examined the perceptions and practices of Speech and Language Therapists (SLTs) in Ghana as regards to cultural responsivity in clinical practice. It sought to answer the following three (3) research questions (RQ):

1. How do currently practicing SLTs in Ghana define culture (knowledge)?
2. What are the perceptions of SLTs in Ghana about the importance of cultural responsivity (attitude)?
3. How do SLTs in Ghana report adapting western SLT practices when providing services to persons with communication disability and their families within the Ghanaian context (behavior)?

Thematic network analysis revealed three (3) Global Themes, with a single global theme linked to each research questions. These themes represented participants' (SLTs) thoughts about how western practices are used, not used, and adapted in Ghana to suit the context and the needs of clients/family's they work with during speech & language therapy, as well as their perceptions regarding the importance of cultural responsivity and their understanding of the nature of culture. The global themes with constituent organizing and basic themes for each network are outlined in Table 2 below.

Table 2. Thematic networks: Global, Organizing and Basic themes

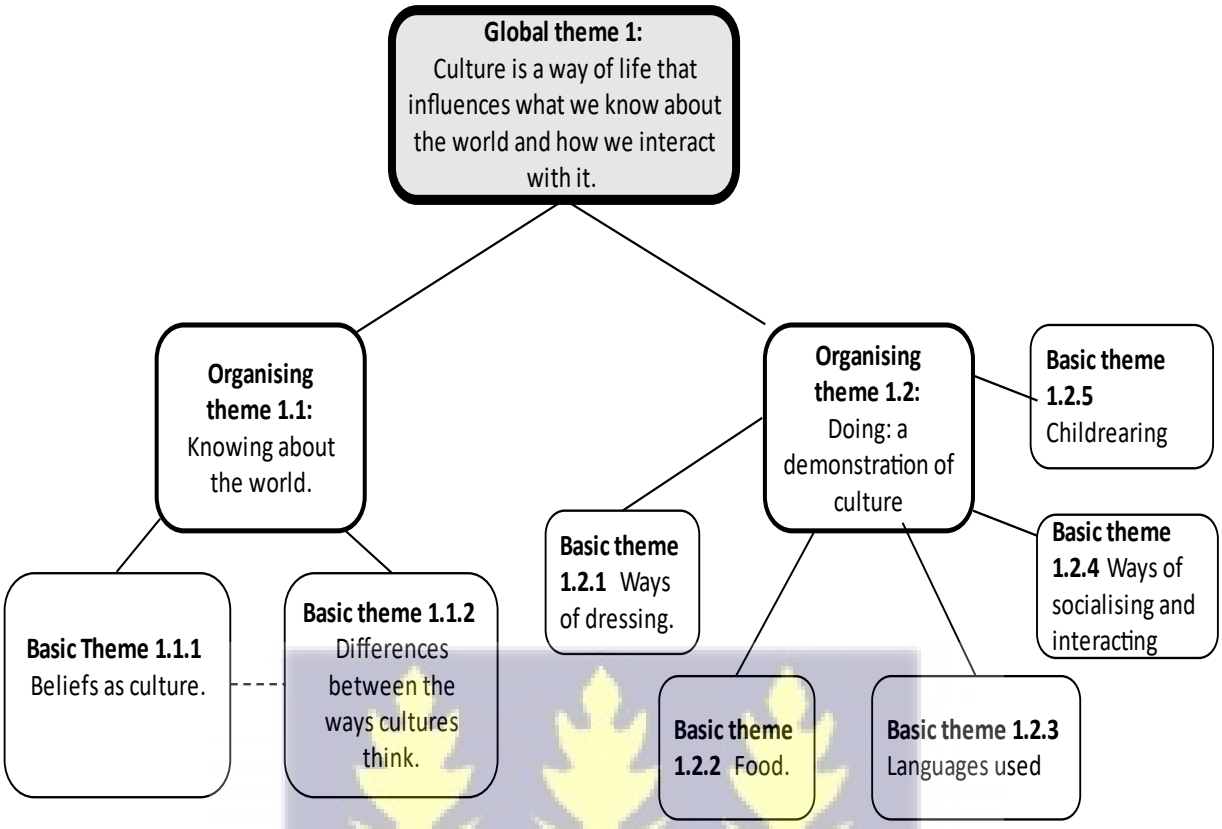
Global Themes	Organizing Themes	Basic Themes
1. Culture is a way of life that influences what we know about the world and how we interact with it	1.1 Knowing about the world	1.1.1 Beliefs as culture 1.1.2 Difference between the ways culture think
	1.2 Doings: a demonstration of culture.	1.2.1 Ways of dressing 1.2.2 Food 1.2.3 Languages used 1.2.4 Ways of socialising and interacting 1.2.5 Childrearing

2.	Culture is integral to creating a shared understanding.	2.1 Culture influences how clients and families respond to speech and language therapy services	2.1.1 Culture influences what families find acceptable 2.1.2 Responding to culture can influence outcomes for clients
		2.2 Cultural understanding supports clinical reasoning in SLT	2.2.1 Cultural understanding shapes SLT perceptions of what they should do 2.2.2 Culture influences how SLTs understand the communication issue
3.	SLTs attempt to use their cultural understanding of clients and families to make clinical practices culturally responsive	3.1 SLTs develop and use cultural understanding about families as part of their clinical reasoning and decisions	3.1.1 Understanding family cultural background to help plan clinical activities 3.1.2 Prioritizing every day and functional activities 3.1.3 Explicitly considering language choices 3.1.4 Deciding which SLT materials are relevant
		3.2 SLTs attempt to use tools and resources they see as relevant to the child and the family's culture (resources)	3.2.1 Using local materials 3.2.2 Making resources 3.2.3 From there to here – adapting western resources
		3.3 SLTs use their understanding of a family's culture to develop therapeutic relationships	3.3.1 Using culture in creating connections with families 3.3.2 Using cultural understanding to explain ideas to families.

4.1.1 Thematic Network: Global Theme 1. Culture is a way of life that influences what we know about the world and how we interact with it.

Research question one (1) investigated participants understanding of culture. Analysis of participant descriptions of culture resulted in the global theme 1, "Culture is a way of life that influences what we know about the world and how we interact with it". All respondents discussed culture as a way of life, comprising a series of elements about how people view the world and live their lives. These were clustered into two organizing themes- "Knowing about the world" and "Doings: a demonstration of culture". Each of these organizing themes are described below together with exploration of the constituent (basic) themes. Direct quotes have been used to illustrate the findings.

Figure 2: Thematic network: Global Theme 1



4.1.1.1 Organizing Theme 1.1. Knowing About the World

This organizing theme represented descriptions of internal ideas and processes that shape people's way of life and worldview. These were described within two basic themes: beliefs as culture, and differences between the ways cultures think.

- Basic Theme 1.1.1: Beliefs as culture. This basic theme represented notions about specific beliefs or beliefs systems held by individuals and communities, with a strong focus on spiritual and religious beliefs.

  The belief systems of people in a particular community (participant 1)

  Religion is part. People believe in religion, whether Muslim, Christian, whichever way there's (a) religion part. (Participant 10)

- Basic theme 1.1.2: Differences between the ways cultures think. This basic theme represented more general references to thinking by cultural groups with a focus on

contrasting one culture to another.

Their worldview could be different from another culture (participant 12)

4.1.1.2 Organising Theme 1.2. Doing: A Demonstration of Culture

This organizing theme brought together ideas about behaviors that demonstrated culture and group belonging. It consisted of five basic themes.

- Basic theme 1.2.1**:** Ways of dressing. This basic theme represented more general references to the ways groups dress as a demonstration of their culture.
- Basic theme 1.2.2: Food. This basic theme represented general references to the type of foods people eat within their culture.
- Basic theme 1.2.3: Languages used. This basic theme described language as a unifying or identifying aspect of culture and cultural belonging.

  Language defines the people. And so, in every community, we have language that defines them. So, for instance, I work in the Eastern region, if you go there its basically the Akupem Twi… then you get…very few people are with other languages, but it is basically the Akueem Twi, the pure Akupem people in that community. (Participant 1)
- Basic theme 1.2.4: Ways of socializing and interacting. This basic theme went beyond the language used to discuss ways of communicating and interacting with others, including social norms.

  For example, if you're talking to an elderly person, you put your hands behind your back. If you have a cap you take it off. That's how they live, that's how, that's what their culture teaches them to do. (Participant 3)
- Basic theme 1.2.5: Childrearing. This basic theme represented ideas central to raising children as culture. Given the topic of the research, numerous examples of elements of childrearing specific to Ghanaian culture overall were describing including relationships

between adults and children, the role of extended family in childrearing and gendering of roles, in terms of behavioral expectations of children and in parental responsibilities in rearing and decision-making about children.

> *Growing up, you interact with adults more and you keep talking, then they will be like, a child shouldn't be doing that. A child shouldn't be doing that. A child shouldn't be talking too much. A child shouldn't be playing with adults too much. As a child, you need to be(on) your lane when adults are talking, go away, let the adults talk. And sometimes when you're even talking to your mom or your dad, you don't have that kind of, mother son relationship because usually you see them as your superiors and don't have that liberty to freely play with them. (Participant 2, relationships between adults and children)*

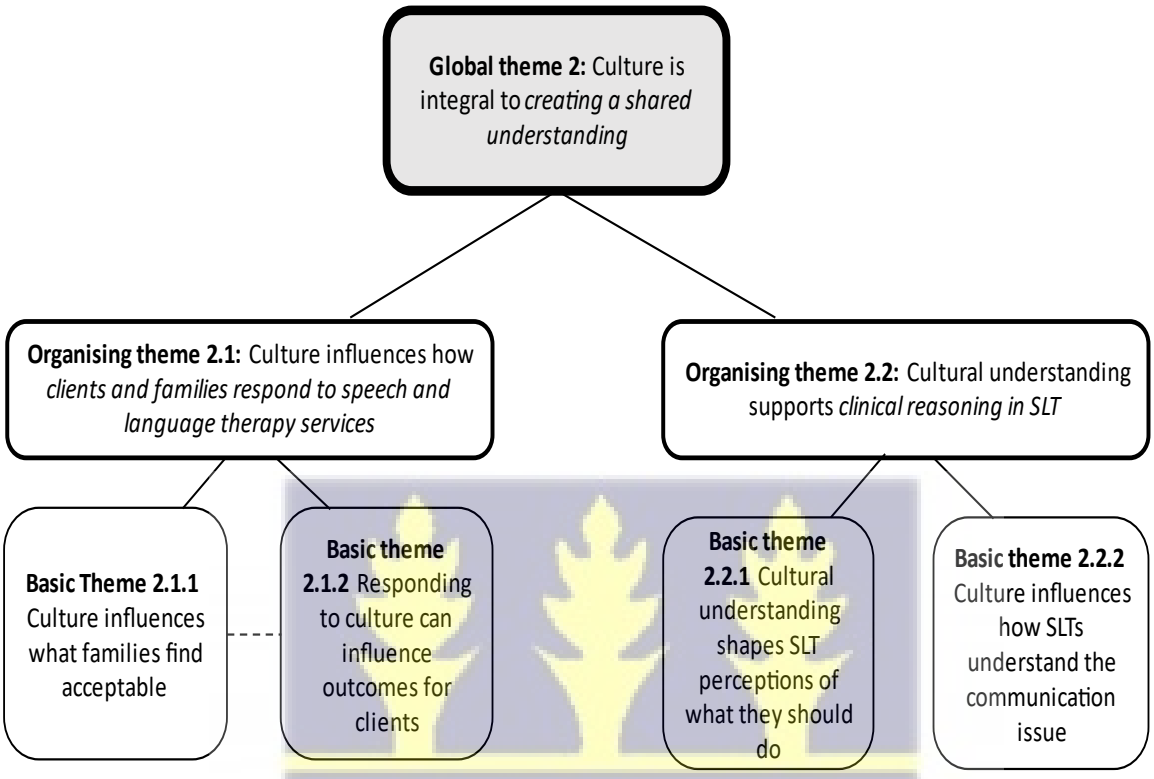
4.1.2 Thematic Network: Global Theme 2. Culture is Integral to Creating a Shared Understanding

Research question 2, explored the perceptions of SLTs in Ghana about the importance of cultural responsivity. All participants indicated that being culturally responsive was very important to their everyday practice. Participants described the reasons for this perceived importance, with reference to both how culture shaped their own thinking about practice with clients, and also describing how culture of their clients influenced whether and how families engaged with services.

Overall, participants saw culture as integral to developing a shared understanding between families and SLTs of the communication issues, and how to best respond to it within the person's everyday context, represented by the global theme, "Culture is integral to creating a shared understanding". Participants recognized the diversity of cultures within Ghana and the importance of adapting and responding to this diversity in their everyday clinical practice. The global theme had two constituent organizing themes-. Culture influences how clients and families respond to speech and language

therapy services and Cultural understandingsupports clinical reasoning in SLT. The thematic network is represented in figure three, with organizing and basic themes described below.

Figure 3: Thematic network: Global Theme 2



4.1.2.1 Organizing Theme 2.1. Culture Influences How Clients and Families Respond to Speech and Language Therapy Services

All participants discussed the role of culture in shaping how families viewed communication issues with their children and how they engage with services. This organizing theme consisted of two basic themes.

- Basic Theme 2.1.1 Culture Influences What Families Find Acceptable.

  Participants discussed the importance of culture in shaping what families find acceptable, in two key ways: the power of belief in influencing understanding and choice, and other ways that culture influences the way families engage with therapy services. Firstly,

participants recognized the strong spiritual belief held by many families, and the role that the spiritual beliefs play in navigating communication disability, including both the interpretation of the cause of the communication issue and the means to improve the situation. An example of the importance of belief in deciding what to do about the communication disability was expressed by participant 1,

> *Even in the process of (SLTs) educating them to let them know that some condition we are seeing are not really spiritual, because, they have beliefs that may be that some conditions are spiritual … in some communities … they think that people who have cerebral palsy, are given by the river. And look when they come into the clinic and you are telling them therapy will work, they think therapy wouldn't do anything. Taking them back to the river will solve the situation. It makes it makes it a little difficult to work with such families.*

Participants also discussed explicitly incorporating discussion of belief into their interactions with families to help them understand their options and to make choices about intervention.

> *You have to also know how to present differing views. So, you your view differs from that of the family or their culture, you have to know how to address the differences. And then if there is a need, or if, if the family sees it as something that they would like to be corrected, then fine, but then you don't have to impose what you think and believe because of your culture. You don't impose it. (Participant 5).*

Secondly, participants also described how culture and cultural mismatch in SLT practice influence the ways in which families interact with services, for example relationships between therapists and parents:

> *In the European countries, if a young person is talking to you the person's job is the*

person's job. So, professional professionally like speaking, but over here when you are young, and most of the time, we are working with people who have children, they ask you {akola- do you have a child?} So, they seem to see us as young girls who have not experienced life. We don't have the right to give them advice on the child. So, they won't take advice, which is also a cultural thing. Because the foreign people that we see, don't give us that idea, they take the recommendations. (Participant 6).

A mismatch between western practices and local culture was commonly noted in early language intervention which focuses on play and language stimulation, resulting in parents struggling to engage in the therapy process, for example,

(SLTs) telling them that when you go home, give more opportunities for the child, you play more with the child, and when you are speaking with the child you come to the eye level so the child is able to interact with you more; they sometime find it difficult…I see I it as a way that with our culture is not something that we do and it's very difficult for us. And so, when you are a therapist and then you advise parents that when you go, may be do labelling of item, label the item before you give it to the child. Sometimes they find it difficult for them to do, and then they will end up telling you the therapist to come home and do it for them to see. (Participant 2)

- Basic Theme 2.1.2: Responding to Culture Can Influence Outcomes for Clients.

Almost half of the participants described the importance of adapting practices to accommodate culture to achieve positive outcomes for clients. Participants highlighted that without responding to culture, SLTs may not be able to offer acceptable interventions, and the same progress in therapy would not be made.

Culture influences the way we do everything. So, the way we think the way we interact, everything is influenced by culture or the environment. And so, we when we when we adapt the materials, we are able to really meet the needs of an individual, we because a child, for example, a child acquiring language, the environment, plays and culture plays a key role. So, with that, if we're able to adapt it and change, the needs of the clients that we serve, I think their needs (will) be well met, it should be able to meet their needs, and then get some progress with whatever we are doing with them. (Participant 2)

Everything is influenced by our culture. If we don't adapt our practices…we wouldn't be able to make any impact that will be accepted by everybody in our setting. …So, that is why it is extremely important. (Participant 11)

4.1.2.2 Organizing Theme 2.2. Cultural Understanding Supports Clinical Reasoning In SLT

Participants talked about the ways in which they used their understanding of culture to understand and interpret the communication difficulties their clients were presenting with and to decide how best to intervene and support the clients and their family. The basic themes constituted around this Organizing Theme were: Cultural understanding shapes SLT perceptions of what they should do; Culture influences how SLTs understand the communication issue:

- Basic theme 2.2.1: Cultural understanding shapes SLTs' perceptions of what they should do. Participants talked about awareness of their own culture as well as awareness of the cultures of their clients as shaping their practice. In reflection, many participants talked about their own culture, and how they attempt to recognize but not let their own cultural background influence their therapeutic interactions in a negative way.

  Okay, so for example, maybe a family walks in, in, in my therapy room, and maybe

... they are like a more modern family, but I'm from a more culturally, let's say, a northern family. And in my culture, you don't you don't sit until offered a seat. So, if the child comes in, and then ...walk(s) straight to the seat and sits down without me telling him, how do I how do I respond to that? Because knowing my culture, it is not permitted or it's not done. So, if if the child walks in and goes to sit down, would I promptly tell the child to get up and wait for me to tell him to sit down? Or how do I respond to such a situation. So be mindful of your own culture and being sure that it doesn't overstep the boundaries set. (Participant 4)

Speaking the same or preferred language of the client was seen as a useful way to respond to the culture and language needs of the family. Therapists openly talked about handing over clients to other SLTs more fluent in that language, if possible, in their workplace.

I'll I start to speak Ga with them, or I speak Eweh with them, then I'm like, oh, I am mainly Ewe, then they are nicer to me. So, it affects the rapport you have with the clients. Also, if another person comes in, who can explain better to the clients, the things you are trying to tell them. They would identify with that person better than you because it's easier for them. If you are having an assessment, and the child is of a different background. (Participant 9)

Many participants described the importance of taking time to understand the cultural background of the client, and the contexts in which families live as this knowledge supported their decision-making about how to offer interventions, such as types of home activities, or who to coach to support the child at home.

What I've come to realize that in Ghana, you cannot just be dishing out a set of activities. Even to a mother or to a father. The first question you have to ask, you know, as a speech therapist who spends more time with the child, okay? Yes, because it could be an auntie. And so, what you do is if it is an auntie, then you ask

that they bring auntie in the next session. So, you talk to, you are giving all the activities directly to auntie, whilst mum is there. The reason is that mom is not a professional. Okay? And so, they might not be able to, you know, sort of coach auntie as you would. (Participant 12)

- Basic Theme 2.2.2 Culture Influences How SLTs Understand the Communication Issue. Culture was seen as an important mediator of knowledge, helping SLTs to interpret the nature of the communication issue that the child presented with. Participants referred to the lack of normative data relevant to Ghanaian communities and languages, and the overuse of western norms. *We don't even know what our system is in terms of ...our typical errors in terms of spoken (language), in terms of understanding what does it mean? What do I say that it (is) okay (when) a Ghanian child is not able to, say to understand the negatives? So, at what age are we saying that (is) okay,this Ghanian child is having this kind of error. (Participant 8)*

Many participants talked about the need to understand culture and language to help them to untangle language difference as opposed to disorders of language, made more complex by the lack of normative data above.

Trying to find out the language disorder and the language difference. You know in our cultural settings the languages that we have, we have our various sounds in the various languages. For example, if I have, in my part, the part that I came from. We usually interchange our /l/and /r/, because some part like the Akupems, they use the /l/ and we use the /r/. So, when someone says bra/bla which means come; we see nothing wrong with it. So, if I have someone say /bla/ they may laugh at the person maybe he is having a disorder. I see that as differences in terms of culture. (Participant 2)

Participants emphasized the need to make language assessments as culturally relevant as

possible, by considering the environment of the child and adapting assessment materials. This type of cultural adaptation was seen by participants as assisting them to understanding the true abilities of the child. One poignant example, from participant 4, described the following situation:

> *I had a client, where I tried to test the receptive language of the client with one of the foreign tests, and this child wasn't performing well... But a teacher insisted that (they) know all these items you're presenting, the child is familiar with them. So, then I thought, okay, how about I change all these test materials to something that child, knows. So, I went in for their class books, their class text book, and I took pictures that were familiar to the test materials from those class books. And then I made them into some form of test. And when I presented this same item(s) to the child, the results showed that he performed, so he knew. He was familiar with the test materials, but then because of the, you know, unfamiliarity with the items of the western test kits. If I were to be a speech therapist that didn't take his culture into consideration, I would have scored him as someone that had a deficit in that area. But that wasn't the case. You see, so that's like, one example because speech therapist we need, so that we get valid assessments result.*

4.1.3 Thematic Network: Global Theme 3. SLTs Attempt to Use Their Cultural Understanding of Clients and Families to Make Clinical Practices Culturally Responsive

The third research question for this study investigated what SLTs in Ghana report doing to respond to culture when providing services to persons with communication disability and their families in Ghana. All participants described how they use culture to frame the ways in which they adapt western approaches to SLT, to make them relevant to Ghanaian clients and their families. There was recognition by all participants about the need to tailor practices to clients and their families, given the

range of cultures within Ghana. The need to understand the culture of each client and their family was clear, leading to the global theme statement, *SLTs attempt to use their cultural understanding of clients and families to make clinical practices culturally responsive".* This global theme comprised three organizing themes, which related to clinical reasoning and decision making (Organizing theme 3.1: SLTs develop and use cultural understanding about families as part of their clinical reasoning and decisions); the use of culturally relevant materials (Organizing theme 3.2: SLTs aspire to use tools and resources they see as relevant to the child and the family's culture); and creating relationships with clients and their families (Organizing theme 3.3: SLTs use their understanding of a family's culture to promote a shared understanding). Thematic network 3 is presented in figure 3 below and each of the organizing themes and constituent basic themes are then described

Diagram 4: Thematic network: Global Theme 3

4.1.3.1 Organizing theme 3.1. SLTs develop and use cultural understanding about families as part of their clinical reasoning and decisions.

This subtheme represented the use of understanding of a client and their family's culture to reason about more appropriate ways to provide therapy services. This organizing theme, included the following four basic themes.

- Basic theme 3.1.1: Understanding family cultural background to help plan clinical activities. This basic theme represented the examples of ways participants described their attempts to understand more about client culture and background to help them consider what types of activities may be useful.

  We (try) to get enough information about family background and culture…the people in their immediate surroundings and the area they are in, because it plays a big role. If I know the child is in Nima, for example, the way I would give the recommendations different from a child (in) …East Legon. I would go, can you at

least you know, try to talk to the moms in school to see if you can get friends (for the child to socialize with). But if I'm talking to somebody from Nima, I will be like "Ma, you know in Nima , there are lots of children there, does the child go outside? Do you mind letting the child go outside and play?" Because, again, they are two very different ideas of how they interact. (Participant 9)

- Basic theme 3.1.2 Prioritizing every day and functional activities. It was clear that many participants used an understanding of families' everyday lives to plan interventions based on an individual's everyday experiences.

It's all based on what they tell me during the assessment, and then … So, if they tell me that, okay, these are their routines, they maybe they have reading time, sleeping time, bath time, and then mealtime, those are their typical routines, things that they tend to do on an everyday lifestyle. So, I tell them, okay, so based on the routines they've given, then (I) advise accordingly. So, it has to do with how the family live, and what they do, their lifestyle and everything and then based on that, I'll be able to suggest based on the information they've given me. (Participant 5)

This was seen to be important, rather than creating additional tasks for parents to do with their children, for example,

I found that that's asking parents to carve out time to work with their child is almost like, you know, asking them to (fly to) the moon. And so, the best is to, you know, sort of get them to embed it in the daily routine. (Participant 12)

To do this, participants described needing to understand details of the natural environments that the child and adult are in, to help them choose activities that they could use therapeutically within the person's everyday experiences. Participant 12 went on to eloquently describe the financial imperative, linked to poverty, of not placing additional time demands on parents:

So, remember that here in this part of the world. Poverty, okay, there's poverty. I've dealt with families in rural areas. And where I asked them, what do you do? And they said, we are farmers. And I say, okay, whilst, you're farming. Where do you put the child under the tree close by? Are you able to sing for the child to hear? Are you able to still talk to the child? And they say, yes, I said, okay, then you can do that. But if (you) don't ask all these questions and you're not ready to work with them and say, oh, you need to carve out time…where's the time? They still need to go to the farm, they still need to fend for their families, so I think I have become more and more culturally aware.

Participants also discussed the importance of understanding and using daily routines, how they were conducted so they could use these routines to provide communication support.

You still have to find things that they are comfortable with. …You don't pick anything out of their space, you try to use everything the family has, that can work for them. So, you don't impose other interventions that you know are not relevant to them. Otherwise, you might not see progress. Try to, you know, find interventions that they can get at home, it's accessible, it's easy to find it's easy to do. It …is in their daily practice, and then you are able to see much progress the next time they come. (Participant 7)

- Basic theme 3.1.3: Explicitly considering language choices. Participants also talked about careful consideration of the language that assessment and intervention were delivered in. Participants discussed their own clinical reasoning about which language that they used with the client and their family.

The language in which the assessment is being carried out, I've really taken a conscious look at that. Because one, when we see the clients, we ask the language the child speaks. You know, so many times parents will tell you, we speak English

and this, we speak English and Twi, or sometimes just English. I've had an instance where a mother continued to say that the child speaks English. But then when you when I did the assessment in English, he wasn't really getting it. Then later on, I asked "Mum, what other languages does he speak?" She said, "Ga". To my surprise, he answered all questions in Ga, you understand. So, we've really taken a very good look at the language, the language we are supposed to communicate, or interact or assess the child in first, that's the most important thing. (Participant 4)

Okay so one is, a colleague sees a child, and then the child is not from his or they don't really know about the culture of that child, or maybe the language of that child, then they try to find a colleague, for example, if let's say I'm seeing a child, and then the language that they speak is Ga, and I don't know that and then they tell me that this child is more exposed to Ga, I'll get a Ga colleague , to maybe go in do the assessment, because he 'll be able to speak the Ga with a child he will be able to get more from the child like when it comes to translating, items. I think we try to get someone to interpret the materials into the local languages to make sure that you're able to, to really get what we're trying to tell them. So, for example, if it's something that I know that maybe their Ga's is something that it's easy to find in their community when a Ga person is there, he would be able to tell me oh, this thing, the child will not be able to know, so let's use this. So, we try to communicate with each other and then maybe find a better way, should I use better or try to find someone who is able to speak their language and can really relate well with their family. (Participant 2)

Despite formal interpreting services being unavailable, several participants talked about translating materials as they conduct assessments, as in:

Participant: Sometimes when the family comes in, you know that the English will

not work. So then in their presentation even though…I'm reading it in English I'm seeing it in English, when I'm talking … about it with a child or with a parent. I change the language.

Interviewer: And in therapy too, do you always do therapy in English or other language.

Participant: So, I mix it. I do some I do in English; some I do in Twi. (Participant 3)

- Basic theme 3.1.4: Deciding which SLT Materials are Relevant. Participants described their thinking about the use of a range of assessment materials for their clients. They indicated using a mix of formal tools and informal tasks, such as play based and functional tasks. Formal materials were predominantly in English, although the use of one Ghanaian resource in both Twi and English was widely mentioned by participants [Osei-Bagyina Twi Articulation Test (OB-TAT) and the Osei-Bagyina Test of English articulation (OB-TEA)]. All participants recognized that the normative data linked to formal (western and /English) tools was not relevant to their clients, but many participants described deciding to use parts of these tools as a starting point for understanding the language issues of the client. For example, participant 3 stated

  "*We picked some of the information from those standardized tools, and try to bring it to our, our, our context" and participant 2 "I can use It (a formal tool), but not try not compare with other kids, but try to look at that child in particular, the strength and weakness' using it informally.*"

Participants also described adapting how tests were administered. Rather than using the whole test, many participants described using only parts (either subtests or particular test items) within a formal test that were judged to be culturally relevant to a child and interpreting findings informally to describe the language of the child, for example,

When I realized that a Ghanaian child will not know this picture that I'm showing, I just skip it and go to the ones that I know that he should be able to, he should be able to say it or know it, I just sift through and stuff. And then at the end of the day, I won't say I did formal, I'll just write. … So, we use that we use that assessment, informally, so when you're writing a report, I'm supposed to state that I used the assessment tool informally for this child. (Participant 10)

4.1.3.2 Organizing theme 3.2. SLTs attempt to use tools and resources they see as relevant to the child and the family's culture (resources)

This organizing theme represented the extensive consideration that participants reported engaging in about the cultural relevance of materials they use. Participants described attempting to ensure materials are relevant by doing three things, representing the basic themes. These included: Using local materials, making resources and adapting available western resources.

- Basic theme 3.2.1 Using Local Materials. Participants described how they use locally available materials within assessment and intervention where possible. This included using real (locally sourced) objects that clients would be likely to be familiar with, with some element of judgement based on their cultural background. For example,

  So, using our Ghanian culture, like specific items in the environment, so if its Banku. If you're talking about food, I will not go and bring fried rice to the Ghanian child who is coming from a very typical zone unless the person is within the East Legon zones, then I can maybe use fried rice because it's, it's common there, but deep down, I will change, the object that I'm looking at in terms of food. In terms of clothing, I will look at different things that are more suitable. (Participant 8)

Almost half of participants discussed the need to understand what resources families have

at home, to help them know which material to use

> *So, I always ask, what do you have at home? what can we use at home, you know, I always will ask what they have, because some parents can't afford buying all these luxurious resources, so I always dwell on what the person has got at home. (Participant 1)*

Linked to basic theme, 3.1.4, where participants described adapting how they used formal assessments, participants described what they do to make resources relevant, including selecting and using local, culturally relevant pictures within assessments and intervention.

> *Also using culturally appropriate pictures. So … you use pictures such as pizza, and broccoli, to …assess a child that had never seen such things, and you scored them, for instance, that they could not identify such things. I think that that wouldn't … so it was good to use culturally appropriate pictures as well. Things that the child knew from their environment. (Participant 12)*

- Basic theme 3.2.2 Making resources. Participants also indicated that they made their own resources for both assessment and intervention with clients, using local materials or creating local pictures.

> *We made some stories in different languages which fitted the sounds that had to be there. If the sound wasn't in the language that we know that it's not part of the assessment, and it's not needed. We did the same for developmental language delays… (participant 9)*

and

> *There were times when we had to go around and take pictures, just so that we could be able to do the assessments, to be able to teach the child you know. (Participant 12)*

Making or creating resources including pictures was seen as important to ensure that

children could be assessed in ways that could best represent their abilities, rather than being culturally biased.

> *And then we've taken note of the resources, especially the picture-based resources, we've made sure that we have pictures that reflect more on the Ghanaian cultural things that the child can easily see, identify and understand. Imagine having a hippopotamus. The child has not seen a hippopotamus in Ghana before. But if you talk if you if you if you go "show me hippopotamus", the child will (not) be there, but then let's replace this hippopotamus with a let's say, cat, or even these hens, cow, goat, Sokoto, Goodale, you know, these animals that are readily seen around the child we immediately point to, because one, he's been seeing it every day. He's heard about it. (Participant 4)*

- Basic theme 3.2.3: From there to here – Adapting western resources.

Participants talked about how they adapted western resources to make them more culturally appropriate. This often-included swapping pictures within the task, as in,

> *We've changed the picture to somebody eating beans or sometimes somebody eating macaroni. We've changed the water to let's say, somebody's drinking water. It's not a glass, maybe sometimes, depending on the area the child comes from, again, because of cultural issues. Sometimes the water if you see them, the water some of the children, you see sachet water. Some of them you see glass, some of them you see Voltic. But it depends on the area. That's how we do it, we see the child were like, Oh, this child, where they're coming from how the mother is talking, if you give the child Voltic, the child will not see the Voltic bottle anywhere, it's sachet they have, so you use sachet. (Participant 9)*

Participants also discussed translating English language tools into other languages.

> *And then sometimes I just like translate, whatever I want to do in the language. So,*

for Ewe, for instance, we don't really have any test kits... So you just have to translate whatever questions in the language that they currently, they understand. So that's, those are some of the modifications that I do. (Participant 6)

However, a few participants recognized that translating was not always easy, for example participant 2 stated

"*Since most of the things we practice are in English and from the western world, sometimes trying to translate it to our local languages becomes a bit difficult*".

Many participants described the need for flexibility in whether and how they adapted resources and tasks for participants, based on their culture due to the diversity of the clients that they see.

So I think that for you to be culturally responsive, or to be able to culturally adapt, it's always to ask, ask, ask what works with the family. Don't assume that even your you think you have culturally done your cultural adaptation, that one size fits all, not one size doesn't fit all. Because remember that we live in a society, in Africa, in Ghana, that our culture is so different, even from unique people from Ashanti region, and then you meet various tribes. You know, in the Ashanti region, they are there. People come from here, people come from there, they do things so differently. Okay, even when you think that you have your culturally responsive material to work with, you still have to ask, you know, because they're telling you that, oh, in our culture, we don't do we don't have anything to do with snails, for instance, you know, here you are reading a snail story to the boy, you know? Uh huh. We always ask what works, what works? (Participant 12)

Most participants clearly expressed those western resources needed adaptation to make them relevant and useful to the client and their family.

More of contextualizing most of the assessments. So, making them relevant to our

culture, let me say yes, making them relevant to our system, our environment, how things work for us, not necessarily just picking that, the assessments and then imposing them on, on ours or on clients. But if there are a few changes, you have to make, you change a bit to suit the kind of patients we see. So I remember that was what we were told not necessarily just lift everything and then give to patients like they are in Europe or America or something. But so, contextualize it, make it make it make it Ghanaian, yes. More or less make it Ghanian, for them. (Participant 7)

For one participant, the importance of adapting resources for use in Ghana went beyond choosing familiar objects and activities, to make the essence of the resources Ghanaian to make clients comfortable. While only one person commented on this, it appears to be a valuable consideration.

And then also, I also got, I learnt that too by learning about the assessment itself. So, I noticed it helps people it was designed for that, like the Europeans and all that it helps them because they able to find themselves in it. So you notice that they do things that are convenient for them. So you notice all the assessment tools, the pictures and all that, are things that they are familiar with. So, upon having the knowledge, I thought changing a few things here and there would suit our system as well so that people can find themselves in it and be able and be comfortable with that as well. (Participant 7)

4.1.3.3 Organizing theme 3.3. SLTs Use Their Understanding of a Family's Culture to Develop Therapeutic Relationships

Participants reflected on how they use their understanding about a client and their family's culture to forge therapeutic alliance and relationships. This organizing theme included three basic themes.

- Basic theme 3.3.1 Considering Culture in Creating Connections with Families.

Participants discussed attempting to understand the cultural background of each of the families they worked with, including the beliefs they have about the child's communication disability, so they would make connections with families. Participants talked about understanding how to deliver information, keeping culture in mind, to enable families to hear and accept information.

> *We know in our culture we don't throw news, especially bad news at people. In our culture, you just don't throw bad news at people like that, sometimes, most of the time, you have to find out how ready the people are, are they the people who will accept whatever you are saying, are they the type who will doubt it. (Participant 11)*

This consideration of how to present information included responding to beliefs about communication disability and sometimes include discussion of beliefs with parents to accommodate both the spiritual and therapeutic aspects, for example

> *So that day I just told her that "You know what, I know you have your beliefs, but look you are also working, you are working so hard to get this child improves some of the skills she has lost." So, it's not about belief here, you know because I felt that, yes, God is there, but we still are working, God is playing their part and we are also doing what we have to do. (Participant 1)*

Some participants described making it clear that they understood the challenges faced by families and try to support them by responding to the emotional aspects of the impact of the communication disability. They discussed demonstrating empathy, for example,

> *I found that when you're talking to them, you have to be a bit more tactical with this, because every little thing you say, takes away the motivation and the encouragement to try. ... Ghanaians like empathy. ... So, you have to be I know how it is. Like, "You know, I don't have kids but only imagine how you feel. I work with*

the children for 45 minutes and sometimes even I get tired too. I know that … every day is hard. But this is how we manage"… (participant 3).

Some participants described creating hope by using examples from other similar families they have worked with, for example, participant 9 stated

"You try to let them know that, okay, we have we've seen children, just like your child. And they are, getting some progress".

Two participants also stressed the need to address the potential for blame and stigmatization,

"*It is very important to know that you are not supposed to tailor it towards a parent being a cause of anything … because stigmatization is very high*"*(participant 8).*

One participant in particular described how they used their understanding of clients' culture to understand how to engage with the family.

It is believed that a man is the head of the family. Okay, so a man being the head of the family. If a family should come around, you try to make the man feel he's in charge of things at home, even though you know, the woman might probably have so much information. You try to give audience to the man a lot, just for him to feel that respect. (Participant 7)

- Basic theme 3.3.2: Using cultural understanding to explain ideas to families.

Participants talked about using their understanding of culture to help them understand how to best explain ideas or therapy processes in ways families would be likely to understand or relate to. Participants talked about the importance of using language in two ways - both in using a language that families would be able to easily understand during the interaction, as in:

Some of them with the understanding of the condition general. I have learnt that you have to explain it to the parent in local language for them to really understand

what it means to say that a child has this condition. Doing a local way helps them to really have a general acceptance of what the condition is about. (Participant 2)

Some participants also spoke about making sure they used language that families were likely to understand

Interviewer: So how do you ensure you explain things in culturally relevant ways? Participant 5: Well, I break it down in, I don't use complex words or big, big grammar, that would make it even more difficult for them to understand. So, I break it down for them, so that they can understand it.

Participants also talked about using what parents are culturally familiar with as relatable examples, using analogies. One participant described a poly tank analogy, another described an analogy for saving money for explaining the development of receptive and expressive language. Understanding the family background was important to making explanations relatable.

Because you've had a conversation with them, you've about maybe the parent themselves, their family, their occupation, maybe their house, their other kids and all that, usually, I would use examples that are relatable to them. ...The Mother, is a seamstress, the designer or the father drives the car... In my explanations, I try to use examples that's it's in line with their work their job, or something that happens in the house that they have told me to talk to them. (Participant 3)

Promoting visual strategies to support understanding of families who may not immediately understand verbal explanations was discussed by a number of participants.

For instance, parents who don't really, they can't read, it's good to use pictures for the visuals. ... Sometimes it's difficult to find appropriate words in our local language to define some of these things. So you use pictures, visuals, to like, explain. And I can go further and get videos as well. (Participant 6).

CHAPTER FIVE

DISCUSION

5.1 INTRODUCTION

This study investigated the perceptions of speech-language therapists in Ghana about the importance of culture in speech and language therapy and the ways in which SLTs use their understanding of culture to shape the ways they offer services, to meet the needs of clients. Three thematic networks offer insight into ways participants reported understanding and navigating culture to provide culturally responsive services. The research questions and thematic networks present findings of the research questions that represent the knowledge, attitude, and behavior of SLTs (Schrader & Lawless, 2004).

5.2 DEFINING CULTURE (KNOWLEDGE)

This research question explored participants' understanding (knowledge) of culture. Understanding what participants know about culture shaped interpretation of findings in subsequent research questions that explored attitude and behavior. Understanding what people know about a topic is relevant as knowledge shapes the thinking of individuals about what is important, and influences how they make decisions about whether and how to use this knowledge (Schrader & Lawless, 2004). Overall, participants in this study described culture as a way of life that influences what we know about the world and how we interact with it (Global theme (GT) 1). This global theme had two clear elements represented by the organizing themes: (1) knowing, or internal beliefs, and (2) doing, outward facing demonstrations of culture. Internal beliefs included spiritual/religious beliefs and perspective about the world, while outwards demonstrations of culture involve, type of food, dressing, language, socialization, and childrearing practices of a group of people. Similarities can be seen on comparison to international literature which describes culture as both knowing and doing. Participants description of culture as 'knowing or internal beliefs, are consistent with those of (Battle, 2011.; Leininger, 1991), as culture was described as what a given cultural group or community know about

the world which may differ from another cultural group. Participants also described the 'doing' of culture, as outward behaviors that demonstrated culture of a group such as types of food, ways of dressing, and language used. Battle (2011) refers to these more obvious enacted behaviors as "explicit cultural behaviors" (p.3). Battle (2011) also describes other behaviors that are more difficult to directly observe as "implicit cultural behaviors" (p. 3). This includes ways of socializing and child rearing practices. Participants in this study identified both implicit and explicit cultural behaviors as part of their understanding of culture, demonstrating an understanding that culture extends beyond explicit, observable behavior and includes implicit behaviors which is shaped by an underlying belief system and practices. Participants discussed the influence of culture on a range of knowledge and behaviors including family values, language preference, childrearing practices, religion, roles, responsibilities of family members and the perception of health by a group of people or community. Spiritual and religious beliefs and world view were particularly found to influence child rearing practices, language used, socializations practices and perception of causes of communication disability (Mcleod et al., 2017; Semela, 2001; Wegner & Rhoda, 2015) and have been shown to be relevant in designing culturally responsive services (Mathisen et al., 2015). SLTs need to find ways to acknowledge and incorporate their clients' beliefs, to promote relationship building, acceptability (Melvin et al., 2020) and provision of person-centered care (Mathisen et al., 2015). Understanding of culture by SLTs as it relates to the family's worldview and cultural frame of reference is important for providing speech-language therapy services that are meaningful and relevant to families (Wylie et al., 2020)

5.3 PERCEPTIONS OF THE IMPORTANCE OF CULTURAL RESPONSIVITY (ATTITUDE)

This research question explored participants' perceptions of the importance of culture to delivery of speech-language therapy services. This represented their attitude to culture in clinical practice (Schrader & Lawless, 2004). Participants clearly felt that culture was important in clinical practice and perceived culture as integral to developing a shared understanding between families and SLTs of

the communication issues, and how to best respond to it within the person's everyday context (Global theme 2). They referenced how culture shaped their own thinking about practice with clients, and described how culture of their clients influenced whether and how families engaged with services.

In this study participants clearly recognized that the culture of families, including their beliefs, influence how clients and families respond to speech and language therapy services, such as belief about communication disability. This is in line with findings of (Semela, 2001; Wegner et al 2015) who describe the importance of culture and belief in utilization and engagement in therapy services in Africa. Specifically, Wegner et al (2015) described how cultural belief can prevent families from accessing services, including beliefs about the causation, stigma, and community-perceptions of disability. Beliefs shape whether individuals believe that rehabilitation will work, and their understanding of the cause of the issue. In this research, participants reflected similar ideas as those discussed by Wegner et al (2015). Participants recognized that the strong spiritual belief held by many families play an important role in the family's interpretation of the cause of the communication issue, as well as what interventions and processes may be acceptable. Participants discussed the importance of explicitly responding to culture including discussing beliefs in SLTs interactions with families, without judgement, to help families understand their options and to make choices about intervention, which was perceived to be vital in making progress in therapy. It is important that SLT uphold this practice as families may pursue other non-evidence-based services or discontinue therapy service due to their beliefs regarding cause of disability intervention process.

Participants also noted a mismatch between Eurocentric SLT practices and local culture, and how this may impact what families find acceptable. This was particularly noted in interventions with young children which focused on developing play, to promote language development (Johnson, 2013; Klatte et al., 2019). Play based interventions, or those where parents engaged in extensive two- way verbal interaction with the child were reported as challenging for parents. This may be because these interventions are based upon western notions, such as assumptions that parents are the child's primary

caregiver and that the family values the child talking a lot (Kleeck, 1994). This finding links closely with research question 1, where participants described child-rearing culture with communication between children and adult family members, as a more distant relationship; respecting and listening to adult caregivers is valued as described also by Nyarko (2014). Previous literature has emphasized the Eurocentric beliefs that underpin many interventions (Pillay et al., 2015; Wylie et al., 2017) may be challenging when implementing speech-language therapy interventions founded in beliefs that are inconsistent with local culture, such as patterns of parent-child interaction. Participants described the importance of responding to this cultural mismatch as allowing for acceptable intervention practices and progress in therapy. While play is a vital intervention approach utilized in speech therapy, culturally responsive practice warrants that speech therapists recognize this mismatch in therapy approaches and provide adequate changes, including patterns of interaction and creating stimulating environments, in congruent with (Wylie et al., 2020). These adaptations may offer a platform to find synergies between approaches used by speech therapy profession and family cultural values to foster engagement.

Participants also described how cultural understanding, of both themselves and their clients, supports their own thinking and clinical reasoning including shaping their perceptions of the communication issue, and of what they should do. They described how awareness of their own cultural background contributes to their thinking and attempt to ensure that it does not influence their therapeutic interactions in a negative way. The first of Verdon's Principles of Culturally Responsive Practice (2015) requires SLTs to critically reflect on their own culture and the way this influences their own perceptions and actions. In this study, participants indicated reflection about their own culture, beliefs, and preferences as part of their clinical reasoning. Reflecting on one's own cultural values and knowledge is an important part of approaching clinical interactions with cultural humility (Hyter, 2022; Verdon et al., 2015).

Understanding the specific cultural and language background of the client, and the contexts in which

families live were described by the participants to be central to decision-making about how to offer interventions, which types of home activities, or who to coach to support the child at home. Decisions of language difference or disorders, such as interchange of /l/ and/r/ phonemes in words are reported to be based on cultural considerations (language or dialect) of the client. Attempts by participants to understand more about the unique culture of families, to help shape both clinical decision-making and interpretation of issues is consistent with the Principles of Culturally Responsive Practice (Verdon et al., 2015). The second of these principles, "knowledge of languages and culture" (p. 82), is reflective of what participants in this study try to do to assist with their interpretation of issues and decision making. Additionally, in 2020 Verdon defined "a willingness to listen, learn, and seek out information about the cultures, perspectives, and experiences of others as a key part of a journey towards cultural responsivity. The focus of our participants on understanding their own, and the cultures of others to decide what the issue is, and what they should do, is encouraging as it displays the centrality of culture to clinical reasoning amongst SLT participants in Ghana. Using cultural understandings to support both clinical reasoning and promoting family engagement in services enables SLTs to create services that are acceptable to families and responsive to their needs.

5.4 BEING CULTURALLY RESPONSIVE IN PRACTICE (BEHAVIOUR)

This research question explored how participants report what they do to be culturally responsive in everyday clinical practice. The thematic network (thematic network 3) represented their behavior in response to their understanding of culture (knowledge) and their recognition of the importance of culture (Schrader et al 2004). The focus of findings in this thematic network was on what participants reported that they do (behaviour), rather than talking in principle about what they could/should do and why (attitudes) which was represented in thematic network 2 (attitudes).

Participants described ways they attempt to use their cultural understanding of clients and families to make clinical practices culturally responsive, including making decisions about which types of therapeutic activities to use with families, how to priorities everyday/functional activities for use by

the family, decisions about language choice, and materials to be used. Their cultural understanding of families framed the ways in which they adapt western approaches to SLT, to make them relevant to Ghanaian clients and their families. Some of these adaptations reported by the participants on comparison are in congruent with international literature. While Verdon et al. (2015) discussed the identification of culturally appropriate motivating goals (Principle of Culturally Responsive Practice 1, p.81), participants in this study did not talk about creating culturally appropriate and motivating goals specifically. Instead, findings indicate that participants are focused on activity choices such as routines, and other activities relevant to the person's culture and everyday life. The recommended home activities are to fit into the family's daily routine; that is, within their everyday experiences rather than asking them to carve out time, which they described as 'asking them to the moon' given the socio-economic status of majority of their clients. Understanding and using daily routines of clients and adapting these routines to provide communication support was highlighted as an efficient way of engaging caregivers in therapeutic processes.

Using these cultural understandings to make decisions about intervening with clients does resonate broadly with Verdon et al. (2015) Principle of Culturally Responsive Practice 4 (p. 84), consideration of the cultural, social, and political context. For example, SLTs in this study stated that details of the child's natural environments, such as socio-economic status of the caregivers, guided the activities that they recommended for families to use therapeutically. In addition, choices made by participants about the use of particular language with clients are consistent with Verdon's principle 2 "knowledge of language and culture" (p. 82). However, our results suggest that beyond knowing the language of the client, participants use an understanding of the language context of families to help with clinical decision making/reasoning about which language (s) to use in therapy with a client. While most assessment tools available for use are in English, the participants described translating English language tools into other languages as they conduct assessments, and carry out interventions in the child's proficient language. Conducting assessment in the child's proficient language was also

reported to be vital in reducing instances of overidentification and obtaining a true picture of the child's language skills. Like this finding, Smith et al., (2018) emphasized the importance of SLTs understanding of the languages used by clients, to make evidence informed decisions about the language to use for assessment and intervention. They also reported using a combination of formal tools and informal tasks, such as play based and functional tasks, like Pascoe et al.'s (2010) descriptions of cultural adaptions made by SLTs in the Western Cape. It is encouraging to see that SLTs in Ghana appear to use their understanding of a client's culture and languages to make decisions about the language used in treatment. As the profession continues to grow, findings may enhance development of culturally appropriate assessment and intervention tools.

Participants described how cultural background of clients informed their judgement of how they use locally available materials within assessment and intervention. Use of resources that are relevant with the SLTs interpretation of culture and context for each client is consistent with Verdon et al.'s (2015) Principle of Culturally Responsive Practice 3 (p. 82), "use of culturally appropriate resources". However, the tension from findings in this study is the lack of availability of culturally relevant materials, as also reported in Pascoe &Norman (2011) in many other low-middle income countries (LMICs). In this study, participants described ways that they contribute to developing materials by adapting resources, making resources, and using locally available materials in therapy. For example, participants reported adapting formal western tools by selecting and swapping pictures within the task and using real (locally sourced) objects or pictures that reflected the cultural realities or the environment where the child lives. Developing culturally appropriate materials that takes cultural variation and potential cultural bias into consideration to meet the needs of a specific client or population is an important way of ensuring that clients are assessed in ways that could best represent their abilities, rather than being culturally biased (Carter et al., 2005). There are some papers that discuss cases of LMICs where people make or adapt materials, such as Carter et al. (2005) and Pascoe et al. (2010), but a novel contribution of this research is to show the broad range of actions that

clinicians report regularly taking to ensure resources are as culturally relevant as practically possible. Participants also described how they used their own understanding of a family's culture to create a shared understanding, including to connect with families and how to explain ideas. Creating a connection with families is an important part of improving engagement of families within the therapeutic process (Melvin et al., 2020); critical to person-centered practice (Forsgren et al., 2022). Participants reported forging relationships with families by speaking the native language of the clients, showing respect to their beliefs about the child's communication disability, and showing empathy. Empathy as a way of engaging in culturally responsive behavior was also reported in Nyantakyi & Oetting (2023). These findings show that participants use cultural understandings (knowledge) to create a feeling of trust and respect in their interaction with families which aligns with (Melvin et al., 2020) theme of trusting relationships to promote engagement.

Participants also described using cultural understanding to help them think about how best to explain ideas to families. Using, the local language, culturally familiar/ relatable examples, or analogies, and visual strategies to support understanding of families who may not immediately understand verbal explanations. This links to Melvin et al.'s (2020) theme of open two-way communication, with consideration of how to make information accessible and relevant to families in order to promote engagement with SLT services and concepts. Whilst the Melvin et al. (2020) study was not specific to cultural responsivity, it is evident that participants use their cultural understanding to maximize engagement for families in the therapeutic process, particularly as ideas or concepts may be foreign to them.

An important outcome from this research is the participants report of navigating culture in two ways: (1) understanding the specific culture of the client and their family and (2) understanding how to adapt western oriented practices to make them responsive to local cultures. This second form of cultural navigation is likely to be experienced by many SLTs around the world, particularly in low- and middle-income countries, as western or European beliefs underpin many speech therapy practices

(Farrugia-Bernard, 2018; Hopf et al., 2021; Pillay & Kathard, 2015; Wylie et al., 2017, 2020). The role of local SLTs in finding, and documenting ways forward, to make SLT culturally responsive to local cultures cannot be underestimated.

CHAPTER SIX

CONCLUSION, LIMITATIONS AND RECOMMENDATION

6.1 INTRODUCTION

This chapter is a summary of all the findings, recommendations and the limitations associated with this study.

6.2 CONCLUSION

It is clear from this study that cultural knowledge and an appreciation of the importance of culture informs how SLTs practice in culturally responsive ways in their everyday practice in Ghana. Findings revealed that SLTs appreciate that culture is a complex mix of world knowledge with intrinsic and extrinsic behaviours demonstrating culture. Participants clearly recognized the importance of culture in everyday speech-language therapy practice, and how it contributes to both family engagement with services and their clinical reasoning about the nature of the communication issue, and the best way forward. Culturally responsive practice was enacted by using cultural understandings about the culture and the context of the family to make decisions about best practice, how to obtain culturally relevant resources and how to create a shared understanding within the relationship between the therapist and the client. The many cultures that co-exist in Ghana means that locally trained SLTs navigate culture in two ways: tailoring SLT interventions to the unique culture of each family and client, as well as continually thinking about Western oriented SLT practices that are relevant and may be adapted. Locally qualified SLTs have an important role to play in the development and documentation of practices that are increasingly culturally relevant to local culture.

6.3 LIMITATIONS

This qualitative research explored four of the six (6) principles of culturally responsive practice by Verdon (2015). It would have been helpful if questions about community engagement were asked to explore Verdon's last two principles. In addition, the trustworthiness of the findings of this research would have been strengthened if participants were given the opportunity to review interview

transcripts and findings for accuracy and clarity. The short period allotted for this research project, is also a major limitation. Another limitation to this study is that majority of the participants of this study work in Accra Ghana. It would have been useful gathering information from participants practicing outside Accra and in other regions in Ghana.

6.4 RECOMMENDATION

While many papers exploring culturally responsive practice are based on expert opinion reported in discussion and review papers, this research offers a unique contribution by talking with clinicians who are continually adapting what they do to meet the needs of their clients. Data driven research in this area is an important direction to enhance understanding of the ways clinicians adapt and respond to cultural needs. Future studies may seek to triangulate the reported ways that therapists engage in culturally responsive practice, with observational data, such as via ethnographic approaches to research.

Another possible next step in this research is to explore elements of the findings in more detail such as participants' reports of their adaptions of Western materials, using ethnography, where the researcher collects detailed examples of culturally responsive practice in action, using observation combined with other qualitative methods. In addition, further research on the validity of standardized tests used in assessing Ghanian children's language skills, is vital to enable adequate development of assessment and intervention tools that are made with Ghanian children in mind, with adequate considerations of their multicultural and multilingual experiences.

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APPENDICES

APPENDIX I: RECRUITMENT FLIER

APPENDIX II: INFORMATION SHEET

INFORMATION SHEET

Title of Research Project: Culturally Responsive Practice: Perceptions and Practices of Speech and Language Therapists in Ghana.

Principal Investigator: Student Researcher- Vivian Kaetochukwu Asomba

Principal Supervisor: Dr Karen Wylie

Address: Curtin University Australia, karen.wylie@curtin.edu.au +61410148865

Secondary Supervisor: Ms. Josephine O. Bampoe

Address: University of Ghana, JBampoe@ug.edu.gh +61474644404

General Information about Research

You are being invited to participate in a research study as you are a speech-language therapist, trained in Ghana and working with children and/or adults with communication disability in Ghana. You are required to avail yourself for about 60mins interview session. The aim of the research is to explore the understanding of Ghanaian SLT's of culturally responsive practice and how they describe adapting western speech therapy practices to deliver culturally responsive services. The study is part of a Masters honors research project at University of Ghana. The research team also includes Dr Karen Wylie, and Ms. Josephine O. Bampoe (Supervisors) and Vivian K. Asomba (student researcher)

Possible Risks and Discomforts

Apart from giving up your time, we do not expect that there will be any risks or inconveniences associated with taking part in this study. If participation in the study causes you any distress, you can discuss this with the researcher or the supervisors.

Possible Benefits

While you may not benefit directly from participating in this study it is hoped that the results will contribute to knowledge about practices speech-language therapist find to be most helpful in modifying western practices to suit the needs of clients in Ghana whom they serve. We hope that the insights gathered will improve the quality of services available to people with communication difficulties and their families, thus improving quality of life. The findings of the study will contribute to what is known about culturally responsive practice in speech and language therapy, here in Ghana.

Confidentiality

Please be aware that your identity will not be revealed or used in this research. Interviews will be held in a private location. An IDs rather than identifying information will be used on all transcripts. Names and other identifying information within the interview will be replaced with codes.

Compensation

A light refreshment will be provided to you at the end of the interview session.

Additional Cost

Apart from giving up your time, we do not expect that there will be any additional cost that may result from participation in this research.

Voluntary Participation and Right to Leave the Research

Your participation in this study is completely voluntary. You may leave at any point without giving us a reason and without any consequences. If you wish to join the study, or find out more information, you are welcome to contact the student researcher: Vivian K. Asomba, get2vivian@gmail.com , 0593890202. You can also contact the research supervisors Dr. Karen Wylie on karen.wylie@curtin.edu.au, +61410148865 and Josephine O. Bampoe on JBampoe@ug.edu.gh. +61474644404

Termination of involvement by the Researcher

The researcher may terminate your participation if already interviewed participants have produced saturation.

Notification of Significant New Findings

A summary of the overall findings of this study will be made available to you if you wish to receive this at the completion of the study.

Contacts for Additional Information

If you have any concerns or would want to discuss the study with someone not directly involved any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the office of the Head of Department Audiology, Speech, and Language therapy Dr. Ewurama Owusu on 0509387607.

Your rights as a Participant

You are voluntarily choosing to be part of the study, you have the right to Information about the research, (before, during and after the study), right of refusal to participate and right to discontinue at any stage of the research.

APPENDIX III: INFORMED CONSENT

STATEMENT OF CONSENT/VOLUNTARY AGREEMENT

- The above document describing the purpose, benefits, risks, and procedures for the research "Culturally Responsive Practice: Perceptions and Practices of Speech and Language Therapist in Ghana" has been red and explained to me in detail in a language of my understanding.
- I have been allowed to ask any question(s) I have about the research and my question(s) has/have been answered to my satisfaction.
- I have been told that I may contact *[Dr. Karen Wylie, and Ms. Josephine O Bampoe or Principal Investigator]* if I have questions about my rights as a study participant, to discuss problems and concerns or suggestions related to the research.
- I understand that a copy of the information sheet and the informed consent forms will be given to me to take home after it has been signed.
- I have read the consent form and agree to participate in this research study voluntarily.

_____ _____

Name and Signature/Thumb print of Participant Date

_____ _____

Name and Signature/Thumb print of person obtaining Consent Date

STATEMENT OF WITNESS

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered, and the volunteer has agreed to take part in the research voluntarily.

Name and Signature/Thumb print of Witness Date

APPENDIX IV: INTERVIEW TOPIC GUIDE

INTERVIEW TOPIC GUIDE

TOPIC: Culturally Responsive Practice: Perceptions and Practices of Speech and Language Therapist in Ghana

Interviews should cover the topics below. In accordance with semi structured interviewing, questions are intended to guide questioning but are not prescriptive (Schutt, 2020)

Orientation/Starting the interview

BEFORE COMMENCEMENT Make a short recording (and then pause) with

- *date, time,*
- *place,*
- *subject number (from consent form)* and then press PAUSE

ON COMMENCEMENT ***Thanks for agreeing…***

- Confirm signed ***consent form***
- Confirm use of ***audio recording*** - perform sound check

INTRODUCTION

Thank you for agreeing to be interviewed as part of this research project on cultural responsivity in SLT in Ghana. As you are aware, today we would like to talk to you about what you think about this topic and what you do to make your work culturally relevant to the families you work with. We will talk about a range of things around this subject. The interview should take between 30 and 45 minutes but feel free to stop me at any time. Are you ready to begin? (***Double check that the recorder is on)***

KNOWLDEGE	Let's talk about what you know about culture to start with. 1. What do you see culture to be? (define/describe) 2. How do you see that culture might play a role in how we practice as speech and language therapists? 3. Given that we know many SLT practices originate from Europe, could you reflect on your teaching at university about assessment and intervention here in Ghana. What were you taught about adapting practices to suit Ghanaian culture? (at university) 4. What about since graduation. What have you learned about the need to adapt practices to suit Ghanaian culture? (Since practicing) a. How have you learned this? (knowledge)
BELEIF	5. How important do you think adapting SLT practices to suit Ghanaian culture is? Use 5-point Likert scale as reference. See page 7. 6. Why do you think it is important to adapt practices to suit local culture / not important (attitude)
BEHAVIOUR	7. What do they do in their clinical practices to ensure things are culturally relevant (behavior)? Subsection: Resources a. What are the main resources (such as tests, and therapy materials) that you use? Probe: Formal (tests and specific resources) and informal (materials) Subsection: Languages b. What languages are the resources you work with in? c. Do you always use English (or the language they are in) to present these resources? Subsection: Activities with families Often when we work with families, we talk about activities they can do at home to support their language development. d. What sort of activities do you use for 'home' practice? e. Which of these do you think are more 'typical' in Ghanaian culture? f. What prompts you to choose the activities you give to families? Subsection: Explaining ideas to clients and families Explaining important ideas, such as the cause of communication problems or how therapy works, can be challenging for families. g. How do you ensure you explain things in culturally relevant ways? h. What sorts of things do you say that you think makes it relevant for families (examples).

8. Is there anything else you would like to add about adapting practices to make them culturally responsive?

DEMOGRAPHICS

Age: Which age group are you in?

	19 years or younger
	20 – 29 years
	30 – 39 years
	40 – 49 years
	50 – 59 years
	60 years or older

Languages: Which Languages do you speak fluently? (at a conversational level)

Year of graduation: Which year did you complete your university based SLT training?

Year of graduation: At which university year did you complete your university based SLT training?

Degree: What type of SLT degree do you have? E.g. Bachelor's, Master's

Location: Which town/city/area are you working in? (Note: If potentially identifiable, this will be aggregated and deidentified during data analysis)

Work – organization: What type of organization do you work for?

	Hospital
	School – general education
	School – special education
	Not for profit community group / intervention centre
	Private practice
	Medical clinic (private) - outpatients
	Other:

Work – client groups: Which type of speech and language therapy disorders do you work with?

	Speech disorders – including developmental and acquired.
	Language disorders – including developmental and acquired.
	Multimodal communication / augmentative communication
	Voice, head and neck
	Stammering
	Dysphagia

Comments

Work – age groups: How old are the clients that you work with?

	0 – 5 years (early intervention)
	6 – 12 years (school aged)
	13 – 18 years (high school aged)
	18 – 59 years (adults)
	60 years and older (older adults)
Comments:	

Five-point Likert scale (importance)

5. Consider the scale below. With 1 being 'not important at all' and 5 being 'extremely important', how important do you think adapting SLT practices to suit Ghanaian culture is?

1	2	3	4	5
Not important at all	Fairly unimportant	Neither important or unimportant	Quite important	Extremely important

Reference

Schutt, R. K. (2020). *Investigating the social world: The process and practice of research*. (2nd ed). Thousand Oaks, CA: SAGE Publications.

APPENDIX V: ETHICAL CLEARANCE

UNIVERSITY OF GHANA
SCHOOL OF BIOMEDICAL AND ALLIED HEALTH SCIENCES
OFFICE OF THE SCHOOL ADMINISTRATOR

September 15, 2022

Ms. Asomba, Vivian Kaetochukwu
Department of Audiology, Speech, and Language Therapy
SBAHS, Korle–Bu.

Dear Ms. Kaetochukwu,

ETHICS CLEARANCE

Ethics Identification Number: SBAHS/AA/ASLT/10874176/2021-2022

Following a meeting of the Ethics and Protocol Review Committee of the School of Biomedical and Allied Health Sciences held on August 29, 2022, I write on behalf of the Committee to approve your research proposal entitled:

"Culturally Responsive Practice: Perceptions and Practices of Speech and Language Therapists in Ghana".

This clearance is valid for three years and requires that you submit three-monthly review reports of the protocol to the Committee and a final full review to the Committee on completion of the research. The Committee may observe the procedures and records of the research during and after implementation.

You are required to report all serious adverse events related to this research to the Committee within seven (7) days verbally and fourteen (14) days in writing.

Please note that any significant modification of the research must be submitted to the Committee for review and approval before its implementation.

As part of the review process, it is the Committee's duty to review the ethical aspects of any manuscript that may be produced from this research. You will, therefore, be required to furnish the Committee with any manuscript for publication.

Please always quote the ethics identification number in future correspondence regarding this protocol.

Thank you.

Yours sincerely,

David Nana Adjei (PhD)
Chairman, Ethics and Protocol Review Committee

CC: Dean, SBAHS
Head, Dept. of Audiology, Speech, and Language Therapy
School Administrator, SBAHS

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APPENDIX VI: COREQ (CONSOLIDATED CRITERIA FOR REPORTING QUALITATIVE RESEARCH) CHECKLIST REPORT

Topic and Item Number	Page Number Reported
Domain 1: Research Team and Reflexivity This domain includes: 1. Interviewer/facilitator; 2. Credentials 3. Occupation 4. Gender 5. Experience and training 6. Relationship established 7. Interviewer characteristics 8. Participant knowledge of the interviewer	The interview team included the student researcher and two supervisors. The team characteristics were reported in the information sheet and reasons for doing the research. Please see appendix II on page 65. The interviewer, which is the student researcher was reported also in chapter 3, methodology section, sub-section 3.5 on page 14.
Domain 2: Study Design	
This domain includes the following items: 9. Methodological orientation and theory 10. Sampling 11. Method of approach 12. Sample size 13. Non-participation 14. Setting of data collection 15. Presence of non-participants 16. Description of sample 17. Interview guide 18. Repeat interviews 19. Audio/visual recording 20. Field notes 21. Duration 22. Data saturation 23. Transcripts returned	The theoretical framework (content analyses) was reported on pages 10 and 20. Moreover, chapter 3 of this study, provided information on how participants were selected - convenient sampling method; how they were approached, how many participated in the study, setting of data collection as well as the demographic information of the participants please see pages 12-20. Also reported are, information on topic guide - see page 15 and appendix IV on page 69 for details. Piloting, data management and saturation were reported on page 17. Transcripts were not returned to participants for checks. This was equally reported in the study, see page 55.
Domain 3: Analysis and Findings	
This includes: 24. Number of data coders 25. Description of the coding tree 26. Derivation of themes 27. Software 28. Participant checking 29. Quotations presented	Coding of the transcripts were conducted by the research supervisors experienced in qualitative research, see page 19. Also, information regarding the software used in coding - page, inductive coding for theme derivation, description of coding tree - see pages

30. Data and findings consistent 31. Clarity of major themes 32. Clarity of minor themes	17-18, as well as presentation of quotations - see results section on pages 21-45. Major themes were clearly stated together with minor themes, see page 21.