Perspectives of SLP clinical educators in a transforming speech-language pathology clinical training program in Gauteng, South Africa

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Abstract

The absence of equitable speech-language pathology services for South Africa's Black majority has triggered a need to transform and decolonise the clinical curriculum as well as to reduce the divide in the availability and access to speech-language pathology services and resources. This study aimed to explore clinical educators' understanding of their positionality and the perceived impact their positionality has on student training in the South African context, when serving under-resourced and unserved populations. A qualitative approach was employed, which included interviewing seven members of a focus group consisting of clinical educators in speech-language pathology. Their responses to the discussions were analysed by using thematic content analysis. The participants highlighted the following aspects of their work: (1) diversity of students, (2) the clinical educator's model of experience and cultural capital and (3) disrupting frames of reference and hegemonic practices as common experiences of clinical education in diverse settings. The results indicated to the complexities of transformation of the clinical education curriculum and the need for a multidirectional and self-reflective approach that encompasses the student, the curriculum and the clinical educators. These findings contribute to the process of supervision and to the transformation and decolonisation of clinical training in South Africa.

Keywords: clinical education, decolonisation, speech-language pathology

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Introduction

As lecturers and course coordinators at the University of Witwatersrand we began interrogating our clinical curriculum in an effort to evaluate and transform the clinical education programme for speech-language pathology students to ensure its relevance to the South African context. As student demographics in our speech-language pathology (SLP) programme are changing slowly but steadily, clinical training needs to better represent the South African context. The curriculum has nevertheless been slower to decolonise (Mbembe 2016: 30). As a result, we have produced speech-language pathologists irrespective of race, who exhibit 'epistemic blindness' with regards to clinical education (De Oliverira Andreotti 2011: 391). Epistemic blindness is the belief that Eurocentric knowledge is the source of all knowledge, and one is blinded to the notion that other forms of knowledge can exist. Epistemic blindness is prevalent among SLPs who have previously and recently qualified in South Africa, and this general prevalence is known as 'professionalisation'. Professionalisation is the collective identity of a discipline that is socially embedded upon socio-eco-political and historical contexts. The professionalisation of most SLPs has caused them to believe that the way they were trained is the only 'truth/knowledge' with regards to how services can be provided in the South African context (Abrahams et al. 2019: 2). Unfortunately, this 'truth/knowledge' is at the expense of marginalised groups that receive SLP services, evident in the way in which the profession has been perpetuating injustices. Thus, it is imperative to challenge the traditional beliefs of clinical practice as well as clinical training in order to bring the profession closer to achieving health equity. Furthermore, it is important to frame this change within a decoloniality perspective in order to move away from professionalisation and move towards alternative ways of knowing that are more responsive, both culturally and contextually.

This study forms a part of a larger research project that has been targeting the decolonisation of speech-language pathology in higher education at the University of the Witwatersrand. It must be noted that the experiences of the clinical educators in this paper is from one particular institution, with a particular way of clinical training specific to this institution that is not necessarily shared by other training institutions. At the University of the Witwatersrand, clinical educators (CE) are speech-language pathologists currently working in either a private or public health or educational setting. The majority of the CE are from Johannesburg and had previously received

training at the University of the Witwatersrand with at least one year working experience post community service. From previous unpublished research conducted by Mupawose, Adams and Moonsamy (2019), we found that CE had great difficulty working in under-resourced contexts which differed considerably from their own- especially with regards to cultural and linguistic barriers. The difficulties experienced by those educators hampered the provision of services where the clients were looked at in isolation and only in the context of the classroom. However, we know that the client needs to be seen within Bronfenbrenner's socio-ecological system's model; where family/caregivers, the community, peers, and education stakeholders among others have a major influence on the child's development as well as their response to intervention.

Therefore, this paper looks at why CE may struggle to work with students from diverse backgrounds in diverse contexts. Furthermore, we argue that being aware that you are uncomfortable is not sufficient, but that you need to engage with those feelings of discomfort and with the context in which you are working. Boler (2005: 16) states that engaging and acting upon one's emotions is empowering and will result in change and growth within individuals. Transforming practices begins with transforming mind-sets.

Background of SLP services

Speech-language pathology in South Africa is entrenched in the legacy of apartheid. Speech-language pathology as a discipline was introduced in South Africa during the Apartheid era (Kathard & Pillay 2013: 85). Initially the SLP's being trained to serve the white minority were predominantly white, while the training of other racial groups remained marginalised (Abrahams, Kathard, Harty & Pillay 2019: 5). In addition, education was being used as a tool to perpetuate views of hierarchy and maintain social order and predetermining racial groupings into their roles in society (Abrahams et al. 2019: 6). The Bantu education schooling system for Black learners that was implemented during the apartheid era, exposed black learners to Eurocentric/white supremacist ideologies. Black South Africans received substandard education with limited resources and government support. In contrast, white South Africans were being trained to work in the service, health and education industries and service the privileged minority. Unfortunately, the speech-language pathology profession has made limited strides in terms of transformation and a large percentage of therapists

are still working in private practices using normative frames of reference and the medical model of care to serve a small percentage of the population (Llewellyn & Hogan 2000: 159; Moonsamy et al. 2017: 32). It has been documented that since democratisation, there has been a decline in the advancement of social justice and economic imperatives in education policies and public discourses (Gebremedhin & Joshi 2016: 176; Vally 2018: 3). There is therefore an urgent need to transform and decolonise the speech-language pathology profession, as well as the curriculum and the practical training of students.

Speech-language pathology services and social justice

In an attempt to dislodge the hegemonic practices of the speech-language pathology department, the department was inspired to commit to the advancement of social justice in an attempt to reduce inequalities between the privileged and the poor (Abrahams et al. 2019: 9). Currently, SLP services are inaccessible and unaffordable for the majority of South Africans. The reduced access highlights how SLP services are unequitable with preferential treatment given to the more privileged (Moonsamy & Carolus 2019: 86). In order to decolonise the clinical curriculum and to stop the perpetuation of the systemic marginalisation of the majority of the population, the SLP department made a concerted effort to select clinical placement opportunities in under-served and under-resourced communities formed by mostly poor, black people. The department is also focusing on the more racially, linguistically and culturally diverse populations. Part of this process is that the students needed to realise that the fundamental knowledge and skills of providing speech-language pathology could be acquired and learnt in under-resourced communities as well. In providing equitable services to all, there is and will continue to be a need for all students and CE irrespective of race; to know that episteme pertaining to the discipline can be attained and applied in all contexts. Therefore, understanding the clinical educator's perspectives and abilities to work and teach students effectively in under-resourced, low-income settings was essential. Black people have a right to receive services that respect and uphold their community practices and to achieve this, clinical educators need to empower communities to respect and value their own knowledge on how communication disorders are diagnosed and treated, which can be achieved through the students that they supervise.

Conceptual framework

According to Mgqwashu (2016) it is essential to first develop a shared understanding of the meaning of the curriculum and decolonisation in order to begin addressing these challenges. We began by examining our approach to curriculum theory and focusing specifically on *curriculum as context* and *curriculum as praxis* (Mgqwashu 2016). By utilising the lens of *curriculum as context* and *curriculum as praxis* we were able to evaluate how the SLP clinical curriculum perpetuates unequal social relations - whereby the SLP professional is the expert or 'the all-knowing one', and the client is positioned as the passive recipient of SLP services. *Curriculum of context* led us to consider developing 'reciprocal community relationships' (Hytten & Bettez 2011: 12) and the need to look at the client holistically and in context. Although, this view is not new, it has not been implemented adequately in order to fit the needs of both the child and their community in which the SLP is served. By fostering reciprocal community relationships (RCR), we attempt to create both shared and negotiated understandings while at the same time generating and disseminating knowledge and practices. After careful examination of our clinical curriculum, we realised there were several areas that needed to be addressed with regards to RCR. Firstly, the clinical placement contexts tended to favour the middle class, consisting mostly of white people who predominately speak English or Afrikaans. Moreover, these populations reside in more affluent urban areas and were more likely to have access to medical insurance or access to private and public services. Secondly, the department noticed a lack of communication between the students and the clinical educators.

Applying the lens of *Curriculum as praxis* we realised that many students had not been achieving clinical competencies that were responsive to working in the South African context. By continuing to conduct clinical training in these environments, we were perpetuating professionalisation. Therefore, in order to commit to the transformation and decolonisation agenda of the clinical curriculum for SLP, the department needed to move away from professionalisation which promotes coloniality and individualism (Abrahams et al. 2019: 5). We need to move to population-based services which promotes universality and pluralism (Abrahams et al. 2019: 7; de Oliverira Andreotti 2011: 384). Pluralism allows for us to recognise and affirm diversity in the contexts we work in as well as respect the knowledge of the populations we serve.

Rationale

In order to work towards a decolonised education system, we need to transform the curriculum as well as facilitate epistemological access for the students and potentially liberate their minds of Eurocentric thinking (Abrahams et al. 2019: 9; Khoza-Shangase and Mophosho 2018: 3; Lubbe, Wolvaardt & Turner 2020: 89). A change in thinking can assist with the awareness of different ways of thinking and generating knowledge of the world. Leibowitz (2017: 97) emphasises that learning is not only cognitive but that it is also an active and experiential process. Decolonised education should focus on democratisation of the curriculum by allowing students to participate in curriculum development. All of this should be done through critical engagement and reflection in which students can imagine a more equal and less oppressive world (Leonard 2004: 15; Bitzer & Withering 2020: 23). This raises pertinent questions around those teaching in higher education, such as how we can expect the institutions to transform if those teaching are untransformed themselves? This 'inner' transformation can only occur if the lecturers within the department and clinical educators within the field, engage in critical inquiry or reflection that not only stops at knowing but also applying action to these 'inner' transformation.

For critical inquiry to occur CE must interrogate and disrupt their frames of reference in relation to their own positionality within the South African context. Santos (2007) refers to this positionality as the 'epistemology of seeing', a self-reflective seeing and recognising of the 'other' as an equal human being -irrespective of real or perceived difference(s). The 'epistemology of seeing' can be very discomforting because it can cause disruptions of firmly held beliefs, values and norms within. Experiencing discomforting feelings, however, does not necessarily translate into transformed thinking or practices (Zembylas and McGlynn 2012: 4). Therefore, the current study was undertaken to explore clinical educators' understanding of their positionality and its perceived impact on the training of students, when serving under-resourced, unserved and under-served populations in the South African context, and to describe their experiences when supervising diverse students in diverse settings. This study recognises the different voices that are required in the decolonisation process, however the current focus will be on that of the clinical educators.

METHOD

A qualitative, exploratory approach was employed, and the participants were sampled using purposive sampling. The data was collected through a focus group consisting of seven clinical educators. The focus group lasted approximately 1 hour and 30 minutes using probe questions (Appendix 1). Data from the focus group was transcribed verbatim and interpreted by using thematic content analysis. All identifying features were removed to ensure anonymity. All ethical parameters were adhered to. Approval to conduct the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (Ethical clearance number # H18/11/24).

Table 1. Participant's demographic information

Participant	Race	Mother tongue	Years of supervising	Training institute (Wits/Other)
1	White	English	1	Wits
2	Indian	English	2.5	Wits
3	White	English	2	Wits
4	Indian	English	2	Wits
5	Indian	English	2	Wits
6	Black	Tswana	1	Other
7	Black	Shona	15	Other

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These CE were training speech-language pathology students at different clinical sites in low-resourced and under-served areas in the Johannesburg area. The table below (Table 2) shows the student demographics.

Table 2. Demographic characteristics of students

Characteristics		N	%
Age	19-20		
Race	Black White Coloured Indian	13 7 1 8	44.8 24.2 3.4 27.6
Home Language	Sepedi English isiXhosa isiZulu Setswana French Afrikaans	4 17 2 2 2 1 1	13.9 58.6 6.9 6.9 6.9 3.4 3.4

FINDINGS

The primary contribution of this study was to understand clinical educators' perspectives in a transformative clinical program. The findings will be discussed in relation to the identified themes.

Diversity in students: language, culture and context

All the clinical educators commented on the difficulties experienced when working with students from different backgrounds, which created a barrier to effective communication. It is a given that factors such as differences in race, culture and language are likely to hinder communication (Black et al. 2017), and it is only through critical reflection and understanding of one's positionality as a clinical educator that one can begin to understand the needs of the students being supervised as stated by Participant 5 "*I feel she (student) has got like issues. I don't know what it is because in the beginning of, of everything she was okay. Like in the beginning when I had her she was okay, she was listening and then suddenly she changed. And ever since from then, she's not been, she would come to, to, practicals not prepared and everything*".

However, supervising students in a setting that is professionally challenging can sometimes prompt self-reflection by both students and clinical educators, which leads to personal growth explained Participant 4, "*... we noticed with our third years ... the growth that they had through the year—personally, not only just as clinicians ... affected their emotions and them as, as, um people. You know? Just not only being sympathetic but having the empathy … help them grow, not just as clinicians but as people. Having empathy and how they can make things functional for them in their centre, just made so much of a difference in that place*". Further, Participant 7 was able to reflect and use it as an opportunity to grow, *"I think like also personally, uh, it makes you to grow. It makes you understand that people are different, students are different... . Also, because they are from different multicultural diversities and from different families*".

Epistemic seeing means that clinical educators need to be more than just aware of differences between themselves and their students but being aware of the 'right' feelings does not necessarily lead to agency or transformation (Zembylas & McGlynn 2012). In the case of clinical educators, agency would require an interrogation of their hegemonic practices in the context of South Africa's past and present realities. This mental interrogation may improve their understanding of why students do certain things or behave in a certain way. Furthermore, clinical educators' biases can negatively affect the way they interact with students in different situations. We therefore argue that reflection as such is not enough, but that one needs to engage with one's reflections and the context in which one functions/operates.

The clinical educator's model of experience and cultural capital

Three of the seven clinical educators showed some insight into how their own positionality impacted on how they supervise students. Many CE expectations are directly correlated with their own experiences and abilities and research has shown that many CE will mirror their own supervision experiences when supervising and utilise what is called *a model of experience* (Higgs & McAllister 2007: e45). This can raise a number of issues when your experience differs significantly from the students you are supervising as well as in the contexts you are working in. This can be a struggle as CE may place their own positionality over a student's potential Participant 1 said, *"Um, in working with different students, I have also learned that I cannot work with students who are not independent. I struggle a lot. I don't know why I struggle. But I do struggle, I struggle with students*".

Zemblas and McGlynn (2012: 45) refer to this 'struggle within' as a discomforting pedagogy. When power and emotions interact within a social context, they create a social norm for emotional and behavioural expression. In this case, the social context is the clinical context of supervision in an under-resourced environment. The clinical educators find themselves in new social context that disrupt their frames of reference with regard to how to feel and act when supervising students. This highlights the need for more 'epistemological seeing'—critical reflection and understanding of positionality and the implications this has for students. Clinical educators are aware of their difficulties, but many are unsure about how to work through these problems, which highlights the fact that transformation requires work and an understanding of one's own position (Khozs-Shangase & Mophosho 2018: 5). This highlights how clinical educators are using cultural capital in the way in which they supervise. Cultural capital suggests that there is a valued hierarchy in which different forms of cultural knowledge, such as language, social interactions and even learning are ordered (Alexander & Warren 2002: 14). Thus, CE's need to be aware of their own cultural capital and how the model of experience may not be appropriate when working with diverse students in varied contexts, particularly those with different backgrounds and views.

In order to understand views and experiences that may differ from your own, you need to immerse yourself in diverse contexts and use it as an opportunity for transformation and adjust your cultural capital. This understanding can provide the CE with an opportunity to learn and teach.

> *"I did find that the students obviously hadn't had personal experience with an orphanage. And the behavioural issues that can happen ... So, it was quite uh, kind of a growth opportunity for them to just realise that these children are not just naughty and that it comes from the competitive environment that they're in, and how every day is almost a survival of the fittest."* Participant 2

The clinical educator's role in this instance was to help the student therapists to remove themselves from their own backgrounds and experiences and enter into the worlds of the clients. The clinical educator was trying to enculturate a pluralistic perspective in the students to enable them. They were trying to to enculturate a pluralistic perspective in the students, where the students can acknowledge and affirm the patient's diversity but still respecting them as equals. However, the clinical educator is still assuming that all students may have a homogenous perspective,

regardless of the student diversity and by doing so perpetuates the colonisers view (Liccardo, Botis & Dominguez 2015: 378). This view was echoed by Participant 6, *"It's just having them really appreciate and understand the environment that these um children are in. So that was the one thing that is just taking them away from their experiences of a normalised upbringing-whatever that is for each student"*.

In this quote the CE speaks about a 'normalised upbringing' followed by 'whatever that is for each student' and again assumes a particular world view about the students' backgrounds and that there is even a 'normal' of sorts. The notion of a normalised upbringing emphasises the ideology that all students have one voice and one view. In addition, this view is one of privilege. However, we know this is not true and that students from different backgrounds cannot all be treated in the same way and disparities need to be addressed (Liccardo, Botis & Dominguez 2015: 379). By utilising this approach, the privileged or 'traditional' student groupings are being rewarded which goes against transformation or decolonisation.

(3) Disrupting frames of reference and hegemonic practices

This study found that five of the seven participating clinical educators were overwhelmed and unsure, which could be attributed to the absence of prior contact with the clinic site. This uncertainty could be attributed to a lack of experience as well as experiencing a feeling of the unknown. It should also be mentioned that the two Black CE (Participant 6 and Participant 7) did not share these same experiences about starting practical work. Although, Participant 7 was a lot more experienced, this finding may also address issues around who is recruited as a CE, where they were trained (both participants were not from the University of the Witwatersrand) and their own experiences of the curriculum.

As these are new clinical sites, many of the CE did not know what to expect and this created a heightened sense of uneasiness resulting in a feeling of inadequate preparation for the clinic as stated by Participant 1, "*But overall it's a school that has-they're really lacking in resources. I mean every child, every morning that I get there is like scavenging around for chairs and for tables. And it's a very, very difficult school to be in …*" and Participant 4, "*All the students are anxious and I am anxious because I need to be oriented as well. So there's so many emotions going on*".

The above educators' responses again indicates that when emotions and power interact in a social context, they can cause tension or discomfort that disrupts frames

of references and can perpetuate hegemonic practices. However, this same discomfort can also be the very thing that shifts hegemonic practices. The CE's anxiety was a result of not only being unprepared but also adapting to a new experience. As mentioned before, CE can use this discomfort to either perpetuate or shift hegemonic practices. For example, this quote highlights an attempt to shift hegemonic practices, "*... helping the students in terms of their themes and what would be relevant to a child. So, try not to do a going to the beach theme, which many of these kids have never and might never experience. Just trying to observe really, where these children are and not trying to bring your experiences and imposing it onto the child*" Participant 3.

This clinical educator encouraged her students to critically engage and develop a meaningful understanding of the physical context of the school. However, the participants still utilise a medical model of care. This behaviourist approach was illustrated where CE required the students to choose the theme and provide the therapy to the child in an one-on-one sitting in a designated room.

> *"I explained to them you know, during a sessional, it isn't just about being our assignment for the week. It's for you guys to actually gather your thoughts, think about the patient for a second and think what they actually need. Your goals need to be appropriate for what they need... So take a moment, sit down and think what you actually assessed. What does this child need? And what is the goal actually to be? And that's why as a therapist you need to be appropriate to the person that's sitting across from you and know what they can actually obtain." Participant 5*

It was interesting that these quotes still support the hegemony and utilising the medical model of care i.e. professionalisation. These quotes emphasised the importance of not only changing contexts but the importance of also utilising a different model of service. To ensure that services are relevant to the context, the CE and the students need to change their service delivery model that speaks to the practices in that environment. Empowering caregivers through knowledge transmission, as well as acknowledging what they are doing and building on their skills (Tayob & Moonsamy 2018: 566). Appreciative enquiry speaks to acknowledging the strengths of the caregivers. Furthermore, this emphasises the need to change the current model of practice in order to transform and decolonise clinical practice.

Conclusion

The prioritisation of equitable service provision to the marginalised black population can assist in developing an understanding of the experiences of clinical educators who supervise clinical training in poorly resourced settings. The identified themes reveal an undercurrent of 'discomfort' experienced by clinical educators supervising student therapists in under-resourced settings. They felt uncomfortable in those contexts because of the way they positioned themselves in relation to the social context in which they practise. In relation to these experiences, prioritising social justice imperatives in clinical education training would mean emphasising 'the intersectionalities of differences and their contextualized manifestations' (Kaur 2012: 491). Clinical educators should therefore confront differences meaningfully, which means that they need to engage critically with differences by adjusting their social positions in relation to the contexts within which they work. Instead of highlighting the differences between their social and work contexts, they should critically engage with the subjectivities they bring to their work so that they can begin to develop an understanding of how their biases shape their personal identities and working lives as therapists (Kaur 2012: 491). Clinical educators need to adapt the way in which they supervise and move away from the model of experience to ensure that their own positionality does not overpower student potential. This study highlighted differing experiences of CE feelings of discomfort and important issues of who we recruit to supervise our students.

It was found that a common experience among clinical educators was that the physical environment in which they provided services was of paramount concern. They felt 'concerned' that the schools are under-resourced and have poor facilities. Such patterns of thinking contribute to the 'deficit discourse' (Kaur 2012: 489). Deficit discourses position low-resourced settings as disadvantaged, thus perpetuating extant discourses about low-resourced contexts and ultimately the way they are served. Critical engagement requires clinical educators to 'change their negative, deficit, counterproductive thinking' (Kaur 2012: 489) in order to change the way in which they provide clinical supervision to students. In addition, the importance of identifying resilience, creativity, the use of indigenous knowledge and assets in the community should be noted. Some of the findings highlighted the need to adapt therapy to suit the context while still broadening experiences and not employing a patronising attitude. Low-resourced environments impose unique

and often uncomfortable challenges and highlight the need for further discussion of the facilitation of contextually relevant and responsive knowledge and learning. Moreover, these findings emphasised a need to transform the current service delivery model and move away from the medical model of care and use one that speaks to the practices in that environment, such as the Bronfenbrenner's systems model.

In summary, the experiences of clinical educators in low resourced settings provide the opportunity to begin reflections on the implications of clinical practice for both the service providers and the community being served. The findings suggest that clinical training should emphasise the uncovering of knowledge through personal reflection (Hackman 2005). To create meaning 'at the nexus of everyday lived experience and intricate social systems; to ask questions that allow individuals to hold multiple, even opposing, identities' (Torre 2008: 106). Although the process of decolonisation is complex, there is a need to transform the clinical education curriculum to include a multidirectional and self-reflective approach that incorporates the student, the curriculum and the clinical educators. At no point should blame be placed on the CE for the cognitive dissonance that might be experienced, as overpowering emotions are a result of circumstances and not a definition of character (Boler 2005: 15). Hence, the clinical training of CE should create safe spaces to explore their experiences and reclaim their emotions as part of the ethical and cognitive inquiry. This will provide hope for changing the quality of life and taking action towards social justice.

The current study was limited by the fact that many of the CE did not have a lot of experience and this may have played a role in how they supervised at different clinical sites. Although, the findings may not be generalised to more developed countries, it can contribute further to our understanding of transformation and the challenges in developing countries as well as difficulties in recruiting experienced CE. Clinical educators with a different background to the majority of their students who they supervise as well as the contexts in which they normally work present them with unique challenges. This study highlighted the importance of positionality as a step towards transformation of the curriculum and since transformation is fluid, determining positionality should be continually established.

This study emphasises the complexities of transformation of the clinical education curriculum and the need for a multidirectional approach that encompasses the student, the curriculum; and we argue, the clinical educators required input in the transformation process. Although the importance of the role

of clinical educators has been emphasised in previous research, this study builds on that positioning and reports specifically on the important role that the experiences of clinical educators have in the transformation and decolonisation of education. Transformed supervision focuses not only on the content but also on the students' development, the clinical educator's growth and the community's empowerment. Attention should be directed to developing and encouraging ways of fostering a space whereby clinical educators can engage in facilitated self-reflective processes of 'epistemic seeing' in order to breakdown years of coloniality. The hegemonic belief that any truth, culture or knowledge outside of the Eurocentric ideology is inferior- must be discredited and the value of pluralistic thinking must be valued.

Appendix 1

1. Can you tell me about your experiences supervising this year?
2. What were some challenges that you experienced?
3. How did you overcome these challenges?
4. What were some facilitators to the supervising process?
5. Has there been any changes supervising at the new site?

Declarations

Ethics approval and consent to participate: All ethical considerations were adhered to in the data collection and analysis processes (Ethical clearance number # H18/11/24).

Consent for publication: Written informed consent was obtained from all the participants.

Availability of data and materials: The datasets analysed during the current study are available from the corresponding author on receipt of reasonable request.

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References

Abrahams, K., Kathard, H., Harty, M., & Pillay, M. 2019). Inequity and the Professionalisation of Speech-Language Pathology. *Professions and Professionalism*, 9 (3), 1-16.

Alexander, B. K., & Warren, J. T. 2002. The materiality of bodies: Critical reflections on pedagogy, politics and positionality. *Communication Quarterly*, 50 (3-4), 328-343.

Andreotti, V. D.O. (2011). (Towards) decoloniality and diversality in global citizenship education. *Globalisation, Societies and Education*, *9*(3-4), 381-397.

Black, M.M., Walker, S.P., Fernald, L.C., Anderson, C.T., DiGirolamo, A.M., Lu, C., McCoy, D.C., Fink, G., Shawar, Y.R., Shiffman, J. & Devercelli, A.E. 2017. Early childhood development coming of age: science through the life course. *The Lancet, 389* (10064), 77-90.

Bitzer, E., & Withering, M. 2020. Graduate attributes: How some university students experience and learn them. *South African Journal of Higher Education*, *34*(3), 13-31.

Boler, M. 2005. *Feeling Power: Emotions in Education. New York: Routledge. Constitution of the Republic of South Africa* [South Africa], 10 December 1996, available at: https://www.refworld.org/docid/3ae6b5de4.html [accessed 18 April 2020] *Constitution of the Republic of South Africa* [South Africa], 10 December 1996, available at: https://www.refworld.org/docid/3ae6b5de4.html [accessed 18 April 2020]

de Oliveira Andreotti, V. 2011. (Towards) decoloniality and diversality in global citizenship education. *Globalisation, Societies and Education*, *9*(3-4), 381-397.

Gebremedhin, A. & Joshi, D. (2016). Social justice and human rights in education policy discourse: Assessing Nelson Mandela's legacy. *Education as Change, 20*(1), 172-198.

Hackman, H., W. 2005. Five Essential Components for Social Justice Education. *Equity & Excellence in Education, 38*, 103–109.

Higgs, J., & McAllister, L. 2007. Educating clinical educators: using a model of the experience of being a clinical educator. *Medical teacher*, *29*(2-3), e51-e57.

Hytten, K., & Bettez, S., C. 2011. Understanding Education for Social Justice. *Educational Foundations*, 7-24.

Kathard, H., & Pillay, M. 2013. Promoting change through political consciousness: A South African speech-language pathology response to the World Report on Disability. *International Journal of Speech-Language Pathology*, *15*(1), 84-89.

Kaur, B. 2012. Equity and social justice in teaching and teacher education. *Teaching and Teacher Education, 28, 485-492.*

Keeton, N., Kathard, H., & Singh, S. 2017. Clinical educators' experiences of facilitating

learning when speaking a different language from both the student and client. *BMC research notes*, *10*(1), 546.

Kessi, S. 2017. Community social psychologies for decoloniality: An African perspective on Epistemic justice in higher education. *South African Journal of Psychology*, *47*(4), 506-516.

Khoza-Shangase, K., & Mophosho, M. 2018. Language and culture in speech-language and hearing professions in South Africa: The dangers of a single story. *South African Journal of Communication Disorders*, *65*(1), 1-7.

Leibowitz, B. 2017. Cognitive justice and the higher education curriculum. *Journal of Education (University of KwaZulu-Natal)*, (68), 93-112.

Leonardo, Z. 2004. The color of supremacy: Beyond the discourse of 'white privilege'. *Educational Philosophy and Theory*, *36*(2), 137-152.

Liccardo, S., Botis, H., & Dominguez – Whitehead, Y. 2015. Background knowledge and epistemological access: challenges black women in a set scholarship programme. *South African Journal of Higher Education, 29,* 373-389

Llewellyn, A., & Hogan, K. 2000. The use and abuse of models of disability. *Disability & Society*, *15*(1), 157-165.

Lubbe, J. C., Wolvaardt, J. E., & Turner, A. C. 2020. Incorporating the mature students voice and lived experiences into continuous quality improvement. *South African Journal of Higher Education*, *34*(5), 82-91.

Mbembe, A. 2016. Decolonizing the university: New directions. *Arts and Humanities in Higher Education*, *15*(1), 29-45.

Mdlalo, T., Flack, P. & Joubert, R. (2016). Are South African speech-language therapists adequately equipped to assess English additional language (EAL)-speakers who are from an indigenous linguistic and cultural background? A profile and exploration of the current situation. *South African Journal of Communication Disorders*, *63*(1): 1-5.

Moonsamy, S. & Carolus, S. (2019). Emergent literacy support for children from marginalised populations. *Folia Phoniatr Logop,* 71: 83–93. DOI: 10.1159/000493893

Moonsamy, S., Mupawose, A., Seedat, J., Mophosho, M. & Pillay, D. (2017). Speech-language pathology and audiology in South Africa: Reflections on transformation in professional training and practice since the end of apartheid. *Perspectives of the ASHA* Special Interest Groups SIG 17, Vol. 2 (Part 1), American Speech-Language-Hearing Association.

Mupawose, A., Adams, S., Moonsamy, S. 2019. (in-press) Facilitators and Barriers to Clinical Supervision of Speech Language Pathology Students in South Africa: Pilot Study, *African Journal of Health Professions Education*

Phillips, G. (2007). Healing, cultural safety and the criminal justice system. In *3rd National Indigenous Justice CEO Forum, Brisbane, Australia.*

Pillay, M. & Kathard, H. (2015). Decolonizing health professionals' education: audiology and speech pathology in South Africa. *African Journal of Rhetoric*, *7*(1): 193-227.

Santos, B.D.S. (2001). Toward an epistemology of blindness? Why the new forms of 'ceremonial adequacy' neither regulate nor emancipate. *European Journal of Social Change, 4(3)*: 251-271.

Tayob, F. & Moonsamy, S. (2018). Caregivers' reading practices to promote literacy in a South African children's home: experiences and perceptions. *South African Journal of Communication Disorders, 65(1),* a559

Torre, M.E. (2008). Participatory action research and critical race theory: Fueling spaces for nos-otras to research. *The Urban Review, 41*: 106-120.

Vally, S. (2018). Missed opportunities: The rhetoric and reality of social justice in education. *KOERS-Bulletin for Christian Scholarship, 83*(1): 1-14.

Zembylas, M. & McGlynn, C. (2012). Discomforting pedagogies: Emotional tensions, ethical dilemmas and transformative possibilities. *British Educational Research Journal*, *38*(1): 41-59.