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DECOLONIZING HEALTH PROFESSIONALS' EDUCATION:

Audiology & Speech Therapy in South Africa

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ABSTRACT

We argue that there is an urgent need to transform how we educate health professionals in South Africa. We focus on Audiology and Speech-Language Therapy, which are health professions that manage people with communication disorders and swallowing difficulties. Our argument for a radical shift in higher education practice is linked directly to an untenable failure of care for the majority population. This failure is deeply rooted in the joint forces of imperialism, colonialism and apartheid which reflexively shaped these health professions' curriculum of practice, viz.: its science, education, policies and clinical practices. The key consequence of this historical precedence is a vastly inequitable practice that has not served the interests of the majority Black African population in South Africa. We refer to three key concepts, viz.: essentialism, reductionism and dis-othering to explain how the professions' curriculum of practice is inextricably intertwined with the colonial empire and its project of domination.

As part of regenerating practices, which are relevant for our people and context, we examine one avenue for change: our graduate education. We argue that only through strong political (re) conscientising in educational processes will *we* find new ways of being health professionals who take ownership of developing practices relevant to Africa. To this end we offer suggestions for how we might educate in a way that works to decolonise health services in South Africa.

INTRODUCTION: THE PROBLEM WITH COLONISED PRACTICES

Rhodes has fallen. On 9th April 2015, the statue of colonialist Cecil John Rhodes was removed from the University of Cape Town, following a month-long of student protest action. In an Al Jazeera News interview (The Stream, 2015), Associate Professor Elewani Ramugondo, ex-Head of Occupational Therapy, University of Cape Town, and part of TransformUCT poignantly noted that this effort was not only about the statue, the symbol of colonial oppression, but that it was also about higher education curricular and about how research is positioned. Ramugundo, along with Harsha Kathard (co-author) constitute a small group of Black academics at UCT. They began challenging issues like why there are so few Black academics at UCT (especially professorships) and what this means for an African University. Importantly, they re-energised the dialogue about how educators may engage being Black, being African in a post-colonial state.

The professions of Audiology and Speech-Language Therapy (abbreviated here as Speech Therapy, also known as Speech-Language Pathology) sit alongside what some refer to as allied health or rehabilitation professions, like Physiotherapy and Occupational Therapy, and 'below' medicine as health care professions. Typically, these professions work with individuals

having communication and swallowing disorders together with their families and communities. Now, while these professions are mainly practiced separately, Audiology and Speech Therapy (henceforth, 'the professions') have similar historical trajectories being created in Europe and America during the late 1800s, established in the early 1900s, and imported to South Africa during the colonial, apartheid era.[1] The combined effect of imperialism, colonialism and apartheid meant that the professions were practiced in ways that best served white South Africans, while struggling to serve the majority of Black South Africans.

While the professions operate in and contribute to an inequitable, racialised world;[2] talking about race, power, oppression, equity, colonisation and dominance are not an easy or common part of these professions' discourse.[3] However, the racial, language and cultural profile of our services' beneficiaries bear testimony of our professions as products of a long history of slavery, colonisation and corporate capitalism. Apartheid (and post-1994) South Africa is a microcosm of the global state for how our professions serve urban/rural, citizen/migrant, North/South, indigenous/diasporic populations. It is a truism that the biggest beneficiaries of our services, globally, are those who are of or ascribe to the minority world's cultural capital – typically middle-class, usually white populations who speak a dominant world language like English. Hence in South Africa this translates to the marginalisation of the majority of people who are Black, African and poor.

We must therefore ask the following pertinent questions that enable us engage critically with the limitations of our debilitating colonial and discriminatory past: How do professions,

[1] Pillay, Kathard & Samuel 1997: 110.
[2] Pillay 2003: 293.
[3] Kathard & Pillay 2013: 84.

whose interests are in health care and well-being, mainly serve the interests of a minority? What is it about our science, our practice and our education that allows for us to be complicit in creating inequities and in reproducing its effects over generations? Hence, in considering how we serve the world's underserved, we have to explicitly position what we know and understand. In this regard, we must question whose interests our professions' skills and theories have best served. Here, along with others,[4] we have repeatedly argued that what we know and do further exacerbate the marginalization of certain populations in the world's cultural capitals.[5] This maligning may be true too for indigenous majority world languages and cultures in various countries in South America, Asia and Africa where practices are entrenched with imported beliefs and practices about. These professions continue their imperial history with, e. g., the current importation of mainly minority world citizens (in paid/voluntary positions) to majority world countries. So, professionals - usually white and middle class, mainly women - may visit or relocate care to sites in Africa (namely, Tanzania, Ghana, South Africa), Asia (Cambodia, Vietnam) and in other regions of the world.[6] Some operate within organised structures such as religious or independent professional organisations from countries like Australia, England and the United States of America.[7]

Apartheid defined and deepened ethnicities similar to how xenophobia, racism, tribalism and religious feudalism operates in Australasia, Europe, North America and other parts of Africa.

[4] For example, Taylor 1986 and Battle 2011.

[5] Pillay, Kathard & Samuel 1997: 113; Pillay 1998: 89, Pillay 2003 & Pillay 2013: 79.

[6] For example see Goulios & Patuzzi: 2008; Wylie, McAlister, Davidson & Marshall 2013, Laperle, Marchese, Smith & McPherson 2010.

[7] See Bell 2013 and Wylie *et al.* 2013.

Mediated by race, this process resulted in the development of hierarchically organized cultural identities, leaving us with 'culture' as a dichotomized experience of 'us' and 'them.' Our own discovery of the injustices began in our own university classrooms when we felt that the form of professional practice being taught was at odds with our lived experiences. Despite this sense of injustice, we were also grateful for the new learnings about pathologies which affected the ways in which people communicate. So eventually our personal knowledge became eroded and replaced by a knowledge made in a foreign land, and was the main way we knew how to practice as a profession in SA. Eventually, we left ourselves outside the doors of our classrooms as we were fed a diet of colonial professional knowledge. However, with the political transformation in SA in the 1990s we were soon re-conscientised about the longstanding influences colonisation and Apartheid which produced a highly inequitable society. This understanding helped us to be self-critical so as to challenge our knowledge, our knowledge production processes and our clinical and educational practices.[8] In order to share our vision of transformation, we attempted to publish our work in mainstream professional journals. Unfortunately, our mainstream journals either rejected or could not always accommodate our kind of articles on 'professional education' or 'transformation' both at local and international levels. Indeed, this situation has not changed much. Our attempts at transformation have made us realize that our situation is created by decades of influence and therefore resistance to change by hegemonic, Western, and largely colonial imperatives. Yet, our own context of change in SA demands rapid transformation: How then do we respond?

[8] Pillay, Kathard & Samuel 1997: 109; Pillay 2003: 293.

As part of our mission to address what we see as professional injustices in our home country, South Africa, and in our world, we have positioned ourselves within a postcolonial framework. Van Zyl (1998, in Hook 2004: 88) offered a South African perspective on post-colonialism as:

> . . . a critical perspective which aims to understand relationships of dominance and/or resistance when one culture (typically Western) owns or controls other cultures (Eastern, African) even after the era of formalised colonialism had ended.

Colonialism has been further explained as a violent practice of dispossessing people while imperialism is a broader ideological thinking which justifies the practice of colonization.[9] Although colonial rule might have ended, the imperial dominance lives on to maintain the *status quo*. In South Africa, we had the further layer of apartheid as a colonial practice: an internal colonisation-dominance of white people, mainly of Dutch, German, British, Portuguese and other European descent, over indigenous Black people. Ndlovu-Gatsheni (2013: 332) has led us to understand that while we are beyond a colonial administration we are not beyond coloniality. Coloniality refers to entrenched patterns of power and influence which have been infused into all aspects of our everyday lives.[10] We therefore find ourselves in a global colonial space in which we struggle with ourselves as colonial subjects. Ndlovu-Gatsheni (2013: 334) has reminded us that Africans through the ages, especially since the 1400s, have been systematically relegated to the most powerless position described as an enforced

[9] Said 1978 in Hook 2004.
[10] Maldonado-Torres 2007: 243.

subalternity.[11] This position begs the question not just for colonised peoples, but for 'Other' neo-colonial subjects like international migrant worker populations.[12] Can the subaltern speak?

The grander colonial narrative created barriers between people, places and things. For example, in South Africa the 'Bantustans' were created as part of a colonial project to separate and antagonise Black and white and to develop inequities. Colonial narratives privileged settlers' voices, which usually refers to middle-class, white, mainly European/British male perspectives. This minimized others' voices such as the poor, Black African, women, Gay/Lesbian and disabled people. So, the same inequities that resulted in the creation of the patient as Other/separate from the practitioner have also resulted in creating distance between races, genders, sexualities, abilities and so on. In clinical education, we were taught to draw up a patient contracts to negotiate attendance and participation in therapy. Sitting in the classroom we thought that this was a good idea. However, putting it into practice was challenging. For example, we remember a patient, a member of our community, being bothered by this contract: 'Don't you trust me?' she asked. Ordinarily, in an everyday interaction with this person, we would not have 'contracted' in such a fashion. The idea of contracting care, did not fit! Trust was usually established in other ways. So the importation of this practice inserted a stranger-hood: a distancing between people. This practice led to a failure of care for the population at large as the dominance of a foreign culture prevailed as if it were universal. Fanon, in speaking specifically to the dilemma of Black people, argued that the power of the universalising discourse was that Black people thought they

[11] Ndlovu-Gatsheni 2013: 334.
[12] Pillay 2013: 79.

had to mimic white people, creating a double consciousness deep in their psyche.[13] In effect it distanced people away from themselves as they were forced to take up the identity and behaviours of a powerful white man. This problem of an 'alienated consciousness' was considered as violence against colonised people because they were dehumanised in the process. This alienation Fanon describes as a social rupture or estrangement in relationship between people and their environments threatening the core of humanness.[14]

TROUBLING OUR PRACTICES

We have previously argued that our beloved empirical science and empire (colonialism) are interconnected.[15] Colonialism and European imperialism, including Britain's colonisation of much of the world over hundreds of years, are interrelated to our professional processes of dis-othering, essentialism, and reductionism. We explain how these processes, which fundamentally underpin our practices, have created a problematic practice exacerbated through implementation in an apartheid and post-colonial context.

Dis-Othering: Spivak's (1988: 272) notion of 'othering' refers to the seizure and control of the means of interpretation and communication resulting in lives that are re-produced as *different* (e. g. us/them, black/white, poor/rich). Dis-othering is a term we coined and used to describe how our others' experiences are rendered lesser than or invisible to, for example, practitioners' experiences of communication.[16] 'Dis' refers to creating the person with a communication DISorder as other. This dis-othering is

[13] Fanon 1952: 103.
[14] Fanon 1952: 24.
[15] Pillay 2001: 299.
[16] Pillay 2001: 357; Kathard, Pillay, Samuel & Reddy 2004: 4.

achieved when, as professionals, we highlight essential characteristics of a patient's or client's disorder, usually in binary opposition to existing theories of normal communication. Etymologically, the Latin use of *dis* (or de) which refers to "away from" is perhaps connected this process of dis-othering. These professional theories represent knowledges rooted in what is defined as normal relative to the social, economic, political, and historical truths of our cultural capital, viz.: the white race, European heritage, Indo-European languages and so forth. Our professions tend to describe what is wrong with the client by referring to *these* notions of normal. Without this process of 'Dis-Othering,' our authority as communication practitioners - interested in disorder - cannot be authenticated.

Also, given our historical development and alignment with the medical and biological sciences, we engage people within a medical gaze,[17] relying on the use of biological referents such as speech articulators, hearing and swallowing mechanisms. Similarly, during Empire, the concept of difference was verified relative to biological referents such as size and shape of noses and buttocks or hair types. Such differences, during colonialism (and beyond), were used to highlight differences between people, between coloniser and colonised. We believe the notion of difference (or disorder) has developed into its present status, richly imbued with such biological meanings, via intimate association with colonialism. Within our professions, the biological metaphor has been used to develop useful boundaries that assist our characterising of, for example, the person who stutters or the person with aphasia.

Indeed, our science was raised and revered alongside the rise of Empire. Treasured, racist anthropological research paradigms, like traditional ethnographic research, still in re-

[17] Foucault 1976: 14.

invented forms perhaps, dominate social science's understandings of the other. Additionally, it may be stated that empiricism is a form of colonial expression, that empirical practices are microcosmic examples of paradigmatic colonial thinking. At the ideological level, what may unite empire and empiricism is the need to establish power, to dominate the lives of people. As the goal of colonialism was to dominate colonised subjects (others), so may it be that practitioners dominate the lives of its dis-othered peoples. Of course, our version of empiricism may be contested,

Essentialism: Betwixt and between dis-othering, the practitioner engages the process of essentialism, a concept that refers to defining a thing's true, fixed essence. Via essentialism, we have developed definitions and classifications of speech, hearing and swallowing disorders, posited stages of development for discrete ages, and established normative criteria for each linguistic, auditory deglutition particle presented by the client. Essentialism has assisted in the production of knowledges and statements about clients such as 'Deaf speech', 'normal auditory processing', 'the aspiration-risk neurogenic dysphagic'and 'the Hispanic aphasic' - amongst a plethora of essentialised notions. Can practitioners grasp the essence of any person? Can people essentialise themselves, a form of what Spivak called 'strategic essentialism?'[18] Whether performed by the practitioner and/or the person with a disability, essentialism creates dualisms that maintain the practitioner as the powerful expert and her Other as the sick, agentless person needy of her intervention.

Reductionism: Our understanding of the tiniest level of damaged cochlear hair cells, the precise movements of the pharynx for

[18] Spivak 1999.

swallowing to the grandest notion about social communication in autism is based on reductionism. Dunbar (1995: 117) refers reductionism to modularisation, defined as when '…complex phenomena are partitioned into smaller segments that are then dealt with piecemeal' (117). Furthermore, Fleck (1935: 20) has posited that science reduces the complexities of cultural influences, and colonialism is one such cultural influence, to produce scientific facts. In these ways we use reductionism to represent whole lives as minutiae. Of course, there is value in our modular scientific approach. We have learned much about communication systems, audition, and swallowing. But: Is this is a useful approach to practice with people who have disabilities? And where does this leave us in our understanding of cross-cultural practice? We lose track of the lives of people with disabilities – their unique and shared experiences as men/women, homosexual/heterosexual, black/white, poor/rich. We overlook their participation in fertile and complex communication experiences. For example, in audiology, value is placed on a reductionist understanding of a person's ability to listen to pure tones, short bursts of frequency, and intensity-specific stimuli that do not occur in the natural acoustic environment of humans. These reduced data are then re-conglomerated to provide an understanding of the whole person's hearing ability.

Reductionism, essentialism and dis-othering are constituent features of individualised, personal, one-to-one health care, a care that occurs alongside gross service inequities. Such inequities have been and continue to be shared by other Majority world countries such as our sister nations in the BRICS (Brazil, Russia, India, China, South Africa) grouping which represent almost half the world's population. Our dominant model of personal, individualised services is wrong if it does not get to people living in Sao Paolo's favelas, Bombay's slums, Beijing's underground cities,

and Khayelitsha's shanty towns, or to those surviving on Rosstat's minimum consumer shopping baskets. It is in these spaces that most of the world's one billion people with disabilities go about their lives.

While useful, reductionism, essentialism and dis-othering are exemplars of the heuristics that critical theories allow us to engage our professional discourse, that which remains largely unchallenged, mainstreamed and very much the *status quo*. We have found frameworks like Guba & Lincoln's (1994: 105-117) interrogative framework for engaging knowledge production useful to identify the dominant epistemological, ontological and methodological bases of our professions. What we acknowledge will be a challenge is how our professional core will respond given that we are soaked in the interests of a dominant majority, who have essentially been educated to best serve a white, middle-class, colonially-rooted world.

WHY CONSIDER PROFESSIONAL DECOLONISATION, NOW?

An analysis of the World Report on Disability (WRD) 2011 showed a gross under-representation of people with communication (including hearing) and swallowing disabilities among the world's one billion people with disabilities.[19] Our analysis added to Wiley's commentary by highlighting that it is not just on impairment or disability that we need to focus, but that our lens should include a focus on people whose communication and/or nutrition (due to swallowing/feeding disorders) is made vulnerable because of social disadvantage.[20] People with impairment together with social disadvantage are who we refer to as the underserved. The point we are making here is that this

[19] World Health Organisation/World Bank 2011: 1-325. See also Wiley *et al* 2013: 1-13.

[20] Kathard & Pillay 2013: 84-89.

population is large, in excess of a billion people – several million of whose needs our professions may never meet using only the current individualised, personal health-care service models. Of course, we also believe that over-focussing on the individualised health care model in itself needs transformation regarding reductionism, essentialism and dis-othering. However, the key point being made here is that the most vulnerable and poorest populations will not be served. To address service inequities we reinforce the professions' shift toward population-based interventions which are significantly different to what we do currently in practice.[21] So, in order to shift toward serving populations, there must be a fundamental shift in professional education, which we view as a significant driver of change. As we shift education, we believe that this opportunity to transform what we do must be driven not just by innovation but must be framed as a de-colonial response – one for Others to consider too. W*e use* South Africa (SA) as a case example to share our ideas on professional education innovation because we consider it to be a social, economic and political microcosm of the world.

As we espouse dissatisfaction with our current service to the several million people with communication/swallowing disorders in the world, we ask: Is our dominant scientific and practice base a good one to take with us as we move to transform an inequitable world? We argue that practice should be relevant to the context and that as Africans we must find our ways of addressing injustices which allow an inclusive population-focused approach. We are aware that there are two processes needed to undo the historical forces: deimperialisation and decolonisation. Ndlovu-Gatsheni (2013: 331-353) argued that for progress to occur in Africa the processes of deimperialisation and de-

[21] Kathard & Pillay 2013: 89.

colonisation must work together dialectically to allow for reconciliation between the coloniser and colonised in the interests of global democracy.

If decolonisation is mainly active work carried out on the terrain of the colonised, then deimperialisation, which is no less painful and reflexive, is work that must be performed by the coloniser first, and then on the coloniser's relation with its former colonies. The task is for the colonising or imperialising population to examine the conduct, motives, desires, and consequences of the imperialist history that has formed its own subjectivity. The two movements – decolonisation and deimperialisation – intersect and interact, though very unevenly. To put it simply, deimperialisation is a more encompassing category and a powerful tool with which we can critically examine the larger historical impact of imperialism. There can be no compromises in these exercises, if the world is to move ahead peacefully.[22] In this way, the burden of transformation, effective and meaningful transformation, is not left to the Third World,[23] but is part of a collaborative project of neo-colonisers and the colonised too. Therefore, in this paper we consider mainly the processes of decolonisation. We offer this perspective to our neo-colonisers, professionals from countries like Australia, Britain, Canada, the United States of America and those in Europe with the full acknowledgement that transformation is only possible when the imperial forces of the West recognise their role in being complicit in global domination. Only then, as part of this global project of professional transformation, may we begin to question that which we describe as professional competencies/competences, what we accept as valuable research – both in terms of what we focus in research and

[22] Chen 2010: 4.
[23] Morosini 1980: 67.

how we produce knowledge and the kinds of practices we regard as reflective of professional gold standards and the like.

POSITIONING PROFESSIONAL EDUCATIONAL INNOVATION AS A DECOLONIAL ACTIVITY

There are three domains of activity in Figure 1 that represent what we do as professionals: clinical practice, research, advocacy and pedagogy. 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). These elements interlink and influence each other. Innovation in these three elements does not occur in isolation and in this paper we focus on professional education as leverage for change.

Figure 1: Professional domains of practice – the Curriculum of Practice (adapted from Pillay, Kathard & Samuel 1997: 110).

Hessels & van Lente (2008: 740-760) reinforced the importance of Mode 1 and Mode 2 knowledge for higher education. These modes are contrasted in Table 1. While education draws from both these modes of knowledge, our argument is that we must have Mode 2 knowledge for innovation to occur.

Table 1: Attributes of Mode 1 and Mode 2 knowledge production (adapted from Hessels & van Lente, 2008: 740-760)

Mode 1	**Mode 2**
Academic context	Context of application
Disciplinary	Transdisciplinary
Homogeneity	Heterogeneity
Autonomy	Reflexivity/social accountability
Traditional quality control (peer review)	Novel quality control

To clarify this extension to and emphasis on Mode 2 knowledge, we need to make explicit the underlying educational bases inherent between these modes. Habermas' (1971: viii-356) knowledge-constitutive interests differentiate between educational bases via three knowledge interests, viz.: the (1) technical, (2) hermeneutic and (3) critical-emancipatory interests. Technical interests lead to 'factual' knowledge transmitted from educator, leading to mainly passive learning, with the replication of knowledge as a key goal. Conversely, a hermeneutic interest leads to co-constructed knowledge where joint meaning-making occurs between educator and learner. Here, learners are developed to maintain the *status quo* of what is regarded, for example, as

acceptable practice. However, being meritocratic, this interest does not necessarily challenge the status quo.[24] Therefore, the critical-emancipatory interest is about purposely recognising social injustices and aligns with Mode 2 knowledge, which offers a viable route that may lead to professional education for innovation. This emancipatory interest:

> . . . goes beyond the technical interest of controlling objects in the environment and the practical interest of fostering intersubjective understanding. The emancipatory interest is concerned with a form of knowledge which leads to freedom from dominant forces and distorted communication (Kincheloe 1991: 70).

We agree with Giroux (2013) to make this transition to innovation, universities must resist the de-politicisation of the curriculum and 'ethical tranquillisation.'[25] The University, where audiologists and speech-language therapists are usually educated, may become a space for passionate learning and for the vocal citizen. In a neoliberal world in which a capitalist, market-driven mentality operates, the value of the public intellectual (interested in social good) is threatened.

The consequences of neoliberal education are that it will eradicate 'radical imagination' to dream the impossible which is needed for creating an equitable society. Said (2000*:* 7) criticised higher education for being reckless and disorganised and argued for pedagogy of wakefulness – where complex ideas are taken to public spaces – suggesting that we must engage learning in a public

[24] Kathard, Pillay & Samuel 1997: 110.

[25] Bauman 2006*:* 86; http://www.truth-out.org)

domain where the issues of ethical, social, historical practices are central to learning. Resonating with bell hooks' (1989: 105) ideal that the personal is the political, educators, like those in our professions, must therefore be brave enough to make the link between the public and private aspects of societies' problems. Indeed, a similar argument was made by Taylor (1986: xii-309) at an American Speech & Hearing Association conference in the late 1960's.

However, the notion that political issues, at the time of the Vietnam War and civil unrest in America, should concern the professions was rejected by a colleague, Jon Michel and followers,[26] and seems to have been adopted and infused with specific reference to understanding practice relative to cultural and linguistic diversity. Therefore, in re-harnessing the sentiment of Taylor's original argument we contend that the professions assume a decolonial stance in professional education. A decolonial stance may reduce the distance not just between the patient and the practitioner but also between teacher and learner, creating a humanising culture of practice. This is because colonial professional education is premised on the belief that replication of knowledge through transmission is a valuable thing. We disagree because replication does not allow for innovation as it leads to a decontextualized practice which privileges an external 'standard' which may result in a 'trained incapacity' of professionals to respond to local contexts.[27] Our education process which is blind to issues of racism, inequity and the like, therefore reinforces our colonisation and our ivory tower image and can be regarded as constituting mandated ignorance.[28] In this way higher education

[26] Taylor 1986: 2.
[27] Geiger 2001*:* 1699.
[28] Brydon & Dvorak 2012*:* viii-321.

also participates actively in the creating, maintaining and transmitting inequities.

WHAT WILL EDUCATION FOR INNOVATION LOOK LIKE?

In the late 1960s, Steve Biko foregrounded Black Consciousness at a time in South Africa when Black lives were significantly devalued.[29] Implicated in the concept of Black Consciousness is Black Pride. Similar to other forms of identity reclamation projects is the intention to recover Black African-ness without thinking it is bad to be Black. Just as this was response to racism and colonisation, so too do we need to respond to colonial professional education by developing and valuing our own (local) ways of doing professional practice, research, and education. As we offer our alternative to current forms of professional education, we are fully aware of the theoretical and practical issues that this raises. For example, theoretically we understand that while we promote a decolonised curricular, this re-imagined curricular may merely end up being another form or orthodoxy, continuing the same kind of colonial trajectory that we wish to abrogate. While this is an outcome to monitor closely – and guard against - we believe that critical-emancipatory ways of knowing, that which we promote as a decolonised education is epistemologically different, it will generate cognitive freedoms, innovations and creativity – away from traditional, empirically-oriented and/or technically-oriented, content drive knowledge processes. This implies a redefinition of what is meant by quality in this form of a decolonised curricular. Both the setting of educational standards and the measurement of how our professions practice, monitor and evaluate quality in higher education is of vital importance. As what we are promoting is a succession to current, dominant forms

[29] Biko 1968: 106.

of knowing, we anticipate that the gatekeepers – academics, researchers, policy-makers and other professional powerbrokers will, as part of the inherently destabilizing process of transformation, respond by contesting and resisting decolonized forms of knowing and ways of being in the profession. We will have to develop ways to manage this resistance and hope that the Curriculum of Practice will for a framework to manage policy, education, research and practice.

In the next section we present ideas for professional education innovations. In essence, educators themselves have to believe in the goal of greater social good and should be public intellectuals who have interest in improving the social condition.

> We have set out on a quest for true humanity, and somewhere in the distant horizon we can see the glittering prize. Let us march forth with courage and determination, drawing strength from our common plight and our brotherhood. In time we shall be in a position to bestow upon South Africa the greatest gift possible - a more human face. (Biko cited in Stubbs: 1968: 106)

Biko's reference to a human face is central to our proposals for professional education innovations. We propose that professional education humanises the process along with the people in it. To enable this humanising process, we highlight three key enablers. These include:

- Enabler one: The Public Intellectual (educator)
- Enabler two: Dialogic Learning (student engagement)
- Enabler three: Context Facilitated learning (curricula)

Enabler One: The Public Intellectual

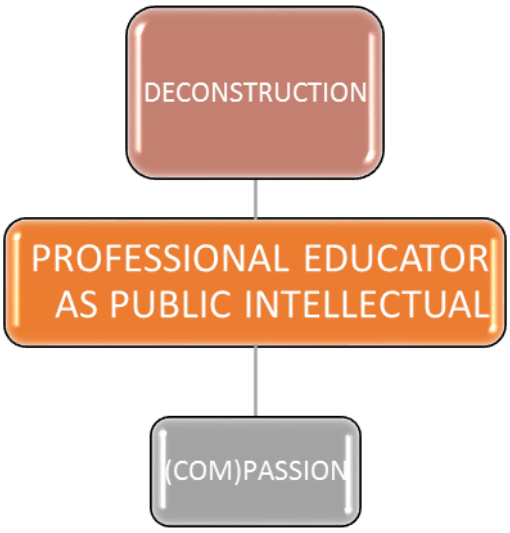

Figure 2: *Deconstruction and (Com)passion in education*

The educational process for innovation requires deconstruction of the dominant knowledge and texts that we use with students and ask: How will this knowledge serve population needs and the inherent inequities? In their role as this type of public intellectual, the educator and learners engage deconstruction to evaluate issues/phenomena, revealing underlying values and beliefs about the dominant content being taught, where it comes from, and why it is maintained even when irrelevant. For example, when we study communication models we often use the metaphor of information processing (receiver-sender-central processing) to explain receptive/expressive communication. Of late, 'culture' has been included as part of the way in which communication must be understood. So while we link our practice to references like Arabic to Zulu cultures, we rarely foreground political relations. Power,

and how it is used by people, is not what is taught via traditional, e. g., Euro-American speech pathology/audiology curricula.[30] Deconstruction can be a destabilizing experience such as that which occurred after the fall of the Berlin wall, the collapse of Apartheid and the reformation of South Korea. So while deconstruction is valuable for making peoples' issues visible, highlighting inequities and revealing the scale of challenges when dealing with large population; it also reveals what we do not know and is likely to invoke controversy. This can be scary and is therefore likely to evoke a range of emotions, particularly that of fear.[31] Said (2000: 7) recognised that a pedagogy of wakefulness implied recognition of human injury inside and outside the academy. While theory (in our case, postcolonial, decolonisation) may be used to change the situation, in doing so we must focus the emotional components of professional education like 'fear' and 'confidence' for a humanising educational experience. If we replicate the fear-teaching practice at a population level, where educators will equip learners to see the social inequities around them – it is important to focus on not paralysing practitioners into being so fearful that they cannot see themselves as ably practicing with people, for instance, the education process should enable a 'practice of potential.' Fear associated with change or transformation, as we have learned from our experience of transition to a post-apartheid society, will always be real. However, our willingness to overcome and work with them in the interests of greater good is paramount. For example, we noted that our students are always a fearful when expected to run services in communities that are unfamiliar to them and where violence and drug abuse is rife. In Khayelitsha, a partially informal township in

[30] Pillay, Kathard & Samuel 1997.
[31] Brydon & Dvorak 2012: viii-321.

the Western Cape, while safety measures are in place, it is through dealing with their fears that students transition to a new practice. So for Khayelitsha, learners interested in populations and poverty means venturing out and being quite literally in a different space, sometimes without signposts on roads, yet with help available at every corner from people who guide and direct. This results in a real, more humanising – less fearful – experience which can only occur through doing. Exposure to a variety of contexts in the diverse ways in which people live earn and learn is a critical competency.

What are some of the things to fear at a population level? Race, language – even poverty – may be presented as overwhelming, challenging, impossible, lacking systems, filled with entrenched real barriers, language, resource constraints, and workforce limitations, etc. For example, Beecham (2002*:* 10) in South Africa documented the linguistic, cultural, social, and even emotional alienation felt when an imported, colonial professional curriculum was taught to Black Africans. So while we may facilitate learners 'seeing' all of these things when we engage the curriculum, we must recognise that we have people who learn, who fear. This emotional aspect of learning must be accounted for as we move toward working with populations.

We argue that fear associated with population-based interventions must be harnessed, and translated into compassion. Compassion is a term we have adapted to represent what professional educators facilitate when they emphasise valuing internal, external and communal resources to innovate practice with populations. By communal resources, we focus on how learning, related to 'work,' 'labour' or 'practice-based,' is a shared activity.[32] For us, this means harnessing fear and uncertainty into

[32] Pillay 2013*:* 84.

positive action – implying that what we know (our historical, colonial certainties) can be negotiated with what we do not know; our uncertainties.[33] This aligns with the ideology that social problems are socially resolved and therefore students see themselves as actors in this process. To do this, educators and teachers must be role models and that they must teach by example that 'the struggle itself is the great teacher.'[34] As such, the educator as the 'public intellectual' is part of this positioning within a critical pedagogy. Such pedagogy necessitates that we must see how the systems at play create the problems and insert our roles into the process, which may be described as 'autocritique.'[35] Autocritique facilitates the creation of new forms of agency through processes which allow for decolonising the mind, where learners bring themselves into the learning in contrast to leaving themselves, their knowledge 'outside' of what is regarded as professional knowledge. At its heart is a process of difficult engagement between teachers and learners to create a better society. Spivak explained that reading the world as text becomes a critical skill so we can become 'well-grounded' rather than 'well-rounded.'[36] The grounded-ness will help us to understand the local in the context of the global, that is, we develop transnational literacy. It is through these processes that the teacher is able develop an itinerary of agency in complicity.[37] Therefore, in line with mode two knowledges, professional competencies that focus innovation within a decolonising educational programme will be that learners become knowledgeable and skilled in the use of deconstruction, in self-awareness and with an ability to engage populations,

[33] Chetty 2001.
[34] Holst 2009: 149.
[35] Spivak 1999.
[36] Mowitt 1997*:* 48-64.
[37] Sanders. 2002.

ENABLER TWO: DIALOGIC LEARNING

Dialogic interaction focuses the value of active learning through the next major competency of engagement. This is a collective engagement and must involve the collective community of, for example, a class of learners. The goal is the development of new meaning. Critical questioning is key to the process which emphasises that all interlocutors ask critical questions. It is also about bringing the outside, inside where participants admit their lives into these learning spaces.[38] Traditionally, the educator's knowledge is valued above learners. Here, however, dialogic learning values the collective expertise, the inter-subjective nature of how knowledge is produced. This valuing of collective expertise/knowledge is critical to the development of new meaning especially when innovation and generativity is the goal.

So when we cannot stick to what we know because what we know is irrelevant, then dialogic learning becomes an incredibly useful process to address uncertainties. In our experience, we have found that dialogic learning is useful to challenge professional pedagogy as well as an innovation as tools for community engagement.

Professionals trained through dialogic models value collective participation which students can transfer into their practices – i.e. engaging meaningfully with communities. Each classroom and each conversation will be different. Therefore unique responses within each partnership is critical as there is no set formula to do this. At the heart of the dialogue is the ability to use especially critical questioning. Such questioning will generate the difficult and conflicted conversations through which new meanings are emergent. Brydon & Dvorak (2012*:* viii-321) value

[38] Bakhtin 2007.

'cross talk' as a strategy in postcolonial classrooms. Cross-talk occurs when the ideological conflicts come into play and the discussion allows the multiplicity of voices to debate and contest. This rule-breaking conversation allows a democratising of the classrooms and allows a sense of belonging of different voices to add their mastery to the topic. However, the value for innovation must also be translated into assessment practices. When dialogic learning is reinforced through assessments then it is imperative that students are aware that they can innovate and therefore will not be held to a single correct answer or a single solution.

Humanising the educational process is valued by critical intellectuals, such as Giroux (2013) and Said (2000*:* 7) amongst others, who have argued for objective, external conditions for change, and simultaneous subjective conditions for change. People create the conditions for change through deep personal changes. We emphasise that this change is actually a moral, ethical competence where the act of professional education is seeing as a moral occasion, *where* it will be immoral not to engage the 'subject' (learners) as active agents in their own learning. Moralism would occur within pragmatic and paradigmatic constraints and is acknowledged as a relational form of educational practice. Moralism is intertwined with our humanity and it is only when this need is recognised deeply and subjectively can the freedom to do differently be realised. Mandela (1995) has argued that foregrounding humanism, especially what is meant by *Ubuntu*, overcomes individualism - the idea of the person alone. Therefore, in the interest of the collective, what we are together and dialogue is a critical process in democratising and humanising professional education. This is a fundamental shift in our professional knowledge production processes.

ENABLER THREE: CONTEXT-FACILITATED LEARNING

Professional educators value clinical learning outside of the academic institution in places like hospitals and schools. To extend critical academic institution-based learning experiences, it is important to relocate learning for innovation. What does this mean? We emphasise that learning be responsive to the context and not just 'occur' on site. For example, when one of our recently graduated clinicians was faced with developing a population innovation in education/school, she initially struggled with listening and responding to what teachers needed. They articulated their need around extending communication of multilingual learners in the classroom. Instead, she chose to design and implement teacher workshops about voice and fluency. So, in focussing on what she knew – 'disorders' – the learner could only replicate a clinical type of practice. Therefore, she was unresponsive to the context. This is what requires changing. So, educators must educate learners to operate by facilitating contextual learning – and this is what may be considered as the decolonial curriculum, in and of itself. Importantly, longitudinal engagement with populations is important to create a sense of belonging (autochthony) so that one can 'hear' populations' needs. Therefore, our educational programmes have to account for how this reduction of distance may be experienced or facilitated via professional educational curricula. This is a challenge because traditional curricula modularise tightly and allow for little, disrupted, and often disconnected relationships with populations. We need to programme time and relationships with people to reduce distances.

Context-facilitated learning demands a critical, social, historical, and political reading of the situation. Then innovations and possibilities may occur in different ways, such as policy

change, management negotiations – strategies that are not traditionally taught in audiology/speech pathology curricula. If the context demands that we move beyond the local level, beyond the individual and the biological, then we have to train audiology/speech pathology learners to claim this innovation as central to their jobs and to develop knowledge and skills at the environmental, systemic level. So professional educational innovations should look dissimilar to what we do; this is not just an acceptable educational goal – it is what is relevant and necessary.

A decolonising response requires that professional educators deeply interrogate local and global contexts as if they were one and the same. For us, for now, we are focussed on the project of a democracy emerging from recent histories of colonisation. Therefore, the notion of what it means to be a competent audiologist/speech therapist interacts intimately with how we may produce ourselves as citizens of the world. Fundamental identities economically developed contexts, may interact in interesting ways with how we position ourselves to our clientele, to each other and to how we facilitate our learning. The result may be a perpetuation of traditional power relations at macro levels across geo-political spaces from North to South while pursuing micro-level changes within intimate patient/client-practitioner relationships. So, as we choose to move toward educating speech pathology/audiology practitioners about caring within democratising frames, we have also to simultaneously shift power relations at a transnational, professional relationship level, without which we risk the innovative development of our global professional educational programmes.

In summary, the following key knowledges and competencies as connected to mode two learning are suggested for professional

learners who, within a decolonising educational programme, may become transformative practitioners:

- knowledge of equity and competence in being equitable
- population literacy, of national and transnational population demographics
- Political reasoning
- Innovation (and the ability to create the new)
- Deconstruction (to resist replication and dominance)
- Personal/self-awareness – to manage our personal fears, anxieties, and power
- Engagement, especially at population level, as a core skill
- Context facilitated

SUMMARY AND CONCLUSION

The argument we have made about responding to professional education, decolonial framework, post-colonial stance is premised on three core ideologies: Firstly, we promote the notion that certainty and uncertainty can be re-negotiated. We also believe that, at this point in our professional development, curricula will be underpinned by uncertainty. Secondly, notions like context sensitive learning is about moralism in an educational process. As an ethical event, moralism is our sense of good and bad as we think about innovation.[39] Thirdly, innovations should be jointly determined and their consequences ought to be shared. Therefore, educational programmes need to, for example, not just teach communal innovations but also assess the individual's role in the innovation.

[39] Pillay 2009: http://l09.cgpublisher.com.

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