Research Article

# Looking Through the Kaleidoscope: Stakeholder Perspectives on an International Speech-Language Pathology Placement

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**Purpose:** In this article, we consider the literature on international student placements to contextualize and describe a 10-year relationship that enables speech-language pathology (SLP) students in their final year of studies at a Canadian university to complete a 10-week clinical placement with a nongovernmental organization in Kenya.
**Method:** This work can be best described as a qualitative case study that includes the varied perspectives of students and colleagues (from both minority and majority worlds) involved in this partnership, which annually places Canadian SLP students in Western Kenya. Perspectives include the director of the nongovernmental organization, 1 East African speech-language pathologist responsible for hosting and supervising students, the clinical placement director in Canada, and the students themselves. The perspectives of minority world universities and their students tend to be privileged and more widely represented. This work contributes to the literature by including the views of the hosting majority world SLP partner agency.
**Results:** The varied perspectives reveal that the perceived advantages and difficulties of international SLP clinical placements differ for various stakeholders.
**Conclusions:** As the SLP profession moves forward in an increasingly globalized world, it may be necessary for SLP peak professional bodies to develop best practice frameworks for overseas engagement.

There are relatively few speech-language pathology (SLP) services in sub-Saharan Africa in relation to the region's population (Wylie, McAllister, Davidson, & Marshall, 2016). Given the discrepancy between the expected numbers of individuals with disability in a population (Wylie, McAllister, Davidson, & Marshall, 2013) and the number of health and education professionals trained to work with these individuals (Hartley & Wirz 2002), it is generally believed that minority world[1] volunteers, students, and short-term medical service trips can fill a practical clinical need in majority world countries (e.g., Sykes, 2014).

Kenya has had a small but emerging SLP profession for the last 50 years. Currently, Kenya has a registered SLP professional body (the Association of Speech-Language Therapists Kenya), a university degree program training Kenyan speech-language pathologists (SLPs) and a group of qualified SLPs, working in private practice and hospitals in the capital city, Nairobi. For rural families of individuals with speech, swallowing, and language needs, finding and accessing services can be challenging. Yellow House Health and Outreach Services (Yellow House) was set up in 2009, partly to meet the needs of these clients in Western Kenya.

Hosting SLP students from minority world countries can help meet these clinical needs in a limited capacity. Certainly, international SLP placements provide minority

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[1]We have selected to use the terms *minority world* and *majority world* as the preferred term over alternatives such as developed/developing countries. Majority world encapsulates the fact that most people in the world live in resource-poor contexts, in contrast to the relatively small and privileged populations in minority world contexts living in resource-rich/advantaged countries.

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world students with an opportunity to develop a multitude of clinical and interpersonal skills, and opportunities for international placement are offered broadly across the health professions. For example, a 2008 analysis of 96 medical schools found that 61% offered international opportunities and 87% offered international clinical electives (Ackerman, 2010).

In the SLP profession, we tend to hear about international work through more informal channels (e.g., American Speech-Language-Hearing Association [ASHA] Leader and conference presentations). Hyter and Salas-Provance (2019) report that there have been 2,679 presentations focusing on international/global issues during the ASHA convention since 2006 (more than 200 per year). The last decade has also seen an emergence of academic writing around international placements in SLP (e.g., Crowley et al., 2013; Hewat, Walters, Wenger, Laurence, & Webb, 2017; Hickey, McKenna, Woods & Archibald, 2012; Wylie, Amponsah, Bampoe, & Owusu, 2016).

The impact of international placements is frequently reported positively and solely from the perspective of the student or the organization sending students abroad and with regard to the benefits to minority world students and novice professionals undertaking the experience. What is less often assessed and written about is the experience of majority world professionals and hosting institutions (Ackerman, 2010; Kung et al., 2016). As Crump, Sugarman, and Working Group on Ethics Guidelines for Global Health Training (2010) note, "little is known about the benefits and unintended consequences of global health training experiences to host institutions" (p. 1178). Even when research has collected ample data on the host experience, the benefits for minority world students can be foregrounded in the presentation (e.g., Ackers-Johnson, 2017).

We consider this article a qualitative case study (Stake, 2005) that grew out of conversations between the first four authors reflecting on our decade-long relationship that has enabled University of Toronto in Canada to annually send two of their students to Yellow House in Kenya to complete a final (and donor/university funded) SLP clinical placement as a part of their university studies. Our central query was: What makes this partnership work and what are the ongoing challenges as we move forward?

This article presents our varying stakeholder perspectives including one of the Kenya-based supervising SLPs (David), the director of the host organization (Rachael), the clinical coordinator at the university (Lynn), and two students (Katie and Dain) who spent 10 weeks in Kenya on placement in 2018. All the authors have been engaged in the clinical collaboration described in this article.

## *The University Partnership*

There is interest among students in SLP programs to participate in clinical placements in global settings, and this is in line with a notable trend across the health sciences (Crump et al., 2010). Universities and academic departments, also, are interested in establishing academic partnerships globally (e.g., Department of SLP, 2018).

We start with the university perspective, not to privilege this narrative but to set the context for this partnership, which started with the university. The university was approached by a donor who wanted to support some students annually to have an international clinical experience in a majority world context. In response, the university reached out to organize placements with appropriate partners including Yellow House.

The university faculty responsible for establishing the partnership was aware that, in many majority world contexts, services addressing communication disorders are quite low by North American standards. They had an agenda to support student's clinical learning in this context, while promoting awareness of communication disorders and potentially nurturing the development of services for clients in majority world regions.

In developing partnership criteria between the university and partnering agencies, the university's priority was clearly and unequivocally stated: The placement must meet the learning needs of the students identified for their clinical course; thus, partnering organizations must have the capacity and the willingness to help drive the students' learning. Because of this, the university holds power in the relationship. There is a tendency to write about this work from a benevolent and somewhat paternalistic stance of providing crucial service provision in majority world contexts. Although this partnership does provide support for SLP services in rural Kenya, it is important to recognize that there is a power imbalance and that students' learning outcomes are a priority.

These SLP placements are aligned with the intentions of the university around international placements and partnerships through collaboration with the university's International Centre for Disability and Rehabilitation. This enables the SLP program to enlist International Centre for Disability and Rehabilitation's expertise in developing sustainable partnerships that are mutually beneficial. Students participate in a range of well-established advance preparation activities beyond that expected for typical clinical placements.

Strategically, and with sensitivity to its position of power, the university attempts to create and maintain long-term partnerships with very few selected partners that are focused on individuals with communication disabilities and developing culturally appropriate and needed services in their communities. The Yellow House partnership with the University of Toronto emerged out of conversations between the first two authors and continued due to the relative success of the experience for all involved.

## *Partner Perspectives*

Yellow House works in a low-resource setting in Western Kenya. The term *low resource* well describes the situation, where there are few trained SLPs available to provide services in Western Kenya's mostly rural

communities, as well as limited funding available for equipment, toys, games, or other physical resources for therapy provision or running SLP programs. There are currently three East African trained speech-language pathologists working in Western Kenya for Yellow House (all graduates of Makerere University, Uganda), and their time is spent partnering with government institutions, such as schools and hospitals, to ensure their services are fully integrated into existing health and education structures.

That these institutions have a high demand for services is twofold. Firstly, there is a large local population. Across the three main counties where Yellow House works, the population is over 3 million people. Secondly, because of ongoing awareness raising about the SLP profession, and the time spent working with other health and education professions, referrals for SLP continue to increase. Yellow House works on a waiting list system and sometimes has over 100 people waiting for SLP input.

Although Kenya now has an SLP university training program in Nairobi, the profession is not currently recognized by the government, which means there are no employment structures to hire SLPs. This presents continued challenges in filling service area gaps, as no positions exist to hire SLPs within public schools, hospitals, and clinics, despite the recently graduated Kenyan SLPs. This lack of service providers influenced and partially motivated the agreement between the organization and the university to help meet the service needs of the community.

Furthermore, because SLP is a relatively new profession in the region and funds are scarce, East African trained therapists have limited opportunities for continuing professional development and limited access to the most up-to-date research and clinical practice literature. It should be noted here that they have few, if any, opportunities for their own international clinical experiences.

Hosting students on clinical placement helps Yellow House SLPs address a resource gap as the team is exposed to current research and practices via the written professional texts and expertise that the students draw on. The team, including students, discuss clinical observations and have access to articles and literature the students bring with them. Over the years, the role of clinical educator has developed to be mutually beneficial with reciprocity of learning between students and clinicians. Yellow House SLPs share their clinical experiences and serve as cultural brokers, whereas students have an opportunity to apply, or question/critique their book learning, and participate in clinical decision making for varied and often complex clinical scenarios unlike those they may have experienced in Canadian classrooms and community settings.

The role of the clinical educator has enabled the Kenyan team to develop and hone their supervision, management, and clinical skills. It is with pride that the team note the university recognizes their expertise as Kenyan speech-language pathologists who work with the challenges a rural, low-resource context in East African brings. Furthermore, with this partnership, comes access to university resources and the wider university network, which, among other things, provides opportunities for professional development for the team.

Students come to Yellow House for 10 weeks, and this length of time is an important requirement for the Kenyan team. This is ample time to account for students' jet lag, acculturation, illness, and orientation and still have time for the students to complete some useful work for the organization. Students participate with clients in two main ways that support the clients and the organization. The students have their own small, carefully selected caseload and provide a block of therapy intervention to these clients during their stay. The students also make needed resources: both for direct and indirect clinical work. Because students come at the same time each year, Yellow House can plan for and depend on the help students bring annually. Furthermore, because of the competitive selection process that happens at the university, Yellow House can also rely on capable, proactive students who will meet the requirements and responsibilities of their role as student clinicians and volunteers.

There will always be an unequal power dynamic in partnerships where one partner holds the funding. However, it is possible to balance the benefits of the partnership to ensure reciprocity. Although the university's priority is student learning, Yellow House can set their own (sometimes changing) priorities for the relationship. For example, the organization can arrange students' placement opportunities around what is needed for service delivery in the community. Yellow House also comes to the partnership expecting that the time, expense, and commitment that go into hosting their students are recognized and acknowledged. For example, the time and monetary costs or calls needed to arrange placements can be substantial and is often overlooked by international partners who have work phones or monthly phone contracts in their home countries. In Kenya, calls are prepaid and charged by the call/minute and can constitute a direct cost to the organization.

Overall, this international partnership has served Yellow House well and given the organization local credibility with community stake holders such as families, the Ministry of Health, the Ministry of Education, and government institutions. This partnership also impacts how Yellow House SLPs view their own practices, creating a sense of responsibility and accountability to provide a consistently high standard of service despite the challenges and limitations in resources and the lack of professional recognition and regulation in Kenya.

The benefits of hosting students presented in this work align with those Kung et al. (2016) reported in their qualitative interviews of host community collaborators for medical students in India and Bolivia (namely, rise in prestige, serving as global citizens, broadening world views, resource enhancement, improved local networks, and leadership development). The more negative aspects of hosting students (perceived hesitancy and apathy of trainees, unfulfilled promises, lack of cultural sensitivity, lack of equal opportunity) are not featured in this collaborative relationship, and this, likely, has to do with the amount

of preparation these university students receive prior to their arrival in Kenya and the long-term nature of the partnership.

### *Student Perspectives*

Dain and Katie, two students who spent 10 weeks in Kenya in 2018, reflected on their learning experiences and their learning goals for their international placement. They had hoped to learn skills to help them become flexible and responsive clinicians able to adapt in a foreign country, as well as bolster their experiences seeing a diverse array of clients. They concur that the placement challenged them to gain a breadth of skills to meet the needs of assigned caseloads—consisting of children and adults with varying communication needs.

They note that, to ensure their own clinical competency in meeting client needs, they frequently referred to university lecture notes and research articles. Yet, these documents on their own were inadequate in preparing them for clients given the cultural context and resource constraints.

Recognizing the cultural differences between families in Canada and families in Kenya was an essential area of learning. For example, parents in Western Kenya interact with their children in ways that are quite different from the way parents in Canada may play with children. For this reason, the recommendation of "playing with your child" and the intent behind this recommendation required reconsidering to gain traction. As daily routines such as meal time, washing, and sleep were common to both parent and child, parents could easily improve their involvement in such familiar activities to reap the same benefits of the interaction.

Flexibility in conducting assessments was another area of growth. Given that standardized tests, typically used in Canada, were irrelevant in the Kenyan context, and that there is little to no research on the developmental norms of Swahili-speaking children in sub-Saharan Africa, it was difficult to determine if a child's language skills were developmentally appropriate. This lack of developmental norms meant assessing clients informally using interview questions, objects, and pictures. In designing treatment plans, activities were selected using locally available materials, such as bottles, rocks, and flash cards. Moreover, collaboration with Kenyan-based SLPs was indispensable in determining what was culturally relevant and appropriate.

Effective communication was a skill honed during the duration of the placement. Overtime, it was possible to craft more concise recommendations with emphasized key words to aid comprehension. Furthermore, using analogies that families would understand and presenting concepts that made sense within their world view of child rearing and child development, recommendations could be appropriately contextualized.

Recognizing that there were time constraints on the possible impact students could have by providing direct clinical services in Kenya, education, counselling, and applying environmental modifications were priorities. Parent groups were organized to educate families about communication disorders and to address the widespread misconception of disability being the result of a curse or demon possession. Working alongside teachers in special education classrooms to implement total communication and model strategies on how to best support students' language development was another strategy to promote generalization. By involving family members and teachers in intervention approaches, it increased the likelihood that therapeutic techniques would be continued beyond the conclusion of the clinical placement.

Katie and Dain reported caring and supportive clinical educators were indispensable to make the cultural and clinical transition to service provision in Western Kenya. In this respect, they had connected with Yellow House SLPs nearly a year before the clinical placement began to develop the clinical relationship prior to arrival in the country. The students openly communicated with hosting SLPs about clinical goals as well as concerns and struggles prior to and during the placement. Dain and Katie attribute this relationship as a key contributing factor to the success of the placement.

There were noted advantages and disadvantages of an international placement that Katie and Dain had not anticipated before choosing to go. The experience necessitated embracing the unfamiliar and being adaptable, so they became more confident in approaching new situations, including job opportunities and clinical challenges.

However, there were also difficult and emotional encounters with patients, or times when they found themselves ill, which made them acutely aware of the long distance between Kenya and Canada. Another disadvantage included missed networking opportunities in Canada in the final stage of their schooling that would have linked them to potential job opportunities. Although some peers transitioned smoothly from a student to a professional at the site of their final clinical placement, they had to start their employment search with fewer connections in their home communities. As well, upon returning to Canada, they discovered that some employers did not see the value of an international clinical placement. Nonetheless, Dain and Katie note that the placement gave them countless new experiences, created situations for analytical reflections, and added essential clinical and professional tools to their SLP toolbox.

## Discussion

For all those involved, reflecting across these varied perspectives, this partnership has revealed that, with the right preparation, student clinical placements can be mutually beneficial for partners, students, and the universities where they study. Some key points that arose from this work follow:

1. It is essential that all stakeholders are honest and up front about the benefits gained from the partnership including any grant/university funding, publication

intentions, and accolades. These benefits must be balanced between partners, and against the costs and challenges, and this conversation should be revisited routinely. It is important to have very structured and clear agreements about the roles and responsibilities of everyone involved. Including explicit documentation around who is doing what, who is paying for what, and the benefits and motivations of all involved (see also Crump et al., 2010).

2. Short-term experiences incur higher costs and are rarely sustainable (Wylie, Amponsah, et al., 2016). As noted by Ahluwalia et al. (2014) and Wylie, Amponsah, et al. (2016), long-term relationships are crucial. Long-term partnerships substantially mitigate the costs (financial, time, opportunity) for all parties. Over time, the investment that both parties make pays off and alleviates the risks and challenges. It does not benefit partner agencies in majority world contexts to agree to supporting one-time clinical placements. It adds to the workload of partners when they do not know the quality of the students or how prepared they are. The responsibility goes both ways; minority world universities should only be approaching partner agencies with an ongoing plan for collaboration.
3. Time is a major factor in designing mutually beneficial clinical experiences. The longer the duration of the student placement, the more useful students can be in meeting local service needs. Time also provides an opportunity for students to move beyond their jet lag and cultural adjustment and acclimatization.
4. The work the university does in preparing students to go overseas and participate as novice clinicians in busy and often over stretched organizations cannot be overstated. The expectations and attitudes of the incoming students will set the tone for the experience (see also Ackers-Johnson, 2017). The behaviors of the students can reinforce or jeopardize community relationships. Though the students may only come one time, they shape how the next students are viewed and received and the willingness of partners to continue supporting students. As stated by Crump et al. (2010), "their actions and behaviors can have far-reaching and important implications" (p. 1180). University partners must plan an enriching partnership from the beginning, by giving due consideration to the advanced preparation of the students, as well as training and supporting the partner as needed.

We agree with Crowley and Baigorri (2011) that "sustainability is the current accepted standards" (p. 27), but we argue that the profession has to move beyond sustainability to incorporating critical reflection on processes of sending and receiving students to ensure that SLPs (even student clinicians) have global competencies (Hyter, Roman, Staley & McPherson, 2017), understand culturally safe practices (Hickey et al., 2012), and are building capacity (Hyter & Salas-Provance, 2019). Furthermore, Hickey et al. (2012) remind us that we have a moral responsibility to provide the best possible care both at home and overseas. We would also like to see more of a commitment by minority world universities to fund majority world clinicians to visit Canada, the United Kingdom, the United States, and Australia so that they have the opportunity to develop their skills in international placements by observing and delivering services in minority world contexts.

Here, we have shared the varied perspectives of community partner, student, and clinical educators. The documentation of these varied stakeholder perspectives is important as we think about SLP students in international placements and move toward establishing best practice guidelines for SLP student practicums in majority world contexts.

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