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Inequity and the Professionalisation of Speech-Language Pathology

Abstract: As a profession, speech-language pathology (SLP) continues to struggle with equitable service delivery to both people with communication challenges and disabilities. SLP clinical practice in its traditional form has an individual focus and therefore cannot adequately serve the large population in need, which, in South Africa is the majority population. Using the concept of social embeddedness of professions as a guiding frame, the article explores the history of the profession and the influence of the medical model and coloniality in shaping SLP profession's knowledge and practices. As such, we argue that professionalisation in its current form perpetuates injustice. The article proposes innovation across clinical practice, education and research as leverage points for imagining new practices.

Keywords: Speech-language pathology, social embeddedness, critical, inequity, social justice

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Professions play a key role in society (Martiminanakis, Maniate, & Hodges, 2009). With a scientific base (Brante, 2011), professionals use a specialised body of knowledge, skills, and competences in service to society (Abbott & Meerabeau, 1998). Professionalisation, as the process of acquiring professional status (Hoyle & John, 1995), requires the acquisition of scientific knowledge through higher education in order to develop professional competencies (Volti, 2008). The process of professionalisation, Larson (1977) argues, created a means to control the production of disciplinary knowledge. In this context, control of knowledge production draws attention to the ability of the profession to define and control what "true" about fundamental concepts (Martiminanakis, Maniate, & Hodges, 2009). Professions, therefore, hold the power to determine ways to think about and act upon problems in their domain of expertise (Evetts, 2014). Montigny (1995) argued that power is realized through the formal education process where students learn how to see and think about the world. This professional autonomy is, therefore, a key distinguishing feature of professionalism (Brosnan, 2015).

Among health professions, medicine was the first Western profession to achieve professional autonomy (Brosnan, 2015). Newly emerging occupations, like social work, nursing and rehabilitation therapists such as SLPs, used the resources, status, and influence of medicine as a platform for their own development (Larkin, 2002) by modelling their occupations on more established professions (Hugman, 1998).

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The dominance of medical science influenced the way in which SLP was conceptualized. As such, SLP, in its knowledge, clinical practice and education is characterized by similar attributes, concepts, logics, and practices (Pillay & Kathard, 2018).

The article is presented in two interlinked parts. In the first part, the article documents the historical development of SLP internationally and in South Africa specifically. It problematizes colonisation and apartheid as political acts that shaped the forming of the profession. Drawing on the work of Lo (2005), the article draws attention to how speaking from a position of neutrality can limit the possibilities for professional practice in its inability to recognize the profession as embedded in coloniality. Lo (2005) argued that the sociology of professions needs to understand how professionals make sense of their social positions and their professional practices as embedded in specific social contexts. In this way, we use the professionalisation of SLP as a gateway to understanding inequitable professional practices. In the second part of the article, we consider how we might address the challenge of inequity by using the Curriculum of Practice (Pillay, Kathard, & Samuel, 1997) framework. We argue that innovation is a key factor in expanding professional practice beyond rehabilitation services to working toward social change.

Role of speech-language pathologists

Traditionally, SLPs work with communication (and swallowing) disorders – affecting listening, speaking, reading and writing. Individuals who are identified with communication challenges by themselves, teachers, or parents are referred for a SLP assessment. Using a battery of standardised tests and informal assessments, the SLP, with input from key stakeholders (e.g. patient, parents, multidisciplinary team), determines the presence of a communication difficulty/disorder, nature of the disorder [e.g. type of disorder (i.e. speech, language, fluency etc.), severity, prognosis etc.] and the implications of the communication disorder on socialisation and learning (ASHA, 2018). From the assessment results, the SLP diagnoses the communication disorder/disability and plans intervention in line with evidence-based practice (ASHA, 2018).

Challenges with current model of service delivery

Traditional practice, underpinned by the medical model, foregrounds the communication disorder with a focus on how to cure/modify/alter the disordered part of the individual (Barbour, 1995; Wade & Halligan, 2004). This deficit model positions the individual as the focus of therapy as opposed to the education system, for instance (Kathard et al., 2011; Staskowski & Rivera, 2005). The clinical process further positions the therapist as the expert who determines the need for therapy and the focus of the intervention (McKenzie & Müller, 2006) with the patient largely positioned as a passive recipient of treatment (Wade & Halligan, 2004). While patient autonomy in the decision-making process has become a more fundamental part of patient engagement with the health professional, the therapist mainly holds the power. For example, Larsen (2016) concluded that while doctors perceived external parties (e.g., managerialism) to disrupt their authority over doctor-patient relationships, there was largely no erosion of the doctor-patient dynamic.

Internationally authors (Hyter, 2014; Pillay & Kathard, 2018; Wylie, McAllister, Davidson, & Marshall, 2013) are questioning the relevance of traditional practice of SLPs in light of the continued service inequality plaguing the profession. Many authors have documented the inequity of service provision, arising from the lack of linguistic and cultural diversity of practitioners and resources (Overett & Kathard, 2006; Pascoe et al., 2010; Pillay & Kathard, 2015; Van Dulm & Southwood, 2013), to the limited human resource capital (Kathard & Pillay, 2013). As a result, SLP practices only serve a privileged minority, with the majority population having limited access (Westby, 2013). In a special edition of the *International Journal of*

Speech-Language Pathology (2013), authors from Australia (Davidson, Hill, & Nelson, 2013), to Bolivia (Buell, 2013), from Brazil (Fernandes & Behlau, 2013) to Malaysia (Van Dort, Coyle, Wilson, & Ibrahim, 2013), debated the need to expand approaches to current practices in response to the World Report on Disability (World Health Organisation and the World Bank, 2011) in both Minority and Majority worlds.

The case of South Africa

South Africa—the "rainbow nation"—is not only known for its vastly different climates and varying geographies but largely for its diversity of peoples and cultures. The country has 12 official languages, with isiZulu (22.7%) and isiXhosa (16%) as the most commonly spoken languages (Statistics South Africa, 2011). In addition, the population comprises of different race group/apartheid classifications (e.g., black, white, Indian, coloured), with black South Africans make up approximately 80% of the population (Statistics South Africa, 2018). Inequality continues to be a distinguishing feature of the country, with a GINI coefficient of 0.63 in 2015 (The World Bank, 2019). The high inequality in South African society is largely as a result of the legacy of apartheid (discussed later in the article). South Africa is a multi-racial, multi-cultural, multi-lingual country in which SLPs need to provide services to a diverse population.

In South Africa, increasingly literature has begun to draw attention to the need for transformation of profession—from highlighting importance of linguistic and cultural background when working with individuals and the subsequent need for developing culturally-fair assessment tools (Mdlalo, Flack, & Joubert, 2019), the need for SLPs to consider their own positionality in relation to the racial, linguistic and cultural diverse populations served (Khoza-Shangase & Mophosho, 2018) to the need to think creatively when considering the needs of the South African context (Moonsamy, Mupawose, Seedat, Mophosho, & Pillay, 2017).

Populations that benefit the most from SLP services are middle class, generally white populations who speak a dominant language such as English (Overett & Kathard, 2006; Pascoe et al., 2010; Pillay & Kathard, 2015). The underserved population is therefore largely poor, Black, African language speaking – the majority population of the country. Currently, SLP services are unattainable, inaccessible, unaffordable for the majority of South African citizens. If the profession continues to practice in this way, it will continue to perpetuate the systemic marginalisation of the groups of South Africans. But, *how* did the profession become this way?

Methodology

A document analysis of journal articles, editorials, books, and professional association newsletters was conducted to gain historical insight (Bowen, 2009) into the professionalisation of SLP in South Africa. The study used published texts available to the university. Both online and hand searches were conducted through archives of SLP related journals, books, and professional association newsletters and editorials. The document analysis involved skimming, reading, and interpretation the data (Bowen, 2009). Skimming involved a superficial examination of the documents in order to identify the most meaningful and relevant information in the text. Once the relevant documents were identified, each document was read and re-read to review the information. The selected data were categorized chronologically in order to identify themes emerging linked to the professionalisation of SLP. Due to the nature of the historical search, some of the documentation was incomplete. In addition, it should be noted that documents are social products and as such are reflective of the specific social, historical and political context from which it was derived (Kutsyuruba, 2017). In this sense, the analysis of published documents is understood

as one account of the professionalisation of SLP within a specific discourse.

Historicising the development of SLP profession

The early history of the profession of SLP lies in the late 19th century in Europe. There was an interest in speech and language from neurology (aphasia) to phonetics (dialects, sounds of spoken English) and elocution (concerned with singing/speaking)—all focusing on their own area of interest (Wilkins, 1952). Within the medical literature, from the earliest writings till the end of the 19th century, the focus was on pathologies of the brain which resulted in disordered language – largely with an emphasis on speech disturbances (Thompson, 1966). With increasing interest, understanding the nature of communication disorders grew, and its links to the medical and surgical conditions underlying disorders became more apparent (Greene, 1970).

In early research in the medical sciences, when little was known about the anatomy of the brain, disorders of communication were often considered confusing. At this point in time, there no distinction was made between disordered speech associated with aphasia or amnesia for example (Jenkins, Jiménez-Pabón, Shaw, & Sefer, 1975). Neurologists such as Franz Joseph Gall, Jean Baptiste Bouillaud, and Pierre Paul Broca pioneered the way for advancements in aphasiology. Research in the area gained momentum, and soon the neurological understanding of disorders of the speech mechanism outweighed the knowledge of typical speech processes (Jenkins et al., 1975). While clinical research continued to progress, there was an increased pressure to begin to understand normal communication (Jenkins et al., 1975). Developments in technology, (e.g. invention of the telephone, radio, and film) and the after effects of the World Wars, lead to speech and language receiving increased attention. Brain injuries from both World Wars drew attention to the neurological basis of speech and language (Jenkins et al., 1975). As a result, there was a growing need for supporting services alongside medicine to assist with the rehabilitation of patients. In the early 20th century, along with other allied health professions, SLP was developing its early modern identity. European interest in communication provided the platform for the knowledge and orientation to the management of communication disorders (O'Neill, 1987). Communication disorder subsequently became the core focus of the profession.

In the United Kingdom, in the early 20th century, while there were institutions established which focused on speech disorders, there was no formalized training established (Wilkins, 1952). The first speech clinics were established in Glasgow (1906) and Manchester (1911) (Wilkins, 1952). Courses were offered in remedial speech at the Central School for Speech (now called Central School for Speech and Drama) in 1913 (Armstrong & Stansfield, 1996). In the early 1920s, there were two hospitals in London which ran 2-year training programmes and by 1936, there were four established training facilities in London and one in Glasgow (Armstrong & Stansfield, 1996).

In the United States, while there were speech correction clinics in public schools since the early 1900s, there was no official established programmes until around the 1930s. The early professionals in the USA either received training in Europe, were trained in the general area of speech, or were classroom teachers (Lawrence, 1969; O'Neill, 1987).

Following in the footsteps of medicine, the profession of SLP, in its research, service, and education, developed its knowledge from the vantage point of science, with an empirical, positivist frame (Kathard, Naude, Pillay, & Ross, 2007).

The profession's journey to South Africa began with Professor Pierre de Villiers Pienaar, a phonetician, who recognised the rehabilitation potential emerging out of the fields of phonetics and voice disorder (Aron, 1991; d1973). He motivated for the institution of professional qualification for SLPs. In 1936, the first SLP programme was established in Johannesburg at the University of Witwatersrand, under the guidance of Professor Pienaar (Aron, 1973). His learnings from his education and travels

to universities throughout Europe and the USA, were incorporated into the academic and clinical work at the university (Aron, 1973).

In 1946, the first professional body, the South African Logopaedic Society was established in 1946 (Ave Atque Vale, 1965) followed by first professional journal in 1953 (Louw, 1994). The foundational knowledge from which the profession grew developed and modelled on the principles and values of both European and American ideals (Aron, 1991; 1973; Ave Atque Vale, 1965).

As the profession grew, a university programme was established at the University of Pretoria for Afrikaans speaking professionals in 1959 (Aron, Bauman, & Whiting, 1967). Initially, both speech and hearing knowledge formed the core of the university programmes in the early years (Aron, 1991). This dual qualification allowed for registration with the professional body as a SLP and audiologist. Following international trends, some of the universities would decide to train either SLP or Audiology professionals (Swanepoel, 2006), allowing for registration as either a SLP or audiologist.

Later, the need to train non-European therapists was acknowledged (Aron et al., 1967) and in 1973, a programme for Indian therapists was introduced at the University of Durban-Westville (Aron, 1973, 1991). Eventually, programmes were established at the University of Cape Town in 1975 and Stellenbosch University in 1989, both in the Cape (UCT, 2018). During this time, most programmes trained predominantly white therapist who served a privileged minority during the apartheid era (Beckett, 1976; Weddington, Mogotlane, & Tshule, 2003), with the training of Indian, Coloured and Black apartheid categories remaining marginalized.

In the 1980s, there was growing awareness for the need for SLP services for marginalized communities. A training programme for community speech and hearing assistants at a diploma level was introduced at the University of Witwatersrand, for mainly Black students. The course was discontinued in the mid-1990s due a number of challenges including to lack of employment opportunities (Moonsamy et al., 2017). In post-apartheid, programmes have also been developed at historically Black universities—Medical University of South Africa (later to be renamed Sefako Makgato University) in 2001 and University of Fort Hare in 2018. Most recently, a professional body for black SLPs, National Black Speech, Language & Hearing Association, was established due to the lack of linguistic and cultural diversity of the other professional associations (Khoza-Shangase & Mophosho, 2018).

Deepening the history of SLP as entangled with colonisation and apartheid

During the same time as the profession was establishing itself, two parallel narratives were occurring—colonisation and later, in South Africa, apartheid. In agreement with Balzer (1996), "professionalisation is not the single thread running through the fabric of modern society…it must be viewed in the broader context of social history or it distorts more than it reveals" (p. 5). Professions and professionalisation, therefore, cannot be understood outside of the social-political environment in which it occurs (Balzer, 1996).

British and European colonisation was violent. Under the veneer of bringing civilisation (Césaire, 1950/2000), colonial conquest was achieved and maintained through violence—exploitation, dispossession, oppression, and killing (Sartre, 1964/2001). Using military force, countless Africans were killed so that colonisers could exploit their land and obtain their wealth (Maathai, 2010). Human rights were denied and maintained by violence. People were kept in poverty and ignorance by force—maintaining their place as subhuman, animal-like (Sartre, 1964/2001). For decades, Africans fought for political independence—a fight against slavery and exploitation (Maathai, 2010).

Later within South Africa, from 1948 –1991, apartheid, a colonial practice, further entrenched racial inequality. Over a 46-year period, apartheid dedicated itself to creating and maintaining white political, social and economic gain (Fiske & Ladd,

2004) through legislation, violence against indigenous people and land and resource appropriation (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Education was used as a powerful tool to maintain social order and to socialize racial groupings into their role within society (Fiske & Ladd, 2004). By perpetuating views of a hierarchical society, education nurtured superior-inferior/master-servant ideologies among all racial groups (Thobejane, 2013). Bantu education, characterized by a lack of resources, poor infrastructure, and rundown, overcrowded classrooms (Hartshorne, 1992), was a means to provide African learners with inferior education. In so doing, restricting their development, and ultimately guaranteeing Africans remained on the margins of the economy, ensuring a constant supply of cheap labour (Fiske & Ladd, 2004). Without access to economy, living standards declined for the majority of South Africans, resulting in rampant poverty, ill-health, malnutrition and unemployment (Thobejane, 2013). Today, the continued impact of the legacy of apartheid is seen in the prevailing untenable inequity throughout all aspects of South African life (Galvaan & Peters, 2018).

Exploring the social embeddedness of SLP

Social embeddedness of professions acknowledges that professionalisation unfolds in close relation with social categories. It is then essential to consider how concepts such as race, gender, and ethnic cultures and ideologies may have become internalized in the collective identity of the profession. A collective identity is understood as a shared professional identity characterized by a sense of common experiences, understandings, and expertise, and shared ways of understanding problems and their potential solutions (Evetts, 2014). This collective identity is produced and reproduced through professional education, socialisation, and vocational experiences and by membership with professional organizations (Evetts, 2014).

Witz (1992) problematizes the notion of a profession stating that traditional understanding of professions takes "the successful professional projects of class-privileged male actors, at a particular point in history and in particular societies to be the paradigmatic case of profession" (p. 37). She concluded that it is necessary when speaking of professionalisation, it is important to consider who is involved in the professionalisation project and to consider the structural and historical context in which professions are developing. In extending this argument, Grosfoguel (2002) states that knowledge (as the subsequent practice thereof) is always generated "from a specific location in the gender, class, racial, and sexual hierarchies of a particular region in the modern/colonial world-system" (p. 208).

For example, SLP continues to be a gendered profession, dominated by females (Litosseliti, & Leadbeater, 2013), while medicine has traditionally been male-dominated (Witz, 1992). Collyer (2018), drawing on the work of Bourdieu's concept of field, argued for expanding the theorizing of the health care sector to consider its interaction with social structures, which both support and constrain social actions within it. In psychology, Lane and Corrie (2007) explored the social embeddedness of the profession. They specifically argue that psychology was predicated on a professional identity of rationality and science which determined which types of knowledge were legitimate or not. The authors concluded that the profession of psychology requires radical reform in order to legitimise marginalized voices. Hearn, Biese, Choroszewicz, and Husu (2016) emphasized that positioning the study of professions and professionalisation as a value-neutral phenomenon is both careless and unscientific. They argue that the gendered and intersectional nature of professions and professionalisation is historically established and emerging in new forms. Adams (2015) considered the convergence and divergence of research publications in the sociology of professions in the English-language. Based on her analysis, she concluded that there is a need to explore the social construction of professions, taking into account the social context, in order to advance the sociology of professions. It, therefore, becomes essential to consider the history of SLP in South Africa, in rela-

tion to the social concepts of gender, class, race and patriarchal hierarchies as established by the country's colonial and apartheid history.

Situating SLP as a project of coloniality

The profession of SLP has its origins in a Euro-/American-centric, white, middle-class, male-dominated health care milieu largely influenced by the medical model. The medical model places value on objectivity rational truth, quantification, where illness is constructed as a breakdown/dysfunction (Broom & Adams, 2009) based on the premise of abnormality within the body (Wade & Halligan, 2004). This premise requires a judgement of the deviance from normality (Hammell, 2004). As a result of this reductionist approach, SLP focus on communication impairment has narrowed the conceptualization of communication to a focus on something that people cannot do (Kathard & Moonsamy, 2015).

Characterizing the disorder is accomplished using a binary approach against normative criteria (Pillay, 2001). In so doing, the profession sets up a normative frame as part of its practice, from which disorder can be identified. The concept of "normal" is determined by rendering the experience of others as lesser or even invisible (Pillay, 2001). Through the profession's work, it imposes definition of normality onto the lives of others. In this instance, first the profession "others" then it deficits the lives of individuals (Pillay, 2001). The profession of SLP has control over the interpretation of communication which results in those falling outside of the normative frame to be re-produced as *different* (Pillay & Kathard, 2015). The process results in the concept of dis-othering, where "dis" refers to creating the person with a communication DISorder as Other (Pillay & Kathard, 2015).

Normative frames informing and underlying the medical model are rooted in the definition of normality relative to the social, economic, political and historical foundations of the profession's cultural capital i.e. white, Western, middle-class, etc. (Pillay & Kathard, 2015). Eurocentric knowledge, (using universities as avenues to forward colonization) under the veil of objective and universal truth, imposed ways of knowing and of producing knowledge (Dastile & Ndlovu-Gatsheni, 2013) while excluding knowledge from the Global South. For example, van Kleeck (1992) demonstrated how mainstream cultural values have become engrained in the very essence of communication interventions. SLP early childhood interventions are grounded in the value of talking in interactions (van Kleeck, 1992). While many cultures regard verbal ability as an important asset, other patterns of socializing children have been found in other cultures (e.g., Western Samoa, Ochs, 1982). In this sense, the cultural values of "the other" are not acknowledged in the professional values of the profession. Knowledge and practice were therefore not framed from an African perspective and subsequently, Africa became saddled with knowledge that disempowers its people (Lebakeng, Phalane, & Dalindjebo, 2006). As such, Africa is a victim of external knowledge generation uninformed by a contextual understanding of African ways of knowing, doing and being (Ndlovu-Gatsheni, 2013).

While formal colonization administration may be over, the world has moved from global colonialism to global coloniality as many non-European states continue to live under European/American exploitation and domination (Grosfoguel, 2007). The concept of coloniality therefore provides a means to understand the continued effects of colonisation (Ndlovu-Gatsheni, 2013). The colonial nature of the profession has been sedimented through the combination of its positivist science, biomedical practice and colonized education (Pillay & Kathard, 2015). The collective identity of the profession in Africa was moulded on imported beliefs and practices which are engrained in the current SLP practice (Pillay & Kathard, 2015). The colonial influences from the early development of the profession continue to guide and shape the ways in which the profession conceptualises, understands and addresses African challenges. As such, the profession of SLP is conceptualized as a project of coloniality. The challenges around equity of service delivery within SLP are therefore located within this historical political context.

Innovation as key for imagining new practices

Positioning the profession of SLP as entangled with coloniality allows for ingrained knowledges and practices to be questioned, critiqued and reimagined in a context of prevailing inequity. If the profession is to consider how to transform, all the activities of the profession need to be considered (Kathard, 1999). The Curriculum of Practice Framework provides an outline of three key features of professional practice (Pillay, Kathard, & Samuel, 1997): clinical practice, professional education, and research (see Figure 1). Pillay and Kathard (2015) posit that "to innovate we must change what we do across these domains. We may change what we know (our knowledge base via research), what we do (our practice) and how we educate entry-level and practicing professionals (professional education)" (p. 207). In this sense, the Curriculum of Practice framework provides a starting point to consider how the profession can begin to change the dominant, individual, one-on-one, health care narrative by expanding into new/different spaces within each element of the framework.

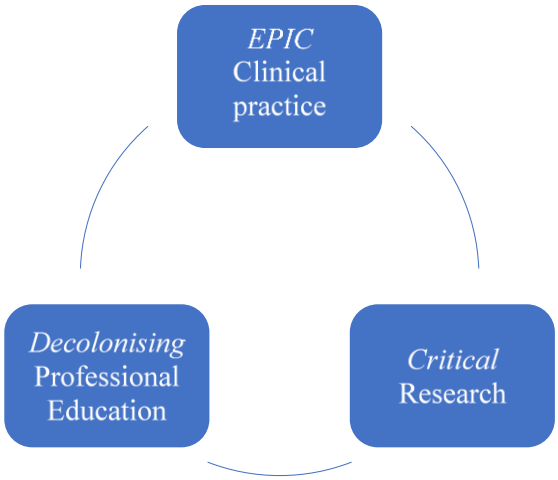

Figure 1: *Innovation tools for social justice. Curriculum of practice framework – adapted from Pillay et al. (1997).*

Clinical practice activities are the activities that a professional performs and the resources which they use to achieve their practice activities such as physical/material, human or financial resources (Pillay et al., 1997). For example, during interactions with a patient, clinical practice activities would include assessments to reach a diagnosis. The knowledge base of the clinical practice activities, informed by research and curriculum, facilitates and reflects practice and are understood as unfolding in close relationship with professional education and research (Pillay et al., 2016). Curriculum is broadly defined as "…interlinked complex of who is taught [i.e. the learners], what is taught [i.e. the syllabi], how it is taught [i.e. the teaching and learning process], who teaches [i.e. the professional educator] and the context of teaching" (Gerwel, 1991, p. 10). Research largely informs the knowledge generated from the best evidence for clinical practice.

To begin exploring new ways of practicing, we provide three avenues of inquiry across the three elements of the Curriculum of Practice.

Decolonising education

Professional education as a key driver for fundamental change should not only be invested in innovation but should be framed within a decolonial perspective (Pillay & Kathard, 2015). A decolonial perspective seeks to engage "an-other thinking" that

may potentially liberate the minds of the colonized from Eurocentric thinking (Mignolo, 2005) toward the realization of alternative ways of knowing, generating knowledge and imagining the world (Dastile & Ndlovu-Gatsheni, 2013). Education that belongs and contributes to a fair and just society is only possible when it recognise the way in which relations of power have shaped history, specifically the process of domination and exploitation that characterized colonializm (De Lissovoy, 2010). Confronting inequity fosters awareness of social injustices (Leonardo, 2004). Beyond merely recognizing how history has shaped the world, decolonial education requires problematizing the underlying Eurocentric ways of knowing and doing as a means to move education toward critical engagement (Bailón & De Lissovoy, 2018). Quality education is just as much about teaching students to be more critical of the world, as it is about creating a space for imagining a better, less oppressive world, of which dreaming is a necessary process for real change (Leonardo, 2004). "Dreaming...is not always an unconscious act, but a metaphor for social intervention that moves the critical social theorist from analysis to commitment." (Leonardo, 2004, p. 15). See the University of Cape Town's Curriculum Change Framework as an available resource to explore decolonizing higher education (CCWG, 2018).

Equitable Population Innovations for Communication approach to clinical practice

Challenging the traditional notions of clinical practice, Pillay and Kathard (2018) present Equitable Population Innovations for Communication, as a guiding frame for reimaging clinical practice. The framework proposes population-based health care as an expansion of the traditional dominant individual health care model.

The notion of equity, as fair and just service provision, constructs clinical practice in a context where services have been grossly unequal. In this sense, the concept of equity allows the profession to think about the mechanisms which support and bring the profession closer to achieving health equality. The history of SLP and its practice bear testimony to the role of the profession in perpetuating injustices (as discussed earlier). The profession needs to consider whether its services are reducing the inequalities between the privileged and the poor (Pillay & Kathard, 2014). Expanding practices from a singular focus on disability to include social disadvantage as means toward inequity redress may be one avenue to consider (see Pillay & Kathard 2018). With the large population in need (as discussed earlier), the individual, institution-based personal health care service delivery model may never meet the need (Pillay & Kathard, 2015). Pillay and Kathard (2018) advocate for a shifting of focus from individual to the community, the district or even the country as a whole, for a meaningful change, to be obtained. The focus is therefore on masses of people, whole school or curriculum-based intervention, not just working with people in a school or stroke unit. A focus on population, i.e., all people in a community, expands the basis of the persons/community being served.

The importance of *innovative* practice highlights the need for creative, innovative solutions/approaches to addressing the needs of under-served populations (Duncan & Watson, 2004; Kronenberg & Pollard, 2005; Wylie et al., 2013).

Communication (and swallowing) aims to reposition the professions understanding of communication from disorder to how people make meaning together (Kathard & Pillay, 2015). In redefining the lens through which the profession works, communication is broadened, to considering a role beyond that of disability. The dominant narrative of DISorder is disrupted, and in so doing, the scope of the profession's work expanded.

Critical focus for research

Based in the positivist discourse, the SLP profession speaks from the position of neutrality, failing to acknowledge how factors (contextual, personal, societal, etc.) influence how reality is perceived [For examples, see Beecham (2004), Kovarsky

(2008)]. Within the South African context, the influences of colonializm and apartheid shaped the current landscape of the society. If the profession fails to acknowledge its history in shaping the present, the understanding of the challenges in the world is limited. Positioning research through a critical approach takes into consideration the political, social, historical and cultural factors influencing the way the world is structured. Existing conditions are critiqued in order to redress marginalization and redistribute power and resources (Weaver & Olson, 2006). Being cognisant of environmental and social factors impacting the well-being and development of individuals, allows the profession to explore how it may contribute to the emancipation of people living on the margins of society due to poverty and other oppressive influences (Kronenberg & Pollard, 2005).

Conclusion

The historical analysis provided a lens to reconsider the early development of the profession of SLP as occurring alongside colonializm and apartheid. In accordance with Lo (2005), the historical analysis challenges the professions to move toward considering social embeddedness. The article highlights the need for the professions to explore the influence of social categories on the way in which professions developed their professional identity. The concept of coloniality provides the professions with a means to explore how ingrained knowledges and practices contribute to continued inequity.

Repositioning knowledge and practice as entangled with coloniality challenges the profession to reflect on the underlying foundational philosophies as situated in a medical, white, male, Eurocentric, middle-class domain. Expanding the profession's focus to include social justice allows the profession to challenge and interrogate traditional practices in the face of inequity. Such questioning provides a platform for rethinking, reconceptualize and reimagining clinical practice, education and research in SLP.

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