Asking New Questions and Seeking New Answers
The Reality of Aphasia Practice in South Africa

Claire Penn

Emerging policy in South Africa has had a marked impact on delivery of service by speech–language pathologists, particularly in the field of aphasia. This article describes major policy influences in the areas of language use, health, education, disability, and the elderly, which have had an impact on service delivery. Aphasia assessment and intervention, in particular, are profoundly influenced by the unique sociopolitical context and opportunities are created for developing innovative perspectives, which expand traditional frameworks and scope of practice. Relevant practice requires awareness both of enabling policy and of the impact of issues such as poverty and culture on assessment and intervention. The profession of speech–language pathology has a powerful potential role in advocacy and social reform and to help develop policy, interrogate traditional models of training, and derive research that is relevant and contributes to a global debate. Key words: aphasia, health inequities, language policy, South Africa

Without language, one cannot talk to people and understand them; one cannot share their hopes and aspirations, grasp their history, appreciate their poetry, or savor their songs.

Nelson Mandela (1995), Long Walk to Freedom

SINCE the miracle of the new democracy in South Africa in April 1994, many pivotal changes have taken place in policy and institutional structures that have had a direct impact on the profession of speech–language pathology and on the delivery of service for persons with aphasia. This article describes such influences; first, in terms of general sociopolitical and health factors in the country, and, second, as factors that specifically influence the delivery of speech–language pathology services in general and aphasia in particular. The rapid transition and complexity of this new society have provided lessons for the broader professional community on how culture shapes communication and how material and social conditions impact management of communication problems.

SOCIOPOLITICAL FACTORS IN SOUTH AFRICA

South Africa presents an extraordinary juxtaposition of cultures, opportunities, and languages. With a population of more than 50 million, the country is relatively advanced
Asking New Questions and Seeking New Answers

industrially and financially, yet many disadvantaged and underdeveloped areas remain. The impact of apartheid in the past, which created disparities between racial groups in health, education, economic employment, and housing, as well as current difficulties in the health care system, has resulted in continued unequal allocation of resources. Many persistent disparities continue to exist for individuals and groups in terms of the availability of and access to health care services. Approximately a quarter of South Africans continue to live in marked poverty, and approximately 85% of the country’s population is dependent on public health care services (General Household Survey 2007, Statistics South Africa, 2007; Statistics South Africa, 2012). High rates of unemployment, poverty, and migrant labor practices have compounded these disparities.

The progressive South African Constitution and Bill of Rights of South Africa, which were adopted in 1996, place a strong emphasis on human rights, including rights of access to education and health and social services that prioritize child and maternal care (Republic of South Africa, 1996). In an attempt to address past imbalances and respond to current challenges, the government initiated various health reforms with the goal of achieving equitable access to health care. Many of its clauses are aspirational and, in practice, have been difficult to implement, particularly in a context of scarce resources. Health care infrastructure remains poor in many areas, and numerous South African hospitals and clinics are experiencing a human resource crisis because of the disease burden of the country (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). As in the past, many South Africans continue to experience barriers to accessing the health care system, interacting with health care professionals, or adhering to treatment regimens.

How such disparities affect aphasia service delivery is addressed in this article. I have examined both the possibilities and realities framed by relevant current policy documents and the specific challenges for the aphasiologist in the country of South Africa.

APHASIA IN SOUTH AFRICA

No understanding of aphasia is complete without an awareness of the unique and exceptionally high burden of disease in South Africa. Life expectancy at birth is 52 years for males and 56 for females, compared with an estimated global average of 68 years. This reflects the spread of communicable diseases as well as an increase in noncommunicable diseases (World Health Organization [WHO], 2013). The global pandemic of HIV/AIDS is highest in sub-Saharan Africa and affects many individuals (Benatar, 2004; Coovadia et al., 2009; UNAIDS/WHO, 2008). With this disease (and with the development and rollout of antiretroviral medications) has come a huge necessity for outreach of medical services, community education, and intervention and regular interface between the community and the health care sector. Although in recent years mortality has decreased and the lives of people with HIV/AIDS have been prolonged, the conditions associated with the epidemic affect a large sector of the population and include stroke and aphasia (Connor, 2007). Table 1 (after WHO, 2013) summarizes the main causes of mortality.

The incidence of aphasia in South Africa is very high. More than two thirds of deaths due to stroke take place in developing regions of the world such as sub-Saharan Africa (Connor & Bryer, 2006; Kolapo & Vento, 2011). The incidence of stroke has risen because of the disease profile in such regions and the impact of urbanization (where people seeking employment move to the cities) on diet and lifestyle. Biomedical causes of stroke and aphasia include hypertension, diabetes mellitus, and HIV/AIDS (Connor, 2007; Connor & Bryer, 2006). There also are many instances of traumatic aphasia resulting from high rates of interpersonal violence, as well as motor vehicle accidents. Sickle cell anemia, a genetic disorder found in immigrants from central Africa, is also an increasing cause of stroke (Wonkam et al., 2012). It is one of several such causes that have changed the stroke profile in South Africa. Another is HIV infection, which
Table 1. Health indicators in South Africa (after WHO, 2013)

<table>
<thead>
<tr>
<th>Selected Indicators (2011)</th>
<th>Country</th>
<th>Regional Average</th>
<th>Global Average</th>
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<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
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<tr>
<td>Total population (thousands)</td>
<td>50,460</td>
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<tr>
<td>Population living in urban areas (%)</td>
<td>62</td>
<td>38</td>
<td>52</td>
</tr>
<tr>
<td>Gross national income per capita (PPP international $)</td>
<td>10,710</td>
<td>2,513</td>
<td>11,556</td>
</tr>
<tr>
<td>Total fertility rate (per woman)</td>
<td>2.4</td>
<td>4.8</td>
<td>2.4</td>
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<tr>
<td><strong>Mortality and burden of disease</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>58</td>
<td>56</td>
<td>70</td>
</tr>
<tr>
<td>Life expectancy at age 80 (years)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Both sexes</td>
<td>17</td>
<td>16</td>
<td>20</td>
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<tr>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td></td>
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<tr>
<td>Both sexes</td>
<td>47</td>
<td>107</td>
<td>51</td>
</tr>
<tr>
<td>Adult mortality rate (probability of dying between 15 and 80 years per 1,000 population)</td>
<td>474</td>
<td>362</td>
<td>190</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>300</td>
<td>480</td>
<td>210</td>
</tr>
<tr>
<td>Prevalence of tuberculosis (per 100,000 population)</td>
<td>768</td>
<td>293</td>
<td>170</td>
</tr>
<tr>
<td>Prevalence of HIV (per 100,000 population)</td>
<td>11,087</td>
<td>2,725</td>
<td>499</td>
</tr>
<tr>
<td>Incidence of malaria (per 100,000 population)</td>
<td>35</td>
<td>20,913</td>
<td>4,082</td>
</tr>
</tbody>
</table>

Note. PPP = purchasing power parity.

aData refer to 2010.

also increases stroke risk (Kolapo & Vento, 2011). Because of such changes, increasingly, younger people are seeking help at aphasia clinics in South Africa.

The persistent disparities in access to health care in general are reflected clearly in services for people with aphasia. On the one hand, one sector of the population has access to information about stroke prevention, advanced neuroradiodiagnostic techniques, rehabilitation by a team in the acute phase, and ongoing therapy paid for in the chronic phase by medical insurance. For these, current global models of practice work effectively and are easy to implement. On the other hand, many individuals whose lives are characterized by poverty and hardship have little access to formal assistance. They receive no speech–language therapy at all, either in the acute phase or after hospital discharge (Wasserman, de Villiers, & Bryer, 2009).

In the public health sector, length of hospital stay for patients with stroke is typically very short. Because of difficulties in access and large distances, few patients have the benefit of post-acute rehabilitation (Connor & Bryer, 2006). Most aphasia tests and materials are not suitable for patients who speak
languages other than English and whose cultural and educational experiences may be very different from those of patients in the private sector. Older populations, in particular, may have limited literacy in all the languages they use because of prior lack of educational opportunity (see Penn, 2007, 2012). For language clinicians, distinguishing between such environmental impact on language abilities and the actual language disorder often becomes a challenge.

Furthermore, models of explanation and treatment seeking are often widely different within the diverse cultural and social groupings of the country. Although little is known about cultural interpretations of stroke and aphasia, some studies have suggested that people in South Africa draw on supernatural frameworks of understanding to explain stroke and associated difficulties with speech and language (Penn, 2007; Legg & Penn, 2013a) and that communities regard both the clinical and social diagnostics of stroke as important in seeking management (Hundt, Stuttaford, & Ngoma, 2004). Legg (2010) used anthropological methods to conduct an extensive study of the lived experience of persons with aphasia living in an impoverished environment, in which challenges of life included financial hardship and limited social and health resources. Legg (2010) concluded that it is impossible to consider the lived experience of aphasia without taking cognizance of cultural dimensions of illness, disability, and language loss. Her study showed how feelings of uncertainty, vulnerability, and isolation emerged for people living with aphasia under such conditions. They reported living in extreme hardship with reduced social networks, intergenerational tensions, and experiences of crime exploitation and stigma (Legg & Penn, 2013a, 2013b). Such experiences reflect what has been described as the “structural violence” (Farmer, 2005) imposed on individuals in a context of poverty. This is a way to describe the harmful impact of established systems and social structures on individuals with needs.

In fact, there are few aspects of aphasia care in South Africa that are not affected by sociopolitical factors and the persistent problems of poverty and inequality (see also Kathard & Pillay, 2013). Funding for aphasia research (and indeed for most communication problems) has been restricted because of the huge allocation of resources to communicable diseases such as HIV/AIDS and tuberculosis. The impact of such aspects is felt in domains of education and health. It profoundly affects the profession of speech–language pathology, challenging the need for novel approaches in service and research.

The need for culturally sensitive practices is illustrated by the example of a patient with stroke who was admitted to the rural hospital as a result of poisoning. Further investigation revealed that the man’s family had been administering rat poison, as they had been told that this is the cure for his problems. The patient was stabilized and given access to appropriate assessment and rehabilitation services, including family education.

This case sensitizes researchers and practitioners to the kind of questions we might ask in our setting: Why don’t patients with stroke come to hospital? What are the perceived causes of stroke in the community? How can we be effective in rehabilitation, given parallel paths of explanation and treatment that exist? What is it like to be a person living with stroke or disability in a rural community?

Such questions cannot be easily answered using traditional paradigms of research, but they have important implications for practice. The essence of this challenge is the need to make services relevant and demonstrably effective for the context the therapist serves, particularly when there are scarce resources. The following discussion addresses the impact of current policy on the delivery of services. In this discussion, I have also aimed to demonstrate with examples how training and practice have responded to such policy.
POLICY ISSUES

Health policy and the profession of speech–language pathology in South Africa

The profession of speech–language pathology started in South Africa in 1936. Currently, approximately 130 graduates a year are trained in six university programs. Despite this, only 1,000 professionals appear to be practicing in the country and many of these are employed in the private sector (Kathard & Pillay, 2013). Thus, there remain limited available professional resources for the population, and the profession is profoundly affected by the challenges and barriers to care imposed by issues such as poverty and the specific illness profile of the population. Until very recently, employment positions have been concentrated in the cities. A large proportion of the country’s population, however, resides in rural areas and continues to have limited access to rehabilitation (Coovadia et al., 2009). To address this imbalance, the scope of professional practice has been modified, reflecting a shift in emphasis to a primary health care framework. South Africa was described as a global leader in the development of the primary health care approach during the 20th century (Kautzky & Tollman, 2008; Mullan & Epstein, 2002). Likewise, in the profession of speech–language pathology, there is now a strong emphasis on the important role of health promotion and prevention and community-based services (e.g., Bortz, Schoub, & McKenzie, 1992; Rule, Lorenzo, & Wolmarans, 2006; Schneider, 1992).

Aligned with this emphasis, graduates in speech–language pathology since 2003 have been involved in compulsory community service for a year after graduation. The goal of this initiative was to distribute health personnel throughout the country in an equitable manner (Department of Health, 1997) and ensure improved provision of service to all citizens. This development has brought with it employment positions, novel opportunities, and extensive new experiences for recent graduates. It has also established a need for a range of new skills and attitudes to match the demands.

Preliminary reports suggest that this policy has contributed to meeting the needs of hundreds of individuals for whom no previous services existed. Reflections of graduates under this system (Penn, Mupawose, & Stein, 2009) suggest that many graduates choose to remain in rural areas after their year of community service and that the unique experiences of the community service year enhance their entry into other positions. Feedback from the community service graduates has also informed changes both in the curriculum and methods of training and in research studies undertaken (McAllister, Penn, Smith, van Dort, & Wilson, 2010). For example lectures on counseling and community work are an integral part of training and are reinforced by a service learning opportunity that involves the development of a workshop within a community of their choice (see Mophosho & Stein, 2008, for details of this component).

Language policy

The official languages of South Africa are Sepedi, Sesotho, Setswana (referred to as the Sotho language groups), siSwati, isiNdebele, isiXhosa, isiZulu (from the Nguni language group), Tshivenda, Xitsonga, Afrikaans, and English. Apart from the 11 languages spoken, a number of other African languages are encountered in everyday health practice. The Constitution of South Africa includes a clause that indicates that patients have a right to treatment in the language of their choice (Beukes, 1996). There are also recommendations to take practical and positive measures to elevate the status and advance the use of indigenous or local languages of South Africa, recognizing their historically diminished use.

A Pan South African Language Board was established to promote such policy (Alexander, 1996; Beukes, 1996), and a policy on language services for the National Department of Health (2011) reinforces the recommendation for multilingual language services. Clearly, the
South African linguistic profile is complex, reflecting the country’s great multilingual diversity (Figure 1).

Complicating the picture, educators often are not from the same linguistic background as the learners in their classroom. New generations are unlikely to be literate in their first languages, and there is a perceived erosion of literacy levels in vernacular languages because of an emphasis on English in South African schools (Brock-Utne & Holmarsdottir, 2004). As a consequence of current educational emphases, younger populations thus may have better written language in their second language than in their first languages.

Because of earlier disparities in education opportunity and literacy levels of previously disadvantaged Black students, most health care professionals do not have fluency in the local African languages. English and Afrikaans remain the two most prominent languages spoken in the public and health care sectors, and the majority of the population is not fully proficient in these languages. Even when health care professionals and patients are culturally and linguistically matched, interactions may take place in a language that is not the patient’s first language. Therefore, for the most part (at least in the public sector), there is a lack of concordance between the language and cultures of health care professionals and their clients.

**Implications for speech–language pathologists with regard to aphasia**

This language profile has implications both for the profession of speech–language pathology in general and for the training and selection of speech–language pathologists (SLPs) for delivery of service. There is an increased emphasis both on attracting students who can speak indigenous languages into the training courses and on including language courses into the curriculum of students. In line with the Higher Education Act (1997) and its goals to transform university programs to respond better to the needs of the country, the selection of speech–language pathology students who speak African languages is seen by many as a top priority. It has also led to the inclusion of an African language (e.g., Zulu or Xhosa) in the curriculum of students. Another model is to promote on-site language learning at clinical sites, especially in regions where there is a predominant language spoken.

Bilingualism/multilingualism is the norm in South Africa (Statistics South Africa, 2011), and factors determining language use are extremely complex and linked to issues of context, sociopolitical history, and social and gender identity. It is not unusual for therapy to take place in the second or third languages of both interactants. Similarly, an interpreter-mediated model of delivering therapy is common. A severe shortage of trained interpreters in the country has led to most medical and therapeutic interactions being mediated by what has been described as “ad hoc” interpreting services. These include interpreting by assistants, family members, and nurses. Thus, there is a greater emphasis in the speech–language pathology curriculum addressing language diversity and working with mid-level workers and interpreters. Particular attention has been paid to asserting the role of the profession in advocating proper language services at clinical sites and promoting the critical potential role of the third party as cultural broker as well as interpreter (Friedland & Penn, 2003; Hsieh, 2007; Penn, 2007; Penn & Watermeyer, 2012).
This unique linguistic profile has provided researchers interested in multilingualism and aphasia profoundly rich opportunities to examine issues in this area. Some of the work that has been published on these topics has contributed to global debate about recovery patterns in bilingual aphasia, choice of language for therapy, the use of translation as a therapy tool, and the adaptation of assessment measures, and so forth (e.g., Penn, 2012).

Findings have supported some fairly unique models of language recovery. Because for most citizens there is a daily interface of diverse languages, the language of home, the media, work, or school all may differ. Frequent practice and exposure to such diversity appear to provide well-rehearsed and flexible compensatory adaptations for the person with aphasia in the face of a primary language deficit. It may also provide a creative and rich basis for therapy, particularly in the group and community settings. For example Penn and Jones (2006) reported on the success of a multilingual group therapy model with aphasia in a community setting.

**Other policy issues**

Care of the elderly is embedded in the Older Persons Act of 2006. In South Africa, the family, and particularly the older generation, is closely involved in caring for children. Older adults often hold a position of great respect in the community and family and are the first to be consulted when there is illness in the family (Barratt & Penn, 2009; Kasanga & Lwanga-Lumu, 2007; King, 2008). This means that, in the clinical caseload, the person with aphasia frequently is a primary caregiver of an extended family.

Although the constitutional and legal framework in South Africa provides for the protection of the rights of the elderly, Ferreira (2004) has pointed out that older people in the society, particularly in rural areas, are vulnerable. They bear the consequences of indigenous law and custom, accompanied by rural to urban migration of younger kin. Other problems occur when older adults follow migrant kin, resulting in displacement from a rural to an urban destination. The challenges faced by the country and citizens as a whole contribute to a lag in the realization of older persons’ rights. The majority of older South Africans live in poor housing, and many have difficulty in accessing health care and adequate nutrition. Many also are dissatisfied with treatment they receive at public health care facilities (Charlton, 2000; Ferreira, 2004).

Another key area in which older persons are vulnerable to violation of their rights is gender inequality. In patriarchal African society, older women’s rights to property inheritance are violated commonly and they are at risk of abuse, violence, and exploitation. In one study on stroke in a context of poverty (Legg & Penn, 2013a, 2013b), residents in an informal settlement highlighted particular struggles of the elderly, as well as the burden for women in terms of access to community services, stigmatization, and exploitation.

**Social assistance grant**

Another major policy influence that has affected persons with aphasia in South Africa is the application of the Social Security Act (2004), which offers social assistance through the provision of social grants. The amount allocated is approximately R1200 (approximately equal to $120) per month, depending on the grant. Persons with aphasia may have access to this sum either because of age or because of disability. In the context of severe poverty, there is a great demand for such grants (Leclerc-Madlala, 2006). It is estimated that, at present, more than 16 million people are currently receiving such grants. However, many who might qualify have great difficulty accessing the grants because of difficulties with systems and institutional disarray. The presence of an older person or a person with a disability in a household is viewed, nevertheless, as access to government funding, which often presents the only source of income for the family. It is our experience that such individuals, therefore, are at risk of being exploited so that their grant may be used for purposes other than care or services for
Asking New Questions and Seeking New Answers

the eligible grant holder. For example Legg described a person in that study as follows:

A frail, elderly woman in her early 70s reported that she had her first stroke after the theft of her pension outside a mobile pension pay-out facility. Her second stroke was attributed to the stress she experienced whilst living with her son, who abused her social grant and consumed alcohol. (2010, p. 100)

**International Classification of Functioning, Disability, and Health framework and its relevance for the South African context**

Disability prevalence ranges from 6% to 12% across different provinces in South Africa. As noted earlier in this article, the national disease profile has contributed to increased prevalence of disability, particularly in underserved communities. The Constitution of 1994 enshrines the rights of people with disabilities. Policy has also been informed by the white paper on an Integrated National Disability Strategy (2007), which is strongly influenced by the social model within the International Classification of Functioning, Disability, and Health (ICF; WHO, 2001).

However, there remain major barriers for people with disability, particularly in impoverished areas. In addition, many studies have documented negative attitudes, stigma, and marginalization toward people with disability (e.g., Heap, Lorenzo, & Thomas, 2009). Emmett (2006) presented data to show that the oppression associated with disability in South Africa is an extension of prevailing systems of power (or conflict) in society, including race, gender, and class. In conditions of poverty, these divisions are exacerbated and people who live with chronic illness or forms of disability are likely to experience vulnerability, isolation, insecurity, and increased domestic flux.

In line with the ICF framework, aphasia globally is increasingly described in terms of impairment, activity limitations, and participation restrictions (Cruice, Worrall, Hickson, & Murison, 2003; Ross & Wertz, 2003; Worrall et al., 2011). As in other countries (e.g., Alford, Remedios, Webb, & Ewewn, 2013), the use of the WHO framework in South Africa has great potential. However, thus far, it has been used in a limited way. In the context of marked poverty, some authors have suggested possible limitations in this conceptual framework and in difficulties in applying and measuring notions such as quality of life for those with communication impairment (Barrass & Penn, 2009; Legg & Penn, 2013b). Interpretations of communication difficulties vary greatly, and it has been observed that persons with communication impairment do not separate communication difficulties from the other struggles that beset their lives. In Legg’s (2010) study, for example, discourses of aphasia were woven into wider narratives about individual, gender, generations, family, and community. Some participants seemed to show small concerns for language disruption when material and social support were lacking. For them, the physical demands of life seemed all consuming and overrode traditional categories and taxonomies for understanding aphasia.

The challenge for the researcher is to embed such evidence within existing paradigms. Viewed within a cultural lens, the lived experience of people with aphasia may be inseparable from the sociopolitical and cultural circumstances of those people’s lives. Aphasia clinicians in such a context require the tools and skills to grapple with the particular sociocultural and economic landscapes in which they work, by extending their knowledge base to principles and tools of anthropological, sociology, and epidemiology. A more anthropological perspective might be called for, such as one that helps identify and reduce the multiple barriers to care and that recognizes cultural precepts as dynamic, individual, and plural. It is hoped that this enabling ICF framework can be extended to incorporate such dimensions, drawing from the type of evidence that is currently emerging in indigenous contexts (Alford et al., 2013).

**Aphasia care as a catalyst for social reform?**

The aforementioned review confirms that the context in which aphasia assessment and
intervention take place is profoundly important. A number of barriers have been identified in South Africa, with the overriding influences of poverty and culture affecting every aspect of the profession.

Through the framework of enabling policy, the profession is attempting to make changes in the scope of practice that can help redress past imbalances and better meet the needs of the population. However, there remains a great shortage of employment opportunities and an overwhelming awareness of the difficulties resulting from the country’s inequities. Burnout is a frequent problem because of high caseloads and exposure to issues such as violence (Stodel & Stewart-Smith, 2011). In addition, a level of distress can result from recognition of the persistent gap between the public and private sectors in terms of access to services and between the aspirations of policy and barriers to the actual implementation of such values in practice.

Despite such barriers, profound opportunities and insights are afforded by the current context in South Africa, with implications for the global community. As discussed, examining the interface between context and aphasia has enabled the profession to derive some valuable and often unique understanding of the disorder. These include the following:

- Examination of bilingual models of intervention (see Kohnert, 2004, 2009) that include the exploration of translation and interpreting as a potential therapy tool as well as the use of code switching in therapy, an increased understanding of the relationship between executive functioning and bilingualism, and of the relationship between structural aspects of language and therapy techniques (see Penn, 2012; Penn & Archer, 2011; Penn, Frankel, Watermeyer, & Russell, 2010).
- Development of new culturally appropriate methods of understanding the condition and the context, which are drawn from disciplines such as anthropology and sociology. Examples are the use of ethnographic methods, long-term community engagement, and the use of narrative, which can be particularly valuable for communities with a strong oral tradition (Kleinman, 1988; Penn, 2002, 2004).
- Forging of new disciplinary partnerships with mid-level health care workers, such as community-based rehabilitation workers, interpreters, and caregivers. Such individuals often reside in the community and do not have formal training. Yet, they are particularly useful in bridging the gap between clinicians and clients. New models of training have emerged for professionals such as medical students (Legg, Young, & Bryer, 2005) nurses, and members of the community, all incorporating sensitivity to breaking down communication barriers (Goldblum & Alant, 2009).
- Extended models of service delivery. As with global practices in aphasia, the group- and community-based model of intervention (Elman, 2006) has emerged as particularly useful in South Africa. The power of multilingual group therapy as a social tool in a multilingual context group models of intervention has been demonstrated (Goldblum, 2010; Penn & Jones, 2006).
- Application of techniques from aphasia management to other areas of health care. An example comes from HIV/AIDS team training packages, in which doctors and members of the public are provided with new communication skills. Some research has also helped in improving the communication factors involved in the process of informed consent in research trials (Penn et al., 2009).
- The exploration of telehealth services in delivery of therapy for remote clients is currently being explored (e.g., Swanepoel & Hall, 2010; Willison & Begent, 2012). Despite a lack of infrastructure, particularly in rural areas, a high proportion of the South African population owns cell phones, and this penetration of cell phone markets (estimated
to be 66%) has been used successfully in marketing as well as in supporting health messages for patients.

- An interrogation of some of the standard methods and ways of looking at disability and language. The context has primed a closer examination of constructs, such as quality of life and the need to gain a deeper understanding of the influence of poverty on professional activities using more culturally attuned and community-driven methods.

- A deeper understanding of the role that prevention activities play in relation to the broader community has become very important for the profession of speech-language pathology. This includes partnerships with public health, which, for example, will promote early identification of hypertension (a significant cause of stroke and aphasia; WHO, 2007).

In short, the context has generated a level of novelty, flexibility, and what has been described as “mundane creativity” (Roberts, 2011), which is an essential component of intercultural practice. It also enables clinicians to address challenges of the workplace, to interrogate traditional models of training, and to derive research that is relevant and can contribute to a global debate. The context has truly challenged researchers and clinicians to ask new questions and seek new answers.

CONCLUSION

From clinical experiences in the new democracy of South Africa, with emerging policies and rich diversity, there is ample evidence to suggest that the profession of speech–language pathology has a great deal to offer to the broader health and education sectors. Our methods and approaches have application beyond the field of communication disorders. They demonstrate sensitivity to broader communication divides in society and have the potential to influence policy decisions and allocation of resources.

Relevant practice requires awareness both of enabling policy and of the impact of issues such as poverty and culture on assessment and intervention. The profession has a powerful potential role in advocacy and social reform and to help develop policy, interrogate traditional models of training, derive research that is relevant, and contribute to a global debate.

A revised model of intervention is emerging that shows a sensitivity to societal factors of displacement, mobility, struggle, sociopolitical history, and dual worlds. Given a huge shortage of therapists, and the difficulties in accessing therapeutic services, we have to make sure that what we do makes a difference. The challenge for future research is to explore authentic mechanisms to address the broader holistic challenge of aphasia. To add value, it behooves the profession of speech–language pathology to take a strong advocacy role, to be aware of rights and relevant legislation, and to challenge individuals and institutions that do not support culturally sensitive positions.

On the horizon is a new health care system that includes establishing private and public partnerships with the goal of more equitable distribution of services, a revitalization of primary health care in South Africa, and a community-based model of health services delivery (National Department of Health Strategic Plan, 2010/2011–2012/2013, Department of Health, 2010). This plan is currently in its pilot phase, and it is hoped that it will encourage the development of innovative models of aphasia management.

The problem of aphasia clearly lies at the interface of social, language, and medical domains and, as such, is affected by multiple policy and societal issues. Embedded in the ethic of care, and along with an awareness of vulnerabilities imposed by age, disease, poverty, gender, and history, the profession of speech–language pathology needs to keep abreast of such issues and be agents of reform. As we are dealing with the needs of individuals with communication impairments who often are voiceless in interface with government structures, our responsibilities with
aphasia are particularly high (Worrall et al., 2013).

MacLachlan et al. (2012) stressed that equitable health care can be achieved only if there is an understanding of the broader socioeconomic context and culture as well as the individual needs of the patient. As the World Report on Disability (World Health Organization and The World Bank, 2011) highlights, different stakeholders are tasked with addressing the removal of societal barriers, and the profession of speech–language pathology appears to be one that has particular potential responsibilities in this regard. This profession has the insights and the tools for dealing with communication, and SLPs are frequently privy to the insights of individuals who have been marginalized because of systems, policies, and access difficulties. This enhances the ability of SLPs to play an advocacy role. The profession has a powerful duty role to play in cultural and political aspects of the global arena.

In conclusion, consider the emphasis of Amartya Sen (2000), Nobel prize winner, in his discussion of poverty in the global context. Sen highlighted how social exclusion can lead to loss of freedom, psychological harm, misery, ill health, loss of human relations, and weakening of social values. Within the health domain and the context of chronic and severe disease conditions such as aphasia, the double burden of deprivation and exclusion can be powerfully felt. Any discipline that can reduce such powerful social barriers has huge import in a context such as South Africa and indeed across the globe. It is hoped that recent changes in speech–language pathology training and service delivery programs will contribute to such important transitions.

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