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# Renewing Our Cultural Borderlands

## Equitable Population Innovations for Communication (EPIC)

***Mershen Pillay and Harsha Kathard***

The professions of speech–language pathology and audiology provide valuable services for persons with communication, hearing, and feeding/swallowing disabilities. However, from a global perspective, mainstream practice discourses represent values from colonial perspectives (called *Northern* here). As such, they remain largely inaccessible to most people in the world. We argue, from a South African perspective, for a postcolonial or *Southern* discourse in alignment with other Africans, Latin Americans, and Asians who historically have had limited opportunities to shape professional practices. We use ideology critique (a disruptive tool) to reflect and make visible hegemonic Northern practices. Critical science and decoloniality are offered as pivotal axes for transformation. Decoloniality is discussed in relation to (i) Equitable (ii) Population-based (iii) Innovations for (iv) Communication (EPIC) using illustrative examples of emerging South African practices. We argue for redefining communication disorder professions' cultural borderlands to engage Northern with Southern ideologies critically to strengthen professional practice transformation. **Key words:** *audiology*, *critical theory*, *decolonization*, *equity*, *population health*, *speech–language pathology*

### HOW DO WE SERVE THE WORLD'S PEOPLE?

Colonialism introduced power structures that displaced indigenous populations from Asia, Africa, and the Americas, creating a cultural borderland where native communities were marginalized politically, economically, and socially (Grosfoguel, 2011). Here, cultural borderlands may be understood, initially, to refer to a form of cultural cartography where the assumption of a borderland is based on borders or boundaries of aspects such as language, ethnicity, race, gender, and/or sexual orientation. In early anthropological fieldwork, this included a theory of cultural evolution that positioned native ways of believing and behaving as less well developed and inferior when compared with the more advanced and sophisticated European societies of the colonial North, a theory that American anthropologist Franz Boas was later to critique as being ethnocentric and leading to the collection of bad data (Boas, 1911). As is discussed in this article, reverberations of coloniality also can be found when certain epistemologies of science are privileged over others as ways of apprehending the nature of clinical reality.

The colonial North institutionalized inequalities that helped establish global health

***Author Affiliations:*** *Discipline of Speech-Language Pathology, School of Health Sciences, University of KwaZulu-Natal, Durban, South Africa (Dr Pillay); and Education Health Sciences, University of Cape Town, Cape Town, South Africa (Dr Kathard).*

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***Corresponding Author:*** *Mershen Pillay, DEd, Discipline of Speech-Language Pathology, School of Health Sciences, University of KwaZulu-Natal, Office E3-617, Westville Campus, P.O. Box X54001, Durban, South Africa (pillaym1@ukzn.ac.za).*

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care disparities witnessed today (Gone, 2007). Our Southern perspective is allied to the Global South, so it addresses social, cultural, and economic disparities characterizing marginalized populations. Therefore, the Global South not only is restricted to poorer countries in the geographic southern hemisphere but also includes those experiencing marginalization and inequities in rich developed countries (Braveboy-Wagner, 2003).

A central problem is that in the Global South, audiologists, speech–language pathologists (SLPs), or related practitioners who serve persons with communication disabilities are too few in an unequal world. For example, in sub-Saharan Africa, 3% of the world's health care workforce engages 24% of the global burden of disease compared with the Americas where 37% of the world's health workers engage 10% of the global burden of disease (Middleton et al., 2014). Thus, in this article, we define the Majority World as the portion of the world that comprises most of the world's nations. This part of the world may be labeled the developing or Third World in other sources. Although such countries make up the largest portion of the globe, it is an area where services of communication disorder specialists have little real impact (if at all). The Majority World construct contrasts with what we are calling the Minority World, which comprises fewer of the world's nations—primarily Europe, North America, and Australasia. The Minority World is often called the developed or First World, but these countries also include selected groups of people with disabilities who remain underserved (Wylie, McAllister, Davidson, & Marshall, 2013).

In the Majority World, of the 15% (~1 billion) persons with disabilities, approximately 38 million are described as living with severely disabling conditions (World Health Organization [WHO] & The World Bank, 2011). There are 27.2 million skilled health professionals for 6.7 billion people, which has been calculated at a current deficit of 8.9 million skilled health professionals, mostly for the South-East Asia region. In sub-Saharan Africa, the ratio of SLPs may be as low as 1:2–4 million people (Wylie et al., 2013). Comparatively, this ratio may be 1:2,500 to 4,700 people for Minority World countries such as those in North America, the United Kingdom, and Australia (Wylie et al., 2013). Similarly, for audiologists the ratio is 1:1 million people in Africa as compared with 1:20,000 people across Minority World countries (Johansson & Olsson, 2013).

Systems that employ rehabilitation professionals, including audiologists and SLPs, are complicit in contributing to global service inequities for persons with disabilities (WHO & The World Bank, 2011). Globally, these professionals are few in number (Wylie et al., 2013); yet, they mainly deliver personal one-to-one rehabilitation care. The purpose of this article is to address questions about the best way to provide service delivery to persons with communication and swallowing disabilities in countries with inadequate numbers of service providers. Are individualized practice metrics the best way to provide rehabilitation to persons with hearing, communication, and swallowing disabilities? We promote an alternative referred to as "Equitable Population Innovations for Communication" (EPIC). This framework foregrounds population-based health care as an expansion of the current, and dominant, personal-based rehabilitation framework. EPIC provides a framework to rethink and to transform clinical practices especially (but not only) for underserved populations. EPIC is underpinned by critical science and decolonial theoretical influences.

## WHY A DECOLONIZING CRITICAL SCIENCE?

In searching for theoretical architecture to position transformation of clinical practice to fulfill unmet needs, we go beyond traditional frameworks for service delivery rooted in an empirically driven, positivistic science. Although beneficial when working within impairment and deficit-based biomedically oriented models of intervention, a positivist

science is constraining for purposes of professional transformation. Therefore, ideology critique is used to make visible (and manage) the logic underlying empirical, positivistic science.

Positivist science was the creation of the colonial North, born of modernism and working synergistically with a biomedical model of knowledge (Vidich & Lyman, 1998). When applied within a medical model, this science promoted a false objectivity alongside focusing on the "disorder" and, beyond laboratory-based or biomedical foci, its use is contestable for the professions of speech–language pathology and audiology (Pillay, Kathard, & Samuel, 1997). Are complex lives and/or heterogeneous persons with disabilities really going to benefit from practices such as measuring disability by quantifying therapeutic outcomes? Although statistical measures are useful for some purposes, they tend to reduce the quality-of-life experiences of multiple realities into factors that can be rationalized, manipulated, and generalized with clinical/research participants (née subjects).

These positivistic influences undergird even clinicians' use of more person-centered approaches. For example, professionals tend to describe peoples' speech/language functions, annotating their deficits by listening to illness narratives, and classifying their communication/hearing (or eating/feeding) within pathological frameworks. Practitioners assign diagnostic labels to, essentially, describe what is wrong with a person's communication. This process is one we refer to as *disothering* (Pillay, 1998), where practitioners contribute to creating persons with pathologies as societies' "Others" or as a marginalized subaltern (Pillay, 2013; Spivak, 1985). Therefore, professional power—which is closely associated with positivistic, empirical science—is used to engage a form of colonization of Others' lives. It is this use of an empirical science (of, for, and by empire) that is epistemologically problematic. Designed to benefit empires and promote colonial knowledge, it has been normalized by journals' editors, valued by professional educators, conference scientific committees, and authors of practice guidelines. A positivistic science, while useful to describe bodily processes and cellular pathologies, limits our imaginations by over-relying on reductionist, psycholinguistic, and biomedical logic. As a cultural ideology (Pillay, 2003), this logic is deeply embedded in professional texts/research and dominates mainstream audiology and speech–language pathology, rendering these professional practices not only invisible but also mysterious to the people of the Majority World (Pillay, 1998).

## CHALLENGING THE DOMINANCE OF ONE WAY OF KNOWING

We argue that a critical science, as opposed to one rooted and dominated in positivism, is a key mechanism to drive innovation in professions that work with people with hearing, communication, and swallowing disorders (Pillay & Kathard, 2015). Habermas (Pusey, 1987) organized human knowledge into three types of knowledge-constitutive interests—technical, cognitive, and emancipatory. Table 1 summarizes these three knowledge-constitutive interests and their associated scientific paradigms. A critical science paradigm is situated as an emancipatory interest. Habermas' knowledge-constitutive interests are positioned as driving all human actions. For professions, these interests undergird clinical, research, and professional educational practices, as described as follows.

### Technical interests

In Table 1, technical interests reflect concerns for "... controlling the environment through rule-following action based upon empirically grounded laws" (Grundy, 1987, p. 12). Technical interests are linked to positivism, which is the dominant scientific paradigm for the professions of audiology and speech–language pathology. In positivism, the search for objective variables that exist external to the self is privileged in order to ameliorate the human condition. The subjective internal states of individuals do not form the basis of knowledge. A technical interest

**Table 1.** Knowledge-constitutive interests and associated scientific paradigms

| | Technical Interest (cf. Empirical-Analytical or Positivist Scientific Paradigm) | Practical Interest (Hermeneutic-Interpretivist or Constructivist Scientific Paradigm) | Emancipatory Interest (cf. Critical Scientific Paradigm) |
|---|---|---|---|
| Features of the knowledge-constitutive interest | • Requires manipulating/controlling the environment<br>• Uses rule-following action, based on empirical laws<br>• Based on ability to predict<br>• Focuses on instrumental action, judged on efficiency and effectiveness | • Aimed at gaining understanding through action<br>• Human beings and their behaviors are viewed within a communicative model<br>• Based on ability to make morally and rationally oriented judgments in specific social situations<br>• Results in subjective knowledge produced via meaning-making with one's environment | • Concerned with autonomous social action for transformation<br>• Uses the concept of ideology critique/critical insights<br>• Emphasizes the recognition and freedom from dominant social and political forces<br>• Relies on intersubjective understanding<br>• Knowledge gained is intended to be utilized for the freedom from dominant forces and distorted communication |
| Reality/ontological comment | Reality:<br>• is apprehensible and objective<br>• is driven by natural laws and<br>• mechanisms (deterministic)<br>• may be reduced to manipulate parts | Reality:<br>• is apprehensible, but multiple realities exist<br>• may change, as the reality constructor (researcher) becomes more informed/sophisticated | Reality:<br>• is historically grounded<br>• shaped by social, political, cultural, economic, ethnic, gender views |

(*continues*)

**Table 1.** Knowledge-constitutive interests and associated scientific paradigms (*Continued*)

| | **Technical Interest (cf. Empirical-Analytical or Positivist Scientific Paradigm)** | **Practical Interest (Hermeneutic-Interpretivist or Constructivist Scientific Paradigm)** | **Emancipatory Interest (cf. Critical Scientific Paradigm)** |
|---|---|---|---|
| Truth/epistemological comment | Truth:<br>• exists outside of the researcher<br>• is accessed by various objective methods | Truth:<br>• is subjective<br>• may be obtained interactively | Truth:<br>• is value-mediated, value-dependent<br>• is socially constructed by investigators and respondent/s |
| Methodological comment | Methods used:<br>• emphasize experiments<br>• can predict phenomena<br>• allow for testing hypotheses<br>• control for confounding conditions | Methods used:<br>• facilitate the creation of knowledge via meaningful interaction with the investigator and respondents | Methods used:<br>• include dialogic/dialectical techniques<br>• emphasize ideology critique |

approach to knowledge is of limited use because it situates communication within the narrow realm of technical interest by reducing its complexity to issues such as word counts and measures of vocabulary. A technical approach leads to a decontextualized understanding of communication.

### Practical interests

Conversely, professionals who enjoy understanding through action may be located within the practical interest, especially if concerned with "language-using being ... using a form of knowledge to communicate with their fellows through the employment of mutually-understood symbols" (Kinchelhoe, 1991, p. 70). As this interest is aligned to an interpretivist (also known as constructivist or hermeneutic) science, it concentrates on one's ability to make moral/rational judgments in certain social contexts that produce subjective, not objective or rule-based, knowledge. Although this interest makes a shift from positivism, and considers communication in more relational ways, it is also limited in locating the nature of communication in a sociopolitical space. Therefore, issues such as intersectional dimensions of race, gender, class, and power as key to human communication processes are not its interest. For example, hearing or swallowing disorders are considered with minimal focus on how race, gender, or sexual orientation is a circumstance intimately connected to the knowledge-making process. Therefore, when persons with disabilities are managed, critical issues central to how disability is produced beyond the impairment or biological lens are addressed as peripheral to the hearing loss, swallowing disorder, or language delay. In this way, rehabilitation professionals such as audiologists and SLPs continue to mask the complexity of what sustains being a person with a disability in the world.

### Emancipatory interests

Finally, emancipatory interests are likely to gravitate toward critical science. We use emancipatory science to engage the goal of developing knowledge that leads to freedom from dominant forces and distorted communication (Kinchelhoe, 1991, p. 70). Grundy focused the emancipatory interest as autonomous social action due to "authentic, critical insights into the social construction of human society" (Grundy, 1987, p. 19). Critical science positions human communication in the context of sociocultural-political histories. For example, a child with a language disorder in the Global South must also be understood as a child who is colonized and one whose opportunities for language learning are enmeshed in a cultural environment that potentially silences and devalues his or her indigenous language while creating little opportunity for learning a dominant language.

Important to this discussion is that Habermas (Pusey, 1987) viewed knowledge-constitutive interests as motivated by rational inquiry. He argued in favor of what is commonly referred to as science as scientism, which may promote "... science's belief in itself: that is, the conviction that we can no longer understand science as *one* form of possible knowledge, but rather must identify knowledge with science" (Pusey, 1987, p. 20). Furthermore, Habermas contended that science can only be understood epistemologically. When considered across knowledge-constitutive interests, it may then be concluded that there is more than one account of truth (Guba & Lincoln, 1994), especially if knowledge is influenced by one's own values. Such value-based choices are not only personal but also embedded in the influence of scientific paradigm(s) on professional practices. Understanding science and knowledge production in this way implies that a diversity of knowledge is possible for different purposes. When science is positioned away from being a narrow, restrictive, and technical endeavor, then it may be expanded to enable newness and/or freedoms in knowledge productions, thus being more likely to inspire change.

A critical science, located as an emancipatory interest in Table 1, is intended to nurture transformation, especially at an epistemic level. As opposed to a narrow science of technical interests, critical science provides

a fertile base of innovation necessary for a population-based approach described later in this article. Within this perspective, knowledge about communication can be historically situated and contextualized according to social, gender, cultural, economic, sexual orientation, and political values. In other words, a critical science views truth/knowledge as value-mediated. In contrast to the epistemology of positivism, we argue that subjectivity can produce valuable knowledge represented in a variety of forms such as life history narratives. The epistemic orientation of critical sciences allows for the innovations needed within a population-based orientation to audiology and speech–language pathology practice. As a knowledge paradigm intended to further emancipatory interests, critical science provides a platform for understanding how people with communication disorders might access meaningful employment; how swallowing or feeding activities can be social, political, and economic events; and how global monopolies and international trade agreements might be modified to be less biased against poorer people who need hearing aids and cochlear implants.

### Summary of Southern ways of thinking

A positivist epistemology elevates pure objectivity as a motivator of human behavior at the expense of human beliefs and values and serves to invalidate the politics (of knowledge) that influences clinical actions. Although audiology and speech–language pathology has been rooted in a science of positivism, which has served the professions at a technical level, we firmly believe that a transformation of the professions' epistemic core is necessary and possible. Building upon South Africa's experiences in transitioning from a colonial state to a democratic one, we are of the view that a *decolonizing* critical science is needed to help frame such a professional transformation in audiology and speech–language pathology. A decolonizing critical science seeks to understand how dominant modes of Western civilization have continued to thrive and dominate a world that is structured unequally to enable systematic patterns of exclusion, the kind of exclusion evidenced in the cultural borderlands through hierarchies that facilitate racism, ableism, and capitalism.

Central to borderland experiences of decolonization and decoloniality is the concept of hybridity in constructing culture and cultural identity through experiences with difference, otherness, and ambivalence (Bhabha, 1990). For example, in *Black Skin, White Masks*, Fanon negotiated his identity as a psychiatrist with being a philosopher, francophone, Afro-Caribbean, and a revolutionary (Fanon, 1967). Recognizing hybridity has meaning for how professionals conceptualize being (dis)abled while possessing racial, social, sexual, gender, and other traits that constitute their cultural identities. Hybridity challenges practitioners to move beyond essentialist understandings of their clients' lives as (centrally) disabled. Noting that decoloniality and critical science may be unfamiliar ideological discourses to practitioners in audiology and speech–language pathology professions, we present the EPIC framework in this article to translate these discourses into practice.

## EPIC ELEMENTS

The EPIC framework comprises four key elements—Equitable Population Innovation for Communication. Figure 1 is a diagrammatic representation of these elements for

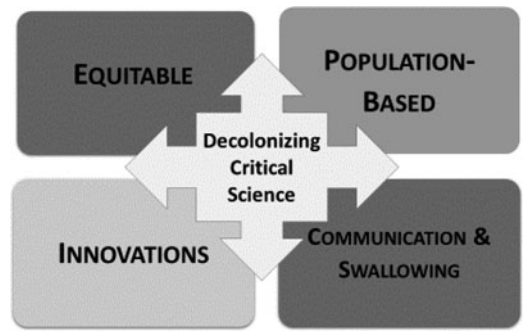


**Figure 1.** EPIC: A framework for equitable population-based innovations for people with communication and swallowing disabilities.

population-based innovations for people with communication (including hearing) and swallowing disabilities. Significantly, the notion of practice in this example not merely is individual, clinical practice but also refers to all kinds of community, population-based activities such as advocacy and policy and/or professional development.

### Element 1: Equitable

We position equity as a concern that cuts across all forms of practice, with the goal to achieve just and fair outcomes. Equity is not synonymous with equality. Equity refers to the use of strategies, such as distribution of resources to achieve health equality. Therefore, equity of access, service, and outcomes must account for broader social, cultural, and political processes within which they are realized (or not). Braveman and Gruskin (2003) defined equity in health, relative to social advantage/disadvantage (wealth, power, prestige), between socioeconomic groups. In this view, equity is present when there is an absence of systematic disparity involving the major social determinants of health and their outcomes. At a global level, the Southern perspective calls for the recognition of marginalized communities to be a key part of health planning as part of the global development agenda (Ruano, Friedman, & Hill, 2014).

Inequities may arise from two distinct but linked processes. The term "vertical inequities" refers to inequities that may exist between people because of their economic status regarding income, assets, and access to resources. It describes the extent to which people with greater medical needs are treated more favorably (Bonfrer, van de Poel, Grimm, & van Doorslaer, 2014, p. 924). The term "horizontal inequities" refers to inequalities between groups relating to social factors. This implies that people with equal need for care should receive equal amounts of care despite factors such as gender, ethnicity, geographical location, age, and disability that may set them apart in some contexts (Bonfrer et al., 2014, p. 925). Inequity also can result when belonging to a marginalized group that may be unrecognized by mainstream audiology and/or speech–language pathology practice such as being gay, being a woman, or living with a disability. A homosexual disabled woman ought to receive equitable (not necessarily the same/equal) care as a heterosexual able-bodied woman because of her marginalized status. Equity is at the heart of professional planning and is the first consideration.

When assessing the gap between the rich and poor across multiple contexts, we draw attention to huge income inequities between the rich Minority World and the poor Majority World. The Gini coefficient (expressed as a ratio or index) is a measure of income inequality, ranging from 0 to 1, where 0 refers to a perfectly equal society and 1 represents a perfectly unequal society (Raffinetti, Siletti, & Vernizzi, 2015). A commonly used alternative is the Palma ratio, which calculates populations' shares of gross national income (divides the poorest 40% into the richest 10%), to show the divide between the rich and the poor. With both measures, a higher number means more inequality. Many low-middle-income countries show huge divides between the rich and the poor, with South Africa being the most unequal society on earth having a 63.38 Gini index compared with the more equitable Ukraine with 24.09 (Barr, 2017).

Income inequalities lead to health care inequalities. For example, Central sub-Saharan Africa, Eastern sub-Saharan Africa, and South Asia are regions with the greatest global burdens of disease. Ramsey, Svider, and Folbe (2018) determined that because of their disease burdens and service inequities, persons with hearing disabilities have little/no access to hearing health care services. When considering inequality based on income, it is important to ask where people with disabilities fit into this schema. Burgeoning statistical data support the clear conclusion that people with disabilities experience personal and/or household income inequalities (Sultana, Mahumud, & Sarker, 2017). Their socioeconomic status has an impact on their access to speech–language pathology and audiology services. For example, in rural South Africa, audiology

and speech–language pathology services are either extremely limited or nonexistent, which makes services more expensive for the individual who must bear the costs of transportation to a service site, accommodation away from home, and loss of income. Therefore, persons from lower socioeconomic groups endure problems with access to speech–language pathology and audiology services (Dada, Kathard, Tönsing, & Harty, 2017). In developed, richer countries where services are available in urban environments, poorer populations remain underserved (Wylieet al., 2013), resulting in accessibility problems akin to their counterparts in poorer, developing countries.

In addition, Johnstone, Limaye, and Kayama (2017) have argued that persons with disabilities who are both poor and members of ethnic minority groups in urban North America remain underserved not only because of their socioeconomic status but also because of their cultural identity. Their study highlighted that the intersectional relationship poverty has with other factors such as race or ethnicity must be accounted for when configuring audiology and other health care services.

In summary, when equity is considered for people served by the professions of speech–language pathology and audiology, it is important to consider how to give whole populations access to those services deemed necessary for success. Although people may be treated in a just, fair, relevant, and sustainable manner, equity is not about practicing equality where everyone is treated the same. The critical question for communication professionals (audiologists and SLPs) is "How does one consider equity in the planning and delivery of these services?" An important aspect of equity is how these professionals intend to serve and target the client population.

### Element 2: Population-based

A focus on population is a concentration on the whole population but not at the exclusion of the person. Population-based health care is a specific approach to public health, which emphasizes the distribution of diseases and health determinants, focuses on prevention, and addresses the needs of whole populations—often defined as communities (Bircher & Kuruvilla, 2014). Population-based interventions utilize findings from clinical epidemiology, adopt a community development perspective, incorporate evidence-based practices, and emphasize prevention (Galvaan & Peters, 2014; Porche, 2004). Regarding population, we emphasize two aspects of population-based interventions for the professions to consider—population scale and population characteristics.

First, the scale of one's clinical efforts needs to be equal to the size of the population (Maller, Townsend, Pryor, Brown, & St Leger, 2006). Initially, when we surveyed speech–language pathology and audiology services for Black African populations in South Africa, virtually the entire country was underserved (Pillay et al., 1997). Second, along with population size, it is necessary to focus on the political, economic, social, and cultural aspects of who remains underserved so that services can be designed to meet community needs.

Given these population-based needs, social, environmental, and epidemiological sciences are generally not foregrounded enough in the professional curricula of communication and swallowing disabilities. For example, to identify populations at risk for feeding/swallowing disabilities, data from large-scale studies such as national censuses, general household surveys, health, and nutrition surveys are required. An example is the work by Razia Motala (Pillay, 2016), whose analysis of the relationship between disability and food security is used to situate persons with swallowing/feeding disabilities. Data from this study will be used for determining school feeding schemes for learners with disabilities. In addition, these data will be used for household-level interventions in terms of managing food and disability in the home. It will also be used to develop advocacy programs as well as influence national policy on specialized nutrition foods and their distribution to persons with disabilities in vulnerable environments.

Therefore, in EPIC, the focus is on masses of people (communities and countries) and whole school or curriculum-based interventions. Health care professions should not be satisfied with defining large populations as people in, for example, a school, a factory or a stroke or neonatal unit. Population in EPIC refers to mainstreaming work with vulnerable, marginalized communities as a whole so that the population (literally in the thousands) becomes the unit of service provision. As the idea is to move an entire borderland community toward equity, this is not merely about data sets but service provision and the holistic management of communication, hearing, and swallowing.

EPIC promotes a radically different practice model where development, promotion, and prevention of impairment occur alongside a deep understanding of communities according to their languages, economic systems, as well as cultural and heritage practices. Current models of service delivery are based on static populations with long-term formal residence (WHO & The World Bank, 2011). In contrast, our experience in South Africa's Western Cape Province reveals that there is a continuous movement of families. Parents and children often do not always live together for many social and economic reasons. How then does a practitioner configure his or her model of practice using home programs intended for nuclear families? How does a practitioner consider intergenerational communication development when siblings or grandparents are primary caregivers? Although these appear as rhetorical questions, the point is that we, like many of our Southern colleagues, find ourselves in a place that imagines we have answers, but as we approach the decolonial project, our questioning becomes a far more powerful tool than simply an interrogative framework that provides specific, set answers. It becomes a method to facilitate reflexivity and for countries with highly dynamic populations, this need becomes greater because of their vulnerability in being displaced peoples, immigrants, or refugees. Therefore, a population-based approach means that to cover everyone, the needs of marginalized groups must be prioritized to achieve equity.

In summary, population refers to all people, the masses. Health care providers need to come to know and understand populations in the same way as they know people and their disabilities or pathology. Notably, providers need to understand the needs of populations that have been marginalized where services are lacking. There are, at least, two critical questions to be answered by professions: Which populations do the professions serve? How well do audiologists and SLPs know the populations they serve?

### Element 3: Innovations

Innovations refer to the "scientific, social, technological, organizational, financial, political, and commercial activities necessary to create, implement, and market new or improved products or processes" (Organisation for Economic Co-operation and Development [OECD], 2005, p. 45). These innovations must be communication-focused and implementable. This means that as a practice-based profession, audiologists and SLPs need to question how useful their current scientific practices are for developing innovative population-based interventions. If they mainly focused what they do beyond (but not excluding) the body, what kinds of innovations may be considered?

Perhaps, upstream factors may then drive innovative practices. Consider the following review points about how practitioners could approach such innovation by considering, as explored later, upstream factors (social determinants of health such as social inequities and health risks), political consciousness, and ideological disruption.

It is important to participate in prevention of upstream factors, which are usually out of the control of the individual but which have a significant impact (Maller et al., 2006). These factors may include policy implications or social inequities based on race or gender. It may also include work and living conditions that place people at risk and to integrate a focus on

disorders of communication into population-based health programs. For example, practitioners may need to refocus who they work with as professionals. Although the persons with disabilities remain the critical focus, it is equally important to acquire new knowledge and skill sets to engage with employers who may have preconceived notions of the disability workforce. At a policy level, working with global organizations such as the United Nations to lobby and advocate for country-level support/policy changes and implementation plans is a viable activity to consider when managing persons living with communication and/or swallowing disabilities.

Political literacy and innovation are a gap in global professional education training curricula (Kathard & Pillay, 2013). Although clinical practice with clients will remain a very important part of professional preparation, understanding the political influences on health is a key competence that also should be an explicit part of professional curricula. The focus on communication as a human right and the focus on food security and disability remain low priorities even in a Minority World context. How clinicians negotiate prioritization about communication, food security, and suchlike is key for all professionals. Therefore, innovations in political consciousness and practice are needed.

Finally, ideological disruptions may be created by critiquing traditional ways of conducting research, constructing professional curricula, and delivering services. These disruptions are catalysts to spur innovation and transform clinical practices in audiology and speech–language pathology. For relevant examples, refer to the Street Trader Socio-Sonic (STSS) project, Tackling Hunger with Research and Innovation in Vulnerable Environments (THRIVE), and School Initiative Improvement (SII) (www.sii.uct.ac.za) programs described later in this article.

### Element 4: Communication and swallowing

In this element, the core of the authors' work in addressing disorders of communication (hearing included) and swallowing is repositioned. As health care professionals working toward Sustainable Development Goals for 2030 (United Nations, 2015), it is necessary to address many issues including inequalities and health, education, as well as food and nutrition security. What remains to be imagined is how the professions of speech–language pathology and audiology can engage practices that, ideally, move them from failure to provide services to the capacity to achieve Sustainable Development Goals for/with vulnerable, marginalized peoples around the world. Therefore, the point of intervention lies not only in the recognition that persons with disabilities are at risk in the domains of work, learning, and socialization but also that it is necessary to advocate broader (social, political) notions of communication, hearing, and swallowing (Pillay, 2011).

Using the EPIC framework, we argue for the reappropriation of knowledge and practice to reframe the current disorder-deficit focus. Occupational therapy, for example, is reclaiming human occupation (Kronenberg, Kathard, Rudman, & Ramugondo, 2015) as a collective phenomenon (Ramugondo & Kronenberg, 2015), describing it as that which professionals do together. Here, we suggest that the basis for understanding communication is how people make meaning together. This approach helps reposition communication disability/impairment as a relational problem instead of one that locates disorders of communication in the mind of the afflicted individual. For swallowing (and/or feeding), we advocate for an extension of the professional horizon to include nutrition for all people with disabilities, locating work focus related to feeding and swallowing within issues of food security. With this relational-based reframing, communication disorders may be situated with respect to the personal, social, historical, and political contexts in which they emerge. Kovarsky (2015) argued that people with communication disorders are, through their relationships, marginalized and occupy a cultural borderland of otherness due to

stigmatization. Kathard and colleagues in a series of studies regarding self-identity formations among people who stutter similarly called for a deeply situated sociocultural, historical, and political understanding of communication disorders through engagement with life experiences (Kathard, 2006; Kathard, Norman, & Pillay, 2010; Kathard, Pillay, Samuel, & Reddy, 2004; Watermeyer & Kathard, 2015).

## EXAMPLES OF PROJECTS USING AN EPIC FRAMEWORK

In expanding the meaning of communication, we draw upon the African philosophy of *Ubuntu*, roughly translated as a person is a person through other people (Praeg, 2014). *Ubuntu* applies to foregrounding communication as a humanizing process. This is an essentially African philosophy that may be applied to all people but is especially relevant to people who have been deeply dehumanized over centuries of colonization. Kenyan postcolonial author Ngũgĩ wa Thiong'o, following South African Steve Biko as a political activist, argued that people must decolonize their minds (Thiong'o, 1986). Thiong'o argued for a regaining of pride in an African consciousness and ways of being (Biko, 2004). These arguments are also useful for audiologists and SLPs. For example, in engaging decoloniality, we believe that *Ubuntu* may be employed to analyze and conceptualize collectively communication, disorder, and impairment. This joint analysis should occur between local and global communities.

Consider how indigenous and settler communities or (neo)colonial peoples in Europe or North America could engage people from the South to assess what/why they position communication (including hearing) and swallowing as they do and how they might conceptualize them differently. These conversations might develop new interpretations that would interpret communication within a (re)humanizing framework. Such knowledge then could become constructed through global and local communities instead of predominantly employing a limiting framework, as illustrated with the following examples of EPIC practices.

### EPIC Example 1: Street Trader Socio-Sonic (STSS) project

This project focuses on urban (street) traders in the city of Durban (eThekwini, KwaZulu-Natal, South Africa), who represent an underserved population. They work every day in a trading hub/marketplace that is a lively, bustling epicenter of economic, social, cultural, and political diversity. Here, music traders play their merchandise with loudspeakers. Traders are exposed not only to loud music but also to urban sounds from traffic and construction.

We began a hearing conservation project with this group, informally, in 2015 with a nongovernmental organization representing the street traders, called Asiye-eTafuleni (www.aet.org.za). This led to the development of a multifaceted hearing conservation program with a team of health care practitioners from the public and private sectors (including nursing; ear, nose, and throat/otolaryngology; audiology; and speech–language pathology), urban activists, architects, occupational health and safety practitioners, community/social liaison practitioners, and urban development researchers. The project has grown to include the services of visiting student audiologists from the University of South Alabama in the United States and the local University of KwaZulu-Natal.

Initially, the team developed audiological screening and diagnostic services and delivered them in this marketplace. Using nontraditional tools and methods, including an audiometer designed in South Africa (the KUDUwave) (Swanepoel & Biagio, 2011), a makeshift otolaryngology and audiology clinic was created at Asiye eTafuleni located off the main market street. Environmental sound (i.e., noise) measurements were completed using mobile phone applications. Worker education and personal ear protection were also included in the intervention. This work was based on Stasik's (2012) *socio-sonic* views on music and society in Sierra Leone's Freetown

and on Schafer's (1977) concept of *soundscaping*, where a sonic identity or memory is located and sound is situated as belonging to/of a place.

The socio-sonic basis became a key innovation for the street trader project, as it allowed for the engagement of traders through their personal life history narratives. These personal life histories were collected using qualitative methods of storytelling, autobiographical writing, photographs (photovoice), and interviews. In going beyond basic clinical case histories, the team positioned hearing beyond noise or ototoxicity (human immunodeficiency virus/tuberculosis medication or chemical exposures) as a pathology. Instead, narrative methodologies are used to map the *multifaceted economy of sound* (Stasik, 2012) where music and urban sounds are presented as a decolonizing activity that connects people by addressing boundaries of Otherness. In relation to the formal sector, Warwick street traders' Otherness is marked by being in the informal sector where they are invisible, marginalized workers with little social, cultural, political, or economic capital. This program has allowed for a shift from traditional audiology/hearing conservation toward highly relevant, deeply transformational practices that locate the ear/hearing as a social, cultural, political, historical, and, of course, biological entity.

### EPIC Example 2: Tackling Hunger with Research and Innovation in Vulnerable Environments (THRIVE)

The THRIVE project is another example of a project based on the EPIC model. It involved repositioning swallowing and feeding to develop transformative practitioners focused on the politics of food sovereignty and security. This project was an outcome of our work on developing a political conscience in audiology and speech–language pathology (Kathard & Pillay, 2013). People with swallowing or feeding disabilities experience difficulties with food availability, access, utilization, and sustainability. To achieve an EPIC practice, we encouraged SLPs and other dysphagia professionals to connect disability, nutrition, food sovereignty, and food security in their everyday practice with the activities described in the following section.

#### *Advocacy and promotion of swallowing/feeding as food sovereignty and security*

This activity occurs via interconnected strategies, such as collaboration with nurses, dieticians, and/or educators, to screen and manage people with swallowing and/or feeding disorders while scaling up professionals impact to influence to hospitals, schools, and community levels. Relationships have been developed with the Health Economics and HIV and AIDS Research Division (HEARD) at the University of KwaZulu-Natal to establish the link between disability, nutrition, and food security. Also, to manage populations, telemedicine/telematics and community-based rehabilitation have become avenues for service delivery (Pillay, 2013). This includes a master clinician program to mentor practitioners in their compulsory service year to provide services to underserved populations in South Africa. This mentoring and telematics program is also being extended, and at varying levels of support, to other African countries (Ghana, Kenya), Asian countries (India, Sri Lanka), and now to countries in Latin America such as Venezuela.

#### *Active participation in national/South African policy development*

This element ensures that the concept of dysphagia as a disability is inserted at the highest level of relevant policy in the country. Here, we engage national and international policy on food security, which is a concept that refers to food availability, access, utilization, and sustainability (Food and Agricultural Organisation [FAO], World Food Programme [WFP], & International Fund for Agricultural Development [IFAD], 2014). This when "all people, at all times have physical, social, and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy

life" (FAO, IFAD, & WFP, 2014, p. 50). Policy engagement is conducted by explicitly referencing people with swallowing and/or feeding disabilities and explaining why all persons with swallowing disabilities are indeed food insecure.

Food security for these populations is highlighted as unique food and nutrition safety concerns such as access to modified foods and aspiration risks. Persons with disabilities experience greater social, economic, and political disadvantages with food production (including agricultural activities) as well as how food-related problems are interconnected to structures/processes governing societies and economies.

### *Development of a critical practitioner mass*

This development occurred via the creation of a national interest group (the South African dysphagia interest group via a Facebook Web site https://www.facebook.com/groups/sadysphagia/). In addition, an international swallowing and/or feeding interest group is currently being formed into an association (International Feeding and Swallowing Network [IFASN], https://www.facebook.com/FeedandSwallNet/). This network serves to link practitioners across the Majority and Minority Worlds and is especially focused on sharing practices for vulnerable populations in resource-constrained contexts. Locally, the International Dysphagia Diet Standardisation Initiative (see www.iddsi.com) is used as an action leverage point to pilot a diet classification system across selected rural and urban health care and education services in the public and private sectors. This project is focused on diet and textural modifications for persons with disabilities as a strategy to manage food security at a population level.

### *Transforming dysphagia knowledge awareness and innovation*

The described elements are critical for transforming the focus on *dysphagia-as-impairment* to *dysphagia-as-disability*—with the latter positioning malnutrition in relation to disability and dysphagia as food insecurity. Awareness and innovation are achieved through the activities described later.

### *Strategic presentations at several international and local conferences*

The development of these presentations included arranging a panel titled "Should poor people, who cannot eat or drink safely, be treated differently?" This was convened by Pillay (2013) and addressed dysphagia practices in 13 different countries at a meeting of the International Association of Logopedics and Phoniatrics. Furthermore, professional meetings of the Dysphagia Research Society have provided a platform for focusing on the delivery of dysphagia services in resource-constrained contexts within a population-based approach.

### *Development of a research cluster focused on THRIVE*

THRIVE includes several research projects at international, national, and institutional levels. All studies are focused on food security and persons with disabilities. The international study is focused on the response of global organizations such as the United Nations, World Vision, and World Food Programme (see Quarmby & Pillay, in press). At the national level, a large population data set (the General Household Survey) was analyzed to position food security and related to dysphagia practice patterns (Andrews & Pillay, 2017). At the institutional level, there is an investigation of a patient data set from a specific public hospital. Beyond securing and mining basic data sets, THRIVE has extended its reach by employing principles of decolonization to develop novel dysphagia interventions. One project focuses on changing dysphagia diets by blending local, indigenous knowledge of diet modifications with advanced information about rheological/textural modification from the field of molecular gastronomy (Pillay, 2016) and the multisensory nature of food, specifically the therapeutic benefits of food's acoustic properties. These interventions are implemented at a population level, with

participation of members from especially vulnerable community environments.

In this project, swallowing (and/or feeding) impairments are reframed within a doubled-edged food sovereignty and food security frame. Food sovereignty involves a repoliticization of food politics (Patel, 2009) and is positioned as a precursor to food security. While food security is about food availability, access, utilization, and sustainability [FAO, IFAD, & WFP, 2014], food sovereignty is about people's rights to define their own agricultural, labor, fishing, food, and land policies, which are ecologically, socially, economically, and culturally appropriate with food that is also nutritious and safe (La Vía Campesina, 1996). Applying Hannah Arendt's (1967) view on the right to have rights, Patel (2009) considered food sovereignty as a basic right. Likewise, for populations with swallowing and/or feeding disabilities, we argue that food sovereignty and security must be promoted as basic human rights. In this way, the national and international research agenda for persons with swallowing or feeding disabilities is being influenced to relate to food and nutrition security.

### EPIC Example 3: Engaging communication through community development

A third example was a project that began in Khayelitsha as part of the University of Cape Town School Improvement Initiative (www.sii.uct.ac.za). Swingler (2017) aptly characterized Khayelitsha as a marginalized Black African community in Cape Town, South Africa. She also highlighted that African languages and communication practices emanating from Khayelitsha are not as valued and privileged as English in mainstream education. Swingler reported on most learners in this community as being challenged in achieving educational outcomes and that problems with (English) language and literacy learning have been identified as one contributing reason for poor educational achievement. Given that learners from this community are from low-socioeconomic-status communities, equity was a key principle guiding the development of an EPIC intervention.

Instead of focusing on individual learners, program directors placed emphasis on understanding the community as a whole with respect to the complexities of oral and written communication. The following question was asked: Given what is known about the resilience of language acquisition among language learners internationally, why do the majority of children in the community fail on (English) language and literacy outcomes? Clearly, there are systemic factors beyond individual development influencing this outcome. Therefore, rather than trying to treat each individual child, a population-focused community development approach was initiated by occupational therapists (Galvaan & Peters, 2014). This approach required language learning to be situated more broadly as something that develops in communities influenced by societal issues ranging from the local to the global (Kathard & Pillay, 2013). Importantly, communication choices by communities were regarded as political acts made in response to systemic challenges. Because of this, language differences and challenges could not be framed as language disorders. Interventions/innovations were focused on understanding how school language policy and its enactment contributed to the creation of the language and literacy problems. Through this process, the political consciousness of student therapists in a speech–language pathology program was raised as they began to question how colonization impacted language learning practices in communities of African children who were having to learn English (the language of power) with minimal systemic support.

In resisting the urge to evaluate each child, student therapists partnered with their colleagues in occupational therapy to learn more about how to engage this challenging situation using an occupation-based community development framework (Galvaan & Peters, 2014). The framework assists with engagement with issues of marginalization through a contextual understanding of communication challenges. Engagement with various role-players in the community served as a basis for identifying opportunities for change by valuing local resources for problem solving.

Student therapists across occupational therapy and speech–language therapy professions became aware of everyday lives in communities and how exposure and support for language development in school and at home influenced the current reality. What it means to communicate (and to be a person with a communication disability) is constructed by the people such as educators, learners, and therapists in the school context. Therefore, everyday interactions between teachers and learners and between learners in school and community environments became sites for enriching communication development. Collective resources within and beyond the local community were used to develop communication. This partnership approach gave rise to projects such as the homework and mentoring program where student therapists partnered with high school learners to provide communication support to junior learners. In addition, the library project was initiated together with librarians to facilitate language learning through collaborative development of resources. The main learning emerging from this practice setting was that SLPs' practice needed to be responsive to the communication context that was created through linguistic, social, relational, cultural, historical, and political realities.

## CONCLUSION

In promoting EPIC practices, we seek to raise awareness of alternatives to personal, individualized health care, which has been made dominant by globalized Northern views of health care delivery. Critically, traditional models of and assessment/intervention are respected and should not be entirely abandoned. However, it must be recognized that expansionist moves require tools that enable transformation to new territories of practice to produce (vs. reproduce) practices that maintain the status quo where service inequities exist.

Such changes challenge customary assumptions about the nature of communication, hearing, and swallowing disabilities. Once challenged, existing theories/thoughts become destabilized. Professionals' treasured values/beliefs about what constitutes good practice may become murky and even attitudes about clinical concepts such as *excellence*, *relevance*, and *effectiveness* may become shredded with service realities. As clinical practitioners, professional educators, and researchers, some professionals report experiencing conflict, uncertainty, and moral challenges (Pillay, 2003). The difficulty of negotiating one's practice identity is paramount when faced with the realization of what it means to be a real, empirically oriented practitioner. This paradigm war (Guba & Lincoln, 1994) will give rise to various forms of resistance from within peers and power brokers from people such as professional association members, journal editors, professional educators, clinical managers, and colleagues. We look forward to critically engaging this resistance to nurture a cultural borderland that encourages innovation in meeting the needs of the poor and marginalized across the Majority and Minority Worlds. This article serves as an invitation to join a critical mass of people to transform the world.

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